Phase 1 Future Hospital development site

East Lancashire Hospitals NHS Trust
Safe Personal Effective Care
for Frail Older People – Shifting Sands, Enduring Principles

East Lancashire Hospitals NHS Trust – Future Hospital Development Site
Final Report – July 2017

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1. OVERVIEW
East Lancashire Hospitals NHS Trust (ELHT) is a provider of hospital and community services for the 530,000 people in East Lancashire and Blackburn with Darwen. We now refer to this combined area as Pennine Lancashire. We work closely with other local organisations to plan and deliver care for these people. We are on a journey to provide more integrated care for local people by developing our services and partnerships in line with the vision outlined in the Future Hospital Commission report (2013). Our current five-year clinical strategy ‘Fit for the Future’ provides a platform to ensure we deliver appropriate safe, effective services in the community; that our hospital based services are high quality, of sufficient capacity and affordable; and our population has access to strong, local, specialist services. Our aim as an organisation is to be widely recognised for safe, personal, effective care.

Our local population has extremes of socioeconomic deprivation, almost half of the population lives in the 20% most disadvantaged areas nationally, there is a high and increasing black and minority ethnic (BME) population in local towns (30% in Blackburn, 12% in East Lancashire), the over 65 year old population will increase by 8% in the next five years.

The aim of our programme of work as an RCP Future Hospital Programme (FHP) development site has been to deliver better safe, personal, effective care for frail older people closer to home where safe and appropriate. This work has become a key component of the Pennine Lancashire Transformation Programme, Together a Healthier Future, as one of six health improvement priorities and a component of our Emergency Care System Transformation Programme.

The work embodies a number of the Future Hospital principles, in particular:
- Hospital services operate across the health economy
- Seven day services in the community
- Intensity of care that meets patient’s clinical and support needs
- Focus on alternatives to hospital inpatients
- Care delivered by specialist teams in community settings
- Holistic care for vulnerable people.

The whole programme of care has taken place in a changing environment, both within ELHT and across the health and care economy (see timeline, Figure 1). Of particular note are that the Trust had already brought two acute hospitals together, and had started to manage community services. It was in special measures from July 2013. Considerable organisational development has taken place, with the trust now being rated as ‘Good’, some of this is outlined in a recent CQC report, Driving Improvement Case Studies from eight NHS Trusts. In addition, the Pennine Lancashire Health and Care System, though the transformation programme, is aiming to become an accountable care system within the Lancashire and South Cumbria STP. All this has influenced the nature of the projects within the ELHT FHP work, which have in turn influenced the priorities of the trust and the health economy.

The key elements of work within the ELHT FHP work have been:
- developing integrated community-based teams to support frail older people
- rapid frailty assessment for frail older people attending hospital as an emergency
- holistic care planning for frail older people approaching the end of their lives
- learning from the experiences of patients and families to improve our services.

Underpinning themes have been raising awareness of frailty across all staff groups, and creating the right care environments to meet the needs of frail older people.
2. PROGRAMME AND PROJECT DETAILS: SET UP, PROGRESS and RESULTS

2.1 Raising the profile of frail older peoples’ care within ELHT and the health economy

Our initial work as part of the FHP explored the characteristics of older inpatients at Royal Blackburn Hospital during November 2014. Data for patients in Royal Blackburn Hospital at midnight on one day were analysed. A spot audit of all patients on MAU on five consecutive days was carried out by a consultant geriatrician and experienced trainee doctor in geriatrics. A more detailed multiprofessional analysis in 50 inpatients aged over 80 admitted on one day in three consecutive weeks was also carried out.

RESULTS: Forty percent of all inpatients in the acute hospital were shown to be aged over 80, of whom 9.5% died during that admission. They had an average length of in-hospital stay of 11 days and, if discharged, 22% were readmitted within 30 days. This is a significantly longer length of stay and readmission rate than younger patients. 20% of Emergency Department attendees were aged over 80 and 75% of these patients were admitted to hospital. On the 42-bedded
Medical Assessment Unit, 1 in 4 patients was aged over 80, of whom 21% could have been prevented from admission or would not require ongoing hospital care. The MDT study of 50 inpatients aged over 80 showed that 1 in 5 had had three or more admissions in the last 12 months, 28% had concurrent mental health needs, 50% were likely to be in their last year of life, and 24% had an episode of possible harm e.g. hospital acquired pneumonia or a fall, during their inpatient stay. Sixty percent had a delay in their discharge from the acute hospital. Only 38% underwent a form of comprehensive geriatric assessment (CGA).

**IMPACT:** These data were used within ELHT and across the health economy to raise the profile of need. In the community the profile of needs for older people was raised through the Community Transformation Partnership (see below).

As a result of shared learning with other FHP sites we agreed to use Rockwood Scale (*K. Rockwood K et al; Canadian Study of Health and Aging, Revised 2008*) for assessment of older adults. We have championed this across our services and have found that it highlights frailty and multiprofessional care planning for those with higher needs; it is easily used by staff.

As a direct result of being an FHP development site focusing on frailty, we proposed and negotiated a local CQUIN (quality funding incentive) for 2016/17 for frailty aligned to the work of the programme. This aimed to increase the use of the Rockwood Scale in assessing older people in all care settings, and the use of patient experience measurement for continuous improvement of services. The CQUIN increased the profile of this work being reported at provider and commissioner Boards.

*Together a Healthier Future* has been developing during the course of the FHP and was formally launched in February 2016, initially developing a case for change, and then co-design of a care model with local people and professionals. Our clinical lead has been the main clinical input from ELHT to the programme. The needs of frail older people have featured highly in prevention, out of hospital care, and in-hospital care components of the programme, but, most importantly, how these are all connected, and has been influenced by the FHP. Frailty is one of six health improvement priorities for the programme and is now coordinated through a steering group, the Frailty Health Improvement Partnership. This brings together the work initiated through the FHP with aligned streams of work, for example, improving care in nursing and care homes and the Age Well programme.

### 2.2 Creating the right environment for care of frail older people

As can be seen from the timeline in Figure 1, the MAU was initially designed as a combined Medical and Surgical Assessment Unit, but the amalgamation of Blackburn and Burnley Hospitals with the designation of Blackburn as the main site meant that this struggled to meet the demands of acute medical assessment for the whole Pennine Lancashire population. This resulted in an average length of stay of 10 hours, with rapid onward movement to other hospital wards. For 1 in 4 patients who were frail this is a very short time to perform multiprofessional assessment, even for the 21% of those patients who would not need onward care in hospital.

During 2015, rapid plans were therefore developed to change from a 42 bedded MAU to an 84 bedded Acute Medical Unit (AMU), with patients able to stay in that unit for up to 72 hours if their care needs could be met there and if they might be discharged within that time. This created a more appropriate environment for multiprofessional assessment of frail older people. The AMU opened as two units (AMU A and AMU B) with similar operating procedures in October 2015.

Supported by the CQUIN we have now embedded Rockwood Scale assessment into the admission assessment processes on the AMUs, as a standardised part of the assessment documentation.
RESULTS: This new clinical model has resulted in a sustained increase in the number of patients discharged within 24 hours following admission to 38.5%, and 45% of all admissions being discharged from the AMUs.

Between December 2016 and March 2017 use of Rockwood scale rose from 10% of patients aged over 75 to 90% of these patients.

IMPACT: The use of Rockwood scale was enabled by a trainee advanced nurse practitioner leading this work with the support of the quality improvement team and rapid feedback of data. She has also developed awareness training amongst AMU staff, and the use of Rockwood, to guide ongoing multiprofessional referral for care planning. This is influencing the cultural environment for frailty assessment in the AMUs.

2.3 Developing integrated community based teams to support frail older people – The community transformation partnership

A major component of our programme has been the development of integrated community teams to support frail older people within their homes, either preventing admission to hospital or continuing care following assessment and care in hospital. ELHT runs community services for East Lancashire. Lancashire Care Foundation Trust runs community services for Blackburn with Darwen. We could therefore directly develop these services in East Lancashire, and could influence and learn from the similar developments in Blackburn with Darwen. Integrated Neighbourhood Teams (INT) and Intensive Home Support (IHSS) with Intermediate Care Allocation Team (ICAT) were commissioned in 2015 following co design with commissioners.

Integrated Neighbourhood Teams (INT)
The aim of INTs is to establish a case management approach for high need individuals, linked to multidisciplinary teams. This was planned to happen on a locality basis, centred on primary care. Through a series of PDSAs starting in one locality in November 2015, and then spreading and adapting for others, a model was developed. The appointment of MDT coordinators and administrators was key to successful INTs. Staff engagement in building the teams and case finding meetings required considerable investment of time. This was developed through a planned integrated community services transformation partnership programme which included significant co-production workshops, formal staff engagement and a managed communication strategy for staff and the public supported by the commissioner. A sense of shared identity across teams and across organisations was established.

RESULTS: From initial case finding meetings, 75% of patients (mainly aged 71-85 years) discussed had no known care plan before the meeting, 50% of these patients required case managed integrated health and social care and follow-up after discussion.

INTs are now well embedded in the majority of neighbourhood areas. The final locality is “going live” in July 2017. The Medicine for Older People consultants are linking into the case management meetings in some neighbourhoods, the service has been very positively received by primary care, and has improved working with primary care immensely. Patients who are being case managed by INTs are highlighted on the hospital patient administration system so that links are made during hospital attendance for care planning and discharge.

Intensive Home Support Service (IHSS) and Intermediate Care Allocation Team (ICAT)
The aim of IHSS is urgent multiprofessional support at home to prevent or reduce hospitalisation. Teams receive referrals from community and work in Emergency Departments and AMUs to identify patients for discharge and care at home which is delivered within 2 hours. The service commenced in December 2015 and has grown to be fully operational and staffed from January 2017.
ICAT is a multiprofessional team that coordinates referrals, care planning and packages and monitor service capacity. This is for health and social care, including wider elements of social care e.g. housing and support from the voluntary sector. The service commenced in December 2015 and has been fully operational from August 2016.

These two teams became integrated during 2016 with a joint managerial and professional structure. The predicted level of activity has been met and exceeded for both step-up (community identified) and step-down (hospital identified) patients. The two highest caseloads are for the frail elderly with mobility problems and respiratory patients. An important component of the IHSS/ICAT model is being part of the Hospital Front Door Team (see below). A commissioning review is underway to explore a consistent approach across Pennine Lancashire.

A Falls Response Car linked into the IHSS and ICAT service with an occupational therapist working with a paramedic to prevent a conveyance to A&E was commissioned in December 2015 and expanded from 5-day working to 7-day working in January 2017. The service aims to put an urgent care package in place to support frail elderly patients in their home with ongoing assessment coordinated through ICAT and delivered by IHSS and then INTs.

### Integrated Discharge Service (IDS)

The aim of the IDS team is to signpost, coordinate and progress discharge plans throughout the patient inpatient pathway, acting as a central point of referral, assessment and information thereby actively reducing length of stay in the acute setting. This commenced in February 2016 and continues to develop. This brought together six teams into one. A hub holds and monitors discharge and re-admission information across ELHT. A single trusted assessment document has been developed though the team and is now being rolled out in community services. Within the hospital, multi-skilled generic workers operate the trusted assessor role. Linking with ICAT for commissioning care packages is a key component.

Full sign-up by local authority social care has been challenging because of their competing pressures. The team are now piloting a Home First (Discharge to Assess) approach that has been agreed across Pennine Lancashire. Discharge and transfer pathways from the acute hospital have been streamlined and clarified.

Overall, community integrated services are now well established, as initially envisaged in our FHP work plans. There is still a need to increase capacity in intermediate care. Implementing the Home First model is a key component of the ELHT Emergency Care System Transformation Programme, and the services are established to enable this. This will now largely be a cultural change at the ward level.

### 2.4 Rapid frailty assessment for frail older people attending hospital as an emergency

This was initially tested on the MAU between November 2015 and August 2016. Led by a consultant geriatrician working with a developing multiprofessional team, a series of PDSAs were done to assess the best approach. Multiprofessional assessment and care planning were vital, including social care. Communication with families, carers, primary and community care and care/nursing homes as part of the assessment were also very important. Input from a general practitioner with a special interest in older people’s care was also tested, and added particular insight to the team’s approach. Structured communication with the GP via the discharge summary was tested and adapted through a PDSA approach.

**RESULTS:** This pilot proof of concept in the MAU demonstrated that 60% of the 22 patients aged over 80 who were assessed and managed in this way were discharged from the MAU.

As the AMUs were developed and implemented from October 2016, rapid frailty MDT assessment was to be a component of this new model of care. However, competing demands on our consultant geriatricians prevented the implementation. We have six geriatricians in post and
three vacancies. They cover hospital and community services, including orthogeriatrics and stroke. The input of the IHSS service and front door team to AMUs for highlighted patients was part of the model and was able to be implemented. This enabled early discharge from AMUs, but more detailed CGA and MDT meetings were not able to be implemented.

Multiple approaches to developing some medical capacity to be part of rapid frailty assessment were explored. Many would have taken considerable time to develop. A Specialty Doctor for Frailty was appointed in August 2016 to lead and be the medical input for rapid frailty assessment, with consultant and leadership mentoring. She began working as part of the front door team in the Emergency Department (ED) of A&E at Royal Blackburn Hospital from October 2016. Once more though a series of PDSAs and weekly review meetings, the ways of working of the more complete front door team developed. The team, comprising Specialty Doctor for Frailty, Occupational Therapist, Physiotherapist and IHSS senior nurse, is based in the ED Monday to Friday 8.30 to 17.00, and assesses patients highlighted by ED coordinators or from "screening" patients in the department. This is a needs-based approach. They work very closely with ICAT for initiating care packages for patients, with early review by IHSS and then feed into INTs. Communication with GPs and care/nursing homes has been tested and adapted through PDSAs, including feedback from GPs and care/nurse home managers. A structured, immediate communication is now in place, with the recommendation that patients are discussed in INT meetings. Patients who are admitted but would benefit from early further assessment are followed through by the team on AMUs. This approach has seen an increase in early discharges from the AMUs.

RESULTS: In the first six weeks, 121 patients were seen by frailty specialist doctor with IHSS, 90 discharged, 23 admitted to AMU, 3 to other specialties, 5 direct to intermediate care, 55 were followed up by IHSS. The specialty doctor has had an impact on many staff in the ED. “Gives me confidence of a safe discharge. She has the time to go into detail that I will never have. The team have a familiarity with support services” – ED Consultant. “She gives us confidence to make higher risk decisions. A greater understanding of what can be treated at home. I am reassured that the patient is going to the right place. We now work in a less risk averse way.” – Occupational Therapist.

IMPACT: ELHT is now planning the next stages of development of the Emergency Care System Transformation Programme. Establishing rapid Frailty MDT assessment 7 days a week over extended hours will be a key component. As assessments and implementing a plan can often take longer than 4 hours, the establishment of this service as part of a Clinical Decisions Unit, with patients being pulled from ED, is in the advanced stages of planning. Medical senior workforce remains the main constraint.

2.5 Holistic care planning for frail older people approaching the end of their lives

The initial study of hospital patients aged over 80 and the rapid frailty assessment pilots identified that a large proportion of frail older people attending hospital as an emergency may be in their last 12 months of life. This is supported by published literature (Clark M et al: Palliat Med 2014). End-of-life care has also been highlighted though patient and family experience measurement.

Following a review on national and international guidance on care planning in the last 12 months of life a format for supporting patient and family discussions and documentation was tested and adapted on one Medicine for Older People ward. This was called the Goals and Priorities of Care Document (GPOC). It went through multiple iterations. It is now in use across Medicine for Older People and Orthogeriatric wards. Standardised communication with primary care has also been tested and adapted and is now in place.

In order to maximise the appropriate use of this tool and approach, analysis was undertaken of 40 patients aged over 80 who died within 12 months following hospital admission, and 40 who
did not, during 2016-17, to see if there were clinical markers of patients who are in their last 12 months of life.

**RESULTS:** The data showed that patients who died were twice as likely to have been admitted from a nursing home, and to have had two or more admissions within the last few months. Dementia diagnosis and high Rockwood scores were not discriminators. More detailed results of the outcomes of GPOC assessments are shown in section 3.

Further spread of the use of GPOC was planned, but the development of support for advanced communication skills is key. Further spread was therefore not implemented until this was in place. A structured approach to the development and maintenance of communication skills has been developed by our Learning and Development department and is now in place. As we were beginning to plan the role out, the national ReSPECT (http://www.respectprocess.org.uk) programme was developed and launched. We have therefore agreed to implement the ReSPECT programme within ELHT, and the GPOC will be an important component of that, adding more details for appropriate patients.

### 2.6 Learning from the experiences of patients and families to improve our services.

The RCP Future Hospital team have emphasised, throughout, the importance of patient involvement in service improvement, as exemplified through the Patient and Carer Network of the RCP. Our local team have been advocates of patient and family involvement. At the start of the programme, wards were collecting a subset of the national inpatient survey on a sample of patients per month, collected by the ward staff, coordinated through the Meridian IT system, and fed back on a quarterly basis. The RCP team were keen to use the RCP patient survey, and initially this was used and tested through ward staff and our patient representative as a volunteer on one Medicine for Older People ward. The results were in line with our inpatient survey, but in our opinion the questions were very doctor-focused rather than looking at team-based care. Results from this survey did not change practice. Our community teams collected more ad hoc patient stories, around the benefits of their services.

A visit to Northumbria NHS Foundation Trust following a talk by Annie Laverty, Director of Patient Experience, at a phase 1 development site event, changed our approach. Our patient representative and ward sister observed how Northumbria had made learning from patient experience mainstream, through the involvement of volunteers and real-time feedback. Given our focus on a whole patient journey in and out of hospital we were keen to develop a more appropriate tool. ELHTs quality and safety unit includes a small patient experience team, and they became part of our FHP team and led this work. We agreed to pilot the use of the Integrated Care Questionnaire that has been developed and evaluated in Northumbria. Volunteers were recruited to test the administration of this questionnaire with older people and their families in the AMUs and the Medicine for Older People ward. During testing, a series of adaptations, in particular the training and support of the volunteers, in administering and especially collecting narrative, were made. The questionnaire was more appropriate, but recruitment and retention of volunteers was challenging. They also found that patients tired during the questioning. Use of the integrated care survey through volunteers, with data and narrative, collected real time on ipads, collated through the Meridian software system, and fed back to ward teams on a monthly basis, is now established. These data and narrative have been more illuminating for teams, particularly highlighting care in other locations, and the need for better information and involvement of carers.

At the phase 1 site event in East Lancashire we focused half of the day on patient experience. This was partly led by our patient representative. He challenged us to think about patient experience more broadly, particularly including carers and thinking about whether patient expectations were met. The input to the discussion of other members of RCP PCN developed the thinking of all phase 1 sites.
We had decided to test structured interviews in patients’ homes. Over the next 9 months we developed a consistent mechanism of identifying patients for interviews, consent, recording, collating and reporting, coordinated through our patient experience team. Other routes of patient experience reporting were used to create stories in a similar format for feedback. These include complaints, PALS enquiries and compliments. Patient stories are now shared on a routine basis to highlight opportunities for improvement to leads of teams involved in the individual’s care in hospital and in the community, at the Pennine Lancashire Frailty Health Improvement Partnership (Frailty Steering group), and to ELHT Quality Committee and Board of Directors.

The strong themes arising from the patient experience reporting have been the need for better information about what care to expect, better involvement of families and carers in care, the importance of other services e.g. community pharmacy, ambulance services and voluntary sector and the importance of good end-of-life care, again emphasising communication and family involvement. In addition, specific care improvement opportunities have been picked up and implemented.

As a result of the patient experience feedback, we co-designed with patients and carers new patient and family information, initially for when the patient is admitted to hospital. This picks up many of the themes highlighted in the narrative of patient experience reporting. It is being tested in one ward before final adaptation and roll-out. We expect this to have a major impact on patient care and it will be incorporated in other quality improvement projects.

3. IMPACT OF FHP ON PATIENT CARE
The following are extracts from our patient experience measurement.

“I don’t feel I am listened to or asked anything.” “They don’t ask what I think.” “Carer feels that sometimes they say things which they do not understand.” “Patient feels they haven’t been given a great deal of information and that some needed more interpretation” “They are so busy, more staff are needed.”

“They are a good team, they know what is going on.” “I am very happy with the care given.” “I am listened to.” “Doctor asks for your opinion. Generally good care given so far, things were explained to me from the start. Always consulted and information given was clear.”

“The Community Nurses come out to me 5 days a week. They involve me in decisions about my care and treatment. They help with everything. They listen to me and now with the dementia creeping in they are very patient with me.”

I asked her if there was any follow-up at home. “Oh yes; two nurses came to see me to check the medication and watch me take it. I like to do it myself, including the injections. After a week they said I was doing fine and were discharging me and gave me this.”

“… showed me a large card with contact details for the Integrated Community Team…..said they told her she could call them any time if she had a problem and they would respond very quickly. …. delighted that this service was readily available to her”

“The lady who is coordinating is really good and very helpful. We are delighted with the service. The concept of all the professions integrating and communicating with each other is marvellous. The hospital, the doctors and nurses, the therapists, the physiotherapists, the dispensary all communicating and coordinated through one office. Any relevant information can be shared very quickly. We are extremely pleased with the service we are now getting. The district nurse visits regularly for the insulin injections and to check up on Dad, and the physiotherapist is still visiting. Dad’s mobility is improving. The dispensary sent someone round to go through the medication and if there is any change they come round again to explain. The physio noticed that Mum had a bit of a problem so they arranged for her to receive some therapy.”

“Clitheroe Health Centre and RBH are excellent and treat us as people; not numbers.”
Our programme is multifaceted and there are multiple other changes in the health and care economy. We cannot necessarily attribute all of the positive aspects directly to our programme, but they will certainly have contributed.

**Figure 2** shows the breakdown of presenting conditions of patients assessed by the front door team. **Figure 3** shows how community services have responded to both these patients but also patients referred directly from community services, including INTs.

Figure 2. Presenting conditions of patients aged over 70 assessed by Front Door team in ED and AMUs. January 2016 to June 2017

As can be seen, the response to the service developments has been a marked increase in referrals to Pulmonary Rehabilitation and a resulting reduction in respiratory nurse visits required. A notable increase in falls prevention advice and input together with less, though reportedly more complex, assessments by the “front door team” is seen. Social care packages have been
consistent and probably limited by availability, IHSS nursing contact within the home have risen as the service capacity has expanded.

**Figure 4** shows that there has been a significant reduction in admissions to hospital as a result of falls and poor mobility, coinciding with the development of IHSS and INTs, and there may have been further reductions since January 2017, though not yet significant. The increase in Nov 2014 is thought to be due to changes in clinical coding. The relative impact of INTs and IHSS, which have expanded and grown their multiprofessional functions over that time, and the impact of the falls pick-up ambulance/OT service cannot be extracted, but are likely to have all played a part.

Figure 4. Acute Hospital Admissions to Royal Blackburn Hospital coded as primarily due to falls and poor mobility between April 2014 and May 2017

The wider impact of our interventions on hospitalisation and experience in hospital is difficult to evaluate. However, we have not seen any increase in hospital admission rates over the last 3 years including in people aged over 80 in contrast to the national trend.

For patients assessed to be in their last 12 months of life the results of Goals and Priorities of Care discussions for 30 of these patients are shown in Table 1.

**Table 1. Outcome of Goals and Priorities of Care discussions**

<table>
<thead>
<tr>
<th>Results of 30 patient discussions</th>
<th>Range</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 with Patient alone, 25 with Families</td>
<td>52-97</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>Age (yrs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rockwood Score</td>
<td>6-9</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Duration of discussion (Minutes)</td>
<td>5-75</td>
<td>30</td>
<td>25</td>
</tr>
</tbody>
</table>

15 (50%) agreed in principle not for readmission in event of deterioration; 7 (23%) agreed in principle not for artificial feeding

**Key Findings:**
- Time and needs to be taken into account when planning ward based care
- GPOC can be by experienced doctors or nurses
- The conversation is the most important, the format helps structure the discussion
- The majority of discussions are with families as most patients have significant cognitive impairment. Multiple discussions may

**GPOC requires advanced communication skills in the professionals**
**GPOC is more difficult in acute assessment areas because of continuity of care**
**Linking with advanced care planning in the community is key**
**Understanding the focus of care on control or comfort rather than cure is helpful to practitioners, patients and families**
**Discussions on feeding and fluid are difficult**
In order to reduce hospitalisation for frail older people a multi-faceted approach across the patient pathway is needed. This includes better and easily accessible integrated community services, rapid assessment of frail older people on emergency attendance to hospital, and improved care planning in the last 12 months of life.

The awareness of staff of the needs of frail older people, and involvement of families and carers in care planning are also likely to have a considerable impact.

4. IMPACT ON STAFF

We believe that there has been a significant change in staff awareness around the needs of frail older people and their families. Whilst we have not been able to directly measure that, it is a theme that appears in the patient stories. This has been achieved through the associated publicity of our improvement programmes, the use of Rockwood scale by staff in assessing patients in all care settings, the involvement of staff through the co-design workshops of Together a Healthier Future, associated improvement projects, particularly “partnerships in care” (See East Lancashire Hospitals NHS Trust video on 1-1 care), joint working with other sectors, and the feedback from patient stories.

In addition, we have seen a reduction in nursing staff sickness in the Integrated Care Group (Figure 5) and increased staff engagement (3.76 2014, 3.86 2015 and 2016) and responsibility and involvement (10% increase 2016 vs 2015) through the national staff survey. Staff friends and family testing has shown an increase in the percentage of staff recommending the trust from 75% at the end of 2014, through 80% at the end of 2016 to 92% at the end of 2017.

Once again, it is impossible to estimate the effects of the ELHT FHP work on these figures, as multiple developments have been happening in the Trust and Health economy.

The RCP staff survey measures for staff involved in the caring for patients across the frailty pathway showed in 2016 over 82% were always or often enthusiastic about their job, an increase from 70% in 2015, and compared to 76% for the organisation as a whole. 49% felt always and often involved in deciding on changes introduced that affected their work, compared to 45% the previous year, and 55% across the organisation. 83% of staff always or often had the opportunity to use their skills compared to 67% last year and 73% across the organisation.

5. RETURN ON INVESTMENT

With healthcare interventions, return on investment is very difficult to show. However, we have assessed the healthcare utilisation of a sample of 155 patients who received multiprofessional assessment through INTs before and after this intervention. In the month before the assessment
the intervention costs for unplanned care for this cohort was £109,145, and in June 2016 for the same patients a number of months after the intervention was £24,200. More detailed analysis has not been possible. Clearly there will be a component of this which is regression to the mean, but it does suggest an economic benefit of case management of these patients following identification across the pathway.

6. CHALLENGES AND ENABLERS

Throughout our programme of work there have been significant challenges. We have been working in an ever-changing environment, as shown in our timeline. Our programme has been wide ranging, though all focused on improving care for frail older people. The wide range of interventions has meant that multiple stakeholders have been involved and that the work crosses a number of internal and external programmes of work. Coordinating and connecting a wide programme of work, whilst keeping focused on the “project” nature envisaged by the RCP’s FHP team has been difficult. Specific measurable objectives were not set for the programme or individual projects. The complexity of our health and social care economy with two CCGs, two community providers, and two local authorities not coterminous with Pennine Lancashire, has also created challenges to having a single coordinated approach. Staff protecting time for service development rather than “fire fighting” service pressures is a constant challenge for all.

Together a Healthier Future as the Transformation Programme for Pennine Lancashire has been very helpful in bringing together our programme of work. It has enabled engagement with the public, patients and practitioners, and shared ownership of the interventions between providers and commissioners. More recently, with frailty as a health improvement priority and the Frailty Health Improvement Partnership developing from our frailty steering group, there is dedicated management support. It brings together both the core programmes and aligned programmes and provides a very firm footing for future developments. Consistent senior clinical leadership of the FHP work, the development of Together a Healthier Future and leadership of the Health Improvement Partnership by the Deputy Medical Director have been instrumental in this. Consistent input to Together a Healthier Future by other team members, notably the consultant geriatrician frailty lead and the general manager for community services, have been vital. In addition, the incorporation of frailty into ELHTs Emergency Care System Transformation Programme, incorporating most of the elements of the FHP work, will ensure senior leadership support, programme management support and scrutiny for delivery.

Resilience has been required with a number of elements of our FHP work. The challenge between delivering the proof of concept of rapid frailty assessment and having a workforce to deliver this was significant and could have been very demoralising. Similarly, there were frequent challenges in delivering the patient experience element of the programme, with difficulty retaining volunteers, information governance, and competing priorities for the patient experience team. Our patient champion kept us on track. The experience of the local leaders of FHP who have been through multiple changes in their careers enabled us to continue towards the “bigger prize”.

The CQUIN for Frailty was a major factor in maintaining momentum and organisational support. With a potential of lost income of £1.2M if this was not delivered, regular reporting to Board of Directors was required, as well as support of corporate teams. Both elements of the CQUIN - use of Rockwood Scale and embedding learning from patient experience, have been major components leading to cultural change that recognises the need for more patient-centred coordinated care across care settings.

Ensuring the programme of work was part of “normal business” of the Trust and Health Economy, and using the capacity of normal business functions have been essential to our progress.
The interventions and developments that were tested, adapted and implemented as part of the FHP are now well established in our strategic development plans, or in our operational processes at ELHT and Pennine Lancashire. This work is being coordinated by the Pennine Lancashire Frailty Health Improvement Partnership (Frailty Steering Group) and the ELHT Emergency Care System Transformation Programme.

The Frailty Steering Group meets on a 6-weekly basis and has representatives from across the health and care economy including Public Health and Voluntary Sector. The main workstreams are Prevention and Awareness, Care Planning, End of Life, Digitisation, and Metrics. Through this a Frailty Scorecard of quantitative and qualitative measures is in the advanced stages of development to measure the impact of future interventions and ongoing care. Patient stories are reviewed at each meeting for learning. Whilst each of these workstreams has an action plan which is developing well, we are using two areas as demonstrators of our joined-up approach to supporting frail older people. These are the implementation of a revised Falls pathway, and the Red Bag Scheme for people in Nursing Homes. All of this work is part of the Together a Healthier Future which has an overarching care model that emphasises out of hospital care, personalised care, prevention and high quality hospital care with specialists working in community settings. It is therefore aligned to the Future Hospital principles. This will ensure a consistent model of care for frail older people across Pennine Lancashire. The use of the Electronic Frailty Index for initial population screening followed by assessment including the Rockwood Scale is agreed. Rockwood scoring is being embedded in assessment and monitoring processes in all care settings, and used as a trigger for Older People’s Assessment, using the Trusted Assessment Model. This is aligned to comprehensive geriatric assessment. Workforce development is a key component of all the plans.

Within the Emergency Care System Transformation Programme the two main elements that lead on from our FHP work are the further development and expansion of Rapid Frailty Assessment from ED and AMUs, and Home First.

Rapid Frailty Assessment is planned to be established in a Clinical Decisions Unit, and capital funding for the development of this as part of an Emergency Floor has just been approved through NHS England. This will also bring together the two AMU wards into one unit linked to ambulatory care and the Clinical Decisions Unit.

Home first and discharge/transfer pathways are being implemented and expanded. We are in a good position for these to be successful as the integrated community based teams have been developed and are in place.

The ReSPECT programme, incorporating GPOC and including advanced communication skills training is planned to be implemented from September 2017 within ELHT. Discussions are underway with primary care colleagues to make this a system-wide approach.

The new patient and family information for patients when admitted to hospital is currently being trialled and will then be adapted and implemented in all areas. This is being overseen by the Patient Experience Committee, which also receives regular patient experience measures reports.

The other programme that will improve patient-centred care for frail older people and is in line with the Future Hospital principles is our Model Ward Programme. This is in the early stages of redesigning adult ward-based care. Design workshops have been completed and implementation has commenced. It is a two-year programme and is overseen by the Emergency Care System Programme Board.
8. SUMMARY

Our programme of work as a RCP FHP development site has been to deliver better Safe, Personal, Effective care for frail older people closer to home where safe and appropriate. This has been an ambitious programme with multiple components. There have been considerable successes and many challenges. Being part of the RCP’s FHP has greatly aided this work through the networking and support of other development sites and the central team, and through the prominence that being an FHP development site has brought in our organisation, raising the external profile of ELHT.

Fitting this work neatly into a project structure as initially envisaged by the RCP team has been challenging. This has been partly because of the scale and scope of our local work, but also the length of time of being within FHP inevitably means that local changes will necessarily change the nature and focus of the work. It is right that in a complex adaptive system that change programmes should adapt as required, keeping the overall vision and principles of the work as the goal. It has been our adaptability to local changes, and embedding the work within them that has brought the current success, and set a platform for the future.

The sense of being part of a community of practice that is testing the real world implementation of the Future Hospital principles has been both invigorating and created resilience in challenging times. The FHP has delivered without external funding for implementation, and without additional staff at sites, and has shown that the Future Hospital principles can be delivered throughout the NHS, not only at Vanguard sites.

Without being a Future Hospital development site, much of our work would not have progressed to this extent. In particular, the prominent culture of care being a continuum that may include hospital care has been exemplified through this work and influenced organisation and system culture. We have raised the profile of a vulnerable patient group, frail older people (in line with FHC) with staff, and the most vulnerable of those, in their last 12 months of life. Multiprofessional staff are better coordinated to meet these families’ needs and improvements in care are progressing fast. There is resolve to improve care for the last 12 months of life though better conversations and care planning. The use of the Rockwood scale, enabled by the CQUIN, have influenced this cultural change. Alongside this we have seen an improvement in staff culture, motivation and satisfaction.

Particular success and progress has been made on a new approach to using patient experience through structured interviews about the whole experience of care, and standardised patient stories used by teams and leadership to guide and invigorate continuous improvement. This has resulted in better information and involvement for patients and families.

We have delivered improvements in care and experience for frail older people in their own homes, when attending hospital and during and following a hospital admission. In particular, admission rates for people with mobility problems are continuing to reduce. We have established systems that will continue to improve care. We have consistently used the improvement methodology of small scale testing and adaptation then moving to wider scale implementation and this has become our local “method”.

We could and should have been better at setting aims and objectives, measuring the processes and outcomes of care, and in the future will spend more time on establishing these at the start of the programme or project. The support of the RCP’s FHP team has put us in a better position to do this. We could and should have been more robust in our project management, this might have brought earlier results, again these systems are now in place.

The remaining challenges for us, and for others working in this way and building better future care for patients and families, are the current workforce constraints, particularly for senior medical staff in specialist care and general practice, and the ever-changing organisational
structures within the NHS. Clinical leaders as a constant will continue to rise to the challenges this brings, though it limits what can be achieved.

Finally, for others embarking on similar work: keep patients at the centre, have robust programme management with flexibility to changing circumstances, link up with others doing similar work and embed your work in the organisation’s everyday business.