

That little bit of help

A plan to help people remain independent in Lincolnshire

2010 - 2013



Foreword

The production of this strategy represents the recognition of the wider value of organisations investing in preventive services to delay people's need for social care and health services and to promote the wellbeing of our community. This in turn provides a platform upon which we can build a shared approach to delivering services to an ageing population through supporting the delivery of the council's vision for the county.

We welcome the opportunity to work in collaboration with our colleagues in NHS Lincolnshire, Lincolnshire County Council, district councils and the third sector to design and deliver this strategy for all adults. A desire to improve services and change the way we deliver them for the benefit of local people is the reason for the Lincolnshire Prevention Strategy; entitled 'That little bit of help'.

Across Lincolnshire we will face many challenges over the coming years as a result of the projected increase in the number of older people and people with long term health conditions as well as the increasing pressure on services due to a reduction in funding from central government. The Coalition Government has promised to 'break down barriers between health and social care funding to incentivise preventative action'.

We believe that delivering this strategy along with the continued focus on the engagement and involvement of the community to support the delivery of universal and community wellbeing services represents a pragmatic and exciting response for Lincolnshire's citizens to the challenges ahead.

In supporting the delivery of this strategy there is an opportunity for health, social care, housing and other partners to come together to address the hopes and aspirations of people living in Lincolnshire to live healthy lives for longer. For this reason we are excited by the possibilities that this strategy has to offer for Lincolnshire's residents over the coming three years.



John McIvor, Chief Executive
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Introduction

This three year strategy sets out the approach to demonstrating the value of preventive services in delaying people's need for costly health and social care services at the same time as improving people's quality of life. As such it covers all adults in Lincolnshire.

It builds on the existing strengths of the services, because prevention is already an important component of much of what organisations in Lincolnshire deliver. Moreover the strategy seeks to accelerate the agenda and establish new directions in partnership with other agencies for developing further on the solid foundations we have in place.


The development of this strategy has been a shared one across health, social care, housing and the third sector.



We have been discussing this for a long time - we need to get on and do it now.

NHS Commissioner

We have engaged with staff, patients, people who use services, carers and members of the community and what they have told us is that they want to be able to live healthy and active lives for as long as possible but that there are times when they will need a little bit of help to do this.



They [public services] should work together better and be more joined up.

Community consultation event attendee

At these times they want services that are readily available and easily accessible which are delivered in a joined up way so as to avoid having to tell the same story to numerous organisations in a bid to get the help they need.

Outcomes

Taking the above as our starting point we have identified two core overarching outcomes for the strategy and for prevention services across Lincolnshire as follows:

- People are well informed about the options available to them through advice and information when faced with potential risks and support needs and;
- Through joined up early intervention, more people are helped to avoid a crisis that could lead to unnecessary admissions to hospital or longer term care.

Strategic objectives

In delivering services to meet these outcomes, via aligning preventive services to this strategy, we believe that local organisations will be able to meet the following two objectives:

- To demonstrate the success of investment in prevention to inform ongoing financial planning decisions and;
- To ensure that effective joint working across the whole system makes the most efficient use of investments in preventive services by maximising their impact.

Times when people need ‘that little bit of help’

We need to make sure that we provide the right services for people at the right time. In order to do this people have told us that there are some key points in their lives when they may benefit from services being better targeted and more joined up. These are as follows:

- | | | |
|---|--|--|
| ▪ When your income changes | ▪ When you have health concerns | ▪ After having a baby |
| ▪ When you move home | ▪ When you feel isolated or lonely | ▪ When you are generally ok, but need a little help with small tasks like getting dressed and shopping |
| ▪ When a carer is ill or moves away | ▪ After suffering a bereavement | ▪ When a need is identified by a GP |
| ▪ Following a divorce/separation | ▪ When you have been a victim of crime | |
| ▪ If your personal situation makes you vulnerable | | |

Through this strategy we aim to ensure that at these times people are supported by local services with the help they need and we will try where possible to work together to make that help as seamless and straightforward as possible.

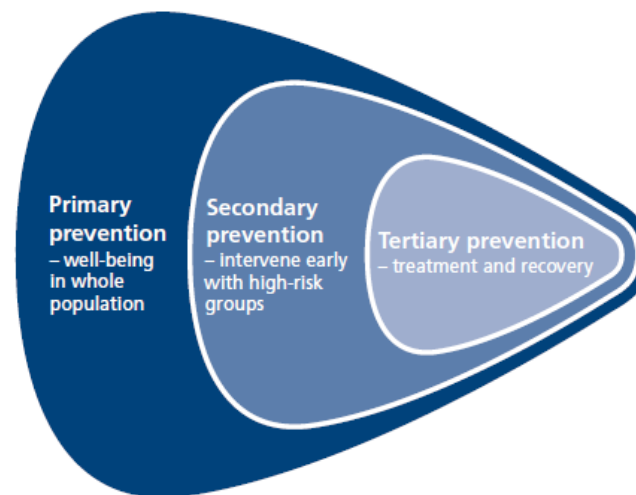
Defining prevention

Government has identified the following definition of prevention in a bid to support local authorities and NHS organisations to target their preventive services more effectively:

- Primary Prevention - Provision of universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles etc
- Secondary Prevention - Identification of individuals at risk of specific health conditions or events, such as strokes or falls or those who have existing low level care needs
- Tertiary Prevention - Maximise people's independence through interventions such as rehabilitation and joint case management of people with complex needs.¹

Consultation has suggested that the focus of this strategy should be on primary and secondary prevention.

However, the course of someone's journey through prevention services is not necessarily a straight line with a person moving through the levels of preventive services in a successive way. For example, a person may still benefit from good quality information (primary prevention) whilst they are in or being discharged from Intermediate Care (tertiary prevention). This concept is perhaps best demonstrated by the diagram below:

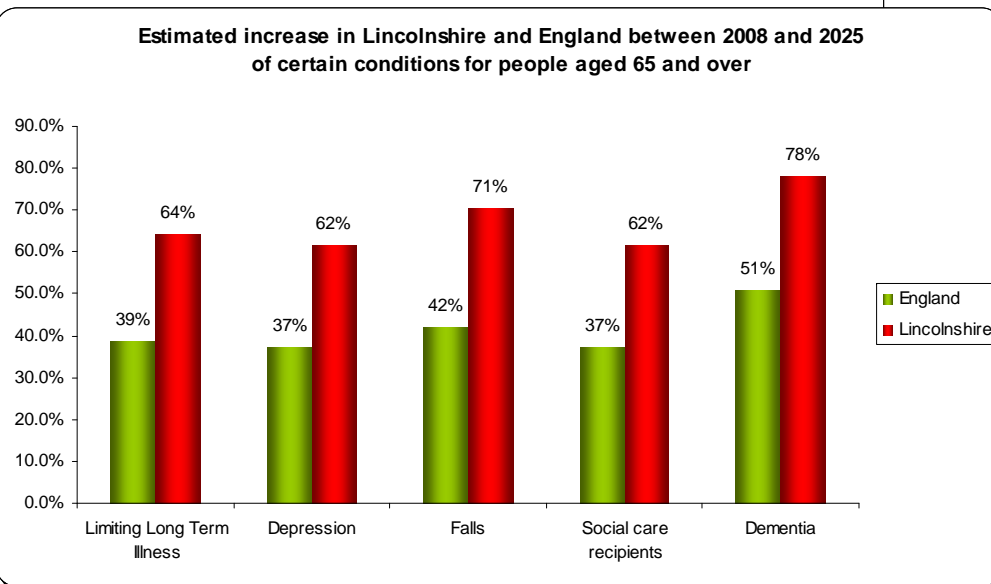
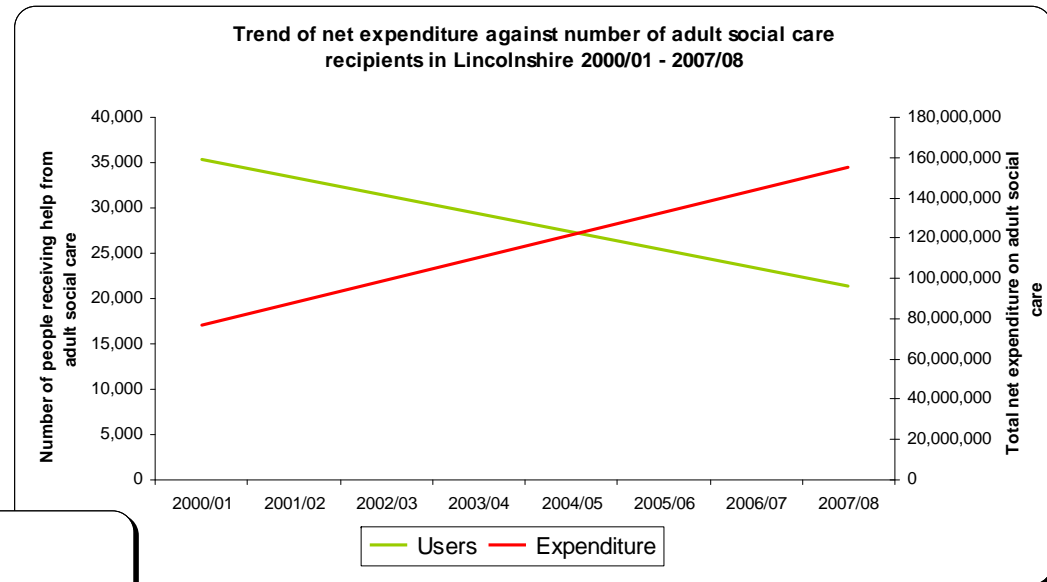


Source: HM Government (2009), New Horizons: A shared vision for mental health

Making the case for prevention

Over the course of the last 10 years more and more money has been spent on fewer people with greater care needs. This is demonstrated in Lincolnshire by the following graph which shows net spend on adult social care against the number of people receiving services. With the predicted increases in population and long term health conditions over the coming years, set against the expected reduction in health and social care budgets, this trend needs to be reversed. This will enable us to deliver the level and quality of care and support people will require.

Source: NHS Information Centre

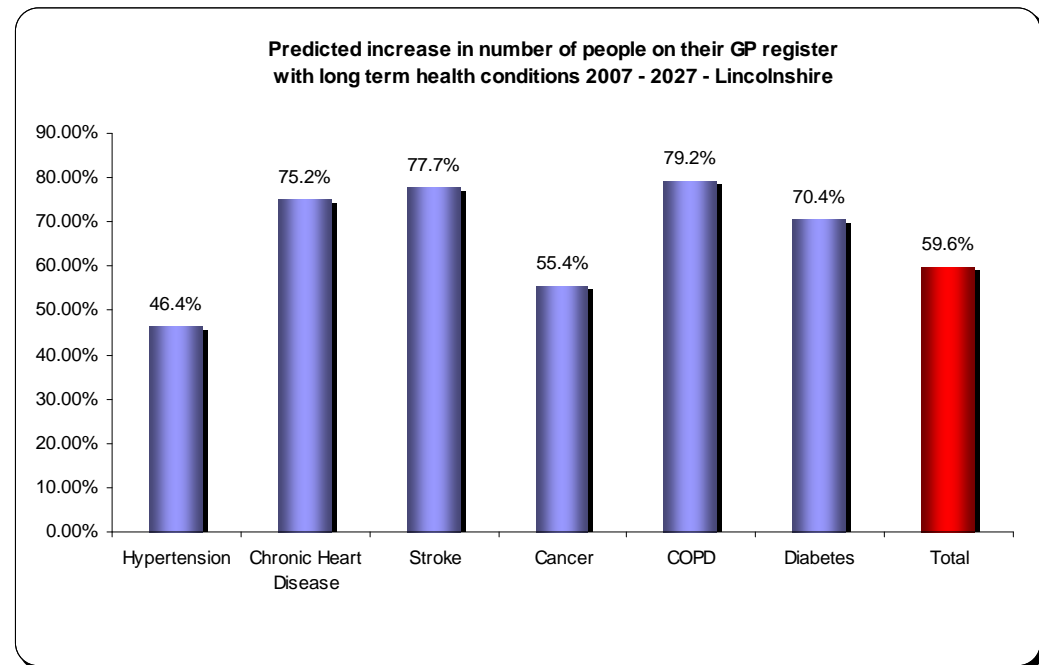


Over the coming 20 years there is expected to be an unprecedented increase in the number of older people as well as people requiring help due to diagnosis of certain health conditions. This is demonstrated in the graph opposite which sets out expected increases in Lincolnshire compared with the expected increases across England over the same period. The difference between the estimated increase across England and Lincolnshire is significant ranging from a 25% difference to a 30% difference.

Source: Projecting Older People Population Information System (POPPI)

Set out in this graph is the expected increases of certain long term health conditions between 2007 and 2027. Whilst a number of factors may contribute to this increase, such as an increasing ageing population coupled with increasing life expectancy, there is a clear need for this strategy to ensure it supports the prevention of people developing long term health conditions (primary prevention) at the same time as supporting people who have been diagnosed with long term health conditions to manage these in such a way as to ensure they are able to enjoy a good quality of life (secondary prevention).

Source: NHS Lincolnshire



In summary, the future holds two key challenges for all organisations working within or on behalf of local health, social care and housing organisations as follows:

- An increase in demand for health and social care associated with an ageing population and changing expectations and;
- A reduction in the growth of public funding for health and social care.ⁱⁱ

National policy has over the past five years been driving health and social care organisations to work together in the pursuit of delivering more joined up services that support people to remain living independent healthy lives, with more choice and control for as long as possible.

The clearest examples of this are 'Our health, our care, our say' (DH, 2006) and the NHS Next Stage Review 'High Quality Care for All' (DH, 2008) both of which include a central tenet to drive the whole system towards ensuring people lead healthier lifestyles in order to prevent ill health and remain living independently for longer. Coupled with this World Class Commissioning (DH 2007) recognises that to tackle health inequalities and to ensure people live healthier lives for longer it is critical that local services work together to design, develop and deliver high quality integrated services.

What we are currently doing

Currently in Lincolnshire there is a range of preventive work being undertaken across public, private and third sector organisations which as individual services are having a real impact on people’s ability to remain living independently and their quality of life. Two examples of this are shown opposite.

Lincolnshire’s First Contact service has helped 1,700 people access 3,700 services in 2009/10 with 80% of people saying the services they got helped them to feel safer in their own home

The NHS funded Income Maximisation project in Lincolnshire generated additional welfare benefits of over £3m in 2009/10. This represented £9 in additional benefit for every £1 invested in the service

The table below shows the level of investment in prevention expected in 2010/11, where we have been able to identify it, across the health and social care system:

Organisation	Amount Invested
Lincolnshire County Council	£ 7,660,443.22
NHS Lincolnshire	£ 7,910,289.00
TOTAL	£ 15,570,732.22

Source: Survey of NHS and Lincolnshire County Council commissioners, 2009

It is worth mentioning that whilst many prevention services are funded from ‘core’ service budgets these will increasingly come under pressure to demonstrate their effectiveness and ability to delay people’s need for more costly care services due to financial pressures on public sector budgets.

Development of prevention services has also tended to be driven in isolation within organisations and so many of these interventions are lacking in scale and scope to deliver the magnitude of improvement which will be required to address the increase in demand versus the reduction in growth of public funding.

In order to deliver against the two overarching objectives set out in the introduction to this strategy, there will be a need to ensure that effective joint working across organisational boundaries makes the most efficient use of current investments in preventive services by maximising their impact. Critical to the success of this is to have in place an agreed way of measuring the impact that prevention services are having on reducing or delaying people’s need for health and social care services. Doing this will ensure that we are able to provide evidence for how services might be configured in the future around ensuring people have choice and control to inform them in making healthier, independent lifestyle choices.

Priorities for change

As part of our consultation we asked people about how we should decide on the key themes to be included in this strategy. This involved jointly agreeing a set of principles upon which we have been able to make decisions about the immediate priorities for investment into prevention. These same principles will also be the basis upon which an ongoing assessment of the success of the strategy will be measured. They are:

- the approach should be **scaleable** – both Geographically, but also across other health conditions;
- there has to be **evidence** and confidence in the evidence that the prevention strategy is delivering and will continue to deliver reduction in demand for other more expensive services;
- **ease and speed of implementation** are critical in order to meet the most immediate financial pressures;
- **developments are sustainable** in terms of the ongoing funding available if the evidence is compelling that prevention services are delaying people's need for more costly care services and;
- evidence of **better outcomes for citizens** through quality of life and effective safeguarding measurements.

With the above principles in mind it has become clear from our discussions with partners and the community themselves that the priority areas for this three year strategy are as follows:

Theme One – Joined up working

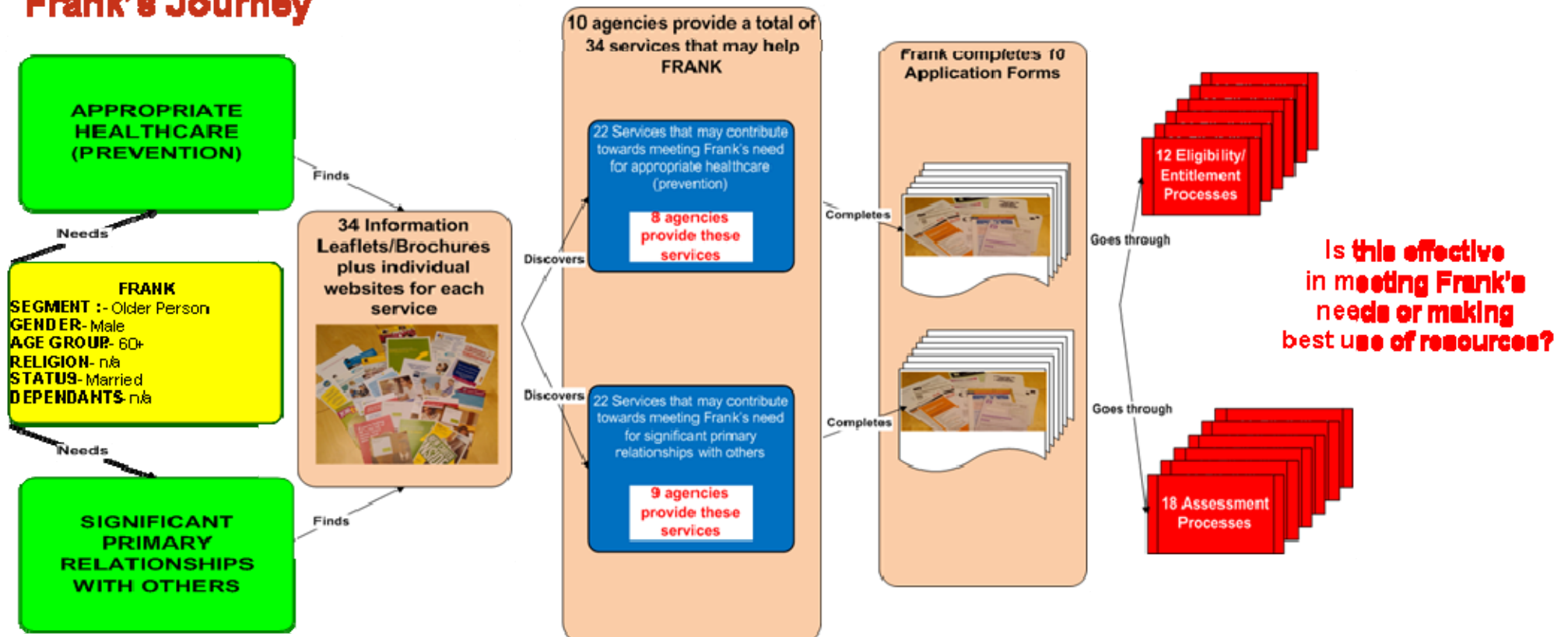
We have some excellent prevention services in Lincolnshire already, such as the First Contact referral scheme, Bridge and falls prevention services, home from hospital schemes and the Frail Older Persons Pathway. Bringing these together, along with other services within Supporting People and adult social care, will create an approach to prevention services that will build upon their existing success. This will also afford the opportunity to scale them up so they are able to deliver greater and better outcomes than the sum of their parts.

Not only does this have the potential to deliver improved outcomes but will also help us to address the issue of duplication by ensuring services are delivered in a more joined up way. Each of the services included here are funded from different sources, under different agreements and for different lengths of time and so any potential to join these services up will need to be undertaken with this in mind.

Evidence and benefits

As part of developing this strategy we reviewed the range and complexity of issues people are faced with when attempting to access existing preventive services in Lincolnshire. We undertook this by way of mapping an imaginary customer's journey through the maze of services available. Set out below is what "Frank's" Journey looked like:

Frank's Journey



There are therefore a number of reasons why we feel we should join up existing services as follows:

- Reduce the number of different assessment and entitlement checks there are of which a significant number will be asking very similar questions of people;
- Feedback from the community has been that they want services joined up to avoid having to tell the same story numerous times and;
- There are potential financial advantages to working more efficiently with what we already have.

Theme Two – Better targeting of services

Better sharing of information will help to monitor the performance of prevention services and track success of existing services as well as the common causes of referral to reactive services. It will also enable us to predict peoples risk of needing hospital or social care services and allow services to be targeted better for people at times when they need some extra help and support.

Better targeting of preventive services and an understanding of their effectiveness in delaying peoples need for more costly care services will also help inform the move towards achieving a strategic shift in the way services are delivered.

The success of this theme can only be achieved by adopting a more systematic approach to sharing information about our mutual customers. Despite people telling us that they expect and want agencies to share their information when appropriate to do so, we need to be conscious that we respect people's wishes for privacy by doing this within the legal boundaries of the Data Protection Act. In line with this, consideration must be given to the quality of data and the ability to accurately identify individuals across organisations and systems.

Sharing information in this way will allow us to target services to people at times when they need and will benefit most from local services working together, such as the times people have told us they might need 'that little bit of help' and are therefore more vulnerable.

To ensure this theme delivers its intended outcomes requires a level of commitment across health and social care as well as from GPs, district councils and other key local service providers.

Evidence and benefits

When looking at existing prevention services it is clear that many services target people with similar needs in order to achieve similar outcomes. Where targeting of services takes place currently it is often linked to the organisation commissioning the service, hence NHS services tend to target people based on clinical needs and social care services target based on social care needs. The reasons why we think that better targeting will support better outcomes are:

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- Capacity planning based on risks which combine health, social care and housing data has the potential to reduce hospital and care admissions. This is due to the ability to use aggregate forecast risks, derived from wider sets of service data, to profile optimum service packages to delay or prevent development of greater care needs.
 - Once risks have been identified targeted campaigns will improve people's ability to manage their own care safely by creating service delivery campaigns based on aggregation of individual citizen data.
 - Personalised service campaigns will improve choice and personalisation of care services by making service recommendations outside of campaigns to enable service teams to directly intervene with individuals at risk. This risk may be one of a number of things such as losing their independence, needing health or social care services or who are in need of safeguarding due to their situation placing them in a position of vulnerability.
 - Using aggregate service data will improve the effective use of resources across the whole system. Creating population level views of the risks associated with people needing high cost care services will deliver evidence to inform effective commissioning and financial planning.

Theme Three – Telecare

Telecare is the use of technology to monitor people's situation and intervene early if an emergency arises. An example of this would be a lifeline alarm system where an older person can alert someone quickly if they have had a fall by pressing a button on a pendant worn around their neck.

The case for investing in telecare is gathering evidence nationally; whilst local investment and achievements to date have been commended. This theme is about building further on this success to expand the scope of telecare services beyond their current focus on those who have eligible care needs to the whole population. We are proposing to enable people to understand their needs earlier and purchase telecare equipment for themselves. This will allow people with low level support needs and their families to have peace of mind that they are able to remain living safely and independently at home for as long as possible.

As part of this theme the opportunities to streamline telecare monitoring across the county will also be explored, which may offer some short term financial benefits. As with Theme One we know that these services are currently delivered within existing contractual arrangements and so any potential changes will likely need to be phased in.

Evidence and benefits

The evidence for the effectiveness of telecare services in delaying or preventing needs deteriorating is still developing however it is viewed nationally as a having the potential to deliver significant efficiencies across health and social care services if it is mainstreamed.ⁱⁱⁱ

Locally we have found there is a belief that widening the scope of telecare services (particularly in the support of self care by way of supporting people to access such services regardless of need) might improve the potential for it to have an impact on delaying people's need for other health and care services. As part of widening the access to these services feedback received shows that this will require a review of how such services are monitored and alerts are responded to (particularly out of hours).

Theme Four – Telehealth

Telehealth services provide technology into people's homes in much the same way as telecare service. The key difference is that telehealth equipment allows someone's medical condition to be monitored by professionals at a distance without having to travel to the person's home. An example might be someone having a unit installed in their home which measures and monitors their temperature, blood pressure and other vital signs. This information can then be reviewed at a remote location (for example, a hospital site) using phone lines or wireless technology.

There is an emerging evidence base for investment into telehealth to help give confidence to sufferers of long term health conditions that any issues with their condition will be picked up. This theme will initially focus on one long term health condition and in one geographic area to ensure that action learning can be undertaken before rolling the service out further to other areas and to other specified health conditions.

This theme will also support self care work which is being undertaken in Lincolnshire by enabling people being diagnosed with diabetes to access support and information to help them to support and manage their condition themselves.

Evidence and benefits

Many of the reasons and the evidence for adopting a more strategic approach to telehealth services are the same as for telecare above. In terms of service integration and delivering services efficiently we have also heard from partners that there may be benefits in discussing how financing and management of telecare and telehealth services can be joined up across health, social care and housing.

The evidence for the effectiveness of these services is building and it is viewed nationally as having potential to allow health and care services to be delivered more efficiently, e.g. by reduced numbers of visits required in rural areas.

Making it happen

A large part of our work on developing this strategy has been to identify some key short to medium term priorities to be taken forward over the next three years.

However, in order to deliver a longer term strategic shift in the way services are delivered more fundamental and challenging decisions need to be taken about integration across organisations.

The Audit Commission has recently highlighted that it is transformational change rather than incremental change which will enable us to meet the challenges set out earlier in this strategy.^{iv}

Integration of service delivery, finance, commissioning and performance can be 'individually-centred' or 'system-centred'. Recent work by the Institute for Public Policy Research (IPPR) has suggested that the best way to create a more responsive and financially effective model of delivering services is to combine both of these approaches.

Individual centred approaches promote enhanced citizenship in the planning and delivery of public services where as system centred approaches are driven by greater financial and operational efficiency.

Recent thinking at a national level has also focused on basing integration around the establishment of 'single issue budgets'. Long term health conditions are a particular area of service delivery where it is difficult to draw the distinction between the roles of health and social care.^v

The Audit Commission has also recently highlighted that where integration has happened it has tended to focus on the system-centred approach (despite the fact that most partnerships would consider improved outcomes and user experience for people to be the primary driving force behind integration). This is in part due to the fact that incompatible information and finance systems lead the integration to focus on systems and processes. Conversely this is often at the expense of the initial driver for integration, i.e. improved experience and outcomes for people.^{vi}

With this in mind, we will be seeking to join preventive services together under one pooled or aligned budget in order to share more effectively the resources we have available in terms of commissioning, finance, performance and service delivery.

We will set out in our action plan the key themes identified in this strategy and the actions we will take to ensure we deliver against these themes and their associated aspirations for a more joined up and effective suite of preventive services available to people living and working in Lincolnshire.

References

- i Department of Health (2008), Making a strategic shift to prevention and early intervention
- ii Department of Health (2010), Improving care and saving money: learning the lessons on prevention and early intervention for older people
- iii Department of Health (2009), Use of Resources in Adult Social Care
- iv Audit Commission (2010), Under Pressure: Tackling the financial challenge for councils of an ageing population
- v Institute for Public Policy Research (2010), Integrating Health and Social Care Budgets: A case for debate
- vi Audit Commission (2009), Means to an end: Joint financing across health and social care