OLDER PEOPLES CARE STRATEGY

2015-2020
INTRODUCTION

St Helens is facing huge challenges as a result of an ageing population, increasing workloads, increasingly complex medical conditions being managed in the community and significant financial challenges. The 5 Year Forward View and the Care Act 2014 has emphasised the need to work differently, focus on prevention and achieve integration across organisational and traditional boundaries.

The needs of older people are a key factor in healthcare in St Helens. Older people are forming a larger proportion of the population and are the most intensive users of health and social care. The over 75’s population grows by approximately 500 every year. The needs of older people are particularly apparent in non-elective care within the acute sector where nearly two-thirds of people admitted to hospital are over 65. Unplanned admissions for people over 65 account for nearly 70% of hospital emergency bed days. When they are admitted to hospital, older people generally stay longer and are more likely to be readmitted.

The 5 year forward view for the NHS in England and the Care Act 2014 advocated new models of care to ensure that the health and social care needs of every one are being met. UK and international evidence suggests that integrating care for older people can deliver better outcomes, improve the experience of older people and reduce increasing costs, and that significant improvements can be made through a dual focus on redesigning services and supporting people to self-care, building on the assets around them. System level integrated care could address the fragmentation of care, shifts the focus away from individual organisations and provide powerful incentives to focus on prevention, self-care and cost reduction at a neighbourhood level.

We know that services within our borough often deliver excellent care, but they were not all originally designed to meet the new profile of care needs, or to help people stay well and prevent illness.

The current estates system within the borough has arisen over many years of development without a single strategy. Our approach to St Helens Cares will evolve and reorganise our community system aligning our model with the Five Year Forward View.

Most health and social care services in St Helens are seeing increased demand and services remain under significant pressure.

Despite the progress made in improving the health and care of the population over the last few years there continues to be significant inequalities. These inequalities are described in detail in the reports
of the Director of Public Health and the Joint Strategic Needs Assessment. The Council and Clinical Commissioning Group are working hard to detect illness early and performs well in chronic disease areas such as dementia detection and will further drive prevention through co-commissioning.

The transformational changes being planned will alter the way services are delivered in St Helens, with more emphasis on supporting people to keep well and more care and treatment in community settings, with proportionately less care delivered in hospitals.

We will enhance access to Health and Social Care and shape services in our community.

The purpose of this strategy is to outline a St Helens vision for the future of older peoples care in the Borough and to identify the key primary and secondary strategic drivers that need to be met to ensure we achieve this vision.

**OUR SHARED VISION FOR OLDER PEOPLES CARE:**

In St Helens older people will experience a health and social care system that is wrapped around neighbourhoods and communities. The older peoples care system will:

- Empower individuals, maximises their wellbeing and independence but also provides high quality care where prevention is not an option.
- Optimise access to all forms of care in their home environment (including care homes and supported housing).
- Give individuals control and responsibility over their own care wherever possible.
- Maximise available resource to deliver the highest quality health and social care.
- Support carers

**Making a Difference:**

St Helens will be recognised nationally as a centre of excellence for older peoples care, because it will perform in the top quintile for measurable outcomes. Older peoples care will be highly effective and consistent at delivering better patient outcomes. It will be safe, patient focused and pivotal to the delivery of health, wellbeing and social care priorities in the Borough.

**Right Care:**
The right care will be built around one holistic assessment process for individuals and will be easily navigable and understandable for service users, patients and carers. It will value the role of family carers and will give individuals control and responsibility over their own care wherever possible.

Right Place:

Care will be delivered in the right place for the older person by optimising care in their home environment (including care homes and supported housing) and ensuring that care is delivered in the most appropriate setting.

Right Time:

Care will be responsive to the needs of local older people and it will be accessible 7 days a week. It will be delivered in a timely way with planning and continuity of care wherever possible, and when end of life care is needed it will be delivered sensitively.

WHERE ARE WE NOW?

St Helens CCG has a General Practice registered population of 194,028, the resident population is 176,221 indicating that a number of people live outside the Borough. Of these people 17,500 are over 75.

LOCAL CONTEXT

Compared to the England Average there are a larger proportion of people aged between 50 and 79 years old and proportionally less aged below 40 years old, consequently St. Helens faces a higher level of ageing population than other parts of the Country.

General advancements in care and quality of life and wellness are improving life expectancy. Consequently more patients are now arriving in their 70’s in either good health or with controlled chronic diseases, where they previously would have succumbed to those illnesses in their 60’s. Over the last 5 years St Helens has seen an increase in the over 75 population of 14.4% (2088 patients) and an increase in the over 85 years of 13.7% (484 patients), whilst the overall population has only grown by 1.5%. These patients also have a high number of chronic diseases [on average 2 or more chronic diseases each and 20% have dementia] and account for the majority of A&E attendances and admissions.
There is also a wide variation across St Helens’ wards in terms of both deprivation and health. Outcomes within some wards are comparable to the most affluent areas nationally and others are among the worst in the country. This combination of an ageing population, deprivation and variation across wards significantly intensifies the challenges and burden for the CCG, and Local Authority to commission and provide high quality health and social care with limited resources.

Transforming Older Peoples Care in St Helens

Our mission and aspiration is to transform older peoples care services into top performing integrated services achieving better patient outcomes. This is highly ambitious and needs strong leadership, courage, clinical engagement and commitment. Transformational change on this scale requires us to identify the key primary and secondary drivers necessary to affect the changes and the section below outlines the necessary primary driver, with a brief summary and a list of relevant secondary drivers that also need to be addressed and achieved.

Older peoples care in St Helens will be delivered in a number of ways to suit the nature of the services. There will not be a one size fits all approach to service delivery. Some services such as Community Nursing, Housing services, may be better delivered in defined localities, other services such as social work assessments, Continuing Health Care support etc, may be delivered on a Borough wide basis. For a number of services, individuals will have a right to choose providers from across the Borough and other areas where appropriate. Care will be taken to ensure effective integration across all services and beyond the boundaries of traditional health and social care services. Priority will be given to ensuring effective communication about the individual service user regardless of the size or nature of the service. We also need to be able to reach those older people that are not known to services, who might be living alone or with low levels of private support. These people would benefit from preventative interventions that may help avoid them needing high level services in the future.

PRIMARY DRIVERS

1. WORKFORCE - there will be a sustainable multi-disciplinary workforce for older peoples care in St Helens

We need the right number of staff with the right skills, right experience, in the right place at the right time. We expect St Helens to be innovative and lead the way regarding changes and developments in caring roles across mental health, acute, community, primary and social care. This will mean
breaking down unnecessary demarcations between staff groups to ensure a genuinely joined up experience for service users/patients.

The secondary drivers we need to achieve are:

- Robust systems for specialist, clinical & mandatory training
- Delivery and support of workforce strategies
- Implement plans for recruitment, retention and succession planning

2. MODELS – Services will need to work more closely in networks and we will integrate them into older peoples care services in distinct neighbourhoods.

UK and international evidence suggests that integrating care for older people can deliver better outcomes, improve the experience of older people and reduce increasing costs, and that significant improvements can be made through a dual focus on redesigning services and supporting people to self-care, building on the assets around them. System level integrated care should address the fragmentation of care, shift the focus away from individual organisations and provide powerful incentives to focus on prevention, self-care and cost reduction at a neighbourhood level.

Secondary drivers to this will be the need to

- Develop and implement a single assessment framework
- Develop a responsive directory of integrated services that can follow patients across settings and sectors
- Review and redesign community nursing.
- Review the provision of Step Up and Step Down community beds, including the utilisation of beds at Newton Hospital.
- Develop a more robust and accessible day assessment unit for older people.
- Build upon the innovations of current pilots and trials such as the APMS frailty service, the Acute visiting service and the care home scheme.

3. CARE SETTINGS – services will need to be delivered in a wider range of care settings and across a different spectrum of need.

At the moment there are limitations to what kind of setting care can be delivered in because of current behaviour and service delivery models. Alongside the changing shape of care models, described above. There will need to be a focus on shifting care closer to home and promoting independence and self-care. To make better use of the resources available we want to ensure that care is delivered in a wider range of settings and across a different spectrum of need.
Currently care is delivered in this way;

Over the next 5 years we will need to shift people’s behaviour and the delivery of services away from traditional settings and dependencies, in order to promote independence and self-care. This will mean much more being delivered at home and through self-care, and much less at the higher end, i.e. acute hospital care.

4. **QUALITY – Services for Older People in St Helens will be Effective, Safe and Responsive to patient needs**

   We will identify a set of quality indicators and ‘Always Events’ for local services and a programme of quality improvement work, the aim being to ensure outcomes (morbidity and mortality) for older people improve, that care is safe and people experience highly positive and compassionate care. We
will address variations in quality across the Borough and will embed a culture of safety and learning across health and social care.

Secondary drivers are;
- Development of a Care Dashboard (identify quality KPIs)
- Delivery of service user Engagement Strategy
- Robust systems for the management of and learning from Complaints and Incidents
- Research and Innovation strategy

5. INFRASTRUCTURE - Estates and IT infrastructure will support the delivery of excellent care

A proportion of the facilities and estates currently used by some St Helens services are old and not fit for purpose and these issues will need addressing to realise our vision. In addition, we will need to make better use of innovative technology across health and social care. This will mean, for example, more streamlined sharing of intelligence and data about a range of services and that they are available in real time.

6. PARTNERSHIP WORKING – Integration, leadership, engagement and partnership working

There has been much closer working in St Helens in the last few years between the Local Authority, CCG and large providers of healthcare. However we need to work closer with social care and other health care providers and be fully integrated with clinical pathways and new ways of working such as new models evolving in St Helens in relation to Out of Hospital Nursing and Intermediate Care.

7. PREVENTION - There will be a strong focus on early detection and primary and secondary prevention across St Helens

There is an ageing population in St Helens many with multiple Long Term Conditions and other significant issues that impact on health and wellbeing such as healthy lifestyles. General Practices are uniquely placed to work closely with Public Health to drive the prevention agenda and to educate the public to take more responsibility for their own health and life-style choices. The secondary drivers to this are
• Primary prevention services- targeted at staying, active, preventing social isolation and eating well and tackling health issues such as falls, pneumonia, shingles, diabetes & stroke

• Secondary prevention services – targeted at chronic disease management

Delivery of these primary drivers will be essential to enable us to realise our ambitions and this will require close working with key partners in particular the Health and Wellbeing Board and patients and carers. In addition, there are four other factors that will need to be managed to ensure successful delivery of this strategy and these are:

1. Financial sustainability
2. Provider engagement
3. Patient and public engagement
4. Operational capacity to deliver the objectives
5. Leadership and cultural change

NEXT STEPS

This strategy identifies the St Helens vision Statement for Older Peoples services over the next five years and the key drivers that need to be realised to achieve these. It has been shaped and developed in consultation with key stakeholders. It is a high level document outlining the transformational change that is required locally to meet the current challenges facing health and social care and to ensure better outcomes for the people of St Helens. It will need to interface closely with other key strategies such as the CCG Primary Care Strategy

It will be supported by an operational plan that identifies lead officers for each primary driver, and smart objectives with measurable metrics that will ensure the Local Authority and CCG are able to monitor progress and measure impact. In terms of service user outcomes it is expected that delivery of this strategy will be a necessary factor in ensuring the Health and Wellbeing Board meet the improved outcomes they have identified for the Borough of St Helens.