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Enhanced Health in Care Homes Frailty and End of Life Care – Learning from the Vanguards

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

Where did this start?

"The NHS will provide more support for frail older people living in care homes"

Addressing real challenges

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- Care homes residents are a **frail, vulnerable population** with **increasingly complex needs & dependency**
- England 3x as many beds in care homes as there are in the NHS but reduction in numbers of nursing home beds this year + **increase in care home closures**
- Social care facing **significant financial pressures**
- Hospital-based interventions have **limited effectiveness** for this population
- **Ageing population** with 1 in 7 over 85 living in a care home
- Need to provide **personalised and technology-enabled care**

Enhanced Health in Care Homes Vanguards

- Six 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 in a joined up way across a place and population
- The how is as important as the what
- £125-305 per resident drug savings reported

		Care Home Vanguards	Non-NCM
Change from baseline period	Emergency Admissions	**-1.4%**	**6.7%**
	Bed Days	**-4.5%**	**1.4%**

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EHCH Care Model Framework

- The Enhanced Health in Care Homes (EHCH) framework was published September 2016
- Based on the common coordinated interventions being delivered in the vanguards
- Significant research base to support the model
- Aims to describe the care model and describe plan for spread
- Care model has seven core elements and 18 sub elements
- Clear signal to spread the care model

What have we learned from the care home vanguards?

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- **Person centred** approach essential and focus on the **populations** health
- Build collaborative system **leadership** and relationships around a shared **vision** for the population
- Care homes are a **critical** partner in the work at all stages
- Able to see very quick benefits for **residents, providers** and **wider system**
- Not one change that makes a difference, requires a **coordinated approach** to improvement as isolated initiatives may create unwanted consequences
- Opportunities to apply the care model **wider than just care homes**
- Can **drive and develop better relationships** between commissioners and providers
- Great work goes on all over the country, but it needs **building upon and coordinating**

Learning guides to support spread

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- We have worked with colleagues from vanguard sites to codify learning on specific elements (or sub-elements) of the EHCH framework.
- They describe the different approaches vanguards have taken, and supply lots of materials that can be used and adapted including job descriptions, service specifications and slide deck presentations.
- A range of Learning from Vanguards guides [now available on the Future NHS collaboration platform]

New care models

Enhanced Health in Care Homes
Learning from the EHCH vanguards
Hospital Transfer Pathway – 'Red Bag'

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Contents

What do the 'How to guides' do? 3
About the hospital transfer pathway – 'Red Bag' 4
What's in the bag? 7
Before you start... 8
Cost of Bags and where can they be bought? 9
Funding 10
Key success factors 11
How do I engage partners? 12
Things to consider 13
Future plans 15
Material to support the Hospital Transfer Pathway 16
Implementing the hospital transfer pathway - to do list 18
Acknowledgements 19

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About the hospital transfer pathway – 'Redbag'

The journey of the Red Bag:
the small change that makes a big difference

VANGUARD
NHS SUTTON CCG

Commissioned by Sutton Homes of Care Vanguard Programme hosted by Sutton Clinical Commissioning Group, in partnership with Epsom and St Helier University Hospitals NHS Trust, The Royal Marsden Community Services, London Ambulance Service and staff from Sutton Care Homes

https://www.youtube.com/watch?v=FH1ui_Z07AY

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High Quality End of Life Care Learning Guide

Care element	Sub-element
1. Enhanced primary care support	Access to a consistent, named GP and wider primary care services
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours urgent care when needed
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system.
3. Reablement and rehabilitation	Rehabilitation and reablement services
	Developing community assets to support resilience and independence
4. High quality end-of-life and dementia care	End-of-life care
	Dementia care
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

- Identifies interventions put in place that have worked particularly well, and could be readily replicated at local and/or regional level.
- Describes a step-by-step approach to support implementation in non-vanguard areas.
- Guide is most usefully considered alongside other learning guides.

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Vanguard service models – Newcastle Gateshead

Service model and resourcing used to fulfil EHCH framework:

- 32 care homes supported by six MacMillan nurses
- Audit of deaths in care homes
- 'Information box' to help inform staff - attempt to reduce OOH calls made by agency staff.
- Worked with local GPs to identify people with chronic diseases who may be approaching end-of-life.
- EOLC training for care homes.

Learning and evolving the service:

- No one has died in hospital during the first year.
- Now funding a bereavement service – open to family and staff.

Lessons learned:

- Co-design template for recording end of life needs, with GPs
- Standardise the format of how practices discuss end of life care at MDT meetings.
- Would encourage other areas to establish a care home palliative care link group.

Vanguard service models – Airedale/East Lancashire CCG

Service model

- The Gold Line is a 24/7 telephone service for people in their last year of life.
- Nurse led service that provides care and support for terminally ill patients and their families across Airedale, Wharfedale, Craven and Bradford.
- A significantly higher proportion of people able to die in the place of their choosing (usually at home).
- It forms part of Airedale's Digital Care Hub, a 24/7 clinical hub which provides teleconsultation
- Further information is available at: http://www.health.org.uk/gold-line

Who is this 'Gold Line' model for?

- Vulnerable group of patients and carers especially 'out of hours'.
- High risk of hospitalisation, sometimes avoidable.
- Coordinating urgent care services to manage these patients.
- Need for advice/reassurance only.
- Support whilst waiting for services to attend.
- Help patients to achieve their preferred place of care and death.

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Things to consider around EOLC for frail people – learning from vanguards

- A systematic, proactive approach to identify residents who may require end of life care.
- Individuals supported to die in their place of choice, using advance care planning, personalised care plans, and treatment escalation plans.
- Where possible, use digital tools to enhance the quality of end of life care e.g. Coordinate My Care to help facilitate better care coordination.
- Care home staff are supported with education and training on palliative care knowledge and skills
- Communication to keep people informed and with clear expectations about and involvement in care planning.
- Services should address the needs of their family, their carers, other care home residents, and the staff who support them.
- End of life care is delivered using a partnership health and social care MDT approach

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Thank you for listening

Join the Future NHS Collaboration Platform page

- https://future.nhs.uk/connect.ti/carehomes/grouphome

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