

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	BHR Older People and Frailty Transformation Board – Best Practice Evidence Review		
Report of the Health and Wellbeing Board			
Open Report		For Information	
Wards Affected: ALL		Key Decision: No	
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Summary: The report was written at the request of the BHR Older people and Frailty Transformation Board to provide evidence on best practice. The paper is structured around the following four priorities: <ol style="list-style-type: none">1. Healthy Well – Helping residents to age well, reducing social inequalities and improve primary prevention and community integration/socialisation.2. Integrated Models of Care – Create new models of care that are co-designed in the local area and that support older people to maintain or reduce their risk of deterioration.3. High Intensity Interventions – Create a system that responds to urgent needs within usual places of residence, and design interventions that prevent increasing dependence.4. End of Life – Supporting a good end of life experience for the older person, their family and carers, particularly supporting elder residents to die in their preferred place, thereby reducing the number of deaths in hospital. <p>The aim of the paper is to stimulate ideas and discussion on how best BHR can achieve an integrated system of care capable of delivering effective support in a timely way and in the right place. Developing a place-based approach will involve cultural change across BHR with health and social care together with the voluntary sector delivering the right mix of services, including prevention, to individuals and families. This paper was presented to the Older Peoples Transformation Board 11 March 2019.</p>			

Recommendation(s)

The Health and Wellbeing Board is recommended:

1. To note the report
2. To discuss how local partners should be working as an integrated care system in this area to improve outcomes for residents.

BHR Older People & Frailty Transformation - Best Practice Evidence Review**1 Introduction**

- 1.1. This paper aims to generate discussion around initiatives and best practice in relation to older people in order to realise a place-based system that improves the health and care for the population of BHR.
- 1.2. 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.
- 1.3. Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England. Their development represents a fundamental and far-reaching change in how Health and Social Care works across different services and with external partners. ICSs' development has been locally led and there is no national blueprint.
- 1.4. In transformation terms best practice needs to be considered not within the current system but the future system. The Integrated Care Partnership Board in order to bring about improvements in health and care, and to place services on a sustainable footing will need to be clear on the distinction between "the whole system" and "place". This will involve a set of principles to enable us to transform to new models of care focused on developing Locality/Primary Care Network - based health and social care relationships within council boundaries.
- 1.5. This involves partners moving away from a 'fortress mentality' whereby health and social care organisations each act to secure their individual interests and future. Instead they must establish place-based 'systems of care' in which they collaborate across the BHR integrated care system to address challenges and improve the health of the residents. This will only happen if we tailor new models of care to local needs and linking to local assets.
- 1.6. Integrated working across health and social care and the voluntary sector is required to deliver the right mix of services to the individual, their family and carers at the right time and in the right place.¹

¹ Making our health and social care systems fit for an aging population (2014)

1.7. An integrated care service that delivers improved outcomes for people is challenging to get right. This paper has identified seven key themes which outline best practice in the development of integrated care. These key themes have been adopted from The National Palliative Care Council's six ambitions² alongside the provision of choice.

1. **Each person is seen as an individual**
2. **Each person gets fair access to care**
3. **Maximising comfort and well-being**
4. **Care is coordinated**
5. **All staff are prepared to care**
6. **Each community is prepared to care**
7. **Choice** (*this report has been added choice to the principles to underlie a strengths based approach³, coproduction, including personalised commission and personal health budgets*)

1.8. These seven themes enable a model which focusses on care being delivered in the community and at the preferred place of residence with the hospital being utilised in a step up scenario.

1.9. Social prescribing and the ongoing frailty pilots are examples of where this new method of working is being implemented already incorporating both statutory services and the voluntary sector. This approach should be extended across the system as a whole.

1.10. This means that no one service can deliver or that old organisational cultures can remain the same and involves unified purpose and sharing risk and costs.

1.11. For reference the Older People and Frailty Transformation Programme Board has identified 4 key work streams to help frame system-change and will be discussed separately in the priority areas below:

- **Healthy Well** – Helping residents to age well, reducing social inequalities and improve primary prevention and community integration/socialisation.
- **Integrated Models of Care** – Create new models of care that are co-designed in the local area and that support older people to maintain or reduce their risk of deterioration.
- **High Intensity Interventions** – Create a system that responds to urgent needs within usual places of residence, and design interventions that prevent increasing dependence.
- **End of Life** – Supporting a good end of life experience for the older person, their family and carers, particularly supporting elder residents to die in their preferred place, thereby reducing the number of deaths in hospital.

² <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>

³ Care Act 2014

1.12. This paper will consider the impact of prevention and tackling issues beyond traditional healthcare in improving the quality of their lives and reducing demand on our health and care system in relation to the key work streams above.

2. Demographics

- 2.1. 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.
- 2.2. 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. This paper will highlight interventions that could contribute towards these targets.
- 2.3. Opportunities for reducing non-elective admissions are not necessarily uniform across the three boroughs. For example, Havering and Redbridge have similar rates of unplanned hospitalisations for chronic ambulatory care sensitive conditions and urgent care sensitive conditions to England for 65–74, 75–79, 80–84 and 85+ year olds (2016/17 data).⁴ In contrast, Barking and Dagenham has significantly lower rates in 75–79 and 85+ year olds compared with England, but significantly higher rates in 80–84 year olds.
- 2.4. Comparison with similar areas (defined separately for each CCG) suggests that Barking and Dagenham has significantly more non-elective hospitalisations for these conditions in older people. However, the higher populations in Havering and Redbridge suggest that modest improvements in those areas has the potential to see big returns.
- 2.5. However, there are similarities for emergency admissions due to falls in people aged 65+ across the three boroughs; Barking and Dagenham, Havering and Redbridge all have lower age-standardised rates than London or England, with the lowest, second lowest and fourth lowest rates respectively in London (12th, 15th and 24th lowest in England).⁵ Nonetheless, this accounted for almost 2,000 admissions across BHR in 2017/18 and hence is not a reason for complacency. Forty-five percent of these admissions were in Havering, 36% in Redbridge and 19% in Barking and Dagenham in line with the population split within the boroughs.
- 2.6. Strategies looking at place of death should also consider the variation across BHR. More than half of deaths (54%) in people aged 65+ occurred in hospital across BHR in 2016.⁶ This is significantly higher than England (47%) and especially high in Redbridge (60%) compared with Barking and Dagenham (53%) and Havering (51%).

⁴ NHS RightCare, Equality and Health Inequality NHS RightCare Packs, December 2018 [<https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs/>].

⁵ Public Health England, Public Health Outcomes Framework.

⁶ Public Health England derived from data in End of Life Care Profiles.

3. Transformation Workstream - Healthy Well

- 2.1. Healthy Well incorporates healthy ageing. The World Health Organisation (WHO) defines healthy ageing as *“the process of developing and maintaining the functional ability that enables wellbeing in older age”*.⁷ Functional ability enables people to live meaningful lives. It includes a person’s ability to meet their basic need and remain socially connected. An individual’s functional ability is influenced by the presence of disease and age-related changes and their environment such as the built environment, the ability to stay warm in winter and to participate and contribute to society.
- 2.2. WHO reiterates that older people are not a homogenous grouping, and this awareness should be reflected in local plans. An 80 year old may have the functional ability of a person many years their junior. Alternatively, someone of the same age may require intensive care and support. How well a person lives with disease is another factor along with the cumulative effect of advantage or disadvantage and its impact on the individual’s experience of aging, their resilience and ability to adapt to new circumstances.
- 2.3. Social connection appears to offer a protective effect against ill health.⁸ However, as a group older people are more vulnerable to social isolation.⁹ Engaging people with others can have a specific effects. For example, group exercise intervention is able to help reduce the onset or progression of frailty.
- 2.4. The Mental Health Foundation conducted a review into the impact of participatory arts on the health and wellbeing of older adults, they found there was increased confidence and self-esteem as well as adoption of new positive aspects of their identity. Where adults had dementia there was improved cognitive function memory and enjoyment of life¹⁰.
- 2.5. Within the NHS Long Term Plan there is a commitment to increase the provision of social prescribing and with that provide Primary Care Networks with funding for social prescribing link workers. This funding is available from 2019/2020 for 1 link worker per Primary Care Network, which within BHR consists of populations of circa 80,000 residents.
- 2.6. Social prescribing is particularly relevant for elderly populations who might be high frequency users of primary care services. Social Prescribing can help the socially isolated and frail elderly residents' access community-based support, this results in reduced demand on the traditional care system. The utilisation of community assets

⁷ What is healthy aging? Accessed at <https://www.who.int/ageing/healthy-ageing/en/> on 05/02/2019

⁸ Social Connectedness and Health Amongst Older Adults 2005 Malta, S. Accessed on 14/02/2019 at https://www.researchgate.net/publication/268416064_Social_Connectedness_and_Health_Amongst_Older_Adults

⁹ ibid

¹⁰ <https://www.mentalhealth.org.uk/sites/default/files/evidence-review-participatory-arts.pdf>

in social prescribing increases the resilience of the community. Reducing social isolation can improve mental health and improve outcomes in the frail.

- 2.7. Currently there are social prescribing programmes running in Redbridge and Barking and Dagenham from which a BHR wide model could be developed.

BHR Frailty Pilots

- 2.8. The Place-Based Care Frailty Pilot in BHR is based on concepts from the Dartmouth Institute, and offers the opportunity to test a new care pathway which uses care navigators and community resources to both improve patient outcomes and reduce the demand for specialist health services. The idea is to improve the integration between health and care professionals with care navigators, or link workers, employed to help frail residents to better navigate the health and care system and stop re-admissions due to falls. There are two pilots taking place in GP surgeries in BHR – one at Thames View Health Centre due to its proximity to Barking Riverside, a test-bed for health and care innovation, and the other at Wood Lane Surgery in Havering. The BHR Frailty Pilots are exploring how clinical care systems can cross over with community based organisations.
- 2.9. Conversely, older people continue to play an important role in local volunteering activity. They benefit the community while enjoying the social participation and sense of purpose volunteering brings.¹¹ It is important to recognise that older people still have a contribution to make and that they are not simply passive recipients of care. Involving older people in the delivery of social prescribing or community initiatives can help reduce demand on care and grow more resilient communities.
- 2.10. Greater use of digital technology can support better self-care and healthy living. The Health Innovation Network South London undertakes a range of clinical and innovation themes including healthy aging. For example, supporting people to live well with long term conditions is part of healthy aging. Here digital solutions can produce significant improvements. ESCAPE¹² is an exercise programme app specifically designed for people who have chronic joint pain due to osteoarthritis to self-manage their condition.
- 3.1. As digital technology transforms the way health and social care is delivered Age UK cautions that older people are not left behind.¹³ Many Public Services are now accessed online and in order that older people are not disadvantaged Age UK recommends three complementary approaches:
- greater support for digital inclusion
 - user friendly technology and design

¹¹ Effects of volunteering on the Well-Being of Older Adults Marrow-Howell, N. Hinterlong, J. Rozario, A.P. and Fengyan, T. (2003) accessed on 08/02/19 at

<https://academic.oup.com/psychsocgerontology/article/58/3/S137/583366>

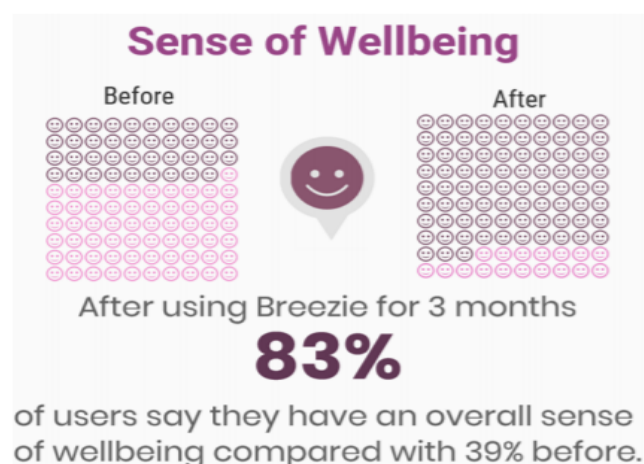
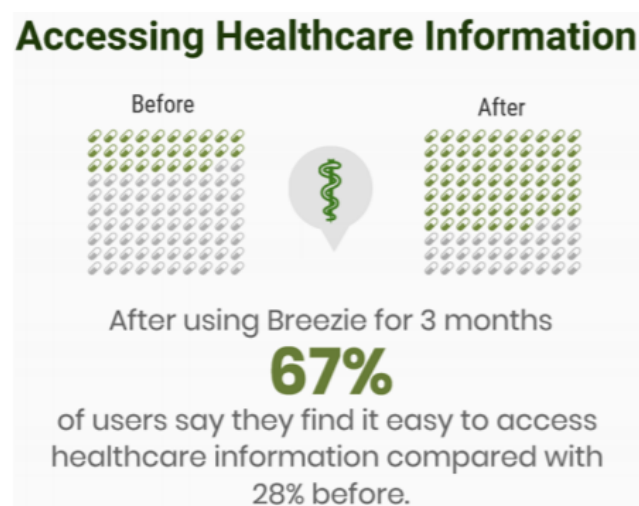
¹² <https://healthinnovationnetwork.com/about/what-we-do/> accessed on 05/01/2019

¹³ Later Life in a Digital World December 2015 Age UK

- alternative access for people who are not online

Breezie scheme

3.2. The “Breezie” scheme in Barking and Dagenham provides isolated older people with user-friendly tablets enabling internet access. This can help to alleviate social isolation and improve digital skills leading to a sense of greater connection.¹⁴



Inequalities

3.13. The Marmot Review¹⁵ outlines outcomes which improve health and tackle the wider determinants of health across the population. The review highlights outcomes across the wider determinants of health such as education, employment, living standards, healthy places and prevention. Work on these areas of wider determinants are key in helping the older residents to age well. Prevention will play a key role in achieving success in healthy ageing and this will require cross organisational working.

3.14. Older people are particularly vulnerable to colder periods and cold temperatures can increase the risk of strokes and other circulatory problems. Fuel poverty is also related to increased hospital admittance. Cold homes are also associated with excess winter

¹⁴ <https://modgov.lbbd.gov.uk/internet/documents/s128088/Breezie%20Report.pdf>

¹⁵ Fair Society Healthy Lives: <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf>

deaths.¹⁶ The transformation board should understand the importance of wider determinants on older people's health in efforts to reduce demand and build resilient communities.

- 3.15. Barking and Dagenham Council has created its own white label¹⁷ energy supplier with the aim of reducing fuel bills. The agreement is with Robin Hood Energy based in Nottingham and the resulting not-for-profit Beam Energy offers pay as you go rates which is estimated to make an average saving of £91 for customers compared with fixed price tariffs. Beam Energy is available to customers in Greater London, including Havering and Redbridge, and East Anglia. Energy supply is 100% from green energy sources.
- 3.16. Other interventions that help tackle the wider determinants of health as outline in the Marmot review such as education, employment, living standards and the places we live are in important. Interventions such as further education for adults and the creation of liveable neighbourhoods can help keep elder residents well for longer and reduce demands on services.
- 3.17. Utilising the new funding from within the NHS Long Term Plan to increase access to these sorts of interventions could prove positive in reducing demand on the are system while improving outcomes.

4. Transformation Workstream - Integrated Models of Care (IMC)

- 4.1. Integrated Care systems are a way of joining up care around the needs of the population¹⁸ in the context of a multi-disciplinary/agency framework. Co-ordinating cross sector work will be integral to making this system work, the BHR frailty pilots are an early example of where this is being embedded across the footprint.
- 4.2. Older populations will require more specialist services than those from the normal population. This is where a truly integrated care system can result in improved outcomes, whether this is in aiding timely access, discharge, hospital prevention or end of life care.
- 4.3. A Kings Fund report¹⁹ makes the critical point that any system of integrated care “... *requires us to consider each component of care, since many people use multiple services, and the quality, capacity and responsiveness of any one component will affect others.*”²⁰ Unfortunately, the reality is that nationally for many service users, their families and carers, the experience is one of trying to navigate a confusing, fragmented system.

¹⁶ Public Health England, Local Action on Health Inequalities: Fuel Poverty and Cold Home Related Problems

¹⁷ A white label means that an organisation which does not hold a energy supply licence partners with a licensed partner supply – in this case Robin Hood Energy.

¹⁸ A Year of Integrated care systems p,12

¹⁹ Making our health and social care systems fit for an aging population (2014)

²⁰ Ibid p. iv

- 4.4. A review from the Care Quality Commission²¹ (CQC) found familiar issues nationally:
- Poor follow-up ***“I have had lots of falls and fractures and no follow-up...I was weak and there was no plan in place to help this.”***
 - Service users having to give the same information over and over again to different professionals ***“Every doctor or other person who came to see me asked the same questions.”***
 - Poor communication between services and service users, families and carers ***“I didn’t even know he was (coming) home so I hadn’t brought his clothes for him to go home in.”***
 - Poor communication between professionals ***“Professionals should sit around a table to discuss a patient’s care plan...a key document that is available to everyone. This is about health talking to social care but also about health talking to health.”***
- 4.5. The CQC found that where poor integration of health and social care existed leaders had not created a culture in which organisations could work across traditional boundaries to deliver end-to-end person-centred care. Leadership from the transformation boards on working across these boundaries is vital for the success of a truly integrated programme.
- 4.6. There are numerous case studies where health and social care integration has been successful and resulted in improved outcomes further upstream in the care journey. Improving how technology is used can yield greater results with integration too. In the BHR system the effective partnership between the NHS and local authorities is also key as much of the upstream prevention work lies in the gift of local authorities.
- 4.7. Shared records provide the framework for end to end holistic care planning. Hammersmith and Fulham CCG have focused on improving communication between general practices and services in the community including introducing information sharing agreements. A significant investment in IT means that GPs share online medical records with hospitals and community groups.
- 4.8. In Camden, Age UK run the Care Navigation Service to help people access voluntary and community services to better help them to self-manage their conditions. The service is for people aged 60 plus who are either frail or identified as being at high risk of frailty. The team consists of six care navigators who provide case management, multi-disciplinary team meetings and complex referrals.
- 4.9. In Hammersmith and Fulham, the Imperial College NHS Trust runs the Community Independence Service (CIS). The CIS includes GPs, a social worker, hospital consultant, community matron, a health and social care coordinator. It aims to provide a single point of referral for older people and a rapid response team. Not only does CIS reduce hospital admissions but it also supports people recovering from a hospital stay helping them to regain independence in their own homes.

²¹ Building Bridges, breaking Barriers (2016)The Care Quality Commission accessed at https://www.cqc.org.uk/sites/default/files/20160712b_buildingbridges_report.pdf on28/01/2019

- 4.10. The Islington integrated Community Aging Team project (ICAT) provides community-based care for care homes, alongside GPs and other community services. This was put in place due to significant duplication and confusion in the provision of care. The acute trust provides geriatrician time to provide sessions in the community which provides continuity of care and allows for better communication upon discharge of patients from acute services back to care homes. A GPwSI and pharmacists also work in the system which provides a blend of clinical experience and prescribing support for care home staff. Since inputting this service there have been a reduction of 26% in transfers to local acute centres from care homes and this has reduced bed days required from care homes by 18%.
- 4.11. A North Wiltshire case study demonstrates how the creation of joint care plans when vulnerable or frail patients are well can contribute to a decrease in bed days, an increase in patient satisfaction and early discussions about end of life preferences. This is a GP led intervention where a plan is created between primary care and the patient during an extended appointment. Community teams and geriatricians are involved in the development of plans. The idea is that the patient has the opportunity to outline their view of their care should their health deteriorate and also for clinicians to outline any known issues with medications etc. This can help to reduce unnecessary or unwanted investigations and admissions to care homes.
- 4.12. The NHS Long Term Plan 2019 observes that people, especially those living with frailty, need support to remain as healthy and independent for as long as possible. The Comprehensive Geriatric Assessment toolkit for GPs and other professionals working in primary care developed by the British Geriatric Society explains the assessment and how it links in with social service involvement.
- 4.13. Comprehensive Geriatric Assessment is a multi-dimensional, multi-disciplinary diagnostic and therapeutic process conducted to determine the medical, mental, and functional problems of older people with frailty so that a co-ordinated and integrated plan for treatment and follow-up can be developed. Evidence shows that where a CGA has been completed there is an increased likelihood that patients will be alive in their own homes and are less likely to have been admitted to a nursing home after a year. CGAs are conducted on admission to hospital and are associated with a slightly increased cost to the health service.

5. Transformation Workstream - High Intensity Interventions

- 5.1. High Intensity Interventions are designed to be delivered to prevent a crisis or an escalation in the support required and support a return to normal for the older person. Within this the transformation board outlines a priority to keep people in their normal place of residence and reduce the need for hospitalisation. Should hospitalisation be required then interventions should be designed to support hospital discharge to a place of resident that optimises independence.
- 5.2. This is an important area of work for the older people's transformation board as hospitalisation is related to worse outcomes and increased costs to the health and

social care system. One of the key targets in the BHR recovery plan is reduce the number of non-elective admissions by twelve each day, which high intensity interventions have the potential to deliver. Obviously, where there is clinical need for admission or specialist care that this is still provided in a safe and timely fashion.

Hospital at Home

- 5.3. The Hospital at Home initiative that has been trialled in Scotland is designed to support those with significant health issues remain in their own home. GPs refer into the team and the patient's care is transferred through to the geriatrician, strong communication remains in place with the GP. A multi-disciplinary team (MDT), with advanced nurse practitioners, occupational therapists and physiotherapists, is based in the community and can deliver care at the place of residence including intravenous and subcutaneous medication. Importantly they have the same access to investigation as traditional inpatients.
- 5.4. There is also a community psychiatric nurse attached to the team and the old age psychiatry service office is located next door to the hospital at home team's office. This close geographical location, as well as a truly integrated community-based MDT means that care packages for those who need them can still be provided at home, which is a huge benefit of integrating health and social care. Only 20% of patients in the programme are admitted to hospital for acute care and many of these return to the community the next day.

Holistic Care – South Sefton

- 5.5. Local GPs in South Sefton a scheme to facilitate coordinated care across organisational boundaries to fill a gap in community urgent care. A community geriatrician is employed to provide clinical support to the programme. Three main programmes support a strong relationship between the geriatrician, nurses and GPs.
 - 1) Virtual Ward – and MDT of community matrons, district nurses, therapists, social workers, health and wellbeing trainers and mental health liaison officers meet virtually to discuss cases as if on a ward round. This allows primary care staff to have access to specialist advice and for strong integration. The community matron and GPs identify patients for the virtual ward and the health and wellbeing trainers ensure strong links with the community.
 - 2) Urgent Care Team – The aim of this team is to avoid admissions for sub-acute patients. The team works out of a walk-in centre and GPs can refer older frail patients who would otherwise have been sent to hospital. A&E staff are also able to refer to the service.
 - 3) Care Home Innovation Programme – Community Matrons and GPs work with allocated care homes to ensure that care plans are in place for patients. The GPs and Matrons have direct access to the community geriatrician for advice and case reviews. Care homes have installed secure NHS video conferencing software which allows for care home staff to have a direct link to the community matron and community geriatrician during office hours and a 24/7 link to a senior nurse.

- 5.6. These three programmes have seen improvement in care outcomes and a 23% reduction in ambulance conveyances. Only 10% of cases seen by the urgent care team have resulted in admissions and crucially patient satisfaction is reported at over 95%.

Extensive Care

- 5.7. With a move to place-based care across the BHR footprint the opportunities for across sector working allow for improvements in outcomes, smarter use of the workforce and an increase in efficiencies.
- 5.8. On the Fylde Coast an NHS vanguard site aims to support proactive and coordinated care in order to reduce the need for unplanned hospital admissions. The programme provides a single point of access to support proactive care. The team is led by a consultant geriatrician, but the aim of the project is to widen the skill set of allied health care professionals and support patients to self-manage in the community. Patients are referred into the service, which is run through local hubs, and then a multidisciplinary assessment is carried out with the patient's care transferred from the GP to the extensive care team. The first year of running has seen positive results within the service population.
- 19% reduction in A&E attendance
 - 22% reduction in non-elective admissions
 - 13% reductions in new outpatient appointments
 - 18% reduction in follow-up outpatient appointments

6. Transformation Workstream - End of Life

- 6.1. The key aims for the End of Life work stream are to support good end of life experience for older people, their families and carers, and to support more people to die in their preferred place of care, and reducing end of life deaths in hospital.
- 6.2. Cross sector collaboration and working is essential to the delivery of end of life care. This includes working with health, social care and the voluntary sector, especially hospice care.
- 6.3. Within this section are evidence of best practice which could create part of the Barking, Havering and Redbridge Social Prescribing Offer especially for older residents.

NICE Guidelines on End of Life

- 6.4. NICE Guidelines state that this includes any care that is delivered to someone who may die within 12 months. Within the NICE guidelines there are 16 statements that

relate to the provision of end of life care. These statements include the timely identification of those who are approaching end of life, proper and timely communication with them and their families, that personalised care is delivered, and their medical and wider social needs are met. The statements have a focus on the provision of integrated care where multiple services are required. Upon death the NICE guidelines outline the timely and sensitive manner that everything is dealt with.

National Council for Palliative Care

6.5. The National Council for Palliative Care (NCPC) have produced a resource which looks at best practice in coordination in end of life care²². Coordinating care around the individual is essential for good end of life care. They reviewed 66 end of life care co-ordination systems those that scored highest shared a number of core features including:

- A care coordination system centre where trained staff signposted and coordinated care across different services and sectors.
- One single access telephone number to the system
- Clinical and non-clinical call handling staff with non-clinical call handling guided to identify clinical need.
- Integration with all other providers in the area.
- Implement digital tools such as EPaCCS to support coordination and record sharing of end of life preferences.
- Consideration of harder to reach groups and how to build links with those communities
- Provides emotional support and interventions for the individuals and their carers where required.
- Is recurrently funded by the CCG.

²² <http://endoflifecareambitions.org.uk/wp-content/uploads/2017/06/Care-Coordination-Quick-Guide-for-Commissioners.pdf>



- 6.6. This work by the NCPC complements the Commissioning Person Centred End of Life Care – a toolkit for health and social care by NHS England²³, this toolkit can be used to help in the commissioning or redesign of services across the BHR footprint.
- 6.7. In addition to creating a co-ordinated care system being at the forefront of best practice in end of life care, the NCPC has also outlined six ambitions (figure above) that should be met in the provision of high-quality end of life care.²⁴
- 6.8. A case study of Rushcliffe in Nottingham where key issues around delayed transfers of care, readmissions and high rate of death in hospital created a ward-based community team to support acute colleagues. The sharing of GP data was key and allowed ward staff to identify end of life preferences that had previously been discussed. The community team based on the ward also increased the knowledge of step up or step-down facilities to aid with discharge. The positive impact on end of life care was noted as a key outcome for patients within the pilot area.

²³ <https://www.england.nhs.uk/wp-content/uploads/2016/04/nhsiq-comms-eolc-tlkit-.pdf>

²⁴ <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>

7. Discussion and Conclusion

5.3. There is a wide evidence base, including peer reviewed literature and case studies that outline the benefits and successes in evidence-based integrated care. Throughout the literature there are common threads that have been identified and these apply through all the key workstreams of the Transformation Board. These are:

- Work through the primary care networks – whether it is social prescribing, hospital at home or community based teams on the ward working through established primary care networks allows for a local approach to be delivered throughout the BHR footprint.
- Access to specialist support – the most successful interventions have been when those delivering the interventions have access to specialist support, whether a consultant geriatrician or specialist nurses. The ability of community based teams to seek advice and support allowed them to realise improved outcomes and help keep people in their community for longer.
- Technology – The use of technology is very important in providing the transformation required. Use of social technology such as Breezie and other apps that can help reduce social isolation and increase connectivity and education opportunities for older adults are key in aiding prevention. Whilst ensuring that the professionals working across the health and social care have access to technology that makes sharing actions and care records as seamless as possible.
- Centre of coordination – In order to ensure quality and equity in care there should be central coordination for the work ongoing across BHR.

Questions for Discussion:

- 1) What are the main opportunities and threats to successfully moving away from a hospital centric system to one that is based in the community?
- 2) Which of the seven key themes outlined at the start of the paper will present the greatest opportunity for successful transformation?
- 3) Based on this what does the transformation board need to do differently to change?

8. Financial Implications:

Implications completed by Murad Khan, Group Accountant:

8.1. This report is mainly for information and sets out to provide the Health and Wellbeing Board the evidence base required to review initiatives and best practice of a place-based system that improves the health and care for the older people's population of BHR. As such, there are no financial implications arising directly from the report.

9. Legal Implications:

Implications completed by Dr. Paul Feild Senior Governance lawyer:

- 9.1. The Health and Social Care Act (2012) conferred the responsibility for health improvement to local authorities. In addition, as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The Health and Well-Being Board terms of reference establish its function to ensure that the providers of health and social care services work in their delivery in an integrated manner.
- 9.2. In a proportion of older people, the normal gradual age-related decline in can be accelerated, resulting in them having limited functional reserve, so that even a relatively minor illness or event such as a fall has a substantial impact on their health. This increased vulnerability is termed frailty. This report is an information item and sets out to support the Health and Wellbeing Board in evidence-based decision making required as a function of the Board. As such, there are no legal implications arising directly from the report.

Public background papers used in the preparation of the report:

None.

Appendices

None.