Integrated Care Services

Bringing together leaders to transform services and outcomes for people living with long-term conditions.
We’re Age UK and our vision is a world where everyone can love later life. We believe that living longer should be celebrated and everything we do is designed to change the way we age for the better and enable everyone to be part of the solution. Together, we can help everyone make the most of later life.

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

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

Through the programme Age UK staff and volunteers become members of primary care led multi-disciplinary teams, providing care in the local community. The pathfinder for the programme has been underway in Cornwall since 2012 and is now integral to the wider local partnership that is one of the Government’s 14 Integrated Care Pioneers; the early results are highly promising in terms of preventing unplanned admissions to hospital and the programme currently holds the Health Services Journal national award for Managing Long Term Conditions.
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‘For me personally, I have been encouraged to look at patients where I thought their dependency levels would only increase and see that with a relatively small level of intervention, they can be encouraged back to a much lower level of dependency.’

Dr Tamsin Anderson, Newquay GP.
Why we have launched the programme

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

The need for a programme like this is already significant and it is growing all the time:

- There are over 14 million people in the UK aged 60 and above and this number is projected to rise by over 50 per cent in the next 25 years.
- Older people represent 60 per cent of all hospital admissions, costing the NHS billions as they are often in crisis by this point and in need of urgent support.
- On average older people’s hospital stays are around 2.5 times longer than those of people between the ages of 15 and 59.

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

Judy, a volunteer on the programme agreed to host a regular coffee morning in her house.

’I help by making tea, coffee and cakes. It helps me as well, I love listening to their stories, and they’re a lively bunch!’

Who we work with

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

Our model works with older people, their families and carers, Clinical Commissioning Groups, GPs, Acute Trusts, Community Trusts, Local Authorities and Voluntary Organisations, including 168 local Age UKs.
Through the programme Age UK’s ambition is to:

• **Improve the health and wellbeing outcomes for older people** with long-term conditions who experience high numbers of avoidable hospital admissions.

• **Deliver cost savings** based on evidence from international best practice, and help to alleviate the financial pressures in the local health and social care economy.

• **Support and deliver transformational change to the whole system** by demonstrating how GPs, community care, hospitals, social care and the voluntary sector work together, with the older person at the centre.

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

As we grow older we all face new challenges but that doesn’t stop us from wanting a fulfilling, independent later life. Age UK is passionate that everyone should have the opportunity to be able to make the most of later life, whatever their circumstances, wants and needs.

We are committed to exploring innovative funding mechanisms to help make this happen; for example, we are modelling a new approach to evidencing cashable savings in order potentially to secure a Social Impact Bond. To support this we are working with partners to adopt different contractual mechanisms that can align incentives and drive change such as Alliance Contracting.

‘One person hadn’t been out for three years – it shouldn’t be forgotten the amount of effort some of the people have to put in to arrange carers and come out on the trips but they say the buzz of going on the trip lasts for weeks and they look forward to us arranging another one.’

**Carolyn Trevithick**, Changing Lives Team Leader.
The programme in action

We are excited by this approach because it represents a fundamental shift from maintaining conditions through a series of separate medical interventions to putting older people in control of their own health and wellbeing, enabling them to regain and sustain their independence and improve their quality of life and coordinating care through an effective multi-disciplinary team.
‘I can’t get out and it’s wonderful that you come and take us out, it’s a new lease on life.’

Val, an older person on the programme.

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

• Our approach is based on strong local health and social care partnerships. Commissioners, local Age UKs, NHS and other providers come together to co-design the service based on a model of integrated care that targets a specific cohort of older people. Risk sharing protocols (resources, finances, commitments etc.) are developed between the organisations as well as measures to monitor and review achievements. Importantly the strength of this partnership enables all organisations to work towards the same set of outcomes, first and foremost improving the quality of life for the individual concerned.

• We use risk stratification to identify those older people most likely to be admitted to hospital and to focus our resources most appropriately. Evidence from Kaiser Permanante’s experience in the United States demonstrates that risk stratification had a positive impact on reducing admission rates, particularly when targeting group of people with the following long-term conditions: Angina, COPD, Dementia, Diabetes, Pneumonia, Stroke and UTIs.

• Using a ‘guided conversation’ an Age UK Personal Independence Co-ordinator works with and alongside the older person. They draw out the goals that the older person identifies as most important for them.

• Supporting people through the effective sign posting and care co-ordination to increase independence and reverse the cycle of dependency. We connect the services that already exist locally through other public and private providers and charities so the services ‘wrap around’ the older person; e.g. benefits advice, social activities and home help, as part of their support plan.

• While each older person on the pathway is matched with a volunteer to support them to achieve their goals, all the older people are encouraged to take the lead in managing their own care and wellbeing. An intensive support service is provided to the older person for three months, with the aim of them having achieved their goals and a greater sense of control, confidence and independence by the end of this period. After this, the older person may still be supported as they are also always able to make contact again through their practice or Age UK Co-ordinator if they wish.

• Integrated working is co-ordinated and supported through a shared care plan, developed with the older person and reviewed regularly by a multi-disciplinary team based within a primary care setting. There are also clear safeguarding and escalation protocols in place to ensure that if and when medical attention is required, this is delivered effectively and in a timely way.

• This promotes independence from primary and community health services, as well as preventing avoidable hospital admissions.

1 www.bmj.com/content/327/7426/1257
Home of care

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

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

Person selection via data analysis and GP assessment

Targeting highest risk with multiple long term conditions

Fully integrated support team

GP
Practice nurse
Age UK Personal Independence worker
District nurse
Social Care worker

Care Co-ordination and guided conversations

Person

Personal Independence worker
Age UK volunteer

Designing person-centred care management plan

C3 One to one support

Care management plans
Escalation plans
Anticipatory care plans
Self care strategies
Peer support network
Motivational interviewing / shared decision making

D Wrap-around local support services

Handy person
Social Activities
Shopping
Information & Advice
Community transport

F Outcomes

Overall improvement in Quality of Life

Good Health
Supportive Relationships
Positive Self image
Financial Support

Quality of Life

Reduction in avoidable admissions to hospital

E Age UK’s integrated care pathway development

Collective accountability across integrated care team (Age UK, clinical and social care services)

Volunteer-led. Access to community services. Clinical coordination: medication, appointments etc.

Assessing immediate needs and addressing barriers to improve quality of life

Enabling self-care. Peer support. Tackling social isolation

Aligned incentives. Financed directly by local bodies or through innovative social investment financial model
Early results from the Cornwall pathfinder project are highly promising.

In the first year 100 older people have been helped, of whom 60 per cent are women and 40 per cent men, with a mean age of 83.

Using the Edinburgh and Warwick mental well-being scale, a 23 per cent average improvement was observed amongst older people in the cohort and there were 30 per cent fewer non-elective hospital admissions.
Early financial calculations showed the potential to save up to £4 for every pound spent for the local health and care system. This relies on re-shaping acute trust services to realise cashable savings. This ratio creates a surplus that is a sufficiently powerful incentive to engage all the key stakeholders in the local health economy to work together.

Projections therefore suggest that, over a period of one year, with a £500 service investment for each older person, £2000 could be saved to help meet incremental demand, support re-configuration and provide net savings to invest in prevention.

Co-producing the care management plan with the older person and focusing on preventative rather than acute interventions saves health care professionals’ time by reducing appointments and costs through removing, reducing or delaying need. There is better integration of services at both strategic and operational level.

In Cornwall both staff and service users report high levels of satisfaction with the service model. Some of the older people who have been helped by the programme have also decided to become volunteers themselves, highlighting how much more confident and resilient they have become.

For the next phase of the programme an evaluation by The Nuffield Trust will be carried out to assess to what extent reduction in hospital admissions can be attributed to this approach. The findings will be available in Spring 2015.

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

Annie, an older person on the programme.
Case studies

Nora
Nora is 74 and lives alone. Her diabetes is not well managed. She is also very breathless, anxious, had a stroke, is partially sighted and in constant pain. This all led to a high dependency on services and professional carers for most daily tasks.

Age UK arranged for tele-health support to help manage her diabetes and for an ‘exercise buddy’ who visited Nora, first at home and then as part of a group, to encourage and support her through an exercise programme. It has taken a while to build Nora’s confidence but she has recently taken the considerable step of coming on an organised shopping trip and not only attends a ladies’ coffee morning with other older people, but is confident and able enough to have hosted one in her home.

John
John lives with diabetes, heart disease, atrial fibrillation and dementia. His increasing dependence on his wife was causing tension between them and he stopped going out on his own, becoming increasingly isolated. John was frequently visiting the GP but missed diabetic appointments.

The volunteer found activities that John used to enjoy, such as short mat bowling in a local church. John also joined a diabetic group where he was able to share his experiences with his peers, and has regularly engaged with podiatry services and the diabetic nurse since. The volunteer also accompanied him through a stress buster course. He now attends the Memory Café, catches up with old colleagues regularly and enjoyed a group theatre trip with his wife.

John’s confidence has increased significantly and he now socialises on his own. He has better control of his diabetes and fewer GP visits. He engages regularly with the diabetic nurse and podiatry service.
Kenneth

Kenneth has angina, dementia and experiences a lot of pain in his shoulders and one of his legs, which left him housebound for a number of years. His wife has struggled to care for her husband and was in desperate need of some help.

Kenneth identified that his main goal was to take his dog out for a walk, but due to his lack of mobility and anxiety about leaving the house, both Kenneth and his wife were convinced this would be unachievable.

With coaching, Kenneth’s confidence and ability to stand grew and he is now able to go on walks with his dog. Using a ball thrower, he threw a ball for the first time in years.

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

Paddy, a member of the Breathers Group.
Beth
Beth had had several falls which resulted in long stays in hospital. She was living alone in one room of her large house. Due to her asthma, dementia and chronic pain in her legs, her care package included four daily visits from carers and a district nurse visit four times a week.

During the guided conversation, Beth described some of the activities she used to enjoy. Together the volunteer and Beth set a goal of getting her hair washed, rather than having to use dry shampoo. Over time we helped her to mobilise with a walking frame and bend down at the sink. Later they booked a mobile hairdresser. With increased mobility and social interaction, Beth is less dependent on carers.

Her district nurse now visits fortnightly and she has not been admitted to hospital since accessing the programme.

‘The Personal Independence Co-ordinators help people look after their conditions and manage their own conditions in their own home and then equally that reduces hospital admissions and reduces NHS spend.’

Lucy Clement, District Nurse and Locality Team Leader for Newquay.
Next steps for the programme

A dedicated Age UK Integrated Care team is in place and is developing and running the programme. With the support of partners, including Improving Care, we are building on our proof of concept.

Cornwall has now entered into phase two of the pathfinder where they are scaling up to 1,000 people. Advanced discussions are also underway in four areas in other parts of England, each planning to support 1,000 older people within 12 months. This will enable further testing at a greater scale, facilitating further financial and service modelling.

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

We are always interested in hearing from localities where NHS and local authority colleagues believe the programme may have an important contribution to make.

For more information, please contact: Integrated.Care@ageuk.org.uk
Twitter @penwithpioneers
www.youtube.com/user/AgeUKCornwall

Acknowledgements

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The photographs throughout this report are not of those quoted.
References – background for Age UK’s Integrated Care programme:

Age UK, “Services for older people – what works”, 2014

Age UK, “Right Care, First Time: Services supporting safe hospital discharge and preventing hospital admission and readmission”, 2012


Centre for Economic and Social Research at Sheffield Hallam University, evaluation of Age UK Rotherham Hospital Aftercare service, 2011

Penwith Pioneer Project Board, “People, Place, Purpose. Shaping services around people and communities through the Newquay Pathfinder”, 2013

Age UK Berkshire is a locally-funded and managed independent charity operating across Berkshire, and a Brand Partner within Age UK.

Research and programme design by Age UK such as illustrated in this brochure can be implemented at a local level by Age UK Berkshire.

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