Ageing Well OGIM - 2021

Why change is needed

People are now living far longer, but extra years of life are not always spent in good health. They are more likely to live with multiple long-term conditions, or live into old age with frailty or dementia, so that on average older men now spend 2.4 years and women spend three years with ‘substantial’ care needs. To ensure older people are able to live happy, healthy and connected lives and are upright at home for as long as possible. To support the Ageing Well agenda so people are able to equitably access high quality, consistent levels of service we need to take a preventative population approach to care, utilising early recognition and intervention with short-term support, and signposting in delivery models to ensure an enabling approach, positive individual outcomes with a focus on wellbeing and sustainable budgets.

Objectives

To work across all parts of the health and social care system to support care of the older person in order to:

- To promote initiatives designed to enable older people to remain active and access suitable housing, transport links, community connections, volunteering, and employment opportunities.
- Proactively identify those who are at risk of or who are living with frailty.
- Promote a personalised approach to anticipatory care planning including support paid care staff and unpaid carers.
- Promote preventative, short-term approaches and a progression approach to care delivery.
- Ensure appropriate services, signposting and VCS resources are available to service users and/ carers, with potential opportunities to co-produce such services explored.
- Achieve an invest to save solution to delivery, promoting reablement and independence and avoiding as far as possible costly long-term care.
- Changing culture to ensure that all involved in delivering care focus on maximising a personalised approach to wellbeing, independence and quality of life pertinent to the individual.

Goals

To keep people happy, healthy, upright and at home for as long as possible, with a focus on wellbeing. Where an admission to hospital is needed there is a personalised and focused approach to interventions, returning to their usual place of residence as soon as they are medically optimised to do so. Utilise the FrailtyICARE toolkit I-Care (frailtyicare.org.uk) as a framework for system delivery Consistent identification of those who would benefit from anticipatory care planning, focusing on a ‘what matters to me’ approach

For those in crisis a co-ordinated response is delivered to meet the persons needs at home where possible.

- To work with community assets to promote prevention and early intervention initiatives to reduce requirements for a crisis response.
- Short-term, preventative and rehab / reablement services are the first option for care delivery addressing physical and mental health needs. People are able to live at home / in the local community for as long as possible. VCS and provider markets are able to support this goal. Where long-term care is required, stakeholders retain a progression approach to ensure that service users are enabled to maintain independence and develop skills, rather than being ‘maintained’ in terms of care. This may include the development of further extra care housing in the County as a community alternative for those with medium and higher levels of need, and where demand supports need for this type of service.
- Technology / digital solutions, carer support and environmental factors including suitable housing are able to contribute effectively to this goal.
- Reablement and intermediate care / hospital discharge services continue to deliver high quality outcomes and sustain or where necessary increase (IC Beds) capacity across the Durham geographical footprint.
- Equipment advice and provision and adaptions are available to support reablement and sustainable outcomes, including the provision of community equipment in care homes in line with the agreed policy.
- Domiciliary care availability, coverage and quality is maintained and able to deliver a supportive approach through appropriate workforce development ensuring consistent staffing with appropriate skills and knowledge, with opportunities for career progression and flexibility. The County Durham Care Academy to continue to focus on this area of work.
- Day and outreach services are commissioned for all specialisms and function appropriate to the needs of the user groups
- Integration between adult social care and community health services delivers improvements in quality and outcomes for older people and their carers which in turn will deliver efficiencies. A Multidisciplinary Discharge Team coordinates the personalised approach for complex discharges reducing errors and improving patient and carer experience embracing shared decision making at all points of the pathway. Teams Around Patients and Locality Teams work closely together to ensure wholistic and seamless support for patients.
- There is a coordinated approach to the provision of training and support to care home and domiciliary care provider staff from the range of community health and Local Authority services that supports the quality of their care, with the County Durham Care Academy supporting this coordination of partner training.
- Older People with a learning disability and/or autism are supported to live safe and healthy lives in their community.
- Older People with a learning disability and/or autism are not subject to health inequalities.
- Have a positive impact on pre-frailty indicators through reducing social isolation and mental ill health.
- Enhance pathways to ensure that older people with co-existing mental and physical ill health can access evidence based care quickly.

COVID – 19

Short Term

- Ensure that critical services, including reablement and domiciliary care, are robust in terms of service delivery and able to function during the winter period and / or during an increase in COVID 19 cases. Contingency planning and system support in place, including continued focus by the County Durham Care Academy opportunities for people not in employment who may be willing to change career and work in care
- Work with patients, carers, families and HCP to recognise where post covid syndrome may be impacting on an older person and ensure appropriate interventions are available.
- Maintain close working relationships with provider to ensure a smooth and timely access to services.
- Work with system partners to address the social isolation and loneliness experienced by older people as a result of lockdown.

Medium Term

- Increased urgency to test new ways of working and, in particular, reablement approaches in wider services, given the need to improve outcomes but also increase the pace of invest to save initiatives, given funding pressures.
- Focus on wider system change such as improved discharge pathways and opportunities to bring forward initiatives at a time when increased partnership working with the voluntary and independent sector has become more prevalent due to the pandemic.
- Recognition that demand is higher as a consequence of Covid19 at least in the shorter term and that investment is likely to be required – not just invest to save approaches.
- Explore new digital solutions and technology enabled care opportunities to support service delivery and improve outcomes.

Long Term

- Recognition that services may change in the longer term, both in terms of strategic aims, desired outcomes and methods of service delivery, including a focus on the wider community assets as part of a population-based level approach.
- Increased focus on digital services and service delivery in post-pandemic environment and acknowledgement of increase in funding pressures and greater urgency to transform services.
- Careful monitoring of OGIM and associated action plans as live documents and ability to change focus to address emerging or changing pressures. Whilst digital and remote working can be used it is more difficult to really establish a benefit realisation of this.

Triple Aim Outcome Measures

Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
Falls - Patients aged 65 years and over with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months.	**Proportion of over 65s in care homes -** Long term support needs of 65+ met by admission to residential and nursing care including mental health provision.	**Vacancy rates in community nursing and therapy** Key health and care workforce vacancy rates across the Durham Care Partnership
Loneliness - The proportion of people [aged 65+ years] who use services who reported that they had as much social contact as they would like.	**Hospital Admissions -** Emergency hospital admission and readmission rates for patients aged 65 and over including MH admissions	**Morale in community services** - Morale rating for key health can care workforce across the Durham Care Partnership.
Depression - Proportion age 65+ who have frailty diagnosis with a diagnosis of depression on the GP Record.	**Long hospital stays -** Proportion of stranded patients in hospital (including MH hospitals): length of stay 7+ and 21+ days.	**GPs per capita -** Number of GPs per capita of population

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities						
Through a system-wide Ageing Well Strategy, reduce social isolation to prevent mental ill health and future frailty.						
Continued investment in VCS infrastructure and services to enable preventative approaches. Includes Public Health and mental health commissioning and interventions.						
Enhancing falls services to support falls prevention. Pilot new falls prevention approaches, potentially using extra care services initially						
Changes to commissioning models / specifications to ensure a focus on outcomes and wellbeing.						
Embed reablement and outcome focussed intervention approaches across the system						
Identify sustainable funding for reablement service, to ensure reablement can be offered to all with potential to benefit.						
Development of a community frailty model including Urgent Community Response and Same Day Emergency Care for frailty, to support the evolving Frailty FoH and complex frailty unit for patients at DMH, UHND & BAGH.						
Ensure the Acute and Complex Frailty offer is seamless with the wider community frailty work in community hospitals, care homes and peoples own homes						
Developing an in-reach model to support discharge from hospital and supporting the Home First community collaborative including Discharge to Assess and community virtual ward as well as specific clinical interventions and rehabilitation previously only available on acute sites; for example, but not exclusively OPAT, IV diuretics, stroke rehabilitation						
Recommissioning of Community Hospital/Intermediate Care/ Designated Setting Discharge Beds to ensure care as close to home as possible as soon as this is appropriate.						
Continue to develop the offer to care homes through the Enhanced Health in Care Home (EHiCH), Enhanced Service and also the County Durham Care Academy / supporting the Provider Market agenda.						
Support the further development of specialised palliative care services and End of Life care both at home and within care homes.						
Review housing / specialist accommodation offer the local older population, with a view to improving support and accommodation pathways.						
Review of Allied Health profession provision for example but not exclusively SALT, dietetics, cardiac rehabilitation, ISC Catheter, lymphoedema and osteoporosis services to support improved patient outcomes linked with the Primary Care Network Additional Role Reimbursement Scheme (ARRS).						
2. Health Behaviours (Alcohol, Tobacco, Nutrition and Physical Activity)						
Preventing loneliness and social isolation pilot – looking at indicators of pre-frailty and possible interventions to prevent progression including links into other community assets e.g., VCSE.						
Increasing participation in exercise in older people including building strength and balance. Focus on improving 'activity' provision in care homes and wider community wellbeing and leisure facilities, as part of the County Durham Care Academy work.						
Using new opportunities from the CMHF to better integrate physical and mental health care, increase the number of older people who are able to access community resources to improve their general health.						
3. Personalised Care						
Embed a personalised care and support approach in all aspects of provision including palliative care and end of life both at home at in care homes						
Development of a co-produced comprehensive model of personalised Anticipatory Care which promotes a reablement/rehabilitation approach						
Continue to embed social prescribing to support a bio-psycho-social model of personalised care and support and wider community connections.						
Further develop and implement the use of personal health budgets (PHBs)						
Increased uptake of PHBs for continuing healthcare patients						
Improve the support available to carers, both for their own emotional wellbeing and to help them in their role caring for people with mental health problems.						
4. Mental Health and Learning Disabilities – for further details please refer to the MH OGIM.						
As work takes place to reduce the gap in life expectancy for people with a learning disability we will review the community models of care and support to enable people with a learning disability to age well.						
We will continue to develop flagging systems for both SMI and LD annual health checks to ensure adjustments are made and appropriate interventions are in place for those people who have a learning disability and/or Autism and are at risk of frailty						
Implement improved crisis and urgent mental health care for older people.						
Ensure that crisis response whether this is predominantly a health, mental health or social care issue is coordinated in a timely personalised fashion being cognisant of the two hour response for health and four hours for mental health crisis.						
Embed MHSOP in the EHiCH MDT to ensure parity of care for both mental and physical health						
5. Children						

Project Gantt Chart Continued	20/21	21/22	22/23	23/24	24/25	BRAG
6. Digital						
Ensure the evolving IT systems within different organisation supporting older people are able to share key information to enable the person to tell their story once.						
Implementation of digital technology in care homes to support better patient care and outcomes, including Health Call, NHS mail roll out, electronic care plan sharing and other digital initiatives / opportunities through the Supporting the Provider Market agenda.						
Improvement and electronic sharing of Emergency Health Care Plans						
Development of Local Directory of Service functionality to ensure that all involved in care provision are aware of local services that are available						
Re-launch of mobile working for NHS community teams including smartphone rollout						
Review technology offer through strategic system groups, including review of care connect service and potential new delivery models						
Work with partners to support strategy to improve digital inclusion.						
7. Finance						
Ensure that there is continual review regarding system wide resources and mechanisms for prioritisation of resource allocation, focussing on areas of the highest need.						
Review of the Community Equipment Service provision ensuring a multi-disciplinary approach across all stakeholders, including a review of the care home equipment policy.						
Review and consider options for future commissioning of domiciliary care in terms of basing delivery / payment on tasks / outcomes with the improved integrated working of Health and Social care.						
Review and consider options for day services including opportunities for remodelling with a strengths based approach and to promote employment, volunteering, training as an alternative to traditional day service delivery, with a potential Invest to Save model; outcome focussed provider interventions including a reablement type approach to access specific employment and/or training.						
Use of new funding opportunities (including Community MH Transformation, crisis transformation, ARRS) to support social prescribing, mental health nurses and other roles to increase workforce capacity.						
8. Integration						
Embed integrated working between physical health, mental health and social care with mental health within the Teams Around Patients framework and wider community assets, including VCSE.						
Improved working between hospital and community teams including developing a multi-disciplinary approach to the Discharge Management Team						
Development of integrated commissioning of nursing and residential care across health and social care; potential for new ways of commissioning care home services to ensure they are on a sustainable footing and able to deliver the quality needed within budgets for the longer term						
Agree and deliver plan for implantation of the Community Mental Health Framework for older adults with SMI.						
9. Cultural Change						
Recruitment and Training support to community providers (particularly domiciliary care / reablement, VCSE?) through Supporting the Provider Market agenda and related County Durham Care Academy.						
Aim to increase / sustain capacity and quality and enable workforce is able to shift to progression / outcomes based model, including through Supporting the Provider Market agenda and related County Durham Care Academy.						
Developing understanding of the services available in the community and their ability to manage patients safely and effectively. This is vitally important for both relationships between acute and community clinicians and also between H&SC staff, VCSE and the public						