Health and Wellbeing Board

23 July 13

Ageing Well Programme Board - Initiation Document

Introduction

At the April 13 meeting of this Board, a programme board methodology was approved as a way of delivering the strategic aims outlined in the Health and Wellbeing Strategy. Two Boards were approved for initial set up ie Ageing Well and Promoting Independence.

The purpose of a Programme Initiation Document (PID) is to define the Programme, in order to form the basis for its management and an assessment of its overall success. The PID gives the direction and scope of the Programme. It outlines the approach to delivering the Programme and provides commitment to proceed.

This paper summarises the initial PID for the Ageing Well Programme Board, and seeks the approval of the Health and Wellbeing Board. It should be noted that PIDS are dynamic documents. It is likely that the scope of this programme will be refined particularly as other programme boards initiate their own activities.

This paper is structured as follows:

- Introduction
- Barnsley MBC
- NHS Barnsley CCG
- Rationale for the Ageing Well Programme
- Targeted Services
- Programme Objectives
- Programme Benefits
- Programme Scope
- Programme Approach
- Patient and Public Engagement
- Programme Board Structure

The aim of the Ageing Well Programme is:

To work collaboratively across health and social care partners in Barnsley to enhance the quality of life of older people by improving their health and well-being through promoting self-caret, carer support and resilience.

Barnsley Metropolitan Borough Council (B MBC)

B MBC commissions Adult Social Care and Mental Health Services (as well as other services) on behalf of the people of Barnsley. The Adults and Communities Directorate promotes and maintains the health, independence and wellbeing of all adults who may need protection, care or support for any reason and to make Barnsley a better place to live, work, and play.

The Council also provides services. It assesses the needs of vulnerable adults, and then designs a supportive care plan that maximises their quality of life, gives choice and control over the services that they receive, and promotes their social inclusion. This assistance is arranged and delivered either directly or in partnership with others.

B MBC is in the process of initiating a transformational programme for Adult Health and Social Care called “Inverting the Triangle”. The proposal is to move away from the traditional approach based on eligibility and reactive ill health provision and systems/services based around the legislative framework.

“Inverting the Triangle” will seek to implement an approach where the ‘front end’ of how people enter the health and social care system and how their needs are met is managed systematically. A key part of this will be to re-focus resources on prevention and early intervention, to reduce the number of people who ultimately require on-going support to manage long-term conditions.

NHS Barnsley Clinical Commissioning Group

The CCG has set out its vision, values and priorities for 2013/14 onwards through its Commissioning Plan; its purpose is to ensure that the highest quality, best value-for-money health services are commissioned and provided for the people of Barnsley.

The CCG has a duty to innovate and integrate services around people, and to be clinically led.

To support the delivery of its commissioning objectives the Governing Body (and this Board) has agreed to set up five key improvement programmes as follows:

- for joint delivery with B MBC as “whole systems” programmes:

Programme A: Ageing Well
Programme B: Promoting Independence

- for delivery by B CCG:

Programme 1: Unplanned Care
Programme 2: Cancer
Programme 3: Planned Care (including long term conditions and cardiovascular disease)

Rationale for the Ageing Well Programme

<u>In the community environment</u>

The Joint Strategic Needs Assessment identifies that there is a growing and increasingly elderly population. Interim projections show that the largest projected increase is likely to be those aged over 65 (increasing by 20.9% in 2021). 20% of the total population will be aged over 65 in 2021.

Older people with long-term conditions (LTCs), including dementia, make most use of health and social care services. The general elderly population growth rate at 3% year-on-year, will represent a significant burden on these services in Barnsley. .Additionally, there are an estimated 23,611 people over the age of 65 years with a limiting long term condition; this is projected to rise year-on-year up to 2015 when the estimate will be at 25,237.

<u>In the acute environment</u>

BHNFT has approximately 35,000 (spells) admissions per year; 65% of these are older people (>65) with about 20% being pragmatically clinically assessed as Frail Elderly (>85).

Benchmarking data indicates that the BHNFT LOS is low (avg. 8 days) but readmission rates are high (15%). Trust Risk Management data suggests there is poor communication with

families and carers of frail older people in addition to poor communication between the Trust and its partner organisations, potentially leading to an adverse effect on patient care. In 2011/12 one third of complaints concerned privacy and dignity, nutrition, discharge processes, patient cleanliness and end of life care.

An audit in 2012 of 312 patients over the age of 80 identified that intermediate care and social service provision does not meet the need of this vulnerable patient group, who has been assessed as not requiring hospital admission.

National and local priorities

The NHS mandate identifies dementia as a key priority area for organisations, and "an ageing population and the need to support independent living" is a top four priority for the Barnsley Health and Wellbeing Board.

Barnsley CCG has a specific commitment, as one of the Quality Premium qualifying criteria, to raise dementia diagnosis levels from 45.1%[1] to 60.6% by April 2014.

Targeted services

The health and social care services which have the largest potential impact on the health and wellbeing of older people in Barnsley are:

A. dementia diagnosis and support
B. intermediate care services
C. other services supporting the frail elderly

These service areas will therefore form the focus of the Ageing Well Programme. These services cover pathways which cross organisational boundaries; delivering improvements to them will therefore require coordinated action from a range of partners.

Programme Objectives

The objectives of the Ageing Well Programme are to:

A. Dementia:

Complete the Memory Assessment Service Review (Phase 2), including developing:
- a clear specification for appropriate Memory Assessment Services
- a plan to re-procure and / or improve services as necessary

Implement the recommendations of the Memory Assessment Review

Complete the implementation of the recommendations in the National Dementia Strategy "Living Well with Dementia" (2009)

Improve dementia diagnosis rates in line with the commitments made in the CCG's Commissioning Plan

Increase support for people diagnosed with dementia

Deliver high quality, timely and easy-to-access memory assessment services across Barnsley

Increase awareness of symptoms of dementia to encourage earlier presentation

Promote the Dementia Friendly Community agenda in Barnsley

Improve the quality of experience of people with dementia and their carers

B. Intermediate Care:

Complete the Intermediate Care Review, including developing :
- a clear specification for appropriate Intermediate Care Services
- a plan to re-procure and / or improve services as necessary

Implement the recommendations of the Intermediate Care Review

C. Frail Elderly:

Improve care for people in nursing and care homes
Revise care pathways for the frail elderly / dying admitted to Barnsley Hospital
Complete the implementation of the recommendations in the National End-of-Life Care Strategy.

Programme Benefits

The Ageing Well programme will deliver the following benefits:

More service users in Barnsley diagnosed with dementia and receiving appropriate support services

More service users, families and carers understanding, and independently managing dementia with reduced recourse to health and social care services

More dementia support delivered in the community and service users' homes, and less in acute and long-term care environments

More integrated, efficient and effective Intermediate Carer Services providing higher quality, more value-for-money support

More frail elderly service users maintained in the community / their own homes, with reduced acute admissions for conditions associated with the frail elderly eg falls-related injuries

Fewer older people dying in hospital

More joined up working between primary, community and secondary care providers (integrated working between Health and Social Care)

Improved service user, family and carer experience.

Programme Scope

The scope of this Programme includes:

Service Areas

All health and social care services which are substantially used by older people in Barnsley, with a specific focus on:

- dementia diagnosis and support
- intermediate tier services
- services to support the frail elderly.

Sectors

Ageing Well will impact on the following health and social care sectors: Primary Care, Community Health Care, Social Care (domiciliary care, reablement, long-term care services), A&E and General Hospital services, Rapid Response services, Ambulance Service, Out-of-Hours services

Service Providers

The work required to improve services and deliver the required outcomes will require collaborative working across care pathways currently supported by (at least): BHNFT, B MBC (as service provider), GP Practices, SWYPFT, Voluntary Sector organisations

Other Partners

We will also seek to work closely with a range of appropriate national and local advisory and support agencies, for example: Age UK, The Alzheimer's Association, Barnsley Independent Alzheimer's and Dementia Support (BIADS), Carers UK, National Association of Voluntary and Community Action (NAVCA), Rotherham and Barnsley MIND, Voluntary Action Barnsley

Programme Approach

As with all our Service Improvement Programmes, the Ageing Well Programme will be underpinned by promoting integrated ways of working that support the service user, their families and carers to take more responsibility for their own health and social care in terms of staying healthy, independent and in accessing the right care in the right place at the right time.

The programme will operate utilising MSP/Prince 2 methodologies. Programme activities will be undertaken by staff members of the Clinical Commissioning Group and the Council, along with projects / work streams undertaken by partner organisations, principally by BHNFT, B MBC and SWYPFT. For some work, where appropriate and cost-effective, additional external resources will be procured.

At this stage, it is expected that the Workstreams will be as follows:

Project 1: Planning, Preparation and Strategic Reviews

This Workstream will comprise:

- development of the initial PID
- maintenance of the PID to reflect the needs of the Programme
- Programme Management
- Reporting to the Ageing Well Programme Board, the Health & Wellbeing Board the CCG's Finance & Performance Committees [and the Council's tbd]

Project 2: Preliminary Activities

The following activities will be initiated immediately, as they are required to inform the overall Programme scoping and planning process:

a) Dementia: Baseline Facts & Figures

It will be important to establish and agree baseline figures for dementia in Barnsley.

Key questions to be answered include:

- No. of people diagnosed in Barnsley with dementia:
- Estimated prevalence
- Commitment to increase diagnosis rate by how much by when (eg "Improve the dementia diagnosis rates from 46.68% to 60.6% in 2013/14" – Commissioning Plan V 6, p 23)
- No of extra people that would need to be diagnosed to achieve the target
- Profiling of reaching the target over 2 or 3 years?

b) Memory Assessment Service and Intermediate Care Reviews: Performance Management Requirements

c) Dementia: "The Nursing Home" Project
It needs to be established what stage this Project has reached, options for continued progress, whether it has any continuing relevance etc.

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d) Memory Assessment Service / Intermediate Care: Procurement Plan

e) Dementia: General research on Innovative Solutions around Dementia Diagnosis and Support

<u>Project 3: Supporting People with Dementia</u>

This Project will comprise the following components:

Memory Assessment Review (Phase 2 & 3)

Phase 2:

- Re-design of the memory assessment pathway and service specification, making them more outcome-focussed; efficient and supportive of service users' and carers' needs; this will be done with input from key stakeholders and clinical leaders.

- Development of options and recommendations on the most appropriate model to deliver an improved Dementia Service.

Phase 3:

- Based on decisions around the most appropriate delivery model, implementation of an improved Memory Assessment Service which has:
  - a significantly enhanced role for 3rd sector organisations
  - a new performance management framework to support the incremental approach to increasing the rate of diagnosis within set time scales.
  - defined outcome measures that capture service user [and carer?] experience and feedback
  - clear protocols, agreed with GPs and BHNFT regarding consistent and proactive management of referrals.

Additional Dementia Improvement Activities

The following activities will also be undertaken within this Project In addition to the improvements generated through the implementation of the Memory Assessment review:

Increasing the Dementia Diagnosis Rate

To meet the Quality Premium-related target of 60.6% by April 2014, a combination of factors and interventions will need to be considered, including:

- the number of additional diagnoses required (likely to be around 400)
- the variation in diagnosis rates across the GP Practices in Barnsley
- the impact of the enhances service agreed with GPs 'Facilitating Timely Diagnosis and Support for People with Dementia'
- the impact of improvements introduced during 2013/14 as a result of implementing some of the recommendations of the Memory Assessment review
- the rate of increase in diagnosis as we progress through the year

Based on the above considerations, specific actions might need to be taken around, for example:

- increased communication and engagement with GP Practices
- targeting of specific GP Practices with significantly lower diagnosis rates than the average
- introduction o f a Local Enhanced Service (LES) to provide additional incentives for GPs to increase diagnoses
- working with BHNFT to increase diagnoses on the acute wards
- working with SWYPFT [?] to increase diagnosis in nursing homes and care homes?
- increasing capacity within the current Memory Assessment Service to undertake more assessments.

Promote the Dementia Friendly Community agenda

Dementia - Increase the uptake of information and advice numbers

Target specific sessions to schools and education centres to be delivered through workforce development and Dementia champions

Increase the number of befriending volunteers (by 20%) for users with dementia

Evaluate the current impact of the End of Life pathway on Dementia sufferers

Dementia - Respond to carers' feedback during 2013/14 by developing strategies to provide support to existing carers and hard to reach carers to maximise opportunities

<u>Project 4: Intermediate Care Services</u>

Barnsley CCG commissions intermediate care support jointly with the Council through a series of key services which are interlinked and to some degree co-dependent. These services are:

- Intermediate care beds in the community
- Intermediate care Therapy Services to IC community beds
- Intermediate care GP Service to IC community beds
- Intermediate Care and Assessment Team
- Rapid Response Team
- Hospital at Home
- Mount Vernon Hospital

Home Assessment and reablement service non-commissioned service

a) Intermediate Care Review

This Review is currently underway and will now be brought under the aegis of the Ageing Well Programme.

Phase 1 of the Review is complete. The conclusions from Phase 1 are that:

- The current service specification is not outcome-based in its design and no longer reflects service delivery requirements for Barnsley.
- There is no outcome-based reporting. The contract data reported is not geared towards demonstrating impact on hospital avoidance, reducing inappropriate admission and reducing delayed discharges. The service specification requires reworking to reflect today's needs in respect of Intermediate Tier Services to enable a seamless passage though associated service provision.
- A seamless pathway does not exist and the interconnectivity between services requires further work to ensure that coherent patient flow through the Intermediate Tier Services is in place to meet future demands.
- There is a difficulty in undertaking meaningful cost-benefit analysis for aspects of the services contained within the review.
- There are associated areas for development within other commissioned services which could improve efficiencies and which could be undertaken in-year e.g. a review of Discharge Procedures and Admission Criteria for the hospital

Phase 2 will comprise the following activities:

- In collaboration with SWYPFT, development of an implementation plan covering all the service specific recommendations identified / contained in the Phase 1 Review Report
- Staging of a "rapid improvement event" to support SWYPFT in delivering quick wins IN YEAR (ie during 2014/14). This will enable all key senior managers to jointly identify gaps as well as solutions by exploring the current pathway and commit to an action plan for implementation collectively, thus ensuring a co-ordinated approach across the services.
- In collaboration with Providers, development of specifications drawing upon perceived best practice.
- Development of options and recommendations on the most appropriate model to deliver an improved Intermediate Tier Service;

Phase 3:

Based on decisions around the most appropriate delivery model, implementation of improved Intermediate Care Services which support the revised care pathway and specification requirements.

b) Develop proactive care home case management

<u>Project 5: Improving Services for the Frail Elderly</u>

Frail elderly service users in Barnsley need to be treated as an individual, with dignity and respect; without pain and other symptoms, in familiar surroundings; and in the company of close family and/or friends.

This Project will review the "frail elderly pathway" across all sectors and settings and identify those areas which require improvement and which are not covered by other parts of the programme. It is expected such areas will include:

- falls strategies and protocols

- elements of telehealth and telecare
- rapid response services
- the EOLC pathway, including palliative care and how it is being implemented
- support for carers and families.

Project 6: Home Truths Phase 2

Published in September 2012 the Home Truths White Paper explored the influencers on Older People's care decisions, in particular the role of GPs. The paper found that as a consequence of misaligned and dysfunctional relationships between social care and GPs, older people were unnecessarily being admitted into residential care. The Home Truths Project was developed following the publication of the white paper to shape how the relationships could be influenced and deliver savings throughout the system.

Following local and national research, four areas for improvement were identified:

1. Relationships
2. Signposting and communicating
3. Early dementia support
4. Proactive social care

For the next phase in Barnsley, iMPOWER Consultants have proposed to deliver detailed business cases for proposal has been received to deliver detailed Barnsley specific business cases on areas 2 and 4 above,

Patient and Public Engagement (PPE)

It will be extremely important to engage with service users, cares and the general public in Barnsley around proposed changes to how services will be commissioned and delivered. Each Project in the Ageing Well Programme will assess the appropriate level of PPE required to develop and implement improvements.

Programme Board Structure

The Ageing Well Programme Board will comprise the following members:

Programme board role	Name	Designation	Responsibility focus
Chair / SRO	Dr Mehrban Ghani	Medical Director, Barnsley CCG	Accountable for Programme delivery Chairs the Programme Board
Senior Executive	Mark Wilkinson	Chief Officer, Barnsley CCG	B CCG corporate
Senior Executive	Martin Farran	Director, Adults and Communities, B MBC	B MBC corporate

Mark Wilkinson
Senior Executive – Ageing Well Programme Board
NHS Barnsley CCG
14 July 13