

The background features a repeating pattern of stylized hands in various colors (orange, yellow, green, light green) reaching out and grasping each other. These hands are set against a backdrop of concentric, semi-circular bands in the same color palette, creating a sense of movement and interconnectedness. The overall design is vibrant and positive, symbolizing community and support.

Cambridgeshire Older People Strategy

Developed by:

- Cambridgeshire County Council
- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridge City Council
- East Cambridgeshire District Council
- Fenland District Council
- Huntingdonshire District Council
- South Cambridgeshire District Council
- Better Health Network

Introduction

Cambridgeshire's Health and Wellbeing Strategy (agreed by all of our organisations working across the county), includes a commitment to support older people to be independent, safe and well. It describes our shared goal to support older people in Cambridgeshire to live healthy lives, engaged and empowered to make decisions about their own health and wellbeing and play active roles within their local communities – as well as providing cost-effective and quality support and services to those that need them.



This document is not intended to set out in detail what each of our organisations will do. Instead it aims to summarise the principles that all of our organisations agree to consider when planning and designing their services.

Our vision for this strategy

Older people are more independent, more active and more engaged in their communities for as long as possible; knowing that if they need them, they can rely on services which are flexible, creative, coordinated and focused on keeping them well.

By working together, the partners signed up to this strategy want to make sure that across Cambridgeshire:

- Older people remain independent, living in homes that are appropriate to their needs and actively engaged in their communities for as long as possible
- People retain or regain the skills and confidence to look after themselves and their families into older age
- Carers of older people are able to cope with and sustain their caring role and choose the support which is right for them
- Older people live with dignity, are safe and protected from harm and isolation.

Finding ways of promoting independence and so preventing people from needing long term health and social care services reduces costs and promotes better outcomes for older people. To do this, we need to start long before health and social care services have traditionally become involved in people's lives.

People's health is affected by many different factors, known as the 'wider determinants' of health. Most people know that our health is affected by age, gender and genetic factors; our individual lifestyles, such as what we eat, and the amount of exercise we get.

However, this strategy recognises that health and wellbeing is also affected by community networks (the amount of support that we get from friends, family and the local community); living and working conditions such as housing and work environment; and wider socio-economic, cultural and environmental factors.

Getting it right for everyone can support people to stay well and stay active into their older age, reducing the need for health and social care services.

Where we want to focus our efforts:

- Building strong, sustainable communities which support people to age well
- Helping people to help themselves
- Preventing crisis and helping people to recover from crisis
- Flexible, coordinated and creative long-term support for those that need it
- Appropriate and person-centred end of life care for residents and their families and informal carers



For more detail please see pages 7-8

Features of an effective system:

- Support that helps people to age healthily
- A universal network that helps older people to find advice, information and community and public sector services
- Coordinated and intelligence-led early identification and early intervention based on local needs, best evidence and good practice
- No wrong point of contact
- A shared risk stratification tool
- Multi-agency and multi-disciplinary teams with joint assessments and a lead professional where appropriate
- Flexibility to use budgets in a creative way that meets need and promotes independence



For more detail please see pages 9-11

Older people's needs in Cambridgeshire

In order to achieve our vision, there are a number of needs and challenges that must be addressed.

An ageing population

In Cambridgeshire, we expect to see the number of people over 65 grow by around a third over the next ten years, with a clear expectation that this will put pressure on services. The number of older people will grow faster than the population as a whole.

Increasing levels of need

Most older people in Cambridgeshire are in good health, but over a lifetime can expect to spend longer in poor health and with disability than previous generations. As the population ages, it is expected that more people will need more intensive support for longer. We will see a significant increase in the numbers of people aged over 85; older people tend to be at more risk of becoming frail or developing conditions such as dementia. This increases, and is often linked to, vulnerability to crises like financial hardship, a fall, or bereavement.

A growing county

At the same time, the county's population is set to grow significantly, with a number of new housing developments – creating opportunities for development, but also challenges in providing the facilities that people need and environments that will promote health and wellbeing and ensure that older people can remain independent in their communities for as long as possible.



More information about the specific health needs of older people is described in the Cambridgeshire Joint Strategic Needs Assessments, visit www.cambridgeshireinsight.org.uk/jsna.

Meeting the challenge

All public sector organisations in Cambridgeshire are facing unprecedented financial challenges, and over the next five years funding is set to decrease significantly in real terms. A wide range of support and services are provided by a number of organisations across the county that have an indirect and direct impact on supporting older people. However, the elderly population is increasing rapidly. If nothing changes, the reality is that unsustainable proportions of our budgets will be spent on health and social care services over the next twenty years.

In the past, services for older people have focused on beginning support for older people when their needs are greatest – such as when they have a hospital stay or following a crisis at home such as a fall. This means that a majority of the budgets across our organisations are spent on providing expensive and specialist support for a minority of older people. By getting good basic services in place that create communities that support people to age well; by intervening earlier and supporting more people to remain independent, rather than only providing support once people reach a serious level of need; and by working together to provide better services tailored to individual people that use them; we can support more people and reduce the demand on funding. **All of our organisations play a part in this.**

The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is responsible for ensuring that high quality NHS services are provided to people in the county. This includes people who are admitted to hospital for emergency treatment, as well as those living with long-term health conditions.

Cambridgeshire County Council is responsible for Adult Social Care services for older people. These include prevention, early intervention and support for vulnerable adults, including provision of advice, information, advocacy and support for carers. It also includes assessing the needs of adults with particular vulnerabilities and then commissioning, procuring and providing services that meet people's assessed eligible needs.

The County Council Public Health service supports adult social care and the CCG in understanding the health, wellbeing and care needs of our local communities and ensuring that health inequalities are tackled, by improving the health of the poorest members of our community fastest, and preventative strategies are developed. This includes completing analysis of need in the population, getting the right evidence to plan programmes and services, and providing advice and support to ensure that health and care services meet the needs of our population.

District Councils and the **City Council** provide a range of services which impact on older people's health both directly

and indirectly. They provide a range of services relating to public health, such as preventative and rehabilitation activities for health improvement; and services including planning; housing and homelessness; leisure and culture; and community safety and anti-social behaviour. They also provide a range of front-line universal services that can act as 'eyes and ears' on the ground to identify older people that may be in need of more support.

Housing providers (whether housing associations or district councils) are major care and support providers, working with local authorities and health partners across the county. Housing associations act as landlords to tenants of public sector housing in many districts (in some areas this landlord role is also provided by the District Council); whether in individual homes or sheltered and extra care housing but they also provide much more, supporting choice and control and the delivery of integrated care in people's homes. Housing associations also offer a range of services in the local community.

Voluntary and community sector (VCS) organisations provide a wealth of services, information and advice that promote independence and help to improve people's wellbeing and thus prevent health problems; as well as delivering health and social care initiatives within communities that avoid the need for more costly or longer term care in other sectors. VCS organisations are crucial in identifying service need; helping to design and provide services to meet that need; and in advocating and campaigning for people whose voices are not always heard.

Where will we focus our efforts?

In order to create sustainable services that help older people to stay independent, active and engaged in their communities for longer, we will look at services across all partners; working to design a system that has five areas of focus:

Building strong, sustainable communities which support people to age healthily

We want older people to enjoy long and healthy lives, feeling safe at home and part of their community. However, there remain major inequalities in life expectancy aged 65; and 11 per cent of people aged over 75 report feeling isolated, and 21 per cent feel lonely. Isolation and loneliness can have a significant detrimental effect on people's mental health. Our services can impact on the wider determinants of both physical and mental health. We need to make sure that people are supported to live in appropriate housing; prevent social isolation amongst people living alone; and promote 'age-friendly' communities. This can be done through our housing and homelessness services; through support provided by local health services to people who are developing greater needs; and by ensuring that a range of services provided in local communities are accessible to all. We also need to support people to age healthily when planning new estates, villages and towns. Providing easy access to local facilities and public transport can encourage more active lifestyles; ensure that people can remain living in their housing of choice; and avoid becoming isolated from others.

Helping people to help themselves

We will support people to help themselves, through easy access to information and advice for older people and their carers; through activities, support and friendship that will contribute to individuals' wellbeing and ability to live independently in their local communities. Alongside communities, supportive families and carers are crucial; families and carers are usually best placed to support individuals.

Preventing crisis and helping people to recover from crisis

We will work together across the services provided by our organisations to identify those that are at risk or vulnerable to developing greater needs, and respond accordingly, by working with them to put support in place that will enable them to remain independent. This will need effective information sharing between organisations and a quick and efficient response to identify whether support would be beneficial. Crises are inevitable and when they occur we will work to ensure that a coordinated response from all agencies is put in place quickly. Our aim is to prevent older people being admitted to hospital when it is not necessary, and wherever possible once the crisis is over, supporting individuals and their carers to enable them to remain in homes that are appropriate to their needs and in their communities as long as possible, rather than moving into long term social care services. We will try to avoid asking older people to make long term decisions in a crisis.

Flexible, coordinated and creative long-term support for those that need it

For people who need more long-term support from health or social care, we will make sure that they are in control of the care they receive and that this care takes into account their full range of needs - not just what they can receive from any one of our organisations.

Ensure appropriate and person-centred end of life care for residents, support for their families and informal carers

The Government defines a 'good death' as one which involves being treated as an individual, with dignity and respect; being without pain and other symptoms; being in familiar surroundings; and being in the company of close family and/or friends. Whilst many people do die like this, and many experience excellent care and support; many other people do not. We will work together to ensure that people approaching the end of their life are well supported and can die as they would wish as far as is possible; with their family and informal carers closely involved in decision making and also receiving the best possible support.

Features of an effective system

In order to achieve the outcomes and focus described above, we will develop a more integrated or 'joined up' approach across all of our services. This will require close working by all of our organisations, the voluntary sector and private care providers. The system is likely to include the following features:

Support that helps people to age healthily

We will help people to plan for ageing, through access to early advice. We will signpost people to financial advice, and advice on healthy lifestyles – such as eating well and remaining active; and ensure that across all of our core services – for example leisure and cultural services or primary health care – people are made aware of opportunities that will help them to age healthily such as 'healthy walks' or exercise programmes often commissioned by district councils. We will seek to work with local employers to provide support for people working longer, and encourage them to plan for their future.

A universal network helping older people to find advice, information and community and public sector services

We will provide coordinated advice on health, housing and social care issues, in ways which will be quick to access, clear, friendly and personalised. We will coordinate information available across our organisations to make sure that people will get the right information, regardless of who they ask. As well as information available online and through leaflets, 'Community navigators' and all partner organisations will work face to face with older people to enable them to access the relevant services and explain how the system works. We will work to provide reliable advice and support for older people before they become frail or need to access more intensive services.

Coordinated and intelligence-led early identification and early intervention based on local needs, best evidence and good practice

We want professionals across all public sector agencies to be proactive in identifying need and either help to address it there and then, or to refer the person quickly to the most appropriate support. To make this happen, where appropriate we will improve information sharing between organisations in contact with older people to help them access the right support. We will agree a set of 'triggers' that are a strong indicator that people's needs have increased – for example if someone requests help in putting out their wheeled bin – that will lead to the most appropriate organisation making contact with that individual to identify if they could benefit from further support. We want all front line staff to act as 'eyes and ears' on the ground to identify and refer potentially vulnerable people to appropriate support. We will also work closely with the voluntary sector to support those caring for family members.

No wrong point of contact

We want people to be able to access support in the way that works best for them, and so we will make sure that support can be accessed via a wide variety of routes, and that people are not turned away for contacting the 'wrong' organisation. We will ensure that people get access to the right support whether they first contact the NHS, social care, Districts, housing providers or the voluntary sector

Flexibility to use budgets in a creative way that meets need and promotes independence

We will undertake strategic work together to develop joint initiatives that will reduce the cost to the public purse. We will use information on local need, best evidence and good practice to identify and implement effective initiatives and services. We will design a more flexible approach to budget management which allows practitioners from different partners to use the available budget in a flexible way or combine their resources or work across organisational boundaries to find the most cost-effective solution.

Multi-agency and multi-disciplinary teams with joint assessments and a lead professional where appropriate

We want to create multi-disciplinary teams for people that need more support, which have access to expertise from health, social care, housing, voluntary and other sector professionals, who will work together to coordinate services. In particular, social work, GP surgeries and other health provision can be much more closely aligned to improve information flows and enable more integrated decision making. This concept of a 'team around the person' is a feature of all Local Commissioning Group plans. We also want to ensure that all professionals visiting and older person in their home will commit to check and review their wellbeing and share this information with other members of the team. Whilst recognising that there may be a point at which a detailed specialist or statutory assessment is needed, it has been agreed that having a shared and joint approach to identifying the primary need in someone who may present as vulnerable or frail would be valuable.

A shared risk stratification tool

To help to coordinate support provided by each of our organisations, we will develop a shared tool that will be used by all professional and providers working with an older person to describe levels of need and develop a common language and way of stratifying risk.

How will we deliver on this strategy?

Delivering on this strategy will require a concerted effort from all of our organisations to shift our resources from supporting people when their need is greatest to encouraging people to live healthy lifestyles so that they do not develop support needs as they age. This will require a change in the culture in each of our organisations. There are a number of current projects that are developing the approach to this transformation:

The Better Care Fund is a partnership between health and social care which will see money transferred from health into a pooled budget between health and social care. This is not new money, but it will be invested in services that prevent people from needing to access expensive long-term social care and acute health services

Transforming Lives is the County Council's new approach to Social Work. It sets out a new approach based on three tiers: Help to help yourself; Help when you need it; and on-going support for those who need it. It emphasises the need for more people to access support in their local community, supported as appropriate to live independently. This is in line with the principles of the Care Act 2014.

The Cambridgeshire and Peterborough Clinical Commissioning Group's Older People Procurement exercise is an ambitious programme to align the local health and social care system and completely re-structure how it operates. Through a new contracting approach which will pay by outcomes, it will create an incentive for the lead provider to transform service delivery and work with other organisations to coordinate services and reduce demand for more long-term services.

There is significant ongoing health improvement and preventative health work in Cambridgeshire through Public Health's Programmes team, commissioned services, and a new 'lifestyles' service is currently being established. We will consider developing a 'lifestyles investment plan' to support healthy ageing.

We are currently developing an ‘operating model’ (see the appendix) which sets out how the system will work in practice, including how different parts of the system relate to one another. This will bring together our ambitions across the system, and form the basis for discussion and negotiation with the new provider appointed by CPCCG in September to deliver older people’s and community health services. We have established a new group – the Cambridgeshire Executive Partnership Board – which will provide whole system leadership and coordinated multi-agency oversight of health and social care service transformation for older people and vulnerable adults in Cambridgeshire. The Board will:

- In line with the Health and Wellbeing Strategy to oversee joint planning and a programme of transformation for older people and adults including mental health (14-64, 65 years +) aligning with the Partnership Strategy for Older People and other related service strategies.
- Support the Health and Wellbeing Board to provide effective leadership, management and governance of the Better Care Fund.
- To provide a forum for multi-agency oversight of the Older People and Adult Community Services contract, risk and financial management including development of annual plans and outcome framework revision.
- To develop and oversee a joint action plan to deliver the transformation programme, and guide the work of joint integration staff.

How will people experience this strategy?

The changes described in this strategy will affect the people that receive our services, and the people that work in our services. As we work on making this change, **we want older people to be able to say:**

Social – I have a sense of purpose and good relationships; I live in my community and can play an active role

Health, care and support – I am able to manage my health and wellbeing, get support when I need it and make choices about that support

Environmental – I live in a place that is sensitive to my needs, healthy and enables active participation

Personal resources – I can make of use my strengths and abilities; I can afford a good quality of life

Improving patient and service user experience will be essential to this work and we will take every opportunity to consult with and engage people living in Cambridgeshire to check that the changes that we are making are improving their quality of life.

Measuring success

We will develop a set of measures to check on progress against the outcomes set out in this strategy. Measuring preventative work is a challenge as it is difficult to demonstrate how organisations have avoided the need for people to receive care.

Appendix: operating model for older people's services across the health and social care sector in Cambridgeshire

