East Lancashire – *building relationships across the community*

**TOGETHER**

**A HEALTHIER FUTURE**

*Services are provided to the residents of East Lancashire & Blackburn with Darwen.*

*Combined population of 529,000.*

- Aims to deliver better quality and more effective services for frail elderly patients
- Use integrated community teams working in localities and neighbourhoods, in partnership with primary, community, social and mental health care services.
Strategic

• Safe, Personal, Effective care for frail older patients closer to home where safe and appropriate.
• Comprehensive patient assessment, with care planning and case management.
• Integrated neighbourhood teams, with case finding.
• Intensive Home Support Service, including Front Door Team
• Redesigning Acute Medical Care
• Integrated Discharge Service

Focus areas

Improving care and communication in last 12 months of life for frail older people

• identification
• collaborative care planning on “goals of care”
• communication across the care continuum

Measuring and learning from patient experience across the continuum of care for frail older people.

• Develop measurement and feedback of patient and carer experience for frail older people in multiple formats
Integrated Discharge Team

Rapid Reactive Care

HOSPITAL

UCC/A&E

Admission Avoidance

Proactive Care

Delivered by Integrated Neighbourhood Teams

Case Management MDT Meetings

GP Team, Integrated Therapies, District Nursing, Mental health, Social care, Voluntary sector

Over 75 Nursing Team

Care Home Nursing Team

Palliative Care Team

Medicines Management Team

Supporting self care

ICAT (Intermediate Care Allocation Team)

Intensive Home Support

Advanced NP, Therapies, Social Care + any needs Based Service

GP input (own GP or GPwSI)

Secondary Care support

Admission Avoidance
Pennine Lancashire Transformation Programme

Population Outcomes
- Health
- Wellbeing
- Independence

Quality of Care
- Safe (including access)
- Effective/evidence based (including equity)
- Patient Centred/experience

Sustainability
- Affordable (including shift to prevention)
- Fulfilled/satisfied workforce
- Culture of collaborative learning and well led

Programme Health
You are invited to attend an engagement event on Monday September 12 2016 at:

Windsor Suite
King George’s Hall
Blackburn
BB2 1AA

Arrival 5pm for light refreshments
5.30pm start. Finishes at 7.30pm

Please come along and help us shape the future of health and social care services in Pennie Lancashire. We need your views and ideas on what works well, what needs improving and how together we can face the challenges ahead.

Please confirm your attendance by emailing Involvement.mlcsu@nhs.net
Frailty Model

- Awareness
- Identification
- Assessment
- Individualised Care Planning
- Review
- Communication Feedback Measure
Frailty RCP FH

Safe, Personal, Effective care for Frail Older People

Reduced Hospitalisation

Increased independence

Proactive care planning for those at risk of “admission”

Multi-professional assessment and care planning (CGA)

Multi agency collaboration

Care planning in last 12 months of life

- Integrated Neighbourhood teams
- Proactive care planning meetings

- Integrated Neighbourhood teams
- Intensive Home Support/ ICAT
- Frailty Front Door Team (ED and AMUs)
- Integrated Discharge Service

Together a Healthier Future
Frailty Health Improvement Partnership

- Identification
- Care Planning GPOC
- Communication
CQUIN 2016/17

**Part 1** Implementation of the Rockwood Scale to facilitate early consistent recognition and assessment of patients with frailty across the emergency medical pathway

**Part 2** Meeting patient’s needs - service user feedback to be designed, conducted, results reported and action planned.
“A Tale of 2 eras”
JB 81 yr Man- Limited mobility, type 2 diabetes, CABG

June 2015
• Fell in garden
• Fractured NOF, admitted RBH
• Operated, to be transferred to Clitheroe CH
• Post op infection delayed transfer by 3 weeks
• Transferred at 10pm to Pendle CH family phoned from ward.
After 4 days back to RBH
• On discharge care package – did not arrive for 4 days. Change of provider
• Family took over care

August 2016
• Admitted with high blood sugar and reduced consciousness
• After stabilisation initial plan for Clitheroe CH, but changed to home with INT, and community Diabetes Nurse, District Nurse, physio
• Community pharmacist did medicines review in home
• Praise for INT coordinator
• District nurse liaises with GP
• Managed exacerbation without hospital
• “treat us as people not numbers”
“My 10 hour fall”
VF 92 yrs lady - previous Cancer, leaking heart valve, Knee Replacement.

December 2016.
• woke at midnight, started to get out of bed, the bed moved and fell on the floor, couldn’t pull herself up.
• crawled into the passage hoping to reach the telephone in the living room, but could not get there
• laid all night until 10.30 in the morning, when son arrived on his daily visit.

• son immediately called emergency services and a paramedic sent. Taken to emergency department.
• “By this time I was nearly passing out and I was very cold because I had only been wearing a nightdress”.

• in a bit of a daze “I think I saw saw four doctors and other staff. They told me my blood pressure was good and her heart was OK and I hadn’t broken any bones.” at the end of the assessment told she could go home,

• Later that afternoon taken went back to her apartment by her sons.
• reablement care package in place to start the following morning.

• She praised the care she was receiving at home with support staff visiting twice a day and other visitors, but she praised a therapist who had got her moving again. “After four weeks I can walk round the park twice and I’ve been to Morrisons with my son”

• The sons have now put a cordless telephone in her bedroom and she has a panic button round her neck. “I never take it off. I can even wear it in the shower. It is more valuable to me than even the carers.”
INT SAMPLE ANALYSIS: (EL CCG patients)

All Unplanned Activity Data Analysis

- Number of Patients in Sample Group = 155
- Number of Meetings Held by INT = 653
- Ratio of Initial : Follow UP 4.2

Max Unplanned Activity Cost in a Single Month (Pre MDT) £ 109145

Cost of this Cohort in 201607 £ 24200

[Source : INT Data]

[Diagram showing chart to show (ELHT) Unplanned Care Activity & Cost for selected Cohort of patients seen in the INT/ILT]
IHSS and ICAT activity
Trusted assessment

The table is to highlight services/actions to consider and should not be used prescriptively but as a guide only. Any referrals made or action taken should be based on the professional’s assessment of patient’s specific need.

<table>
<thead>
<tr>
<th>Vulnerable - Mild</th>
<th>Moderate - Severe</th>
<th>Very severe - Terminal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-management education</td>
<td>INT – case manage</td>
<td>Implementation advanced care planning</td>
</tr>
<tr>
<td>Social support</td>
<td>Red flag</td>
<td>DNACPR</td>
</tr>
<tr>
<td>Medicines management</td>
<td>Discussion re: advanced care planning</td>
<td>Special cautionary note</td>
</tr>
<tr>
<td>OT – Home assessment</td>
<td>Contingency care</td>
<td>Supplementary medication</td>
</tr>
<tr>
<td>Physio – Personal exercise programmes</td>
<td>Preferred priorities</td>
<td>Gold standards framework meetings</td>
</tr>
<tr>
<td>Falls screen</td>
<td>Advanced decisions</td>
<td>OOH – update</td>
</tr>
<tr>
<td>Personalised plan of care</td>
<td>Hospital avoidance care plan</td>
<td>Fast track/Hospice/Marie Curie</td>
</tr>
<tr>
<td>Local support groups</td>
<td>Specialist nurse</td>
<td>Macmillan</td>
</tr>
</tbody>
</table>

Clinical Frailty Scale

1. **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
2. **Well** – People who have no acute disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.
3. **Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.
4. **Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up,” and/or being tired during the day.
5. **Mildly Frail** – These people often have more evident slowing, and need help in high order (ADLs) (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
6. **Moderately Frail** – People need help with all outside activities and with keeping house (e.g., they often have problems with stairs and need help with bathing and might need minimal assistance (e.g., standy) with dressing.
7. **Severely Frail** – Completely dependent for personal care from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
9. **Terminal Ill** – Approaching the end of life. This category applies to people with a life expectancy <6 months. who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same questionnaires and social withdrawal. In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help.

*1. Canadian Study on Health & Aging Revised 2008
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### IHSS "Front Door" activity

<table>
<thead>
<tr>
<th></th>
<th>Pennine</th>
<th>BwD</th>
<th>East Lancs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients assessed by Front Door Team</td>
<td>4431</td>
<td>941</td>
<td>3490</td>
</tr>
<tr>
<td>No. of patients deflected From ED</td>
<td>1534 (35%)</td>
<td>427</td>
<td>1107</td>
</tr>
<tr>
<td>No. of Patients deflected from AMU A &amp; B</td>
<td>1706 (39%)</td>
<td>307</td>
<td>1399</td>
</tr>
<tr>
<td>No. of patients supported Discharge from ELHT wards</td>
<td>571 (13%)</td>
<td>16</td>
<td>555</td>
</tr>
</tbody>
</table>
Front Door Frailty Team

121 patients seen by frailty specialist doctor with IHSS over 6 weeks

90 discharged, 23 admitted to AMU, 3 to other speciality, 5 direct to intermediate care, 55 followed up by IHSS

Quotes: re addition of Frailty Specialist Dr ED Consultant: “Gives me confidence of a safe discharge. She has the time to go into detail that I will never have. The team have a familiarity with support services”

OT: “She gives us confidence to make higher risk decisions. A greater understanding of what can be treated at home. I am reassured that the patient is going to the right place. We now work in a less risk averse way.”
IDS Discharge pathways

IDS Headline Metrics – Reportable Monthly

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>Current Position (January 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDA Score</td>
<td>&lt;3.75%</td>
<td>5.79%</td>
</tr>
<tr>
<td>Average Daily Discharges – differential between weekend and weekday</td>
<td>&lt;50</td>
<td>40.6</td>
</tr>
<tr>
<td>MFFD</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>

Patient no longer has care needs that can only all be met within an acute hospital setting

Professional Discussion re appropriate discharge to assess pathway

MDT

Pathway Decision

TTNs arranged

Pathway 1
- Home with Reablement
  - Patients needs can be safely met at home

Pathway 2
- Residential Rehab Bed
  - Unable to return home and requires rehab

Pathway 3
- Complex Assessment Bed
  - Unable to return home – has complex care needs and may need CHC

Pathway 4
- Complex Rehab & Recovery Bed
  - Unable to return home – has a combination of sub-acute and complex care needs and may need CHC

IDS to confirm plan with patient and ward and arrange transport

Voluntary Sector
Reablement
Therapies
Community Rehab / ESD

Home with rehаб / reablement
- Olive House
- Castleford
- Springfield Resi-Rehab
- Turfcote Resi-rehab

Resi - Rehab bed in the community
- Up to 5 weeks
- Self Care
- Pathway 1
- Care Home

Rehab & Nursing out of hospital bed
- 3 weeks
- Long term care
- Pathway 1 & 2

Community Hospital Bed
- 3 weeks
- Long Term care
- Pathway 1, 2 & 3

CHC
HOC
Patient experience measurement

94% treated as an individual
96% treated with care and compassion

Considerable training and support of volunteers in administering surveys

Emphasis on narrative is important
Interviewing carers more difficult to organise

Additional learning from patient stories following discharge

The main themes for improvement:
• involvement of patients and carers in their care plans
• consistent information about care processes.

**ACTION**: review of current patient information used on wards, and best practice examples.
Develop new patient and carer information for frail older people.

<table>
<thead>
<tr>
<th>Combined result from all questionnaires submitted between 27/09/2016 and 22/11/2016</th>
<th>Number of questionnaires submitted between 27/09/2016 and 22/11/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>69.67%</td>
<td>32</td>
</tr>
</tbody>
</table>

**Results**
1. How likely are you to recommend the health and social care services to friends and family if they needed similar care or treatment?
   - Overall Meridian score for this question: 82.26% (based on 32 responses)
   - Distribution of results:
     - 43.75% Extremely likely
     - 40.63% Likely
     - 9.38% Neither likely or unlikely
     - 3.13% Unlikely
     - 0% Extremely unlikely
     - 3.13% Don’t know

3. Are your views taken into account when deciding on any care you might need?
   - Overall Meridian score for this question: 65.63% (based on 32 responses)
   - Distribution of results:
     - 50% Yes, definitely
     - 31.25% Yes, to some extent
     - 18.75% No

4. Are you involved as much as you want to be in decisions about your care?
   - Overall Meridian score for this question: 65.63% (based on 32 responses)
   - Distribution of results:
     - 50% Yes, definitely
     - 31.25% Yes, to some extent
     - 18.75% No

5. Are you treated as an individual (so your needs, values and preferences are respected)?
   - Overall Meridian score for this question: 67.19% (based on 32 responses)
   - Distribution of results:
     - 55.13% Yes, definitely
     - 28.13% Yes, to some extent
     - 18.75% No
Successes

• Multi-professional around the patients and their family – focus is care for patients within the own homes.

• ICAT
  – Merging IHSS with ICAT - MDT Approach from beginning of the patient journey.
  – Single professional navigation function for intermediate care.
  – Linking to the IDS - one system

• Trusted Assessments – receiving referral information and accepting the patient, building upon the information already given. This ‘document’ follows the patient and informs commissioning decisions.

• IHSS input at the Front Door – deflections, supported discharges

• Rapid Responsive element – 2 hour response times

• Being part of an Integrated Care Organisation (vertically integrated) allows immediate access to specialist opinion.
Challenges

• Working across two local authority areas.

• Home of choice policy

• Recruitment & Induction –
  – Recruiting staff with the right skill sets and competencies, and the right values,
  – Timely turnaround to be up and running safely as soon as possible.

• Measured marketing of the service to match building the service capacity.

• Cross Divisional working
  – Different management
  – HR, wages, annual leave etc.
  – Which team are they part of?

• Time for other staff to shadow – internal and external

• Locality based vs one team
Challenges and Barriers

- Working as a whole system – at least 6 organisations
- Daily operational pressures
- Staffing – e.g. numbers of Geriatricians

- Together a Healthier Future – structure and support
- Being part of an improvement programme – internally and externally
- Developing collective leadership roles of other staff
A story of a change in culture! – “we can”
PW – 84 year old lady – last week

11am – Referral to East Lancashire Social Services from the front door team
- patient to ED by husband following recent discharge with Package of Care but who was struggling to cope.
- “Potential Turfcote recovery bed candidate”.

11:45am – Social Worker and Complex Case Manager “Do not admit into any hospital bed base”.

11:50am – Patient notes - no medical needs. Trying to leave the unit to catch the bus. 1:1 supervision required.

12.10pm – CCM and SW assessed the patient who presented as ‘eccentric’. Able to answer some questions but lacked insight.

12:30pm – Requested for MH team to review. Known to OAMHLT but they are not funded to cover ED. On call MH team assessed. Deemed as lacking capacity. Known frontal dementia.

12.50pm – CCM and SW completed formal capacity assessment.

13.10pm – Contacted hospital safeguarding team? DOLs required. Advised not needed in ED.
If discharged to 24 hour care home they will apply for the DOLs.
A story of a change in culture! – “we can”

PW – 84 year old lady – last week

13.20pm – Contacted next of kin “ cannot return - not coping – I am undergoing a procedure at another hospital”
13.30pm – Decision made in patients best interests - 24hour care placement
13.45pm – CHC considered – Non trigger.
13.50pm – Verbal funding approval sought and gained from Social Services manager.
14.00pm – Social Worker assessment completed and typed.
14.05pm – Referral made to Care Home Select for emergency placement.

15.35pm - Confirmation received from CHS that a placement had been found.
15.40pm – CCM contacted ED to confirm discharge destination and advise to organise medicines if required and book transport.

Patient discharged to 24 hour care from ED, patient arrived at 21.45 pm
Next steps

• Widening the scope with NWAS – amber pathway to prevent unnecessary conveyances to hospital for other conditions/symptoms

• 24/7 same ethos at the “front door”

• More appropriate assessment area/time

• Build upon the mobile working elements and reduce paperwork to create more efficiency

• A true Discharge to Assess (D2A) model with home as the default position

• No CHC assessments in acute hospital

• Better information and expectation for patients and families
Lessons for others

• Culture is the key

• Good model but also recognise that constant change and evolution.

• That the right mix of staff is crucial.

• Work as closely as you can with other Community Services to ensure that the patients and family receive the right treatment without the “trauma” of navigating the NHS system alone.

• Allow self-referrals once the patient is known to the service – they can phone ICAT and have response on their door stop within 2 hours.

• Continuity of care – regardless of condition see the same team members – creating trust and confidence, do not have to “re-tell” their story.
Summary and Conclusion


- Patient and staff experience build resilience and resolve