JOINT COMMISSIONING PLAN

Older Peoples Services – Health and Social Care Joint Commissioning Plan 2010/11

1.0 PURPOSE OF REPORT

1.1 The purpose of this plan is to provide an overview of the areas of joint commissioning activity between Central and Eastern Cheshire Primary Care Trust (PCT) and Cheshire East Council (CEC) (CWaC?) that are taking place during 2010/11. This one-year plan will be followed in 2011 with a whole system partnership strategy for the Ageing population that will cover the five years from 2011 to 2016. This current plan describes the priorities for older people’s health and social care services for 2010/11. The plan has been written by the CECPCT and CEC in partnership with local services, e.g. hospitals, ambulance services, council services. Note: this plan does not include those services which are commissioned exclusively by either the PCT or CEC e.g. stroke care.

2.0 OVERVIEW

2.1 During 2009, a Joint Commissioning group was established to focus on services for older people. This group is accountable to the Health and Well Being Thematic Group for Cheshire East within the Local Strategic Partnership arrangements. One of the requirements of the group is to develop an Ageing Strategy for the local population. As a first step towards this a one year joint commissioning strategy has been written by co-ordinating all the existing joint work streams that relate to older people. This work has been aligned to the existing outcome framework developed in Cheshire in 2008 “Every Older Adult Matters”, to link the plan to the areas that relate to older peoples lives. The full framework can be seen at www.cecpct.nhs.uk.

2.2 A summary of this plan was prepared to share with older people at an engagement event in Crewe in February 2010. Around 60 members of the public attended the event, with eight different organisations represented through activities, workshops and information stands. Feedback from the event was very positive with attendees appearing to have enjoyed the event, the displays and workshops. Many of the comments and questions on the day confirmed that the plans are focussed on the right areas, i.e. those areas which are priorities for older people. The comments received at the event have been used to work up the plan below.

3.0 OLDER POPULATION OF CHESHIRE EAST

3.1 Following analysis of information on the current population the Cheshire East Joint Strategic Needs Assessment (JSNA) Executive Summary 2010 identifies improving the health of older people as one of its priority measures. The evidence the JSNA highlights is:

17.8% (30,500) of the population in East Cheshire is over 65 compared with 15.9% nationally. This results in a high “old age” dependency ratio, i.e. low numbers of working-age people supporting a high non-working dependant older population. The percentage of “older” or “frail” old is also considerably higher, with 2.3% (8,200) persons 85 and over compared to 2.1% nationally. Cheshire East has the fastest growing older population in the North West. By 2016, the population aged 65+ will increase by 29.0% and the population aged 85+ by 41.5%. Cheshire East’s high life expectancy and Ageing community is something to celebrate and planning services to keep this population relatively fit and active is important for our residents to enjoy a healthy older age and lower the risk of long-term illness into old age.
However the projected increases in the residents over 65 and particularly the “frail” old (85 years and over) will need to be considered in service development proposals. This potentially vulnerable group will require more input from both social and health services. It is of particular importance to plan services and review care pathways for falls prevention, stroke and dementia services.

3.2 The plan includes the key areas emphasised in the JSNA and will continue during 2010/11 compiling information to assist in the improved planning and delivery of health and social care services that are targeted to meet the needs of local communities.

4.0 JOINT COMMISSIONING PLAN

4.1 The diagram below illustrates the areas of the plan mapped to the domains of the Every Older Adult Matters Framework.

The following table identifies the national performance measures that relate to each work area (colours link the work areas back to the diagram above). Work is continuing to develop local performance measures for each of the work areas and these will be added to the plan as they are agreed.
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<th>Work Area</th>
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<tr>
<td>1</td>
<td>Community Equipment</td>
<td>• Review the options for providing this service from 2011/12, including how the service is provided and over what geographical area</td>
<td>PCT/CEC Cheshire West and Chester Council Western Cheshire PCT Prescribers in health and social care organisations Patients/Custumers Carers Ability Aware Retailers Suppliers</td>
<td>• Improved Quality of Life • Increased Choice and Control • Maintaining personal dignity and respect • Improved health and emotional well being • Reduce the number of delayed discharges</td>
<td>Contributes to: <strong>VSC03</strong>: Proportion of adults (18 and over) supported directly through social care to live independently at home <strong>VSC10</strong>: Number of delayed transfers of care per 100,000 population (aged 18 and over) <strong>NI 125</strong>: Achieving independence for older people through rehabilitation / intermediate care</td>
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<td>2</td>
<td>Dementia</td>
<td>• Provide training for health and social care workforce • Diagnose dementia earlier to allow people to be more involved in decisions and better planning of care • Provide support and advice to be given to carers, particularly with regard to end of life care • Provide high quality of care and support in hospital • Raise awareness of dementia and lifestyle factors that can contribute to reducing the possibility of having dementia.</td>
<td>PCT/CEC Cheshire and Wirral Partnership Foundation Trust Statutory &amp; Non Statutory Organisations Patients/Custumers Carers</td>
<td>• Improved Quality of Life • Making a Positive Contribution • Increased Choice and Control • Freedom from discrimination and harassment • Economic Wellbeing • Maintaining personal dignity and respect • Improved health and emotional well being</td>
<td>42% or 2,605 of the expected number of people with dementia in 2009 will be recorded on a dementia register and have an active care plan</td>
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| Healthy Ageing | - Identify all physical activity programmes and funding  
- Further develop the directory of activity programmes and make links to appropriate care pathways  
- Work across all organisations to fill gaps in activities  
- Ensure that older people’s health needs are considered and identified so not to exclude them from health promotion activity.  
- Volunteering opportunities  
- Transport  
- Having a voice | CEC  
PCT  
All providers of health and social care  
Patients/Customer Carers  
Housing Associations  
Third sector | Increased Levels of Activity in the older population leading to improved health and well being. | • People can join in with physical activities that are tailored to their needs and improve their well being, strength and mobility.  
• People are able to take part in health improvement and promotion programmes that help them to remain well and independent for longer.  
• Increased Levels of personal activity leading to improved physical and mental health including reduced social isolation | N18: Adult participation in sport and active recreation  
VSC 25/N1 137: Healthy life expectancy at age 65  
Linked, but not direct cause and effect:  
VSC 31: Self-reported measure of people’s overall health (EQ5D) |
| Intermediate Services | - Increase the range of services that respond rapidly when people are ill or not coping at home. These services are for people who are not ill enough to be in hospital, or who are being discharged from hospital and are not yet able to cope at home. | PCT  
CECH  
CEC  
East Cheshire Trust  
Mid Cheshire Trust | Support a further 750 people during 2010/11  
Increase the number of intermediate services beds and community hospital beds from 115 in 2008/09 to 220 in 2014  
Reduce in avoidable hospital admissions  
Reduction in demand for long term care | • People receive services that are centred on and tailored to their individual needs  
• People are provided with the opportunities to maximise their independence and reduce their dependency on services  
• People avoid unnecessary admissions to hospital  
• People have more support to enable them to live in their own home and community  
• The demand on Carers is minimised | NI 125: Achieving independence for older people through rehabilitation/intermediate care  
VSC04: Proportion of people achieving independence 3 months after entering care/rehab – rate per 10,000  
Contributes to:  
N134: The number of emergency bed days per head of weighted population  
VSC10: Number of delayed transfers of care per 100,000 population (aged 18 and over) |
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<td>5</td>
<td>Integrated Care (Community)</td>
<td>CEC/CECH</td>
<td>Community services work together to meet the needs of the local population in the most efficient way More people are supported by, where appropriate, reducing the numbers of professionals involved in each person’s care</td>
<td>PID (BB to add) People are supported to manage their long term health conditions Each person with complex needs has a case co-ordinator to support them in living in their own home and community</td>
<td>NI 125: Achieving independence for older people through rehabilitation/intermediate care VSC04: Proportion of people achieving independence 3 months after entering care/rehab – rate per 10,000 NI141: Percentage of vulnerable people achieving independent living NI142: Percentage of vulnerable people who are supported to maintain independent living VSC10: Number of delayed transfers of care per 100,000 population (aged 18 and over)</td>
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<td>6</td>
<td>Integrated Care (Hospital)</td>
<td>CEC, CECH PCT</td>
<td>Reduction in avoidable delays in discharge from hospital Acute Hospital beds are used for those who need them most, e.g. acutely ill patients</td>
<td>Patients receive timely support to assist them in leaving hospital in a safe and timely way Each patient with complex needs has a case co-ordinator to support them in their transition form hospital</td>
<td>VSC10: Number of delayed transfers of care per 100,000 population (aged 18 and over) VSC20: Number of emergency bed days per head of weighted population</td>
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<td>Reablement</td>
<td>• All people accessing Social Care will receive a Reablement Service if appropriate • Reablement services will also be offered at review points to support the opportunities to increase independence and/or assist someone to regain skills where a change in their health and wellbeing has impacted on these. • Carers will also receive a Reablement Service response that looks at their needs for support and information.</td>
<td>CEC, PCT, reporting to the Cheshire East Re-ablement Steering Group Intermediate care Patients/Customer Carers Housing Associations Third sector</td>
<td>Reliance on and demand for long term support services is reduced</td>
<td>• People receive services that are centred on and tailored to their individual needs • People are provided with the opportunities to maximise their independence and reduce their dependency on services • People have more short term support to enable them to live in their own home and community • The demand on Carers is minimised</td>
<td>CQC Outcomes: • Improved health &amp; well being • Improved quality of life • Making a positive contribution • Increased choice and control • Freedom from discrimination &amp; harassment • Economic well being • Maintaining dignity and respect</td>
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| 8 Falls   | • Agree a pathway that coordinates all services involved in for caring for people who have fallen and/or are at risk of falling  
• Work across all organisations to fill gaps in the pathway | PCT/CEC  
All providers of health and social care  
North West Ambulance Service (NWAS)  
Patients/Customer Carers  
Housing Associations  
Third sector | All services who are in contact with older people identify whether people are at risk of falling  
Services are provided to identify the specific causes of falls for each person and action taken to address these | People who are at risk of falling or have fallen are offered an assessment and support to reduce the risk and avoid future falls | Contributes to:  
**N134**: The number of emergency bed days per head of weighted population  
**N18**: Adult participation in sport and active recreation |
| 9 Nail Cutting Service | • Working with the social enterprise, Caremart, to develop a nail cutting service in local communities | PCT, CEC  
CECH Podiatry Service  
Age Concern | To provide people who do not have a medical need for podiatry with an affordable nail cutting  
Promotion and monitoring of health and wellbeing and access to services via regular contact with older people | • People have access to a local affordable nail cutting service  
• People have regular contact with a low level support service which can advise on health and well being and access to services | Numbers of people accessing the service  
Caremart has adequate numbers of customers to ensure it is self sustaining in 12 months |
| 10 Safeguarding | • Develop an integrated Safeguarding Service.  
• Cases to be allocated based on complexity, need and risk.  
• Continue to offer support to victims of domestic violence | CEC, PCT  
All providers of health and social care  
Patients/Customer Carers  
Housing Associations  
Third sector  
Fire, Police, Third Sector Congress, Probation (18 service users aged 65+ in Cheshire East) | • Maintaining personal dignity and respect  
• All services to work in accordance with the "No Secrets" Policy – not really an outcome | The safeguarding service protects and prevents vulnerable adults from significant harm and promotes recovery, well-being, choice and independence | Have to supply Trigger Forms (POVA)  
Number of Independent Management Reviews  
**NI128/VSC32**: Patient and user reported measure of respect and dignity in their treatment |
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| 11 Care Homes | • Work with 96 care homes in Cheshire East Council area (There are 52 Nursing homes and 51 Residential homes within the PCT area) to monitor quality of their care and work intensively with poor providers. | PCT/CEC  
Care Home Providers  
Patients/Customer  
Carers  
Third Sector  
Hospitals  
Primary Care  
Intermediate Care  
Community Support Centres | • Improved Quality of Life  
• Maintaining personal dignity and respect  
• Improved health and emotional well being  
• Improve poor practice in care settings | • Individuals are protected from harm  
• Promote dignity in care | N134: The number of emergency bed days per head of weighted population |
| 12 Dignity | • Include dignity standards and targets in service contracts  
• Identify dignity “champions” in priority services  
• Work with Universities to ensure dignity is a core element in training programmes for trainees  
• Specific work on care provided at; End of Life, Hospital Care and Care Homes | PCT/CEC  
All providers of health and social care  
Patients/Customer  
Carers  
Primary Care  
Links | • Increased Choice and Control  
• Maintaining personal dignity and respect  
• Improved health and emotional well being | More people report that they were treated with dignity when receiving health and social care services | N1128/VSC32: Patient and user reported measure of respect and dignity in their treatment  
• Single Sex Accommodation -  
• Measured through Patient Survey  
• Breaches of Single Sex Accommodation Targets  
• Complaints  
• Reviewing Contract Compliance Complaints |
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<td>13</td>
<td>Common Assessment Framework For Adults (CAF)</td>
<td>• Test out joint health and social care information systems that can provide the public with information about services and support professionals with information about peoples needs. • This project includes the IT infrastructure for the Directory of services and information gateway</td>
<td>CEC PCT Department of Health</td>
<td>• Information can be shared between organisations and services • Efficiencies can be made by reducing the amount of time in collecting and recording information separately • There will be direct and timely information available on the interest in, uptake of and user feedback on services • This information will be used to plan future services • Service providers across all sectors will be able to use the resource directory to market their services directly to the public</td>
<td>• Greater sharing of information between services reduces the number of times people are asked about their details and circumstances • Professionals have the necessary information to care for people • People will be able to use the internet to look up services and provide feedback on them • Those people with a personal budget will be able to choose and purchase a range of services via the internet</td>
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## Work Area Plans Partners (Leads) Organisational objectives/outcomes Individual outcomes Performance Measures

### 14 Information Gateway
- Develop an accessible internet information system for Cheshire East provides information to help individuals to managing their health and wellbeing and provides information about services available within their local area.
- Consider how local centres e.g. health centres, Independent Living Centres, and Libraries can help people to access information within local communities.
- Consider how mobile services can help people in rural areas and people without transport to access information and advice

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<td>Individual outcomes</td>
<td>People will have access to timely and helpful information in respect of their health and wellbeing as well as to information on who is providing services in their area and where to go to access support, advice and guidance.</td>
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### 15 Resource Directory
- To provide a comprehensive web-based directory that supports the health and needs of older people.
- Train InfoLink “Champions” within community pharmacies, urgent care and selected Health and Wellbeing centres.
- Link to all Councils Departments Consultation Process

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| Individual outcomes | • Better access to health promotion services  
• Better access to community services  
• More support for people with long-term health needs  
• Individuals have access to reliable, current information that can help them to take greater responsibility for their health |

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*Issued: April 2010*

Joint Commissioning Team

Joint Commissioning Plan – Older People v8

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5.0 REPORTING

All of the work areas have their own governance reporting arrangements into either strategic programmes or organisational structures. The Joint Commissioning Group for Older People will not be duplicating these local arrangements as it will be responsible for monitoring the overall achievement of the plan and reporting to the Health and Well Being Group on progress and any risks.

6.0 NEXT STEPS

During the second half of 2010 the commissioning leads from CEC (Lucia Scally) and the PCT (Bernadette Bailey) will be working with local people and a wide range of services and organisations to develop a **whole system partnership strategy for the Ageing population focussing on reducing health inequalities and building a better later life.** The “Ageing Strategy 2011-16” will be a large piece of work that will require involvement from many people across many sectors of our communities. The plan is that the strategy will be completed by April 2011.

A plan is currently being developed for the preparation of the Ageing strategy, and is available on request.

Authors: Bernadette Bailey, Commissioning Manager, Central and Eastern Cheshire Primary Care Trust
          Lucia Scally, Strategic Commissioning Manager, Cheshire East Council