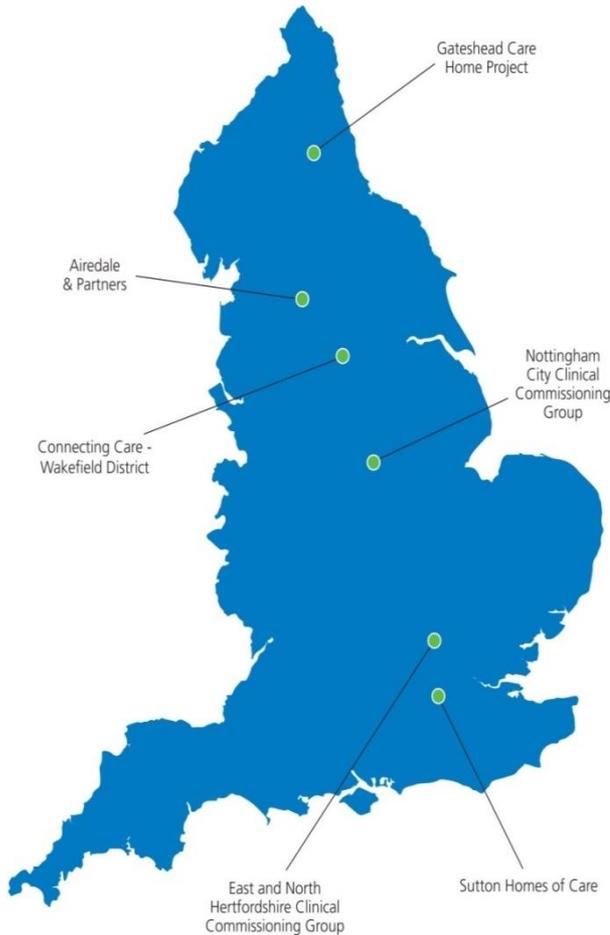




Enhanced Health in Care Homes
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Our values: clinical engagement, patient involvement, local ownership, national support

Enhanced Health in Care Homes



- 6 exemplar sites across the country
- Providing joined-up primary, community and secondary, social care to residents of care/ nursing homes and Extra care Living Schemes
- What the vanguards are doing differently is trying to do this is a joined up way across a place and population
- The how is as important as the what
- In the first six months of operation those implementing the model most comprehensively have cut emergency hospital admissions per care home resident by 4%
- Up to 21% reductions reported emergency hospital admissions
- £125-305 per resident drug savings reported
- 7% reduction in oral nutritional support usage
- 1%-30% reduction in ambulance call outs

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How are the vanguards improving care?



Selected work the care home six are implementing:

1. Newcastle & Gateshead	2 . Airedale & Partners	3. Wakefield
<ul style="list-style-type: none"> • Homecare/Community beds • Virtual Ward MDT / Ward Rounds – GP, Community team & Care Home Staff weekly ward rounds for care planning and MDT for complex decision making • Outcome Framework based on ‘I’ statements and Local Metrics • New care pathway for frail elderly, encompassing homecare/community beds, supported by a growing Provider Alliance Network, and development of outcome-based contractual / payment model. 	<ul style="list-style-type: none"> • Using technology to support care home residents by providing a secure video link to senior nurses. 	<ul style="list-style-type: none"> • MDT - a proactive care homes support team will provide person-centred care planning and co-ordinated input to the care home staff and residents • Community Anchors - trained individuals helping those in care/nursing homes & ECLS access community assets & networks to reduce social isolation • Introducing holistic assessment tools such the LEAF 7 assessment and Portrait of a life to increase wellbeing and health for those in care homes
4. Nottingham City CCG	5. East and North Herts	6. Sutton
<ul style="list-style-type: none"> • Joint commissioning with local authority as lead contractor, using an NHS-standard contract. Underpinned by robust quality monitoring processes. • Person-centred outcome measures developed with Age UK and local citizens • Dementia outreach team is commissioned to provide dementia care, case management and training and support for care home staff. The team also run care home managers’ and care coordinators’ forums 	<ul style="list-style-type: none"> • Health and social care data integration • A complex care framework: Supporting care home staff to be confident in their care for their patients • GPs aligned to specific care homes • An integrated rapid response team which offers a timely assessment and alternative model of care to hospital admission for appropriate patients who are in a ‘crisis’. 	<ul style="list-style-type: none"> • Hospital Transfer Protocol (red bag) • Standard Assessment Form • End of Life Care • Engagement with care homes

New care models



The framework for
enhanced health
in care homes

Our values:
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local ownership, national support

September 2016

www.england.nhs.uk/vanguards #futureNHS

- Based on the common coordinated interventions being delivered in the vanguards
- Significant research base to support the model
- Framework published 29th September
- Aims to describe the care model and describe plan for spread
- Care model has 7 core elements and 18 sub elements
- Intention to spread the care model across England next year

Enhanced Health in Care Homes (EHCH) care model



Care element	Sub-element <i>(further detail on each sub-element in annex)</i>
1. Enhanced primary care support for care home residents	Access to consistent, named GP
	Medicines reviews
	Hydration and nutrition support
	Out of hours/emergency support
2. MDT in-reach support	Specialist clinical advice for those with complex needs
	Navigating the system (single point of access to advice)
3. Re-ablement and rehabilitation to promote independence	Rehabilitation and reablement services
	Community engagement
4. High quality end of life care and dementia care	End of life care
	Dementia care
5. Joined up commissioning between health and social care	Shared contractual mechanisms
	Co-production with providers and networked care homes
	Access to appropriate housing
6. Workforce	Training and development for care staff
	Co-ordinated workforce planning
7. Data, IT and technology	Linked health & social care data
	Access to care record and secure email
	Better use of technology

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End of life care – achievements of the care home vanguards



Newcastle Gateshead	Wakefield	Sutton	Airedale / East Lancashire
<ul style="list-style-type: none"> • 32 Care Homes supported by six MacMillan nurses, who are able to support staff and liaise with families. • Using templates on EMIS to identify people with chronic diseases who may be approaching End of Life. • Previously experienced lots of calls made by agency and Out of Hours (OOH) staff, so have developed an 'information box' with a signposting leaflet and other materials to familiarise temporary staff quickly with where to obtain advice and guidance. • Training rotates (five homes at a time based on geographical location, and incorporates an End of Life dying document. 	<ul style="list-style-type: none"> • Single point of contact for End of Life across the area. • Education for care home staff is provided to and by the MDT. • An End of Life care facilitator works with acute trusts to support patients to be discharged back to care homes. • Senior nurse goes into care homes providing support for advanced care planning. • The health and social care system has also developed a End of Life Care network , supported by a dedicated CCG-employed project manager. • One sheet captures a person's wishes at end of end of life care (palliative care). This is then uploaded to EMIS. 	<ul style="list-style-type: none"> • Coordinate My Care Individual Care Plan. • Clinical end of life support to patients and care home staff, including education and training. • Specialist palliative care via hospice partnership. • Hospice at home - Highly trained HCAs bring generalist hospice care to people at the end of life in any setting. • GPs that medically support care homes attend the MDT team meeting and raise agenda points for those patients who are in last year of life. 	<ul style="list-style-type: none"> • The Gold Line is a 24/7 telephone service for people in their last year of life part of Airedale's Digital Care Hub, a 24/7 clinical hub which provides teleconsultation for a range of settings, for patients and their families. • A specialist nurse practitioner, working on a locality basis, visits care homes and supports admission avoidance, advanced care planning and comprehensive geriatric assessment. • Care home End of Life care and education forum developed by local CCG and hospice. • High quality end of life and palliative care training and have developed an education directory.

End of life care – common themes and challenges from the vanguards



Data, recording and sharing information:

- Think about data – putting in place an appropriate and proportionate system of flags across systems can support proactive care and in turn prevent inappropriate admissions through reassurance and support for care home staff, families and carers.
- Establish an effective template for recording end of life needs, through meetings with registered GPs.
- Standardise the format of how practices and wider staff discuss End of Life care at MDT meetings.

Keep it personal

- Need to remember that patients aren't always in the 'right place, right time' – the service needs to be flexible to meet their needs rather than other way around. The service should be people orientated.
- Support for care homes when there are deaths – to ensure there is someone to talk to – support after death.
- MDT approach to care planning will get best result.
- Consider how to identify and best meet spiritual needs.

Effective team working and co-ordinated care

- A true MDT approach is essential.
- Consistent and standardised understanding and use of advanced care planning documentation.
- Engagement with out of hours care and health providers is vital.
- Would encourage other areas to establish a care home palliative care link group.

Effective partnership working

- This must be a process led by both providers and commissioners
- Aligned GP can help in terms of supporting and planning
- Map existing education and training provision.
- Build on the expertise of local hospices, and involve them in training and advice.

Address stigma and fear through training and support

- Cannot underestimate how difficult the subject is. Demystify through teaching, make people aware of indicators, what's going to happen, use training to let people know what to expect and how care home staff can respond.
- Build on those informed and knowledgeable staff who are most interested e.g. via a 'Champion' approach.

Make the case

- This is about planning for the rest of people's lives – being supported to live the rest of your life until you die.
- Better symptom control and care and death in your preferred place of care.
- Good end of life care is an opportunity to meet needs holistically across mental and physical health and help people attain their goals.
- Most people don't want to die in hospital investing in End of Life Care improves quality of life and can also help reduce non-elective admissions and ambulance callouts.

Our values: clinical engagement

partnership, national support

Low Cost No Cost actions vs 5YFV triple aims



The Low Cost No Cost actions are small, proven changes within each of the EHCH care model elements with positive impacts vs the NHS triple aim, which can be introduced at no or low cost to commissioner/provider.

<i>Low / no cost actions</i>		<i>Impact vs three 5YFV 'gaps'</i>		
<i>Action</i>	<i>What this means in practice</i>	<i>Improved health and wellbeing</i>	<i>Transformed quality of care</i>	<i>Funding and efficiency</i>
NHS secure email	Providers can sign up to receive an NHS.net email account, this enables them to transfer secure emails between providers, reduce the use of fax machines and reduce the cost of transcribing information from paper to an electronic form.		✓	✓
Comprehensive Geriatric Assessment	Comprehensive geriatric assessment (CGA) is a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances.	✓	✓	✓
Red Bag and functional levels assessment	The Sutton Hospital Discharge Pathway (Red Bag) is a new hospital transfer pathway known as the 'red bag' because when a resident becomes unwell and is assessed as needing hospital care, a dedicated red bag is packed with their standardised paperwork, medication, day of discharge clothes and other personal items including glasses, dentures and toiletries. The pathway includes an assessment of the functional level of the residents when well. This allows the hospital that they are admitted to, to understand the functional level they should be aiming for to support discharge. This is provided to the hospital upon admission.	✓	✓	✓
'This is me' pen portraits	Successfully used for residents with cognitive impairment but have proven useful for all residents in supporting the NHS to ensure residents have their needs met, either as inpatients or when NHS staff attend the care home.	✓	✓	
Medicine reviews	Medicine reviews- there is loads of evidence on this and they can be carried out by appropriately trained staff, the staff costs are paid for in drug cost reductions several times over	✓	✓	✓
Patient online access	Patient online system is used by residents (and staff with proxy access rights) to access care records, repeat prescriptions and GP appointment bookings. This supports effective liaison between care homes and primary care and enables the care home to better support the resident and ensure access to primary care.	✓	✓	
Networking for care home staff	Networking care home staff within an organisation or area supports the staff to learn and develop. This also offers a means of develop common working practices and sharing of best practice using a community of practice model. Some areas report that this has a positive impact on staff retention.		✓	✓
Description of the UEC system	care homes consistently state that they call ambulances because they don't know who else to call, in Sutton, they have created a simple poster that tells home staff who to call and in what situation. Staff report that this has increased confidence to make a decision and made them less likely to call an ambulance	✓	✓	✓
Use of NHS Contract	Adopting the NHS standard contract as the basis for care home contracts with a common set of metrics means that local economies can consistently benchmark health and social care providers and simplify the contract process for dual registered providers.		✓	

Our values: clinical engagement, patient involvement, local ownership, national support

- To provide equitable access, to high-quality NHS healthcare for those who need it most
- To address growing acuity and complexity of need in an underserved population
- To make best use of scarce resources and create cost-saving opportunities
- Ensure more patients/ residents are dying in their preferred place of death
- Reductions in ambulance call outs; A&E attendances; and non-elective admissions
- To implement proven changes, in a systematic and consistent manner across England

- The Enhanced Health in Care Homes (EHCH) framework was published in September 2016.
- Since that point over 60 CCG and Sustainability and Transformation Partnership (STP) areas are already adopting the EHCH model.
- This includes Greater Manchester STP as a whole, and several examples of CCGs as part of 'success regime'
- We are tracking this organic spread and engaging with regions
- We continue to support the six Enhanced Health in Care Homes vanguards to fully implement all elements of the care model, and to continue to demonstrate a positive impact on key metrics and staff and resident's lives.

Benchmarking progress against the care model nationwide



- We have developed a benchmarking tool which allows areas around the country to simply and quickly benchmark their existing progress against the framework.
- The benchmarking tool has been sent to all four regions.
- Returns have been received from around 60% of CCGs and STPs in the North and Midlands and East regions, and are expected from the South Region on 19th June.
- Responding to demand, the London region intends to set up its own implementation programme, and will use the completed benchmarking tools to assess starting position and drive progress. We will continue to engage the region at regional and STP-level events.
- We will use the completed tools to get a full and rounded picture of progress so far around the country and evaluate where support is needed.

- Using the benchmarking returns we will consider the most suitable support offer the whole NHSE system and partners can offer to each STP and CCG.
- The Accountable Care Systems (ACSs) announced by Simon Stevens on 15 June will be our first and most intensive cohort for spread. These areas will be supported in a bespoke manner, as a first cohort for spread.
- Our support offer will form part of, and align with the wider NCM offer to ACSs, with a range of resources and tools also available for all STP and CCG areas.
- We have begun to produce data packs, analysis and recommendations for the ACS sites who have shared completed benchmarking tools and will offer these to all the ACS areas in due course.
- However the EHCH programme will also have the ability to support any new sites that are non-ACS, based on the benchmarking returns and local appetite
- Resources available include a range of 'How to Guides', case studies, learning sessions, Communities of Practice, linking to national work for DToC etc

- The strongest sustainability and transformation partnerships (STPs) have been given the opportunity to evolve into accountable care systems (ACSs).
- ACSs will be an ‘evolved’ version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care.
- In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital.

Where are the ACS areas?

- Frimley Health
- South Yorkshire and Bassetlaw
- Nottinghamshire
- Blackpool and Fylde Coast
- Dorset
- Luton, with Milton Keynes and Bedfordshire
- West Berkshire
- Buckinghamshire

- Any Questions?