

Integrated Care Services

.....
Bringing together leaders to transform
services and outcomes for people living
with long-term conditions
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Who we are

We're Age UK and our vision is a world where everyone can love later life. We believe that living longer should be celebrated and everything we do is designed to change the way we age for the better and enable everyone to be part of the solution. Together, we can help everyone make the most of later life.

We are the largest charity and social enterprise working with and for older people. We have local and nationwide experience and expertise in developing and providing services for older people and we understand their needs and concerns.

What we do

Age UK is dedicated to identifying and testing a pipeline of new and innovative service models that can be adapted locally and scaled up across the UK and beyond. We share knowledge and best practice across the system as we work to join up services and drive innovation to ensure that older people receive the best possible services and truly holistic and personalised care.

Our Integrated Care Programme in a nutshell

Age UK's Integrated Care Programme operates across England. We work to bring together voluntary organisations and health and care services in local areas. Together we provide an innovative combination of medical and non-medical personalised support for older people living with multiple long-term conditions who are at risk of recurring hospital admissions.

Through our Programme, Age UK staff and volunteers become members of primary care led multi-disciplinary teams, developing tailored care plans and providing essential support in the local community. The Programme has been underway in Cornwall since 2012, with a further eight new sites launched in 2015. Initial results are highly promising in terms of improving the wellbeing of older people, preventing unplanned admissions to hospital and reducing the costs of social care.

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‘For me personally, I have been encouraged to look at patients where I thought their dependency levels would only increase and see that with a relatively small level of intervention, they can be encouraged back to a much lower level of dependency.’

Dr Tamsin Anderson, Newquay GP.

Why we have launched the Programme

We know that too many older people with multiple long-term conditions are not getting the personalised, integrated care and support they need to live full lives at home and to sustain their independence for as long as possible. Instead, all too often they are in and out of hospital with no sustainable plan to keep them fit and well at home. Working with older people and local services, we have developed an approach which is proving effective in supporting their health and wellbeing by enabling them to stay at home and have fewer unplanned hospital admissions.

The need for a Programme like this is significant:

- There are over 14.9 million people in the UK aged 60 and above and this number is projected to rise by over 50 per cent in the next 25 years.
- Older people represent 55 per cent of all hospital admissions and all too often arrive at crisis point and in need of urgent support.
- On average, people over the age of 75 spend five and a half days longer in hospital than those between the ages of 15 and 59.

Older people want and deserve services that are joined up and respond to their wider needs. In order to reduce hospital admissions, we know we must put much more emphasis onto earlier intervention and prevention so we can support older people to manage their long-term conditions as successfully as possible, while maintaining, or hopefully even improving, their overall health and wellbeing. Age UK's Integrated Care Programme puts these important principles into practice.

NHS Five Year Forward View

Published in October 2014, the NHS Five Year Forward View sets out the 'road map' for the future of the NHS. It is the widely agreed, collective view of how the health service needs to change given system pressures. It recognises the use of trained volunteers and health and social care professionals working together in an integrated way as the 'future' and an 'already emerging' potential sustainable model for delivering personalised care and support.

Who we work with

We have an ambitious Programme which, uniquely, brings together leaders from the local health, social care and voluntary sectors as equal partners.

Our model works with older people, their families and carers, Clinical Commissioning Groups, GPs, Acute Trusts, Community Trusts, Local Authorities and Voluntary Organisations. Our learning also supports over 160 local Age UKs who are seeking to develop similar models in their localities.

'Carers and nurses are so busy. They have so many people who they need to look after, but we've got more time. We can do things that help make people's lives so much more interesting and bring a little bit of joy back to their life. Being a volunteer is wonderful: it's fun, I've met new friends and I've started living my life again by volunteering.'

Jane, a volunteer on the Programme.



Through the Programme, with our partners, Age UK's ambitions are to:

- **Improve the health and wellbeing outcomes for older people** with long-term conditions who experience high numbers of avoidable hospital admissions.
- **Improve the experience and quality of care and support amongst older people** by tailoring services to meet their needs and providing the right support at every stage.
- **Reduce cost pressures** in the local health and social care economy.
- **Support and deliver transformational change to the whole system** by demonstrating how GPs, community care, hospitals, social care and the voluntary sector work together, with the older person at the centre.

Through this Programme, we want to transform the quality of life of older people by working with partners in health and care to drive sustainable whole system change, maximising the value of hard pressed statutory funds in the process.

As we grow older, we all face new challenges but that doesn't stop us from wanting a fulfilling, independent later life. Age UK is passionate that

everyone should have the opportunity to be able to make the most of later life, whatever their circumstances, wants and needs.

We are committed to exploring innovative funding mechanisms to help make this happen; for example, we are working towards developing a Social Impact Bond to make the Programme sustainable. To help us achieve this we are working with partners on contractual mechanisms that can align incentives, such as Alliance Contracting.

'I heard of a couple who hadn't been out of the house for six months. Age UK saw them and took them out to the local new supermarket for tea and cake and to have a look around. They were delighted to have left the house after six months. It's those 'soft skills' statutory health and social care don't pick up.'

Dr. Matthew Boulter, Penwith Pioneer Project Board.



‘I can’t get out and it’s wonderful that you come and take us out, it’s a new lease on life.’

Val, an older person on the Programme.

The Programme in action

This is an exciting new approach because it puts older people in control of their own health and wellbeing, enabling them to regain and sustain their independence and improve their quality of life. It also represents a new way of working, which represents a radical shift away from siloed medical interventions towards a model featuring non-medical support delivered by multi-disciplinary teams that include the third sector.

An integrated care pathway is at the heart of the Programme with these key steps:

- Our 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 these partnerships enable all organisations to work towards the same set of outcomes, first and foremost improving the quality of life for the individual concerned.
- We use **predictive risk stratification to identify those older people** most likely to be admitted to hospital and to focus our resources most appropriately. Evidence from Kaiser Permanente’s experience in the United States demonstrates that risk stratification had a positive impact on reducing admission rates, particularly when targeting groups of people with the following long-term conditions: Angina, COPD, Dementia, Diabetes, Pneumonia, Stroke and UTIs.¹
- 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.**
- The next step is actively supporting people through effective signposting and care co-ordination to increase independence and reverse the cycle of dependency. We connect the services and activities 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.
- 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 approximately 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 always able to make contact again through their practice or Age UK Personal Independence Co-ordinator if they wish.
- 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.
- To support local partnerships, we have co-designed and developed a performance management and outcomes framework that, supported by a financial model, tracks the impact of the Programme on individual services and how they are used. This enables local partnerships to confidently plan service transformation. It also means that the teams working with older people can clearly see their achievements and outcomes.

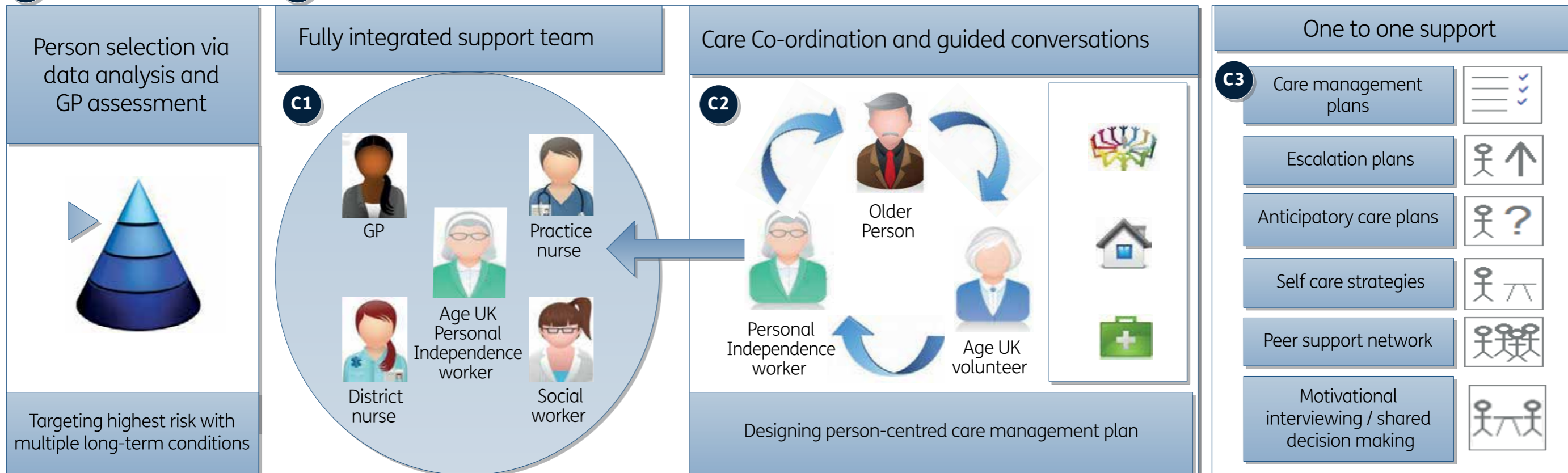
In summary, this approach promotes independence from primary and community health services and prevents avoidable hospital admissions.

¹ www.bmj.com/content/327/7426/1257

A

Whole system change: Local voluntary organisation at centre of person's health outcomes

B Cohort identification **C** Person-centred multi-disciplinary team and the role of the Age UK Personal Independence worker



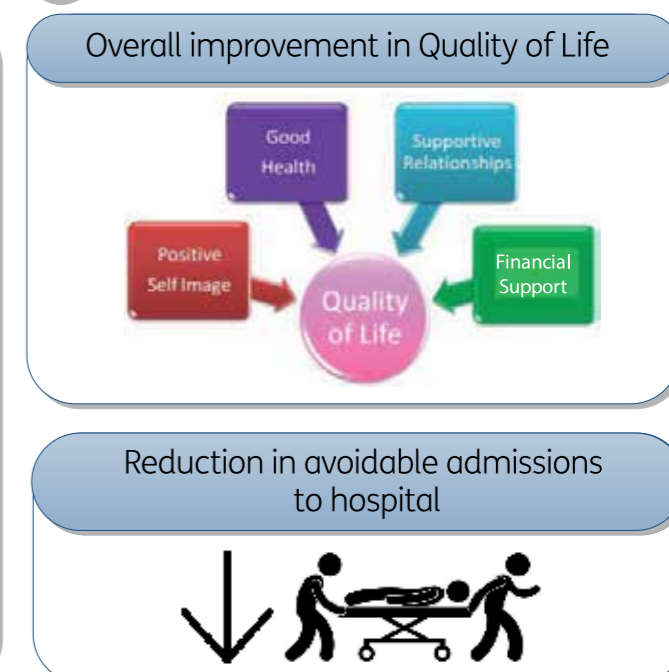
D Wrap-around local support services



E Age UK's integrated care pathway development



F Outcomes





Achievements so far

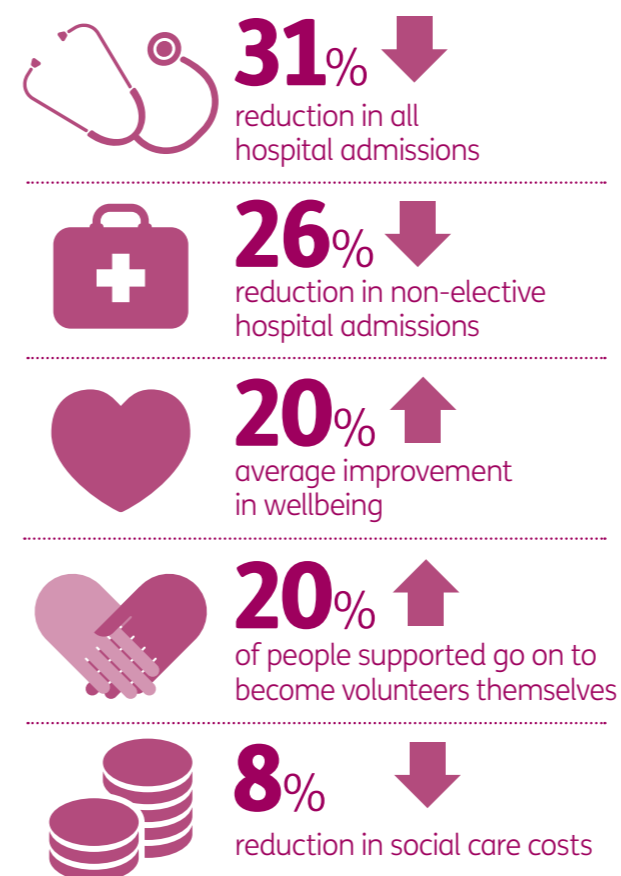
Early results are highly promising and live up to ambitions. This has led us to scale up our Programme to nine sites in total and recruit more than 4,000 older people to take part.

Since launching the Programme, we have seen:

- 1 An improvement in people's wellbeing:** Our Programme has led to an improvement in older people's health and wellbeing assessed using the Warwick and Edinburgh Mental Wellbeing Scale.
- 2 People being reconnected with their communities:** Reports show that both older people and their carers feel more connected to their communities after taking part in the Programme. A number of the older participants go on to become volunteers themselves after taking part.
- 3 A reduction in pressure on the health and care system:** Co-producing the care plan with the older person and focussing on preventative interventions has led to a reduction in emergency and non-elective admissions, alleviating cost pressures on the health and care system. This has saved healthcare professionals' time and simultaneously boosted their morale.

Cornwall's 'Living Well' Integrated Care Programme

Interim results from our Programme in Penwith, Cornwall show:*



Building on our successes, in 2015 we extended the Programme to eight new sites across the country, each aiming to support a further 500 to 1,000 older people over the course of one year. These sites are: Portsmouth; North Tyneside; Ashford and Canterbury; East Lancashire; Blackburn with Darwen; Redbridge, Barking and Havering; Sheffield; and Guildford and Waverley.

'The team supported someone who'd been in hospital several times to remain at home. They supported her needs and she's not been readmitted to hospital since.'

Peter, a leading occupational therapist involved in the Programme.

*All results taken from a locally commissioned data analysis of the first 325 older people on Cornwall's Programme. More extensive evaluations from the Nuffield Trust will be available in due course (see 'Next Steps for the Programme' for more information).

Case studies



Jim

Former businessman Jim had problems with his mobility and often experienced falls as he moved around his house. On top of this, he had frequent contact with his GP and Community Matron due to a low mood, pain in his knee and diabetes.

Jim's concern was to stop feeling like a burden and regain his independence. To help, we referred Jim to an assessment by an Age UK Postural Stability Instructor and he joined a balance and stability class three weeks later.

We noted Jim hadn't been attending podiatry appointments, despite his feet difficulties, so we explained the benefits of attending and supported him with transport for an appointment arranged for the following week. Furthermore, Jim didn't always know what to ask his GP and we prepared questions on pain management and sleep patterns that he could take to his next appointment.

Since his referral to us, Jim's confidence and independence has really improved. He has joined a cinema club and goes to the 'silver screening' fortnightly. He has made new friends and become involved in a local charity fundraising group.

Whilst on the Programme, Jim had a hospital admission due to pneumonia. The team were able to arrange an early discharge with support at home.



Gina

Gina has angina and dementia, amongst other conditions. She had repeated falls and in the previous year had had regular contact with her out of hours services. She was very much housebound which made her depressed and anxious. Her husband is her main carer, but he was struggling and needed time to himself.

When talking to Gina, it became apparent that her main goal was to take her dog for a walk on the beach, but she was concerned about falling, particularly after being housebound for such a long period of time. We arranged for Gina to have a functional assessment and an exercise buddy helped her with balance training at home. Gradually, her mobility improved.

Gina's mobility has since improved sufficiently for her to attend a regular social event, giving her husband a chance for respite and to go out and enjoy himself. What's more, she can now not just take her dog for a walk but also throw a ball for him on the beach, which she previously thought impossible. She has had no further hospital admissions.



Ruth

Ruth had enjoyed an active life including parachuting and horse riding. But recently she lost her husband and was living alone. She had a bad fall in her garden leading to a six week package of care and was in frequent contact with her GP which left her feeling low. To compound matters, a chronic digestive problem caused Ruth to lose weight and meant she needed to be close to the bathroom, heightening her anxiety.

Ruth's priority was to feel confident enough to leave her house. We arranged for a volunteer to build her confidence, starting with talking with her over a cup of tea at home before going out once a fortnight to a nearby café.

We referred Ruth for a functional assessment from the Age UK Postural Stability Instructor, with a view to her attending a balance and stability class. Additionally, we worked with her GP to arrange meals and drinks that Ruth would like and wouldn't cause her further stomach problems, as well as a medication review.

Within a few weeks, Ruth was engaging with social activities. She now regularly goes walking with another lady from the Programme and also joined a coffee morning group. Her confidence has been boosted enough that she feels she can share her problems with others. Her wellbeing score has gone from 17/35 to 32/35.

With the help of a volunteer, Ruth planned and undertook a trip to see her sister who had been taken poorly. She is delighted with the Programme, saying it has given her things to look forward to and be part of.

'We decided that the exercises benefited us (people with COPD) so much we decided to start our own club with the help of Age UK... We just generally support and help each other.'

Paddy, a member of the Breathers Group.

Peter

Peter, a former diamond trader, suffered from bereavement issues after his wife died 10 years previously. He has Parkinson's and could only leave his house with help. His family are supportive but based far away and the only person he saw regularly was his cleaner who came on a weekly basis. He used to draw and be a member of his Rotary club, but lost interest as they evoked memories of his wife.

When having his guided conversation, Peter said he wanted to meet new people and 'feel useful'. He became particularly animated when talking about his former job and we thought there would be interest in him talking about it publicly. With a volunteer assigned to help him with research, we arranged for Peter to give a couple of talks in a local Day Centre and Coffee group, which were well received and had the audience engaged.

To help him meet new people – and rekindle some old hobbies – we organised for him to go to a local art group and an Age UK coffee morning.

Peter's social life has really been boosted since he joined the Programme. He has renewed his interest in art and attends the group on a weekly basis doing pastel drawings. His friends from the group sometimes pop round to visit him at home, keeping him company. At the coffee mornings, he has met new people and undertaken a mentoring role so when people attend for the first time he takes them under his wing. Moreover, after his success in the first two, we are hoping to arrange more diamond trading talks.

'You should name Age UK, Age OK, as I now feel all OK!'

Peter.



Next steps for the Programme

The Age UK Programme in Cornwall has now supported 1,000 older people. An evaluation covering one year of Cornwall's Programme is being carried out by the Nuffield Trust with findings expected in spring 2016.

During 2015 we extended the Programme to eight new sites: Portsmouth; North Tyneside; Ashford and Canterbury; East Lancashire; Blackburn with Darwen; Redbridge, Barking and Havering; Sheffield and Guildford and Waverley.

This expansion will enable more testing at a greater scale, facilitating further financial and service modelling. Indeed, a full evaluation based on a matched control study will be carried out by the Nuffield Trust once 4,000 older people from our sites across the UK have gone through the Programme. The findings will be available in spring 2017.

Through our own learning and knowledge networks, local Age UKs are benefiting from the development and delivery of the model and many are developing elements of it with their commissioners and local populations.

With older people across the country starting to benefit, interest in this approach is growing and we are always pleased to hear from localities where NHS and local authority colleagues believe the Programme has an important contribution to make to older people's quality of life and wellbeing.



'Before I met young Caroline it was very boring and I was very lonely. Living so long I think I needed more to interest me... I needed someone to talk to and I found out you (Age UK Cornwall and Isles of Scilly) were supplying that need, now I look forward to it every week.'

Annie, an older person on the Programme.

For more information, please contact:

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We would also like to thank our partner Improving Care and our partners in Cornwall, Portsmouth, North Tyneside, Ashford and Canterbury, East Lancashire, Blackburn with Darwen, Redbridge, Barking and Havering, Sheffield, and Guildford and Waverley.

Finally, we thank all of the older people, carers and volunteers who have taken part in our Programme.

In some instances, the names of those quoted have been changed.
The photographs throughout this report are not of those quoted.

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