Putting **People First**
Transforming Adult Social Care

Making a strategic shift to prevention and early intervention

A guide October 2008

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Introduction

This document is designed to provide practical guidance to local authorities and health communities on how to make a strategic shift to prevention and early interventionIn doing this it draws on the experiences and evidence emerging from the first two years of the Partnerships for Older People Projects (POPP) programme and other related initiatives such as the Department for Work and Pensions' Linkage Plus programme. The guide focuses on promoting the independence and wellbeing of older people and is intended to develop over time to include transferable learning for other client groups.

How to use this guide

This resource is aimed at supporting key groups of people:

- Those people leading the transformation of social care and implementation of Putting People First
- Commissioners in health and social care with a responsibility for older people's services
- Leaders from a range of public sector organisations who are involved in the whole systems work, under the auspices of Local Strategic Partnerships and the Local Area Agreement, to promoted the quality of life of older people
- Older People's Champions and those supporting the involvement of older people.

A summary of the key messages contained within this guide is available **here**. This might be more appropriate for key decision makers at Chief Executive, Chief Officer and Lead Member level.

This guide focuses on specific areas of learning, however more detailed information on a number of areas is available on **Prevention and Early Intervention website**. Where this is the case it is highlighted within the text.

General information about the **Partnerships for Older People Projects (POPP) programme, along with descriptions of the pilot sites** is available, as are further details on the **Department of Work and Pensions Linkage Plus programme**.

A tool is available to enable Councils and their partners to self-assess their strengths and key areas for development in making a strategic shift toward prevention and early intervention.

Policy Framework

Sets out the importance of prevention as a key element within a number of national policy strands, in particular the transformation of social care.

The need for a shift towards prevention, early intervention and wellbeing is central to many key national policy strands:

"An integrated approach to health and wellbeing will require a step change in the relationship between local NHS organisations, local government, other relevant statutory services, employers, third sector and independent sector providers. We want to ensure synergy between the development of vibrant primary and community care services and the 'Putting People First' transformation programme led by local government"

Next Stage Review, Darzi, 2008

"Local public services will need to change. A sole focus on the care needs of the most vulnerable in the community is no longer enough, and will not address the needs of the wider older community…Shaping core and targeted services for an older population will enable people to remain independent for as long as possible. Local mainstream public services will need to be accessible to the growing older community; and older people will need well-planned, targeted interventions that support them when their independence is threatened."

Audit Commission, "Don't Stop Me Now – preparing for an ageing population

"We will boost preventative housing services through investing in proven approaches, such as advice and information, adaptations and repairs, which can prevent health and care crises for individuals"

Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society, 2008

Shifting resources into prevention

"We must set out a new direction for health and social care services to meet the future demographic challenges we face. We must reorientate our health and social care services to focus together on prevention and health promotion. This means a shift in the centre of gravity of spending."

Our health, our care, our say, 2006

"Commissioning needs to be more proactive, transformational and forward-looking, focusing on promoting good health, investing for prevention, independence and well-being.

Commissioning Framework for health and wellbeing, 2007

"…five key aspects of independence and well-being have emerged from research and from discussion with older people themselves as being important:

- *Making a contribution to society, in particular through employment*
- *Material well-being, in particular the need to continue tackling pensioner poverty*
- *The level of health experienced in later life*
- *Satisfaction with home and neighbourhood including, for example, the impact of factors such as access to service, transport and crime, and social contacts; and*
- *The ability to maintain independent living, while being supported with health and care services where needed."*

Public Service Agreement 17: Tackle poverty and promote greater independence and wellbeing in later life

"The National Dementia Strategy needs to ensure that effective services for early diagnosis and intervention are available for everyone across the country. There is evidence that such services are cost-effective – when established they can release substantialfunds back into health and social care systems…"

Consultation on a National Dementia Strategy, 2008

"The direction is clear: to make personalisation, including a strategic shift towards early intervention and prevention the cornerstone of public services."

Transforming Social Care

"The Department is building on the NSF with a prevention package for older people that will set out older people's current entitlements to prevention services and will explore potential new entitlements that will be developed over time. This is in recognition of the significant changes to the health and social care policy landscape that have taken place since the NSF was published, to improve service delivery and standards of care for older people. This package is intended to complement Putting People First and the choice agenda, understanding that many older people do not have the choice to stay at home or the opportunity to benefit from personalised care services because of the absence of preventative services."

Secretary of State for Health, 2008

"This PSA…reflects our ambitions set out in 'Our health, our care, our say' .to create a health and adult social care service that genuinely focuses on prevention and the promotion of health and well-being.."

Public Service Agreement 18: Promote better health and wellbeing for all

"The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services."

Putting People First

Putting People First and Social Care Transformation

Making a strategic shift towards prevention and early intervention is one of the central objectives of **Putting People First**, and the Social Care Reform Grant provides resources to facilitate this kind of transformation.

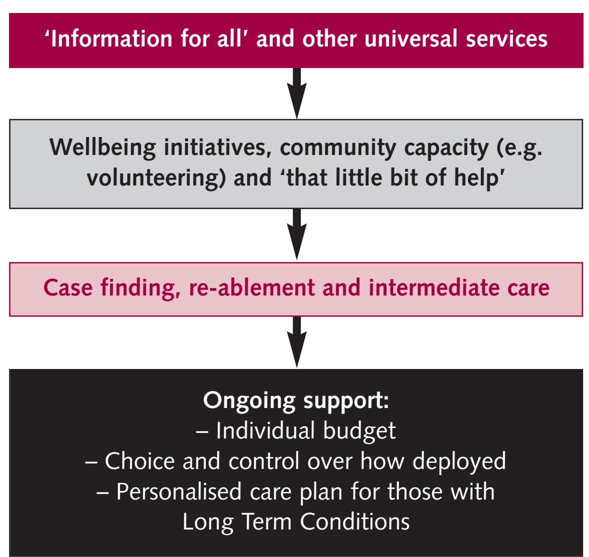
The transformation of social care, as indicated in the **Putting People First** concordat and the Local Authority Circular **Transforming Social Care**, sets out a clear direction – i.e. **"to make … a strategic shift towards early intervention and prevention, the cornerstone of public services".**

The vision for adult social care for the next decade and beyond is laid out in Putting People First. At its heart are four main themes:

- Facilitating access to **universal services**
- Building **social capital** within local communities
- Making a strategic shift to **prevention and early intervention**
- Ensuring people have greater **choice and control** over meeting their needs.

These themes are not discrete or separate, but rather they are interdependent. Therefore, whilst this document focuses on prevention and early intervention, it also highlights the themes of promoting access to universal services, developing social capital, and delivering choice and control.

The interdependencies can also be considered in terms of a pathway – initially people access **mainstream or universal services**, however as their needs progress and they prepare for old age they are likely to require a wide range of support and **capacity developed within local communities**. A rapid deterioration or crisis may then occur, leading them to benefit from **preventative work** – such as an enabling or rehabilitative support which helps people to regain a level of their previous functioning. Any ongoing needs are then met in a personalised way through the provision of an individual budget which gives them maximum choice and control over how they arrange their support.



This diagram is for illustrative purposes only and is intended as a conceptual framework for how different Putting People First elements interconnect and can be applied across the full spectrum of needt. It is not to suggest that all people will actually proceed along such a pathway.

Evidence of Effectiveness

Outlines the emerging evidence from a range of sources.

The evidence for the effectiveness of preventative approaches is getting stronger. For example, the interim findings from the **National Evaluation** of the Partnerships for Older People Projects (POPP) programme is showing a positive picture:

Evidence and learning is also emerging from:

- **The Linkage Plus programme**
- **The work of the Innovation Forum**
- **The locally commissioned evaluations of the 29 POPP pilot sites**.

Key messages from the national evaluation of the POPP programme

- POPP pilot sites continue to have a demonstrable effect on reducing hospital emergency bed-day use when compared with non-POPP sites
- The results show on average that for every £1 spent on POPP, £0.73 will be saved on the per month cost of emergency hospital bed-days, assuming the cost of a bed-day to be £120
- People reported that their health-related quality of life improved in five key domains, (mobility, washing/ dressing, usual activities, pain and anxiety), following their involvement in the POPP projects
- An analysis of those sites where data is currently available (11 out of 29) appears to demonstrate the cost-effectiveness of POPP projects
- POPP partnerships across the health and social care economy seem to have strengthened and accelerated developments around joint commissioning. In particular, there has been recognition of the value of involving voluntary and community organisations in service planning and delivery
- To date, only 4% of the projects across the POPP programme have indicated that they do not intend to sustain their service after the end of DH funding.

Further information is available **here**

Material from these and other sources has been drawn upon in order to develop this Resource Pack.

Defining prevention and early intervention

Sets out a framework for understanding what is meant by prevention.

The term prevention can mean many different things to different people. It is therefore important to have a clear frameworkThe following framework is helpful as it has a broad focus. It identifies three categories:

- **Primary prevention/promoting wellbeing:** this is aimed at people who have no particular social care needs or symptoms of illness
  - The focus is therefore on maintaining, independence, good health and promoting wellbeing. Interventions include combatting ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc
- **Secondary prevention/early intervention:** this aims to identify people at risk and to halt or slow down any deterioration, and actively seek to improve their situation.
  - Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those who have existing low level social care needs
- **Tertiary prevention:** this is aimed at minimising disability or deterioration from established health conditions or complex social care needs
  - The focus here is on maximising people's functioning and independence through interventions such as rehabilitation/enablement services and joint case management of people with complex needs.

"It is essential that councils work the with the NHS, other statutory agencies, the third and private sectors and their local communities to ensure a strategic balance of investment in prevention and approaches to promote independence and providing intensive care and support for those with high-level complex needs."

Transforming Social Care

The key message is that interventions are required across the whole spectrum of need

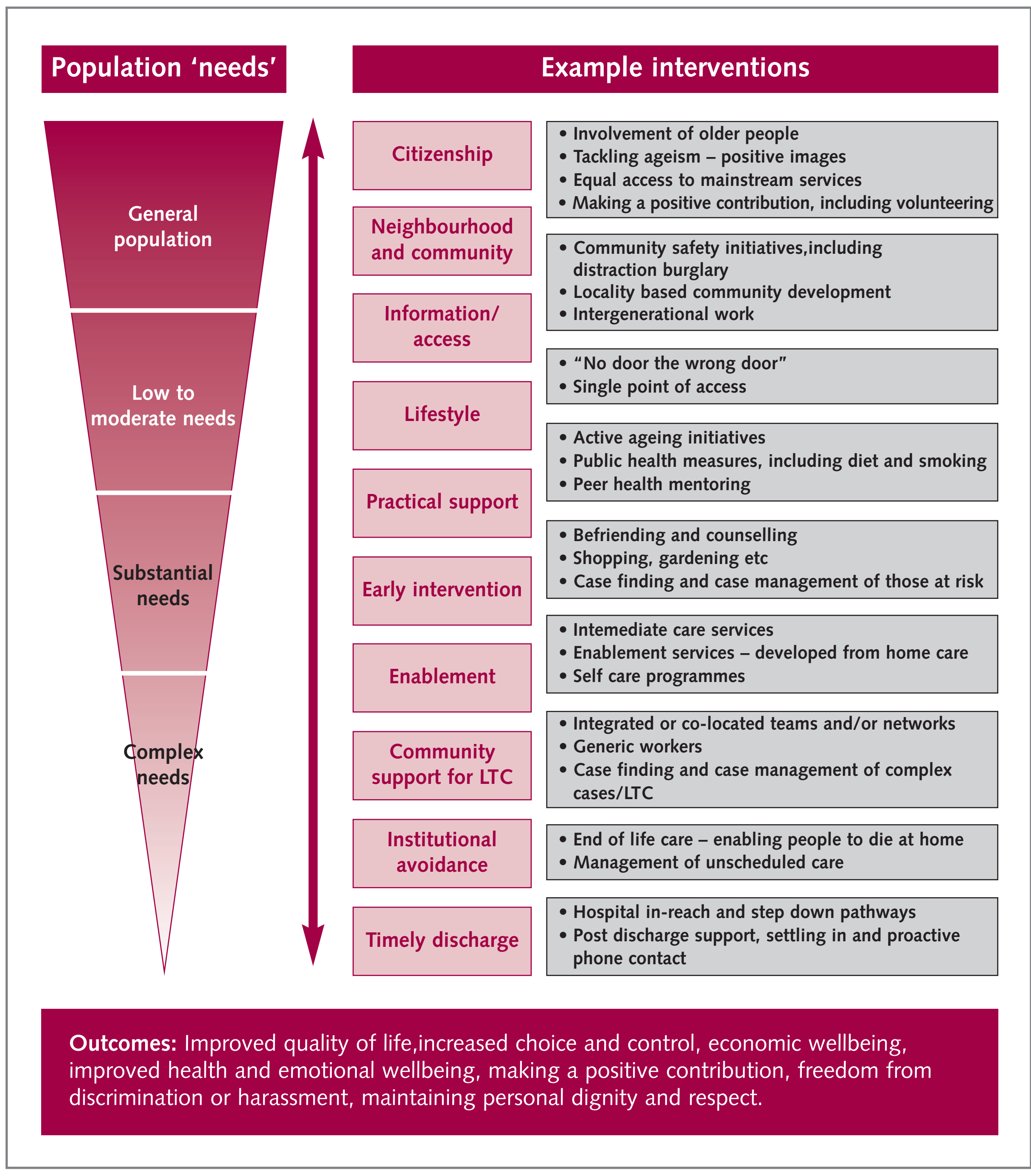
A new framework

Putting People First and Transforming Social Care are clear that the strategic shift required to deliver transformation must be wide ranging and cannot just be limited to those who are "FACS eligible". The experience of POPP supports this and has shown that there is a need for interventions which address the whole population of older people – not just the 15% who come into contact with social services.

Actions and services to promote independence and wellbeing incorporate a broad spectrum of interventions. These range across the following:

- **Citizenship rights –** i.e. ensuring that discrimination is tackled; people are actively involved in the assessment of their needs; and that the barriers to older people having equal access to goods and services are addressed.
- **Neighbourhoods and communities –** that have a clear identity and vibrancy, which are safe to live in and where there is good 'cohesion' across the generations
- **Information** about ways for people to maintain their independence or access support in order to do so is crucial, including for those people who may have the resources to pay for their care and support needsIn addition to the simple provision of information, older people can benefit hugely from having help to 'navigate' around 'the system'Joining up access routes and information systems is key to achieving a situation where "no door is the wrong door" for older people is also an important objective
- Focus on promoting **healthy lifestyles** (including mental well-being and emotional health) are important to older people's quality of life. Working with Public Health promotion is a common intervention here
- Provision of **practical support** (often defined as preventative services) which provide a range of low cost practical, and sometimes emotional help. Their defining features tend to include very simple eligibility criteria (if any), fallout with care management, and principally (though not exclusively) are delivered by the voluntary and community sector
- **Early intervention**, which is about working proactively to identify people whose independence is at risk, is the next key dimension. Case finding and other tools for predicting risk are important here
- As the focus begins to narrow onto the most vulnerable people there is a need to have in place an **enabling** or rehabilitative response which does all it can to maximise people's functioning. Re-engineering home care and/or the development of intermediate care services are key features
- **Community support for people with long term conditions** is most effective when delivered by health and social care working closely together. This approach is equally important with regard to end of life care
- **Institutional avoidance**. These are the initiatives which are required to avoid inappropriate admission into a care homes or hospitalIntensive case management is an example as is extra care housing
- **Timely discharge**. The interventions which enable people to spend no longer than is necessary in hospital and to return safely to their own homes – hospital inreach being a common feature.

This is demonstrated in the following diagram: (**NB** it is important to remember that even those with complex needs will want to make use of many of the 'lower level' interventions.)



The key points to take from this are:

- Interventions need to happen across the whole spectrum of need. Action to promote wellbeing/primary prevention is very important – as are the other levels of prevention
- The above representation should not however be taken to suggest that people near the tip of the triangle no longer need to benefit from the services and activities listed alongside the base. In other words, even those people with substantial or complex needs will continue to make use of other interventions such as social and community activities, universal services etc
- Delivering a strategic shift to prevention and early intervention requires a 'whole system' approach – this is not just about health and social care. It needs to involve the full range of council departments and other stakeholders such as the Pensions Service, Community Safety Partnerships etc.

"Ultimately, every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population. Binding together local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits and advice and education/training"

Putting People First

What would a strategic shift towards prevention and early intervention look like?

Sets out a number of ways for monitoring progress on delivering a strategic shift to prevention.

Achieving a strategic shift towards prevention and early intervention would mean:

- Better outcomes for older people

And would involve:

- Delivering the requirements contained within the Social Care Reform Grant conditions
- Making improvements in performance on a number of relevant indicators in the National Indicator Set

Each of these is addressed in turn.

Outcomes

Putting People First set out an initial outcome framework which included the following:

Shared outcomes should ensure that people irrespective of illness or disability are supported to:

- *Live independently*
- *Stay healthy and recover quickly from illness*
- *Exercise maximum control over their own life*
- *Participate as active and equal citizens, both economically and socially*

(from Putting People First)

The Commission for Social Care Inspection (CSCI), as part of their **performance framework** have set out descriptors to enable Councils to measure their progress on achieving the outcomes contained within Our health, our care, our say:

- Improved health and emotional well-being
- Improved quality of life
- Making a positive contribution
- Increased choice and control
- Freedom from discrimination or harassment
- Economic wellbeing
- Maintaining personal dignity and respect

Grant requirements

There is an expectation that by 2011 councils will have used the Social Care Reform Grant to have made significant steps towards redesign and reshaping of their adult social care systems. The transformed systems are expected to include:

- **A whole systems approach to shifting resources** from crisis orientated provision towards prevention and improved wellbeing
- A **commissioning strategy which balances investment** in prevention, early intervention, re-ablement, with providing intensive care and support for those with high-level complex needs
- **Universal, joined-up information and advice available for *all* individuals** and carers, including those who self-assess and self-fund
- A shift towards **recognising family members and carers as 'partners'**, providing them with appropriate training to enable carers to develop their skills and confidence
- An established mechanism to **ensure that views and experiences of users, carers and other stakeholders is central** to every aspect of the reform programme
- A variety of mechanisms to promote **personalisation, self directed support and choice and control.**

Councils need to "…create a strategic shift in resources and culture from intervention at the point of crisis towards early intervention focused on promoting independence and improved wellbeing…"

Transforming Social Care

National Indicators

Given the wide agenda that prevention and early intervention cover, there is no single indicator which could be used to monitor progress. By using the triangle framework set out above, it is possible to 'map' a number of the indicators from the National Indicator against the range of interventions relevant to prevention and early intervention.

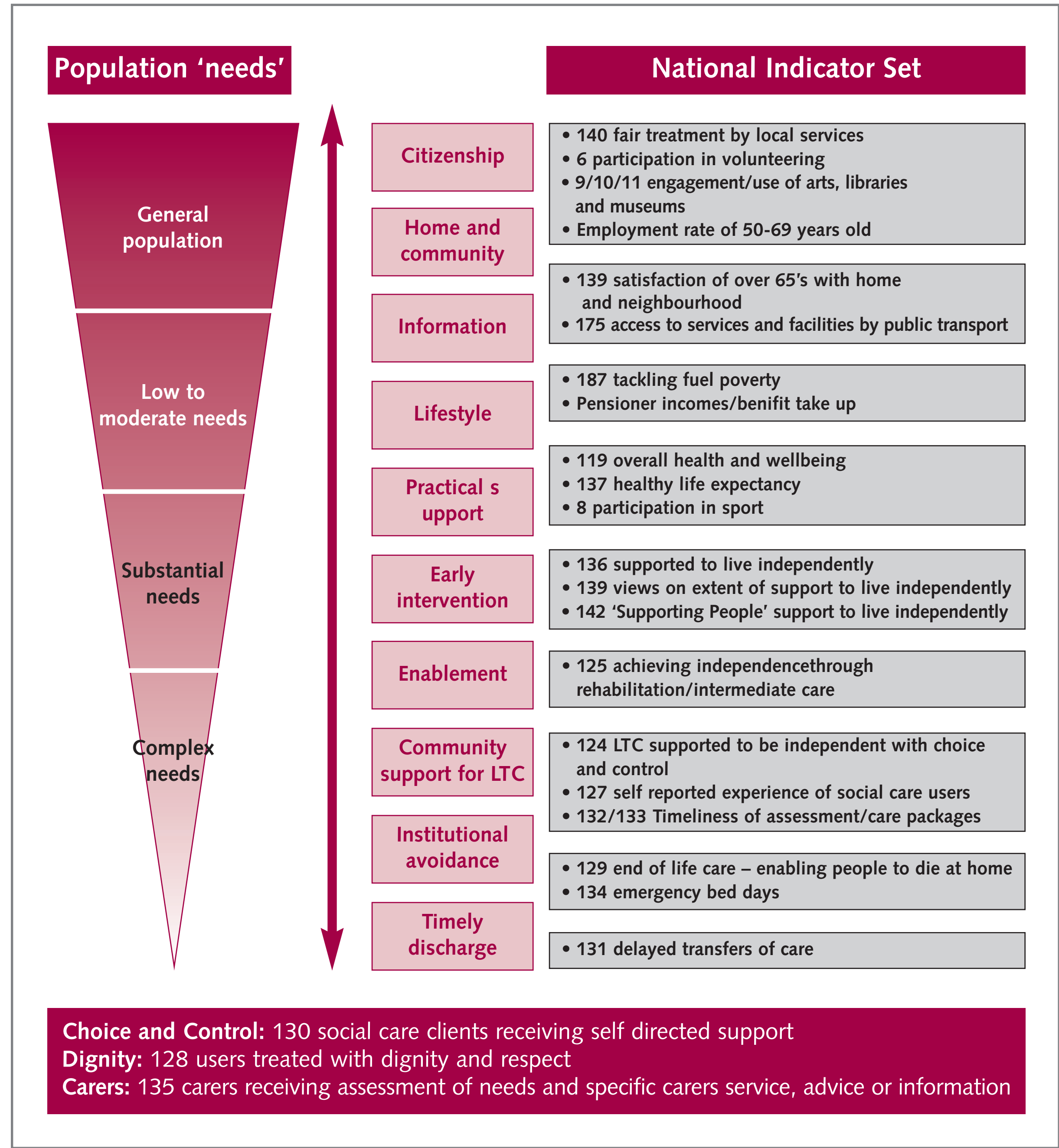
This framework of indicators can therefore be used to measure progress on making a strategic shift towards prevention and early intervention.

Points to note are:

- It will be necessary to ensure that data relating to older people can be separately identified for each indicator
- Some of the definitions and methods of collection are not yet finalised
- How 'success' in some indicators is interpreted requires careful consideration, in particular, for "NI 136 Supported to live independently" – a reducing score might indicate progress in focussing public intervention only on those who really need it rather than representing a move away from supporting people's independence and wellbeing.

An example of a whole system performance framework for measuring progress in making a strategic shift towards prevention and early intervention is attached at **Appendix A**.

It combines National Indicators with local outcome survey questions and aligns them with the seven outcomes set out in Our health, our care, our say.



NB: for reasons of space some of the titles of the national indicators in this diagram have been abridged

How to make the strategic shift

Sets out a number of ways for monitoring progress on delivering a strategic shift to prevention

As with any change programme, making a strategic shift towards prevention and early intervention will require a number of key processes to be in place. Experience from POPP and other initiatives suggests that the following elements are crucial. **There are tools** which can help identify strengths and areas for development.

The involvement of older people – is vital to ensuring that services meet older people's needs. It is important that older people are fully involved in co-production, rather than just consulted on service development. There are a wide range of ways of doing this (see **Appendix B** for further information).

A clear vision about the desired outcomes and how and when they are to be deliveredThis can then find expression through the Local Area Agreement and other strategic documents.

Effective leadership – which needs to extend to levels beyond that of chief officers and lead Members, to include frontline practitioners, middle managers, commissioners and back bench elected members.

Whole systems approach – is required in order to:

- Ensure that the breadth and complexity of older people's needs are addressed
- Secure resources from various sources
- Negotiate the sharing of risks and address the potentially unequal distribution of benefits – i.e. investment in social care interventions have been shown to deliver reductions in the use of emergency bed daysTo achieve sustainable change local agreements will be needed between health and social care about how to 'share the benefits'.

"Councils are uniquely placed to mobilise, influence and lead both their communities and partner organisations so that local areas become places where people can thrive and continue to enjoy a good quality of life as they age"

Audit Commission, "Don't Stop Me Now – preparing for an ageing population

Commissioning for strategic change

Sets out how a robust commissioning approach is required in order to secure the resources and put in place the right interventions to produce the strategic shift towards prevention and early intervention.

Making a strategic shift towards prevention and early intervention will only be achieved by means of a clear strategic commissioning process. The shift will require the alignment of new and existing resources with an understanding of need and the procurement of a number of new or re-engineered service interventions. Councils, health communities and other key stakeholders will need to work together to achieve this.

"Local commissioners working with local partners, in particular the NHS, should consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need."

Transforming Social Care

The POPP programme has demonstrated successfully how sustainable change can be achieved using time limited grant funding.

This learning is very relevant to the task of using the some of the time limited Social Care Reform Grant to bring about a strategic shift towards prevention.

Resource requirements

The scale of investment required is variable and will largely depend on where local authority and health systems are starting from.

Many of the key elements are not that costly in themselves, e.g:

- Processes for involving older people
- A 'first contact checklist' system as developed by **Nottinghamshire Linkage Plus**
- Peer information and navigation service as developed by **Tameside POPP**
- An infrastructure to support the involvement of older people as volunteers
- Intergenerational initiatives
- Exercise initiatives
- Delivery of **Expert Patient or Expert Carer 'self care' programmes**
- Application of **case finding methodologies**.

Others will involve the reshaping of existing resources in the system:

- Development of **re-ablement services** from existing home care
- Development of **joint health and social care teams addressing complex needs**.

And for other elements there is already new money in the system, eg:

- **Carers**
- **End of Life Care**
- **Minor repairs and adaptations**

Commissioning approach

There are a number of sources of good general guidance on **commissioning for health** and **social care**. The following commissioning approach encapsulates key learning points from the POPP programme and other initiatives.

Understand need

The Joint Strategic Needs Assessment is a fundamental building block for making a shift towards prevention and early intervention. **Understanding the local population and their needs is crucial**.

An important dimension of this work is to provide the data and analysis to enable preventative interventions to be targeted appropriately.

This requires a good understanding of different groups of people within the population. Some specific health conditions also warrant further local analysis. For example, there is evidence that hospital admissions and subsequent demands on care services could be reduced through more effective targeting and service development to address some specific medical conditions – i.e. stroke care pathways, podiatry care, dental care, monitoring dehydration and continence care.

"Councils need to make better use of information to understand their communities so that they can target resources where they will have the biggest impact. This will include:

- *Understanding the local demographic profile and the projections for the future*
- *Engaging with the older community to understand the priorities for the area*
- *Using council information to target services at those who will benefit most"*

Audit Commmission, 2008

Understanding how the system is currently responding to need is crucial to working out how to re-engineer it produce better outcomes.

For example, knowledge about the characteristics of hospital admissions (time of day, prevalence from care homes, profile of those in contact with services etc) is fundamental to working out how to address the crises that precipitate the admissions. In this scenario, analysis of service activity data could help inform decisions about whether to prioritise work with care homes with high hospital admission rates or to concentrate instead on joint intensive case management within the community.

"It is essential that councils work the with the NHS, other statutory agencies, the third and private sectors and their local communities to ensure a strategic balance of investment in prevention and approaches to promote independence and providing intensive care and support for those with high-level complex needs."

Transforming Social Care

Prioritise the areas for change

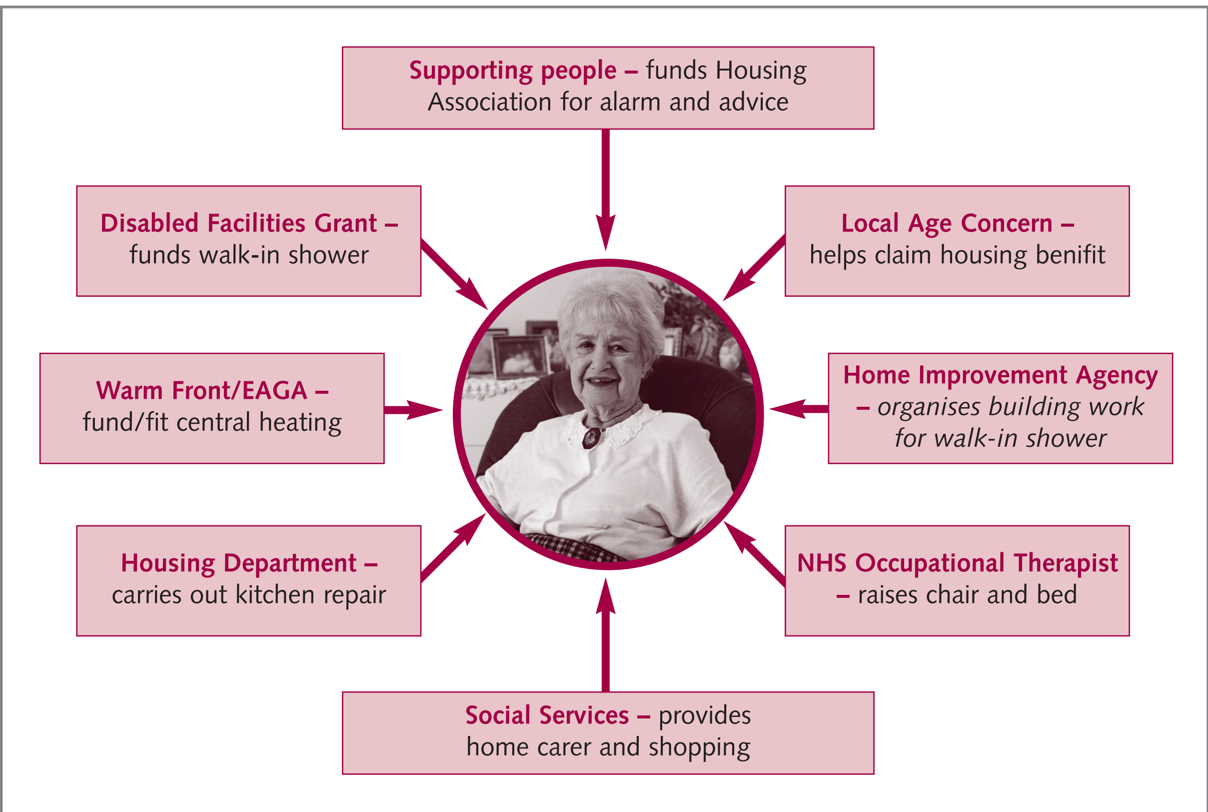
It is important to recognise what areas need to be prioritised. There are **tools** which can help local partnerships to recognise their strengths and areas for development. Most systems will have a number of preventative elements in place (e.g. intermediate care/rapid response), but even with these there is a need to assess their effectiveness and whether there is sufficient capacity. Other elements will need to be commissioned from scratch (possibly with input from other departments or agencies – see below).

Engage partners

Promoting independence and wellbeing is not the sole province of social care, nor even social care and healthThere are a large number of other Council departments or statutory organisations with a responsibility to act, and with money to invest. Particular examples include supporting people, public health, regeneration, community safety, leisure and cultural services, transport, education etc

One way of engaging other partners is to look for the areas of 'shared interest' – i.e. outcomes which are going to contribute to the policy or performance drivers of different departments/organisations. The National Indicator set is very helpful here. The **Public Service Agreements 17** and **18** are also important as they provide the overarching strategic framework for joint working on this agenda.

At the level of the individual, the contribution of resources from across the whole system begins to look like this:



From "Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society; Communities and Local Government, 2008.

Invest rather than spend

The commitment of resources is best thought of in terms of an 'investment'. Different investments produce different outcomes – some will produce net savings, some will produce improvements in quality of life, and others will improve service quality and/or efficiency.

Savings are clearly crucial to the sustainability of any preventative shift, however a sole focus on 'net savings' is too narrow and will fail to deliver the required outcomes. **A broad 'investment portfolio' is required, and as noted above, many of the investments can be undertaken jointly with other partners.**

"Pooled budgets and integrated funding between health and social care can provide the flexibility for funds to be invested in early intervention and preventative approaches."

Transforming Social Care

Use the levers and drivers

There are a large number of national policy drivers (some with new resources attached) which call for an increased focus on this agenda:

- **Transforming Social Care**
- **Putting People First**
- Comprehensive Area Assessment
- **Don't Stop Me Now: preparing for an ageing population, Audit Commission**
- **End of Life Strategy**
- **Dementia Strategy**
- **The Darzi Next Steps Review – Vision for Primary and Community Care**
- **Secretary of State 'Prevention Package' announcement**
- **Our health, our care, our say**
- **Commissioning framework for health and wellbeing.**

There are also **financial levers** to be used, in particular **Practice Based Commissioning**. Whilst it is acknowledged that developments have been slow there are nevertheless some encouraging examples of good practice emerging . There is the potential to engage with GPs on this agenda. Where they can see the evidence of effectiveness of preventative working – particularly in relation to people with long term conditions, then there is the possibility of initiating a 'virtuous cycle' of investment – i.e. re-investing savings from reduced hospital admissions into more joint working on preventative approaches. A number of the case finding approaches combined with joint health and social care teams are likely to be of greatest interest (see below).

"We will work with the NHS and with the professions to redefine and reinvigorate practice based commissioning."

Next Steps Review – our vision for primary and community care

Guidance exists to encourage the **flexible use of resources through practice based commissioning to improve health and wellbeing**. It sets out how PCTs can agree a menu of local flexibilities with practice based commissioners. The menu of interventions could include the following:

- Supporting healthy lifestyles through exercise programmes
- Provision of information, advice and advocacy services (e.g. benefits and debt)
- Social and practical support for isolated older people and for their carers
- Self care programmes and self monitoring equipment for people with long term conditions
- Respite care for carers
- Crisis avoidance and intervention – e.g. urgent adaptations and equipment
- Support for people approaching the end of their lives e.g. emergency respite or personal care.

Rigorous medium to long term business planning

Making a strategic shift doesn't happen over night – it can only be addressed over the medium to long term (i.e. 3 to 5 years)Business planning should therefore be undertaken over this kind of horizon The experience from the POPP programme has demonstrated that the business planning process itself needs to be rigorous.

The sites which have been able to make the greatest gains are those which were the most rigorous in the business planning processesThis becomes particularly important in relation to sustaining outcomes beyond time limited funding regimes. There were a number of POPP sites where business planning allowed the council to sit down with PCT partners to assess the benefit of 'bridging funding' in order to produce well evidenced gains which were predicted to arise at a future date.

Within the POPP programme the 'Economic Appraisal' methodology set out in the HM Treasury 'Green Book' was found to be very helpful in developing this kind of effective business planning approach. A worked example is attached at **Appendix C**.

Scrutinise the core spend

Mainstream expenditure warrants the same kind of scrutiny and calls for 'evidence' as that which is often demanded of preventative initiativesTaking a rigorous, analytical approach about 'what works' is equally (if not more) applicable to the large scale expenditure on mainstream servicesDe-commissioning or change of non-effective services is an important dimension here. There are large budgets in any local system and there should usually be potential efficiencies and re-prioritisation which can release resources for new approaches.

Monitor performance and evaluate effectiveness

One of the most important lessons from the POPP programme has been the importance of monitoring activity, and using this data to evaluate effectiveness. Resourcing 'good ideas' without a paying attention to what they deliver is of little value. It is vital to:

- develop evaluation frameworks which set out what outcomes are expected
- establish baselines
- undertake regular monitoring of performance indicators and other deliverables

This approach requires investment in performance management and the capacity to monitor outcomes. This kind of capacity is essential and should not be underestimated, particularly if 'savings' are to be generated for re-investment in other parts of the system An example of a 'data rich' report for commissioners incorporating this kind of rigour is attached at **Appendix D**.

Make best use of new money

The Social Care Reform Grant has been provided specifically for 'system reform' and should be used to provide the 'bridge funding' to enable the strategic shift in resources towards promoting independence and wellbeing to take placeIt is a resource to be used strategically.

Experience from the POPP programme suggests the deployment of short term funding for strategic change requires a certain discipline:

- Where resources are to be used for change management (e.g. training, project management, communication strategies, process re-engineering etc), the investment should be strictly time limited and closely aligned to the change management plan
- Where the resources are to be used to invest in new or enhanced service capacity, then close attention needs to be paid to how the outcomes will be sustained beyond the time limited funds.

"Local commissioners working with local partners, in particular the NHS, should consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need"

Transforming Social Care

Developing a joint commissioning plan – to deliver the change programme.

It will be important to incorporate within a joint commissioning plan an explicit agreement about the sharing of any financial risks and benefits associated with shifting resources away from institutional responses to community alternatives. This is important:

- On the one hand to avoid 'cost shunting' disputes
- On the other hand to try and establish a 'virtuous cycle' of investment between health and social care towards prevention and early intervention.

Effective interventions

Sets out an analysis and description of the most effective preventative interventions.

Overview

The POPP programme, and other initiatives (Linkage Plus, Invest to Save Budget, Innovation Forum etc) have demonstrated a wide range of effective interventions

Evidence from POPP indicates that the savings effect seems to be most pronounced where interventions are specifically focussed on 'hospital avoidance' (e.g. intermediate care, rapid response, hospital in-reach, case management of long term conditions etc). **The effect has also been discernable even where interventions have been more focussed on improving people's quality of life** (e.g. befriending, peer support, practical assistance etc)

Some of the following interventions are newOthers are in existence in some shape or form in most authoritiesWhat is significant about the learning from POPP is:

- The emerging **evaluation data to validate their effectiveness**
- The recognition of **the need for a balanced portfolio of investment across the full range of interventions** in order to promote older people's independence and wellbeing
- The experience which confirms that the starting point for any service redesign should be engagement with older people.

The following interventions are judged to be key to generating a strategic shift towards prevention and early intervention

- **Age proofing mainstream services**
- **Range of wellbeing services**
- **Providing information for all**
- **Case finding**
- **Case co-ordination/service navigation**
- **Managed pathway for those not eligible to ongoing social care**
- **Building capacity in local neighbourhoods**
- **Re-ablement**
- **Joint health and social care community support for people with long term conditions/complex needs**
- **Support to care homes**
- **Crisis response services/out of hours services.**

There are a number of other important interventions which are not covered here because they have been, or are about to be, addressed well in other placesMost notable of these are:

- **Telecare**
- **Extra Care Housing**
- **Supporting People programme**
- **Falls**
- **Carers**

Age Proofing Mainstream Services

Before looking at special initiatives it is important to recognise the importance of mainstream services in promoting the quality of life of older people. They have to be designed and delivered with older people in mind, and attention needs to be focussed on addressing the barriers to the inclusion of older disabled people.The Audit Commission in their report **"Don't stop me now: preparing for an ageing population"** have devised a checklist for 'age proofing' mainstream services:

- Involve older people in planning from the outset
- Design mainstream services that older people can use
- Use existing resources wisely
- Adapt mainstream services where appropriate
- Be innovative in finding ways to improve mainstream services; and in how you work with partners to improve other essential services
- Work with transport providers to find solutions to complex transport problems.

"The majority of older people will not require social care as they age; but all older people will have a continued need for other core local services.... It is essential that the older community is able to access universal services. Improving access to core services is key to making independent life an option for as many older people as possible, for as long as possible."

(Audit Commission, 2008)

Wellbeing services

A comprehensive range of wellbeing services might include:

- Activities to address **social isolation** – e.g. befriending and luncheon clubs
- **Practical help** with things like shopping, gardening, minor repairs and adaptations in the home etc

- **Healthy living advice** and support – e.g. exercise classes, diet advice, awareness of risky lifestyle issues etc
- **Inter-generational** initiatives
- **Community safety** – fire safety, anti-social behaviour, victim support, crime prevention etc
- **Housing choices and improvements**
- **Transport** and other forms of getting out and about.

Many of these wellbeing services will be provided by the voluntary and community sectorOthers though are mainstream services (such as transport) or provided by a range of statutory organisations (such as Public Health, Housing etc)

Only a minority of these services are likely to be funded through social care – the supporting people programme, public health, community safety partnerships, housing etc are most likely to be providing the majority of the resources.

The delivery and sustainability of these services requires a focussed approach with particular attention needing to be paid to relationships with the voluntary and community sector. There are a number of ways in which capacity can be developed and enhanced:

- **Business development –** targeted work with voluntary organisations to support them as providers and to work in partnership (with other VCS organisations as well as the statutory sector), and their ability to tender for and deliver on service contracts
- **Outcome focussed commissioning –** whereby commissioners focus more on specifying outcomes and thereby rely more on the ingenuity and inventiveness of the VCS to organise delivery
- **Joint commissioning –** There are particular opportunities and potential benefits from a much more co-ordinated approach to commissioning wellbeing services through:
  - supporting people
  - public health
  - adult social care 'grant funding'

  The potential synergies and therefore increased effectiveness from commissioning in a joined up way are significant
- **Engaging with faith communities –** who can be a very significant resource in delivering wellbeing activities – both in terms of buildings and as willing volunteers and networksThey are often very well aware of older people at risk of isolation and deterioration
- **Supporting volunteering –** enabling older people themselves to make a positive contribution

"...opportunities to maximise the potential in the over 65 group can be missedFor example, in 2008, 27% of over 65s participate in voluntary and community activities, leaving significant potential untapped"

Audit Commission, "Don't Stop Me Now – preparing for an ageing population

- **Inter-generational initiatives –** which can produce enhanced wellbeing for both older people and children and young people
- **Whole system working –** engaging, joining up and/or exploiting the synergies between a wide range of services such as homebound library services, police and community support officers, housing advice services, extended schools initiatives, fire safety checks, trading standards services etc etc.
- **Making older people's mental health everybody's business –** through working with all voluntary organisations (not just the specialist OPMH services) and commissioning them to deliver their 'mainstream' services in a way which also addresses the needs of older people with mental health problems.

Providing information for all

Access to good quality information and help with how to navigate complex public services is fundamental to ensuring that older people have choice and control over how they maintain their independence and wellbeing. Whilst there is clearly a need for good quality and well publicised websites, telephone contact centres, leaflets etc, the evidence suggests that there is a huge amount to be gained from:

- Supporting staff to deliver a system where "no door is the wrong door" for older people.
- Actively seeking out people who could benefit from information and advice and delivering this face to face.

The following examples are some ways of doing this:

Nottinghamshire Linkage Plus First Contact Checklist

First Contact Checklist provides front line practitioners from a range of statutory and voluntary sector organisations a series of ten simple questions offer an effective means of 'opportunistic' case finding. The questions are:

- Have you got a working smoke alarm on each floor of your house?
- Do you have any repairs that need doing to your home?
- Do you need any adaptations to your home?
- Are you able to keep your home warm?
- Have you fallen and injured yourself in the last 12 months?
- Would you like advice on crime reduction and home security?
- Would you like advice on money you may be entitled to?
- Are you interested in information about community transport?

- Would you like to know mare about local voluntary and community groups and clubs?
- Would you like advice on different types of accommodation that may be available?

The checklist is used by practitioners from wide range of public services (community safety, housing officers, pensions advisers, fire officers, voluntary sector workers etc etc) who apply it when the first come into contact with an older person as part of their day to day work. There is a streamlined process which allows the practitioner to arrange for appropriate services to be delivered according to the needs identified in response to the questions. The older person receives a written 'receipt' telling them which services they have been referred to, and the Contact Centre phones them after four weeks to check actions/outcomes. If things are satisfactory, there is no further contact.

Devon Linkage Plus '360 degree Wellbeing Check'

The framework for a '360 degree well being check' developed by Devon County Council is based on the information identified as being important for the wellbeing of older people as highlighted in the 'Sure Start to Later Life' report of the Social Exclusion Unit. The framework has:

- Been developed into a tool for individuals and front line staff, to assist in the holistic assessment of older people's needs. This is available for the public to access on the **Getting the Most Out of Life website**

- Provided the domains used by the Care Direct service(front desk contact centre) to answer queries and deliver a holistic assessment of people's needs
- Been incorporated into the Single Assessment Process (SAP) with an agreed set of documentation for all health and social care organisations within the SAP partnership
- Been used by Age Concern Devon's ABC Line befriending and care line staff.

Dorset POPP 'Wayfinders'

The Wayfinder Programme has 66 people (many of them older people) working within local clusters to provide 'signposting' support for older people.

They provide information on a range of topics including welfare benefits and pensions, social activities, exercise opportunities, transport, toe nail cutting, telecare, carers issues, lunch clubs and coffee mornings. Wayfinders make themselves available and visible in GP practices, libraries, shopping centres etc.

The Wayfinders purpose is to build supportive neighbourhoods with and for older people in Dorset – so that they can live as part of these local communities, and receive appropriate, timely help to stay there for as long as they wish.

Wayfinders each work nine hours a week (for which they are paid) to raise awareness of services, give out information, 'signpost' to sources of specialist help within local communities. Volunteers work alongside Wayfinders to carry out promotional and awareness raising tasks such as leaflet drops, coffee mornings and information events at Country Shows.

Gloucestershire Linkage Plus 'Village Agents'

Gloucestershire County Council, in partnership with the Gloucester Rural Community Council, has successfully set up the **Village Agent Project**, covering more than 160 parishes in some of the most isolated areas of the county Thirty village agents work within clusters of communities which have limited or no access to services locally Each individual parish cluster contains a 50+ population of between 331 and 1125 people

Village Agents are paid a small weekly retainer to work 10 hrs/week within the local community, targeting people aged 50+, providing face to face information and support, promoting access to a wide range of services, carrying out practical checks and identifying unmet need, and help individuals make informed choices about their future needs Village Agents are local people, who become a trusted community member and resource. Agents also identify unmet need within their community and respond by initiating and supporting new social and healthy activities.

Organisations to which people are referred to are expected to feed back what action has been taken/delivered; if there has been no feedback, the Village Agent project manager follows up. Some cases are held for a short time to ensure appropriate actions are taken and problems resolved.

Village Agents complete a two day training course and a training manual has been devised to assist themThere is also a website with information links, team support meetings and one to one supportAgents also keep detailed monthly diaries, which offer an excellent way of recording the wide variety of contacts and topics covered, useful for training, planning and monitoring purposes

Tameside POPP 'Opening Doors for Older People'

The project is a new way of linking older people to the services that they need to improve the quality of their life before they get to crisis point One of the key parts of the project is 'Check and Support'.

The service is delivered by a large volunteer workforce of older people who make contact with people in their own homes to find out what information and support they require. They do this by completing a 38 point weighted questionnaire – the Community Options for Remaining Active (CORA) form. Then, depending on scoring, the volunteer advisers will:

- Give people information about what services are available and how to access them
- Help the person get in touch with people who can provide them with support
- Contact the right people on their behalf
- Check up on the person later to see whether they have got the help they require
- The volunteers are trained and supported by the local Age Concern.

Case Finding

Case finding is the process of working pro-actively to identify people who could benefit from having access to information and/or services. It represents a marked departure from systems which just wait to receive referrals.

There are a number of methods used to identify people, including the following: *(much of the material on case finding is based on work produced by Devon County Council)*

Screening Tools

These are simple criteria or questions which are applied to individuals being seen by, or on the caseload of, front line practitioners.

The questions/criteria have been validated as being predictors of risk:

Emergency Admission Risk Likelihood Index (EARLI)

This is a validated simple-to-apply tool for identifying older people who are at risk of having an emergency admission within the following 12 months. EARLI can be used as a simple triage-screening tool to help identify the most vulnerable older people. This approach can help to target interventions and support in order to reduce the demand on hospital servicesIt can also be used as a means to test the effectiveness of different preventive interventions

The questions used are:

- Have you ever had any of the following illnesses:
  - Heart problems?
  - Leg ulcers?
- Can you get out of the house without help?
- Do you have problems with your memory and get confused?
- Have you been admitted to hospital as an emergency in the last 12 months?
- Overall, would you say your state of health is good?

This tool could be used routinely or be incorporated opportunistically in a variety of situations. For example:

- Community Pharmacists could use this tool in conjunction with their medicines use reviews (MUR), to identify people at risk, particularly those who are older and on multiple medicines

- Flu Clinics
- Repeat prescriptions
- Contact with surgeries.

It can also be used by social care practitioners, and has been successfully deployed for example in the Brent Integrated Case Co-ordination Service (see below).

Sherbrooke Questionnaire

Risk is indicated by positive answer to three or more questions (or a "no response" to telephone or postal contact)

- Does the person live alone?
- Does the person take more than three different medications every day?
- Does the person use a cane, a walker of wheelchair?
- Does the person have difficulty with seeing?
- Does the person have difficulty with hearing?
- Does the person have problems with your memory?

Castlefields Criteria

Criteria for identifying people at risk of deterioration or future hospital admission developed by the Castlefields practice. Caseloads or practice lists can be screened against these criteria. Older people over 75 are deemed to be at risk if they meet at least three of the following criteria:

- Four or more active chronic diagnoses
- Four or more medications prescribed for six months or more
- Two or more hospitalisations (not necessarily emergency) in past 12 months
- Two or more A&E attendances in past 12 months
- Significant impairment in one or more major activity in daily living
- Significant impairment in one or more instrumental activities of daily living, particularly where no other support
- In the top 3% of frequent visitors to GP practice
- Who have had two or more outpatients appointments
- Whose total stay in hospital exceeded four weeks in a year
- Whose social work contact exceeded four assessment visits in each 3month period
- Service users who receive more than 25hrs/week home care
- Taking six or more prescribed medicines
- Whose pharmacy bill exceeded £100 per month.

Social Exclusion criteria

The Social Exclusion Unit identified the following predictors of risk of exclusion, based on their analysis of the English Longitudinal Study of Ageing (ELSA), 2006.

Older people most at risk of exclusion are those who:

- Are aged 80+
- Are living alone
- Have no access to car/never uses public transport
- Are living in rented accommodation

- Have a low income/benefits as main income
- Have no access to telephone.

Predictive Tools based on routinely collected data

As the title suggests these are tools which draw on data which is already 'in the system'. The tool contains complex algorithms which automatically generate the risk score for each individual. One of their key benefits is that there is no requirement for the collection of any special or additional information by front line staff.

Kings Fund 'Patients At Risk of Re-hospitalisation (PARR')

This is a software tool that can be run monthly using hospital activity (SUS) data. When an individual is admitted to hospital the tool uses the patient's recent admissions data (up to four years) to calculate the likelihood of re-admission over the next 12 months. This takes into account factors such as prior utilisation, diagnoses and socio-demographic information and gives a high rate of predictive accuracy. The data is encrypted and requires written authorisation by the GP to allow other people to access it.

Kings Fund 'Combined Model'

This is a development of PARR which by incorporating primary care data as well as hospital data enables a whole population's risk of admission to hospital to be stratified (not just those people who have had a previous hospital admission). It requires ready access to primary care data.

Dr Foster's 'High-impact User Manager (HUM)'

HUM allows NHS organisations to:

- Access hospital activity (SUS) data, which is updated monthly, to build lists of potential patients by PCT or GP practice who are, or who may become, 'high impact' users of secondary care services
- Identify patients with conditions for which hospitalisation is considered at least partially preventable, e.g. ambulatory care sensitive conditions (ACS), chronic conditions (asthma, COPD, diabetes) and acute conditions where immunisation can prevent illness
- Select various predictor values such as number and type of admissions, number of bed days used, tariff costs
- Drill down to individual patient records to analyse their admissions history and associated costs.

Predicting who will need intensive social care

The predictive tools currently available are largely driven by health orientated data focussing on likelihood of admission to hospital. The Department of Health has commissioned the Nuffield Trust to explore whether similar tools might be used to predict the risk of needing intensive social careA review of the literature shows that many factors are known to be statistically predictive of the future decline in functioning and the need for intensive social care. Such factors include physical and cognitive disability, sensory impairment, poor housing, poverty and lack of social capital. Certain medical diagnoses are particularly likely to affect independence, for example, cerebrovascular and cardiovascular disease, arthritis, dementia and depression.

All of these factors are more or less amenable to 'upstream', preventive interventionThe development of this new tool is expected in Spring 2009.

Professional judgement

Although little formal evaluation has been carried out to assess relative accuracy professional judgement is a valid route for experienced clinicians such as GPs and other practitioners (such as social care staff) who are in regular contact with patients or service users. They can be effective in identifying people who appear likely to need increasingly intensive services or risk admission to hospital or long term care. This includes medical, clinical and social factors such as the life events like bereavement, becoming a carer etc, which often trigger a rapid decline. Some GP practices host inter-agency 'whiteboard meetings' to discuss patients who are cause for concern.

Activity Data

This involves the inteligent use of information already 'in the system'.

Out of hours activity

Out of hours information is routinely sent to GP practices to enable follow up to identify any treatment given. This data can be helpful in determining which patients, in particular those using out of hours services frequently, might benefit from more proactive case management to better manage their situation or condition.

Ambulance 'non conveyed' data

In some parts of the country ambulance trusts have established mechanisms for sharing 'non-conveyed' data with out of hours GP services. Patients consent is sought to allow appropriate follow up. This information can therefore be shared with practices. In doing this, emergency response services may pick up those who do not routinely access health care and instead use emergency services in crisis situations.

It is clear that ambulance services can play an important role in case findingIn relation to falls prevention specifically, over a third of the patients involved in these emergency responses are "not-conveyed" to a hospital because the patient is not injured, or because another referral pathway is more appropriate. These patients have a high risk for further falls and/or the development of a behavioural response characterised by 'fear of further falls' such that they become housebound with features of anxiety/depression. Ideally, these people should be positively identified and made known to the local primary and community care services. Early intervention can be expected to reduce the need for future health and social care servicesSpecific action is required to ensure the routine engagement of primary and community care services with this group of vulnerable older people who have "fallen but not-conveyed" as automatic notification does not always occur.

Acute Hospital Information Flows

This is distinct from active case finding in the community, but relates to the wider development of systematic approaches to planning discharge and avoiding unnecessary admissions.

In some parts of the country the expectation has been established that GPs receive daily information regarding patients who have been admitted to hospital both for emergency and elective treatment. This data allows identification of patients already known to case management teams who can then support timely discharge. The data also allows patients to be identified who may require an assessment for case management or ongoing care needs.

Case Co-ordination/ Service Navigation

Case co-ordination and **Service Navigation** are terms used to describe a holistic approach to working with people with the objective of addressing their needs before they trigger a crisis or rapid deteriorationThe common characteristics of this type of intervention are that it:

- Is jointly commissioned by **health and social care**, with staff drawn from both
- Involves a discussion with the person about their situation/needs. The scope of this discussion, or **'assessment', is generally 'holistic'**, going beyond the narrow boundaries of any one agency
- Works with the person over a **limited period of time** (depending on individual needs)
- **'Plugs people into' mainstream or voluntary sector services**, or other possibilities for meeting their needs. This goes beyond 'signposting' and actually arranges and co-ordinates people's access to services
- **Makes contact with the person at a future date** (typically three months) to check whether their outcomes are satisfactory.

Case co-ordination can be targeted at different levels of 'need' and has been found to be most effective in reducing crises and rapid deterioration where it is explicitly targeted at those people who straddle the boundary of being eligible for services (FACS). This works best where there is strong engagement with local GP's and information sharing with A&E and the ambulance services.

Evaluation results from some of the case co-ordination projects show impressive results in reducing falls, emergency bed day usage (from admissions and lengths of stay), and A&E attendances.

Brent POPP 'Integrated Care Coordination Service'

This is a 'holistic' service targeted at older people over 65 who may be at risk of avoidable hospital admission, premature admission to institutional care, or simply causing concern due to medical, physical, emotional or social issuesIt achieved this by undertaking assessments and then co-ordinating a range of interventions responding to identified needs - operating across health, social care and other organisational boundaries as requiredInterventions include odd jobs around the home, assistance with moving into more appropriate accommodation, benefits and pensions advice or referrals to health and social care providers, podiatrists, occupational therapists etc.

Findings (3):

- Overall the ICCS is extremely cost effective in reducing hospital A&E attendances, admissions to hospital and hospital bed-days
- The development of savings builds up over time due to the continuing accrual of savings after the ICCS has closed the case
- Assuming no other sources of savings, the ICCS would break even (i.e. savings minus costs), if it prevented 5-6 bed days per client per year – in fact it saves between 14 and 29 bed-days
- It also results in 2-6 fewer admissions and 3-7 fewer A&E attendances
- There is a dramatic reduction in falls. In the first month of service 21% of people experienced a fall – this reduced to 4% of cases by the fifth month
- More people were helped to live at home but no measurable effect on admissions to nursing and residential care was found
- The impact on hospital activity was corroborated by other evidence

The graph below illustrates one of the core parts of the analysis – the actual and projected hospital admissions for ICCS clients.

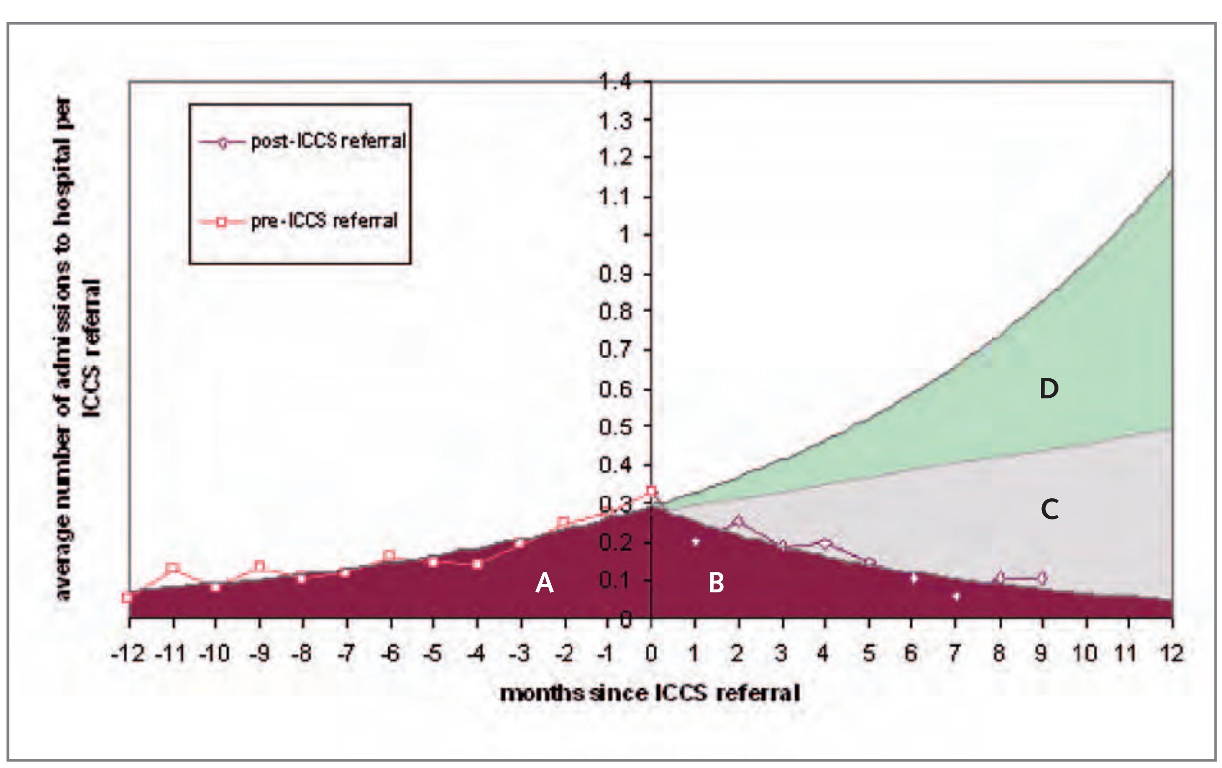


Figure 1: The pattern of admissions pre and post ICCS intervention with fitted trend curves applied (key: A= actual admissions in previous 12months; B= actual admissions 12 months post ICCS intervention; C=prevented admissions based on constant growth assumptions resulting from ICCS intervention; C+D = prevented admissions based on accelerated trend resulting from ICCS intervention)

East Sussex POPP 'Navigator Service'

A partnership project between East Sussex County Council and Anchor Staying Put, the Navigator Service employs trained workers to visit older people aged 60+ in their own homes. They talk through problems using the structured Background Information and Contact Assessment tool (part of the FACE suite of data recording tools) to record personal details and likely needs. The target group are those deemed to be at the 'moderate' level of FACS.

The team consists of one senior navigator, three navigators and an administrative assistant, all full time. Navigators receive in-house training tailored to their needs. This includes single assessment process (SAP), 'trusted assessor' training (for low level equipment needs), FACS criteria and how to apply them, confidentiality, record keeping and so on. Team members also receive regular sessions with a senior member of the Adult Social Care staff, to discuss cases and monitor quality.

All cases are followed up following initial contact, to ensure that recommended actions have been carried out.

Achievements include:

- **Reductions in unscheduled acute NHS care –** after Navigator Service intervention people were less likely to visit hospital for an emergency or inpatient treatment, or to have an overnight stay in hospital (23% post-intervention compared to 46% pre-intervention)
- **Improvement in quality of life –** 'before and after' service user surveys reveal that, as would be expected, people do not feel that their health has improved over the three to six month measurement period (i.e. because the service provides no medical intervention). However there is clear evidence of improvements in:
  - people knowing more about their condition
  - feeling they can manage their condition themselves
  - feeling less worried about their condition
  - feeling that they have a role to play in keeping themselves well
  - feeling that their overall quality of life is good.

Devon POPP 'Community Mentors'

The Community Mentor service is a voluntary sector service employing paid staff who combine task focussed goal oriented short term work with individuals with a community development and groupwork approach which improves the capacity and inclusivness of the community and attracts participants without stigma or the creation of dependence.

The staff identify participants through community activity and promotion of the service as well as through referral from other services. Their assessment covers individuals' needs for personal development and fulfilment and goal setting. They involve participants in activities which are meaningful for them, and help groups to become independent. Mentors also coordinate others – sometimes called enablers, who have particular backgrounds or skills needed by individuals or groups.

Mentors are not ‘counsellors’, ‘befrienders’ or health and social care professionals. Their job is to enable people to take control of their own lives, supported by, and contributing to, their communities, gaining an improved sense of well-being and quality of life. In a practical way, mentors are often helping people understand they can learn again, take risks, and regain a valued social identity – sometimes later expressed through volunteering.

Participants vary widely in age and circumstance. Some are in their 50s and 60s, many in their 80s and 90s, with multiple disabilities and sensory impairments associated with age. They often feel isolated, anxious or depressed, many have lost a partner or job, had a period in hospital, experience a lack of confidence, have mental health issues, or feel ‘a gap in their lives’. Some have mentoring as part of a care package, others have nothing to do with statutory services (outside usual health services) at the time of using the service.

The Community Mentoring Service is seen as a key part of the modernisation agenda, helping to personalise the support people need to live their lives fully. Already it has been used to transform individuals’ experience from traditional Day Care to more enjoyable, appropriate and local social activities. Although it usually works with people so they don’t need formal services, it can also work with people using Direct Payments or an individual budget where they have eligible needs but cannot meet these alone.

The skill set and occupational requirements for mentors are being established, and learning about this service, which began with the Upstream project in Mid Devon (Lottery funded) was continued using LinkAge Plus funds and has been rolled out across the County of Devon using POPPS (in Devon called My Life My Choice) funds. The service is the subject of a controlled trial of effectiveness due to report in 2009, and an economic study of the costs which will report shortly after the controlled trial. These are being conducted by the Peninsula Medical School.

Knowsley POPP ‘I Know a man who can (IKAN)’

The IKAN project is based on proactive case finding and is focussed on tackling the entrenched social and cultural factors that lead to poor health, and a high level of emergency admissions to hospital.

Usually older people come into contact with health/social services when they have experienced a crisis or trauma. The IKAN project catches people before they reach this point and offer a range of services that supports and empowers them, without formally bringing them into the health and social care system, unless necessary.

This project has brought together a multi-agency team all with different work backgrounds and expertise, including health and social care, the fire service, pharmacy and leisure.

Initial work was undertaken in conjunction with colleagues in Public Health Intelligence to map out and quantify the over 55 population living in the most deprived areas of Knowsley. It is over simplistic however to think that all over 55s in Knowsley are the same. The IKAN team therefore mapped out profiles for seven distinct groups of older people. Marketing materials were reviewed in the light of these and feedback was gained from early adopters of the service. As a result materials were adapted to include case studies of individuals who had used the service. These personal case studies were promoted using targeted door drops, local press, radio and PR.

Referrals are responded to by a home visit and comprehensive assessment carried out by paid workers. People are then signposted to appropriate services, with a fast track into Handyperson, Befriending and Health Visitor services. IKAN provides easy access into a complex system. IKAN has strong focus on falls prevention and there is evidence that this has had an impact on reducing the number of falls and fractures.

Managed pathway for those not eligible for ongoing social care

Wherever thresholds are set there are likely to remain people who are deemed to be in-eligible for ongoing publicly funded social care. Just signposting these people off to voluntary and community services is not an appropriate response, particularly where there is no follow up to find out if the person has been able to access the support they require.

Better outcomes can be achieved with a managed pathway for those people into something else – namely the sort of case co-ordination service outlined above or the Wellcheck service outlined below. These interventions are configured to match people in need of help with the right services or activities – and to provide a follow up to ensure that people's needs have been met.

Worcestershire POPP 'Wellcheck'

This service is commissioned from the local Age Concern. People not meeting the Council's FACS criteria are referred to the Wellcheck service (and referrals are also taken from third parties and from self referral). A 'holistic assessment' is undertaken in the person's home, using many of the domains of the Single Assessment Process, by paid 'Wellcheck Officers' who are employed by Age Concern (all these staff complete a two day assessment course, run by the University)

'We screen in, rather than screen out'

All people contacted are given a personalised checklist detailing suggested services or other ways of meeting the person's need. This is held in their home in a 'red folder'. If people cannot make contact themselves Wellcheck staff will do this and provide some time limited support with this process. Periodic follow up is undertaken by Age Concern volunteers to check outcomes and current situation.

Building Capacity in local neighbourhoods

There are a number of reasons for adopting a community based approach to improving the lives of older people:

- Improving the quality of life of older people cannot solely be addressed by focussing on the needs of individuals. Older people live within communities and communities are an important resource for delivering better outcomes for older people

"As we grow older, the neighbourhood becomes an increasingly important factor in the quality of everyday lifeWhen local shops, local services, of the local park or leisure centre are inaccessible or even dangerous, older people can literally be trapped in their own homes without the confidence or opportunity to get out, make friends or get the help they need…Our vision is about promoting and supporting the interdependency between older people and their local communityLifetime neighbourhoods will ensure that older people feel they belong and are empowered to participate in their communities"

Lifetime Homes, Lifetime Neighbourhoods: a national strategy for housing in an ageing society, 2008

- For most older people the opportunities for making a positive contribution are most likely to occur in their local community
- Providing better co-ordinated access to services is often most effectively delivered at a local level.

Sure Start for Older People

The Social Exclusion Unit's Report **"A Sure Start to Later Life"** articulated a strong vision for a community based approach to improving the lives of older people. The 'Sure Start for Older People' model combines the notion of joining up access to services and information with a focus on local areas and the empowerment of older people in determining local priorities.

As well as giving better access to information and services, this kind of approach supports older people to 'make a positive contribution', thereby enhancing the capacity within an area to promote the wellbeing of its older people.

"Sure Start was created for children and families living in disadvantaged areas to access education, care, health, family support and other services in one place. Part of its success comes from locating a single, accessible gateway to wide ranging services in the community, where potential problems are identified quickly and prevented from becoming worse. Older people also highlighted to us the importance of a full range of services being delivered locally and in one place – rather than being pushed from pillar to post by service providers.

The Sure Start to later life approach would use the same methods as the children's model to improve access, bringing together services around older people."

A sure start to later life,
Social Exclusion Unit, 2006

Common characteristics of this approach include:

- **Working with older people to identify priorities –** this entails some form of local 'governance structure' – a local committee or advisory group which includes older people has a say in determining the priorities for older people in the area and what activities should be organised. In some cases this approach is taken a step further with some budget/commissioning responsibilities for the locality being devolved to the locality governance structures
- **A locality approach, using existing community facilities –** working in a locality is largely undertaken by using existing good quality community facilities such as community centres, village halls, extra care housing facilities, church halls etc. Although 'centres' are required – this type of approach is much more about community development than buildings

Although 'centre' implies a building, it is more about a different way of working.

- **Outreach –** older people have different needs and preferences. For example, some older people may not wish to join in group activities, and there are likely to be other older people who are so vulnerable and isolated that they are unaware of what services or activities are available or how to engage with them. Many of the examples listed include a focus on reaching out to isolated or vulnerable groups of older people and taking help and social contact to them in the form of volunteer befrienders.

  Work is also undertaken with local voluntary and statutory agencies so that they are fully aware of what is being offered in the community so that they are able to refer isolated people to them
- **Joining up services and making them more accessible for older people –** as outlined in the SEU report "A Sure Start to Later Life" older people can be socially excluded through difficulties in accessing services. These approaches provide a way of delivering a 'single gateway to services' – i.e. by public bodies taking their services to older people rather than requiring them to go 'from pillar to post' to get what they need. So for example a key feature is regular 'drop in sessions' by Pensions Service staff giving benefits advice; housing advice workers; community nurses undertaking simple screening tests such as blood pressures; Police and Community Support Officers providing home safety advice and listening to people's concerns; Home Improvement Agency staff talking with people about simple 'handyperson' tasks they may require, etc

- **An infrastructure for promoting health and wellbeing –** these approaches can provide an 'infrastructure' for promoting the health and wellbeing of older people, which can be developed over time through a range of additional initiatives

The engagement of older people within these locality structures and activities provides a mechanism for statutory organisations to work with older people on a wide variety of issues and initiatives

A Sure Start to later life – improving participation and prevention

- **Older people making a positive contribution –** in all cases, these approaches require the active involvement of older people in delivering many of the activities. In many respects the philosophy is about – "older people doing it for themselves"- but with appropriate support. Not only is this an important principle in itself it is also vital to building capacity and sustaining successful outcomes.

One of the key outcomes has been the creation of 'participant volunteers'These are older people who join an activity and then take on a specific role within their group to support ongoing activity and development.

Keys to success include:

- Ensuring that older people are appropriately supported to identify and articulate the needs of older people
- Partnership working with all the relevant statutory agencies
- A partnership approach with the voluntary and community sector – enhancing rather than replacing existing activities
- Developing an inclusive approach (and activities) which engage different groups and communities of older people. For example, the 'younger' older, faith communities, disabled older people, carers etc.
- Engage local elected members.

Examples

Leeds Neighbourhood Networks

The Leeds Neighbourhood Network Schemes are voluntary sector organisations that provide a range of services, activities and opportunities promoting the independence, health and well-being of older people throughout Leeds. The very first Neighbourhood Network Scheme was established in Leeds in 1985. There are now over forty Neighbourhood Network Schemes working throughout the city. The Neighbourhood Network Schemes support over 25,000 older people every year. They are run by older people for older people. Each Neighbourhood Network Scheme is managed by a committee of local people and a team of committed staff and volunteers, including many older people. Six of the schemes focus on specific minority ethnic groups in Leeds and these have an important role to play in identifying the needs of ethnic minority elders and helping statutory bodies to provide appropriate culturally sensitive services

The Neighbourhood Network Schemes provide a range of activities that promote independence including Advice, information, advocacy; annual needs assessment visits to individual older people; bathing; befriending and voluntary visiting; bereavement support; community transport; computer classes; counselling. craft classes; dancing classes; day trips and social activities; day centres; decorating; food co-op; gardening; handyperson scheme; health checks and health promotion work; holidays; home insulation programmes and provision of low energy light bulbs; hospital visits; inter-generational work; library visits; local history

classes; lunch clubs; provision of Christmas hampers; provision of thermal clothing; provision of smoke alarms; provision of window and door locks; reminiscence work: shopping trips; sitting service; support for stroke victims; support for carers; swimming groups; video club; welfare benefits checks.

They are all registered charities either in their own name or in the name of their parent organisation and some are charitable companies limited by guarantee. They all work in close partnership with Leeds Social Services and have link staff from Social Services who attend committee meetings as advisors.

Somerset POPP 'Active Living Centres'

Project is aimed at actively promoting independence and well-being by establishing an infrastructure of 50 very local Active Living Centres throughout Somerset. Each Centre serves its immediate local community operating from the church/village hall, sheltered housing scheme or other suitable local venue, with outreach facilities for those who are unable to, or do not wish to, attend physically.

Centres are a vibrant 'hub' providing a café style environment, and hosting a variety of activities, as well as being a source of information and referral to the full range of preventive services available locally. The centres use peer group volunteers to support self-assessment and person-centred selection of strategies for maintaining independence, including healthy living.

Active Living Centres have become the 'hub' for the full range of preventive and well-being services already provided by the participating agencies. Some services delivered within the Active Living Centre itself, whilst others will be provided through 'networking' from the centre.

Active Living Centres work to the principle of inclusion by signposting and improving access to mainstream and 'universal' services wherever possible and appropriate. They serve as focal points through which the full range of agencies with a stake in prevention and well-being can establish a presence in local communities and make their services more easily available to all those who might need them.

Tower Hamlets Linkage Plus 'Network Centres'

Tower Hamlets Linkage Plus project has established 4 LinkAge Plus Network Centres each with its own Network co-ordinatorThe Network Centres differ in size and character to reflect the differing population profiles and needs of the areas in which they are located. The Network Centres are run and managed by community organisations including older people themselves.

The Network Centres:

- Provide a single accessible gateway to services, including Social care, preventative Health services, Pensions/benefits, housing, local voluntary sector organisations, home safety and improvement, fire, police and neighbourhood wardens, transport, access to information about employment and volunteering, adult education, leisure services

- Use assertive outreach; employing outreach workers who provide an outreach service within the borough to pro-actively identify and engage with isolated and vulnerable older adults and other hard to reach groups, reaching out to individuals who are isolated with the aim of including them, if they wish, in the activities provided within or outside the Network Centres.

The outreach service work:

- With older adults who are neighbours or members of tenants' associations, knocking on doors or otherwise making contact with individuals;
- Running a peer support scheme, with older people who are in contact with the centres acting as volunteer befrienders;
- With individual older people in their own homes or in the centres to help them access any support they may need to help retain their independence.
- Use older adults to provide and facilitate Network services; older people are both employed or given the opportunity to work as volunteers

North Lincolnshire POPP 'Fresh Start Centres'

Fresh Start involves the development of four centres. Although 'centre' implies a building, it more about a different way of working. Each centre is based around a central location in a community accessible building, and generates a range of locality specific projects.

Fresh Start Centres serve the locality in which they are based and are accessible to a broad range of communities, voluntary, public and independent sector organisations and local businesses. The Centres encourage and extend contact with people in the local community, reaching out to `isolated and hard to reach` people and linking them into facilities and activities that suit them and encourage self-help or new support networks.

Each Fresh Start Centre has:

- A designated locality, based in an existing community facility and easily accessible for seven days a week to older people in the surrounding area
- Human resources to assist with listening to the local population, community development, co-ordination of activity, administration and management and links with all the services that are available to support the locality
- Capacity to train and develop new volunteers, older people and their carers, staff in the public and voluntary sector and anyone else who can help to improve the quality of life for local older people
- Ability to draw together existing services and add new activities to ensure local people can find what suits them best through good information and sign-posting to those that can help
- Ways to stimulate new ideas and thinking about what the locality needs to support its population, and encourage new enterprise to provide and develop new services, approaches and networks through which people can find the help they need

- A brief to assist the local community to take more responsibility for its own health and quality of life and to be able to identify and assist those who are vulnerable or at risk of deteriorating quality of life in later years
- Support to monitor what it does, understand what this achieves or not for the local population and share that learning with others
- A management structure that can involve local older people in developing and reviewing what it does, and planning for the future
- Clear accountabilities with advisory and professional support from partnering organisations and communities who will invest time, monies and facilities into making Fresh Start work.

Calderdale POPP 'Neighbourhood Schemes'

Two pilot Neighbourhood Schemes (NS) have been set up and are run by local older people for their peers. They meet local needs in a flexible way to provide the services, activities and opportunities that older people want. The Neighbourhood Schemes offer a range of activities that promote health, well-being and independence. This includes a mix of advice and information – e.g. information days, drop-in clinics, leaflets, signposting and referral on to appropriate services.

It also includes social, recreational and learning opportunities e.g. coffee mornings, outings, arts and crafts, University if the Third Age, volunteering opportunities and inter-generational activities. There are also healthy living activities, e.g. T'ai Chi, weight management, dancing and other physical activity classes.. Another key element is practical help and support provided by volunteers e.g. running IT and mobile phone workshops.

Staffing consists of one full-time Neighbourhood Scheme Co-ordinator and one part time Support Worker per scheme whose tasks are to undertake community development work by liaising with local older people about their needs, identifying buildings and other resources available and developing the NS services alongside older people.

Co-ordinators and support workers support the Management Committee in their work – helping them to fundraise, assist with publicity, plan activities and organise training. They locate and support isolated, hard-to-reach older people and those with long-term conditions locally, providing transport and other practical support to enable them to access the activities on offer. At least 50% of people on each site's Management Committee are older people from the locality. Older people run, develop and evaluate the pilots with support from the Co-ordinators, Voluntary Action Calderdale, Calderdale PCT, South West Yorkshire Mental Health Trust, Calderdale Pensioners Associationand Calderdale Council, this includes updating local older people on progress via newsletters and leaflets.

Rochdale Borough POPP 'Townships'

The Rochdale Borough Townships are focussed on delivering a major transformation through community empowerment. Four Township Older Peoples Partnerships (TOPPs) have been established – comprising representatives from Pensioners Associations and other older people's organisations. They are supported by the Council for Voluntary Services Rochdale (CVSR) who are funded to provide dedicated capacity building and training to the Partnerships to enable them to become constituted as independent organisations.

There are five generic 'Outreach Workers' who undertake face to face work with individual older people in each Township, signposting them to services and community activities which may help improve their quality of life. Any unmet needs identified through this outreach process are then gathered and collated to inform the TOPPs, who each hold a commissioning budget for developing new community services and activities to fill identified gaps.

TOPPs give older people a stronger profile and voice, and help them directly influence service development within the community. The commissioning budget gives the TOPPs the responsibility for developing local activities and promoting older people led/supported initiatives. Dedicated capacity building has been included to support people gain the confidence and skills for commissioning and development, and to support the building of a volunteer and resource base within each of the Townships

Re-ablement

Recent research has demonstrated the significant financial and quality of life gains which can be achieved from a more rehabilitative and therapeutic intervention at point of referral to social care. Enablement based services appear to be able to make significant reductions in the number of older people requiring support after a 6 week intervention, with further reductions in the number of people who needed a lower level of service than had initially been assessed. In many authorities progress is being achieved through the re-commissioning of home care services. Connection with intermediate care services is very important.

"Councils have increasingly shown how developing homecare re-ablement services can support independent living and deliver value for money. Assistive technology such as telecare and minor adaptations, like fitting a handrail, can also enable people with support needs to continue to live in their own homes."

Transforming Social Care

More information is available **here**

Joint health and social care support in the community for people with long term conditions/complex needs

People with complex health and social care needs, largely associated with long term conditions, benefit greatly from joint health and social care assessment, care management, and flexible support interventions. As well as improving the outcomes for individuals the evidence strongly suggests that joint approaches reduce demand on both health and social care systems.

There are a number of important interventions. The ones addressed in this document include:

- Joint health and social care community teams
- Re-engineering of pathways out of hospital
- Rapid response services
- End of life care.

Joint health and social care community teams

Devon POPP 'Complex Care Teams'

23 Complex care teams in Devon provide a responsive, co-ordinated, person focused service for adults with long term conditions and/or complex needs. Teams work with adults and their carers to promote independence and choice in their own homes or close to home, supporting populations of around 30 – 35,000.

These integrated health and social care teams work alongside primary care GP practices, delivering the service to practice populations within designated geographical communities or 'clusters'. Their emphasis is on proactive case finding ensuring the prevention of further decline, hospitalisation and long term care. Teams also seek to promote self care and self management alongside active health promotion in partnership with primary care practice staff, GPs and public health colleagues.

Key roles in a complex care team:

Community nurses; Community matrons; therapists; Social workers; Community care workers; Domiciliary Pharmacists (in some areas); CPNs and ASWs undertake case management and associated treatment and rehabilitation interventions for individuals who may have a combination of complex single or multiple conditions and intensive needs, and whose care requires coordination.

Each Complex Care Team includes an active and paid **voluntary sector representative** as a full member. Representation is arranged through a contractual agreement with Devon Association of CVS and each representative undertakes the following:

- Attend weekly multi-disciplinary Complex Care Team meetings
- Represent the voluntary and community sector as a whole, not just one organisation
- Raise awareness of the range of voluntary and community sector opportunities and resources available to support people in the community
- Refer appropriately and impartially to voluntary/community sector services in a 'signposting' capacity

- Create and maintain key relationships with voluntary and community sector organisations
- Contribute to the collation of information regarding opportunities to promote and develop voluntary sector activity where provision is limited
- Receive referrals from CCT core members and primary care.

Each team also has a **co-ordinator** whose role is to:

- Support the complex care team members in the utilisation of a range of 'case finding tools'
- Be a central co-ordination point for the local multi disciplinary activity, including the facilitation of the 'core group' function
- Be responsible for a high quality customer service function in recording contact information, supporting the initial prioritisation of contacts, subsequent feedback and ongoing liaison with referrers and relevant others
- Maintain IT based information systems and take a key responsibility for the production of key performance data.

Key Functions:

- Case Finding: utilising case finding tools and data to proactively identify people who may be at risk of loss of independence or unnecessary hospital admission. In partnership with GP practices, Teams will use Predictive Tools such as:
  - Patients At Risk of Re-hospitalisation (PARR)
  - Dr Foster High-impact User Manager (HUM)
  - Emergency Admission Risk Likelihood Index (EARLI)

  And Activity Data such as:
  - Doctors out of hours activity
  - Ambulance Service non conveyed data
  - A&E and acute hospital admission and discharge information.

Alongside these methods clinicians and team members, including voluntary sector representatives, will be opportunistically identifying patients who present with current risks to their independence and well being. Guidelines have been issued to help implementation.

- **Case Management:** planning, monitoring and anticipating the changing needs of individuals, and co-ordinating their care across all parts of the health and social care system; proactively managing long term conditions; supporting rehabilitation and self care
- **Patient held records**: accessible records for the service user, family, carers and clinicians who are involved with their care containing as a minimum a care plan and advice regarding contingencies in the event of an exacerbation of the person's condition or other predictable event
- **Core groups:** regular (at least weekly) multidisciplinary meetings to support good communication between all involved in delivering services to patients, established in ways that enable full participation. Its function is to maintain an effective and systematic 'admission', assessment, care planning, monitoring/reviewing and 'discharge' arrangement.

Virtual Ward

Croydon Primary Care Trust (PCT) has been piloting the practical use of the Combined Model predictive risk and has developed a form of intervention called **virtual wards** that it offers solely to people at highest predicted risk.

In essence, virtual wards use the systems, staffing and daily routine of a hospital ward to provide case management in the community. Virtual wards copy the strengths of hospital wards: the virtual ward team shares a common set of notes, meets daily, and has its own ward clerk who can take messages and coordinate the team. The term 'virtual' is used because there is no physical ward building: patients are cared for in their own homes. The only way in which patients are admitted to a virtual ward is if their name appears at highest on the predicted risk score on the Combined Model.

Each virtual ward has a capacity to care for 100 patients. Using hospital parlance, each virtual ward has 100 'beds'. The catchment population for each ward is roughly 34,000 ie approximately one ward for every 15 GPs. However one of the key strengths of the Combined Model is that it enables predicted need to be mapped across a borough. The catchment population for each virtual ward can therefore be adjusted so that in areas where there is a high level of predicted need, the catchment population will be less than 34,000 and vice versa. In this way it is possible to counter the Inverse Care Law that states that the healthcare provided in a locality is usually inversely proportional to its level of need.

If the virtual wards are going to be successful in the long term then they need to be embedded with GP practices.

Each virtual ward is therefore permanently linked to a group of GP practices (three or four large practices, or a larger number of small practices). In this way the virtual ward staff can develop close working relationships with their constituent practices. It is hoped that in future, groups of practices may wish to commission virtual wards through practice-based commissioning.

In the same way that certain hospital nurses will cover several acute wards (eg asthma specialist nurses in a district general hospital) so the specialist teams in the community will likewise cover several virtual wards.

Ward Staff

- The day-to-day clinical work of the ward is lead by a community matron. Other staff include a social worker, health visitor, pharmacist, community nurses and other allied health professionals.
- A key member of staff is the ward administrator ('ward clerk'). With a dedicated telephone number and email address, the ward administrator is able to collect and disseminate information between patients, their carers, GP practice staff, virtual ward staff, and hospital staff.

Virtual Ward A
Community Matron
Nursing complement
Health Visitor
Ward Clerk
Pharmacist
Social Worker
Physiotherapist
Mental Health Link
Voluntary Sector Helper

- Medical input is comes from daily telephone contact between the community matron and the duty doctor at each constituent GP practice. The matron is also able to book surgery appointments to see any patient's usual GP.

Specialist Staff visit several virtual wards

- Specialist nurses for Asthma, Continence, Heart Failure, etc
- Palliative care team
- Alcohol service
- Dietician.

Admission to a virtual ward

At the time of admission to the virtual ward, the community matron visits the patient at home and conducts an initial assessment. This record, and all further entries by ward staff, is entered into a shared set of electronic notes. A summary from the GP computer system is pasted into these ward notes before the initial assessment, so as to provide background information and avoid unnecessary duplication of work. The GP practice is informed of all significant changes to the patient's management.

"We will provide support to those organisations that wish to go further in integrating health and social care services… We will invite proposals for pilots that involve clinicians working on a more collaborative basis across primary, community and secondary care – and with local authorities and others…"

Darzi – Vision for primary and community care, 2008

Members of the virtual ward staff hold an office-based ward round each working day. Patients are discussed at different frequencies depending on their circumstances and stability.

Of the 100 patients on each ward, 5 patients are discussed daily, 35 are discussed weekly, with the remaining 60 patients discussed monthly. The community matron can move patients freely between these different intensity 'beds' according to changes in their clinical conditions.

Communications

Every night an automatic email containing a list of each virtual ward's current patients is sent automatically to local hospitals, NHS Direct and GP out-of-hours cooperatives. This information is uploaded onto these organisations' clinical computer systems. Should a virtual ward patient present to their services (eg to a local A&E department) then the staff working there will be alerted automatically to the patient's status. They then know that by contacting the virtual ward administrator, they can obtain up-to-date details of the patient's care. They can also arrange early discharge back to the care of the virtual ward team.

Discharge

When a patient has been assessed by all relevant virtual ward staff, and has been cared for uneventfully for several months in the 'monthly review' section of the ward, then the ward staff may feel that the patient is ready to be discharged back to the care of the GP practice. They also receive a prompt when the patient's name drops below the 100 people with highest predicted risk in the catchment area according to the Combined Model.

Unique Care

The Unique Care programme is aimed at helping people with complex long-term conditions within a primary care setting. It involves setting up a coordinated approach between health, social care and other services, and is particularly aimed at patients over 65. A personal care plan is agreed in advance of any crisis so the patient is able to remain at home, and not be admitted to hospital. The key benefits are:

- Better quality of life and improved health outcomes for patients
- Greater choice and control for individuals over how their needs should be met
- Reduction in emergency admissions and emergency bed days in hospital
- More appropriate use of resources and a reduction in duplication of services across the system as care is better organised.

It is based upon the socio-medical model of case management developed at the Castlefields Health Centre in Runcorn and was developed through working with PCTs, acute trusts, practices and local authorities. It is a system of coordinating health and social care to respond to referrals more efficiently and more effectively, to involve community staff in developing discharge plans for inpatients and to identify high risk individuals for preventative interventions.

The model brings together primary and community services, secondary care, social services, housing, the voluntary sector, allied health professionals and others. With the focus on patient-centred care, intermediate care and the promotion of healthy living and self-care, the model is adaptable and transferable to many different client groups.

The approach is underpinned by five key principles, however it is not a one-size fits all universal solution to anticipatory care and how the principles are addressed is down to local circumstances.

The five key principles of Unique Care are:

- Ensure local health and social services work side-by-side to effectively coordinate care
- Establish excellent communications between GPs, community nurses and social workers
- Establish proactive, practice-based systems to identify people at risk of falling into crisis
- Establish 'in-reach' systems in hospitals to ensure patients return home as soon as they possibly can
- Constantly adapt and respond to the individual needs of patients and support people to live at home.

These principles differentiate it from other case management approaches and, in order to establish effective implementation, all five key principles need to be addressed.

Other important elements of the approach include:

- Social care requirements are central to the process
- Patients can discharge their team once they are confident in managing their own care
- Patients come out of hospital quickly and easily through close working with the hospital discharge team from the point of admission
- Patients are able to take responsibility for their own health and social care, with support as and when required.

Southwark POPP 'Community Multi-disciplinary teams'

Four locality-based multidisciplinary teams (MDTs) have been established to address the health, social care, therapy and mental health/well-being needs of a group of older people. The multidisciplinary teams comprise.

Each MDT comprises of a range of specialists within health and social care including:

- Team Managers, Senior Practitioners and Social Workers
- District Nurse Team Managers, District Nurses and Community Matrons
- Community Old Age Physician
- Physiotherapists
- Occupational Therapist
- Older People's Community Mental Health Teams
- Nursing Team Leads from the Elderly Care Day Units
- Pharmacists
- Voluntary Sector Co-ordinator
- Other health professionals as relevant (e.g. GPs, Elderly Care Co-ordinators, Hospital Discharge and Urgent Care Teams)
- Team administrator.

Each locality team meets monthly and up to five service users requiring multidisciplinary input are presented at each meeting Multidisciplinary action plans are formulated during the MDTs. Cases previously discussed are also reviewed at each meeting for feedback and/or closure.

Evaluation indicates that contrary to the trend for the over 65 population as a whole, interventions by the MDT appear to have produced a reduction in hospital admissions of 19% and a reduction in A&E attendance of 25% and a number of residential care placements

Re-engineering the pathways in and out of hospital

Particularly effective interventions include step down pathways to ensure that decisions about long term placements are not made (under pressure) in an acute hospital bed.

Southwark POPP 'Hospital Discharge Pathway'

The skills mix of hospital discharge teams were reconfigured to provide home-based support for a wider and more complex group of clients. The Mental Health Intermediate Care team became an integral part of the discharge process, intervening in complex discharge cases and providing advice and training to increase the discharge teams' capacity to deal with mental health issues. This enabled teams to tackle potential barriers to returning home, such as depression and anxiety. Therapy input was increased with occupational therapists and physiotherapists tackling more complex cases and providing home-based rehabilitation and adaptations to promote independent living. The community geriatrician provides support to the discharge teams, attending monthly multidisciplinary teams and clinics at day hospital and intermediate care units.

Placing social workers on the care of the elderly wards in the two hospital trusts resulted in the early identification of patients potentially requiring intermediate care and the proactive planning of discharge, so that patients could be discharged as soon as they were medically fit.

As the hospital discharge teams gained experience, patients with more complex needs were able to be taken home for rehabilitation or re-enablement to maximise their potential.

Evaluation data indicates:

- A reduced length of stay on care of the elderly wards
- A 12% reduction in placements in residential and nursing home care
- Reductions in the average size of social care packages from over 16 to under 12hrs per week
- Although increased care packages may have been required for those cases where placements in residential care was avoided, this was balanced by reductions in overall hours ordered by the discharge teams
- Inputs from occupational therapists, physiotherapists, the Mental Health Intermediate Care Team and the use of telecare equipment has enabled more appropriate care packages.

Rapid response teams

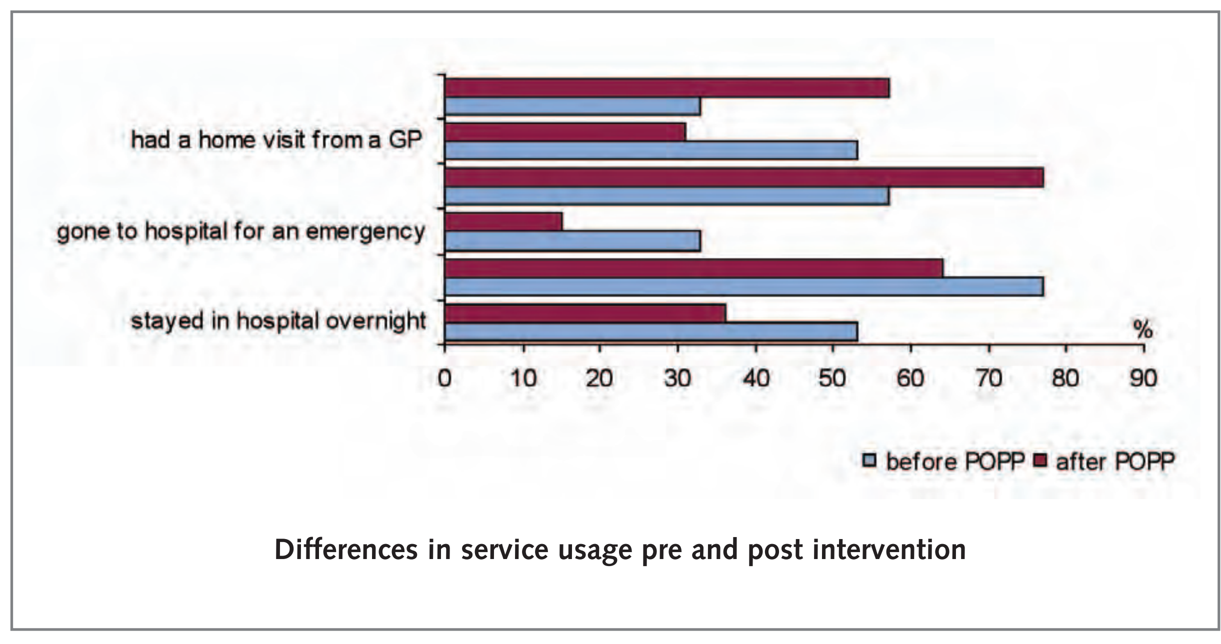
The important factor here is that teams are able to respond quickly to provide care to people who do not require hospital admission but who cannot stay at home safely without care and support. Addressing the needs of older people with mental health problems is particularly important.

Bradford POPP 'Intensive Support Teams'

Aimed at providing community-based support to older people with mental health problems at risk of institutional care. This was achieved through flexible, instrumental and psychosocial support delivered over a 6 to 12 week period. Service users were those considered to be at risk of admission to hospital of long term care or those requiring support to facilitate earlier discharge from hospital.

Findings:

- 26% of users were prevented from being admitted to a care home
- 13% admission to hospital was prevented or delayed in a further 13% of users



Differences in service usage pre and post intervention

- 15% were supported to be discharged from hospital earlier than would otherwise have been the case
- there was a 29% reduction in the number of home care hours immediately after intervention, levelling out at a 26% reduction on month after intervention
- When operating at full capacity the Intensive Support Teams are projected to produce net savings of around £550k per annum.

East Sussex POPP 'Intensive Community Support team'

Offers short-term and highly intensive community support across an extended hours service during the day and in the evenings and at weekends, and supplements care packages provided by Community Mental Health Teams. Staff offer short-term and highly intensive community support across an extended hours service in the day, evenings and at weekends, and supplement on-going care packages that might otherwise break down. Referrals to the intensive community support service are from other members of the CMHT. The target group is older people who, without the service, would be at risk of avoidable admission to (psychiatric) hospital, or xperience a delayed discharge from hospital. The aim is to anticipate and proactively manage these risks to prevent deterioration or crises.

East Sussex POPP 'Enhanced Response Team'

A home care service provided by Social Care Services. The service takes referrals from the hospital social care assessment team (or the Single Telephone Access Number out of hours), and is able to respond quickly in and out of office hours to provide home care to older people who do not require hospital admission but cannot go home safely without care and support.

The service aims to respond within three hours. Once they arrive at the older person's home the team will conduct an environmental risk assessment of their home circumstances and whether it is safe for the older person to stay there. If home circumstances are not or cannot be made safe or satisfactory, the older person will return to hospital. The team can also provide services that would not otherwise be provided by Adult Social Care services, such as shopping, cleaning, bathing tasks, and sorting out of domestic matters such as bill payments and other environmental and daily living issues. The service is provided for up to 14 days.

End of life care

Joint health and social care approaches is particularly important in providing support to enable older people to die in the place of their choice. Work in this area has been boosted by **national policy development**.

Leicestershire POPP 'DALE (Decisions at Life's End)'

Supports people looking to die in a place of their own choice. The individual has a dedicated member of staff that supports them through the process of dying, often for their last week or 10 days of life. It allows as many people as possible to have a dignified death in their own home.

The project is reversing the increasing number of older people who die in hospital, often separated from family and friends, as a consequence of the general trend of increased unscheduled admissions. It is achieving this by improving the infrastructure in community and primary care that enables older people to choose to be cared for in their own home, or close to home, in the last few days of life.

The key elements of the project are:

- **A joint health and social care Immediate Response 'end of life' Team (IREOLT):** When an older person's death is predicted and care at home is requested and agreed by clinician as safe, a single call is made to the 'end of life' team (IREOLT) to activate the nursing and practical care required to support both the person and their carer at home and to deflect admission or to facilitate hospital discharge. This team has access to a rapid delivery equipment service to provide essential equipment to support the care at home
- **End of Life Plans:** Through media publicity and promotional work with key voluntary groups, older people are encouraged to prepare an individual 'End of Life Plan'. This records where a person would prefer to be cared for at the end of their life. Where known in advance, this is noted in 'special patient records' and care plans or older people may choose to retain their plan at home
- **Re-education and training of key professionals:** This is a major feature of this project with the aim of changing cultural and institutionalised attitudes to dying.

Support to Care Homes

A number of possible interventions aimed at reducing admissions to hospital, including at end of life, and to improve the quality of life of residents. Typically involves training of care home staff by nurses in order to increase the skills and capabilities of both care and nursing staff, and/or providing additional capacity in-reaching' into the homes.

Gloucestershire POPP 'Care Homes: part of our community'

Gloucestershire is redesigning the provision of care provided within and outside of its 164 care homes. A key aspect of the project is outreach services, which extends the capacity of care homes to provide different types of care and support to a greater number and wider range of older people and carers in the community. With care homes in the centre of such a hub, older people will be able to play a full and active part in their communities. This will result in healthier and self-sustaining communities and change the perception of care homes so that they are seen as a community resource

The project has also developed a range of treatment and rehabilitation services that are available in the care homes across the county rather than in acute hospitals. It has also instigated a systematic training programme within care homes for all care staff across the county to ensure the right skills are available to support this change.

The approach aims to promote, improved care pathways and better whole system working through:

- **Countywide New Care Homes Support Teams –** These multi-disciplinary teams include medicines management, case management of those with long-term conditions, access to psychological therapies and a range of other services
- **Outreach Services –** These services develop the capacity of Care Homes to provide different types of care and support to a greater number and wider range of older people and carers in the community. For example planning for older age (finance, housing, care, healthy ageing advice), use of IT for those in care homes and in the community etc

- **New Care Pathways –** This involves providing care for older people using different pathways e.g. step up and step down beds
- **Training for Care Home staff –** This ensures that staff are skilled to deal with more challenging older people and with care of the dying, enabling more residents a choice of where they should die
- **The involvement of older people** in the evaluation, planning and inspection of services
- **Innovative retraining and recruitment of older people –** including training for carers, for older people for second careers, lifelong learning and voluntary work.

Providing nursing support within residential care homes

A joint NHS-Local Authority New Types of Worker initiative in Bath and North East Somerset provided a dedicated **nursing and physiotherapy team to three residential care homes**. The initiative was aimed at meeting the nursing needs of residents where they lived and to train designated care home staff in basic nursing.

Evaluation indicates:

- Residents were likely to benefit from improved quality of life from early detection of illness
- Able to avert between 81 and 197 potential hospital admissions over the first two years and 20 early discharges were facilitated
- Model has had a positive impact in preventing longer admissions and facilitating early discharge
- Data suggests 20 residents prevented from transferring from care to nursing home
- Estimated overall saving of £250k per annum, principally from avoided hospital admissions, closely followed by avoided transfers to nursing homes, and then earlier discharges from hospital
- Savings were mainly in reduced use of NHS services, while the Primary Care Trust and Adult Social Services both funded the intervention, highlighting the need for partnership working to sustain funding.

Crisis response services/ out of hours services

There is evidence to suggest that effective crisis or rapid response services can have a positive impact on the care pathway and outcomes for older people. Key features of more effective services include:

- A single integrated point of access which is covered at all times
- A support service is delivered within a locally agreed minimum time
- generically-trained community support staff able to modify the package if necessary
- There are links to intermediate care services and medicines management.

Alternatives to the standard ambulance response are available

Norfolk POPP 'Night Owls'

Night Owls are generic workers capable of responding to a range of health, social care or domestic problems which cannot wait until morning without leaving someone in discomfort or distress, yet do not need a response from the emergency services.

The service is free and can be directly accessed by any older person or someone on their behalf. Night Owls have close relationships with other services such as out of hours GPS, Social Workers, District Nurses and housing personnel.

The Night Owls team operates 365 nights a year with 3 – 4 staff members are on duty through the night. During 07/08 the team helped 2256 older people across Norfolk. Tasks performed included helping people who had fallen but were uninjured, cleaning up after a flood, comforting someone after a burglary, reassuring relatives who live too far away to help, and supporting other professionals.

21% of visits were to people, who had fallen and without the service would have needed an ambulance. A similar percentage of people needed help with continence care and 5% needed help with catheters or stoma bags. This has resulted in savings to services and in releasing time for more appropriate activities.

East Sussex POPP 'Paramedic Practitioners'

Paramedic Practitioners are highly trained paramedics who work autonomously to diagnose, treat, and discharge or refer people to an appropriate healthcare professional within the community. This service was set up to attend and treat older people who fall, rather than using an ambulance to take them to hospital, but also works with people other than those who fall.

A Falls Prevention Service is in place, but there is a gap between when a person falls and their referral to the Falls Prevention Service, especially out of hours. The usual model is for a full ambulance team to be called out for a fall or fall-related injury.

In the new model, Paramedic Practitioners respond to falls calls instead of a two-person ambulance, with the aim of diverting people away from A&E and hospital admission, where appropriate.

The Paramedic Practitioner service is still an emergency service but, in addition to their paramedic training, PPs are clinically trained to provide additional safe and effective treatment at point of need and refer on where appropriate to avoid acute intervention. They provide a holistic response to patient need by diagnosing, treating, discharging or referring to an appropriate healthcare professional within the community. The aim is to improve patient care and the patient experience within the primary care and pre-hospital setting. Paramedic Practitioners work autonomously and are clinically trained to deliver assessment for respiratory, cardiovascular, neurological, abdominal, ENT, and minor injuries callouts. PPs are trained to provide an enhanced service to that provided by an ambulance crew, enabling more people to be treated at home rather than going to an acute setting for diagnosis and treatment.

Nationally there is evidence that Paramedic Practitioners responding to 999 calls provide more timely care for patients, with fewer transfers and ultimately reduced A&E attendances.

Conclusion – Action check list for making it happen

Making a strategic shift towards prevention and early intervention is a relatively complex and multi-faceted programme, and needs to be undertaken as part of a wider programme of transformation as set out in Putting People First. This paper provides a lot of the guidance and learning to support this

What follows is a general 'checklist' of actions which will be important for most local authority and health systems to look at:

Process	Content
Undertake an assessment of Council and health system's strengths and weaknesses on this agenda by using the self assessment tool **"Strategic Shift to Prevention:assessing the strengths and challenges"**. It provides a structured approach for assessing the priority actions that need to be addressed	Use the Social Care Reform Grant to to support the strategic shift to prevention and early intervention
Ensure that an ongoing and effective process for involving older people is in place and that it is integral to system re-design processes	Develop a balanced portfolio of investment across the full range of possible interventions
Gain 'sign up' across the whole system – (i.e. beyond health and social care to included other Council functions and other public sector stakeholders) for vision, outcomes, performance management and resourcing	Pay particular attention to commissioning proactive ways of providing information and advice to older people, including for those who can afford to fund their own care and support.
Adopt a strong business planning/strategic commissioning approach	For those not eligible for ongoing social care support it is important to provide a pathway into some function which assesses their needs, facilitates their access to universal/wellbeing services and checks up on their situation at a future date.
Invest rather than spend – i.e. consider the different 'returns' that investment in particular interventions deliver	Age proof mainstream services
Ensure sufficient performance management capacity is in place to establish baseline and monitor progress over the transformation period	Ensure that a comprehensive range of wellbeing services are in place and strengthen relationships with the voluntary and community sector in order to maximise capacity
Undertake work to 'age proof' mainstream services	Employ community development skills to support the growth of capacity within the community of older peopleInfrastructure support for volunteering and inter-generational work are key
Establish protocols for sharing information between different agencies	Develop a case finding and case co-ordination function
Build the capacity of the local voluntary and community sector so that they are more able to respond to a commissioning led approach to prevention and early intervention	Re-configure capacity in order to deliver a re-ablement serviceEnsure good linkages with intermediate care services
	Develop joint health and social care networks and/or teams to support people with long term conditions/complex needs, and to deliver more effective end of life care.
	Assess the potential for more joint approaches to out of hours/crisis response services, including alternatives to ambulance responses.

Appendices

A Quality of Life Performance Framework

B Older People's Involvement and Co-production

C Rigorouse financial planning and use of Economic Appraisal methodology

D Commissioning Report Template

Appendix A

Quality of Life Performance Framework

Outcomes	Measures of perception for 50+ years (from Place Survey or other survey work)	Performance indicators
Improved health and independence	• NI 119 Self reported measure of people's overall health and well being • NI 137 Healthy life expectancy at age 65 • % satisfied with health services • % satisfied with social services • % who take moderate exercise 5 times a week • % who have a long-term illness, health problem or disability which limits their daily activities or the work that they can do • % who think of themselves as a disabled person? • % who feel in the last 12mths their health has been good on the whole • % who smoke • % who have accidentally fallen in the last 12mths • % who eat 5 or more portions of fruit and vegetables each day	• NI 125 Achieving independence for older people through rehabilitation/intermediate care • NI 131 Delayed transfers of care from hospital • NI 134 Number of emergency bed days per head of weighted population • Number of emergency bed days (over 2 day stays) occupied by people aged 75 or over • NI 136 People supported to live independently through social services • NI 135 Carers receiving needs assessment or review and a specific carer's service, or advice and information • Number of households receiving intensive/substantial home care per 1,000 population aged 65 or over • Number of people over 75 who have access to a telecare/community alarm package per 1,000 aged 75 or over

Outcomes	Measures of perception for 50+ years (from Place Survey or other survey work)	Performance indicators
	• % of carers who feel they are well supported by social services or family and friends • % who feel that they have been given the information required to promote a healthy lifestyle • % of people in hospital or care homes who feel that they receive appetising and nutritious food	• Take up of GP referrals under 'books on prescription' schemes
Improved quality of life	• NI 138 Satisfaction of people over 65 with both home and neighbourhood • NI 175 Access to services and facilities by public transport • NI 140 Fair treatment by local services • NI 9 Use of public libraries • NI 10 Visits to museums or galleries • NI 11 Engagement in the arts • % with easy access to a food shop and to GP • % who have been a victim of crime in the last 12mths • % who feel safe outdoors in their neighbourhood after during the day or after dark • % who feel fear of crime affects their day to day life • % satisfied with leisure facilities/services for people over 65 • % who feel inaccessible public transport prevents them from leaving their house more often than they'd want or need to • % who feel lack of support and assistance prevents them from leaving their house more often than they'd want or need to • % who feel caring responsibilities prevent them from leaving their house more often than they'd want or need to • % satisfied with the state of repair of their home • % satisfied with their life as a whole these days	• NI 142 Number of vulnerable people who are supported to maintain independent living • NI 8 Participation in sport • Numbers of older people enrolling for adult learning courses

Outcomes	Measures of perception for 50+ years (from Place Survey or other survey work)	Performance indicators
Making a positive contribution	• NI 6 Participation in volunteering • % who feel that they can participate in the life of their local community • % who use services feel that they are able to have an input into how services are shaped • % who feel they can influence decisions in their local area	• Number of older people involved in inter-generational activities with children and young people which have been organised by the council and/or its partners
Increased choice and control	• NI 139 People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently • % of people who use services who feel that they have been supported to express their individual needs and wishes • % of people who use services who feel that they know how to access their records and how to contact service providers when they need to do so • % of people who use services who know how to make a complaint	• NI 124 People with a long term condition supported to be independent and in control of their condition • NI 130 Social care clients receiving self directed support (Direct Payments and Individual Budgets) • Number of older people being supported to chose and control how they meet their needs (by way of Expert Patients or Carers Programme)
Freedom from discrimination and harassment	• NI 140 Fair treatment by local services • % who have been discriminated against because of their age or race • % who feel that ethnic differences are respected in their neighbourhood • % of people who feel that eligibility criteria are easy to understand	
Economic wellbeing	• % who feel information and advice on benefits is available to them • % of carers who feel supported to enable them to continue their employment or return to work	• Number of older people in receipt of Pension Credit, Carers' Allowance, Attendance Allowance • Employment rate of 50-69 year olds • NI 187 Tackling fuel poverty – People receiving income based benefits living in homes with a low energy efficiency rating
Maintining personal dignity and respect	• NI 127 Self reported experience of social care users • NI 128 User reported measure of dignity and respect in their treatment • % of family members or carers who feel that they are treated as 'care partners'	• NI 129 End of life acces to palliative care enabling people to chose to die at home

Appendix B

Older People's Involvement and Co-production

Introduction

The involvement of older people is an integral part of creating a strategic shift towards prevention and early intervention, and is inextricably linked to delivering other key outcomes:

- Enabling older people to make a positive contribution
- Promoting older people's 'choice and control' – "Nothing about us, without us!"

In 1969 Sherry Arnstein, describing the need for community participation in America, created her "Ladder of Participation" (see below and for a fuller explanation **here**)

Ladder rung	Category
Citizen control	Degree of Citizen Power
Delegated power	Degree of Citizen Power
Partnership	Degree of Citizen Power
Placation	Degree of Tokenism
Consultation	Degree of Tokenism
Informing	Degree of Tokenism
Therapy	Non-participation
Manipulation	Non-participation

The examples that follow are all within the 'citizen power' end of Arnstein's spectrum, and there is a strong sense in many of them of local authorities beginning to 'co-produce' system re-design and change. The White Paper **"Communities in Control: Real People, Real Power"** outlines a strong national policy drive towards citizen involvement and gives some other examples of how this is currently happening.

This is such an important area that further work and developments will be reported on a special section of **our website**.

Although there are different ways to engage effectively with the older population, all successful engagement models share a number of key characteristics:

- *A cross-cutting process, engaging the community, partners and all council services*
- *An effective lead champion, supported by champions at all levels of the organisation*
- *A focus on driving improvement*
- *Monitoring outcomes; and*
- *A process that evolves and improves"*

Audit Commission, "Don't Stop Me Now – preparing for an ageing population

It is important to recognise that older people are not a homogenous group. There are a wide range of ways in which different groups of older people can be involved depending on their preferences and needs. Key areas may include involvement in the design, delivery, governance or co-production of services and activities to promote improved health and wellbeing.

Examples of the following different approaches are provided below:

- Elected scrutiny
- Setting priorities and holding public bodies to account
- Strategic decision making and agenda setting
- Locality commissioning
- Drawing on older people's experience
- Monitoring and evaluation
- Delivering services
- Older People as local advocates
- Involving older people with mental health problems.

Elected scrutiny

This is where a degree of independent legitimacy is given to older people who have been elected to work with public sector bodies with the explicit expectation that they will represent and act as advocates for other older people.

Case Study

In June 2003 **Brighton & Hove** became the first local authority in the country to establish a directly elected older people's council. The Older People's Council (OPC) is an independent body set up and supported by Brighton and Hove City Council. The OPC works in partnership with the City Council and other large statutory services (e.g. health) making sure that older people have a say in the services and policies. The idea of a directly elected body came from Denmark where it is a statutory requirement for every town and city to elect a Seniors' Council.

The Older People's Council exists to ensure that the needs and contribution of older people is never ignored. The success of the OPC is due to the hard work and diligence of its elected members, who scrutinise policy and committee papers, keep up to date with a vast range of issues, attend meetings and forums, and take up issues with city councillors, local MPs and directly to government Ministers when appropriate

Members of the OPC are elected by older people living in Brighton & Hove. Any older person aged 60 years or over and resident in the city can stand in the election. Elections for the OPC take place every four years around the time of the elections for the local city council.

Setting priorities and holding public bodies to account

This involves a structured process for involving older people in the setting of priorities and then holding public officials and politicians to account for their actions in delivering them.

Case Study

The 'Really Important Questions' process in **Tameside MBC** is an example of older people being fully involved in discussing priorities and holding public bodies to account. The Really Important Questions (RIQ) process is made up of people over 50 who want to be involved in the planning of health and social care services

There is an annual conference with:

- Workshop sessions which discuss areas of interest to older people – i.e. Health and Wellbeing; Qualtiy of Life; Making a Positive Contribution; Choice, Control and Risk; Economic Wellbeing; Dignity in Care etc
- The workshop discussions produce three priorities which people feel are the most important issues that older people want addressed in the coming year
- These priorities are then put to a whole plenary session which votes on the one top priority in each area
- The Council and partners undertake work on these priorities during the course of the year
- At the Conference the following year senior figures from the Council and partners agencies (i.e Lead Member, Chief Executive, Heads of Service, NHS Trust Chief Execs etc), make a presentation to the whole conference setting out what they have done to address the priorities.
- The process is then repeated each year.

Strategic decision making and agenda setting

This is the process whereby older people are involved as partners in discussions and planning at a strategic and cross agency level

Case Study

In Bristol the older people are involved at a strategic level as part of an Older People's Partnership Board. This is an integral part of the Local Strategic Partnership (LSP) structure and presents a key forum for making progress on 'cross cutting agendas' such as promoting the independence and well being of older people. Bristol's Older People's Partnership Board includes:

- Senior managers from the key council and other statutory agencies, Adult Community Care, Housing, Culture and Leisure, Transport and Planning, Equalities and Community Development, PCT Commissioning, Public Health, Pensions Service, Community Safety Partnership
- Voluntary sector infrastructure organisations (including those for BME communities), Age Concern and Carers Centre
- **But most crucially of all, 50% of the membership of the Board is allocated to older people and carers** (including several places specifically reserved for older people and carers from black and minority ethnic communities)
- The Board is chaired by the Director of Adult Social Services, with the Vice Chair being drawn from the local Older People's Forum.

Locality commissioning

This is where older people are involved in identifying the needs of an area and making decisions about the deployment of (often delegated) resources.

Case Study

Worcestershire Locality Management Groups were developed in three areas as part of their POPP project.

The Locality Management Groups comprised:

- 50% older people
- 1 social care practitioner
- 1 health practitioner
- 2 Councillors
- 2 voluntary sector representatives.

The were supported by a team comprising:

- A Neighbourhood Network Manager
- 2 community development workers
- 1 health development worker.

The Locality Management Groups:

- Contributed to and agreed a needs profile for their area
- Made decisions about the allocation of the locality budget (approx £150k per annum)
- Scrutinised and approved the 'local delivery plan' and individual bids to a 'Community Investment Fund'
- Monitored delivery of services they had commissioned
- Worked with vol orgs to promote more co-ordinated working.

Drawing on the older people's experience

This involves an explicit and systematic approach to engaging older people and supporting their input into statutory service planning and decision making.

Case Study

The Sheffield Expert Elders Network was developed as part of their POPP project comprises over 100 older people who volunteer their time to advise the NHS and local authority on the planning, design and delivery of local services. Older people are invited to register their specific interests and the type of involvement the are interested in – i.e. ranging from commenting on draft policies, to sitting on service modernisation boards, to helping write job descriptions. Council departments and other statutory agencies are advised about the availability of this 'well of knowledge', and are encouraged to register requests for older people's participation.

The Expert Elders Network is designed to empower older people, to ensure they have a strong voice in how services are shaped to meet their needs. Their focus is not just on health and social care services but also other mainsrtream services that help people go about their live, i.e. public transport, building design, parks and open spaces, housing and libraries.

The network represents the diversity of Sheffield, with 15% of members coming from black and minority ethnic communities, and 67% being female. There is evidence that opinions and voices from outside the traditional male, white community are now being heard.

Monitoring and evaluation

This is where older people themselves are engaged (and supported) to undertake the evaluation of services.

Case Study

As part of their local evaluation of the Gloucestershire POPP, a research team at the University of the West of England (UWE) have recruited older people from across the county as volunteer community researchers. Information about this opportunity was advertised in local newspapers and community newsletters. As a result, 28 older people contacted the research team for more details and 12 attended an initial meeting to find out more. 8 of these decided to be involved and subsequently attended a training session a few weeks later. This covered a range of topics, including:

- Stages of the research process
- Recruiting participants and arranging research interviews
- Ethical issues: consent, confidentiality, distress and disclosure
- Interviewing skills: theory and practice
- Note taking tips
- The interview schedule.

The UWE team assisted in arranging interviews between older people researchers and care home residents. Ongoing support is being made available to the community researchers, including meetings to enable them to share and evaluate their own experiences.

The partners in the Gloucestershire POPP (these include Gloucestershire PCT, Gloucestershire County Council and Gloucester Older Persons Assembly), are keen to continue to work with this group of older people as researchers/evaluators beyond the life of the project.

Delivering services

In many ways the most practical and powerful way of involving older people is to recruit and/or support them to deliver services themselves to other older people

Case Study

Tameside POPP has recruited older people as volunteers to deliver its signposting service. People offered a health and social care 'check and support' visit, which looks at a variety of factors including health risks, mobility, falls, social contact, carer support, and how they manage their medication. The 'Check and support' visits carried out by a team of volunteers aged 55 or over, who are organised and trained by a community sector organisation. After each 'check and support' visit, the older person is given customised information and advice. This may include directing or 'signposting' the older person to services or sources of help, for example befriending, falls prevention and schemes offering help with managing medication, social and luncheon clubs, or neighbourhood day care services. The volunteers receive training and support to deliver the service.

Gloucestershire Linkage Plus pilot has recruited a number of older people to act as 'Village Agents' to delivery information and signposting services in local neighbourhoods. The Village Agents are paid for 10hrs work per week. The Village Agents are supported by:

- Training programmes
- Publicity material
- Adult Helpdesk, (a holistic telephone referral service for social care)
- Occupational therapy and health technology
- Mobile telephone
- Lap top with mobile internet access

- One to one support and opportunities to share good practice.

They are supported by Gloucestershire County Council, Adult Helpdesk and Gloucestershire Rural Community Council

Older people as local advocates

This involves older people being given a role to act as advocates on behalf of older people within a particular locality

Case Study

The Dorset Leadership Programme has 33 paid part-time staff (all of whom are over 50) working within local 'clusters' to challenge and change the way that services are provided to older people. The Leaders work with service providers and older people to identify gaps in service delivery, as well as local opportunities for their development. The Leaders role is to reflect in the needs, desires and aspirations of older people, in order to engender change. The Dorset Leadership programme helps and trains older people to identify, articulate and address needs where they live. Older people are involved in:

- Supporting each other
- Promoting links across the generations
- Working together to develop active and supportive communities.

The Leaders are also engaged in what are called 'action learning sets' to look at a range of specific issues including:

- Transport
- Avoidable hospital re-admissions
- Closure of essential services, including post offices and public toilets.

Involving older people with mental health problems

"You need to focus on the ability and the contribution that we can make rather than what we can no longer do."

Involving older people with dementia and other mental health needs is often overlooked. Given that they are such important stakeholders in services this is a situation which needs to change, particularly as their involvement is cucial to ensuring that services properly meet their needs.

"I'm still me. My memory may not be as good as it as, but it doesn't stop me from being me".

Important issues regarding involvement and consultation

- It is possible to consult people with dementia about their views of services
- It is possible for staff to undertake service user consultation work
- There are many different possible approaches to communication and consultation
- Approaches to communication and consultation must be developed on an individual basis
- Giving the person with dementia maximum control over opportunities for communication and, subsequently, consultation seems to be the best strategy
- Devising and trying out approaches to communication and consultation requires considerable amounts of time and energy

- Communication and consultation should not be seen as a special activity which is set apart from other work
- Organisational features of service do not always support efforts to undertake work of this nature
- Investing effort in developing communication and so consultation can be highly rewarding for staff
- Staff need to be helped to recognise the complexity of the task they face and the sophistication of their own skills
- Staff need to be supported in tolerating vagueness and confusion
- There are dangers in adopting pre-planned approaches
- Progressing from general to specific approaches is a rational way to approach the task
- There is a need to recognise the importance of apparently small details of communication
- Staff need to be open-minded about approaches which seem unsuccessful
- Documentation and reflection are important parts of the process
- Particular approaches to communication may function as confidence-boosters for staff
- Many people with dementia express needs and preferences in non-verbal ways
- The issue of consent applies to practice as well as research
- Communication and consultation can be personally very demanding.

Further information is available at ***www.olderpeoplesmentalhealth.csip.org.uk*** where there is a toolkit on involving people with dementia.

Appendix C

Rigorous financial planning – the use of an 'Economic Appraisal' methodology

Introduction

Making a strategic shift towards independence and wellbeing requires a detailed and longer term approach to commissioning. Within the POPP programme the 'Economic Appraisal' methodology set out in the HM Treasury 'Green Book' was found to be a very helpful in developing this kind of effective business planning/commissioning approach.

What follows is:

Part 1 – An overview of this approach

Part 2 – A worked example from the POPP programme

Part 1 – Overview

In very simple terms the economic appraisal methodology allows a structured way of assessing the likely costs and benefits of an investment proposal over the medium to long term. As such, it is ideally suited to supporting the sort of transformational change expected through the Social Care Reform Grant.

The approach helps to produce:

- Clear thinking about the true costs associated with investments
- Realistic estimates about the benefits (e.g. 'savings') that will be generated – though other non-financial benefits also need to be included to provide a proper framework for decision making
- A longer planning perspective over which to see the pace of 'transformation' and realisation of benefits.

It requires:

- Good financial data
- Transparent and reasonable assumptions about expected benefits
- Clear specification of outcomes and target activity
- Regular and tight monitoring of actual spend and benefits against projections
- Tight performance management to address any deviations from projections.

It needs to be an integral part of:

- Srategic commissioning processes
- Project/programme management arrangements
- Reporting to Governance structures.

Main components of the approach

Costs and benefits

A clear breakdown of the elements making up the costs and benefits is required, together with the underlying assumptions, and a sensitivity analysis of the key variables.

Net benefits

The sum of the benefits less the sum of the costs in each year gives net benefits for the year in question. Net benefits should be calculated separately for each year.

Optimism Bias – assumptions and risks

It is a truism that there is always a tendency for those proposing an investment to over-state the benefits and under-state the risks. It is therefore important to compensate for this by factoring in an explicit reduction in expected benefits

Discount factor

Discount factors are a means of reducing future net benefits to their value in the base year (Year 0). It is recommended that the first year in which the investment is committed is chosen as the base year. On this basis, the discount factor in the base year will be 1 (i.e. costs and benefits which accrue in this year do not need to be discounted further). In practice, it is usually sufficiently accurate to treat all sums accruing during the course of a year as falling at mid-year. During the period of the POPP programme the discount rate as set out in the 'Green Book' was 3.5%

Net Present Value

The discount factor for each year should be multiplied by the net benefits in that year to give a net present value (NPV) for each year of the investment. In cases where calculations are undertaken purely in terms of costs, the sum of the costs in each year should be multiplied by the discount factor to give the net present cost.

Cumulative Net Present Value

The cumulative NPV is the sum of the NPVs up to the year in question. Hence, the cumulative NPV shows in which year the investment 'breaks even'.

Part 2 – Worked example

Introduction

The following section sets out in detail a 'worked example' of a fictitious transformation programme focussed on improving the outcomes for older people with mental health problems.

The purpose of this, and hopefully its value, is to illustrate the kind of detailed approach to commissioning and financial planning that is required, and the importance of a longer term horizon in making a truly strategic shift (in this example the 'break even' point doesn't appear until year 4, with the full 'pay back' of investment not accruing until year 8).

We are indebted to Bradford MBC for their contribution to this example.

Example

The imaginary programme contains three strands:

- **Community Involvement Networks –** a programme of work with the mainstream voluntary and community sector to encourage them to address the needs of older people with emerging mental health needs
- **Managed Clinical Networks –** a range of initiatives to train and support specialist and mainstream staff to meet the needs of older people with mental health needs
- **Mental Health Enablement –** development of new intensive support teams within the community, focussed on supporting people at times of crisis to remain living in their own homes.

Expected Benefits – overview

It is important to take a broad appraisal of the possible benefits of the transformation programme. In other words there will be significant non-financial as well as financial benefits. These can be summarised as follows:

- Service User and Carer Benefits, e.g. improved health, improved Quality of Life
- Strategic Benefits, e.g. links to Our Health Our Care Our Say, Putting People First priorities etc
- Performance Benefits, e.g. links to PSA targets identified in Securing Better Mental Health for Older Adults
- Care Knowledge Benefits, e.g. advances in evidence base for clinical/ care interventions
- Financial but Non-Cashable Benefits, e.g. savings not realisable to sustain the programme
- Financial and Cashable benefits, e.g. that are realisable to sustain the programme
- A summary of service user and carer, performance and strategic benefits and expectations from the programme can be found in table format in Annexe E.

Benefits – detailed assessment

Care Knowledge Benefits

The programme has great potential to evaluate the outcomes of innovative services and for these to be shared across the health and social care community.

The opportunities offered include:

- **Quality of Life research –** the wide scope of the programme and its emphasis on early intervention means that the 'well-being' of people with mental health problems and their families and carers can be examined
- **Building community capacity & early interventions –** the benefits of social and physical activity for people participating in mental health cafes and sessional activities will be measured and followed through over a period of years to evaluate benefits to both quality of life and independence/ admission avoidance
- **'Co-morbidity' –** collation of assessment data to monitor prevention of hospital and longterm care admissions will give valuable prevalence data for mental health problems with physical illness and injury. This will be linked to outcomes on hospital discharge to give valuable insight into the most fruitful interventions to promote independence.

Financial Benefits – Non-cashable

The programme is expected to give rise to real financial benefits that are important to identify but which cannot be expected to come back to sustain the programme. The principal ones are:

- **Acute hospital lengths of stay –** the setting of 'trimpoints' and excess charges as part of Payment By Results (PBR) is unlikely to lead to significant savings in charges for excess days, as trimpoints are set well beyond the great majority of actual lengths of stay. Enablement teams and managed clinical networks are expected to impact considerably on lengths of stay.

This will benefit the acute trusts, by receiving a PBR payment for a shorter stay, but is not 'cashable' directly by the programme.

- **Practitioner problem-solving and casework time –** it is expected that the programme will lead to clearer and simpler pathways for crisis management and care planning. These are not 'cashable' benefits, but will benefit other people waiting for assessments, and balance out increased carer assessment and support when people are not admitted to care homes.

Financial Benefits – Cashable

These are expected as follows:

- Reduction in admissions to long-term care, including emergency placements, offset against increases in medium/intensive support at home.
- Reduction in small/medium size packages of support at home.
- Reduction in non-elective hospital admissions, including A&E and ambulance costs.

Annexe F1 shows in detail how the expected benefits have been calculated from unit costs and expected reductions in admissions, offset against costs of support at home. Annexe F2 shows the sources and assumptions underlying the calculations. Annexe F3 examines the clinical links between mental and physical health conditions, particularly for falls-related injuries, and strengthens the case that there are very significant savings to be made. Annexe F4 applies mental health prevalence data to population projections, to illustrate the demographic growth to be expected in long-term care home placements and underpin the savings estimates. The 'bottom line' of these calculations is as follows:

Year / Project	1	2	3	4	5 & ff.	KEY to cells:
Community Involvement Networks	0 0 -(£30,420)	0 0 -(£33,800)	14 11 £119,910	28 28 £294,910	35 53 £532,070	number of non-elective hospital admissions prevented number of care home admissions prevented estimated cashable benefit for year[1]
Managed Clinical Networks	11 2 £42,000	65 6 £234,000	174 17 £631,500	217 25 £849,000	217 25 £849,000	
Mental Health Enablement	8 3 £75,300	20 8 £241,180	45 25 £544,600	45 25 £619,100	45 25 £619,100	

1 *estimated cashable benefit will be net of home care costs.*

The table does not include a 'total', because risk weightings must be applied before figures are added – this is shown in Annexe D for the financial benefits, and in the 'evaluation & performance management' section for setting of targets.

Benefits 'Cashable in kind'

There are two further 'cashable in kind' benefits that must be acknowledged as assumptions underlying the programme, these being:

- **Use of intermediate care beds.** The programme will have two effects: Reducing lengths of stay in bed-based intermediate care; and increasing the access to intermediate care services for people with mental health problems30. The assumption is that no net increase in capacity for bed-based intermediate care will be required, i.e. that the two effects will balance each other out. This assumption seems reasonable given the significant expansion of homebased enablement
- **Specialist day-care places.** It is anticipated that people with mild and some moderate levels of dementia will benefit from accessing the mental health cafes and brokered sessional activities, and this will create capacity in traditional SSD day-care.

  The assumption in the programme is that this capacity will be at least sufficient to meet the additional needs of people and carers where long-term care admission has been prevented. Therefore, when considering the costs of intensive home support below, no additional amount has been specified for day care.

Assumptions & Risk Weighting

Any programme will be subject to risks and assumptions, and the potential of these to bring unanticipated consequences. The key assumptions underlying the programme are summarised as follows:

- Admissions to long-term care and hospital happen far more than they need to for older people with mental health problems, because of lack of interventions at important times
- A significant proportion of the estimated £15m pa. spent on long-term care and perhaps £10m on nonelective admissions linked to people with mental health problems could be saved by investing in early support, and timely interventions as conditions progress.

In order to allow for project and programme risk factors and assumptions, the following weightings are given to estimated benefits:

Project/Risk Weighting (%)	Year 1	Year 2	Year 3	Year 4	Year 5
Community Involvement Networks	70	60	50	50	50
Managed Clinical Networks	50	60	70	80	90
Enablement Teams	60	70	80	90	90

These weightings have been used in AnnexeD to reduce expected benefits. The rationale is:

- Community Involvement Networks: in years 1 & 2, it is relatively likely that the initial effects of increased home-based service uptake will occur. The lower weighting in years 3-5 reflects less certainty that admissions to care homes and hospitals will be prevented. This is because by its very nature, outcomes are hard to predict from an innovative scheme over a long timescale
- The reverse profile for the other projects arises from potential loss of 'synergy' between these projects and 'leading and teaching in mental health'. This would lead to slow initial progress, but this resolves as time progresses and all projects become fully established. The high weightings in Years 3-5 reflects confidence that there are significant numbers of preventable admissions
- Managed Clinical Networks start with a lower weighting than Mental Health Enablement, reflecting that this is an innovative approach, with more risk of delays in development, compared tothe more 'concrete' establishment of actual teams.

It is important to emphasise the high risk associated with 'doing nothing'. Demographic projections indicate the potential pressure on services and costs linked to an ageing population33. This is particularly the case with Alzheimer's disease and other dementias, where there is no expectation of 'compression of morbidity' associated with many physical conditions.

Appraisal of Sustainability

The project costs and benefits have been entered in a spreadsheet format, to calculate 'Net Present Value' (NPV) for the programme from Year 1 to Year 8 (Annexe D). The estimated benefits are reduced according to the above risk weightings. The 'bottom line' is

- 55% of expected benefits are realised from reduced hospital admissions
- With 45% from reductions in long term care admissions and home care packages.

Year	1	2	3	4	5	6	7	8
Benefit – NPV	-£1,091,817	-£886,507	-£175,398	£380,563	£557,386	£549,533	£541,718	£533,941
Cumulative – NPV	-£1,091,817	-£1,978,324	-£2,153,722	-£1,788,991	-£1,231,605	-£682,071	-£140,353	£393,588

The Evaluation and Performance Management section (below) describes how evidence is be gathered to demonstrate the flow of benefits from the programme. A key aim of Evaluation and Performance Management is:

- To minimise cross-organisational cash-flows to simplify the funding of continuing service delivery
- To ensure that savings continue to be 'earmarked' to sustain the programme.

Summary

- The programme sustains itself during Year 3, with the exception of final year Programme Office costs, and is completely self-sustaining from Year 4 onwards
- The notional 'payback' of investment is achieved early in Year 8
- The programme is strong in terms of delivering person centred user and carer benefits, and for adding flexibility to the system to better meet the needs of BME communities
- There is a clear fit between programme aspirations and national and local policy and performance targets
- The economic appraisal is grounded in local data & research evidence, is conservative and risk-weighted. Risk monitoring against realisation of benefits is integral to performance management
- The estimates for admissions prevented and for people supported at home are used to set targets for performance and risk monitoring and are incorporated within performance management arrangements. Thus economic sustainability is clearly linked to overall programme management.

Evaluation & Performance Management

Performance Monitoring of Outcomes

Care Packages and Admissions

The following tables summarise programme expectations related to key Indicators:

Non-risk weighted table – 'what we think we can achieve'					
Numbers of people	Year 1	Year 2	Year 3	Year 4	Year 5
Increase in people supported at home	28	64	141	184	209
Increase in intensive support at home	2	5	18	26	34
Reduction in hospital admissions	19	85	233	290	297
Reduction in long-term care admissions	5	14	53	78	103

Risk-weighted table – admissions reductions required to sustain the programme					
Numbers of people	Year 1	Year 2	Year 3	Year 4	Year 5
Reduction in hospital admissions	10	53	158	228	232
Reduction in long-term care admissions	3	9	36	57	70

Monitoring Against Targets

The measurements and targets described above can be used directly to monitor programme success and risks, and to identify 'perverse outcomes'. The exception is the hospital admission figures, where mental health 'screening' at point of admission would be necessary to separate out relevant figures.

The evidence for admission reductions achieved will have to be developed, based on: admissions linked to key physical illness/injury categories (see Annexe F3 for discussion); and in-patient referral numbers where mental health needs are identified subsequently from SAP. A 'baseline' will be established in or prior to Year 1, for comparison thereafter.

Annexe I: Cost & Benefit Calculations Showing Net Present Value

Year	1	2	3	4	5	6	7	8
PROGRAMME COSTS								
Community Involvement Network	£273,812	£372,717	£459,271	£474,886	£491,507	£508,710	£526,515	£544,943
Leading & Teaching in MH	£64,500	£57,680	£59,412	£61,432	£63,582	£65,808	£68,111	£70,495
Managed Clinical Networks	£257,329	£224,418	£215,519	£222,847	£230,646	£238,719	£247,074	£255,722
Mental Health Enablement	£333,467	£407,297	£411,128	£425,106	£439,985	£455,385	£471,323	£487,819
Programme Office Costs	£207,595	£153,037	£111,614	£0	£0	£0	£0	£0
COST TOTAL from Year 3 onwards, project/programme costs change only with inflation/increments.	**£1,136,703**	**£1,215,149**	**£1,256,944**	**£1,184,271**	**£1,225,721**	**£1,268,621**	**£1,313,023**	**£1,358,978**
PROGRAMME BENEFITS								
Community Involvement Networks	-£30,420	-£33,800	£119,910	£294,910	£532,070	£532,070	£532,070	£532,070
Managed Clinical Networks	£42,000	£234,000	£631,500	£849,000	£849,000	£849,000	£849,000	£849,000
Mental Health Enablement	£75,300	£241,180	£544,600	£619,100	£619,100	£619,100	£619,100	£619,100
Assistive Technology	£0	£0	£70,000	£70,000	£70,000	£70,000	£70,000	£70,000
BENEFIT TOTAL prior to adjustments	**£86,880**	**£441,380**	**£1,366,010**	**£1,833,010**	**£2,070,170**	**£2,070,170**	**£2,070,170**	**£2,070,170**
BENEFIT RISK WEIGHTINGS								
Community Involvement Networks	0.70	0.60	0.50	0.50	0.50	0.50	0.50	0.50
Managed Clinical Networks	0.50	0.60	0.70	0.80	0.90	0.90	0.90	0.90
Mental Health Enablement	0.60	0.70	0.80	0.90	0.90	0.90	0.90	0.90
Assistive Technology	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
BENEFIT TOTAL after risk weightings and inflation adjustment (3% pa.)	**£44,886**	**£297,614**	**£1,069,053**	**£1,588,656**	**£1,865,334**	**£1,921,294**	**£1,978,933**	**£2,038,301**
NET BENEFIT prior to discounting	**-£1,091,817**	**-£917,535**	**-£187,891**	**£404,384**	**£639,613**	**£652,673**	**£665,910**	**£679,322**
Discount rate - %	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
Discount factor	1.0000	0.9662	0.9335	0.9019	0.8714	0.8420	0.8135	0.7860
BENEFIT – NPV	**-£1,091,817**	**-£886,507**	**-£175,398**	**£364,732**	**£557,386**	**£549,533**	**£541,718**	**£533,941**
CUMULATIVE NPV	-£1,091,817	-£1,978,324	-£2,153,722	-£1,788,991	-£1,231,605	-£682,071	-£140,353	£393,588

Gross cost of project investment Years 1 & 2	**£2.35 million**
Net cost of programme years 1,2 & 3 (prior to discounting)	**£2.20 million**

Annexe II: Summary of Non-Financial Benefits

1) Person Centred Outcomes

The following table summarises the outcomes expected from each project against the outcome framework from Our health, our care our say.

Key:

– timescale for start of realisation is given in years

– likelihood of benefits realisation given as H (High), M (Medium) or L (Low); ie. the inverse of the risk.

Outcomes / Project	Improved health	Improved quality of life	Making a positive contribution	Exercise of choice & control	Freedom from discrim-ination or harrassment	Economic well-being[2]	Personal dignity
Community Involvement Network	✔ Yr 2, H	✔ Yr 1, H	✔ Yr 1, H	✔ Yr 1, H	✔ Yr 1, M	✔ Yr 3, M	✔ Yr 1, H
Managed Clinical networks & specialist staffing	✔ Yr 1, M Yr 2, H	✔ Yr 1, M Yr 2, H		✔ Yr 1, M Yr 2, H	✔ Yr 1, H	✔ Yr 1, M Yr 2, H	✔ Yr 1, H
Mental health enablement	✔ Yr 1, M Yr 2, H	✔ Yr 1, M Yr 2, H		✔ Yr 1, M Yr 2, H	✔ Yr 1, H	✔ Yr 1, M Yr 2, H	✔ Yr 1, H

2 *Interpreted here particularly as benefit for carers.*

2) Strategic & Policy Benefits

The following table summarises how the programme fits with the desired 'direction of travel' with key policy themes & indicators.

Key:

– no. of dots indicates strength of linkage.

Policy / Project	NSF – promoting good mental health	Early recogn-ition & manage-ment	Access to Specialist Care	OHOCOS – Access to Uni-versal Services	Social inclusion	'Emerging Needs' – Preventive services	Complex needs – intensive support	Timely interven-tions which promote indep-endence	Building Comm-unity/ VCS capacity
Community Involvement Network	●●●	●●●	●	●●●	●●●	●●●		●●	●●●
Managed Clinical networks & specialist staffing	●●	●●	●●●	●●●	●●	●●	●●	●●●	●
Mental health enablement	●●	●●	●●●	●●	●●	●●	●●●	●●●	

3) Performance Benefits

Key:

– shows expected level of impact H(igh) – M(edium) – L(ow) and start of expected timescale in years.

Indicator / Project	PAF B11 Intensive Home Care as % of IHC + Res Care[3]	PAF C32 Older People helped to live at home[4]	PAF C26 admissions of older people to res & nursing care	PAF C62 services for carers	PAF D41 Delayed discharges	PAF E48 Ethnicity of older people receiving services	Securing better MH/ PSA reducing mortality from suicide	Securing better MH/ PSA reduce emergency bed days[5]
Community Involvement Network	M Year 3	M Year 1	M Year 3	H Year 1	L	M – Yr 1 H – Yr 2	M[6]	M Year 3
Managed Clinical networks & specialist staffing	M – Year 1 H – Year 2	M Year 1	M – Year 1 H – Year 2	M Year 1	M Year 1[7]	M Year 1	M	M – Year 1 H – Year 2
Mental health enablement	M – Year 1 H – Year 2	H Year 1	M – Year 1 H – Year 2	M Year 1	M Year 1	M Year 1	M	M – Year 1 H – Year 2

3 *PSA target 34% by 2008, Bradford 2004-5 performance was 18.4%*

4 *PSA target to add 1 % - or 10 per 1,000 - each year in 2007 & 8Bradford performance in 2004-5 was 86.4 per 1,000 people aged 65+.*

5 *PSA target to reduce by 5% from 2003-4 baseline to 2008.*

6 *some expected impact from community engagement and social inclusion, but not researched in detail.*

7 *impact limited by existing low numbers incurring reimbursement.*

Annexe IIIi: Calculation of Cashable Benefits

This annex shows how estimated benefits have been calculated. Ultimately these calculations are based on a judgement of what the projects can achieve, it is important to show the basis of judgements and how they are used. Further detail of how unit costs, prevalences etc. are arrived at is in Annexe IIIii.

1) Unit costs and assumptions used in these calculations are as follows:

- home care costs £13ph; 1 hr per week for a year costs £676pa.
- preventing an admission to residential/nursing care makes a net saving of £4,500pa.
- preventing a residential care admission incurs a benefit over a two-year period[8], so tables show each yearly estimate added to the previous year's.
- preventing a non-elective hospital admission saves between £2,100 – £4,200 (one-off saving under 'Payment by Results'), depending on the reason for admission, including emergency ambulance and A&E attendance.

8 *PSSRU publication Care Homes for Older People Vol 2 suggests average life after admission to care is 30 months, but can be shorter for people with mental health problems.*

2) Community Involvement Networks:

These are planned to reach 350 people and their carers. The benefits are calculated on the following basis:

Per 100 people	Year 1		Year 2		Year 3		Year 4		Year 5 & ff	
Increase in home care uptake from better knowledge of/ access to services	40 hrs pw. /15 people	-£27, 040	50 hrs /20 people	-£33, 800	60 hrs /25 people	-£40, 560	80 hrs /30 people	-£54, 080	80 hrs	-£54, 080
Reduction in medium-sized care packages from increased activity, access to advice & strategies	10 hrs	£6,760	30 hr	£20, 280	70 hrs	£47, 320	90 hrs	£60, 840	100 hrs	£67, 600
Hospital admissions prevented from eg. falls/fractures, poor nutrition, infection	0	0	0	0	4	£14,0 00[9]	8	£28, 000	10	£35, 000
Long-term care admissions replaced with care packages	0	0	0	0	3	£13, 500	8+3	£49, 500	15+8	£103, 500
TOTAL		**- £20, 280**		**- £13, 520**		**£34 ,260**		**£84, 260**		**£152, 020**

9 *Average estimate of £3,500 from various HRGs in Annexe F5, including A&E and emergency ambulance costs of £230 per admission.*

Multiplying up from 100 people gives the following figures to insert into the economic appraisal:

Year 1 150 people	Year 2 250 people	Year 3 350 people	Year 4 350 people	Year 5 350 people
-£30,420	-£33,800	£119,910	£294,910	£532,070

3) Managed Clinical Networks

These are expected to impact on long-term care and hospital admissions, with a 'lead-in' delay given the time required for knowledge to be acquired, applied and shared. It is not appropriate to estimate according to service 'capacity', because these networks are intended to be effective across all service provision. Therefore, the method is to estimate a 'baseline' total of admissions and a percentage reduction achievable.

For non-elective hospital admissions, a 'baseline' is obtained by looking at those preventable physical health conditions linked to older people's mental health problems (discussion in Annexe F3). Those which cause the most significant annual costs are identified from Annexe F5. The aim is not to specifically 'target' any reasons for admission, but to obtain a realistic overall estimate based on physical conditions where mental health is known to impact on incidence, recovery and /or functioning[10].

Condition	PCT annual admissions (65+)	Extrapolated to Bradford-wide	Unit cost (PBR plus A&E, ambulance)	Annual cost	Annual saving from 1% reduction
Fractures	164	595	c. £4,200	£2.5m	£25,000
UTI/kidney inf.	107	388	£2,800	£1.1m	£11,000
Pneumonias	114	414	£3,300	£1.4m	£14,000
Syncope/ collapse	213	773	£2,100	£1.6m	£16,000
TOTAL		**2,170**		**£6.6m**	**£66,000**

Table showing calculation of estimated 'baseline' for preventing non-elective admissions.

For residential & nursing care admissions, the calculation is based on projected numbers admitted each year with SSD funding and with mental health as a main reason – (from Annex F4)

Year	1	2	3	4
Estimated admissions to residential/nursing care (MH cause)	369	372	375	378
Estimated % reduction	0.5	1.5	4.5	6.5
Estimated admissions prevented	2	6	17	25

Table showing calculation of estimate for admissions prevented to res/nursing care from managed clinical networks

10 *Please note that admissions for 'Alzheimers/Senile Dementia' are not given here, this is to avoid 'double-counting' of benefits from Mental Health Enablement.*

	Year 1		Year 2		Year 3		Year 4 & ff	
Prevention of non-elective hospital admissions	0.5%	£33,000	3%	£198,000	8%	£528,000	10%	£660,000
Care home admissions replaced by care packages	2	£9,000	6+2	£36,000	17+6	£103, 500	25+17	£189, 000
TOTAL		**£42,000**		**£234, 000**		**£631, 500**		**£849, 000**

Table showing estimated savings from Managed Clinical Networks

4) Mental health enablement

This is expected to show savings from preventing admissions to hospital and care homes, but with a shorter lead-in than above arising from immediate service availability.

Savings will also arise from care packages being adjusted over 2-12 weeks to the appropriate long-term level.

Teams are expected to work with 200-350 people each year, depending on length of involvement. Benefits are therefore estimated on the basis of outcomes from 250 people per year.

	Year 1 for 75 people using service		**Year 2** for 150 people using service		**Year 3 & ff** for 250 people using service		**Year 4 & ff** for 250 people using service	
Reduction of long-term home care hours pw.	50	£33,800	180	£121,680	350	£236,600	350	£236,600
Prevention of care home placements	3	£13,500	8+3[11]	£49,500	25+8	£148,500	25+25	£225,000
Prevention of hospital admissions pa. @ c. £3,500[12]	8	£28,000	20	£70,00	45	£157,500	45	£157,500
TOTAL		**£75,300**		**£241,180**		**£544,600**		**£619,100**

Table showing benefits estimated from Mental Health Enablement

11 *Again, current year's number added to previous year's reflecting 2-year effect of preventing residential/nursing placement*

12 *This is estimated as nearer the PRB cost for Alzheimers/senile dementia – Annex F5.*

Summary

The 'bottom line' summary of cashable benefits is therefore:

Please note that all these benefits are estimated using current costs, so an 'inflation' adjustment of 3% is added in the final cost & benefit calculation (Annex I).

Year Project	1	2	3	4	5 & ff
Community Involvement	-£30,420	-£33,800	£119,910	£294,910	£532,070
Managed Clinical Networks	£42,000	£234,000	£631,500	£849,000	£849,000
Mental Health Enablement	£75,300	£241,180	£544,600	£619,100	£619,100

Annexe IIIii: Cashable Benefits: costings, assumptions and evidence

Costings, Sources and Assumptions

- Subnational population projections accessed via ***www.statistics.gov.uk***
- Prevalence rates for dementia used are:

Age band	Prevalence - female	Prevalence – male
40-64	0.1%	0.1%
65-69	1.5%	1.4%
70-74	2.2%	3.1%
75-79	7.1%	5.6%
80-84	14.1%	10.2%
85+	27.5%	19.6%

- Prevalence rate for age 40-64 is from ***www.kingshill-research.org/whatis/facts.asp***
- Other age groups from Melzer, Pearce, Cooper & Brayne Alzheimers disease & other dementias - from Medical Research Council – Cognitive Function in Ageing Study. ***http://hcna.radcliffe-oxford.com/dementia2.htm***
- Estimated numbers with dementia correspond well to other sources, eg. Alzheimers Disease International – Factsheet 3. Nos. aged 40-64 are included in totals for planning purposes
- The breakdown into 'mild'/'moderate'/'severe' categories comes from Melzer et al (op cit) – Table 5.

The severity prevalence (figures given for every 100 people with dementia) based on MMSE scores in the study is:

Age band	Mild	Moderate	Severe
84 & under	35	41	24
85+	22	44	34

- The probabilities of being in residential/nursing care are also derived from Melzer et al Table 5, using simple calculations of the numbers in care compared to at home for each age & severity 'band'. They are:

Age band / Severity	84 & under	85+
Mild	5.7%	18.8%
Moderate	30.5%	37.5%
Severe	55.6%	76.3%

Probability of a person with dementia living in a care home, given severity of condition & age.

- Proportion of people in care homes who are funded is estimated at 73%. This comes from PSSRU (University of Kent) data in Care Homes for Older People, Vol 2, Ch 2 para 4. Bebbington, Darton & Netten
- In 2004-5, Bradford SSD was paying the following net contributions (ie. after deduction of client contributions) for residential and nursing care placements (not including preserved rights placements):
  Residential 'R1' – £174pw
  Higher-dependency 'R2' – £204pw
  Nursing – £240pw (not including RNCC, typically £75)

NB the use of net amounts is important in reaching a conservative estimate of potential savings

- Net unit cost for an hour of home care in Bradford is £12.83 (£13 used in costings). This is an average covering in-house provider, volume contracts and spot contracts, as well as other support at home eg. in-house sitting service, Crossroads. This is appropriate given that older people with dementia at home will require a mix of provisions including 'sitting' services
- PSSRU publication Unit Costs of Health & Social Care estimates the average cost of a CPN home visit to be £24
- Estimates of net savings from preventing a care home admission residential/nursing care are based on the cost of 'R2' placement offset against an assumed care package: 7-10 hours pw. home care x £13 = £91-130; CPN every 4 weeks: £24/4 = £6 pw. TOTAL = £97-136 (midpoint approx £115pw)
  This gives an estimated saving from preventing a long-term care admission:

care home pw/£	care package pw/£	savings pw/£	savings pa/£ (rounded)
204	115	89	**4,500**

- 'Alzheimers Scotland' has published a 'planning signposts' model at ***www.alzscot.org/pages/policy/planning signposts.htm***. This model is based on 100,000 'planning population' rather than numbers of older people; Bradford has a slightly younger average population than national average, which might be why the estimates given are slightly larger than those above
- As well as enabling some comparison and checking of estimates, the Alzheimers Scotland data also estimate new diagnoses (200 per 100,000pop)

- The estimates relating to people going into care homes at time of admission are from PSSRU (University of Kent) publication Bebbington, Darton & Netten Care Homes for Older People, Vol 2. They found that:
  - 'mental health' given as a reason in 43% of adms
  - 'lack of motivation' in 21% (each adm. could have multiple reasons, these are not necessarily the sole reasons). An estimate of 50% is used for admissions to care homes with mental health as an important reason
- As a local check, a Principal Care Manager (covering one PCT area for community-based staff) shared her 'placement approval' monitoring covering 2004-5 Of 103 placements made, 'clinical'/functional reasons for agreeing the placement were noted for 63. Of these, 30 noted mental health, dementia in the great majority of cases. 30/63 = 48%, comparable to the 50% estimate above. Mental health problems may well have been present in other cases where physical health was the main reason
- The projected no. of funded admissions where mental health problems are an important factor is calculated by taking 2004-5 figure of 730 funded admissions; multiplying by 50% (above estimate); and then multiplying by the projected increase (from 2005 baseline) for people in the community with dementia

Annexe IIIiii: Clinical/Research Basis of Cashable Benefits

- Mental health problems are linked to many of the physical conditions that cause admission to hospital and to long-term care. Some relevant research findings are outlined below, although there is not scope here for anything like a comprehensive review
- The link between falls and dementia, and the consequent risk of fractures of pelvis/upper and lower limbs is explored below, using local hospital admission data. The conclusion is that these kind of injuries in older people with dementia might cost PCTs £650,000 - £950,000 pa. under Payment By Results. This illustrates the potential benefits of the programme in enhancing capability of falls-prevention and intermediate care services
- The Royal College of Speech and Language Therapists[13] has noted significant benefits to people with dementia and carers (informal and employed) in promoting strategies for better communication. This is linked to eg. independence, social inclusion, confidence, decision-making, accurate reporting of & consent to health & care needs, adult protection and frustration leading to behavioural difficulties
- SLT services are described as essential to improved eating and drinking; this is linked to hospital admissions for reasons of eg. poor nutrition, UTI, collapse. Of those concerned about such difficulties, only 8% of carers and 40% of professionals had obtained SLT advice

13 *Speech and Language Therapy Provision for People with Dementia – position paper April 2005.*

- There is also a significantly increased risk of aspiration–related pneumonias arising from swallowing difficulties in moderate-severe dementia
- Annex F5 shows that UTIs and 'atypical' pneumonias lead to admission costs for older people totalling over £2m under PBR
- Stroke/CVA is well-known as linked to both vascular dementia and depression, which can both impede rehabilitation. These effects are well-known to geriatric services and thus it is hard to estimate potential benefits arising from 'Leading & Teaching'
- Self-neglect and resistance to service provision are key areas for enablement teams to address with people with depression and dementia.
- Continence management services are another important link for clinical networks – next to 'behavioural difficulties' and going out unsafely ('wandering'), it is the most frequent reason cited for admission to care homes for people with dementia[14]
- Longer-term prevention via promoting physical activity has been shown to prevent admissions to both care homes and hospitals[15]
- Throughout the programme and its projects, there is a particular focus on the character of dementia as an illness and its contrasting impact on people's lives. Although the condition is 'chronic' and causes slow deterioration in brain capacities, the functional changes can be relatively sudden (not just in vascular dementia) and the tendency is for 'crisis' presentations that require timely interventions. An overall risk for the programme is that it might only take one failure to respond to a crisis to lead to a placement that is then very hard to reverse

An example – Estimating prevalence of dementia among in-patients admitted with fall-related injuries.

Table showing numbers of non-elective admissions to acute hospital for older people from Bradford S&W PCT, 2004

	HRG description			
Age Band	**Fractured U Limb /disloc.**	**Fractured Pelvis/ Lower limb**	**Fractured Neck of femur**	**Total – all types**
65-74	11	17	15	**43**
75-84	22	28	31	**81**
85+	12	16	25	**53**
Total – all ages	**45**	**61**	**71**	**177**

14 O'Donnell et al (1992), *Incontinence and troublesome behaviours predict institutionalization in dementia in Journal of Geriatric Psychiatry & Neurology Vol 5(1):45-52Armstrong (1999), Factors affecting the decision to place a relative with dementia into residential care in Nursing Standard 14(16):33-37.*

15 *Seymour & Gale (2004) – Literature & Policy Review for the Joint Enquiry into Mental Health and well-Being in Later Life. 'mentality' for Age Concern England & the Mental Health Foundation.*

The 'multiplier' for the total admissions for older people from S&W PCT to the whole of Bradford is 3.63. The following table shows the 'multiplied up' totals for each age band (right-hand column above x 3.63), against population figures (from Annexe F4):

Age Band	Estimated admissions from 3 fracture types	Estimated no. of people with dementia in population	Estimated no. of people without dementia in population
65-74	156	710	35,090
75-84	294	2,220	22,180
85+	192	2,020	5,980
Total – all ages	**642**	**4,950**	**63,250**

Research evidence suggests:

- 'fracture rate' of people with dementia is "more than three times the age- and sex-adjusted fracture rate in the general population" (Buchner & Larsson (1987), Falls and fractures in patients with Alzheimer-type dementia in JAMA, Vol 257(11):1492-5
- Identifying people who 'wandered' increased this 'odds ratio' to 3.6; specifically 6.9 for hip fracture (ibid.)
- A review article suggests that people with dementia are twice as likely to fall, and three times more likely to sustain a fracture when falling; ie. six times more likely to sustain the type of injury above; Shaw & Kenny (1998) Can falls in patients with dementia be prevented ? in Age and Ageing, Jan 1998
- Furthermore, people with dementia are then five times more likely to be institutionalised and have up to three times higher mortality within 6 months

Therefore, calculations have been made based on the admissions rate being a) three times greater for people with dementia and b) six times greater. In the following tables, P(#/dem) means the probability of admission with one of the above fractures during the year for a person with dementia in each age group. P(#/nd) means the probability for a person without a dementia.

Age Band	P(#/dem)/ admissions per 1,000 pop.	Estimated admissions with fractures - with dementia	(P(#/nd)/ad missions per 1,000 pop.	Estimated admissions with fractures – without dementia	Total	% admiss-ions with dementia
65-74	24.0	16	4.0	140	**156**	10%
75-84	49.8	111	8.3	184	**295**	38%
85+	63.6	128	10.6	63	**191**	67%
Total – all ages		**255**		**387**		**40%**

Table based on P(#/dem) = 6 x P(#/nd)[16]

Age Band	P(#/dem)/ admissions per 1,000 pop.	Estimated admissions with fractures - with dementia	(P(#/nd)/ad missions per 1,000 pop.	Estimated admissions with fractures – without dementia	Total	% admiss-ions with dementia
65-74	12.6	9	4.2	147	**156**	6%
75-84	30.6	69	10.2	226	**295**	23%
85+	47.7	96	15.9	95	**191**	50%
Total – all ages		**174**		**465**	**642**	**27%**

Table based on P(#/dem) = 3 x P(#/nd)

The method of estimation assumes that admissions of older people with the above three fracture types are, in the great majority, falls-related injuries. Different estimates from research of the probability of fall and fracture for people with and without a dementia are used in calculations.

The conclusion is an estimated range of c. **25 – 40%** for the proportion with dementia of older in-patients with these fracture types. For the oldest old (85+), the estimate rises to **50 – 67%**.

The foreword to Securing better mental health for older adults refers to “perhaps… 50%” of older hospital in-patients having a mental health problem. If we allow for mental health problems other than dementia, and that those with mental health problems will tend to have longer stays, then the estimate of 25-40% seems in accordance.

16 *Calculation method for values of P not shown in detail, but involves multiplying relevant known population figure without dementia by the relevant P, and the population with dementia by (in this case) 6P Adding the two results gives a simple formula where a known multiple of P equals a known no. of admissions.*

Appendix D

Commissioning report template

We are indebted to East Sussex County Council for their contribution to this example

Bedhamptonshire Rapid Response Team

Service Report: June 2006 – March 2008

Specification

Service name	Rapid Response Team
Service provider	Bedhamptonshire PCT
Target group	Anyone at risk of admission who can be managed at home with nursing and social support
Description	The Rapid Response Team takes referrals from hospital and community staff, and is able to respond quickly to provide care to people who do not require hospital admission but cannot stay at home safely without care and support.
Area covered	Bedton area
Staff	3.0 WTE community nurses 3.0 WTE health care assistants
Annual cost	£161,548
Planned outcomes	Reduced emergency admissions

1 Service model

Model

This service is testing whether providing nursing support rapidly in people's own homes helps avoid hospital admissions.

Service outline

The Rapid Response Team (RRT) operates from 8am-10pm Monday to Friday, and 9-5pm weekends and bank holidays. The team provides a short-term programme of nursing, recuperative and personal care to patients who are at risk of hospital admission in people's homes. The service is for people over the age of 18, although most clients are older adults. Nurses may visit three or four times per day to help nurse people in bed, help them use the toilet, administer intravenous medications and so on.

Objectives

The service aims to:

- Assess 300 referrals per annum (25 per month)
- Reduce unnecessary admissions to hospital
- Improve people's quality of life by helping them maintain their independence.

2 Activity

Example

Mrs T is 77 years old. She fell outside her own home and was transferred to A&E by ambulance. Following attendance at A&E the Rapid Response Team (RRT) visited Mrs T and arranged the appropriate equipment including a commode, bed lever and back rest to be installed in her home. The RRT commenced visits each morning and lunchtime and arranged evening visits from social services, to assist in and out of bed, personal care, preparing meals, give prescribed medication and ensure pain relief was adequate.

In the first few days of being home Mrs T required encouragement to eat and drink, to take regular pain relief and to try to be as independent as her difficulty/pain allowed. Mrs T's mood became more positive with the support she was receiving from family, Social Services and RRT. RRT also referred Mrs T to domiciliary Physiotherapist and Chiropodist. Within 2 weeks, Mrs T was managing to prepare her own breakfast, and within 5 weeks was preparing her own lunch and went out for the first time since her fall.

Key objectives achieved:

- Avoided hospital stay
- Helping Mrs T maintain independence at home

Service activity

Most of the data in this report relates to figures up until March 2008, twenty two months after the service began.

Table 1 shows the number of new referrals and the number of clients accepted on to the Rapid Response Team caseload. The target for this service is 25 new referrals per month, or 300 per annum. The service achieved this target in 2007-08, as the Rapid Response Team Leader has been working hard to promote the service. Every referral received has a home visit and is assessed by the team to determine whether they are appropriate. 63% of referrals were accepted on to the caseload in 2007-08. When a referral is not suitable for the Rapid Response Team caseload, where appropriate, they are referred on to alternative community services.

Table 1: Progress towards activity targets

Indicator	07/08 Target	06/07 activity	Apr-Jun 07	Jul-Sep 07	Oct-Dec 07	Jan-Mar 08	07/08 activity
New referrals	296 (25 per mth)	250 (25 per mth)	64	87	101	82	334 (28 per mth)
New clients (accepted on caseload)		170 (17 per mth)	43	51	60	58	212 (18 per mth)
New clients recorded as a step up		141	30	31	45	48	154

Service users

Based on data between April 2006 and March 2008, 63% of service users were women. Figure 1 provides the age distribution.

Figure 1: Age of service users (June 2006 to March 2008)

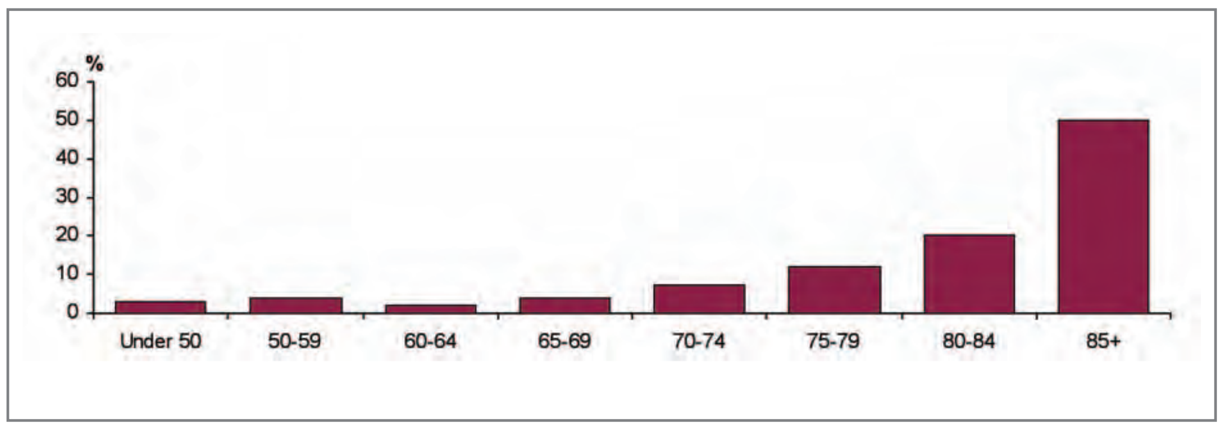


Figure 2 shows the referral source for all referrals to the service between June 2006 and March 2008. The breakdown of inappropriate referral sources is broadly in line with the proportions shown in Figure 2, demonstrating that there is no one particular group of referrers who are disproportionately referring to the service inappropriately.

Figure 2: Referral Source - all referrals (June 06 to March 08)

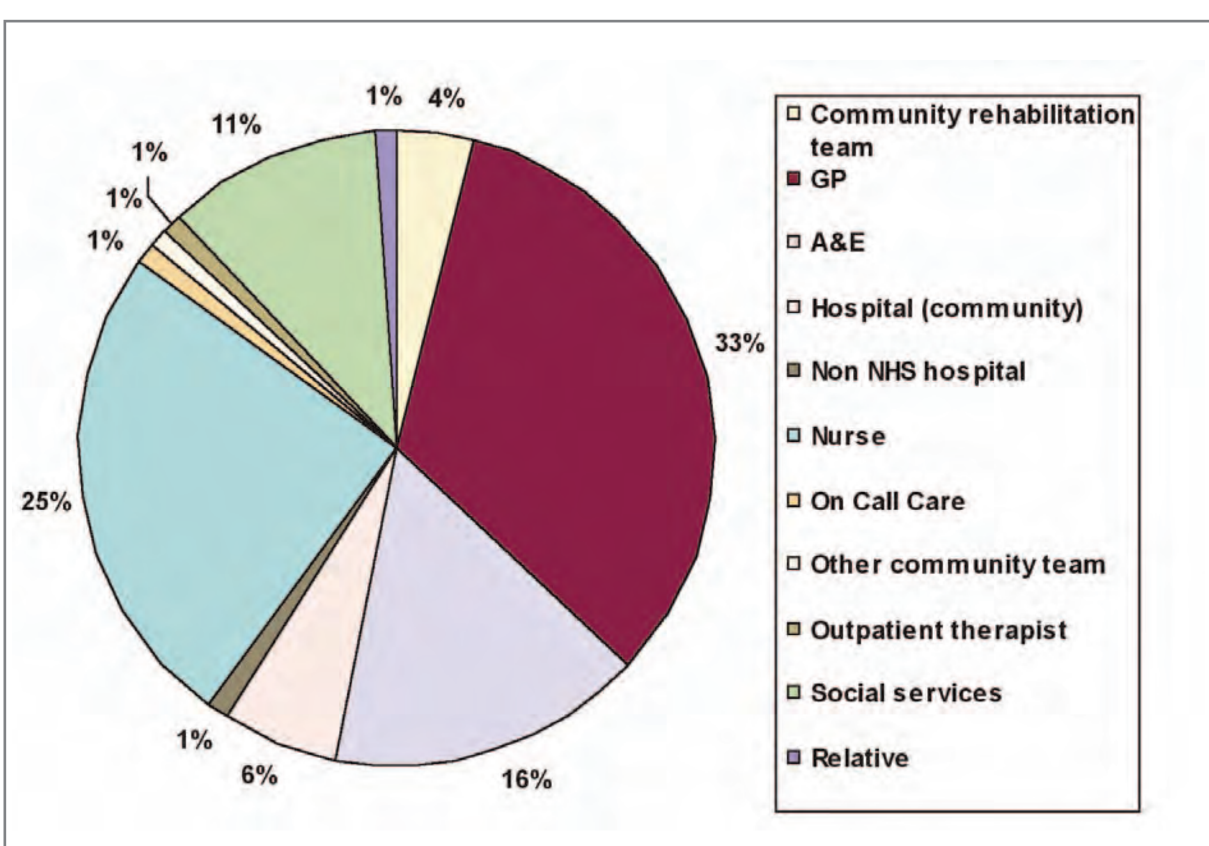
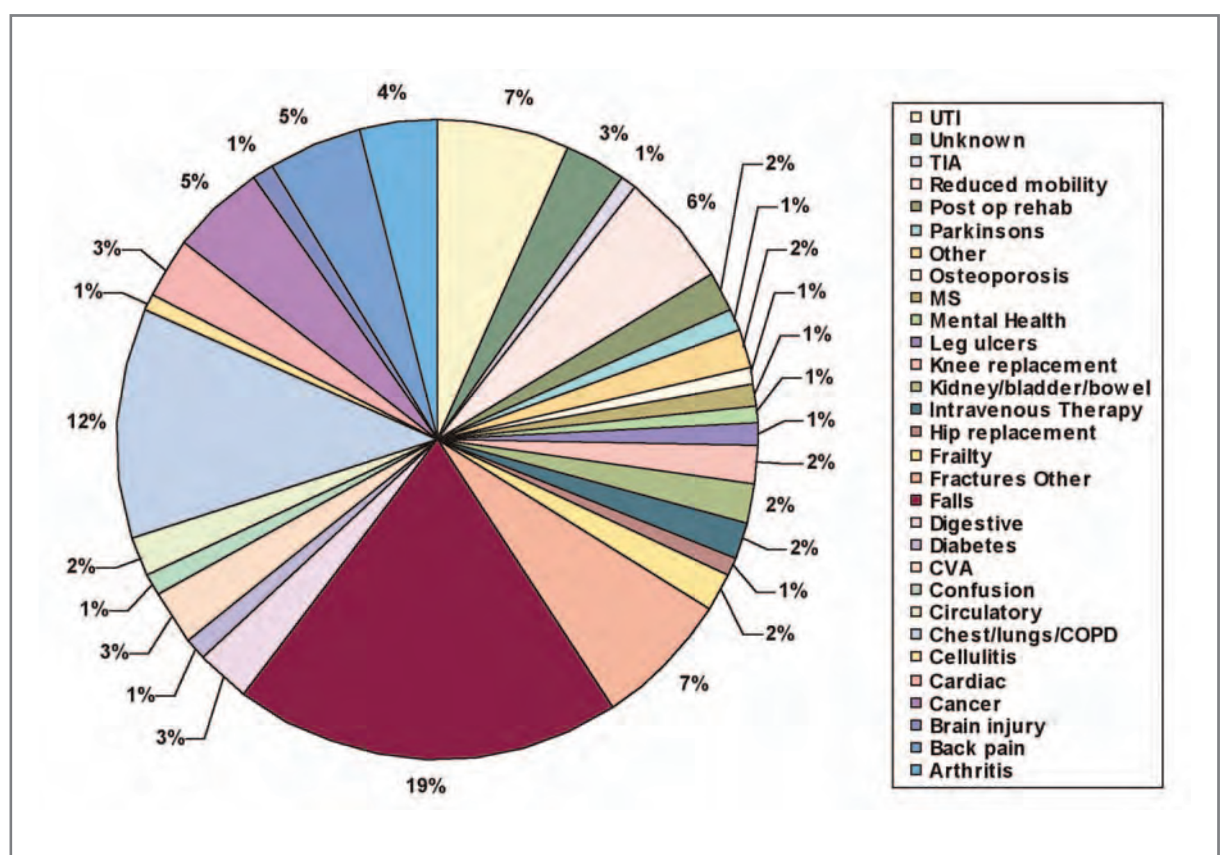


Figure 3 shows the primary reason for referral for service users of the Rapid Response Team. The top five reasons are falls, chest/lungs/COPD (chronic obstructive pulmonary disease), urinary tract infections, reduced mobility and fractures. The average time spent on the team's caseload was 14 days.

Figure 3: Primary Referral Reason (June 06 to March 08)



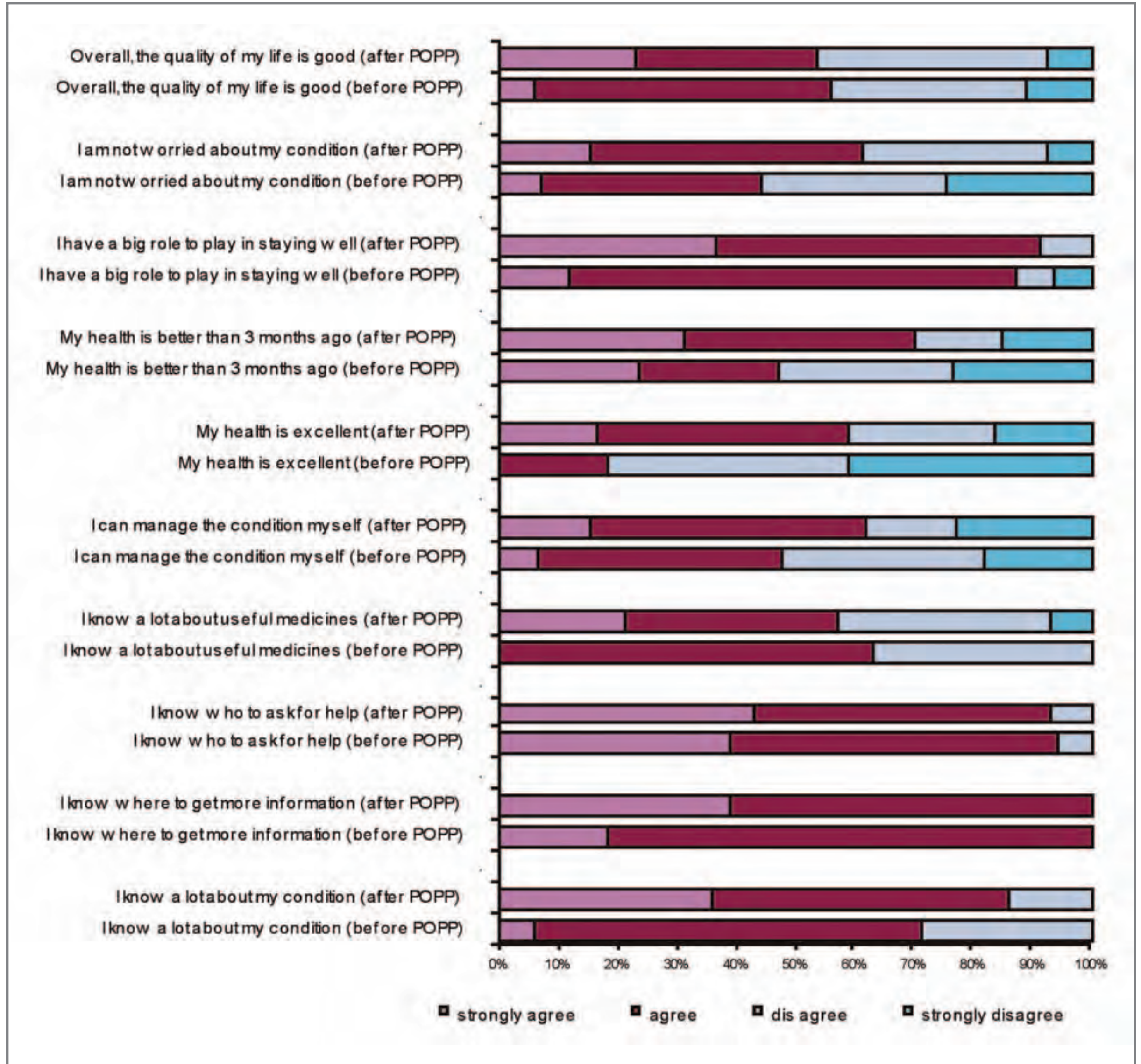
3 Client feedback

All Promoting Independence services have been asked to use a one page feedback form to monitor quality of life. Services give out the questionnaire the first time they see a client (to get 'before' or baseline responses) and send a follow up questionnaire three to six months later. Most services began using the short before and after quality of life survey in February 2007.

As at March 2008, 71 'before' questionnaires have been returned, and 100 'after' questionnaires have been returned.

Figure 4 illustrates people's changing perceptions of their own health, knowledge, and quality of life before and after using the Rapid Response Team. If the service is achieving its objectives, we would expect to see more 'green' in the 'after' bars and more red and orange in the 'before' data.

Figure 4: Perceptions before and after using the Rapid Response Team service



The graph shows that over the three to six month measurement period, there is a trend towards:

- people feeling less worried about their condition,
- feeling that their health is better,
- feeling more able to manage their condition
- feeling they know more about their condition.

We cannot state that the service was responsible for these positive trends, as many other services and initiatives are operating. But it is positive that those using the service perceive positive changes.

Open ended comments reinforced this feedback:

"This is a great scheme just what is needed, everyone has time to spend with you; nowadays that is rare to find"

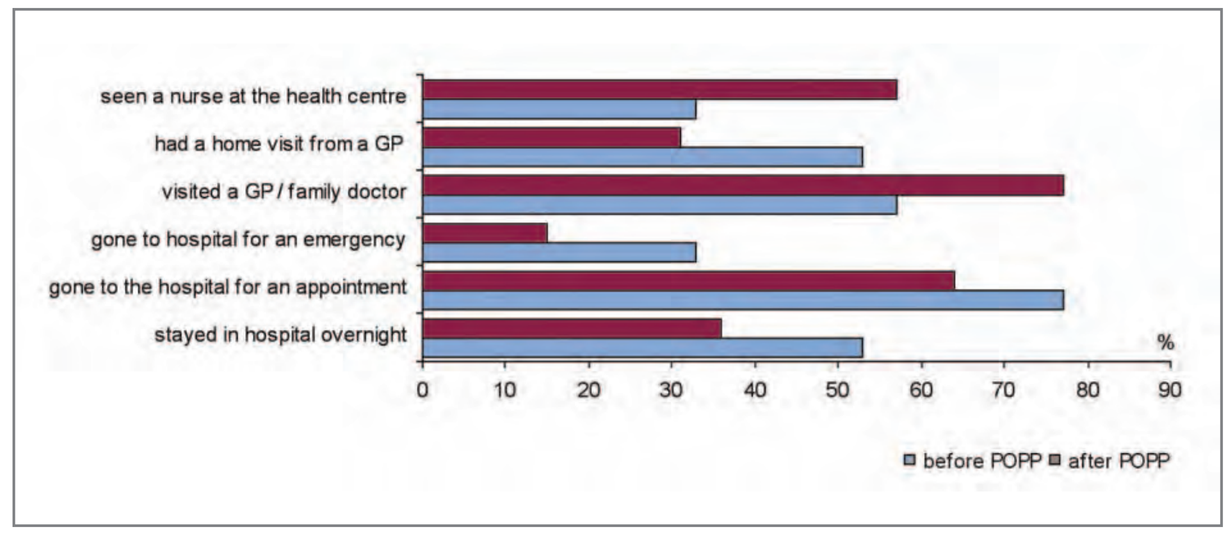
"You looked after my mother's needs in a most professional, efficient and caring manner. The co-ordination between you, the discharge team and other Professionals was seamless"

"The care and attention to detail was second to none…I am confident that my mother's speedy return to feeling strong and able to cope was due to all your kindness and understanding"

"Without this service I would not have known who to turn to"

The questionnaire data also suggests that after using the service, people were less likely to be admitted to hospital in an emergency (see Figure 5), but more use of primary care services.

Figure 5: Use of services in three months prior to completing a questionnaire



4 Economic impact

Costs

The total annual cost of the service is £161,548. Table 2 shows the cost for the rapid response team each quarter.

Rapid Response service budget

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2006-2007	£14,444	£40,387	£40,387	£40,387	**£135,605**
2007-2008	£40,387	£40,387	£40,387	£40,387	**£161,548**

Savings

The service sees only people who would have been admitted to hospital if not for the Rapid Response Team. Therefore every care package provided is assumed to save an unnecessary hospital admission.

In the 2006-2007 financial year (10 months of funding), the net savings for the Rapid Response Team were £67,035. In 2007-08 the net savings increased to £99,848 (over a 12 month period).

Overall costs and savings

	2006-2007 (June 06 onwards)	2007-2008
Costs		
Total Costs	£135,605	£161,548
Savings		
Savings: actual activity (@ £1192 per admission in 06-07 and £1233 in 07-08)	£202,640 (170 units)	£261,396 (212 units)
Net difference between costs and savings		
Actual savings minus costs	£67,035	£99,848

Note: The table above presents savings for the health and social care economy as a whole, and the savings have been calculated based on 100% of the unit cost. The annual costs or savings to an individual PCT, however, would be 50% of the total for 2007-2008, based on agreements between the PCT and providers. The tariff used relates to the average cost of admitting someone via A&E as an emergency for 0-3 days.

5 Actions

Progress rating

Using a green, amber and red 'traffic light' system, **the service is currently operating at a 'green' level** (see Table below). This is because the service is breaking even and achieving some savings, as well as achieving the 2007-08 target number of referrals.

The service has not made any significant changes to the model being tested.

Overall rating of progress

	Green	Amber	Red
Testing original model	●	○	○
2006-07 level of operation against planned activity	○	○	●
Progress towards objectives: 25 new referrals per month	●	○	○
Progress towards objectives: reduce unnecessary admissions	●	○	○
Progress towards objectives: improved quality of life (limited data)	●	○	○
Progress towards achieving breakeven position	●	○	○
Achieve 2007-08 targets	●	○	○

Note: Green = on target, Amber = some issues, Red = serious issues

Lessons Learned

An important lesson is the need to build in adequate time to engage with and promote services to GPs, A&E and community staff. Although the team have met with the various staff groups to discuss referral criteria and care pathways, it appears that there is an ongoing need to engage with and promote the service to continue momentum.

It is recognised that when services are part of pilot projects there is a need to clarify the future funding of the project as early as possible. Indecision and messages not flowing quickly and effectively from one part of the PCT to another has resulted in uncertainty and worry for staff.

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