Caring Together
Western Bay
Health and Social Care Programme
Gofalu Gyda'n Gilydd
Bae'r Gorllewin
Rhaglen Iechyd a Gofal Cymdeithasol

"What matters to Me" – Supporting the health and wellbeing of our older population

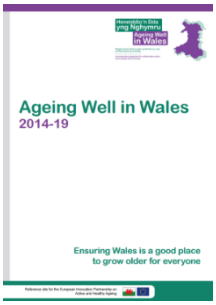
The new way of working for health and social care across the Western bay region

What we will do

1. We will focus on the needs of older people at risk of losing their independence
2. We will all plan and implement community services around the 11 Community Networks
3. We will focus on early intervention and prevention to tackle loneliness and social isolation
4. We are committed to implementing ‘What Matters To Me’ consistently across Western Bay, ensuring all older people have the same services available to them and are called the same thing irrespective of where they live
5. We will roll out the same ‘acute clinical team’ model across all localities, ensuring the right service for those in crisis and linked to ambulatory care
6. Our core community services will deliver pro-active anticipatory care planning to keep care as close to home when needed
7. We will integrate services on the basis of ‘only doing things once’ where possible, such as assessment, single case manager and single care plans, including integrated Older People’s Mental Health in a ‘team around the person’ approach
8. We will use innovative ICT solutions to give the workforce the tools they need to do the job
9. We will develop our workforce through team development and leadership for staff – moving to a ‘core competency framework’
10. We will work with third sector to build the infrastructure needed in communities to support people
11. We will minimise delays for patients who have had unplanned admissions to hospital by improving the interface between community services and hospitals

1. Introduction

The need to change ways of delivering care and supporting the health and wellbeing of older people is well evidenced in health and social care research and policy, with the drivers for change more pressing than ever.



People are living longer and as a result are vulnerable to mental and physical ill health conditions and have complex needs that require care. Across the Western bay area it is predicted there will be a 34% increase in the number of people aged 65+ by 2033.

Whilst significant progress has been made, health and social care provision in the Western Bay area needs to adapt further to ensure services are fit for purpose and sustainable; giving individuals every opportunity to take ownership of their own health.

In 2013, *Delivering Improved Community Services* set out an ambitious plan for addressing the pressures resulting from an ageing population. We have come a long way in the last 18 months – through delivering phase 1 of that plan, for example through delivering the intermediate care programme – but over that time period we have learnt a lot. This document sets out how phase 2 of the project will be implemented, taking the learning so far and applying it to new models of care arising in different parts of the UK.

As such, this document sets out our commitment to deliver high quality integrated health and social care that meets the current and future needs of older people across Swansea, Neath Port Talbot and Bridgend. The document has been developed through a process of research and discussion with partners in health and social care, including the 'Focus on Frailty' event on 27th March 2015 and building on the engagement with partners as part of *Delivering Improved Community Services.*

2. Our Vision

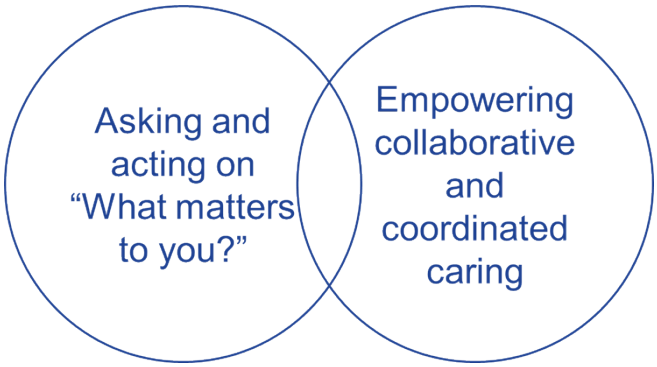
"Healthy independent ageing with proactive high quality care close to home when needed"

We aim to support older people in our community to:

- Live healthy, independent lives in their own homes
- Be listened to by people who are responsible for services, working with them to understand how they can live the lives they want
- Stay as independent as possible through accessing the right information, advice and assistance
- Receive services in their home when needed
- Have their health and social care problems solved quickly and considered as a whole rather than individually

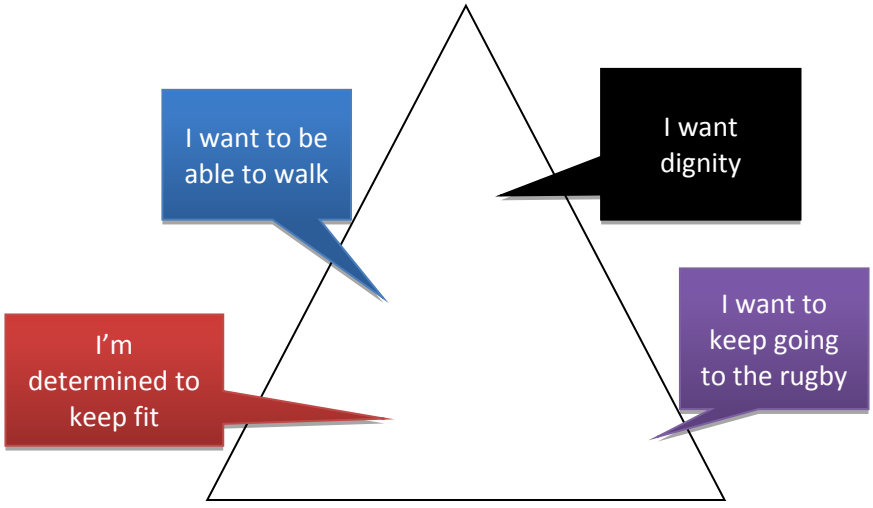
3. Principles

Two overlapping principles are central to helping us deliver our vision:



Asking and acting on "What matters to you?"

All individuals are different. They have different life priorities combined with different health and social care needs.



Central to effectively and efficiently supporting the health and wellbeing of our older population is understanding these perspectives by asking **"What matters to you?"**

This must be at the forefront of all care and organisational thinking.

By doing this we will:

- Ensure the relevant health and social care needs of people are met
- Help individuals engage in their personal care and have a positive experience when interacting with health and social care systems.

Box 1. **Using personal stories to inform better health and social care**

We intend to engage members of the public and staff to understand stories of experiencing health and social care. This will provides a consistent foundation for transforming care. *(Example below)*

DORIS' STORY – MAY 2015

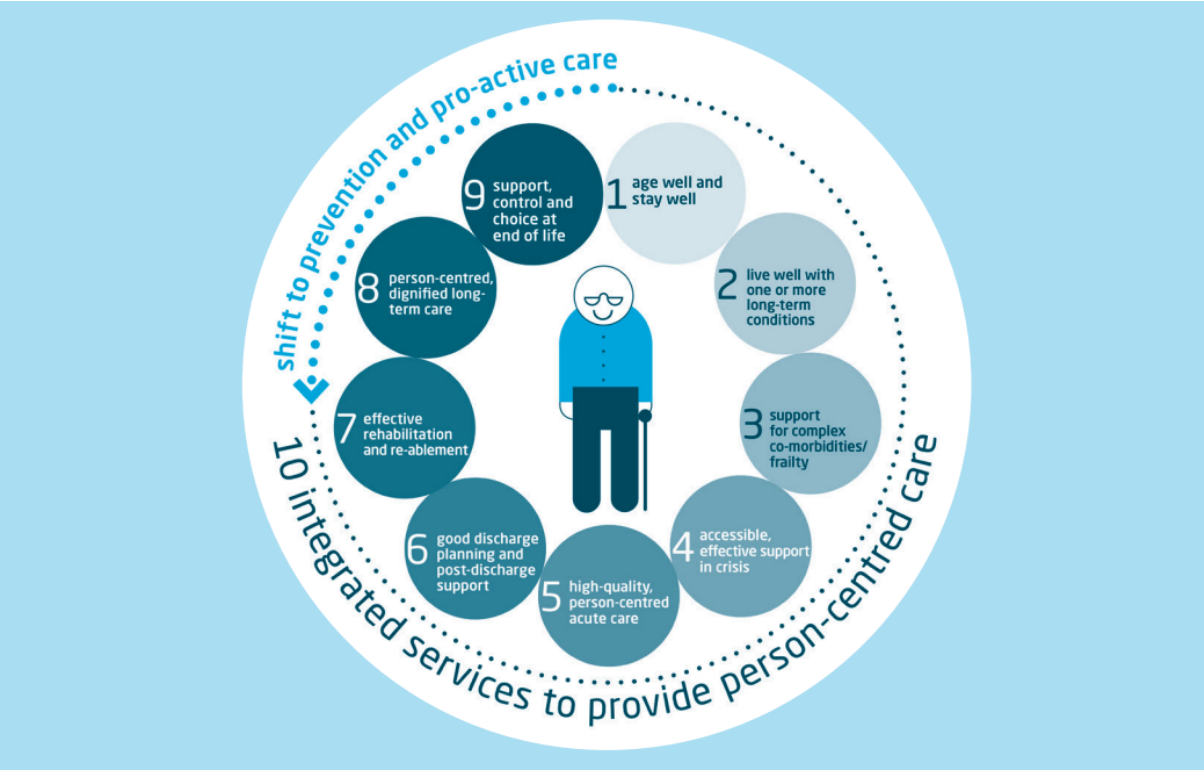
I was talking to my daughter recently about the huge change there has been over the last couple of years in the care and support I receive. I am 85 years old, and have lived in the area for most of my life. The past ten years since my husband died have been a struggle. I have lived with diabetes for twenty years, and now have heart and breathing problems as well. If that were not enough, I've been getting a bit confused at times.

Since last year though, things have got a lot better. The main difference has been Penny. I think she is a nurse, and her main job is to co-ordinate the care I need. I still see some different people, but they all now seem to have an up to date picture of how I'm doing. I still regularly see a physiotherapist and a mental health man has started to visit. They've recently added an extra carer visit, so I now see somebody who helps me with my medication and to get up and dressed and things three times a day. Penny says that most of them are now based in an office nearby, so there is only one number we need to phone if there's a problem. The person who answers the phone is really helpful, and will always put me in touch with somebody if Penny is not there.

The great thing is that I've not had to go to hospital, except for appointments for the past twelve months. The year before, I was taken in three times, twice in the middle of the night. When I got out of the ambulance and into hospital, nobody seemed to know much about me, and it looked to be a real struggle to make arrangements to get me home. They were also talking about me maybe needing to go into a care home, but that seems to have stopped now.

I see my GP every two months, and she says that this new system is fantastic. She works closely with Penny and her team, and says she knows I will get the help I need if there's a problem. She also says it makes her life a lot easier, and that the area does this better than most places. I always used to think the people I saw talked to one another. It's so much better now that they do.

Empowering collaborative and coordinated caring



Supporting the health and wellbeing of older people often involves addressing a range of physical, mental, environmental and social needs and the collaboration of multiple individuals and groups, with the older person themselves at the centre.

To support the health and wellbeing of the older population we must empower this collaboration and ensure it is coordinated in a seamless manner. This includes:

- enhancing integrated teams already developed
- making new connections between individuals and groups
- harnessing the power of third sector and communities
- giving confidence to the public and staff to proactively assess needs, deliver care for themselves or others and acts as brokers of knowledge

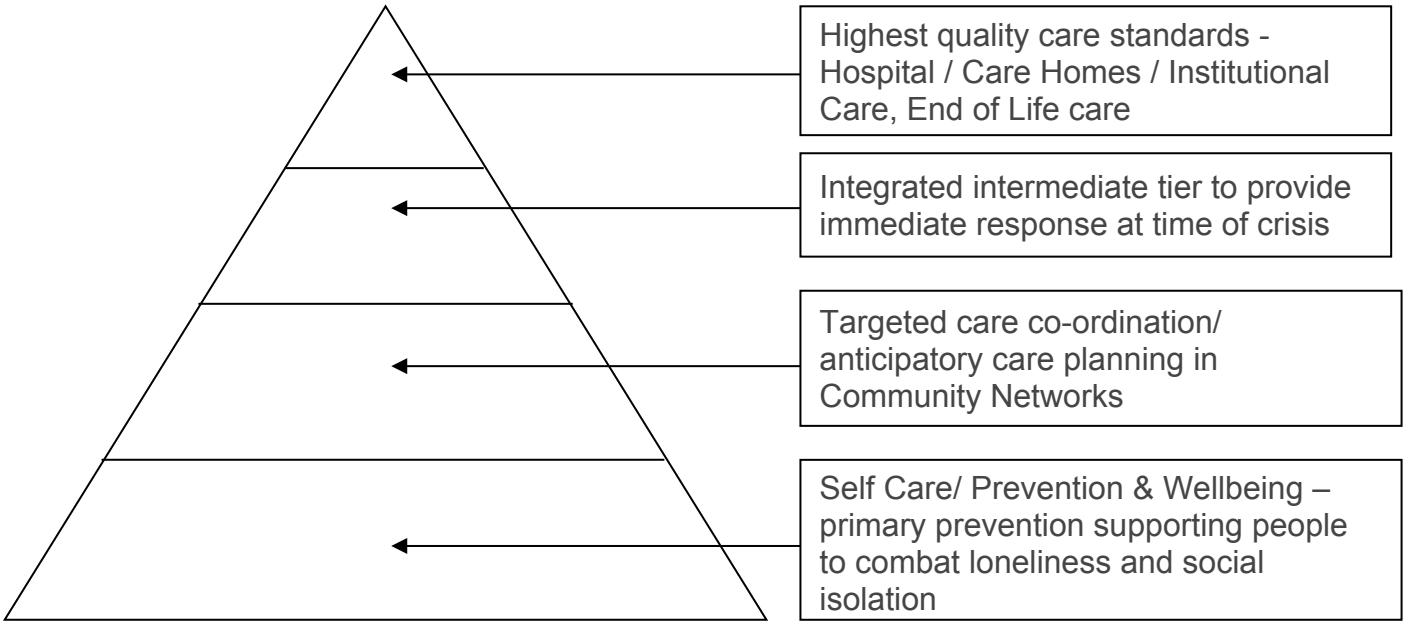
By doing this we will:

- ensure all the people necessary are involved and engaged with care
- develop structures and pathways to facilitate transitions of care
- install the required capacity and capability for those involved – including the ability of the public and staff workforce development

4. Delivering at a service level

With these principles in mind, to turn our vision into reality requires the specification of difference levels of care to frame decisions, conversations and delivery of care. These delivery aims were designed as a result of direct feedback from over 220 stakeholders at the Focus on Frailty Event on 27th March 2015.

(A collation of best practice from other areas of the country is provided in an appendix to this document)



The sizes of the segments emphasises our vision of **supporting the health and wellbeing of older people at home when possible** and in healthcare institutions when necessary.

The levels of care do not suggest additions to the current health and social care services but rather **a new way of person centred, collaborative and coordinated** working that builds upon existing core services and organisations and addresses recognised gaps in services and workforce capacity and capability.

a. Self-Care/ Prevention & Wellbeing – primary prevention supporting people at risk of frailty

Aim: to help people take action to manage their health and wellbeing, live as independently as possible and to keep out of hospital.

How:

- Support to combat loneliness and social isolation
- Tools, motivation and confidence to take responsibility for their health and wellbeing
- Taking the learning from local initiatives such as Local Area Coordination to begin to use innovative ways of tackling loneliness and social isolation
- Supporting the maintenance of a healthy lifestyle – regular exercise, not smoking, reduced alcohol consumption, health eating
- Installing a culture of independence and empowerment through self-care and wellbeing, supported by families, carers and community
- Enabling people to live healthy and independent lives engaged in their community and remaining active
- Ensuring there are regular mechanisms in place to check-in with people and their health and wellbeing

This support for patients could be provided by a range of sources - from health and social care organisations to families and communities to other public groups or mechanisms that can facilitate any of the above points.

b. Targeted care co-ordination/ anticipatory care planning in Community Networks

Aim: To deliver anticipatory care for those most vulnerable in communities

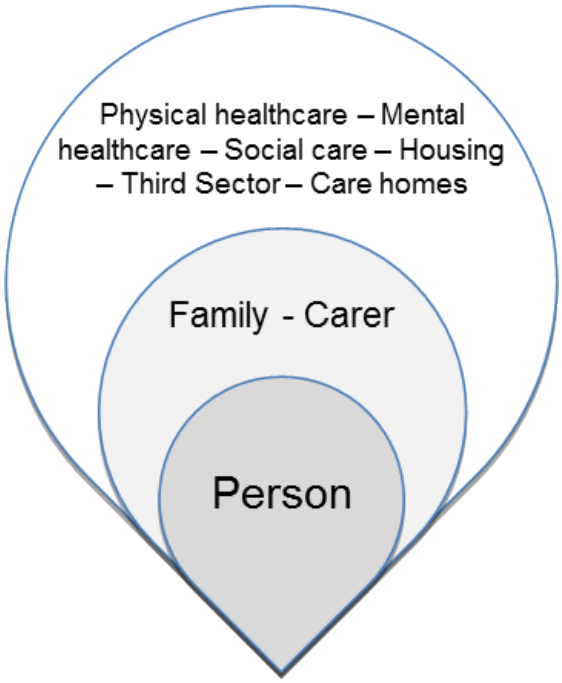
How:

- Case finding and regular review of individuals who would benefit from coordinated care and continuity with a named case manager
  - Includes patients with simple or complex long term medical conditions as well as with a range of other health conditions and changing social support needs
- Encourage individuals and carers to play an active part in determining their own care and support needs as part of a collaborative care planning process
- Develop personalised care plans through shared decision making between the person and staff centred on “what matters to me?”
  - An iterative process based on co-creating goals for maintaining and improving health, support options, personal preferences and the needs of family and carers
- Capture care plans on a standardised, person held document ("This is me" passport).
  - Supports and reduces duplication of conversations between individuals, families, carers and health & social care
  - The care plan is shared with all those who may touch the lives of those people, such as the Ambulance service, GPs, day service provider, etc.

- Ensure the proactive ***case management*** of those at risk of deterioration and the best possible ***care coordination*** arrangements are in place with a named case manager and coordinator

To achieve this requires close working with General Practice, community teams and families to identify and coordinate care to help people live independently in the community.

The above aims and service level



Box 2. Definitions for Targeted care co-ordination/ anticipatory care planning

Case management

Case management is a personalised and time-limited intervention aimed at preventing a specific occurrence or event, often a deterioration of health and hospital admission.

It may involve a range of groups or people delivering a range of interventions or support services.

Care coordination

The role of a care coordinator is to act as the first point of contact for questions, concerns or problems for an identified person in regards to their health.

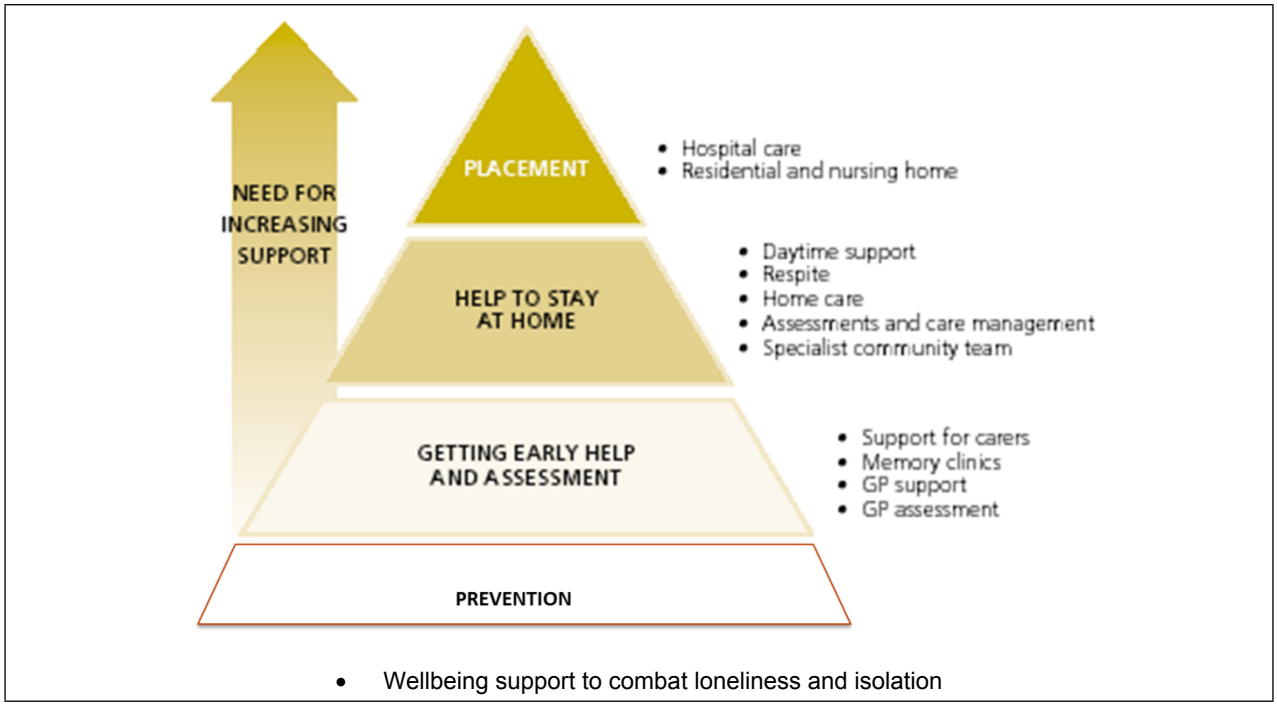
They would take responsibility for checking in with the person and having oversight of their care plan, but not necessarily responsible for delivering the care plan.

Tasks would also include medicines management, self-care support, advocacy and negotiation, psychosocial support etc.

The process of care coordination is seen as a way of working which can be adopted by a range of staff, rather than an additional caseload or task ascribed to an individual practitioner on top of existing duties.

Box 3. Older people's mental health

Care for older people with mental health needs can also be viewed in a similar format and will be considered within every level. An example below outlines this for care of people with Dementia



c. Integrated intermediate tier to provide immediate response at time of crisis

Aim: Maximise recovery and on-going independence and reduce the need for institutionalised care whilst also limiting duplication and hand-offs between health and social care agencies

How

- Short term interventions that address needs at a time of crisis, when people's needs change, of after illness or injury
  - Rapid support close to home when required
  - Good rehabilitation/ re-ablement after acute illness or injury

Much progress has already been made at this level of care through the development of community resource teams (CRTs). These teams support integrated and co-ordinated care management including specific admission avoidance and supportive discharge schemes, chronic condition case management, enhanced preparation for scheduled care, enhanced medicines management and advanced access to diagnostics. Going forward, it will be necessary to harness the learning in developing these teams and integrate with the other levels of care

d. Hospital / Care Homes / Institutional Care, End of Life care when required

Aim: Deliver high quality care in healthcare institutions for those that need it

How

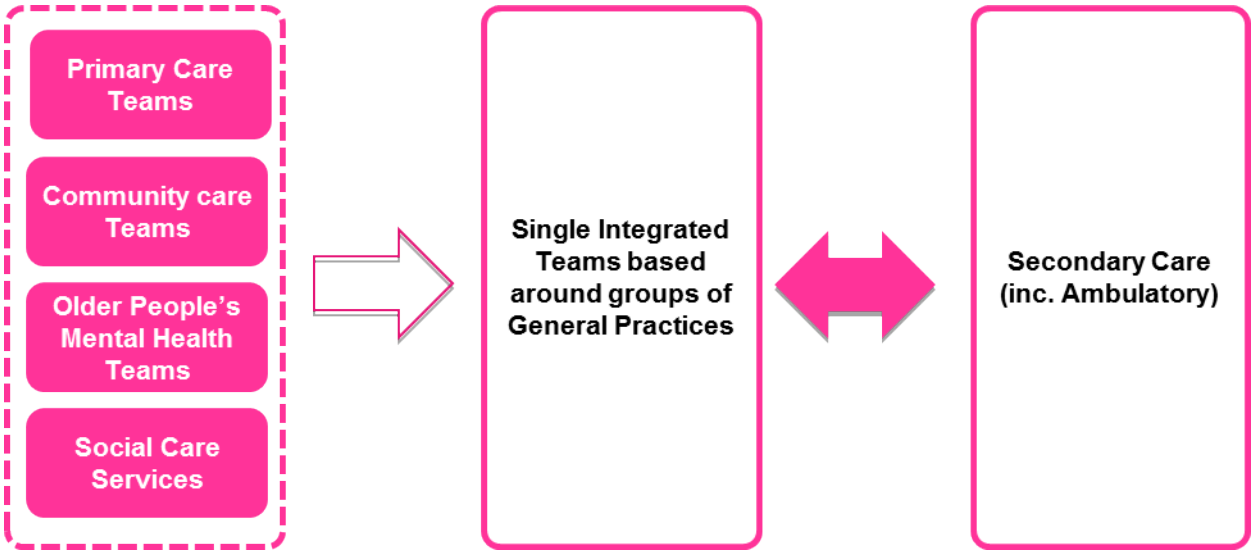
- Good acute hospital care when (and only when) needed
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life
- Good discharge planning and links to post-discharge support aiming to return to their community without delay.

Collaborative and coordinated working with other individuals and groups is necessary to ensure this is a smooth, safe, proactive transition of care.

Box 4. Interface between community, hospitals and ambulatory emergency care

For the levels of service delivery to function effectively there needs to be seamless interface between secondary care and community services (including primary care)

To do this effectively we will look to leverage the integrated community workforce which assesses & proactively plans to meet the needs of older people.



The aim will be to provide community services that are coordinated for people. Our local older people in Western Bay, if unwell or need support, will be cared for or supported by the most appropriate professional – this might be the Community Mental Health Nurse, the GP or a Social Worker – whoever it is the care and support will be coordinated around the needs of the individual.

Community teams are also pivotal to ambulatory care working well, that is treating people on the basis of need when in crisis without the need for admission to hospital – ambulatory care as the default. A key issue facing the NHS is that of managing the increased demand for emergency care within a reducing resource of inpatient beds and staff. Ambulatory care aims to ensure a significant proportion of emergency patients are managed safely and efficiently on the same day, avoiding admission to a hospital bed. Pivotal this is the joint working of community and secondary care.

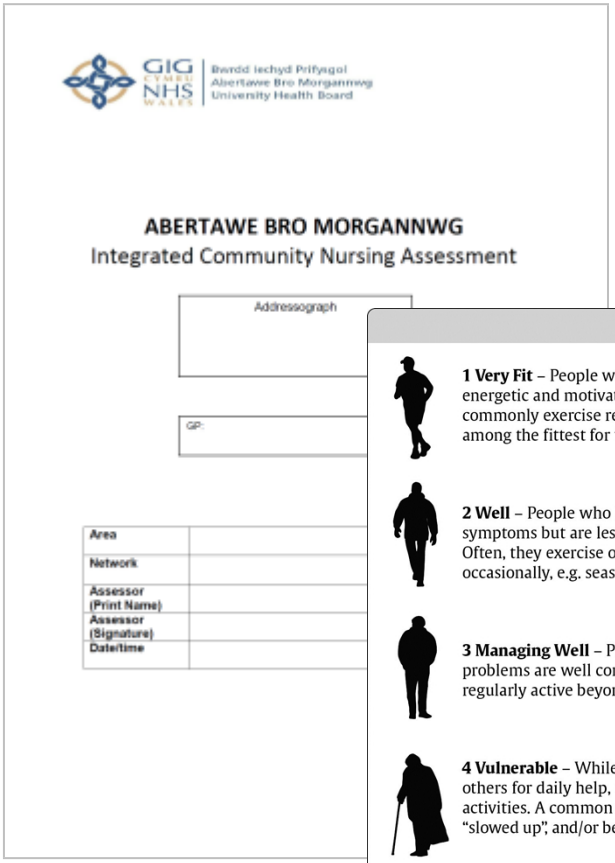
The Western Bay region has recently joined the Ambulatory Care Network which will be used to extend the good foundations already achieved.

5. Enablers

Integrated Assessment

Key to enabling the health and wellbeing of the older population is the ability and consistency to identify support needs. A focused Task and Finish Group was established in November 2014 to research the most suitable assessment criteria for older people requiring health and social care. The rationale for this was that many different assessment criteria were being used across health and social care.

The group consisting of Geriatricians, nurses and social work professionals agreed the common assessment should be the Integrated Assessment documentation. This will be supplemented by the Rockwood Frailty Scale for further assessment of frailty.



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

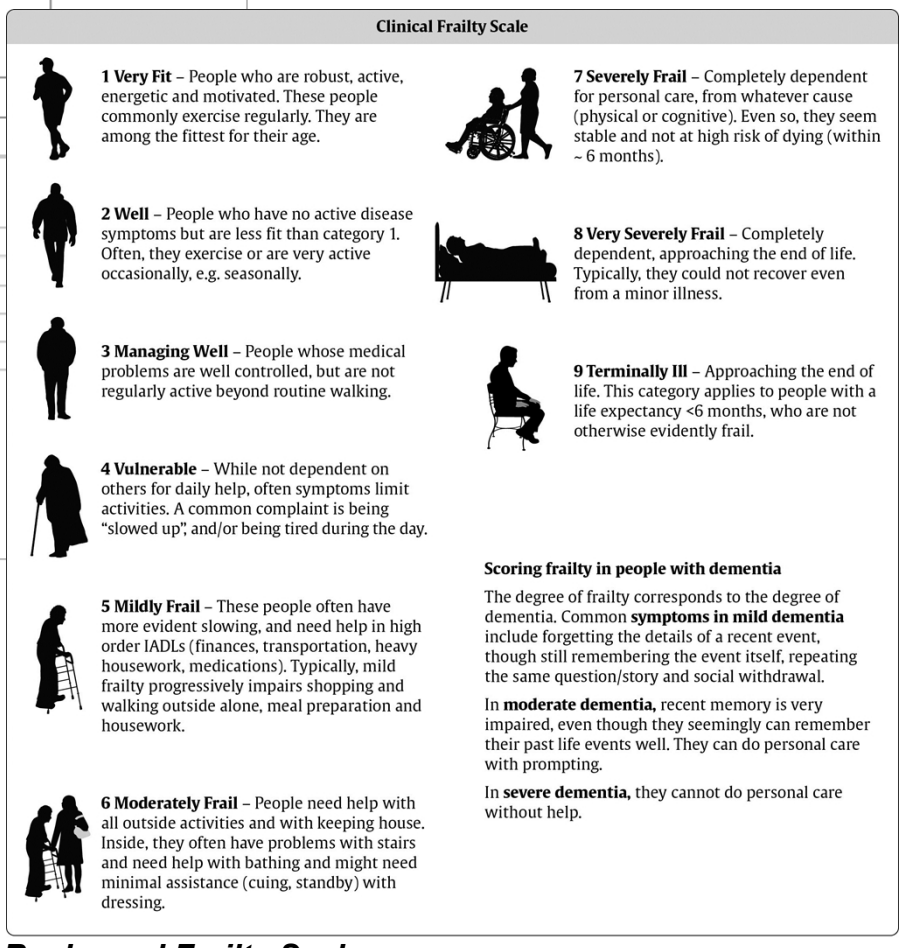
ABERTAWE BRO MORGANNWG
Integrated Community Nursing Assessment

Addressograph

GP:

Area	
Network	
Assessor (Print Name)	
Assessor (Signature)	
Date/time	

Integrated Assessment documentation



Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Rockwood Frailty Scale

Workforce Development

Another key enabler is the development of skilled and motivated workforce with the right number and allocation of roles.

The future health service will see more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations. Individual roles, teams and governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings. The workforce will frame, prepare and deliver an organisational development programme.

We aim to develop a working environment and culture where everyone comes to work each day thinking they can improve outcomes and customer service within the resources we have – providing better care for our older population. To achieve this, our strategic and operational visions will be linked to a complementary Organisational Development strategy.

Planning for these workforce developments is already underway. Some potential actions to continue these efforts include:

Skills and motivation

- Develop culture change examples and morale boosters – aiming to get everyone on the same page in terms of integration and focus on proactive and not reactive care models
- Develop a core competency framework
- Modify core training programmes to align with new service needs
- Develop new learning environments that build on multidisciplinary approaches

Number and type of roles

- Take a stocktake of the current workforce and its needs
- Manage immediate and forecasted workforce supply shortages
- Reshape existing roles through ongoing training, education and development
- Develop and pilot new roles
- Evaluate and research the effectiveness of new roles and workforce configurations

6. How we'll deliver on 'What Matters To Me'

At a meeting of the Western Bay Leadership Group on 1st July 2015, it was agreed there needs to be a robust governance structure for the Community Services programme to implement the work going forward. The specific request was to amend the current governance arrangements and set up a new Community Services board/group which includes all the relevant stakeholders and reports up to Leadership Group.

It is therefore proposed to have a *Regional Planning and Delivery Board for Community Services*, which will have responsibility for planning and commissioning of community service for older people as well as providing a strategic cross challenge function on service implementation. This would address the issue of inconsistent local implementation and provide the mechanism for standardisation across the region. By establishing a Board that addresses both planning and delivery it will allow one meeting per month for key stakeholders rather than two separate meetings. The stakeholders will include:

- x3 Directors of Social Services/Heads of Adult Services
- Service Director for Primary and Community Care – ABMU
- Nurse Director/Medical Director – Primary and Community Care
- Service Director/ Medical Director for Mental Health
- General Practitioner
- Third Sector Chief Officer
- CS Programme support

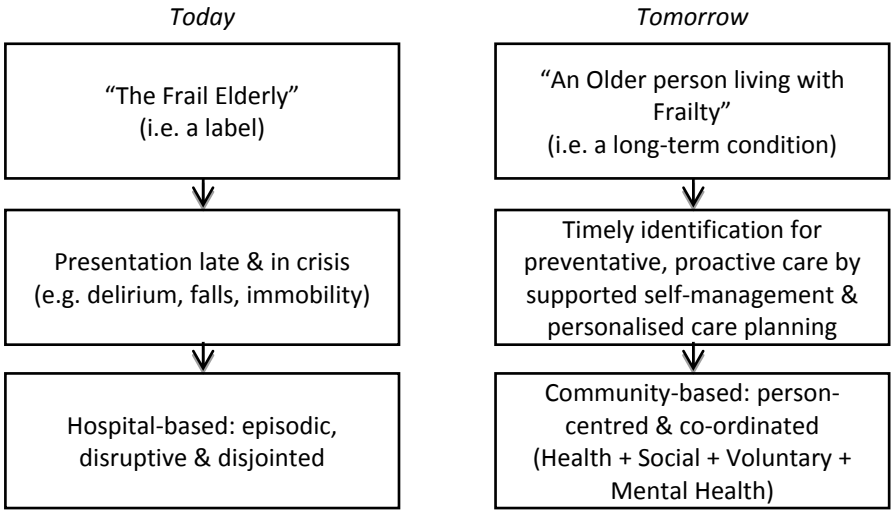
A Terms of Reference will be drawn up in consultation with the key stakeholders before the Board commences in October 2015.

Appendix

Examples of best practice to guide our work

Examples of best practice that link with the articulated priorities within the system are outlined below from an overarching view of care and within the individual levels. These have been drawn from and summarised for the Kings Fund archive of best practice and NHS England publications.

1 Overarching views of caring for older people

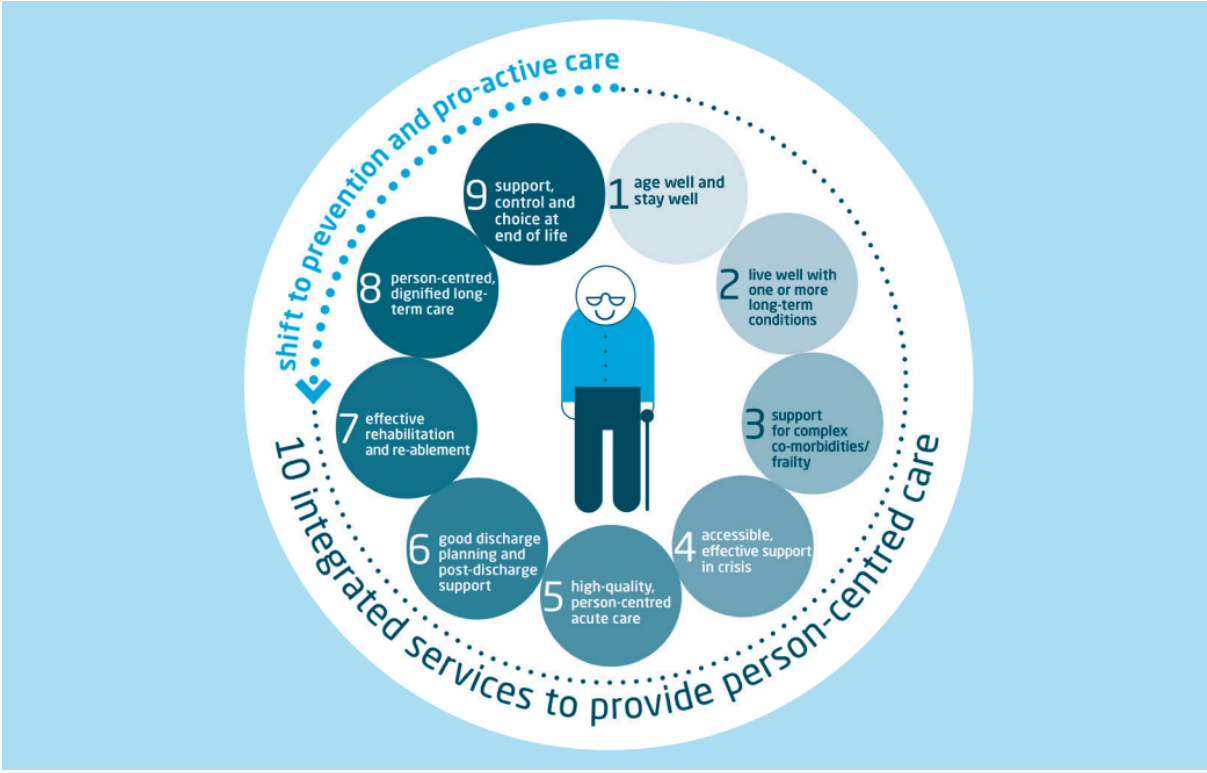


The full presentation can be found here - http://www.kingsfund.org.uk/audio-video/professor-john-young-primary-care-based-model-frailty

Making our health and care systems fit for an ageing population – The Kings Fund & Safe, compassionate care for frail older people using integrated care pathway - NHS England

The Kings Fund and NHS England both outline a wide overview of evidence based elements of care for older people. They identify 9 key areas which are outlined in the list and diagram below and overlap the 4 levels of car outlined.

- Good acute hospital care when needed
- Good discharge planning and post-discharge support
- High-quality, long-term nursing residential care for those who need it
- Choice, control, care and support towards the end of life
- Healthy active ageing and supporting independence
- Helping people to live well with simple or stable long-term conditions
- Helping people live with complex co-morbidities, including dementia and frailty
- Rapid support close to home in times of crisis
- Good rehabilitation and re-ablement (outside acute hospitals) after acute illness or injury


shift to prevention and pro-active care
1 age well and stay well
2 live well with one or more long-term conditions
3 support for complex co-morbidities/ frailty
4 accessible, effective support in crisis
5 high-quality, person-centred acute care
6 good discharge planning and post-discharge support
7 effective rehabilitation and re-ablement
8 person-centred, dignified long-term care
9 support, control and choice at end of life
10 integrated services to provide person-centred care

2 Highest quality care standards - Hospital / Care Homes / Institutional Care, End of Life care

Emergency care pathway for older patients - Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Teaching Hospital one of the hospital's three MAUs has become a unit focusing on the medical admissions of frail older people with the co-location of all the specialist, medical, nursing and therapist staff who deal with frail older people.

To overcome the often delayed process of discharge from hospital for these patients, where the patient is medically fit to leave hospital but waiting for home support to be in place, inter-agency working with both the local authority and primary care has supported the introduction of a 'discharge to assess' system. This is where patients are discharged once they are medically fit and have their support needs assessed on arrival at home by members of the community intermediate care and social care teams. This enables them to access the right level of home care and support much more quickly

Following this introduction he Frailty Unit saw a 34% increase in patients being discharged on the day of their admission or the following day, with no increase in the proportion of patients readmitted to hospital. The change has truncated a discharge process of up to two weeks to care packages being put in place directly with the patient at home, enabling the Frailty Unit to reduce length of stay and therefore shortening the overall patient pathway.

Further information can be found here - http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf

3 Integrated intermediate tier to provide immediate response at time of crisis

Examples of addressing these elements are provided in the overarching best practice examples.

Joint emergency team (JET) - Greenwich

A collaboration between Greenwich Community Health Services, Oxleas NHS Foundation Trust and Royal Borough of Greenwich Social Care has seen the development of a team of nurses, social workers, occupational therapists and physiotherapists working together to provide a multi-disciplinary response to emergencies arising within the community which require a response within 24 hours.

The team responds to emergencies to which they are alerted within the community at care homes, A&E and through GP surgeries, and handle those which could be dealt with through treatment at home or through short-term residential care.

Over a two-and-a-half-year period, over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

Further information can be found here - http://www.local.gov.uk/documents/10180/12193/Greenwich+-+Getting+back+on+your+feet+-+value+case/9cd224ae-b63d-42f9-872e-18943767a695

Frailty Pathway - Lincolnshire West CCG

Lincolnshire West CCG led the creation of an integrated frailty pathway, supported by a wider range of services including a community response team, to enable the frail elderly to remain healthy and safe at home.

It included a number of service changes, including:

- Developing a range of third sector services (e.g. transport and befriending services)
- Creation of a community geriatrician post
- Establishment of integrated community response teams
- Additional training and enhanced GP involvement for local care homes.
- Use of the Canadian Frailty Scoring Tool to identify patients at risk of unnecessary hospital admissions

They have reflected upon the importance of securing buy-in from all partner organisations from the start, acknowledging the time and effort that is required to develop such a pathway and the benefits of involving patients and carers to help articulate how the new service will be different in practice and how this will improve the care that is delivered

Further information can be found here - http://www.nhsiq.nhs.uk/media/2570535/ltc_case_study_lincolnshire_frailty_pathway.pdf

4 Targeted care co-ordination/ anticipatory care planning in Community Networks

Transforming Primary Care in London - London Primary Care Transformation Board and Primary Care Transformation Clinical Board.

A new framework for commissioning primary care in London has outlined elements of Accessible, Proactive and Coordinated care specification. The coordinated care specification refers to patient centred, coordinated care and GP/patient continuity. A number of elements apply to the provision of care for the frail elderly:

Case finding and review

- Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.
- Patients with complex conditions who need care from more than one professional or team are to be added to a coordinated care register and will be provided with an enhanced level of service. These patients may have long term conditions but may also be patients with a range of other health conditions and social support needs such people with mental health conditions; people in nursing homes; people at the end of life; or vulnerable people who find it hard to access services.
- Patients are to be identified using a combination of clinical alerts, risk profiling and clinical judgment. Every practice or network of practices where appropriate, will run a regular risk profiling/risk stratification process in order to identify patients who should be on their care coordination register.

Named professional

- Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.
- Patients may also be allocated an additional member of the practice team or an additional health or social care professional as a care coordinator to act as their first point of contact if they have questions, concerns or problems. This person who coordinates their care should work with the patient to achieve their goals.
- Patients with more complex needs would ideally be able to contact their care coordinator 24/7 for certain periods of very acute clinical risk or towards the end of their life.

Care planning

- Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.

- Development of the care plan should follow the approach described in Delivering Better Services for People with Long Term Conditions – Building the House of Care. This represents a departure from the current focus on individual diseases towards a generic approach in which patients' goals drive care delivery and greater attention is paid to the contribution that people make towards managing their own health. Care planning should be based on a philosophy of co-created goals for maintaining and improving health. It should be an iterative process that continues for as long as an individual has complex needs. Patients identified for coordinated care, and their carers, should be encouraged to play an active part in determining their own care and support needs as part of a collaborative care planning process. This should involve discussing care and support options, agreeing goals the patient can achieve themselves, and co-producing a single holistic care plan that includes the needs of family and carers.

Patients supported to manage their health and wellbeing

- Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing. A culture of self-management support will underpin care coordination, recognising that the personal information that patients, their carers and families bring to the development of care plans can be as important as the clinical information in medical records.
- Support for patients could be provided by individual practices or across a number of practices and could for example include internet resources; advice from staff skilled in lifestyle training and/or motivational support; information packs; services provided by volunteers or voluntary organisations and access to patient groups in which patients support each other.

Care Coordinator - Wiltshire CCG, The Great Western Hospital Foundation Trust (GWHFT) and Primary Care in Wiltshire

At a local level, Wiltshire NHS organisations have collaborated to develop a new model of care targeted at frail older people and people with complex long term conditions.

It has seen the deployment of 23 WTE Care Coordinators (one per 20,000 population) to work in GP surgeries and focus on ensuring that the people referred to them by GP's and sometimes identified using a Risk Stratification Tool:

- re receiving the right care, at the right time, in the right place,
- Know what services they can access and how
- Have support for their discharge from hospital
- Access appropriate community resources (not just those traditionally available from statutory authorities).

The Care Coordinators links with practices themselves but also with their local Community Teams, acute hospitals, social care, and voluntary sector and community groups.

Further information - http://www.kingsfund.org.uk/sites/files/kf/media/Great%20Western%20Hospital%20NHS%20Foundation%20Trust%2C%20Care%20Cordination%20Project.pdf

Clinical Management Plan (CMP) - NHS South Worcestershire Clinical Commissioning Group

Targeted art care home residents, but applicable to a wider range of individuals, NHS South Worcestershire have developed a Clinical Management Plan (CMP) to help improve the coordination and management of care.

The CMP is one single individualised patient plan, available for any health care clinician treating the patient and includes details of a residents care needs and preferences in regards to end of life care or avoidance of hospital admission. The CMP facilitates residents living well by ensuring their CMP is agreed between the resident, Community Nurse Practitioner (CNP), care home staff and the GP. It remains with the patient at their care home, allowing direct access to ambulance crews and GP Out of hour's services for rapid support close to home.

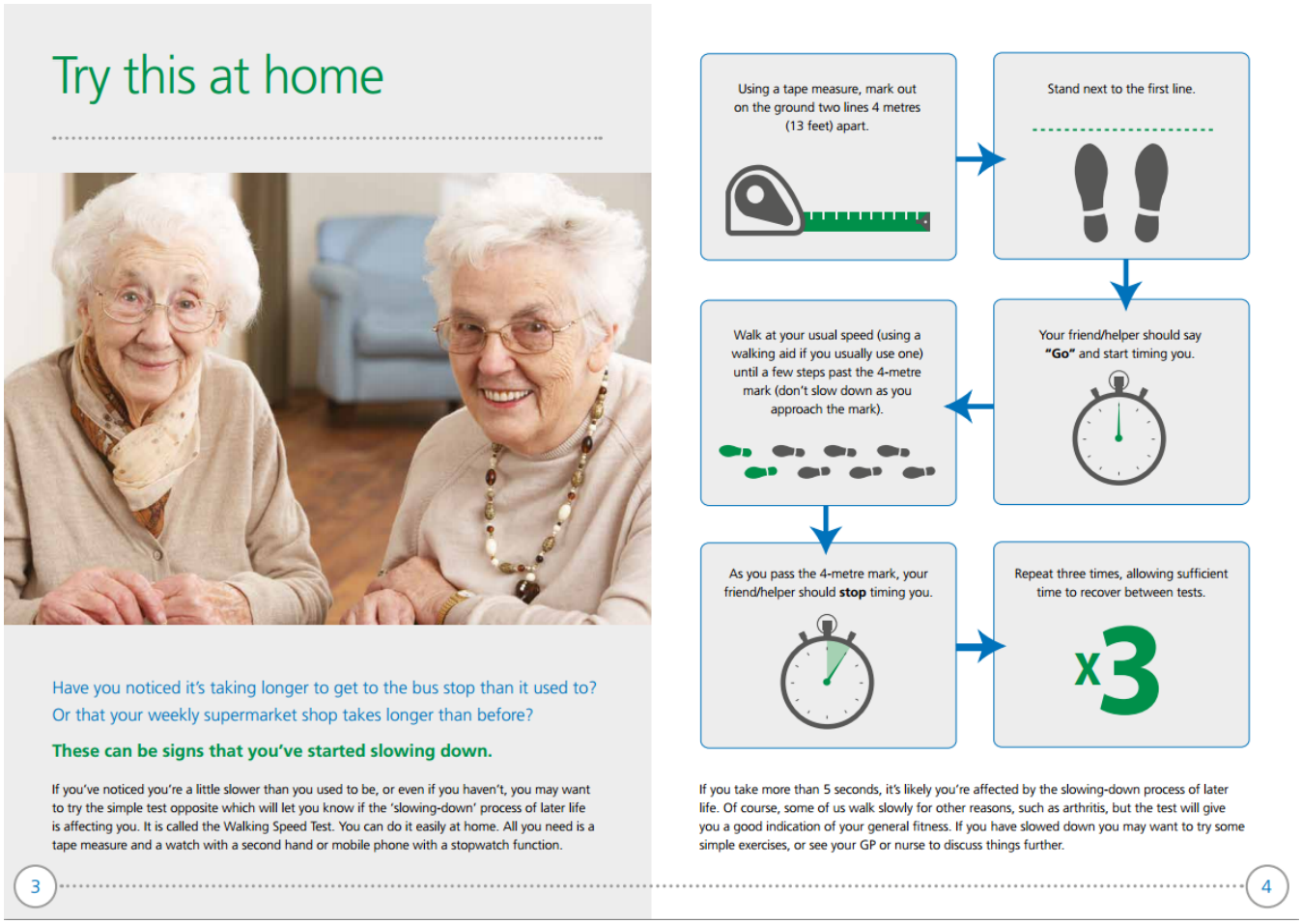
The individualised CMP facilitates patient engagement and offers care home residents the opportunity to express and record their care wishes, particularly in regards to end of life care. One CMP accessible for all helps to avoid error and improves communication speed

After 11 months the evaluation of the project has seen a 15% reduction in admissions from Care homes in South Worcestershire, fewer ambulance call outs and fewer episodes where residents were conveyed to hospital, with savings in the region of £500.000. More recent information suggests a 25.3% reduction in all admissions when compared to this time last year.

Further information - http://www.kingsfund.org.uk/sites/files/kf/media/NHS%20South%20Worcestershire%20Clinical%20Commissioning%20Group%2C%20Clinical%20Management%20Plan.pdf

5 Self-Care/ Prevention & Wellbeing – primary prevention supporting people at risk of frailty

Practical guide to health ageing – NHS England & Age UK



Try this at home

Have you noticed it's taking longer to get to the bus stop than it used to? Or that your weekly supermarket shop takes longer than before?

These can be signs that you've started slowing down.

If you've noticed you're a little slower than you used to be, or even if you haven't, you may want to try the simple test opposite which will let you know if the 'slowing-down' process of later life is affecting you. It is called the Walking Speed Test. You can do it easily at home. All you need is a tape measure and a watch with a second hand or mobile phone with a stopwatch function.

3

Using a tape measure, mark out on the ground two lines 4 metres (13 feet) apart.

Stand next to the first line.

Your friend/helper should say **"Go"** and start timing you.

Walk at your usual speed (using a walking aid if you usually use one) until a few steps past the 4-metre mark (don't slow down as you approach the mark).

As you pass the 4-metre mark, your friend/helper should **stop** timing you.

Repeat three times, allowing sufficient time to recover between tests.

x3

If you take more than 5 seconds, it's likely you're affected by the slowing-down process of later life. Of course, some of us walk slowly for other reasons, such as arthritis, but the test will give you a good indication of your general fitness. If you have slowed down you may want to try some simple exercises, or see your GP or nurse to discuss things further.

4

NHS England, in partnership with Age UK, have produced a leaflet with advice to help improve the health and general fitness of people of any age, but written to be particularly relevant for people who are 70 years or older. It includes a guide to a self-assessment of the "slowing down" process related to the effects of ageing on the body and specific advice regarding a number of areas: looking after feet and eyes, making the home safe, keeping active, talking about medicines, getting hearing testing, preventing falls. Looking after mental well-being, and getting ready for winter.

To access the leaflet: http://www.england.nhs.uk/wp-content/uploads/2015/01/pract-guid-hlthy-age.pdf

An Ageing Well strategy - Newcastle West CCG & Newcastle Council

Newcastle CCG & Council also provides a specific example of a local region developing a strategy which considers a range of different stages of ageing,

including: preparing for active old age; active old age; vulnerable old age; and dependent old age.

The strategy includes:

- Health checks aimed at identifying risk factors such as obesity, physical inactivity and poor diet in those aged 40-74
- Engaging older people as volunteers and health champions
- A focus on case-finding to identify older people who are vulnerable to deterioration or dependency so that they can received proactive support
- Focus on supported self-management

Care Networks – Cambridgeshire Care Network

The Cambridgeshire Care Network, through a combination of qualified paid staff and trained volunteers, has developed a infrastructure of support for over 100 local community groups. Approximately 1,200 volunteers have been engaged in the work. The network includes:

1. **Community Development** – supporting communities and groups to support local older and vulnerable people.

2. **Community Navigators** – providing information about activities and services which older people might enjoy or find helpful

3. **Help at Home** – providing short-term practical and emotional support to older and vulnerable people at a time of need.