Older People & Frailty Transformation Programme

Havering Health and Wellbeing Board

April 2019

Whole system case for change

Whole system case for change

Nationally, older people are the fastest-growing population in the community, with the number of people over 85 expected to double within two decades. It is also recognised across BHR that significant signs of frailty can be observed in those as young as 50 years of age and there is a need to make sure that models of care address the needs of the wider frail populations and not just those over 65 years.

Older People's health and social care has been identified as an area where cost savings can be made to contribute towards the BHR recovery plan. Specifically, a reduction in non-elective admissions and increasing the number of patients who die in their preferred place of death

•BHR has seen a 22% increase in NEL admissions in the last 3 years in the 65+ age group. A review of all emergency care admissions for 65+ age group patients shows a 5% increase in activity and therefore demand in 2018/19 compared to 2017/18.
•40% of the 65+ age group are admitted via LAS conveyance
•Havering has the largest number of Nursing Home residents in NEL and has seen a 13% increase in the number of nursing homes beds in the past 5 years
•A recent local audit suggests that 18% of the ambulance conveyances to hospitals can be avoided and could be managed at home. Locally, we see an average readmission rate of 27% following hospital discharge from our geriatric acute hospital beds
•BHR has the 3rd, 4th and 8th highest hip fracture prevalence of all London boroughs, with the average cost of all acute hospital falls activity being almost 17% higher than the NCEL average in 2017/18. Falls result in a loss of independence and increased long-term dependence on care and health services.
•In 2018, on average 54% of predictable deaths across BHR in people aged 65+ occurred in hospital, compared with the England average of 47%

It is estimated that by reducing the non-elective admissions by 12 per day across BHR and decreasing predictable deaths in an acute setting from 45% to 35% would provide £15.1 million net over two years. The opportunities for managing demand on social care services is currently being worked through and the business case will be updated when this information is available.

Whole system case for change .. contd

There is a need to change the way health and social care is delivered across BHR in way that reduces demand on specialist services and brings care closer to home whilst allowing people more control over their health and wellbeing throughout their life course. Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England

Whilst some integration of services has been achieved across BHR, a stakeholder mapping and review of the “as is” model of care as identified that the system is not operating in an integrated way. Activities are duplicated as people move between social care, health care and community partners and communication and co-ordination across organisations is not consistent. This is impacting on patients experience and access to services across BHR.

Interventions to support healthy ageing are not embedded into the current service model. National estimates from 2015 suggest 19% of people are seeing their GP for non-health reasons, whilst local GPs suggest that up to 40% of GP appointments do not need to see a GP and are seeking support for wider issues that can be better solved elsewhere.

There is a wide evidence base that outlines the benefits and successes in delivering integrated care, with the following themes identified to support successful system working:

- Working through primary care networks – whether it is social prescribing, hospital at home or community based teams
- The ability of community teams to access to specialist support
- Professionals working across the health and social care having access to technology that makes sharing actions and care records as seamless as possible
- Central co-ordination of system delivery to ensure quality and equity in care

Vision and overarching Model of care

Our vision

The Older Peoples and Frailty Transformation programme was established to co-ordinate transformational change across older people's services to improve quality, patient outcomes and to ensure services are as efficient as possible and integrated around the patient. The Transformation Board, with input from stakeholders and local residents has developed an overarching vision for the programme:

'For our Older and Frail residents of Barking and Dagenham, Havering and Redbridge to live healthier for longer, in their preferred place of residence - through our integrated services proactively supporting their health and care needs.'

A patient reference group was set up to provide feedback on patient experience of services for older people and advise on the development of a new model of care. The group developed ten principles that they felt should underpin all transformation initiatives, which are summarised as the **"Ten C Principles"**

Key objectives

The key intention of the Older People & Frailty Transformation Programme will be to offer a sustainable transformation platform that meets and controls the current and future demands on the local BHR wide health and social care resources. By achieving this it will ensure that the system consistently delivers good quality of care that meets individuals needs and supports individuals to maximise their own independence.

The board agreed to take forward the four key objectives to focus the transformation developments.

1. Help local people to live healthier lives

2. For all older people to have a good experience of their care, living well for longer and supported to remain independent for longer

3. Embed integrated care interventions that minimise frailty and where possible avoid unnecessary long-term increases in care and/or health needs

4. To acknowledge a persons wishes, and support their end-of-life needs in their preferred place of care

So as to meet these four key objectives the programme has identified the following as areas that will require highlighting throughout the various work streams.

•**Prevention of Frailty**: There is a commitment to embedding the prevention of frailty throughout the programme recognising the current and future impact this can have on reducing demands and utilisation of provider resources. Through supporting community assets and increasing community connectivity our local residents will be supported to remain independent for longer by taking responsibility for their own and their communities' health and well-being.

•**Integrated Care**: Through the development of a truly integrated care system the local area will see an improvement in the quality of health and care. These new ways of working across traditional organisational boundaries will enable our health and care resources to consistently deliver the Right Care, in the Right Place, at the Right Time (as upheld by the 2019 NHS Long Term Plan).

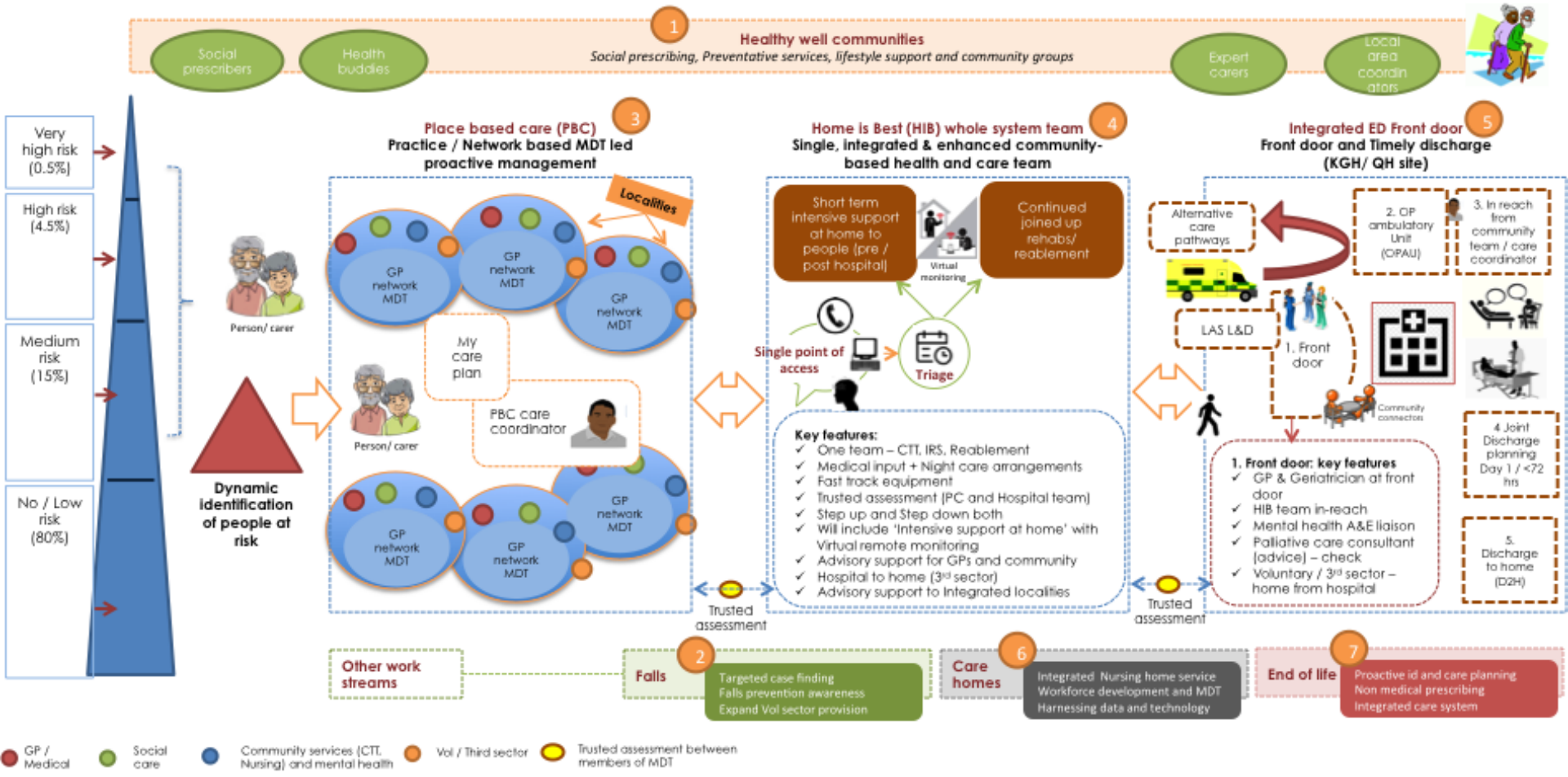
•**Personalised Support**: Through early identification and proactive intervention, the integrated care approach will ensure that the needs actually meaningful to the individuals are supported to be met. Effective care-coordination enhanced by the introduction of a single multi-agency care plans that are co-designed with the individual, will truly personalise the support provided.

•**Optimising Independence**: We will introduce a proactive and multi-agency approach to our populations frailty management needs that enables individuals to remain independent for longer within the community. Additionally, the new ways of working will see enhanced co-ordinated support following any life-crisis that continues through to recovery and, where possible, avoid longer-term needs.

•Supported **End of Life Care:** By redesigning our end-of-life services, the integrated palliative care model will offer a consistent access to good quality palliative care that meets the needs of the local population and reflects the national standards of palliative care.

•**Improved Efficiencies:** By fostering appropriate use of our limited resources, reducing duplication, and respecting others' discussions, the whole-system will see improved efficiencies and increased satisfaction across organisations, the workforces and by those using or affected by the services.

Overarching model of care



Model of Care – Key Work Streams

A number of work streams (set out below) have been set up to support the implementation of the new model of care. Over time it is anticipated that these will reduce as new delivery models such as placed based care become more developed.

1. Healthy Well Communities	This work-stream will support the local community to take meaningful steps to improve the longer-term well-being of local residents focusing on initiatives that prevent frailty, tackle social isolation and consider the wider determinants for health, such as housing and the local environment.
2. Falls Prevention	This workstream will deliver a BHR falls prevention strategy with an initial focus on improving the recognition and recording of falls to enable those at risk to be supported to access falls prevention initiatives, including a full-holistic assessment and management for those at high risk of falls.
3. Place-Based-Care	This workstream will see the development of a new way of working for community health and care services, integrating care across GP networks. Multi-disciplinary teams will use a risk stratification approach to proactively identify older and frail people in need of support and provide seamless person centred care. New care navigator roles will be developed to both improve patient outcomes and reduce the demand for specialist health services.
4. Home Is Best Model	This workstream will establish a single, integrated and enhanced community based health and care team which will provide short intensive support to people at home pre/post discharge. This will be achieved by bringing existing services together to deliver a new service model with enhanced medical leadership and support.
5. Integrated Emergency Department Front Door	This workstream will initially develop a single-integrated team at the front-door of our main emergency department. Recognising that any extended stay in the hospital environment often results in unnecessary deconditioning for an older person, the frail attendees will be fully assessed to determine if and how with the full-support of appropriate community services the individual could return home to recover at home. Subsequent evaluation of the initiative may expand the service to other sites.
6. Care Homes	This workstream will focus on the delivery of *New models of care, the framework for enhanced health in care homes"* All care homes will receive enhanced primary care support delivered by the GP Federations. Other initiatives supported by Healthy London Partnership include training care home staff to recognise and appropriately respond to the signs of deterioration in their residents, the expansion of the "Red-Bag" scheme and the introduction of "Care Home Trusted Assessor" roles.
7. End of Life	This worsktream will develop a BHR-wide ICS model for end-of-life and palliative care, enhancing and streamlining the current end-of-life services to ensure that local residents and their families experience good quality and supportive care through the later stages of life. In the short term there will be a focus on rolling out the shared-care-record (Co-ordinate my Care) across BHR and implementing non-medical prescribing in the local hospice-at-home service.

Impact on quality and outcomes and savings

Quality Improvement

The table below provides a summary of how the model of care will impact on quality domains across the system.

Leadership	• An opportunity to develop and embed well-led cross-organisation new ways of working • Clinically led improvements that reflect local population needs • Development of new roles and responsibilities across the workforces leading to improved job satisfaction.
Integration	• Multi-agency new models of care and whole-system integration of care offers opportunities to showcase innovation across the system • Opportunities to develop / adapt new model of care to meet local need. • Streamline the interface between traditional organizational boundaries, reducing duplication, sharing risks and implementing excellence.
Innovation	• Adoption of digital innovations to support service delivery • Use of communication technology to support efficiencies i.e. video-conferencing • Develop a cross-organisation shared records platform • Use of live agile data bases to support access to meaningful care when required.
Patient and Service User Experience	• Local residents will benefit from the timely delivery of coordinated multi-agency services and be supported to implement their own personalized shared care plan that reflects their actual needs and has been co-designed by themselves and their care-coordinator. • Leading to positive reported outcome and experience measures (PROM & PREM's) and improved Friends & Family satisfaction with local services as demonstrated by BHR system wide HealthWatch service experience appraisals.
Safety	• Multi-agency peer review and support that fosters ownership and measures of an individuals safety that avoids unintended or unexpected harm • Learning from critical appraisal of reported "near-miss" incidents to improve future service delivery • Plan-Do-Study-Action development cycles will be embedded into all areas where multi-agency new ways of working are introduced enabling: testing, re-modelling and delivery at scale of the new models of care derived from transformation. This will ensure that optimal cross - organisation collaboration and resource utilization is achieved as the new models are embedded into usual practice.
Workforce experience	• The support of the whole-system workforce to design and implement real-world new ways of working that enhances care delivery, will create a more desirable working environment working so improving the recruitment and retention ambitions of the local area. • Opportunity for unique cross-organisational working arrangements • Opportunity for personal development and attainment of recognised transferrable skills (professional development) for whole workforce.

Proposed work streams and summary impact

- The following table provides an overview of estimated reduction in activity, cost and net savings across key work streams
- The impact of transformation will be wider than just non-elective admissions such as
  - Impact on social care, which has not been quantified due to non-availability of baseline spend in domiciliary and residential care.
  - Improvement in efficiency across the system through reduction in duplication and better interface between frontline workers
- The investment costs do not include any additional project management costs. Delivery of projects will be done through system wide delivery teams and groups that will be supported by system wide PMO
- More details on individual work streams are in the individual business cases (PIDs)

		19/20 PYE				20/21 FYE				Total FY			
	Workstreams	Reduction in activity	Gross Saving	Investment	Net Saving	Reduction in activity	Gross Saving	Investment	Net Saving	Reduction in activity	Gross Saving	Investment	Net Saving
1	Place Based Care	184	£388,817	£222,751	£166,066	318	£678,247	£56,555	£621,692	502	£1,067,064	£279,306	£787,758
2	Falls Programme	176	£497,086	£200,284	£296,802	150	£496,646	£50,428	£446,218	326	£993,732	£250,711	£743,021
3	Home Is Best (HIB)	674	£1,582,300	£783,768	£798,532	796	£1,866,888	£817,215	£1,049,673	1470	£3,449,187	£1,600,983	£1,848,205
4	ED Front Door	370	£846,974	£293,968	£553,006	230	£524,640	£97,990	£426,650	599	£1,371,614	£391,958	£979,656
5	Integrated Nursing Home Service	210	£1,738,294	£896,214	£842,080	155	£442,891	£0	£442,891	365	£2,181,185	£896,214	£1,284,971
6	EOL	175	£610,169	£152,543	£457,626	400	£1,380,936	£345,233	£1,035,703	575	£1,991,104	£497,776	£1,493,328
	Total Older People	**1789**	**£5,663,639**	**£2,549,528**	**£3,114,112**	**2049**	**£5,390,248**	**£1,367,420**	**£4,022,828**	**3838**	**£11,053,887**	**£3,916,948**	**£7,136,940**

- **Key messages:**
  - Total estimated reduction in activity in year 1 is 1789 (5.8% of total NEL admissions for older people) with a further reduction by 2049 (6.7%) admissions in year 2. In summary, we aim to reduce NEL admissions for older people by approx. 12% in two years
  - Please note that the net reduction in activity will be influenced by demographic and non-demographic growth. Hence, the net residual impact on 2018/19 baseline will be 3.5% (please see next slide) against growth
  - The total investment in year 1 is £2.5m and year 2 is an additional £1.3m
  - The total net savings is £3m and £4m for year 1 and 2 respectively

Amanda's story – before and after

What are we trying to address; Amanda's Story

The following depicts a real journey of an older person living in Havering; names have been changed to protect the identity of the individual

Amanda:
- 84 years old
- No LTC
- Very active
- Walks daily
- Gait becoming laboured and unsteady
- Always lived alone
- Only family; niece & nephew, live 2 hrs+ away, visit rarely

2017

- Lots of friends & very active with local church
- Volunteers in a local school library; loves this job
- No previous history of falls

Aug 2017
DETERIORATION: Significant functional deterioration; Neighbours and people Amanda comes into contact with notice that she has started staggering and that her gait is very unsteady; unsure how to address this

If an intervention had taken place here; would Amanda have still fallen/deteriorated further?

Sept 2017
FALL
Amanda falls at home and breaks her ankle; on the floor for hours until manages to crawl to the phone; 999 called, LAS transfer to hospital, two month length of stay. No rehab during this time

Nov 2017
Discharged from Hospital to Care Home for Respite for 6 weeks, then discharged home with Care Package; no shopping or cleaning support set up; relies on good will of Neighbours. Balance worsening

Dec 2017
FALL; Carer can't gain access to property; calls Police. Break in & Amanda found on floor. Dial 999, LAS transfer to hospital. Week long stay, transferred home, Care Package re-starts, falls alarm set up

Number of smaller falls during this period managed by Carers & neighbours

Dec 2017
FALL: Amanda presses her alarm as she has fallen; alarm company ask neighbour to call 999. LAS transfer to A&E and Amanda is admitted. Week stay, then transferred for rehab bed, then home Jan

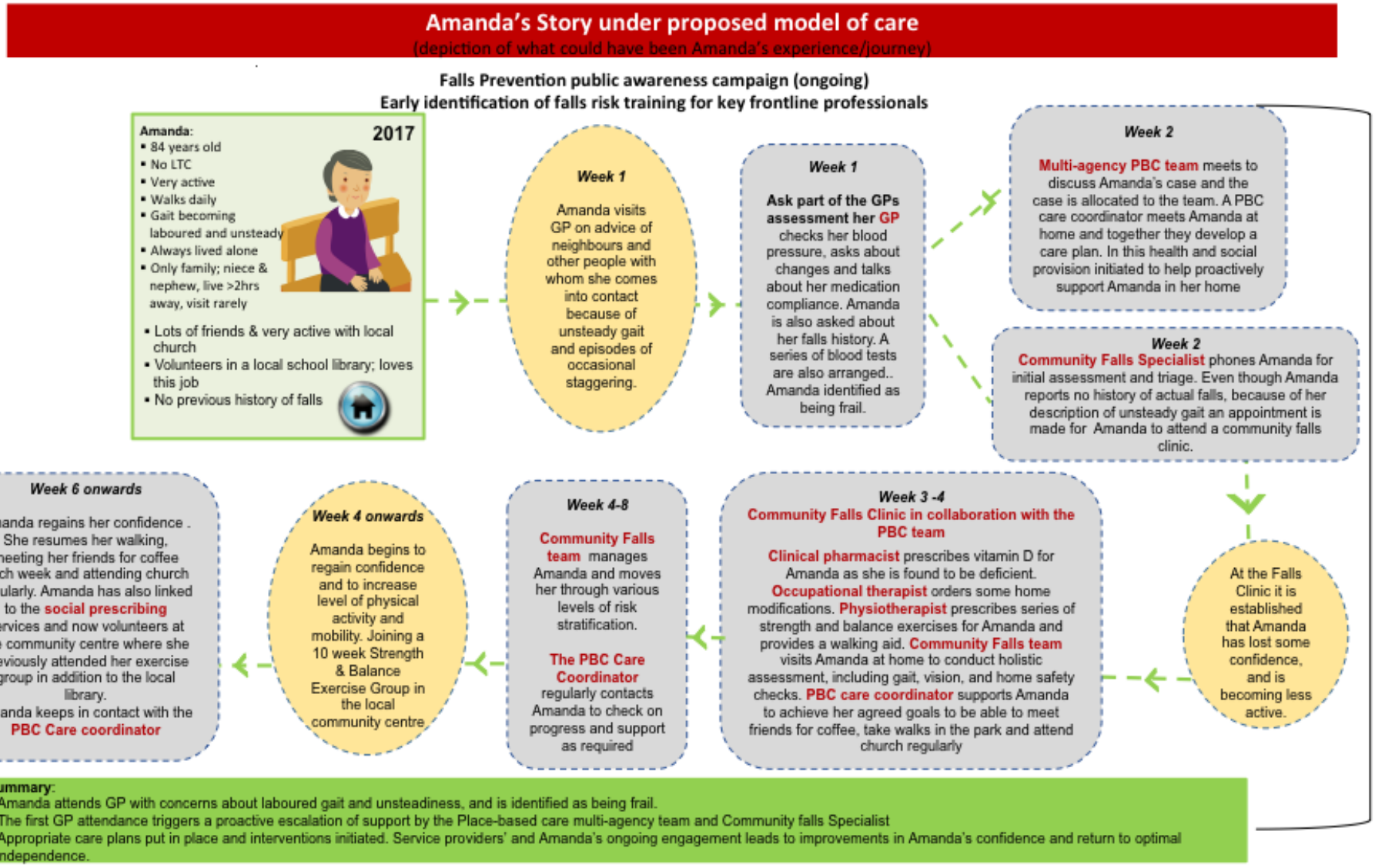
Number of smaller falls during this period managed by Carers & neighbours

Jan 2018
DETERIORATION: Amanda's mental health declines significantly, calls the Police claiming the Carers are moving people into her home. Number of falls and calls to neighbours during this period. Hallucinating

Feb 2018
Transfer to Care Home: Nephew comes to see Amanda and discusses her going to live in a Care Home; Amanda permanently moves to the Care Home she had previously refused when she had capacity

Summary:
- Rapid deterioration of previously very independent, active older lady
- Significant number of falls, LAS calls, calls to Police, A&E attendances, and lengthy acute admissions in a short period of time (5 months). The care received did not lessen this, and the eventual result is rapid mental health decline, coupled with an outcome – transfer to a Care Home – that was not what this lady wanted when she had full capacity.

Amanda's story – before and after



Falls Prevention Services; Place-Based Care; Healthy Well-Communities

Model of Care key outcomes – in development

Key Outcomes (Dashboard development in process)	Current baseline available Yes / No / partial
Increasing participation in community via social prescribing	Partial
Reduce 1st time falls and related injuries in all BHR adults (aged 65+) Reduce 1st time and recurrent falls in all BHR adults (aged 65+) in the community and care homes	Yes
Reducing social inequalities across BHR and reduced social isolation	Partial
Reduced non-elective admissions / attendances & Reduction in unplanned hospital admissions from community and care homes	Yes
Fewer ambulance conveyances to ED from community and care homes	Yes
Fewer admissions to long term care (care homes) and long term care packages reduced	Partial
Positive PREMs/PROMs	No
Increase proportion of local population involved in health and wellbeing activities that will reduce their risk of frailty (including falls or fractures)	Yes
Care homes: Patients have an excellent experience of care and support (CQC ratings; CMC; PPC)	Partial
Integrated care system - multiagency collaboration / partnership working inc: LA – BHRUT – community (NELFT) – Care Home Providers – Care Agencies – CVS	No
Shared care record accessible across partners	No
Increase CMC recorded and shared	Yes
Increase number of patients who die in their preferred place of care	Yes
Reduce EOL deaths in hospital	Yes

Key risks and how we will mitigate

No.	Risks	Mitigating actions	Status (RAG)
1	Partners will continue to operate in silos which will hinder system transformation.	Ensure strong leadership at all levels through the OPTB to advocate for change. Ensure the programme is patient centred and outcome focused. Develop the enablers that will support whole system working e.g. contracting, IT.	
2	Management of unintended consequences that may occur such as triggered demand in other services and impact on staffing levels	Identify potential areas for increased demand and monitor against baseline Utilisation of non-traditional and community assets to cater to demand Baseline current manpower in relevant service lines and ensure robust workforce development and recruitment to be integral to transformation	
3	Patients do not experience a better service and an improvement in patient outcomes cannot be demonstrated.	Regular patient engagement to review and evaluate services and identify areas for improvement.	
		Focal group and working groups to embed “10 Cs” in the delivery plans and monitor patient outcome measures in dashboard.	
		OPTB communication and engagement strategy to regularly communicate programme outcomes; develop case studies.	
4	The model of care does not address the needs of frail and older people and acute activity continues to increase.	Business cases developed to secure additional capacity in integrated out of hospital services.	
		Baseline of activity and capacity pre and post implementation to measure impact.	
		KPI/outcome dashboard monitored by OPTB	
		Ongoing review of pathways by Focal Group.	
5	The delivery of the programme does not happen at the pace required to achieve system savings.	Establish system delivery group to drive forward implementation	
		Support PDSA approach to testing change and enable "just do its".	