OLDER PEOPLES JOINT COMMISSIONING STRATEGY 2013/16

‘HEALTHIER AT HOME IN OXFORDSHIRE’
(blueprint)

(The blueprint describing the ‘end state’ for service components that will deliver care for Older People at home or closer to home, rather than in Acute Hospitals, this is predominantly focussed on priority 2, Older Peoples Joint Commissioning Strategy 2013/16)

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EXECUTIVE SUMMARY

Overall purpose of Healthier at Home

- The current care system is not working well for service users and their carers. The move through it is slow, it reacts to crisis not before, the hospitals are overflowing, too many older people are losing their functioning ability because of staying in hospitals too long and too many people are going into long term care too early.
- The growth in the population and burden of disease means that without significant change the pressure on the system will increase.
- Some changes have happened, some are happening, some need to happen.
- The ‘blueprint’ is designed to piece the components together so they all support one other and work as one.
- The blueprint is a framework that will be used to achieve the changes needed and describes the end state following those changes.

What does the model look like?

- It is an integrated community model for services. The aim is to help primary care look after older people in need better and reduce hospital and nursing home use.
- It can be seen as 4 components:
  1. prevention and early support
  2. primary care
  3. community care
  4. acute care.
- Specific services that community care is focused on are ‘community hubs’ that deliver specific functions, including Emergency Multidisciplinary Units (EMU), integrated teams, interface medicine, and primary care.
- The hubs will have the ability to do a same day multidisciplinary team (MDT) assessment instead of admission, provide initial treatment with a support plan for ongoing care. What is wanted is an early referral, comprehensive assessment and observation followed by discharge with support and plans.
- Integrated teams are health and social care teams that are able to provide a single route in, a MDT approach, a care-coordination role and work together to avoid duplication and support people at home.
- Interface medicine teams are medics that are able to provide enhanced skills to primary care, based in the EMU but with the ability to provide a home visit with a MDT team support. There are other potentials for this, and they are not a replacement for primary care.
- Primary care has a central role and its challenge is to develop systems for predicting and planning for problems. It will in addition, also have to consider how it can respond quickly to calls for help from older, housebound patients and how to stop the increase in 999 admissions.
- All these components are not standalone, all overlap and need to work as though it is one system of care that enables people to live healthily at home.
OLDER PEOPLES JOINT COMMISSIONING STRATEGY 2013/16

‘HEALTHIER AT HOME IN OXFORDSHIRE’
(blueprint)

THE LINK TO THE STRATEGY

The Older People’s Joint Commissioning Strategy 2013/16 (hereafter called the Strategy) has been written collaboratively between the two commissioning organisations (Oxfordshire Clinical Commissioning Group (OCCG) and Oxfordshire County Council (OCC)), people who use services, their carers, representatives or organisations who deliver services to older people and people who represent those who use services. It lays out a number of outcomes of success that people have said they need in order to ‘enable people to live successful lives’ (the vision from the Strategy).

‘Healthier at Home’ (blueprint) focuses predominantly on priority 2 (although it does draw on all the priorities): ‘I get the care and support I need in the most appropriate way and at the right time’ and identifies the components that need to be in place to deliver this outcome, and what success will look like. As with all strategies, there are overlaps with other priorities and these will be identified throughout this document. It should be noted that there are specific work streams for the other priorities and the overlaps in this document reflect the work of those work streams.

WHY CHANGE?

The health and social care economy faces an unprecedented twin challenge; a significantly increasing older people’s population growing more frail with a prevalence of dementia increasing by 31% over the next 25 years (in people aged 85+) and a significantly decreasing financial envelope to fund it. Additionally, carers of those affected are part of that population.

We know that unplanned inpatient admissions of older people are rising; in Oxfordshire a high number of older people are delayed in services, and in spite of a number of policy directives and service changes to shift resources in to the community, this remains a considerable challenge. A third factor is an emerging view that there is a ‘Post-Hospital Syndrome’; a multifactorial physical and psychological decline in older people that can persist for days/weeks following discharge from hospital.

We now know it’s healthier to stay at home, people tell us they want to be at home and our planning and our services must be geared to work from the premise that people will be supported to return or remain at home following an essential acute hospital admission.

Current services are too reactive and hospital-centric, with admission being an easy default. On discharge, too many people go straight into care homes or an assumed step down to community hospitals with only some people going home. To achieve the shift required to address all these factors, a transformational change predominantly in the health and social care system must happen.

“No-one wants to stay in hospital longer than necessary, but the support needs to be in place. “
The majority of people who have previously attended A&E or been admitted to acute hospital services with urgent care needs will now be supported at home or through services provided in the community. To enable this, some funding for the attendances and admissions in acute hospital services will have to be transferred to the community. This blueprint describes the core elements of the future service model to deliver that change.

This change to these core functions aligns with the Outcome domains 2 and 3 of the NHS Outcomes Framework 2013 to 2014 and domains 2 and 3 of the Adult Social Care Outcomes Framework 2013/14. In addition, as mentioned this is also a key part of the implementation plan for all the priorities in the Oxfordshire Older People Joint Commissioning Strategy 2013/16 (see appendix 1 for the priorities). Added to this it is underpinned by:

- Oxfordshire’s Joint Health and Wellbeing Strategy 2012/16.
- Outcomes Based Incentivised Commissioning project (OBICs) for frail elderly people’s phase 1 report.

Throughout this document the assumption is that all services that provide care for adults and in particular, older people will be a part of that change. This will not be about building on, or adding to current services; it will be about replacing them through a transformational change with the new model of care and services, in line with the described core components in this document.

There are additional assumptions that underpin this blueprint and it is essential that all these are core to all services delivered as part of the new model of care listed in Appendix 3.

**WHAT IS THE ‘BLUEPRINT’?**

This describes the ‘end state’ to be achieved through transformational change. The approach taken is not to describe the actual services needed, (that is for the providers to determine), but to set out the core components (domains of care) of the new transformed care system. The blueprint explicitly allows for local variations, led by OCC and OCCG and the six Localities that form it. These will be determined as part of the change process with core elements that will be consistent throughout Oxfordshire.

Whilst the transformational change required will predominantly be in the health and social care sectors, change will need to involve the City and District Councils and the services they commission and provide (e.g. Transport, Housing, and Leisure) and other sectors as well, including the voluntary sector. The assumption is that this whole system blueprint model will be signed up to by all the key sectors.

**WHAT IS THE VISION AND MISSION?**

The vision of the Older People’s Joint Commissioning Strategy is to ‘enable people to live full and successful lives’. This blueprint is part of building that vision.

The key mission of this change is to:
Enable people (and their carers) to take responsibility as far as possible to maintain their own health, and take an equal part in planning the care they receive.

Support people to remain living at home, and only by exception transfer to long-term care.

Ensure that when people become ill (or have an accident not requiring immediate acute hospital care) then they receive their care, whenever possible, in a community setting.

WHAT OUTCOMES ARE WE EXPECTING?

Whilst we have identified the mission of the changes work was completed by the OBICs project drawn from the Strategy; these outcomes are identified below:

1. That frail, elderly and vulnerable older people are enabled to be as healthy, active and independent as possible in their own home with the support needed to do this.

2. In a care crisis or health emergency the person is supported as effectively as possible, and that there is an efficient transfer of care between agencies with any necessary health and social care support to them and to their carer.

3. That the treatment and care provided is right for the person’s needs in the right setting and respects the person’s individuality and dignity.

These outcomes have been the subject of an engagement phase with clinicians, managers, users of services and carers, and have received wide spread support. Added to this, the Strategy identifies a number of outcomes, defined through ‘I’ statements by the person who needs care and their carer (see Appendix 2). All these (and the OBICs outcomes) will be used as part of the monitoring and evaluation processes for the blueprint.

WHAT ARE THE CORE COMPONENTS OF THE MODEL?

The core components** of this approach are:

- **PREVENTION AND EARLY SUPPORT**: (Priority 1, 4 and 5 of the Strategy) People and those who have carers will take responsibility for keeping healthy.

- **COMPETENT PRIMARY CARE**: (Priorities 2, 4 and 5 of the Strategy) Should people become ill or have an accident (other than one that will require an emergency ambulance to hospital) they will be seen in the community, near home. This will be by their GP and when required the GP, who will have access to specialist expertise and advice on the care of older people, will carry out any required diagnostic blood tests in or near the person’s home.

- **COMPETENT COMMUNITY CARE**: (Priorities 2, 3, 4 and 5 of the Strategy) if people need further diagnostic testing and a multidisciplinary assessment, this will be carried out through contacting the single point of access and may need to take place in an emergency multidisciplinary unit (EMU). If needed, a short spell of rehabilitation or treatment will be provided.

“More local clinics would help to save older people having to travel”
at home and for a smaller number of people bed-based (sub-acute) treatment or respite care (possibly to relieve carer strain) will be supplied through this service and take place in the community. Longer term support at home will be arranged mostly through personal budgets that support people to live independently at home. For some people with specific needs, long term care in a care home may be necessary.

- **COMPETENT ACUTE CARE:** (Priorities 3, 4, and 5 of The Strategy) Should people need acute care they will go to an acute hospital, receive a good service and be discharged quickly.

**it should be noted that all the components are underpinned by priority 6 of The Strategy ‘I see health and social care services working well together’.

The key principal is that people will receive care in their own homes, should they need bed-based treatment or care, they will return home following that episode of care.

**WHAT DO THESE COMPONENTS LOOK LIKE?**

1. **PREVENTION AND EARLY SUPPORT**

Function
This component relates to all adults, focusing on people aged about 50+, when they are thinking about growing old and keeping well. Ageing successfully depends on people planning early to ensure they can keep well physically, mentally and socially. This will include financial planning, self-caring and becoming or staying physically active.

Role

1. To enable people to take part in a range of activities and services that help them stay well and be part of a supportive community.
2. To enhance people’s confidence and quality of life of people growing older.

Key Components will consist of:

1. Advice and information to aid future planning, accessing activities and accessing care (including for people who pay for and arrange their own support).
2. Advice on how to stay well through self-management of their condition; this is particularly for people who have one or more Long Term Conditions.
3. Exercise programmes set up specifically for people who are in their middle years and aware of the issues as they grow older.
4. Balance and strengthening training and exercises for people who may be losing their functioning.
5. Prevention (smoking, alcohol, obesity) and taking part in screening for early detection of illness or deterioration.
6. Secondary Prevention (bone health, vascular health etc.). This is for people who have had significant accidents (e.g. falls, strokes) to prevent a further accident.
7. Housing and a range of housing options, benefits advice, targeting pensioner poverty.
8. Social and community support projects.
9. Schemes to address loneliness and isolation.
10. Programmes to help with winter and fuel poverty.
11. Simplifying transport for people needing to attend services, and improving access.
12. Support to carers identified by the carer themselves and accessed through their GP or social care services (45% of carer's of older people have a Long Term Condition themselves).
13. Early support in the form of equipment and assistive technology will be available to people to enable them to retain their independence. This is a component of capable community services as well.

The above services will be delivered by a variety of providers from all sectors, some will be self-funded, some privately funded and some funded through public services. A co-production approach in delivering these services is vital to be successful.

2. **COMPETENT PRIMARY CARE**

**Function**

1. To provide responsive, reactive, but also proactive health care for people living at home, returning home and for people living in long term care.
2. To manage the population of older people in primary care, so that disease and reducing function is recognised and interventions are planned earlier to prevent crisis and decline.
3. To provide a comprehensive and responsive medical assessment and review of the older person in the community working alongside the single point of access to support people at home.

**Role**

1. Preventative screening for people growing older.
2. High quality Long Term Condition management.
3. Risk stratification and intervention with medical care for older people living at home or in long term care.
4. More specialised medical support for older people, consisting of assessment (home and building based), advice, diagnostics, care planning and support accessible for GPs assessing older people at home (or in a care home) in need of urgent treatment and on-going management of complex cases at home.
5. Proactive liaison with community and acute services in supporting people to remain at home and return home if in hospital.

3. **COMPETENT COMMUNITY CARE**

**Function**

To support vulnerable and frail older people at home, to return home or in a care home, so as to prevent deterioration and aid recovery following illness which may have involved an acute hospital admission. This will involve providing short term bed-based care when required.

**Key Components and their roles**
It is important to note that interventions to reduce unplanned admissions take place in a highly complex environment. There is an emerging evidence base about a number of different interventions needed; many have been listed below, however it is very difficult to establish the cause and effect of the various interventions. The Kings Fund paper ‘Avoiding Hospital Admissions: What does the research evidence say?’ December 2010 reminds us that ‘…a combination of interventions intended to reduce admissions may be expected to have a ‘cumulative effect’ and, although each may have little effect individually, there may be greater benefit overall than the combined effect of single interventions’.

The components in this section have an evidence base that is identified in The Kings Fund paper ‘Avoiding Hospital Admissions: What does the research evidence say?’ December 2010.

3.1 Single point of access supporting the integrated pathway.

This will be the gateway accessed by referrers from the whole county and will provide the pathway to a multi-disciplinary assessment and an integrated pathway of care. The assessment is for vulnerable people who may need advice, support at home or a full assessment due to an episode of ill health, it will lead for the majority of people to a home based package of support and for the minority a bed-based service to aid their recovery. There will be appropriate gate keeping to these services, with the intention that the services provided through the community services are there to support the GPs to enable people to remain at home.

There will be a single, whole system care pathway; this will start at home with step-up care, increasing with the complexity of the person’s needs, and the default will always be to return people home or to the place of their choice. The pathway will include meeting the needs of people with specific conditions such as people who have had a fragility fracture, a stroke or are in need of end of life care; it is set up to meet the needs of people who have conditions that emerge as people grow older.

3.2 Multidisciplinary assessment and on-going co-ordination of services.

Initial assessments will be carried out in the most appropriate, efficient setting. Consideration will be given to it taking place at the person’s home if possible, if not then it will be in a multidisciplinary unit, sometimes known as an Emergency Multidisciplinary Unit (EMU) or an urgent care centre. The response will be a same day assessment with the capability of responding within 2 hours.

The multi-disciplinary assessment will be consultant led and include, where appropriate, a medical assessment (by a capable clinician with enhanced skills in old age medicine), with appropriate diagnostics available; therapies; social care; and a psychological assessment. The approach will be holistic, with professionals involved from physical and mental health, social and psychological care. An individualised

“There is a need for clear advice which crosses all care organisations”

“Whether one has to go into hospital or not it is important to feel that the various organisations involved are working together and that you will be safe.”
multidisciplinary care plan, involving the person and their carer, will be completed and an identified professional will take responsibility for ensuring the delivery and active on-going monitoring of the care package. Wherever possible, this will be delivered using a personal budget. The person’s carer may need an assessment and support; this will be completed as part of the whole process.

It may be that the person will have a Long Term Condition or dementia for which they and their carer will need advice and support on active self-management, using assistive technology where appropriate to aid recovery and so as to avoid the use of acute services.

3.3 Immediate, short and medium term Interventions

For those who need immediate treatment, home support or medication reviews, these may be able to be carried out at home through a hospital at home service; if not it will be in the multidisciplinary unit. The outcome of this should be for the person to return home with a package of health and or social care support where necessary.

For people needing day treatments (e.g. blood transfusions) these will take place within the unit. For people needing short term bed based rehabilitation, treatment or care this will take place within the unit or close to the person’s home. The specific basis of the treatment or care is recovery focussed with the outcome being that the person returns home. Where this is not possible the person will go to long term, bed-based care. The front door to bed-based services is through the single point of access and the MDT assessment which will start the admission with a diagnosis and a plan.

3.4 Community Hospital, Intermediate Care and (OP) Mental Health Beds

There is a strong view held in Oxfordshire that we have an overly bed-based service with a large number of community hospitals which is spread over a large number of sites. Health and social care commissioners have been working with system leaders to consider how to make the pathway more efficient and effective; to do this we have brought our thinking together to consider the population’s needs in term of community hospital beds, intermediate care beds and beds that are currently used for older people with a mental health diagnosis. Our view is that we should have a single plan for all these beds and have a range of beds that deliver services to meet people’s varying needs required by this population who live all over the county. These beds will need to flex up and down and vary in numbers for each ‘type’ according to clinical need.

There needs to be a number of ‘types’ of interventions delivered which are:

3.4.1 ‘Step up’ and ‘step down’ beds, often called ‘sub-acute care’. The majority of the beds are to be for people being admitted from the community with the minority of beds being used for people who have had an episode of acute hospital treatment and need follow on care.

3.4.2 Rehabilitation beds for people needing specific rehabilitation by health professionals, usually physiotherapists, to increase a person’s functioning in order to return home.

3.4.3 Beds for assessment to give time for decisions to be made about a person’s next move either home or to a care home.

3.4.4 Respite beds for people to relieve their carer.
3.4.5 **Beds for people with dementia** who have complex acute needs.

3.4.6 **Beds for older people with complex needs** who have a functional mental health need.

(The bed based service that is required by people with a functional mental health problem may well need to be planned as part of the mental health service. This is yet to be determined and will need further work in discussion with the current providers.)

### 3.5 Care Packages.

A key component of the integrated pathway is the organisation and delivery of timely care packages that support people to return and remain at home, this will meet the varying needs of people so as to avoid admission and ensure a timely discharge. As with all services on the pathway, the package of care should be individually planned with the person and their carer. Flexing the care packages up and down in line with the person’s needs in a timely responsive way is essential to the design of the services and is best delivered through a personal budget.

Initially, when people are returning home with high care needs, they may need intensive nursing care (hospital at home) alongside home support which will be supplied in line with the care pathway.

There is evidence that older people discharged from hospital benefit significantly from reablement training and support for 6 weeks following their discharge, for 60% of people in this group they will not need on-going support in the community following input by the reablement services. A responsive reablement service that maintains this outcome for the population of people being discharged is an essential component of care as part of the pathway.

The needs of people with dementia should be specifically identified and met as part of all the services available.

The availability of a home care service that is delivered at a time or crisis for the person (or their carer) will be in place. This is an essential component of care that helps avoid hospital admissions.

### 3.6 Long term bed-based care

The blueprint emphasises the need to plan care assuming that all people will return and stay at home throughout their lives. However, as people become older and their needs become more complex it is inevitable that a small number will not be able to remain at home, so will need long term bed based care. This will be provided as part of the pathway of care. It is crucial that the care they receive is high quality and set in an environment that avoids accidents or a deterioration of ill health where possible.

3.6.1 There will be a variety of bed based care that will vary according to the person’s choice and in line with the person’s level of need. The funding of this will be via a variety of sources.

3.6.2 All providers of long term bed-based care will work collaboratively with health and social care providers; firstly to ensure that their workforce delivers care in line with...
agreed standards, secondly to ensure optimal level of functioning of all their residents working through a pro-active approach, anticipating deterioration and where possible preventing this and thirdly in response to residents’ rapid deterioration in ill health or as a result of an accident.

3.6.3 As with all services, bed-based care will be aligned with the end of life strategy.

3.6.4 A well-trained workforce available to deliver the care in this sector is one of Oxfordshire’s major challenges. The providers in this sector are to work in collaboration, aided by commissioners to create a sustainable, well-trained workforce available for this sector.

The medical cover for the residents of long term bed based care will need to be provided in collaboration with other services (gerontology/ interface medicine, therapies, psychological, social work, nursing, medicines management services) to provide a multi-disciplinary approach to giving a consistent, predictive and proactive service that meets the required standards. The medical care will help avoid unnecessary admissions to hospital.

3.7 Interface medicine capability.

A key element to ensuring that all these care components work at an optimal level is the inclusion of an ‘interface medicine’ capability. This is to consist of a number of clinicians with a high level of capability in assessment, treatment and the management of care with frail, complex people whose needs will be met, mostly at home. They will work alongside gerontologists and have input all along the pathway from primary, through community to acute hospital care. The essential aspect of this component is that it is integrated in to the care pathway and act as a bridge between home, community and acute care. These clinicians will provide a specific service on the interface between primary, community, acute and long term care services; it will include the medical support to ‘community beds’ (community hospital and intermediate care beds), provide a specialist in-reach and leadership role to medical support in care homes and, in addition, in-reach in to acute services. The detail of this component of clinical care has yet to be defined and will be developed as part of the transition to the new model of care.

3.8 Transport

Emergency patient transport will need to, in the main, be directed away from acute hospital services towards emergency multidisciplinary units/centres so that unnecessary journeys and transfers for patients are avoided.

Wherever possible, non-emergency transportation of people who need services should be organised and carried out by the person or their carer. For people who are not able to organise their own transport, non-emergency transport is to be arranged for the person to take them home or out of hospital and to and from community provision in a timely way.
4. COMPETENT ACUTE SERVICES

Function

The component will cover the provision of treatment of people who have had an accident or are in need of a 24/7 specialist treatment and service that cannot be provided in the community.

Role

To treat the person, involving their carer, so as to restore them to their previous functioning (ensuring they receive an integrated co-ordinated) service with a timely discharge home.

Key Components

1. A senior gerontology-led multidisciplinary team with active involvement by integrated psychological medicine will be part of the assessment and care of an older person as soon as they enter acute hospital services.
2. Recognition of people with cognitive impairment is essential and all services should be set up in recognition that people with cognitive impairment and a dementia diagnosis will be a significant section of the population of people needing treatment and their needs are to be specifically catered for.
3. Active discharge planning in line with Oxfordshire Discharge Pathway with access to rehabilitation and enablement services.
4. In reach by interface medicine and community teams.
5. High quality proactive nursing care with strong leadership.

(** it is not intended that there should be a detailed description of the components of acute services particularly for older people, this will be part of the work stream that will identify the transition to the new model of services)

LEADERSHIP, QUALITY AND WORKFORCE

Whilst quality is everyone’s responsibility and is about delivering an excellent service in the most effective way possible, a key plank to this is strong leadership by the system leaders and senior clinicians, and having the availability of an appropriately qualified and trained workforce. All these are essential requirements for the successful transformation to the new model of care.

It is recognised that this is a key aspect of the work of providers, however, there are some significant challenges such as the requirement of a new workforce for interface medicine and the recruitment and retention of a workforce for people to deliver home care. Commissioners will give the support necessary to enable providers to overcome these.

PROCUREMENT

Commissioners are aware that financial stability for service providers significantly aids the required increased quality performance and rapid transformational change necessary for this new model of services. With the new procurement environment and changes in requirements that have to be met by commissioners in securing services, the tendering of services will become much more commonplace. Due consideration to these potentially
conflicting issues will be given in making a decision on the procurement route. Once agreement has been reached it will be communicated to providers as soon as possible.

SERVICES IN SCOPE
Please see Appendix 4

REFERENCES
Please see Appendix 5

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Appendix 1

Older People’s Joint Commissioning Strategy 2013/16 (The Strategy)
6 Main Priorities

Priority 1: I can take part in a range of activities and services that help me stay well and be part of a supportive community.

Priority 2: I get the care and support I need in the most appropriate way and at the right time.

Priority 3: When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.

Priority 4: As a carer, I am supported in my caring role.

Priority 5: Living with dementia, I and my carers receive good advice and support early on and I get the right help at the right time to live well.

Priority 6: I see health and social care services working well together.
Appendix 2.

Older People’s Joint Commissioning Strategy 2013/16 (The Strategy)

What will success look like?

Older people, their families and carers, regardless of who they are, where they live and what their needs are, will be able to say:

a) I am generally healthy and I am aware of and supported to take actions to help me remain as healthy as possible as I become older.

b) I am aware of and able to access services and advice to keep me healthy and/or if I need help.

c) I take advantage of the free screening programmes available to me including the NHS health checks programme.

d) I am treated with dignity and respect.

e) I am given control of my care and support and supported to make choices in my daily life.

f) I do not have to describe what my needs are again and again to lots of different professionals and the services that support me are of the right level to cater for my individual needs.

g) I am protected from avoidable harm and supported to live safely in my home environment, yet I have my own freedom to make independent and informed choices.

h) I understand how my care and support works, my care is regularly reviewed in my best interests, and I know what the options are for what happens next.

i) I see public money being spent well by joined up services, without duplication and waste and in a fair and consistent way.

j) I am helped and supported to keep in touch with my family and friends.

k) I get the right treatment and medication for my needs and I get the support I need in the right setting.

l) I am happy with the quality of my care and support.

m) I find that all local organisations have policies that support me to maintain my independence and good quality of life.

4.2 The health and social care system will ensure that:

a) Services and advice are available and accessible to help people remain healthy for as long as possible.

b) The person and their carer/s are at the centre; services are designed around them and matched to the individual’s needs.

c) Services will be planned and available on a seven day a week basis.

d) Support is provided in the most appropriate and timely way and at the closest point to the person’s home/usual place of residence.

e) Where hospital care is needed, planning to move back home starts from day one of admission – with the aim of people living in the community, supported by local services.

f) Support for a person’s physical, mental, cultural and social needs is co-ordinated and delivered in a joined up way.

g) Support is focused on improving the quality of care and quality of life and promotes dignity, human rights, choice and independence.
h) Needs determine the services people receive, not the location or who pays the bill and support provided is good value for money.
Appendix 3.

UNDERPINNING ASSUMPTIONS

1. Population. Our approach is not to be age restrictive, in recognition of the varying levels of functions of people as they get older, the intention is for the care delivered by the community component to be based around the needs of patients/clients whatever their age. However, the focus will be mainly on people aged over 50 who are currently vulnerable, have long term conditions, are in need of care, or who are simply not functioning well; for financial purposes we are using the age of people who are 60 and older. With regard to the Self Care component, this blueprint’s population focus is on people who need to take proactive measures to prevent becoming part of this group.

2. The approach used by those who deliver the services will be a holistic one that brings together the physical, social, and mental health care domains centred around the person.

3. All who work in the services will demonstrate positive attitudes towards people based on dignity and respect.

4. There will be strong clinical leadership that promotes a predictive, proactive approach, and enables timely decision making to ensure a single seamless integrated pathway is in place to and from the person’s home.

5. People will be seen within their own familiar environments as far as possible, and care provided will require people to move from one care setting to another as little as possible.

6. There will be a fundamental commitment by all involved to the continuity of care, avoiding admissions and prioritising the movement of people along the care pathway.

7. There will be patient and public involvement at every point of the pathway, with a ‘co-production’ approach by all staff working with the person and their carer in designing their care plan and how it will be implemented.

8. Care packages will be provided using personalised budgets when appropriate. This means that people who need care will be assessed to have their own budget for their social care and where possible it will be combined with a budget for their health care.

9. Care provided will be evidence based and underpinned by the ‘Silver Book’ quality standards, ‘Quality Care for Older People with Urgent and Emergency Care Needs’ (British Geriatric Society, June 2012), the Phip principles, NICE guidelines and ‘think local and Act personal’ guidelines.

10. Services will be run on a seven day basis and care will be planned on a 24-7 basis (so that there is a plan what to do out of hours).

11. Workforce development will be required to ensure key competencies are in place specifically to support the needs of older people with complex needs who require ‘sub-acute’ care.

12. A key specific behavioural change in service provision will be in working with people who have cognitive problems and dementia. Services need to be adjusted, planned and delivered assuming that the main cohort of older people needing care will have cognitive impairment and for many, a diagnosis of dementia.

13. Taking a person’s choice into account will be a key aspect of the whole system care pathway.

14. Monitoring and evaluation will be through:
- Clinical audits, arranged in agreement with commissioners, will be carried out on services annually
- User/carer evaluations through face to face contact annually and more often when required
- Outcomes identified through the Outcomes Based Incentivised Commissioning (OBICs) project

15. Milestone plans and key performance indicators will be agreed with all the providers to ensure the delivery of quality services with the agreed financial savings. These will be part of the contractual arrangements.
SERVICES IN SCOPE

- Single point of access
- Integrated community teams
- Emergency multidisciplinary unit
- The reablement service
- Supported hospital discharge service
- Early supported discharge services for specific conditions (e.g. Stroke)
- Home care services
- Crisis Response Service
- Crisis Service (mental health)
- Community hospitals
- Intermediate care beds
- Registered and Nursing care.
- Older People’s mental health CMHTs and inpatient beds
- Social work services
- All therapies including occupational therapy provided both by Oxford Health and OCC
- The rehabilitation service
- Care home support service
- Patient transport (including emergency)
- District nursing service
- Community nurses
- Hospital at home
- End of Life services
- Specialist nurses
- Integrated psychological medicine service
- IAPT services for people with long term conditions
- Medicines management
- Medical assessment units
- Minor injuries units
- ‘Interface medicine capability’

Impact on and of these services to be considered:

- 111/999
- Out of hours
- Emergency duties team
- Continuing healthcare service
- Falls service
Appendix 5

REFERENCES

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**House of Lords Select Committee on Public Services and Demographic Change. March 2013.** Ready for Ageing?

**ADASS (Association for the Director’s of Adult Social Service March 2012.** The Case for Tomorrow. A joint discussion document on the future of services for Older People

**iMPowerdemandmanagement 2012.** Home Truths. Relationships between GPs and Social Care Staff
GLOSSARY OF ACRONYMS

A&E – Accident and Emergency
EMU - Emergency Multidisciplinary Units
MDT – Multidisciplinary Team
OCC – Oxfordshire County Council
OCCG – Oxfordshire Clinical Commissioning Group
OP – Older People