AGE UK Integrated Care Programme

March 2015

Briefing for Ashford Health and Wellbeing Board

Age UK is implementing a national Integrated Care Programme across England. It brings together voluntary organisations and health and care services in local areas to provide an innovative combination of medical and non-medical support for older people who are living with multiple long term conditions, at risk of recurring hospital admissions. Through the programme Age UK staff and volunteers become members of primary care led multi-disciplinary teams, providing care in the local community.

The first pilot site was established in Cornwall in 2012 and there are three other pilot sites in development elsewhere in England.

The pilots are seeing good results in terms of acute hospital admission avoidance and patient outcomes/satisfaction. In the first year with a cohort of 100 patients, using the Edinburgh and Warwick mental well-being scale, a 23% average improvement was observed amongst older people in the cohort and there were 30% fewer non-elective hospital admissions.

Early financial calculations showed the potential to save up to £4 for every pound spent for the local health and care system. This relies on re-shaping acute trust services to realise cashable savings. This ratio creates a surplus that is a sufficiently powerful incentive to engage all the key stakeholders in the local health economy to work together. Projections suggest that, over a period of one year, with a £500 service investment for each older person, £2000 could be saved to help meet incremental demand, support re-configuration and provide net savings to invest in prevention.

The initiative is receiving considerable national attention. It won the HSJ Long Term Conditions Management award. Simon Stevens and Norman Lamb have endorsed the approach and are encouraging other areas to adopt it. The Nuffield Trust is supporting the programme with an evaluation.

Age UK has been seeking a further pilot area and has indicated that Kent would be a strong contender. An invitation to bid to become the next pilot was published at the end of October 2014. Ashford and Canterbury applied to become a pilot site.

Age UK in Kent operates a consortia arrangement and the local braches/consortia expressed an interest in applying for the pilot. KCC, KCHFT, Ashford and Canterbury CCG and EKHUFT all agreed to work with Age UK to assess the potential to become the next pilot site for the national project.

A initial meeting of interested parties in Kent was held on 10 October, hosted by the national and local Age UK offices. All interested parties were represented.

Subsequent meeting have happened since where confirmation has been given by all parties to proceed.

2. Background

2.1 Aim of the Age UK Integrated Care Programme

The purpose of the Age UK Integrated Care programme is to co-develop with local partners new and innovative services that aim to reduce the risk of and prevent vulnerable older people being admitted to hospital. These services will focus on maximising the independence and self-reliance of older people using a range of approaches including promoting self-management, peer support, building and maintaining social networks and practical support alongside existing health and social care interventions.

2.2 Objectives

The primary objectives of the programme are:

- Improving the physical health, mental health and social care outcomes and experiences of older people.
- Increasing the independence of older people with high level of health and social care needs.
- Reducing avoidable emergency admissions to acute care among older people.
- Reducing the dependency of older people upon social care services including delaying the use of high intensity social care (residential and domiciliary care).
- Ensuring more appropriate use of statutory services for older people with different kinds of need (allocative efficient use of resources).
- Supporting financial sustainability in the local health and social care economy.

In achieving these aims the partners will monitor and respond to the health and social care outcomes and experiences of carers of people on the programme and seek to increase participants' uptake of wider community services and support

2.3 The key features

- **Partnership**

The Age UK approach is based on strong local health and social care partnerships. Commissioners, local Age UKs, NHS and other providers come together to co-design the service based on a model of integrated care that targets a specific cohort of older people. Risk sharing protocols (resources, finances, commitments etc.) are developed between the organisations as well as measures to monitor and review

achievements. Importantly the strength of this partnership enables all organisations to work towards the same set of outcomes, first and foremost improving the quality of life for the individual concerned.

- **Risk stratification**

The pilot uses risk stratification to identify those older people most likely to be admitted to hospital and to focus resources most appropriately. Evidence from

- **The guided conversation**

Using a 'guided conversation' an Age UK Personal Independence Co-ordinator works with and alongside the older person. They draw out the goals that the older person identifies as most important for them.

- **Signposting**

A key feature is supporting people through the effective signposting and care co-ordination to increase independence and reverse the cycle of dependency. The pilot connects the services that already exist locally through other public and private providers and charities so the services 'wrap around' the older person; e.g. benefits advice, social activities and home help, as part of their support plan.

- **Self-care and independence**

While each older person on the pathway is matched with a volunteer to support them to achieve their goals, all the older people are encouraged to take the lead in managing their own care and wellbeing. An intensive support service is provided to the older person for three months, with the aim of them having achieved their goals and a greater sense of control, confidence and independence by the end of this period. After this, the older person may still be supported as they are also always able to make contact again through their practice or Age UK Co-ordinator if they wish.

- **Integrated working**

Integrated working is co-ordinated and supported through a shared care plan, developed with the older person and reviewed regularly by a multi-disciplinary team based within a primary care setting. There are also clear safeguarding and escalation protocols in place to ensure that if and when medical attention is required, this is delivered effectively and in a timely way. This promotes independence from primary and community health services, as well as preventing avoidable hospital admissions.

- **Systems benefits**

The programme aims to achieve the following system wide benefits:

- Efficiencies and cashable savings in the local health and social care economy

- Aligned incentives and rigorous performance management systems
- High quality patient tracking and data collection systems
- New models of integrated health and social care that harness social capital

2.4 Timeframe

The programme runs for between one year and nine months and two years. Funding is attached, details to be confirmed.

2.5 Appendices

See Appendix 1 for the co- design principles and Appendix 2 for the main phases, activities and roles.

3. Assessment

It is proposed that the pilot initially focus on east Kent (Ashford and Canterbury Coastal) for the following reasons:

- The east Kent Age UK branches are the most interested
- There is a previous Age UK project in Canterbury that will give a good foundation
- The neighbourhood teams and MDT working is well established in the Ashford and Canterbury area
- Health and social care co-ordinators are established in the eastern localities
- There is a good strategic fit with the Ashford and Canterbury Coastal integrated community networks development
- The health trainer model operates effectively in the eastern localities.
- Rural Ashford has set up a virtual ward which would work well with this model.

4. Recommendation

Ashford Health and Wellbeing board to note details in briefing. Ashford Health and Wellbeing board to ask for updates and outcomes to be returned to the board at a future date

Project Group

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Appendix 1

The Co-design Principles

Build on existing services

- Build on existing initiatives in Kent, and collectively commit to add value to what is already happening

Use best practice

- Combine proven international best-practice and local best-practice in the service model of care integration

Identify an appropriate patient cohort

- predictive risk stratification to identify patients (500) who would most benefit from the programme, alongside case management and other relevant criteria agreed by the partners
- Develop additional approaches for identifying social care service users who would most benefit from the programme.

Focus on improvement opportunities related to patient conditions and co-morbidities

- Actively consider those morbidities/conditions where evidence from international best-practice demonstrates improvements in care and reductions in avoidable emergency admissions can be made, alongside other local data specific to the morbidities most relevant to Kent

Build multi-disciplinary working including the third sector

- Multi-disciplinary teams of GP and community health providers that include dedicated voluntary sector key workers and volunteers with tailored case management to achieve the key patient and system outcomes.

Support health and wellbeing approaches

- Prevention and wellbeing services provided to people that include self-management support, guided conversation and motivational support through volunteers, coordination of clinical and non-clinical interventions, evidence based and clinically endorsed care pathways

Develop Workforce

- Draw on learning to shape future workforce requirements, including that of volunteers
- Identify values and principles that support the delivery of personalised care
- Co-design and develop an operational climate that enables the multi-disciplinary teams to identify and overcome operational barriers

Demonstrate clear benefits

- Demonstrate how benefits will be realised in the programme. This will include better quality of life for older people, improved service provision, managing clinical risk and identifying efficiencies and cashable savings in both health and social care

Develop sustainable financial and contracting models

- The pilot will explore innovative funding mechanisms; for example, we are modelling a new approach to evidencing cashable savings in order potentially to secure a Social Impact Bond. To support this Age UK are working with partners to adopt different contractual mechanisms that can align incentives and drive change such as Alliance Contracting.

Use effective performance management systems

- Include the development of performance management tools and processes required to track progress
- Measure and track all of the key outcomes throughout the programme

Incorporate appropriate evaluation

- Use both internal formative evaluation processes linked directly to performance management, and external summative evaluation through involvement with the Nuffield Trust evaluation of the wider integrated care programme
- Develop and co-design within each work stream ‘real time evaluation’ and continuous service improvement throughout the programme

Develop wider learning

- Develop the programme on the basis of a ‘shadow’ gain-share and risk-share model across all of the partners to inform understanding and learning about the potential for creating an integrated care alliance contract between the partners
- Contribute learning from the programme to inform the development of the wider national Age UK integrated care programme

Development of tools

- The partnership agrees that all partners have ‘joint ownership of tools developed to support the programme

Appendix 2 Programme Phases and Roles

The pilot involves with following phases and main activities and roles:

Phase	Co-diagnosis 3 months	Co-design 6 months	Build and delivery One year
Tasks	Shared analysis of the challenge and the opportunities Understanding the 'fit' of the programme with existing initiatives. Joint assessment of readiness for change Identify the patient cohort (500-1000)	Create Partnership Agreement. Undertake detailed work streams covering: • Governance and stakeholder engagement • Patient cohort and financial model • Care pathways and clinical governance • Workforce development • Patient and system-wide performance management, patient tracking and evaluation	Recruiting staff and volunteers Development of multi-disciplinary teams in participating GP practices 'Guided conversations' with patients as they join the programme Performance management of the programme Real-time evaluation to inform service and system improvement
Roles	Age UK conversations with local partners, analyse documents and policies etc. CCG undertakes initial data analysis of patient cohort. Meeting of key partners to assess potential for the programme	Local statutory staff and local AUK staff undertake workstream tasks within existing resources e.g. data analysis, agreeing care pathways Age UK national support for tasks through specialist advisers e.g. alliance contracting, financial modelling,	Amendments to existing statutory service practice to meet requirements of care pathways and system changes Service delivered by local MDTs and volunteers and support from wider 3rd sector

End.

Delivering Differently in Neighbourhoods

Kent County Council in partnership with the communities of Wye and Newington

Project Rationale: The biggest demand pressure facing local government is from Adult Social Care because of ageing populations, increased longevity and rising expectations combined with the required dramatic budget reductions. Transformational change is urgently needed to secure a sustainable model of social care which will continue to meet the needs of the most vulnerable people in our communities. Our project is about how we support individuals', carers' and communities' resilience - supporting people to support themselves and others.

Project Description: In essence our project is about testing out new models of care and support that are more community focussed and accountable, through working with local residents to co-design alternative models of care and support**.**

It is becoming increasingly apparent that traditional models of public service delivery cannot solve our most complex social problems. In recent years policymakers and politicians have taken a growing interest in' bottom up' ways of working that give citizens and communities more control.

Traditional models of time and task social care find recruitment and retention of staff increasingly difficult, businesses are finding it difficult to drive enough profit out of care to succeed and therefore cuts that are made impact on the quality of the service delivered.

The Coalition government's Mutuals Programme, run by the Cabinet Office has recognised the value of employee ownership in creating greater freedom and innovation of staff and the added social value via reinvesting profits back into the local community and services.

Social Care Co-operatives: Are not-for-profit businesses owned and run by and for their members (customers, employees and residents). As a minimum our intention is that co-operatives deliver social care in the home e.g. tasks of daily living and personal care. However our aspirations are broader: we will also explore whether the co-operatives can undertake assessment and signposting activity and indeed do preventative work e.g. befriending/preventing loneliness, facilitating attendance at community activities, providing information and advice.

Our aim is to work with a range of community stakeholders using co-production techniques to explore and understand what people need to remain active, well and connected to their communities:

- To support self-management, enabling people to find their own care and support solutions and prevent or delay the need for statutory assessment and services.

- To explore viable alternatives to traditional social care provision which are more locally accountable to the communities that they service, providing increased choice and control.

Kent County Council will work with two communities in contrasting neighbourhoods, testing out whether this is a financially viable vision that achieves better outcomes for individuals and communities and the impact on internal processes and systems, to determine whether there is a case to roll this approach out across Kent.

The two neighbourhoods are:

- Wye and Hinxhill, a largely ***'affluent and rural***' parish near to Ashford
- Newington, a ***'deprived and urban'*** ward in Ramsgate, Thanet

In Wye and Hinxhill KCC has been championing and supporting the development of the DCLG Locality Programme "Our Place" which is in essence is about community budgets.

KCC has been working closely with the parish council and local advocates and already considerable needs analysis and asset mapping has been undertaken.

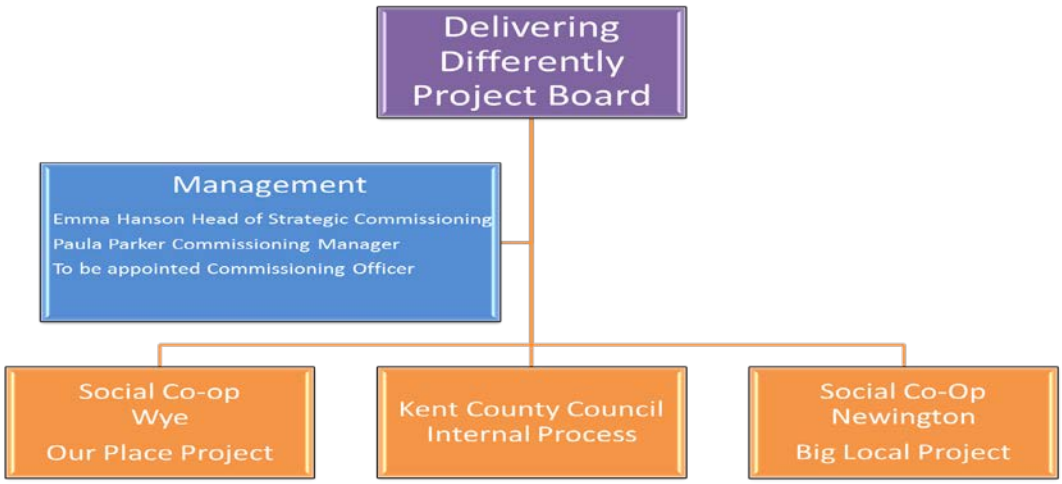
We anticipate being able to create a social care co-operative quickly in Wye because of the significant foundation established from Our Place and because we are already well engaged with the community who are already thinking along these lines.

Newington, an urban ward in Ramsgate, was given money in December 2012 under Big Local. They have an active residents' committee to oversee the funding which, amongst many other things, is doing some innovative work around skills and independence training for people with learning disabilities. This neighbourhood is very different from Wye, but again the residents are already organised and we anticipate that we can move quickly. Newington is also an area with considerable needs in relation to families under pressure, and we recognise that this model has wider application than adult social care.

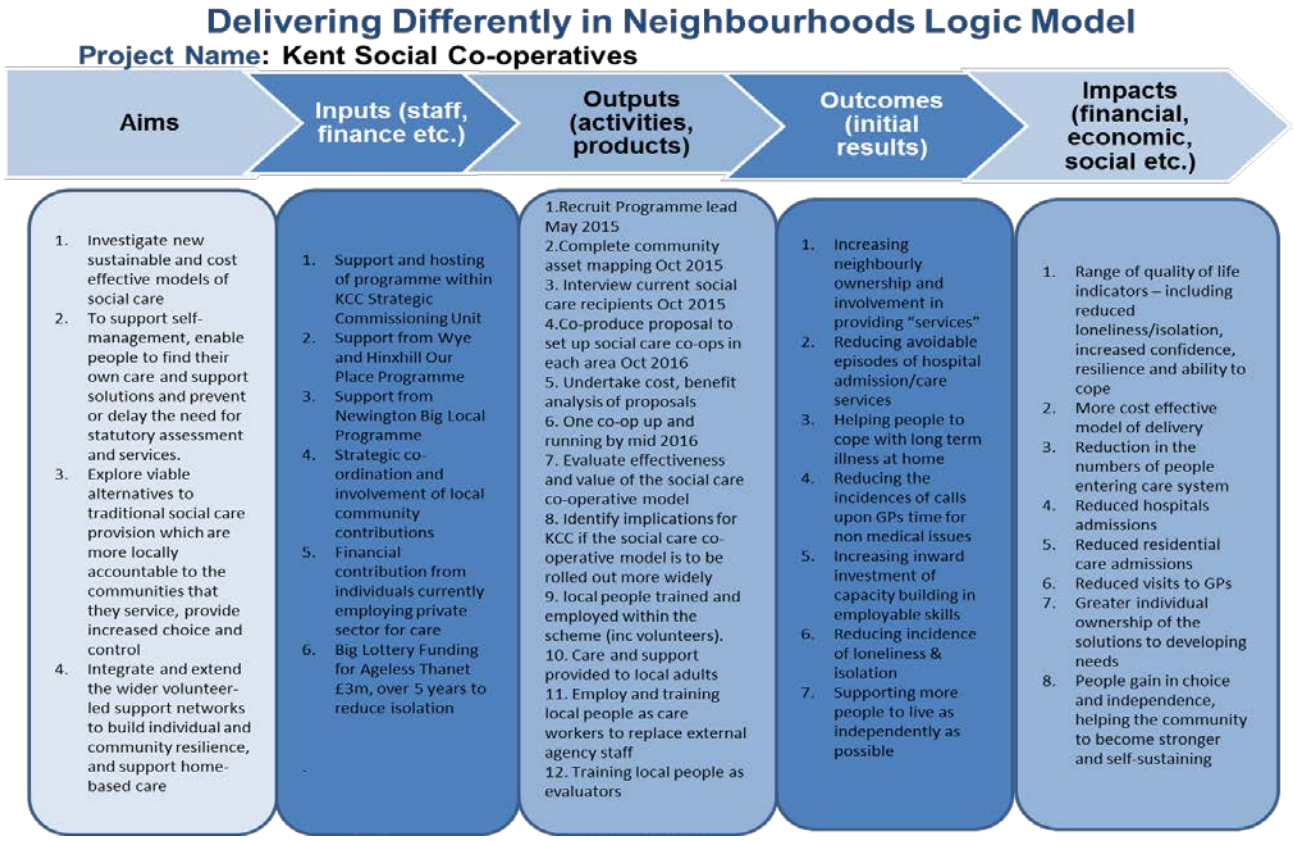
By contrasting these two areas with one where there is not yet a well-defined residents' committee or group, we will learn what the challenges are in co-designing and establishing a social care co-operative in an area that has not had additional funding for a neighbourhood project. This will be important for assessing the costs of roll out more widely.

Project Governance

Our project has three main workstreams: two community-based projects where Wye and Newington will establish what is required locally to establish a social co-op and one KCC workstream to investigate what business processes and policies need to alter to facilitate local social co-operatives.



Project Logic Model



Project Outline and Key Deliverables

- Establish project management & governance
- Map local assets and resources
- Establish/research numbers of people currently in receipt of care support – privately funded and/ or via KCC/NHS
- Programme of "conversations" with current users of services to ascertain how well current support meets need and what is missing
- Understand issues relating to "switching" to social co-op new provider – how choice sits with a co-op model, implications for current providers
- Establish critical mass - would the co-op be just Wye/Newington or need to cover further afield, other communities, villages & parishes
- Research and establish local interest in being a worker in the co-op, terms and conditions rates of pay role and duties
- Explore connection with both communities – economies perhaps on joint arrangements for training, finance and organisational
- Engagement programme from local people - stakeholders especially people in receive of care and their and families
- Undertake cost benefit analysis of social co-op model
- Explore social return on investment and payment by results/outcomes
- Explore funding & investment opportunities
- Develop business case for roll out to other communities

Wye Community

The overall aims and objectives of the Our Place:Wye strategy are to nurture a more inclusive, integrated community, which is more resilient and responsive to individual needs, age and social profile, and stimulates a healthy, caring and sustainable community in Wye and the surrounding areas.

We anticipate that to achieve this we will need to plan and deliver a programme consisting of up to nine projects, comprising three priority projects, four or five 'stepping stone' projects, and an over-arching independent monitoring and review project. These will all be undertaken over a three-year timeframe, delivering value as they go along.

The principles behind The World Health Organisation [WHO] model for Age Friendly communities will also be embedded into our specific project for Intergenerational Learning. The principles will be carried forward into other project areas, so that over the life span of the overall programme, we will be demonstrating a commitment to having our community recognised as one of the first villages in the UK to receive WHO accreditation, which is seen as a planned programme outcome and one of our key performance indicators.

The overall Our Place: Wye operational plan seeks to deliver 8 projects over a five year period.

Project 1: Establishing the community connector service:
Project 2: Developing the social enterprise and new cooperative ways of working:
Project 3: Establishing the community café/food hub:
Project 4: Establishing a community information and technology hub:
Project 5: Extending the community information network:
Project 6: Extending the range of care services in the community:
Project 7: Creating the Intergenerational Activity in the community:
Project 8: Measuring Outcomes through independent Assessment

Project 2: Developing the social enterprise and new cooperative ways of working is closely aligned to the Delivering Differently in Neighbourhoods project, because it aims to establish a multi-stakeholder Social Co-operative way of working, which is responsive at a human scale to serve an ageing population, who are known and understood as individuals, with person-centred care. In essence, the scope and objectives of Project 2 are:

- Creating a new age-friendly enterprise for the community to improve health and well being;
- Clarifying what services will be included in the new ways of working;
- Gaining commitment and funding from stakeholder partners on redirecting commissioning of services more locally.

Through several of these projects we intend to develop a series of new service delivery models that are economically efficient, and replicable; we want this to integrate with and extend, the wider volunteer led support networks already in place to build individual and community resilience, and to support more home-based care.

Timetable:

- March-June 2015 to evaluate the options for a new enterprise, and to consider establishing the new organisational structure and legal format.
- Autumn 2015 – Developing the new commissioning arrangements for agreement with stakeholders.
- Mid 2016 – March 2017: Planning the transition to new arrangements

Process of setting up the co-operative structure in Wye

The Parish Council remains the accountable body for Our Place: Wye until April 2015 when our new governance body – the Programme Management Group – will be created to oversee the development and implementation of the Programme.

Emma Laycock, the Co-operative Advice Manager at Co-operatives UK, has advised us to engage either one of the Co-operative Development Bodies: - Principle Six or Mutual Advantage to advise on the appropriate business case. We are breaking new ground in Kent as most social co-operatives are worker-owned, so we will draw on the experience of co-

operative development experts. Emma Laycock will also help us with the **governance arrangements** and Co-Ops UK will produce an **Options Paper** to highlight appropriate legal forms and models and assist with the **registration.** Emma indicated that the entire process could be completed within three months approximately and for around £2,000. We have the funds for this in the current budget.

Newington Community

Newington is a Big Local community. Big Local is an exciting opportunity for residents in 150 areas around England to use at least £1m each to make a massive and lasting positive difference to their communities. Big Local brings together all the local talent, ambitions, skills and energy from individuals, groups and organisations who want to make their area an even better place to live. Big Local is funded by the Big Lottery Fund and managed by Local Trust. Nationally they work with a range of partners to deliver Big Local, building on the skills and experiences of others to provide expert advice and support for residents.

The Big Local programme aims to achieve the following outcomes:

- Communities will be better able to identify local needs and take action in response to them
- People will have increased skills and confidence so that they can continue to identify and respond to local needs in the future
- The community will make a difference to the needs it prioritises
- People will feel that their area is a better place to live

Two years of community engagement, (Newington was announced as a Big Local area Dec, 2012) led to the creation of a resident led partnership (residents must always form at least 51%) that seeks to engage with stakeholders, including local authorities in order to make Newington an even better place to live. Local Trust endorsed Newington's community led plan for the first two years of the programme – setting out priorities and aspirations, in autumn 2014 – including the pursuit of locally connected models of care and support. The Newington plan states:

> **….. one persistent problem in Newington is that services are often 'parachuted' in from outside. Agencies and staff are not known to local residents, and as a result take-up can be very poor; we rarely see the creation of paid roles for local people.**

The social co-operative will build on work in Newington to date and the projects planned for the coming year. For example, Newington has access to the 'Star People' programme run by UnLtd, (alongside Big Local): The Foundation of Social Entrepreneurs – which encourages

people in Big Local areas to think co-operatively. Although the 'Try it', 'Do it', 'Build it' approach was initially designed for individual social entrepreneurs; we believe it could be adapted to a whole community.

Newington is also a 'Connecting Communities', (C2) area, (pre-dating Big Local): a cost-effective way of working with communities to empower both local residents and frontline service personnel to improve health, well-being and local conditions in disadvantaged areas. Newington residents have been working with Hazel Stuteley OBE on C2. Hazel Led the reversal of a deeply stigmatized 'sink' estate in the 90's which became a national 'flagship' for health improvement and community renewal (Beacon Project, Falmouth 1995-1999). Hazel is Fellow of the Centre for Welfare Reform.

West Kent Housing recently won the contract to build a new 40 bed extra care sheltered scheme in the heart of Newington. We envisage developing new and exciting outreach and in reach models of care and support; making shared facilities, including a restaurant and gym available for the wider community.

The Newington Project will have strong intergenerational element to align with our aim of revolutionising delivery of social care in the long term. With this in mind we will seek to engage young people through the Marlowe Academy – a secondary school that sits at the heart of the community and whose Sponsor/Chair of Board of Trustees is Sir Roger De Haan CBE. Sir Roger is supporting major initiatives to improve access to education at primary and secondary levels and received a knighthood for services to Education and to Charities in Kent and overseas in the New Year Honours 2014. It is hoped that we can build on this spirit by supporting young people to develop skills that can be reflected in a social care co-op model for the community; changing perceptions of care as a career path.

Kent Rural Community Council

Action with Communities in Rural Kent is the delivery partner in the county for 'Village SOS': a new initiative from the Big Lottery Fund to launch a rural revival and inspire people to start community businesses that will breathe new life into their areas and create jobs. The programme offers tools, support and expert guidance to help communities take a step towards starting their own businesses and guide them through the journey from their initial idea to transforming the area. We believe working with Rural Kent on Village SOS between the two neighbourhoods could fit well with the creation of the social care co-op.

Co-Designing New Models of Care

One clear feature of an age-friendly society would be the consistent involvement of older people in the governance and co-production of services, initiatives and activities, and our approach to 'Care and Support' has this at its centre. Creating the social co-operative will be an essential infrastructure step towards this, but overtime, we want to go further than just arranging a new way to manage what exists today.

We think that there are three elements to the issues of "care and support" that will need enhancement to achieve greater levels of sustainability and closer integration with community/village life:

- Improving the quality of the arrangements whereby people enter into contracts with private/third sector to provide non- personal care for family members, provision of meals, cleaning, shopping etc
- The support for family carers
- Developing design and implementation options for new services for joint Community-led, publicly funded care, currently managed through KCC and the NHS.

Burstow's Report – Commissioning on Home Care

If homecare is not yet in crisis, it soon will be. That was the stark message delivered by former care minister Paul Burstow's commission on homecare. Key recommendations from the Key to Care report include a living wage for all care workers, along with clear training and career pathways for care workers in both health and social care.

We believe that this project will inform and enable new and locally accountable models of delivery which will support KCC in achieving the key outcomes of the Burstow's Report. Local people working to provide care in their communities will reduce travel time, the roles developed will be far broader than just time and task home care with workers in the co-op working to ensure peoples wellbeing and independence is maximised. The model will be locally accountable for delivery of outcomes and high quality dignified care.

Internal processes and policies with Kent County Council

The KCC internal workstream will scope out what processes and policies need to alter to support development and delivery of local social co-op including:

- Referral Systems
- Assessment of Need
- Eligibility and allocation of resources
- Case Responsibility
- Safe Guarding / mental capacity and consent
- Impact on charging policy and Care Act Care Cap Calculations
- Social return on investment and payment for results / outcomes
- Developing mechanisms to fund social co-op for delivery of care and support

    - Provider Managed Services
    - Community Brokerage
- Information Governance Issues and data sharing protocols

Cost Benefit Analysis

We must understand if our vision for a social co-op is financially viable, delivers better outcomes for individuals at educed costs and what changes would be needed to KCC's internal processes and systems.

Mapping of adult social care current spend in the two communities shows;

- Wye and Hinxhill with 2282 residents of which 35% are over 65 and 54 people are aged 90 or over there are 28 people who receive an ongoing support package. The total annualised average spend is over £358,000 - in addition to this will be many people who fund their own care.

- Newington with 5210 residents of which 14.5% are aged over 65 and 20 people aged 90 or over. There are 51 people receiving an ongoing support package. The total annualised average spend is over £168,000 - with less people funding their own care.

In both communities care and support is currently provided via a range of different contracted and grant funded providers. The residents in receipt of support have a range of needs. Most are older people but some are people with physical, sensory and learning difficulties and people with mental health needs. We believe that it will be possible to provide the more tailored support that people want, more cheaply through the co-operative model, but …… **The most important benefit must be reduced health and social care costs, because if this model does not significantly reduce costs then it will not be possible to roll it out.** The evaluation must therefore provide robust evidence of cost reduction and increased efficiency.

Identification of other stakeholders and partners

Although this project has begun being adult social care sponsored and focused through the life of the project we will be identifying opportunities to work with other stakeholders and commissioners including:

- Public Health
- Clinical Commissioning Groups
- Children's Commissioning
- Thanet District Council (Newington)
- Ashford Borough Council (Wye)

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