

Joining the Dots or Unbridgeable Distances?

**A summary of the learning from the
Joining the Dots Project**

February 2011

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Joining the Dots (JTD) is a response to the ageing population and the changing needs and aspirations of older people. The project set out to change the way in which we do business by:

- Joining older people up to the services which will meet their needs;
- Joining up service providers to use their resources more effectively;
- Engaging commissioners in the process from the outset so that the findings could be built into commissioning plans.

JtD is funded jointly by NHS North of Tyne and Newcastle City Council's Adult and Culture Services Directorate.

The initial two year programme has enabled a wide range of stakeholders to build consensus around a whole system approach to prevention by learning from existing local and national practice, building on existing assets (organisations and people); testing out new ways of working and making the links between initiatives. The process undertaken throughout the Joining the Dots project is an example of co-designing solutions, which has resulted in stronger networks and wider ownership of the recommendations by older people, service providers and commissioners.

The programme has been overseen by a multiagency steering group which includes older people and carers and has engaged a Project Manager; Occupational Therapist from Intermediate Care (part time) and a GP (part time) to support the delivery of the programme.

The main areas of progress and resulting benefits

Challenge 1 –Joining up services with older people - The Linkworker

An initial hypothesis for the programme was that there is a need for more 1-1 support for more vulnerable older people to enable them to navigate the system and access the services to meet their needs. There are a number of models across the UK for this type of service which were analysed and considered e.g. Village Agents; Local Area Co-ordination; Dementia Advisers.

Working within the principles of the JTD programme to learn and build on existing practice, 190 people (118 front line staff ['potential interfacers'], 3 Commissioners, and 70 Potential Beneficiaries) directly participated in considering the best option for Newcastle.

The conclusion from this work was that

- there are a number of staff and volunteers who currently provide a level of 1-1 support across a spectrum of activity from professional support (e.g. occupational therapists; social workers; advice workers) to peer support (e.g. health trainers). Putting in additional capacity to do this could duplicate rather than enhance the existing system. Resources would be better used by ensuring that staff know their local system well; understand the boundaries of their respective roles and have the opportunity to build relationships of trust and easier referral routes. This was tested out by delivering an information day which attracted 50 staff from Intermediate Care and Community Nursing to meet with 15 VCS groups. Feedback showed that this was valued and highlighted an appetite from both sectors to improve knowledge and relationships;
- underpinning networking opportunities there is a need for a strong information base and simple referral mechanisms. These have been provided through the Information and Advice workstream of the Putting People First programme and include Information NOW; My Care Newcastle; First Contact and 'Just What I Need';

- the need to further develop community-based provision which is open to all and therefore non-stigmatising but which can accommodate people in need of additional support. At present this provision is patchy and fragile and would benefit from sustained investment and innovative design;
- there is a **gap** at locality level in terms of facilitating the networking and building trusted relationships between front line staff; mapping and supporting the development of community-based activities; identifying when/where the 'system' is not working well; ensuring this intelligence from the ground informs policy and service design and commissioning. In response to the findings of the workshops cited above, an area-based **strategic linkworker** model was co-designed by a cross-sector team and a job description and person specification was produced. The implementation of this recommendation is pending until the resources can be found to test out this model.

Challenge 2 – Joining the Dots between service providers

The work to build relationships between health, social care (and to a lesser extent housing) and community-based VCS services has been delivered in partnership with the Occupational Therapist, a GP and HealthWORKS Communities for Health project. This work has also drawn on the resources of a health trainer funded to work with older people.

The result of this has been:

- Communities for Health Newcastle as an exemplar of community-based commissioning given the initiative grew out of evidence from a range of community engagement activity including WEHEAR and 'Health Action Networks' [Community Action on Health];
- an operational model of successful GP to community referral including holistic assessment and goal setting for person-centred outcomes. This has been developed through intensive work with GP practices to develop a simple referral process and feedback loops leading to trusted and effective working relationships. The implementation of this model is variable between GP practices and requires further work;
- testing out the interface between Intermediate Care and community based services, through undertaking research with Intermediate Care and Community Nursing services to understand the barriers; creating information sharing/networking opportunities (see Challenge 1) and by testing out working with the 'older people's health trainer'. As part of developing a whole system re-ablement model it is proposed that new Therapy roles working between reablement and Intermediate Care can develop and extend the knowledge of , and relationship with community-based providers to continue effective and time referral, information sharing and signposting;
- testing out a holistic assessment model using the Outcomes Star and sharing the learning with Intermediate Care, Re-ablement and Your Homes Newcastle. This has included understanding the skills and competences required in an assessor; the links with First Contact and preliminary discussions as to whether the Outcomes Star could provide a common framework for assessment and monitoring across organisations, thereby building a stronger evidence base for prevention. This requires further discussion with partners and commissioners to establish whether it is appropriate to develop this model further;
- testing out the 'lead provider' model as part of the Communities for Health project with HealthWORKS acting as lead provider sub-contracting with Search Project and West End Befrienders;
- sharing the learning on 'Social Prescribing' at a VCS Open Forum event to gather views from the sector on the lead provider or alternative models and the potential of social prescribing as part of the mix of voluntary sector activity/funding.

This element of the work has included creating opportunities for sharing information and learning on the following developments:

- Diabetes Year of Care. One result of this pilot project is that Newcastle Bridges GP consortium will be introducing care planning into their practice;
- Provider Partnership Initiative and understanding the relationship between this work and access to community-based services;
- Your Homes Newcastle Floating Support and Activity Provision pilots by facilitating two consultation sessions to inform this development and making a commitment to the steering group for this initiative;
- 'Patient Centred Care and Vulnerability' PhD by Clare Abley, Nurse Consultant for Vulnerable Older Adults.

Challenge 3 – Understanding how to respond to the needs and aspirations of older people, in particular those at risk of isolation

This work has included:

- A programme of workshops with front line staff, volunteers and older people to share learning. This resulted in a 'map' of the services currently available to people with moderate to high level needs and evidence of the fragility of many of these services. It also resulted in a shared understanding of key factors associated with working with this client group e.g. importance of trusted relationships; small things make a difference; need for universal/non-stigmatising services.
- Intensive case study work by the Occupational Therapist with four clients resulting in evidence of triggers for early intervention; the input required to deliver a case co-ordination approach which includes building relationships, identifying goals, addressing 'disengagement'; empowering individuals to take action; the value of a 'single point of access' to community-based activity; a cost-benefit analysis of case co-ordination approach and recommendations for areas of further research/development e.g. virtual wards.
- Testing out a 'dementia café' in a community-based setting which included building relationships between the Memory Clinic and community based support networks.
- Initiating a service design approach with the Age UK Newcastle Befriending Service with a view to testing out new approaches to meeting the needs of isolated older people currently being referred for befriending or lunch club services. This work will continue to be delivered by Quality of Life Partnership during 2011.

What next?

Opportunities

- A seminar being organized by JtD/C4H steering groups to share the learning from the work to date and engage partners in determining the next steps. (Provisional date: 24th March 2011)
- To take forward the learning and activity from the JtD into a geographical 'age-friendly city' pilot building on the work in the West End and potentially exploring taking a similar approach which builds on the local resources and capacity in a.n. other locality in the city;
- To work with partners to ensure that the learning from the JtD project informs the proposed Wellbeing Strategy for the city and the relevant JSNAs and supports the case for pooled budgets to deliver prevention;

- To further explore the 'lead provider' or other commissioning models with GP consortia and the voluntary and community sector;
- To further develop the referral protocols and assessment tools developed as part of the Communities for Health pilot with GP practices, Intermediate Care, Re-ablement and the Your Homes Newcastle Floating Support Pilot;
- To further explore and test innovative models of provision for frailer and more isolated older people as part of the service design work being taken forward by Quality of Life Partnership/Age UK Newcastle;
- To explore opportunities for taking forward the recommendations from the Intermediate Care component of JtD into the development of Intermediate Care and the Provider Partnership Initiative.

Longer Term Challenge

The primary focus of JtD has been on prevention and early intervention to prevent or delay the need for high cost health and social care services. However, it is recognized that there will always be some people with complex needs for whom we need to find a more effective solution. An issue highlighted by the work of the Occupational Therapist is the gap in case co-ordination which will enable the coordination of services to meet a client's health, social and emotional wellbeing needs to avoid crisis situations/rapid deterioration when the client requires multiple services from multiple providers. It is unclear given the current changes where the leadership to take this forward lies and it remains a longer term challenge.

Risks

- Lack of clarity/changes in commissioning structures potentially resulting in missed opportunities to pool budgets and build on current work as a contribution to promoting the wellbeing of individuals and communities;
- Lack of resources to test out the Strategic Linkworker model;
- Lack of resources to sustain prototype of GP referral pathway and the investment in local activity provision currently delivered by the Communities for Health project;
- Impact of the transfer of PCT provider services to the NHS Foundation Trust and risk of the learning from the Intermediate Care input to JtD being lost in the transition;
- Impact of Local Authority/NHS re-structuring in response to the following policy changes: Capable Communities and Active Citizens; Equity and Excellence and Healthy Lives, Healthy People;
- Reduced capacity and choice in community provision in the light of the current funding position.

References:

The following reports underpin this report:

Joining the Dots – Interim Report – March 2009 – April 2010

Communities for Health Project Report – 2008-11

Joining the Dots – Report by Jeanette Robson – Occupational Therapist (Intermediate Care) – October 2010

Joining the Dots – Case Study Report by Jeanette Robson – Occupational Therapist (Intermediate Care) – October 2010

Prepared by the Joining the Dots Steering Group – February 2011

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