North Tyneside Health and Social care Integration Programme – Programme Board Update

Board Name	Older People	Board Representative	Lesley Young-Murphy	Date of Update	November 2015

Objective	Action(s)	Start Date	End Date	Current Position / Issues	Key Issues for Older People's Board 9.11.15
CarePoint – establish a 24/7 enhanced access point to ensure that "1 contact is all it takes from the referrer"	Design and implement revised referral protocols	Apr 15	Sep 15	Work is under way to establish computer access protocols and information sharing agreements; develop multi-agency referrals forms; and investigate secure email. Direct referrals between hospital ward staff and reablement are now in place. Direct referrals between OTs and reablement are planned. Pathways from NSECH to NTGH and Newcastle Hospitals have been reviewed	Systemwide "sign off" of pathways and protocols. Resolution of arrangements around social care staff and ongoing project management.
	• Bring together AART, Hospital to Home, hospital social work, and reablement services as a multidisciplinary team, operating from a single location	Nov 15	Dec 15		
	Project Group to recommend a plan for Phase 2, covering additional services (including voluntary sector) and integrated management arrangements	Dec 15	Jan 16		Discussion and agreement to the scope of this work needed on 9 November 2015
Commission **an agile, interoperable technological solution** (which is interoperability compliant) for North Tyneside which in real time facilitates matching the needs of older people against currently commissioned services	Older Persons Programme Board to consider a Project Initiation Document		Sept 16	Agreed the piece of work with an external provider needed to take a different approach.	
	CCG to convene a meeting to agree a service specification and an immediate low-tech solution within existing capabilities		Nov 15	Meeting arranged for mid November to maximise current information exchange and communication methods. Good system wide ownership and existing forums through which to progress the work.	Assurance that the correct people are involved and that this work is prioritised by all partners.
Review existing Intermediate Care and Rehabilitation beds with a view to moving to a locality based model of service provision commissioned from the independent sector.	Phase 1: Analysis of current usage and develop future optiaons	Aug 15	Nov 15	Commencement of this project was delayed from April 14 to Aug 14 to take account of the impact of opening of NSECH Analysis work underway.	Full system wide sign up. Timeframe does not allow for any change in provision over 15/16 winter. System response to possibility of emergency closure of The Cedars.
	Phase 2: Working Group recommendation of future service model, with full option appraisal and cost benefit analysis	Dec 15	Jan 16	Accuracy and availability of information.	
	Phase 3:Commissioning and delivery of agreed service model.	Jan15	April 16	Six month notice of any change would be good practice.	.
Optimise the effectiveness of the home based **Reablement Support service**,	Phase 1:Agree and report metrics for throughput and outcomes		April 16	Metrics routinely reported. Skill mix review on track.	

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by reviewing the skill mix within the term					
	Phase 2: Consider to consider recommendations for the further development of the service following evaluation.	Apr 15	Jan 16		For agreement at January 2016 mtg.
Optimise the use of Volunteers, reducing the reliance on statutory services:	Undertake a strategic review of volunteer programmes across health and social care	Aug 15	Nov 15	Work on going.	
Design a **common approach to care planning** with the older person at the centre	Establish working group; develop planning passport	June 15	Sept 15	Good practice guidance for all staff completing care plans and for patients/carers on what to expect has been drafted and agreed with agencies involved. Guidance and care planning approach discussed at Proactive Care Group. GP 's planning to meet on 25 November to input and feedback to lead.	Agree expectations on how this area is to be progressed to the next stage with timescales.
	Consult with stakeholders, agree and implement	Oct 15	Dec 15	Dependent on the above.	
Maximise the use of technology with telecare and telehealth	Deliver training package for referrers; deliver communications campaign for stakeholders		Sept 15	Continued growth of calls to CareCall service.. 99% of these calls are completed without invoking a further healthcare response such as ambulance or A&E	
Resolve inconsistent service delivery for North Tyneside GP Registered Patients with a Newcastle postcode & those in the North West locality.			tbc	CCG is preparing a paper for CCG Clinical Executive on options for commissioning a unified mental health service for older people	Update required for November mtg.
Develop joint commissioning frameworks	Conclude a formal agreement between the CCG and the Council for arrangements for management of the Continuing Health Care budget		April 16	Agreement reached between CCG and LA on management of community care.	Future of BCF.
Provide a proactive care programme and avoid unplanned admissions	Implement the national scheme for a GP-led proactive care programme, with additional input from geriatricians, pharmacists, and community nursing	April 15	April 15	Service live – need to understand activity and impact	* To receive impact evaluation from PC programme group for Jan2016 board (in line with BCF processes around return on investment and quantified impact)
Strengthen **End of Life** Care	Align care homes to GP practices	April 15	April 15	Service live with participating GP practices ensuring a tailored package of support and care	Review and impact report for Jan 2016 board

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				centred on the residents as an individual.	
	Provide a specialist end of life nursing service to nursing homes			Service currently in place with care homes; pilot service in place evaluating resource requirements for roll-out to nursing homes.	Report on progress and impact required for Jan 2016
	Provide a Hospice at Home service		Sept 15	Staff recruitment under way	Verbal Update for Dec Board
Implement a **Falls Pathway**				Service live – no issues	See *
Implement **Seven-Day Social Work**				Service live – no issues	See *
Provide an **immediate response and overnight home care service**				Service live – no issues	See *
Provide **a community navigators** service				Service live – no issues	See *
Commission "**Living Well at Home**", an improved homecare service				Service live – no issues	See*
Commission "**halfway to home"** beds				As an interim measure we are spot purchasing beds in the independent sector and using the OT and physio from reablement to support placements.	Agree a systemwide definition of "Halfway to Home" and disseminate.

Engagement Activity			
Title and Purpose of Activity	**Target Group**	**Details of Activity**	**Outcome of Activity**
To understand patient flows though services, interagency working and staff experience of delivering care. To understand peoples experience of care delivery in North Tyneside. To identify what patients, carers and staff feel are key areas for improvement	Staff Delivering services across health and social care.	MY Care My way: (involved > 850 people 28 service pathways mapped involving staff across organisations 4 workshop sessions attended by staff , patients and carers supported by patient forum members, Community Health Forum, Age UK and Health watch Targeted "sensemaker " questioners and interviews in Nursing homes and with protected group's via Community Health Forum, Health Watch and Age UK	.Identified a comprehensive map of services in NT and areas for improvement Identified what the picture of care delivery should look like in North Tyneside and Provided common themes for improvement, Coordination of Care across systems , improved communication, early involvement of patients and carers.
Reviewing patients experience of integrated care	700 people who had attended outpatient clinics	A survey was issued to 700 people who had attended outpatient clinics. The response rate was 21%, There were 27 questions which were linked to NICE guidance and the National Voices messages. In addition, a set of guided conversations were held with patients	Focus for improvement : people want better access to care that feels personal to them, they would like info that is very easy to understand, they'd appreciate more emotional support and help to manage their own care