ICOPE
Integrated Care for Older People in Worcestershire

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ICOPE strategy for Worcestershire

2018 - 2023

This strategy has been developed In partnership with: NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG, NHS Wyre Forest CCG, Worcestershire Acute Hospitals NHS Trust, Worcestershire Health and Care NHS Trust, West Midlands Ambulance Service, Worcestershire County Council – Departments of Adult Social Care and Public Health, Age UK Herefordshire and Worcestershire, Worcestershire Association of Carers and older peoples representatives.

Foreword

One of the inevitabilities of life is that the vast majority of us will get old. Ageing at the beginning of the 21st-century is a very different experience to that of my grandparents generation. We are living longer but not necessarily healthier lives. Formal support for older people has become fragmented with care provided by different organisations and teams with limited or no flow of information between them. Older people and those acting on their behalf are expected to navigate their way between a bewildering array of services with parcels of care provided in a way that meets the parameters of those services not the priorities of the older person themselves. There is little or no focus on the opportunities to improve well-being and independence in the second half of life and little acknowledgement of the current and potentially even more valuable contribution that older people make to their communities.

For over 20 years I was a GP in Worcester City and more recently have had experience of working with community services across Worcestershire. My current GP role is to provide support to care home residents. Wherever I have worked I have seen excellent standards of care provided by committed staff but I have also seen the gaps between services. This results in resources being wasted in duplication and generates significant frustration for older people and those supporting them.

I am excited to have been given the opportunity to bring older people together with organisations across the county to develop a system wide strategy for Integrated Care for Older People in Worcestershire. As somebody who has recently embarked on the second half of life (I have every intention of living to 108!) I am committed to improving the experience of ageing in Worcestershire not only for our current population of elders but also from myself and my peers who expect to live well into the latter half of the 21st-century.

Maggie Keeble

Strategic Clinical Lead for ICOPE Worcestershire

ICOPE
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1.0 Executive overview

The overall population of Worcestershire is 583,100 with 128,000 residents aged over 65 years and 6,439 residents over 90. Demographic shifts over the last few years have seen the ageing population increase with particular increases in residents over 90 years. It is projected that there will be a population increase of circa 39,000 in Worcestershire by 2027, of which more than 50% will be over the age of 65. The gap between life expectancy and healthy life expectancy means that people are living longer but in poorer health. Currently this gap is 15.8 years for women and 13.3 years for men across Worcestershire.

Worcestershire partners need to work together to support the older population to stay healthy, active and independent. Current interventions are reactive in nature and set up to respond at times of crisis. As someone becomes increasingly frail and dependent a discussion with them about options for levels of care and intervention prior to a decline in health will enable the recording of their wishes and preferences. This can be then be taken into account if they are unable to tell us at the time of a deterioration to enable a reaction in line with their wishes.

For older people and their supporters, care feels fragmented and disjointed because health, social care and the voluntary sector do not work together as an integrated team. There is a need for Worcestershire partners to work collaboratively by utilising new ways of working and innovative technology which support integration and enable the effective response to older people's needs – wherever and whenever they come into contact with services.

2.0 Background

2.1 Background

In October 2017 a Global Consultation on Integrated Care for Older People (ICOPE) took place in Berlin. The Global Consultation meeting provided an opportunity for discussion and debate among global experts and World Health Organisation (WHO) member states about how health and social care systems can implement integrated care for older people. The WHO Global strategy and action plan on ageing and health was developed which calls for action on aligning health systems to the needs of older populations and provides direction on how to initiate such system changes.

In December 2017 Dr Maggie Keeble challenged the Worcestershire Alliance Boards to consider how Worcestershire could rise to this call for action and develop and deliver a system wide change to integrate care for older people across the county.

In May 2018 a Worcestershire Frailty Workshop took place with all partner organisations and an agreement was made to take the ICOPE programme forward with key leads identified from within each organisation. An ICOPE Clinical lead was appointed in September 2018 and an ICOPE Steering Group established initiating the start of the programme in Worcestershire and the development of this strategy.

2.2 Definition: What do we mean by Older Age and Frailty?

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What is Frailty?

Frailty and Old Age are not the same thing. Some people in their 80s and 90s are very active and independent and robust. Others may be living with frailty in their 50s or 60s.

Frailty is a syndrome associated with but not directly related to age characterised by a deterioration of function where a small insult (e.g. infection, change in medication) may result in a striking and disproportionate change in health state. For example the onset of a cold under normal circumstances is frustrating but not debilitating but for someone living with frailty this could cause deterioration with the onset of drowsiness, confusion, worsening mobility and an increased risk of falling, breaking a bone and being admitted to hospital.

People living with frailty are dependent on devices, home adaptations or people around them to remain independent. Those living with severe frailty are fully dependant on others for most or all activities.

Why is recognising frailty important?

There is evidence that investment in certain activities and life styles can delay or even prevent the onset of frailty.

At earlier stages of frailty there is emerging evidence that investing in certain activities and lifestyles can restore a degree of function and independence.

In later stages of frailty there is a limit to what can be to be done to reverse the situation but plenty to be done to ensure that an individual's wishes and priorities are respected to enable them to live the best life possible to the end of their lives. A diagnosis of severe frailty should prompt a discussion about someone's priorities and an understanding that interventions may be of limited benefit.

The term frailty should be considered a diagnosis not a description.

2.2 Key Drivers

Ensuring integrated care for older people is a key agenda on international, national and local platforms. The following have been key to driving this case for change in Worcestershire and the development of the ICOPE strategy:

- The World Health Organisation (WHO) - Global strategy and action plan on ageing and health
- National Policy - NHS England drive for integrated care aiming for people to live healthier lives and to receive the care and treatment they need, in the right place, at the right time. The ICOPE programme is driven and inspired by a number of key national documents including:

  - NHS England - Five Year Forward View[1]
  - Kings Fund – Shared responsibility for health: the cultural change we need[2]
  - British Geriatric Society - Position statement on primary care for older people[3]
- Local Policies and Strategies including:
  - Herefordshire and Worcestershire STP Plan[4] – Some of the top priorities within the STP plan are around integration of care and the prevention of illness through encouraging people to live healthier lives. The ICOPE Programme reports to the 3b workstream – Primary Care and Integrated Care
  - Worcestershire Joint Health and Well-being Strategy[5] – Being active at every age focus on older people
  - West Midlands Healthy Ageing Project[6]
  - Worcestershire Director of Public Health Report 2018[7]
- Worcestershire population projections predicting an ageing population
- The experience and opinions of older people in Worcestershire, their families and those supporting them

2.3 Worcestershire ICOPE programme

The Worcestershire ICOPE programme has been developed collaboratively with:

- South Worcestershire CCG, Wyre Forest CCG and Redditch and Bromsgrove CCG
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Health and Care NHS Trust
- Adult Social Services
- Public Health
- Age UK Herefordshire and Worcestershire
- Worcestershire Association for Carers
- Older people representatives

Wider involvement with the general public, community and voluntary groups is essential to the success of the programme and will be at the forefront of our plans moving forwards.

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[1] NHS England, NHS Five Year Forward View, October 2014, https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [accessed November 2018]

[2] Kings Fund, Shared responsibility for health: the cultural change we need, November 2018, https://www.kingsfund.org.uk/publications/shared-responsibility-health [accessed December 2018]

[3] British Geriatrics Society, August 2018, Position statement on primary care for older people, https://www.bgs.org.uk/policy-and-media/position-statement-on-primary-care-for-older-people [accessed December 2018]

[4] Herefordshire and Worcestershire STP, 2017, Herefordshire and Worcestershire STP Plan, www.hacw.nhs.uk/yourconversation/ (accessed November 2018)

[5] Worcestershire County Council, 2016, Joint Health and Well-being Strategy 2016 - 2021, http://www.worcestershire.gov.uk/info/20565/health_and_well-being_board (accessed November 2018)

[6] Public Health England, 2016, Healthy ageing in the West Midlands, https://www.lfphwm.org.uk/our-networks/healthy-ageing-network/573-healthy-ageing (accessed November 2018)

[7] Worcestershire County Council, 2018, 2016-2018 Director of Public Health Report, http://www.worcestershire.gov.uk/info/20122/joint_strategic_needs_assessment/1498/jsna_director_of_public_health_annual_reports (accessed November 2018)

There is a clear ethos among all partners that they need to work together to support our current and future older population, to stay healthy, active and independent. It is envisaged that in order to embed and truly deliver system changes, the ICOPE programme will be delivered over five years and by 2023 the shared visions and aims will be instilled across the system and throughout the wider community.

3.0 Our Vision, Aims and Objectives

3.1 Our Vision

Our vision is to make Worcestershire the best place to live the best life possible in later life.

The World Health Organisation (WHO) tells us that older people want:

1. To have their basic needs met
2. To be mobile and independent
3. To continue to learn, grow and make decisions
4. To build and maintain relationships
5. To contribute to society

To maximise the chances of this happening for older people in Worcestershire we need to radically change how we view older people, their potential contribution to our society and the services available to them.

They need to have the information and resources to be as independent as possible for as long as possible. When they need support and care, that support and care, should be responsive to and appropriate for their wishes and situation.

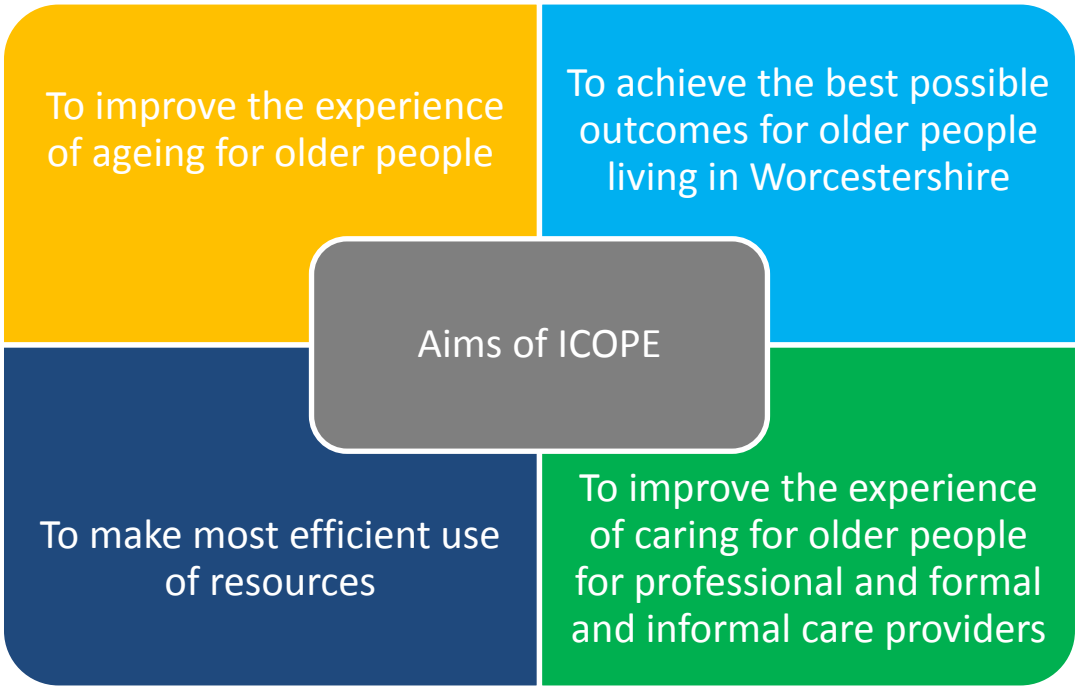
Older People tell us that they want to feel that their care is co-ordinated, that the professionals and services they come into contact with 'join up' around them, that they are known where they go, that they do not have to explain their situation every time.

"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."[8]

3.2 Our Aim

The ICOPE programme utilises the quadruple aim model to ensure the focus of the programme will be on improving older peoples experience, improving the use of resources, improving outcomes and improving professional's experience across the system. In summary the four key aims of the ICOPE programme are:

[8] National Voices, Think Local Act Personal, May 2013, https://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care [accessed November 2018]



3.3 Our Objectives

Underpinning each of the programmes four aims are a number of key objectives outlined below:

Aim 1 – To improve the experience of ageing for older people

By 2023 we will:

1. Improve awareness and understanding of the process of ageing, the nature of frailty as a long term condition and how to maximise functional ability
2. Improve understanding of end of life states and the ability of individuals to express and record information about their wishes and preferences
3. Improve awareness and access to resources and services that will have an impact on older peoples experiencing of ageing

How will we know we have achieved this? We will see the following outcomes:

- Increase in the proportion of older people that are aware of the services and resources
- Increase in the proportion of older people that are able to access services and resources
- Increase in the proportion of older people receiving person centred care
- Increase proportion of older people with a good understanding of the process of ageing, the nature of frailty and quality End of Life care

- Increase use and recognition of 'This is Me' or similar documentation and information[9]

Aim 2 – To achieve the best possible outcomes for older people living in Worcestershire

By 2023 we will:

1. Increased availability of interventions and services proven to have an impact on healthy life span
2. Ensure that a greater proportion of older people will be able to have a dignified and comfortable death

How will we know we have achieved this? We will see the following outcomes:

- Increase in the proportion of older people who are active and independent
- Increased proportion of older people having Advance Care Plan discussions
- Increase in the proportion of older people achieving a dignified and comfortable death in the place of their choice

Aim 3 – To make most efficient use of resources

By 2023 we will:

1. Improved efficiency of resources across the system ensuring that we have the most appropriate people in the right place at the right time
2. Achieve integration of digital systems ensuring that older people, their formal and informal care givers all have access to live information about them, their care and their wishes
3. Reduce duplication and inefficiencies across the system, services and within teams

How will we know we have achieved this? We will see the following outcomes:

- Reduced duplication and repeated collecting of information resulting in improved efficiency
- Reduced inappropriate admission and readmission rates
- Reduced length of time older people stay in hospital when they no longer need to be there
- Reduced rate of older people not returning to their own homes but permanently going into a residential home after stay in hospital

[9] Alzheimer's Society, 2018, This is Me, https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me (accessed November 2018)

Aim 4 – To improve the experience of caring for older people for professional and formal and informal care providers

By 2023 we will:

1. Improve understanding of the current experience of providing care for older people and explore the perceived barriers to quality of support
2. Support the development, education and training of the local workforce of professional, formal and informal carers to increase awareness and understanding on the process of ageing, the nature of frailty and quality end of life care
3. Improved communication between all partners in the system with a shared approach to older people living with frailty
4. Increased emphasis on individual choices to determine right care in the right place at the right time

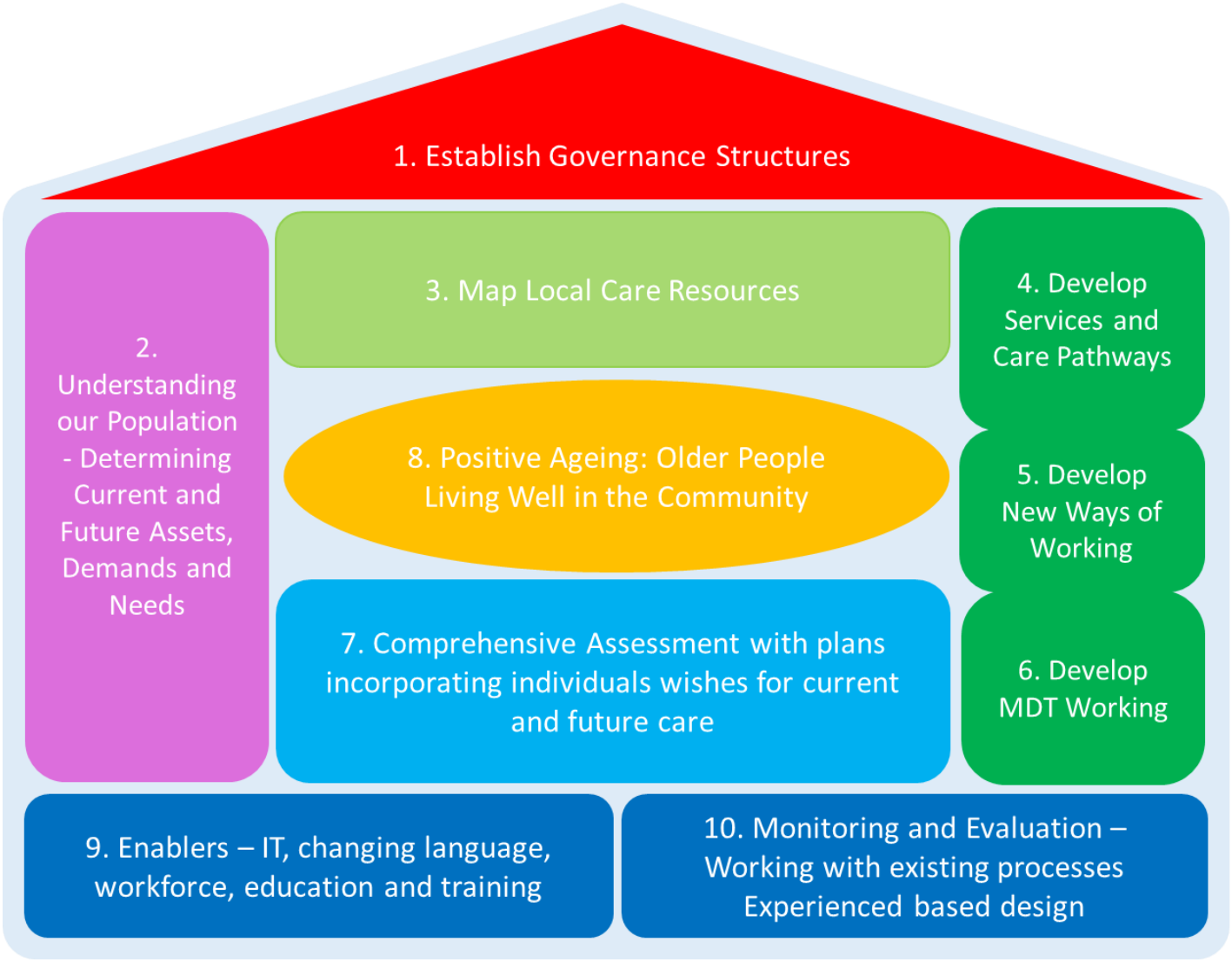
How will we know we have achieved this? We will see the following outcomes:

- One common tool used to identify frailty
- An agreed common ICOPE comprehensive assessment format (ICOMPASS) incorporating future planning discussions
- Reduced duplication and repeated collecting of information resulting in a better experience for those providing care
- Timely and well informed response to an acute deterioration
- Increased numbers of staff who are competent and confident in recognising the need for and initiating End of Life conversations
- Improved experience and job satisfaction of the workforce
- Improved recruitment and retention rates of the workforce
- Improved experience of caring for informal carers

In order to achieve these keys aims and objectives the ICOPE programme will utilise a comprehensive framework of ten building blocks essential to enable integrated care for older people to be implemented, evaluated and sustained. These are outlined in section 4.

4.0 Ten Step Framework

The Worcestershire ICOPE programme will utilise a Ten Step Framework, which sets out the desired direction of travel for the integration of health and social care for older people in Worcestershire, and underpins the programmes implementation plan. Each building block is an essential step towards enabling integrated care for older people to be implemented, evaluated and sustained across the system and to achieve the programmes overall aim. The ten building blocks are outlined below:



4.1 Establish Integrated Governance Structures

Establishing local governance across health and social care (including the third sector) with senior sponsorship is a fundamental starting point on the journey towards integrated care for older people.[10]

Headline approach and intentions - Provide effective cross system leadership for ICOPE:

- Implement an integrated governance structure for ICOPE
- Establish an ICOPE Steering Group with appropriate level of clinical and operational leadership to develop and deliver sustainable change
- Ensure key reporting mechanisms to accountable boards are in place
- Develop and agree an MOU between all partners
- Develop and embed an overarching ICOPE Strategy
- Develop a detailed project plan, based on the ICOPE Strategy, with short, medium and long term goals and establish appropriate Task and Finish groups to undertake actions

An outline of the ICOPE governance structure is available in appendix 1.

4.2 Understanding Our Population

2. Understanding Our Population – determining current and future assets, demands and needs

Population planning describes the demographic and social characteristics of a target population. It is a key component in planning, developing and implementing integrated care for older persons (Kings Fund 2015).[11]

Headline approach and intentions – Identify frailty and determine current and future assets, demand and needs, in Worcestershire:

- Undertake a population analysis exercise to understand and determine what our population is, current and future numbers and where they sit in the system
- Review frailty coding on GP system
- Audit systems and processes across all partners

[10] Jupp, B. (2015) Recognising accountability in an age of Integrated Care, The Nuffield Trust, London

[11] Kings Fund, February 2015, Population Planning - Going Beyond Integrated Care, https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systemskingsfund-feb15.pdf [accessed November 2018]

- Understanding the current contribution older people are making to supporting their peers in the community – assets in the system

4.3 Map Local Care Resources

Mapping of local resources is essential for older people, their support networks and the wider system to understand the community offer and services available and to enable and empower older people to self-manage and live well. Bringing together Worcestershire partners to ensure a shared awareness of local resources and develop a portal for older people and those supporting them to have information available in a straightforward manner that is relevant to their location and requirements.

Headline approach and intentions - Improve understanding of local resources and the community offer in Worcestershire:

- Bring together Worcestershire partners who have their own directory of services to ensure a shared awareness of local resources and develop a portal for older people and those supporting them
- Map Care Homes and associated services
- Create an Older Peoples portal at a Neighbourhood Team level
- Implement a process to ensure information remains up to date
- Undertake a gap analysis of services currently available and resources required to support people living well to delay the onset of frailty to live the best life possible in later life

4.4 Develop Services and Care Pathways

Services and Care Pathways need to be adapted to meet the needs of Older People. It is important to recognise that interventions and services may differ at different stages in someone's life. The approach needs to be in tune with an individual's wishes and preferences whilst ensuring they are appropriate in relation to their intrinsic capacity and life expectancy.

Examples of proactive, reactive and future planning interventions at different severities of frailty can be seen in the Appendix 2.

A care pathway planning exercise will be undertaken to identify services that need to be enhanced and developed and to reduce duplication between services. This process will

involve older people and enable families, carers and support networks to become part of the journey.

Headline approach and intentions - Implement a clear cross partner integrated pathway for people living with frailty ensuring co-production with older people and their supporters:

- Work with older people and those supporting them to develop and enhance services
- Undertake a review of a person's journey through the system to understand where care is currently siloed with the view to reducing duplication
- Maximise opportunities for Comprehensive Assessment (ICOMPASS, outlined in Appendix 3) in the pathway, through the care mapping exercise (link to building block 7)
- Develop an Experience Based Design evaluation to include older people and those supporting them in the development of existing/new services, engage with local people in pathway mapping discussions and ensure co-production approach to service design
- Improve access to interventions proven to have an impact on the development of frailty and the loss of intrinsic capacity
- Undertake a gap analysis of services currently available and resources required to support people living well to delay the onset of frailty to live the best life possible with frailty

4.5 Develop New Ways of Working

Person centred care is defined as care that is respectful and responsive to individuals needs and values, and partners with them in designing and delivering that care[12]. Multi-professional teams will work together to deliver a seamless ICOPE service. Current interventions are reactive in nature and set up to respond at times of crisis. Focus must be upon proactive care that supports older people to remain active and live well for longer.

Headline approach and intentions - Enable older people to live independently at home with the right support and ensure an appropriate reactive response to a deterioration wherever someone is in the system:

- Explore the experience of formal and informal care providers to understand the barriers to those providing care, for older people, and to learn from the excellent care currently taking place. Care will be delivered across the system breaking down organisational barriers
- Develop a consistent approach to older people living with frailty
- Implementation of a single, common frailty screening tool (Appendix 2)
- Embed and implement the 3 conversations model across the system, work with voluntary sector to develop community support

[12] Health Information and Quality Authority (HIQA), 2012, Safer Better Healthcare standards, www.hiqa.ie, [accessed November 2018]

- Secure a timely and well informed response to acute deterioration (maximising the Frailty Assessment Unit and future intentions around Frailty Admissions Unit)
- Devise and implement an approach by which the community Neighbour Teams are alerted of patients as they enter an acute phase

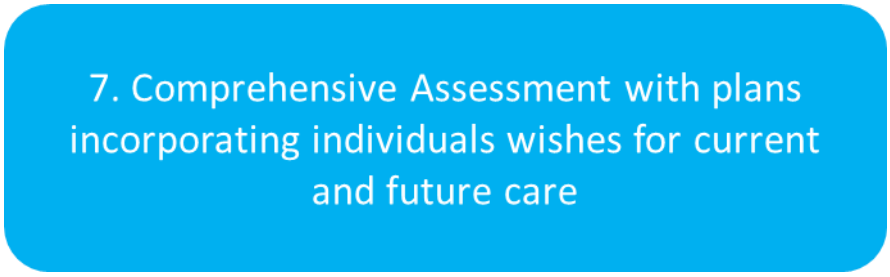
4.6 Develop MDT working

A multidisciplinary team approach is a co-ordinated way of health and social care practitioners and allied workers collaborating to achieve the best outcomes for older people.

Headline approach and intentions - Improve coordination of care, communication and consistency between organisations across the system:

- Develop a multidisciplinary team approach with neighbourhood teams, health and social care and voluntary care professionals working in a coordinated manner
- Use examples of Multidisciplinary Team (MDT) good practice to inform and lead quality improvement measures to ensure best use of the Multidisciplinary Team Meeting (MDTM) format
- Use a comprehensive assessment process to ensure a consistent approach to MDTM discussions
- Ensure standardised datasets are in place to inform an MDT approach (link to building block 7)
- Develop person centred care plans owned by the patient (link to building block 7)

4.7 Comprehensive Assessment with plans incorporating individuals wishes for current and future care



Person centred care planning is defined as care that is respectful and responsive to individual's needs and values. Older people and their supporters will be actively encouraged to become equal partners in planning, developing and monitoring care to meet their current and future needs. Proactive planning will facilitate the earliest possible return to place of residence following an acute episode. Focus will be upon future planning and proactive response to further episodes of deterioration in a managed and supportive way.

Headline approach and intentions - Enable choice and increase control for the older person - recognised care planning including their current and future wishes:

- Design and embed person centred plans incorporating individual wishes for current and future care
- Improve understanding of frailty and its implications by providing information and educational resources for Older people and their formal and informal care providers enabling realistic expectations
- Development of a standard assessment format (ICOMPASS) to ensure that the same baseline information is being collected at all points in the system
- Ensure timely access to an older persons ICOMPASS dataset and their previously expressed wishes at every interface of care to improve the use of clinicians time and to ensure an appropriate reactive response at a time of deterioration
- Raise awareness of the importance of having an informed Health and Welfare Attorney and the ability to express and record their wishes
- Ensure that Advance Care Planning discussions, supported by the ReSPECT process, become a routine part of practice to encourage people to express their priorities about end of life care
- Encourage the use of 'This is Me' or similar method to record a person's interests, wishes and preferences

4.8 Positive Ageing

As the number of older people in society increases the construct of ageing is being revisited. Getting older should be seen as a time of opportunity with society and communities benefitting from the skills, generosity, and experience of older people. The factors that influence successful ageing are multidimensional. The way older people perceive themselves and how they are viewed by others can have a measurable effect on health and wellbeing and their ability and reliance on services as they near the end of their life. Actively encouraging older people to stay fit and healthy and age well is key to addressing some of the health and social care issues that arise from an ageing population. There is evidence that modifying life style can delay and even prevent the development of dementia Disability and frailty in later life[13]. The World Health Organisation describes this in terms of maintaining Functional Ability through improving Intrinsic Capacity or altering the environment[14].

WHO Healthy Ageing

[13] NICE, 2015, Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset, www.nice.org.uk/guidance/ng16 (accessed November 2018)
[14] J.P. Michel a,b,*, C. Dreux b, A. Vacheron (2016) Healthy ageing: Evidence that improvement is possible at every age, European Geriatric Medicine 7 (2016) 298-305

The WHO defines Healthy Ageing "as the process of developing and maintaining the functional ability that enables wellbeing in older age". Functional ability is about having the capabilities that enable all people to be and do what they have reason to value. This includes a person's ability to:

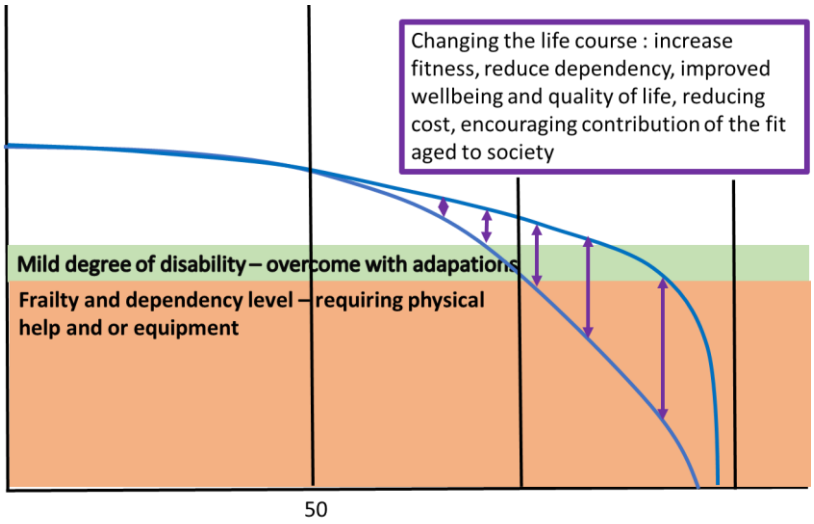
- meet their basic needs
- to learn, grow and make decisions
- to be mobile
- to build and maintain relationships
- to contribute to society

Functional ability is made up of the **intrinsic capacity** of the individual, **relevant environmental characteristics** and the interaction between them.

Intrinsic capacity comprises all the mental and physical capacities that a person can draw on and includes their ability to walk, think, see, hear and remember. The level of intrinsic capacity is influenced by a number of factors such as the presence of diseases, injuries and age-related changes.

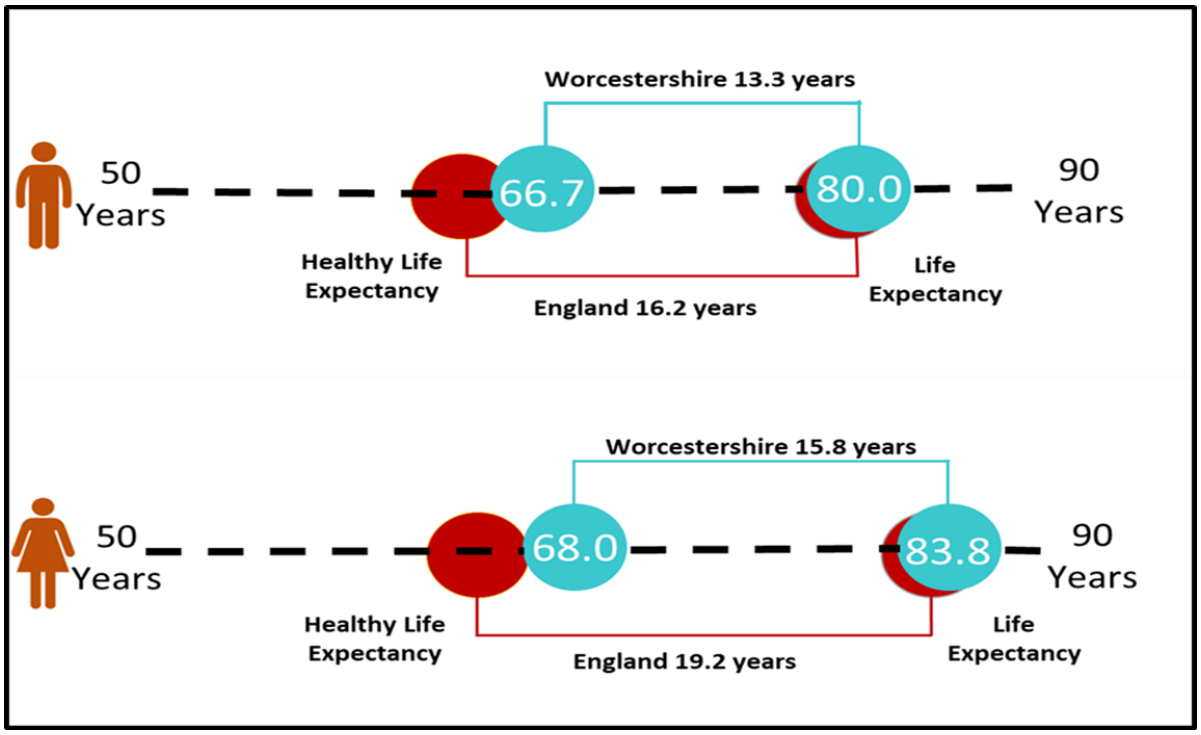
Environments include the home, community and broader society, and all the factors within them such as the built environment, people and their relationships, attitudes and values, health and social policies, the systems that support them and the services that they implement. Being able to live in environments that support and maintain your intrinsic capacity and functional ability is key to Healthy Ageing.

Enabling people to understand how to maximise their functional abilities and encouraging them to do this has the potential to reduce the demand on health and social care budgets over time. This will be achieved when higher levels of capability are maintained for longer without adding significantly to life expectancy. Reducing an older persons time with functional loss i.e. compressed functional decline, allows for all the associated benefits of a more engaged and active older population[15]. An example of this potential to compress function decline can be seen in the graph below:



[15] Gore PG, Kingston A, Johnson GR, Kirkwood TBL, Jagger C (2018), New horizons in the compression of functional decline, Age and Ageing, Volume 47, Issue 6, 1 November 2018, Pages 764–768

The gap between life expectancy and healthy life expectancy shows how much of a population's life is spent in good health. Improving this ratio will be key to understanding our health systems sustainability and can demonstrate a real shift towards healthy ageing across the system:



The NHS has a duty to narrow health inequalities and to improve health and wellbeing. Although average measures of health and wellbeing are generally better in Worcestershire than England, we are aware that inequalities can be masked. We recognise that there are persistent health inequalities between groups of people, significant differences between deprived and non-deprived areas, a rising burden of avoidable illness and increasing numbers of older people living in poor health. Addressing health inequalities and improving the health of disadvantaged people will require targeted work with those with greatest need.

Headline approach and intentions – Increased and common understanding of the abilities, potential contributions as well as the needs of older people amongst professionals, across organisations and to the wider public. Working with the University of Worcester, Active Ageing, to understand the impacts of physical active on intrinsic capacity:

- Establish a public forum to ensure the voices of local people are listened to and to encourage the sharing of messages
- Work with the University of Worcester's School of Sport and Exercise Sciences and Sports Partnership to understand the barriers and motivators for undertaking activity in later life
- Improve understanding of the process of ageing by providing information and educational resources for Older people and their formal and informal care providers
- Improve availability and access to opportunities and interventions proven to improve functional capacity and compress functional decline
- Build a compassionate community model focusing and planning for active living/living well, encouraging active participation and contributions from older people

- Improve understanding of how to maximise functional ability by providing information and educational resources for older people and their formal and informal care providers
- Embed Making Every Contact Count (MECC) principles and training and empower and support people to make healthier choices - Improving fitness and healthy eating
- Embed self-management support through working with the voluntary sector to develop community support
- To understand accessibility challenges, such as transport, and to explore new ways of working to combat these such as Skype

4.9 Key Enablers

9. Enablers – IT, changing language, workforce, education and training

Integration of care is only possible through communication and sharing of patient information. This needs to be made available to many different professionals in different locations working within integrated care teams. In order to embed ICOPE across Worcestershire, effective information sharing is a critical success factor. Existing and new technologies will be exploited to enable clinical information sharing across settings, coordination of care and support of older people to live well. Alongside this a local workforce strategy will be developed that includes education and training for all professionals across the system to reflect the needs of older persons.

Health and social care professionals often use language which can alienate others, including those working outside of these professions. Language has developed over the years which is not helpful when describing an older person's situation at the time of an acute deterioration or when they are approaching the end of their lives. We need to ensure that we are all speaking the same appropriate language to support our ultimate aims of improving experience and outcomes for older people.

Headline approach and intentions - Ensure integrated IT systems are implemented. Ensure there is a common language and understanding of the needs of older people amongst professionals and frailty is embedded as a specialism to all those that need:

- Review the availability of current equipment and investigate the role of new technologies
- Implement an integrated IT solution across all partners which enables transparency and seamless working and enable the timely electronic transfer of information between care providers
- Enable an older person to access to information about them electronically that can be shared with care providers at interfaces of care to ensure they tell their story only once

- Develop and implement a local workforce plan to include education, awareness and training for professionals on how to support older people living with frailty and the impact of frailty on the system
- Develop and implement a robust communications and engagement strategy
- Changing language with a view to changing the culture of care for older people e.g. talking about future planning rather than discharge planning

4.10 Monitoring and Evaluation

10. Monitoring and Evaluation – working with existing processes, Experience Based Design

Measuring the impact of integrated care can be a challenging task. When multiple health or care improvement activities are in place in one area, it is not always clear which parts improve outcomes and which do not. There is not always a straightforward link between improvements in reported outcomes and changes in the way services are delivered. To attempt to measure any qualitative or quantitative outcomes for any health care programme it is essential that reliable baseline data exists. Measures need to be developed across systems and teams.

Headline approach and intentions: Embed the 10 step framework across all health and social care providers in Worcestershire. Put an outcomes framework in place to measure each of the 10 steps of the integrated care programme:

- Develop an outcomes framework for each building block
- Develop ICOPE tools to measure progress of structural and process measurements
- Develop ICOPE tools to measure clinical outcomes of older people
- Develop ICOPE tools to measure older people and carers experiences
- Develop ICOPE tools to measure staff experience

5.0 Communications and Engagement

The ICOPE communication and engagement plan will be integral to the development of the ICOPE programme and realisation of its vision.

5.1 Our Key Stakeholders

The ICOPE programme aims and objectives can only be achieved when all partners across the system work together and commit to making Worcestershire the best place to live well in later life.

A short exercise in stakeholder mapping was undertaken in the initial phases of the ICOPE Strategy, this identified a broad range of stakeholders outlined in Appendix 4.

The following stakeholders were identified as being integral to the development of the programme and have been invited to be members of the ICOPE Steering Group. The ICOPE Steering Group was established in September 2018 and meets on a four weekly basis. The Terms of Reference of the Steering Group are available in Appendix 5.

ICOPE Steering Group Members

Older Peoples Voices

- Older person representative

Commissioners

- Worcestershire Clinical Commissioning Groups
- Public Health - Worcestershire County Council
- Adult Social Care - Worcestershire County Council

Providers

- Worcestershire Acute Hospitals NHS Trust
- Worcestershire Health & Care NHS Trust
- West Midlands Ambulance Service
- Care home representatives
- Primary Care

Voluntary sector

- Worcestershire Association of Carers
- Age UK Herefordshire and Worcestershire

Other stakeholders have also been identified such as local charities, care homes, voluntary groups, support groups etc. and these will be invited to attend future stakeholder events.

Regular communications and engagements will be made to all stakeholders through a variety of mediums including:

- Stakeholder briefings providing regular updates on the programmes progress
- News releases issued to the local media at key milestones in the programme
- The establishment of web information – Directory of Services
- Social media
- Events and meetings
- Involvement of older people and their support networks – Experience Based Design

- Attendance at meetings convened by internal and external groups and organisations including, but not limited to, GP Advisory Forums, divisional and departmental meetings, HOSC, Health and Wellbeing Board, Local Medical Committee, Patient support groups, Healthwatch, etc.

5.2 Engaging Older People and their Support Networks

Older people and their support networks will play a vital role in the development, implementation, delivery and evaluation of the ICOPE programme.

The programme will utilise an Experience Based Design (EBD) methodology to engage older people, staff and carers to transform services. EBD will enable the programme to capture, understand and use the actual experiences of those receiving and delivering care across the pathway. This will also form a key outcome measure for the programme.

5.3 Engaging Our Workforce

Engaging staff in the co-production and implementation of ICOPE is vital. Staff are instrumental in developing integrated care, changing the culture of language and breaking down organisational barriers. A workforce strategy will be produced as a key component within the 10 step framework and will include a variety of joint training and education opportunities for staff across the system.

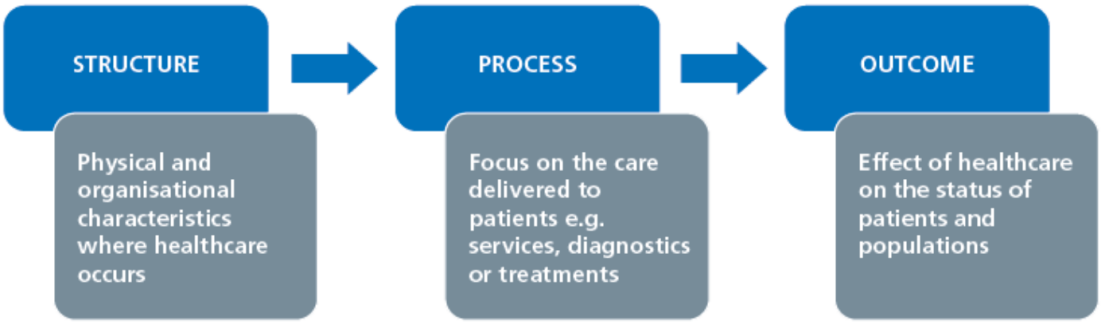
6.0 Outcomes Framework

Measuring the impact of integrated care is a challenging task. When multiple health or care improvement activities are in place in one area it is not always clear which parts improve outcomes and which do not. To attempt to measure any qualitative or quantitative outcomes it is essential that reliable baseline data exists and establishing this will be a key milestone for year one of the programme. Measures need to be developed across the system, services and teams involved in the programme.

A logic model has been developed based on the programmes aims and objectives to assess the anticipated local outputs and anticipated outcomes. The programmes initial draft logic model is outlined in Appendix 6 and demonstrates the relationships between the programmes key components of change and the overall vision.

The programmes logic model will be used as the basis for an evaluation framework. The evaluation framework will develop measures to assess the impact of integration. Different types of measurements will be used and these can be broken down into the measurement categories in diagram 1. Each type of measure has a different purpose in determining whether the programme has achieved the desired impact.

Diagram 1



Outcome measures are of key importance; these reflect the impact on older people and demonstrate the end result of the ICOPE programme and whether we ultimately achieve our aims. In order for us to be confident that the changes actually occurred in practice and consequently link the improvements to this programme it is also key to measure structural and process measures. These measures can be beneficial in determining effective change and action in the short term, particularly when an intervention is complex or where outcome measures can take a long time to determine. Below is an example of some of the structural, process and outcome measures that will be used to evaluate the programme:

Structure

- Governance Structures and reporting in place
- Directory of Services for Older people is live
- Population planning is completed
- Standardised baseline set

Process

- Discharge destinations
- Number of interventions delivered to the older person
- Number of clinical contacts during an emergency admissions

Outcome

Clinical Measures

- % of patients living with frailty who are admitted to secondary care inappropriately
- Higher proportion of patients aged 65 + screened for frailty
- % patients aged 65 years and over attending ED

Older People Measures

- Experience based design
- Number of patients satisfied or very satisfied with their service – utilising key touchpoints
- Higher proportion older people with person centred plans and recorded wishes for future care

Staff Experience Measures

- Staff satisfaction

Balancing measures will also be considered when evaluating the programme to assess the unintended and/or wider consequences of changes.

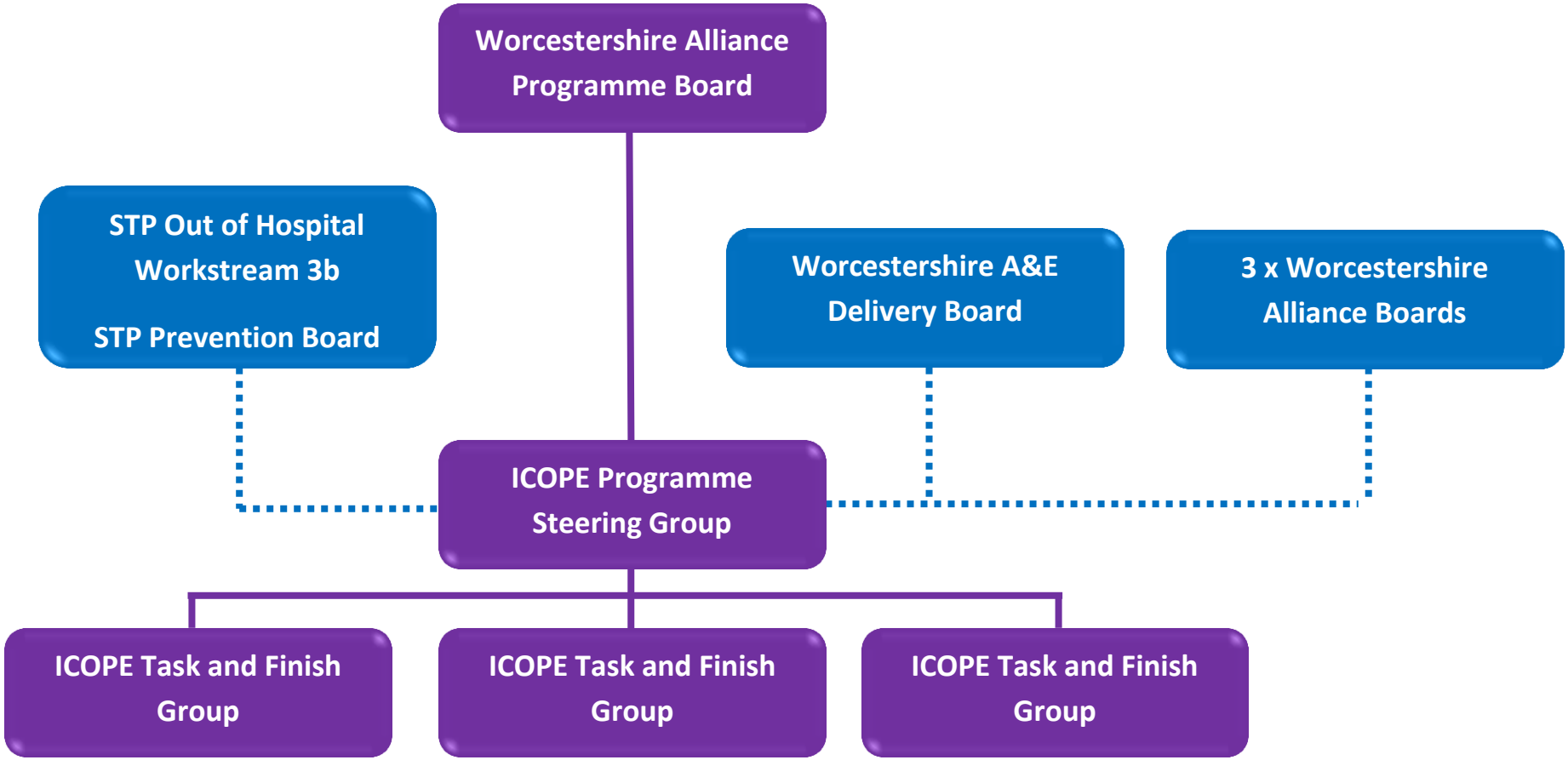
7.0 Summary

Faced with an ever-increasing ageing population, we need to rethink old age, and move from a reactive approach, responding at times of crisis, to more focused proactive care that supports older people to remain active and live well for longer. Establishing an integrated system wide approach is fundamental to tackling this challenge.

Worcestershire partners are committed to work together in a joined up way, innovatively using technology and new ways of working to support integration to effectively respond to older people's needs. It is recognised that in order to embed and truly deliver system changes the ICOPE programme will be delivered over five years and by 2023 the shared visions and aims will be instilled across the system and throughout the wider community.

Appendices

Appendix 1: Governance Structure



Appendix 2: Rockwood Clinical Frailty Scale and Modified Approach to Frailty Dependent on Severity

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.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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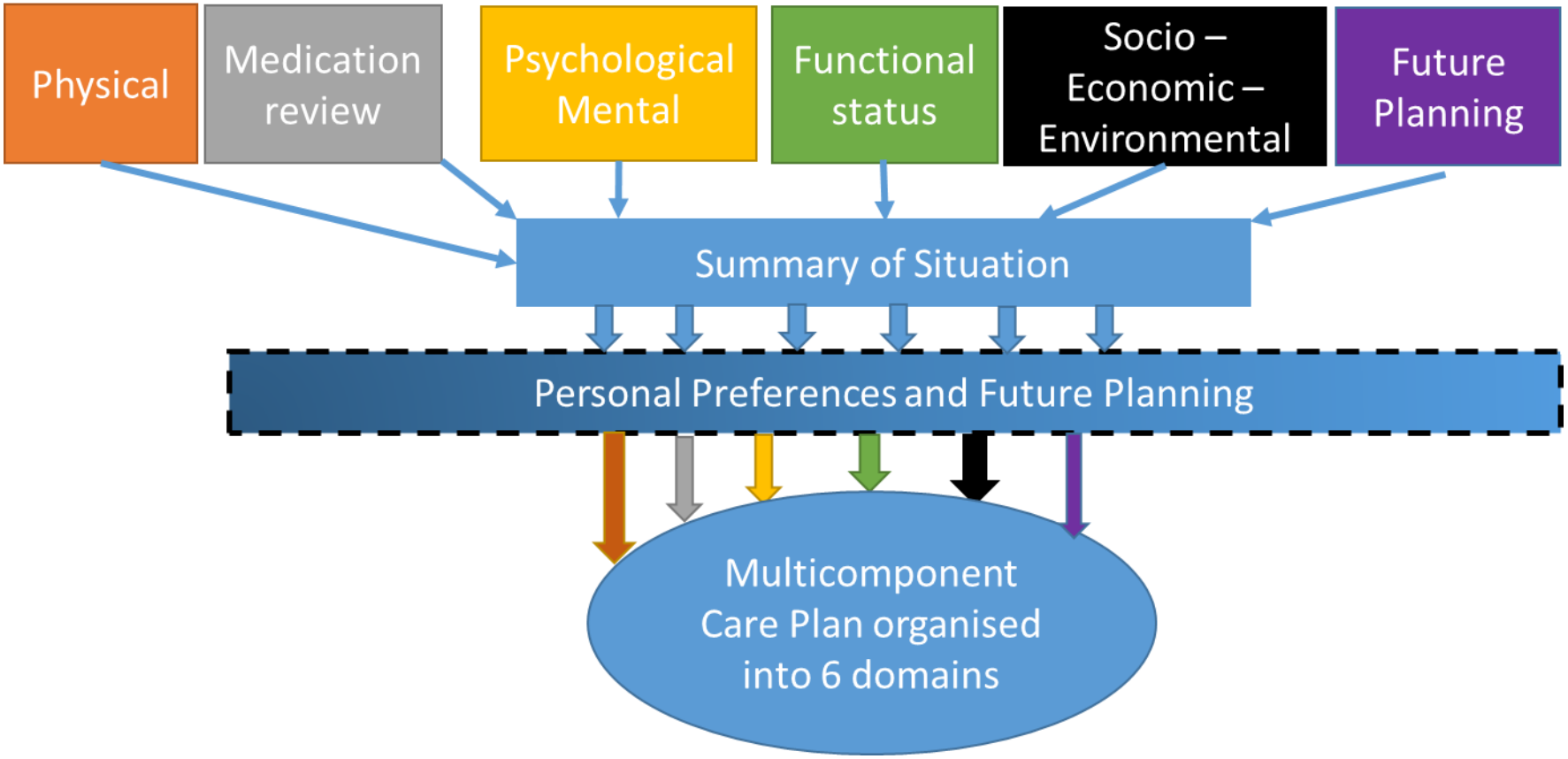
	Pre-Frail	Vulnerable and Mild Frailty	Moderate Frailty	Severe Frailty
Rockwood Clinical Frailty Score	1-3 	4-5 	6 	7-9 
Proactive Assessment	* Healthy Ageing Advice * Life style changes to improve diet and improve core strength and balance * standard approach to LTCs * supported self-management of LTCs	* Healthy Ageing Advice * Life style changes to improve diet and improve core strength and balance * modified approach to LTCs in keeping with priorities * supported self-management of LTCs * consider advance care planning options as part of life style choices	* Life style changes to improve diet and improve core strength and balance * supported self-management of LTCs * comprehensive assessment and future planning * Modified approach to LTCs in keeping with priorities	* Comprehensive Assessment and prioritised planning * Medication optimisation and discontinuation of inappropriate medication * Future planning

		discussions		
Appropriate Reactive Response	* Priority sustaining life * Rapid hospital transfer for assessment * High intensity interventions	* Priority sustaining life * Rapid hospital transfer for assessment * High intensity interventions * Consider advance care planning in discharge	* Priority and actions dependant on previously stated wishes or best interest decision * Comprehensive assessment at usual place of care or starting at the front door if transferred to hospital * Admission and interventions only if felt benefit would outweigh burden * Discussion re future planning prior to discharge	* Priority and actions dependant on previously stated wishes or best interest decision * Priority likely to be comfort and dignity rather than sustaining life * Comprehensive assessment at usual place of care or starting at the front door if transferred to hospital * Admission and interventions only if felt benefit would outweigh burden * Discussion re future planning prior to discharge
Future Planning	* Independent and self-managed * Early discussion if diagnosis of dementia	* Independent and self-managed * Early discussion if diagnosis of dementia	* Future planning routinely included in Comprehensive assessment	* Future planning routinely included in Comprehensive assessment

Appendix 3: Components Comprehensive Assessment – ICOMPASS

Components of COMPrehensive ASSessment



Appendix 4: Stakeholders

List of all stakeholders:

• ICOPE Partners – WHAT, WHCT, WMAS, WCC, Public Health, Age UK, Carers Association, Worcestershire CCGs • Workforce • Sustainability and Transformation Plan (STP) – 3b Workstream • Workforce • A&E Delivery Board • Worcestershire Programme Alliance Boards • 3 x Worcestershire Alliance Boards • Police, Fire and Rescue – Health and Wellbeing Checks • Practice Nurse Forums • Health Overview and Scrutiny Panel (HOSC) • Health and Wellbeing Board (HWB) • LMC and local GPs • Out Of Hours – Care UK • Healthwatch • SW Healthcare • Local Prescribing Committee (LPC) • WODA • Neighbouring CCGs • University of Worcester – Active Ageing • Sports Partnership • Older People • Older People Advisory Group • Care Homes • WHIN • Practice Nurse Forums • GP Practice PPG Groups • Patient Advisory Group (PAG) • Hospices • Worcester Telecare	• NHS England • Neighbourhood Teams • Academic Health Science Network(AHSN) • STP: Clinical Reference Group (CRG) • Local Workforce Action Boards • NHS England • RCGPs • British Geriatric Society (BGS) • CEPNS Community Education Provider Networks	• Local Media • Local MPs • Local Charities • Dementia Organisations • Parish Councils • Local Councillors • District Councils • Community Transport • 3rd sector/voluntary groups • Rotary/WI/Probus/Roundtable – etc. • Older Peoples Support Groups • Uni Third Age (U3A) • Worcester Telecare • Domiciliary Care Providers Meeting • Local Churches and community resources •

All the programmes stakeholders have been mapped into a grid in order to understand their interest and influence over the programme. This grid will be used as a basis for establishing frequency and method of communication for all stakeholders in the future.

Appendix 5: ICOPE Steering Group Terms of Reference

ICOPE

Integrated Care for Older People in Worcestershire

ICOPE Programme Steering Group

Terms of Reference

Background

The overall population of Worcestershire is 583,100 with 128,000 residents aged over 65 years and 6,439 residents over 90. Demographic shifts over the last few years have seen the ageing population increase with particular increases in residents over 90 years. It is projected that there will be a population increase of circa 39,000 in Worcestershire by 2027, of which more than 50% will be over the age of 65. The gap between life expectancy and healthy life expectancy means that people are living longer but in poorer health. Currently this gap is 15.8 years for women and 13.3 years for men across Worcestershire.

Worcestershire partners need to work together to support the older population to stay healthy, active and independent. Current interventions are reactive in nature and set up to respond at times of crisis. Focus must also be upon proactive care that supports older people to remain active and live well for longer. The development of contingency plans for when a crisis occurs will delay the progression of frailty and effectively support older people and their carers to take responsibility for their own changing (and challenging) circumstances, empowering the population. There is a need for Worcestershire partners to work together in a joined up way, innovatively using technology and new ways of working to support integration and in order to effectively respond to older people's needs wherever and whenever they are likely to come into contact with services.

The ICOPE Programme will be developed directly from the ICOPE Strategy and will provide focus for core deliverables across a complex programme of work.

Purpose

The ICOPE Steering Group will set the direction and vision for the service redesign, planning and delivery of care for Older People in Worcestershire.

The ICOPE Steering Group is responsible for:

Setting the objectives and whole system work programme of the frailty network.

Overseeing the execution of the objectives and strategy for the ICOPE Programme, as agreed with Worcestershire Alliance Programme Board

Determining practical solutions in order to deliver the ICOPE Programme across partners in Worcestershire

Working across service boundaries in Worcestershire, upholding the aims of the new models of care being developed – enabling organisations to interact and support each other

Providing cohesive leadership across the system to help the health and social care economy improve the experience of people living with frailty and those at end of life and their families and carers

Establishing appropriate levels of authority and accountability for work to be undertaken to improve care and support for people living with frailty and those at end of life across the health economy

Acting as a conduit for information about frailty and end of life care in the health and social care economy to ensure the direction is clear and consistent

Reducing the number of people who are living with frailty who attend and are admitted to secondary care inappropriately

Membership

The ICOPE Programme Steering Group will comprise of key leads from each part of the health and care system across Worcestershire. The ICOPE Programme Steering Group will be chaired by the ICOPE Clinical Strategic Lead – which aims to be representative of all parts of the Worcestershire health and care system.

Core ICOPE Programme Steering Group Membership
ICOPE Clinical Strategic Lead – Maggie Keeble (CHAIR) – CCGs/WHCT/WAHT
WCCGs ICOPE Lead – Associate Director of Transformation and Delivery – Andrea Guest
ICOPE Programme Co-ordinator – Tracy Meadows (WCCGs)
WHCT ICOPE Leads – Jan Austin and Jo Jones
WAHT ICOPE Leads – Jane Ball, Jenny Garside, Donna Kruckow
WCC Social Care Leads – Richard Keble, Nikki Rouse
WCC Public Health Lead – Rachael Leslie, Matthew Fung
WMAS Lead – Jenny Sears-Brown
Older People Representative – Beryl Quennell
Worcestershire Association of Carers Lead – Mel Smith
Age UK Herefordshire and Worcestershire Lead – Jane Longmore
South Worcestershire GP Lead – Nicole Burger
WCCGs – Admin Support – Jess Bryant

Reporting Arrangements

The ICOPE Programme Steering Group will operate by consensus.

The Steering Group, whilst not a formal decision making body, will make recommendations to the Worcestershire Alliance Programme Board and will present at the Board on a quarterly basis with a programme update. The programme will have close links with the 3 Alliance Boards to ensure priorities align across Neighbourhood Team development with the Strategic Clinical Lead representing Alliance Board Chairs and communicating accordingly.

The ICOPE Programme Steering Group will ensuring reporting is undertaken to the following forums:

A Programme Highlight Report will be generated via Verto and submitted to Worcestershire Alliance Programme Board on a monthly basis

The same Programme Highlight Report will be submitted to STP 3B Out of Hospital workstream and AEDB for information purposes only, on a monthly basis

The same Programme Highlight Report will be submitted to each of the 3 Worcestershire Alliance Boards on a monthly basis

Reporting in person to Worcestershire Alliance Programme Board and the three Worcestershire Alliance Boards on a quarterly basis or as requested

Meeting Quoracy

The meeting shall be deemed quorate when there is at least one representative from each of the following organisations this should include at least one clinician:

- Worcestershire CCGs
- Worcestershire Health and Care Trust
- Worcestershire Acute Hospitals NHS Trust
- Worcestershire County Council

The ICOPE Programme Steering Group will meet:

Four weekly – face to face

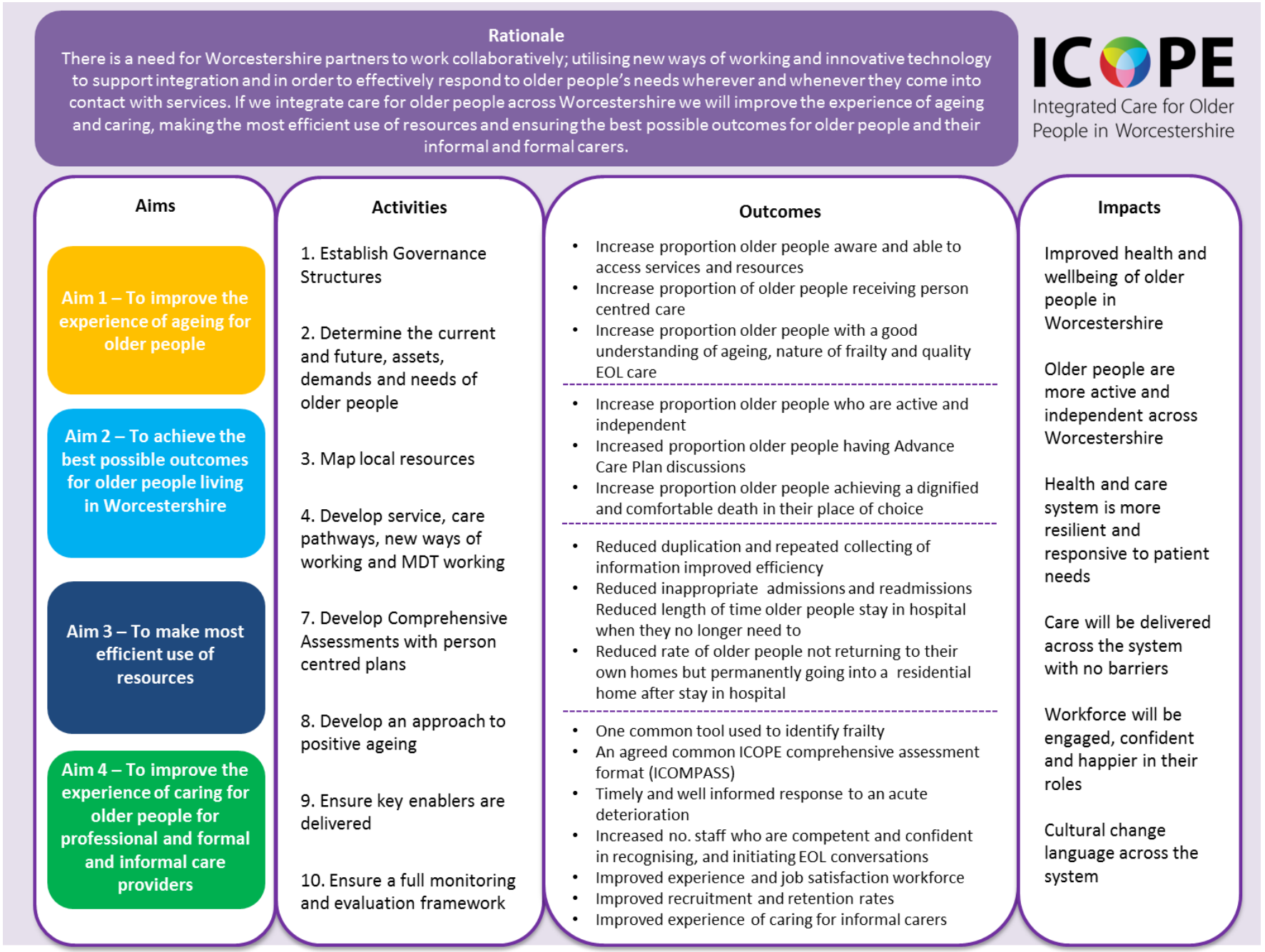
Administration

The Worcestershire CCGs will provide administrative support to the ICOPE Programme and ICOPE Steering Group. Action notes will be produced and circulated within 5 working days of executive meetings.

Communication

A written stakeholder brief will be prepared on a monthly basis with key messages and progress. The ICOPE Programme Steering Group will agree the stakeholder distribution list and communication requirements and review on an on-going basis in order to maximise comms. ICOPE Steering Group Members will be responsible for communicating progress to include in the stakeholder briefing. ICOPE Steering Group members are responsible for ensuring communications within their respective organisations.

Appendix 6: Programme Logic Model



Glossary

EBD	Experience Based Design – A method of capturing Patient/Service Users experiences
ISAX	Ireland Smart Ageing Exchange
ICOPE	Integrated Care for Older people
IT	Information Technology
HIQA	HIQA is an independent authority that exists to improve health and social care services for the people of Ireland. Acute and Community Healthcare Services.
HOSC	Health Overview and Scrutiny Committee - To review and scrutinise matters relating to the planning, provision and operation of health services
ICOMPASS	ICOPE Comprehensive Assessment – A well-recognised format for the collecting of information about individuals medical, psychological, functional, social and environmental factors as well as future planning
LMC	Local medical Council
Logic Model	Logic modelling is a tool that can be useful in the development of monitoring and evaluation plans as they help to identify short-, medium- and long-term outcomes that are linked to the key activities of a programme or strategy
MDT	A Multidisciplinary Team (MDT) is a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions
MOU	A **memorandum of understanding** (MOU) is a nonbinding **agreement** between two or more parties outlining the terms and details of a partnership, including each parties' requirements and responsibilities.
Neighbourhood Teams	Local neighbourhood teams work across the county. Neighbourhood Teams will bring together Community Nurses, Enhanced Care Teams, Promoting Independence, Community Therapists and other closely aligned services to work in a more collaborative way with social care and GP colleagues. The teams will wrap around their identified cohort of patients who are vulnerable or at greater risk of hospital admission. By providing more proactive and responsive support the aim is to keep people well at home for longer.
ReSPECT	ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.
Worcestershire Alliance Boards	The three Worcestershire Alliance Boards, South Worcestershire, Redditch and Bromsgrove and Wyre Forest. Each Alliance Board is a partnership of commissioners and health and care providers who have come together to deliver more joined-up community care, predominantly for older people living with frailty, who are vulnerable to sudden deterioration.