# BORDERLINE & PETERBOROUGH SYSTEM OUTCOME SPECIFICATION OVERVIEW

**Draft V1A**

**The purpose of this High Level Outcome Specification is to give Providers an early indication of Commissioner intentions, and to seek Provider feedback in general**

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# 1. Demographic background

Peterborough has a relatively young population compared to the national average. Based on 2010 figures the population aged 65+ is set to rise by 34% by 2024 (an increase of 8,300) and by 57% for people aged 85+ by 2024 (an increase of 1,700).

Peterborough's older population has relatively high levels of deprivation which is a significant risk factor for poor health and demands on health and social care services. In 2013, the overall percentage of people aged 65+ affected by deprivation in Peterborough is 25.8% compared to a CCG rate of 15.7%.

By contrast Borderline LCG areas older population sits within the national average and the population is relatively wealthy. The challenges for meeting the needs of frail elderly in Borderline are rurality and managing the interface with three local authorities; Peterborough, Cambridgeshire and Northamptonshire.

# 2. Vision

The vision for Borderline & Peterborough LCGs integrated care is a whole system model of care. It reaches from upstream information and advice/support services through to sub-acute care in the community and the front door of the acute hospital. It is acknowledged that patients may not progress in a linear way through the Model and can access services based on the presenting need at that time. The vision will be achieved through:

- enabling strategies
- tackling the various stages of the pathways with targeted initiatives

# 3. Principles/Outcomes

The older people programme has identified the following programme outcomes:

- Improvement in patient experience measures as care provided with services organised around the patient
- A reduction in avoidable emergency admissions, re-admissions and extended stays in acute hospitals (including delayed transfers of care)
- An increase in the % of frail older people cared for "out of hospital" and improvement in quality of these services
- Better partnership working between different parts of the health and social care system and other partners
- The above delivered within the identified budget

The main principle for the Borderline and Peterborough LCGs integrated model is 'get it right first time' to ensure timely access to the right service at the right time.

Further principles include:

- Holistic care that meets the general and mental health needs of older people
- Coordinated assessment and care planning to meet the holistic needs of older people

- The system of care and support for this cohort of patients sits within a wider context of up-stream prevention and early intervention

The integrated care model focuses on working across organisations for the benefit of patients/people who use the services. We believe that true integration is a about a way of working rather than about organisational structures. The Borderline and Peterborough LCGs believe that integrated community services, for this group of patients, include:

- Alignment of strategic planning across the NHS and the local authority that spans upstream information and advice to the general population through to downstream sub-acute services
- Whole system commissioning requiring the alignment of resources and commissioning intentions
- Seamless delivery of services across health and care domains provided by public, third or private providers

## 4. Target population

The target population for the integrated community service model in this specification are persons who have one or more of the following needs:

- health and care needs associated with ageing
- co-morbidities, including organic and functional mental health needs
- high level dependencies for activities of daily living
- at risk of admission to long term care or acute hospital.

The age of 75+ is a guide but not a restricting factor. More important are the presenting needs of the individual.

## 5. Scope of services

The scope of services is not yet firmly decided. Services likely to be included are:

- Acute unplanned
- Mental health
- Most adult community services
- Other services eg EOL

## 6. Key areas of focus

Key areas of focus include:

- Extend MDTs including:
    - Manage the assessment and coordinate the care of frail elderly registered within one or more GP practice/s
    - Support people to manage their health and care needs in their own homes by exercising self-management, choice and control where possible

  - Use of telecare and telehealth to support self-care
- Ensure intermediate care:
  - Focus on therapeutic interventions
  - Admission avoidance to long term care
  - Reablement to reduce dependence on high intensity, long term home support
  - Therapeutic interventions to facilitate early discharge from acute hospital
  - Assess for aids and adaptations in the home
  - Manage interim beds
  - 7 day working
- Focus on sub-acute services:
  - Focus on clinical care eg IV anti-biotics, catheterisation
  - Manage patients in the community (including care homes) at risk of hospital admission
  - Assertive in-reach to ED and MAU to avert admission
  - Manage interim beds
  - 7 day working
- Create voluntary sector alliance to coordinate vol orgs
- Create Single point of access:
  - Enable timely and easy access to the right service
  - SPA to be developed for:
    - Third sector information, advice, prevention and early intervention services
    - Multi-disciplinary teams
    - Intermediate care
    - Sub-acute care
- Institute Single Assessment Process:
  - integrated assessment of individual need
  - care coordination
  - individual service planning
  - Third sector prevention and early intervention services can initiate the SAP

## 7. Key dependencies

Due to the financial circumstances at PSHFT, Monitor has sent in a Contingency Planning Team to assess the viability of the Trust and potential future options. Monitor will decide what course of action to take which will take several months to determine. There is a potential significant impact on the Older People programme which will need to be risk assessed at each stage as greater clarity emerges.