BHR Older People and Frailty Transformation Programme update March 2022

1.0 Introduction

1.1 In 2018, health and care partners in Barking and Dagenham, Havering and Redbridge (BHR) agreed to work together on a system wide transformation programme to co-ordinate transformational change across older people's services with the aim of improving quality, improving patient outcomes and ensuring services are as efficient as possible and integrated around the patient.

1.2 In 2019, the Integrated Care Partnership approved an overarching business case which set out a three year programme. This was underpinned by a number of business cases to enhance out of hospital services and support a shift in activity from acute services to primary and community care. It was intended that transformation would be delivered over 3 years – the first year focused on building the foundation, moving to full scale transformation in year 2 and delivery through an Integrated Care System (ICS) in year 3.

1.3 Some progress was made in year 1, including integrating frailty services at the front door of the hospital, enhanced health in care homes, falls prevention and end of life care. The delivery of the year 2 plan was impacted by the COVID-19 pandemic as resources were directed to responding to emergency COVID measures. A positive outcome of the pandemic, however, has been the strengthening of collaborative working across agencies.

1.4 Improving outcomes for frail and older people continues to be a priority for the BHR system and Place Based Partnerships have agreed to continue to collaborate on the BHR transformation programme for older people and frailty. The case for change has not diminished and there are new challenges for the older population post COVID that services will need to respond to. We know that:

- the population of older people is growing - nationally, older people are the fastest growing population in the community. It recognised that in Barking and Dagenham significant signs of frailty can be observed in those as young as 50 years of age
- COVID -19 has widened the inequalities gap in older people and there is evidence of an escalation of need and complexity of condition in the over 65 cohort. [1]

[1] Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults. PHE publications gateway number: GOV-9256

Demand for acute services is high and there is an increasing demand for social care packages, residential and nursing home placements

- Across BHR, the various models of care and systems are not working together as well as they could, seen by a lack of integration and repeated duplication of effort when a person moves between social care, health care and community partners; a lack of co-ordination and fragmented communications results in poor resident experience

1.5 As the health and care system transitions into an Integrated Care System (ICS), there is a need to review the older people and frailty transformation plan to ensure that it is focused on initiatives that deliver the greatest benefit to residents and to system partners and that it is able to contribute to the ICS purpose of:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes in experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development

1.6 This paper provides an update on the current programme and sets out a proposal for refocusing the transformation strategy and delivery plan for the next 2 years.

2.0 Progress with current programme

2.1 To deliver the programme of transformation, the Older People and Frailty Transformation Board established a number of operational working groups tasked with designing, developing and implementing improvements to older peoples care across Barking & Dagenham, Havering and Redbridge. The operational working groups focus on falls, frailty, end of life care, care homes, discharge, dementia and prevention.

2.2 The Older People and Frailty Transformation Board and the operational working groups have worked with stakeholders from across Barking & Dagenham, Havering and Redbridge to successfully improve a number of services for older people. The initiatives achieved so far are as follows:

Acute Frailty Units and Acute Frailty Service

2.3 Building on the success of the King George Hospital Frailty Unit, we launched the Queens Hospital Frailty Unit in May 2021. The Frailty Units allow those who are aged over 75 and not in need of immediate emergency care to be taken directly to the frailty unit bypassing the traditional Accident & Emergency (A&E) route. This allows those individuals to be provided with the specialist care they need faster, improving their chances of not needing lengthier stays in hospital.

2.4 Between May 2021 and January 2022 a total of 5841 older people have been treated by the Frailty Units. Based on the latest full quarter of data available (October to December 2021) the discharge conversion for people who accessed the frailty unit pathway was 52.8% compared to those people who followed the A&E pathway which

had a discharge conversion rate of 36.5%, demonstrating the effectiveness of the unit in supporting people to return home.

Urgent Care Two Hour Response

2.5 In August 2021, we expanded the Community Treatment Team to support with a new nationally mandated two-hour community urgent care response standard. The community treatment team (CTT) works with adults in the community with an acute physical need who could potentially be treated at home, rather than attend accident and emergency (A&E). The aim of the service is to prevent unnecessary hospital admissions for those people who are experiencing an acute, physical health crisis, for example: a suspected infection or an exacerbation of a long-term condition such as COPD (Chronic Obstructive Pulmonary Disease).

2.6 Since the launch of the expanded service, emergency admissions for conditions which the Community Treatment Team can attend to have decreased by 18% (804, when comparing Aug-21 to Nov-21 with Aug-19 to Nov-19, latest data available). Equally, the percentage of people treated within two hours in the community has increased from 39% in October 2019 to 62% in October 2021 (*latest month available).

Bridging Service

2.7 We are commissioning a Bridging Service that is due to start in April 2022. The Bridging Service supports the CTT team with the 2 hour crisis response including improved care at home up to 72 hrs post discharge from the emergency department and Frailty units.

Falls Prevention

2.8 In April 2021 we commissioned an extension of the Strength & Balance Service to ensure patients from Barking & Dagenham, Havering and Redbridge all have access to the service. The Strength & Balance Service is run by Age UK and provides exercises classes to the elderly to improve mobility, strength, aerobic fitness & balance, the exercise classes support with an improved quality of life and help prevent the risk of falls.

2.9 Between April 2021 and January 2022, 1536 patients have participated in the classes, as a result, low acuity falls related emergency admissions for the cohort eligible for the classes have decreased by 21% (when comparing Apr-Nov 2021 with Apr-Nov 2019, latest available data). However, it must be noted that if we look at the B&D patients in isolation, low acuity falls have increased by 12% (using the same time frame comparison mentioned above). This is due to lower participation in the classes from B&D residents – of the 1536 patients that have participated in classes, only 41 are from B&D.

Community and Care Homes Falls Services

2.10 We have been seeing an increasing number of referrals to our community falls services. This is due to patients having become deconditioned as a result of the impact of Covid-19. As a result, the waiting lists for access to the Community Falls Service began to increase. As of January 2022 we have commissioned the expansion of the Community Falls Service, the falls practitioner proactively identifies people at risk of a fall, we also introduced a single point of access email for the Community Falls Service. Comparing the waiting list as at December 2021 with the waiting list as at January 2022, this has decreased by 40% from 1,315 to 794.

2.11 The Community Falls Service mentioned above aims to ensure the provision of a holistic falls prevention service for all Barking & Dagenham, Havering and Redbridge patients who have been assessed and identified as being at high risk of experiencing a first time and/or recurrent falls. We have invested in the Community Falls Service to ensure a dedicated part focusses on reducing falls in care homes, this will be available to all care homes from April 2022.

Dementia Pathway

2.12 Following extensive reviews and workshops with stakeholders from across the healthcare system, we have commissioned an improved dementia pathway in Havering, the new pathway and services launched in January 2022 and include the following improvements:

- Stronger support to GPs for patients who present with dementia and improved links from primary care into the community memory clinics
- Improved memory clinic capabilities through the use of memory clinic multiple disciplinary teams (MDT) being enhanced with therapists, dietetics, navigators and caseholders
- Putting post diagnosis support in place at the right time by bringing existing services together to work jointly for the benefit of patients
- The addition of an early onset element to the pathway
- Providing a more comprehensive dementia support offer to care homes to diagnose patients and support to assist them with challenging behaviour
- Strengthening links between acute and community dementia service, for example not duplicating scans which can cause unnecessary distress for patients
- The addition of a community MDT that will help coordinate the care for dementia patients using existing services and provide support to carers and direct care to patients.

2.13 With the revised pathway and services having launched in January 2022, dementia A&E and emergency admission activity is not yet available to determine if the changes are supporting a reduction in unnecessary hospital activity for dementia patients. Our modelling of the changes made to the services in Havering indicate that there will be 181 less A&E attendances and 176 emergency admissions for the dementia cohort over a 12-month time frame. Consideration is being given as to how the model can be rolled out in Barking and Dagenham and Redbridge.

Discharge

2.14 Three new discharge services were launched in October 2021 to support patients to return home when they are medically fit to be discharged, this prevents patients from staying in hospital unnecessarily long which can be detrimental, as well as ensuring our hospitals have capacity to treat new patients as the demand increases. The three services were:

- **Hospital Discharge Service (HDS) and Single Point of Access (SPA)**: This service has been put in place to provide a single point through which discharges should be co-ordinated, with a focus on rehabilitation and out of area placements. **SPA** developed out of the disaggregation of the JAD (Joint Assessment and Discharge Team) that included referral co-ordination and social workers. This SPA commenced in August 2021 and will integrate with HDS into one stop single point of access for discharge over 2022 and 2023.
- **Discharge to assess:** This is a national model, where the patient is discharged to continue their care (recovery and rehabilitation) and assessment out of hospital. Our local discharge to assess service has been improved by providing occupational therapy and physiotherapy assessment to patients discharged to block booked nursing home beds.
- **Home First:** This service supports patients who are assessed as being ready for discharge at 9am to be discharged by 5pm the same day. The additional therapy staffing in the home first team helps achieve the same day discharge target.

2.15 Comparing October 2021 to February 2021 with October 2022 to February 2022, the proportion of all patients that are staying in hospital for 21 or more days increased from 13% to 17%, the proportion of patients that are staying in hospital for 7 days or more increased from 43% to 48%. However, this scenario has played out across London, we are still in line with the 7 day London performance of 47% and better than the London 21 day performance of 19%.

End of Life

2.16 We are currently mobilising an Out of Hours End of Life Rapid Response Team and the first patients will be seen April 2022. This service will ensure palliative patients can receive the care they need in the community, overnight, rather than having to be transferred to hospital when other healthcare services are closed. The team will be working alongside community nursing services to maximise the offer to patients overnight.

2.17 The Older Peoples Transformation Board has a number of schemes in development which are working their way through various stages of governance. Upcoming transformation schemes include:

- Employment of Advanced Care Practitioners within Community Treatment Teams to support medication reviews – this will help reduce emergency admissions for patients in relation to medication compliance issues.

- The creation of catheter hot clinics – this will provide an alternative to the emergency department for patients who have issues with their catheters.

- Domiciliary care pilot – the pilot will help upskill domiciliary care workers to undertake a greater role in monitoring conditions of patients at home using technology to record key health information and inform health professionals of changes to a patients condition.

- Enhancing the Hospice End of Life Service offer – this will provide increase support to a 24-hour helpline for palliative care patients and their carers, additional nursing capacity to treat palliative patients in the community and training for care homes in relation to end of life care.

3.0 Older People and Frailty Strategy refresh

3.1 The Older People and Frailty Transformation Board is in the process of refreshing the plan for the next two years, aligning in and out of hospital strategies to support the core aims of the ICS. The core question underpinning the refresh is "***What needs to happen to support our frail and older residents to live healthier for longer, in their preferred place of residence - through our integrated services proactively supporting their health and care needs".***

3.2 As part of the refresh we will be reassessing the challenges that are faced by the older and frail population; reviewing what is working well and should be sustained and developing a plan for the roll out of the national Ageing Well programme. Investing in primary and community health services to support Ageing Well is a commitment in the Long Term Plan. Investment has been earmarked for:

- Improving the offer for urgent community response and recovery support
- Enhancing community multi-disciplinary teams aligned to PCNs to enable integrated community care
- Enhanced support for people living in care homes

3.3 To deliver improved outcomes for older people it is recognised that we need to ensure that we take an integrated approach, working with local communities, third sector, social care, primary care, community health services, mental health services and acute health services. Working in collaboration with Place Based Partnerships will be critical to engaging with local communities and understanding how the BHR programme can best support place-based delivery.

3.4 A proposal for the strategy refresh has been endorsed by the BHR Health and Care Cabinet and Integrated Care Executive Group. This recommends that the transformation plan focuses on a small number of high impact areas:

Population health management and anticipatory care
Much of the transformation work to date has focused on the hospital end of the pathway and it is recognised that more needs to be done to prevent escalation of need to cope with growing demand. There is a desire in the next phase to focus on place based and anticipatory care, harnessing population health management approaches and tackling the wider determinants of health to enable a person-centred approach to managing an individual's needs in the community.

Admission prevention
To prevent people being admitted to hospital when they could be cared for at home, we need to ensure that practitioners have access to alternatives to hospital admission in the community and are supported to enable consistent decision making. The development of the community frailty hubs in each borough to support Primary Care Networks (PCNs) proactive case management would be a key part of this workstream.

Intermediate care and discharge
To support the flow in and out of hospital and to help people to achieve as great a level of independence as possible, using resources as effectively as possible, we need to ensure we are commissioning the right mix of intermediate care.

3.5 A two-stage approach is proposed for the development and delivery of the plan for the next 2 years. The first stage is to undertake the planning and analysis to inform the development of the plan. Evidence derived from data and from talking to our residents and staff will help to identify opportunities for improvement and measure impact against agreed system heath and care outcomes. In addition to identifying pathway improvement opportunities we also want to understand what the impact of change may have on our staff and how they can be supported to work differently. This would then be followed by a design and implementation phase to enable bottom up delivery of the transformation plan.

4.0 Alignment with the Barking and Dagenham Place Based Partnership

4.1 The Barking and Dagenham, Havering and Redbridge Place Based Partnerships have agreed to continue to collaborate on a BHR wide transformation programme. Through the refresh of the strategy the Older People and Frailty Board will be engaging with the borough partnerships to develop the evidence base for change (through the planning and analysis work described above) and then the design and implementation of new models of care.

4.2 The Barking and Dagenham Place Based Health Management pilot should provide some rich information that will inform plans for anticipatory care for frail and older people in the over 50 age group, helping people to stay independent for as long as possible at home focusing in what is important to the individual. There is a national expectation that by 30 September 2022, Primary Care Networks will be required to agree a plan for the delivery of Anticipatory Care with their ICS and local partners with whom the service will be delivered jointly. National guidance is due to be published on this shortly.

4.3 It is recognised that as Place Based Partnerships develop there will need to be further discussion and agreement on which transformation schemes are led at borough level and which are best delivered over a wider BHR or NEL footprint. The Barking and Dagenham Delivery Group has committed to establishing an adults workstream which will provide the interface between the BHR and borough programme.

5.0 Recommendations

5.1 The Health and Wellbeing Board is asked to:

- note the contents of the report

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