Current Issues for Frail Older People

Successive national surveys have highlighted that frail older people want to:

- Remain living in their own homes as independently as possible, for as long as possible;
- Be involved in the planning and delivery of any support they need;
- Be treated as a whole person, in the context of their lives, community and personal aspirations.

However, similar evidence indicates that current health and social care systems and practices often:

- Support more institutional forms of care, including hospitals and care homes;
- Debilitate and reduce independence;
- Focus on the service not the person;
- Are fragmented and inefficient.

Welsh Government policy and evidence e.g. recent reports from the King’s Fund, Nuffield Trust and Audit Commission, indicate that frail older people benefit from an integrated approach that addresses their complex needs and that progress needs to be made ‘at scale and at pace’.

The Frail Older People’s Service Delivery Programme reports to the Integrated Health and Social Care Board, which covers Cardiff and the Vale of Glamorgan. The partners include:

- Vale of Glamorgan Council
- Cardiff Council
- Cardiff and Vale University Health Board
- Third Sector in Cardiff and the Vale of Glamorgan

The Programme has drawn on an international and national evidence base plus a series of local collaborative interagency workshops and discussions, to produce a clear Vision for Cardiff and the Vale of Glamorgan and a new Model for service delivery. These are attached as Appendices 1 & 2 respectively.
Key Barriers

Cultural

- Creating a different mindset where support in the community is the default position, and risk is shared between agencies and with the individual.
- Unpicking traditional practices and territorialism to become more citizen focussed.

Structural

- Different organisational structures, accountabilities and governance requirements.
- Numerous and varied performance management requirements across the partnership.

Operational

- Information sharing, including IT issues and system access.
- Cautionary approach to sharing detail across the partnership re service planning and development.
- Variable understanding of service provision and co-ordination across the sectors.

Financial

- Budgetary constraints for all partners (also an opportunity?)
- Traditional budget protection/cost shunting. Money follows the service not the person.

Proposed Actions

The Programme has a detailed Delivery Plan designed to address the operational changes required to implement the new model.

In Year 1 (August 2011 to end March 2012) the key priority areas are:

1. Developing the ‘Community Toolbox’. This represents the range of health, social care and voluntary sector wrap around services that can be tailored and co-ordinated around a frail older person’s individual need.
2. Improving the Experience of Frail Older People in Hospital. This focuses on timely Comprehensive Geriatric Assessment at the ‘front door’ of the hospital and streaming into the most appropriate community or hospital service. If admitted the individual will be proactively case managed to facilitate safe and timely discharge. This workstream is also considering options for an Integrated Assessment and Transfer of Care Teams.
3. Joint Commissioning of Longer-term Care. This workstream has explored the themes currently leading to frail older people being ‘stuck’ in the system and has an action plan to address them. A comprehensive needs analysis has been undertaken by Public Health colleagues, and support to translate this into service planning recommendations is being provided by Welsh Government.

Year 1 activity aims to address some immediate issues and demonstrate the ability to deliver quick wins together.

Year 2 (2012/13) aims to build on this and follow the John Bolton model. The workstreams from Year 1 will therefore morph into that model’s key themes:

1. Universal Services;
2. Targeted Interventions; and
3. Longer-term Care.

A gap analysis of existing provision against the proposed model has already been undertaken in order to inform next year’s work.

Underpinning Workstreams, supported by the Programme Manager for the Integrated Health & Social Care Board, include:

- Communications and Stakeholder Engagement;
- Performance;
- Workforce; and in due course
- Finance and Sustainability.

The proposed high level performance indicators are attached as Appendix 3.

**Support Required from the Cardiff Integrated Partnership Board**

The support required from the IPB will become clearer as detailed proposals emerge. The most pressing request is for:

- Visible sign up and promotion of the Vision and Model.

The IPB is also requested to:

- Give a view on the proposed Performance Indicators;
- Commit in principle to improved information sharing protocols and IT solutions;
- Authorise transparent discussion on the detail of service delivery and planning;
- Consider protocols for cross-boundary working as they are developed, e.g. for the potential Integrated Assessment & Transfer of Care Teams;
- Consider options for joint risk sharing and joint commissioning as they are articulated over the coming year.
“Elevator Pitch”

Who we are:

The Integrated Health and Social Care Partnership for Older People covering Cardiff and the Vale of Glamorgan. The partners include:

- Vale of Glamorgan Council
- Cardiff Council
- Cardiff and Vale University Health Board
- Third Sector in Cardiff and the Vale of Glamorgan

Why are we doing this?

All partners have recognised that the challenges we face can only be tackled by working together. Integration allows us to share our expertise, resources and capabilities so that we can deliver responsive services that maximise the independence of citizens.

Aims of the Partnership

- Raising the quality of our services through service and process redesign
- Maximising the independence and well-being of our citizens and their families in the context of their lives and communities
- Continuing to develop our staff expertise – working differently together
- Maximising finance by pooling our resources into a single organisation and to benefit citizens

Challenges

The challenges are simple

- Continue to improve the quality of services and service delivery, whilst
- Meet the rising demand for these services; and
- Reducing the cost base of the organisations

There have been a number of strategies, reports, and action plans to address the needs of older people, e.g. top 10 issues, 1000 lives plus, etc. These strategies and plans require a collaborative approach that brings Health, Social Care and the Third Sector together to meet these challenges.

When we achieve this collaborative approach, the outcome will be older people seeing and talking about their experiences in positive terms.
This is just one possible set of statements from Mr. Davies, who lives in Cardiff. The comments attempt to encompass a set of principles that Integrated Partnership for Health and Social Care will commit to for Older People.

“My wife gets wonderful support”

“I understand what is happening to me”

“I have one person that I call if I have any questions, concerns or problems.”

“I’m in my own home”

“My carer lives locally as does the chap that comes in to sort the garden. It is a joy to sit on my bench and see the flowers.”

“I’m able to be part of my local community”

“Money is always tight but I was helped to ensure I receive what I am entitled to…”

“When I went into hospital, my medical problems were sorted very quickly and I was able to get back home with the right support without any delays”

“There can be dignity in being cared for…”

“I feel safe and in charge of my life”

“When things broke down last year, I was seen quickly and helped to get back on my feet”

“I feel that I am listened to and able to decide what gets done and when.”
Operating Principles

The principles that support our vision for older people’s social care and health services in the Vale of Glamorgan and Cardiff have at their heart dignity, social inclusion and autonomy. Our principles are:

- **Prevention**: people and communities working together with services to help people stay independent for longer.
- **Personal**: putting individuals in control of their own care, through universal access to information and a commitment to provide person-centred care.
- **Partnership**: different public, voluntary and private organisations coming together with individuals and communities to deliver care and support.
- **Plurality**: matching the scope and variety of people’s needs with diverse service provision and a broad range of high quality providers. Working with older people to co-design and co-deliver services to meet their needs.
- **Protection**: securing sensible safeguards to protect the most vulnerable people from abuse or neglect.
- **Productivity**: greater local accountability to drive innovation which will deliver more productive and higher quality services.
- **People**: the care and support workforce leading the changes on the ground, with the right skills, freedoms and support to do so.

These principles inform how older people in Cardiff & the Vale of Glamorgan will experience the services that the Councils of the Vale of Glamorgan and Cardiff, the Cardiff and Vale University Health Board and the voluntary sector will deliver. We recognise that to truly improve the experience of older people in the Vale of Glamorgan and Cardiff, we need to address all of the areas below.
To achieve this vision, what do we have to ensure we deliver? The following is a list of what Older People can expect from us. These include:

**Universal Services**

What citizens should expect is:
- to be seen or dealt with quickly
- to have access to the appropriate person with the right expertise
- to be treated with dignity and respect
- to be provided with the appropriate information, guidance and advice
- to be signposted to information, support and other services wherever possible
- To have rapid access to acute medical care and specialist services when required
- to receive safe and appropriate care
- to be involved in decision-making about their care

**Targeted Interventions**

What citizens can expect is:
- a focus on maintaining and regaining independence
- to be encouraged to manage their own lives for themselves
- services delivered in their own home and community where possible
- time-limited services based on their needs
- access to a range of expertise, including a Geriatrician
- If they require hospital treatment they should expect:
  - early diagnosis & Comprehensive Geriatric Assessment
  - treatment on the right ward for their needs
  - Multidisciplinary working to facilitate discharge to their home
- treatment approaches based on evidence and best practice

**Care and Support**

What citizens can expect is:
- a continuous focus on maximising independence
- ongoing care in their own home for as long as possible
- support for the carer or carers of the person receiving services
- a proactive approach to supporting those with long-term conditions and frailty
- access to a range of expertise, co-ordinated by one named person
- tailored support drawn from a wide range of local services
- some services may require a financial contribution Support tailored to meet both physical and mental health / memory problems when they co-exist
- access to advice and advocacy support when needed
- care planning based on comprehensive assessments
- continuity of care wherever the setting
What the partnership plans to focus on in the next two-three years is the development of a range of services that fall into one of three strands:

### Universal Services
- Advice & Information
- Primary care health services, e.g. GPs
- District Nurses
- Dentists
- Welfare rights
- Information, Advice & Guidance
- Communications Hub

### Targeted Interventions
- **Community Resource Teams**
  - Hospital admissions will include Comprehensive Assessment; early diagnosis and management; effective care followed by **Safe and timely discharge**
  - Rehabilitation
  - Telehealth & telecare
  - Case management for people with chronic conditions
  - Equipment & adaptations
  - Locality Management of Community

### Care and Support
- Assessment & Care Management
- Choice & Control
- Direct Payments
- Long-term care in own home
- Care Homes
- Continuing Health Care

### Supply
- **Joint Commissioning** of the right range of services
- Procurement
- Joint Equipment Service
- Joint IT Strategy

Note: The items underlined are the immediate priorities for the partnership.
### Frail Older People Service Delivery Model

**‘Regaining and Retaining Independence’**

<table>
<thead>
<tr>
<th>Equilibrium: Coping at home</th>
<th>Trigger event or crisis</th>
<th>Community Support/Step up</th>
<th>Hospital Admission</th>
<th>Recovery &amp; reablement</th>
<th>Equilibrium restored: coping at home</th>
<th>Longer-term care &amp; support</th>
<th>End of life care &amp; support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual is able to live independently in their usual place of residence.</td>
<td>Will have access to core NHS services, e.g. primary care, dentistry etc.</td>
<td>Contact with public health agenda</td>
<td>Frailty Register facilitates targeted prevention work e.g. falls, home safety checks etc.</td>
<td>Able to access advice and signposting via Communications Hub</td>
<td>May need ‘low level’ support from voluntary sector or informal carers.</td>
<td>E.g. Fall Increased cognitive impairment Carer breakdown Clinical illness Elective surgery</td>
<td>Leads to contact with services, usually via GP, Ambulance Service or Local Authority contact centre.</td>
</tr>
</tbody>
</table>

#### Equilibrium
- **Coping at home**
- **Trigger event or crisis**
- **Community Support/Step up**
- **Hospital Admission**
- **Recovery & reablement**
- **Equilibrium restored: coping at home**
- **Longer-term care & support**
- **End of life care & support**

#### Universal Services
- **Targeted Intervention**
- **Universal Services**
- **Longer-term Care**

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**APPENDIX 2**

The aim of the targeted intervention approach is to regain equilibrium and independence to previous levels wherever possible. Where longer-term support is required, the same principles will apply i.e. service provision will be based on individual choice and outcomes. Delivery will be undertaken in partnership with a named care co-ordinator/case manager for the person & their carer(s). People receiving long-term care will access universal services including targeted prevention to delay further decline. Wherever possible end of life care will have been discussed and planned for.

The care co-ordinator will continue to apply the principles of choice and control. They will arrange tailored increased and specialist support for the individual and their carers. This will include inreach into care homes.
<table>
<thead>
<tr>
<th>Proposed High Level Performance Indicators (adapted from the recommendations of the recent Audit Commission Report)</th>
</tr>
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<tbody>
<tr>
<td>1. Emergency admissions to hospital for people aged 65 and over</td>
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<tr>
<td>2. Emergency bed days for people aged 65 and over</td>
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<tr>
<td>3. Admission to residential or nursing care</td>
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<td>4. Admissions to residential or nursing care direct from hospital</td>
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<td>5. Discharge to usual place of residence</td>
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<tr>
<td>6. Numbers of people dying at home (Planned and through choice)</td>
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</tbody>
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