

CARE CLOSER TO HOME

Update on the implementation of the service for OSC February 2017

1. Background/Introduction

Plans to shift services and resources closer to people's own home originally began in 2012, culminating in the award of the contract by Greater Huddersfield and North Kirklees Clinical Commissioning Groups (CCG) to Locala. The service went 'live' on 1 October 2015 with Greater Huddersfield CCG taking the role of lead commissioner.

The Care Closer to Home (CC2H) programme has critical inter-dependencies with the Right Care Right Time Right Place and Meeting the Challenge hospital services programmes; the vision for CC2H is for an integrated community based health care service for all including the frail, vulnerable and older people and also end of life care. The vision for the service is a five year transition with community activity increasing over the lifetime via a planned and agreed, with commissioners, Service Development and Improvement Plan (SDIP); it is crucial that sustainable changes are made to our health and social care system to ensure that services are fit for purpose in the future and fully support developments of smaller, different acute hospital reconfigurations.

Key characteristics of CC2H are:

- Improved primary and community care providing the right care at the right time in the right place
- Provision of services in the community that promote independence and wellbeing for patients so they can support themselves by exercising self-management, choice and control
- Integrated high quality services at times required to meet the needs of the community
- Providing more planned care earlier thereby reducing reactive, unscheduled care
- Care provided as one coherent package, with a focus on individuals and helping people to get better

The main elements of the model are:

- Risk assessment to identify people who are most vulnerable and most likely to be admitted to hospital
- Proactive care management by multi-disciplinary teams
- High quality local information and support to enable people to manage their own condition and access the most appropriate care
- Person centred care delivered through a single assessment process and single care plan 24/7
- Care at or near home wherever possible

2. Where we are now/What are the issues?

An audit on where and what Locala are currently achieving against the service descriptors and Key Performance Indicators (KPIs) is underway, this will develop into a gap analysis and subsequent action plan to ensure that we, as a partnership, are on track with our overall five year vision.

Some issues have arisen over the life of the contract which are being worked through to achieve a satisfactory outcome, particularly in relation to patient care. For example:

- In relation to the Memorandum of Understanding between the individual GP practices and Locala. A round table discussion was held involving GPs, practice managers, Locala managers and front line staff as well as commissioners. A similar workshop has also taken place involving primary care practice nurses and Locala community nurses to review wound care pathways and improve patient care.
- A wider understanding of the issues and specific definitions (to avoid several different interpretations) of 'housebound' and 'communications and multi-disciplinary teams' for example was arrived at. Issues around the basic running of meetings and which patients would be discussed were raised.
- It transpired that therapists were not part of the MDTs – it was agreed that the invitation should apply to all staff.
- Some of the issues were very basic; however the opportunity to air them and discuss solutions was greeted positively by all.
- An under resource was identified within North Kirklees CCG to take the SDIP forward and a lack of engagement with some key partners. Additional resource has now been secured and a lead has been identified to develop the SDIP from a commissioning and contract management perspective. This piece of work has begun in collaboration with key partners.
- Single Point of Contact (SPoC), which is the 24/7 call centre for CC2H services is currently located alongside Gateway to Care in Civic Centre 3. SPoC is using the same telephony and IT system as the council which has led to a number of system failures since February 2016 when the service was set up. In addition, it is often difficult for SPoC call handlers to access Locala electronic systems through the Council's network. Back up arrangements have been put in place in case of any failure of the system in the future and Locala is working with Council colleagues to look at a long term sustainable IT and telephone system that is more reliable.

3. How has CC2H changed and impacted on patient pathways:

3.1 Many of the services which come under the umbrella of Care Closer to Home either directly or indirectly prevent avoidable hospital admission (a step-up service) or facilitate timely hospital discharge (a step-down service).

3.2 The Single Point of Contact ensures that ALL referrals are managed through one single point, for any professional, patient or carer. The service includes call handling, information gathering, and using that information to determine immediate next steps and appropriate onward referral.

3.3 Promoting self-care is inherent within all services; commissioners are working on a future development to promote self-care and support patients to manage their asthma/inhaler technique more effectively. This has not yet been fully mobilised through the contract and forms part of the SDIP.

3.4 At the start of CC2H, Locala developed a Maximising Independence strategy with a steering group and dedicated project lead and trainer. The project lead delivered a workforce development programme and rolled out training for colleagues working directly with patients to help them build confidence and promote self-care. This training included elements of motivational interviewing, the importance of a comprehensive and detailed first assessment and the development of a core assessment template that staff now complete for all patients. There is also a questionnaire at the start of patient care and on discharge where patients are asked to comment on how they feel their independence has been supported and maximised.

4. A patient story example of the above:

Locala's Colne Valley Integrated Community Care Team (ICCT) has made a difference to an 82 year old cancer patient after helping her to become independent on post-chemotherapy injections. The patient was diagnosed in February with high grade non-Hodgkin lymphoma, a cancer that develops in part of the immune system. Since then the patient has undergone six rounds of chemotherapy and was referred to the ICCT for post-chemotherapy injections to boost the white blood cells in the immune system.

Locala encourages patients to manage their healthcare whenever possible; the patient wished to go on a family holiday so was keen to learn how to inject herself independently. The patient was taught by one of the nurses and her confidence is growing. She has details of what to do if her temperature rises or she needs help and support.

She said, 'All of the nursing staff were friendly and supportive when they were demonstrating how to do my injections. I felt I could ask them anything and they would always take time to listen. My day-to day life is more or less the same, I've just learned to pace myself. The team have helped me to keep my independence and for that I'm grateful'.

5. 7 day services

7 day services have been further developed in line with national work. For example Outpatient Antibiotic Therapy (OPAT) provides a 7 day service which prevents patients being admitted and provides the service within the community. Further work is in progress to enable more patients to receive all (including the first) doses within the community.

The OPAT team are qualified nurses who provide intravenous antibiotics to patient's in their own homes across Kirklees. They assist in preventing an acute hospital admission or facilitating an early discharge for medically stable patients requiring intravenous antibiotics. Patients are accepted with a wide range of conditions, with referrals being made via the SPoC 24/7 365 days per year.

5.1 OPAT supporting patients to go home earlier:

Recent feedback provided to Locala, from a patient and his mother highlights what a difference the service makes to patients and their families; "A huge thank you for everything you have done these past weeks. Your compassion, empathy and friendliness is completely unrivalled. I almost want to keep my central line in! You have played a huge part in my recovery and I am forever in your debt". Feedback from the patient's mother reads: "We have had 21 days of impeccable visits from the IV Team. Every day the staff came to the house and provided not only excellent care but also emotional support, advice and reassurance. Nothing has been too much trouble for them. This is a 7 star service and the entire team are incredible, capable professionals as well as wonderful people. Without this service my son would still be in hospital, which would not have aided his recovery, being home has enabled his recovery more. Thank you for everything."

Also clinician provision in SPoC in the evening and weekend promotes an efficient way of triaging patients, especially at weekends when there is a lack of external support from GP practices for example. This promotes keeping patients at home, following patient-specific emergency care plans.

6. In-Reach services

6.1 The In-Reach team facilitates patients being 'turned around' in A&E where previously they may have been admitted. There is a Locala nurse based in both A&E departments (Dewsbury District Hospital and Huddersfield Royal Infirmary) who is part of the In-Reach Service. The nurse works with the A&E clinical teams and the Hospital Avoidance Teams (HAT) commissioned to provide additional social care support by Kirklees Council to assess and source appropriate care in the community

to avoid unnecessary admission to hospital. To date, the In-Reach Service has avoided over 300 admissions to hospital for North Kirklees patients and 643 for Greater Huddersfield.

In-Reach works across 7 days, the service is currently analysing how best to link with and support the developing frailty approach. There are daily examples of patients being turned around in both A&E departments and how the In-Reach teams' ability to follow patients up once they return home provides additional reassurance to acute hospital colleagues in discharging rather than admitting patients.

The importance of having a multi-skilled team as well as shared competencies can be seen in In-Reach; having therapy and nurses, knowledge can be shared about patients who present as palliative as well as patients with fractures etc.

6.2 An example of the work of the In-Reach team supporting a patient to return home following reduced mobility:

1. SITUATION – Seen by the In Reach team in A&E HRI 26/12/17 , presented lower back pain unable to get out bed following fall 2/7
2. BACKGROUND – Male 87 years, lives with wife in bungalow, no care package in place .Normally independent with mobility. Dementia and prostate cancer.
3. ASSESSMENT – Lumbar spine x-ray NAD, transferred CDU assessment mobility and pain. Seen by CHFT physio, bed loop / combined toilet frame / wheeled Zimmer frame provided. Demonstrated use of towel as leg lifter, advice analgesia provided. Wife declined homecare support, returned home same day.
4. RECOMMENDATION – Home visit provided by Locala In-Reach team to reduce risk of re-admission

Locala In-Reach team home visit:

28/12/16, on arrival patient struggling with bed transfers, not taking regular analgesia, wife unable to assist as now has sciatica.

Actions

1. Mobility assessment – patient having difficulty using bed loop due to poor coordination. Sleeping in camp bed with thick mattress on top – bed too low and unable to raise, bed loop too big but stable when used. Wife reported 3 falls in December, 2 in shops and one at home, falls assessment completed. Chair at home good height suitable back rest and arms.
2. Wife reported cloudy urine – specimen obtained found to be clear. Plumbers present on visit fitting new bathroom / walk-in shower facilities.
3. Advise provided on bowel management and analgesia
4. Rapid response home care commenced 29/12/16 – support personal care
5. Pillow raiser and care phone ordered
6. Referred to chiropody

7. Referred wife to carer support – Sitting service, GP advised to take up yoga ease sciatica but unable to attend
8. Referred to falls practitioner
9. GP updated
10. Referred to community therapists - bed transfers and assess in new bathroom
11. Therapy follow up arranged through the Integrated Community Care Team and further equipment ordered

7. Workforce changes and developments

- In order to manage capacity i.e. the increases in demand produced through hospital avoidance and timely discharge, and the subsequent overall reductions in the bed-bases, the skill mix of the workforce and teams is changing.
- The transforming of the workforce is critical to ensure that Locala can deliver high quality community services effectively. Service reviews have been completed in November and December to review how effective the model for delivering CC2H is delivering care for patients one year on.
- Locala has instigated a working group to look at the workforce needs, including reviewing skills and training needs and has prioritised the Calderdale Framework to support colleagues working in community teams to help them meet the challenges associated with changing patient need and the complexity of patients now being managed in their own homes.
- The working group's programme of work includes; undertaking a Training Needs Analysis (TNA), developing competencies (using the Calderdale Framework) and promoting skill mix and integrated working across disciplines. This includes plans for using the opportunities presented by the new Apprenticeship Levy, with Apprenticeships available in a broader range of health and care roles.
- The review and outcomes will be completed by the end of March 2017 with an implementation plan to be in place from April.

8. Intermediate care

Work is also underway within the Intermediate Care bed bases to stream line the patient journey and develop a multi-disciplinary approach to assessment, provision and planning of care. Working with SystmOne to improve pathways and ensure right care, right time, right place, avoiding duplication and speeding up the discharge process.

9. Partnership working

- Major partnerships continue to be developed and worked on, particularly with primary care which is acknowledged as being challenging, acute trusts and social care.
- In order to facilitate these changes there is a need for greater integration, both internally to Locala and with teams/services from other organisations.
- The In-Reach team at HRI and DDH are working with the Frailty Team at HRI and HAT team at DDH on joint assessments. The team is also part of the High Intensity User Group (patients who attend A&E regularly) at both sites which has involved developing an inter-agency sharing protocol, and has shown excellent outcomes from the ambulance service. The group includes the Police, YAS, In-Reach, Community Matrons, A&E, Safeguarding, Social Services, Mental Health Services and Health Trainers.
- The In-Reach team is based on both hospital sites in Huddersfield and Dewsbury and is working with the Emergency Departments and key wards on both sites to ensure that patients are directed to care and support options in the community at the earliest opportunity.
- Locala has an Intermediate Care Matron liaising with wards to support assessment of patients prior to admission in to Intermediate Care beds. This has helped to ensure patients are placed in the right setting for rehabilitation and transfer is as smooth and timely as possible. Locala and social care staff work together to ensure there is joint working to the same aim for patients for discharge planning.
- The approach to integration includes more innovative use of partnerships with third sector organisations to ensure people are supported with more basis daily living needs.
- Locala has had a particular emphasis on developing partnerships with third sector organisations such as Age UK, Millen Care, Connect Housing and the Denby Dale Centre as they often work with people in different and innovative ways and can engage with people who may not use more mainstream services. This will help to identify and harness additional community capacity, knowledge and connections and avoid duplication of work across health and social care partners. For example, Locala ICCTs are already undertaking social care assessments as part of the care assessment where relevant.

10. Minimising Duplication

- Single Point of Contact (SPoC) being co-located within the council services, allows joint assessment of need, across social and health boundaries, identifying the best service to meet patient's needs. Carephones, mobile response, emergency social workers and out of hours social care all work together to best provide for the needs of Kirklees residents.
- SystemOne web based referrals are being developed and the launch of e-referrals gives smoother access to Locala services for GPs and other referral partners.
- SPoC clinicians link daily with care homes in North Kirklees to provide clinical advice (GHCCG commissions a specific Care Home Service).
- Through the night, social care and district nursing night service are an integrated team. This allows patients to get the best care they require, ongoing assessments by nurses are timely and capacity is increased as integrated working allows greater geographical coverage.
- Work is ongoing with Mid Yorks around discharge of patients, investigating making the patient journey smoother and sharing assessment information between teams to avoid duplication.
- The Intermediate Care bed bases are working with social care to ensure data entry is not duplicated and streamlined care is delivered.
- There is a partnership in place in relation to the Reablement service; Locala provides therapists to support Reablement carers working with patients awaiting a care package where an optimisation of their condition is undertaken for a period of six weeks. Locala assesses the patient and develops a reablement programme for the care staff to deliver as well as providing training and development for the care staff. This helps to ensure that the service is minimising the need for long term care packages.

Commissioners and Locala are working together to refine reporting and data collection with a specific focus upon hospital avoidance/avoiding emergency admissions are captured and reported each month. This is broken down to team level, it is anticipated that this will be complete by April 2017; this will be a major marker in demonstrating the effectiveness of the contract.