Proactively caring
for the Elderly and those with Complex Need in Sussex

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Context

The purpose of this document

This document aims to establish a framework which we will expect CCGs, their local authority partners and provider organisations to use to deliver a seamless and integrated approach to improving services for our frail/elderly populations.

Why is this work important?

Our population is changing. Sussex already has one of the oldest populations across the UK. Our frail and elderly population will grow and we will have greater prevalence of those diseases that come with age.

A changing population

- Just over 20% of the Sussex population was over 65 in 2010
- East and West Sussex have higher proportions of people over 65 than England overall. Brighton and Hove has a much smaller proportion of elderly people compared to the rest of Sussex and England
- The over 65s are expected to grow fastest in East and West Sussex, and slowest in Brighton and Hove. East and West Sussex elderly populations are expected to grow faster than England overall over 2010-20.

<table>
<thead>
<tr>
<th>Region</th>
<th>Population of over 65s in 2010</th>
<th>% of population over 65 in 2010</th>
<th>Average expected growth rate of over 65s 2010-20</th>
<th>Expected % growth of over 65s, to 2014</th>
<th>Population of over 85s in 2010</th>
<th>% of population over 85 in 2010</th>
<th>Expected % growth of over 85s, to 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brighton and Hove</td>
<td>35,700</td>
<td>13.9%</td>
<td>0.5%</td>
<td>2.5%</td>
<td>6,600</td>
<td>2.6%</td>
<td>3.0%</td>
</tr>
<tr>
<td>East Sussex Downs and Weald</td>
<td>79,100</td>
<td>23.5%</td>
<td>2.3%</td>
<td>12.0%</td>
<td>13,300</td>
<td>3.9%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Hastings and Rother</td>
<td>42,300</td>
<td>23.5%</td>
<td>2.2%</td>
<td>11.3%</td>
<td>7,100</td>
<td>3.9%</td>
<td>5.6%</td>
</tr>
<tr>
<td>West Sussex</td>
<td>166,500</td>
<td>20.8%</td>
<td>2.3%</td>
<td>11.8%</td>
<td>26,700</td>
<td>3.3%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Sussex</td>
<td>323,600</td>
<td>20.5%</td>
<td>2.1%</td>
<td>10.8%</td>
<td>53,700</td>
<td>3.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>England</td>
<td>8,585,000</td>
<td>16.4%</td>
<td>2.1%</td>
<td>11.0%</td>
<td>1,193,000</td>
<td>2.3%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>
Quality

Our current systems and services do not offer the right quality. We have services which have:

- Grown historically and in an unplanned way
- Become poorly aligned with the needs of local patients
- High levels of variation from area to area
- Silos, leaving gaps in care pathways
- Duplicate process, such as assessments,
- Too many ‘hand-overs’ of care, which generate confusion amongst patients and clinicians
- Too many patients inappropriately in acute hospital beds
- Staff who become disillusioned when they are not empowered to provide the highest quality care

Our current systems and services are also too reactive and hospital-centric. This is not affordable, doesn’t offer good quality care for patients and is not sustainable as our population changes.

Vision and values

Values

In working to improve services for our elderly and those with complex needs we will,

- Improve the quality of services for our patients and provide value for money
- Transform current services as a whole health and social care system,
- Establish seamless and integrated pathways around patients

The Sussex vision

By April 2014, our plans for improving services for frail/elderly people across Sussex will have delivered,

- Care wrapped around the patient, whatever the setting of care and which is experienced by them as a single delivery system
- Reduced inequalities by delivering the best possible outcome
- High quality pathways for people to maintain and maximise independence, to live in their own homes and where inappropriate admission to an acute hospital is seen as a system failure
- A sustainable and cost effective system across health and social care, supported by the right financial framework
- Transformed services through a seamless and integrated approach to health and social care based around a primary care hub and including:
  - Risk stratification to target the right services, at the right level, to the right people
  - Multi-disciplinary, multi-organisational integrated care teams
  - Enabling the maximum number of people who self manage at all levels of need
→ A system which creates a richer professional experience for clinicians and practitioners

- Effective management of long term conditions including dementia
- Effective management of End of Life care
- Effective support for people in care homes
- Effective medicines management for every patient

In achieving our vision, we will:

- Reduce non-elective admissions for those over 65 by 30%
- Reduce the length of stay for those over 65 by 30%
- Realise a significant reduction in people in long-term residential placements
The Pathway

The pathway is based on a collation of international, national and local evidence and best practice and in line with the NHS Long Term Condition QIPP programme. Each element of pathway is described below, showing the minimum service requirements. *Appendix A-all evidence docs*

The pathway must be seen as a whole, delivered by one integrated system.

### Staying Healthy

Proactively supporting frail/elderly people to keep well and reduce risk of deterioration.

**Minimum service requirements**

- Bone health
- Strengthen and balance training
- Smoking, weight and alcohol programmes
- Influenza and pneumococcal vaccination programmes
- Effective medicines management
- Screening
  - Depression
  - Dementia
  - LTC-DMT2, IHD, AF
- Housing programme
- Care home training and education programme
- Carer support
Proactive Community Care

Proactively identifying and supporting frail/elderly people and their carers who are at the greatest risk to prevent deterioration.

Minimum service requirements
- Risk stratification (using hard AND soft intelligence)
- Active case management
- Integrated multidisciplinary team (MDT)
  → Plan, coordinate and deliver care
  → Support the whole pathway, inreaching into the hospital
- Integrated long term condition and dementia care with:
  → Early diagnosis
  → Agreed pathways of care
  → Specialist services supporting the MDT not running separately
- Promote and work with maintaining independence services
- Assistive Technology (Telecare/telehealth)
- Integrate and enable proactive End Of Life care

Admission avoidance

Proactively avoiding all inappropriate admissions to hospital by providing comprehensive geriatric review in the community alongside safe, robust community care. Hospital admission for a frail elderly patient can reduce functional ability and hospital avoidance is, therefore, a mark of quality.

Minimum service requirements
- Single point of access
- Rapid assessment
  → Urgent GP home visits requests seen within an hour (GP/paramedic practitioner/community team)
  → Senior assessment (consultant/GP) of all frail/elderly in A+E and AMU
- Rapid response MDT team
  → Outreach to community
  → Inreach to A+E, AMU
  → Provide short term care
- Comprehensive geriatric review
  → Rapid access clinics
  → Ambulatory service
  → Telephone and email advice
- Step up beds in the community (care homes, community hospitals)
- Easy access to patient transport
In-hospital care

Proactively ensuring that frail/elderly people requiring admission to hospital receive holistic and high quality care that is fully informed by the patient and carer’s health and social care needs.

Minimum service requirements
- All frail/elderly people should be looked after by elderly care specialists leading multidisciplinary teams
- Proactive community teams in reach into hospital
- Shared patient records with the community

Discharge to assess

Proactively ensuring that frail/elderly people only stay in an acute hospital when they require a 24/7 specialist service and once medically stable they are supported to regain previous level of function.

Minimum service requirements
- Coordinated integrated discharge planning that begins at the point of admission
- Early supported discharge before full recovery*
  → Integrated discharge service
  → Geriatric follow-up in the community
  → Community support teams
  → Coordinated rehab/re-ablement in community settings
  → Short term care packages
- “Search and rescue” proactively
- Step down community beds (care home, community hospital)
- Easy access to equipment services
- *

*This will require a local price agreement to ensure shift of resource

Maintaining independence

Proactively supporting frail/elderly people and their carers to self care and remain independent.

Minimum service requirements
- Self care programme
- Carer support
- Prevention services eg centralised falls service
- Low level support networks
Delivery

Effective provision for the frail/elderly population is delivered through an integrated service model which has the following characteristics:

- It will **proactively identify and care for frail/elderly patients** at every stage of the pathway
- Be **one integrated health and social care multidisciplinary team** (MDT) at the heart of the service
- **The MDT team will be THE community service.** It is instead of, not as well as current provision

What might the model look like?

![Diagram of the model](image)

The Multidisciplinary Team (MDT)

- One team per 30K registered primary care list
- There is no ‘one size fits all’. Local teams must be allowed the flexibility to develop and respond to their population, but adhere to the same core principles
- Effective communication and leadership are vital
- Using ‘Live’ and ‘Dormant’ lists drawn from the risk stratification scoring, ensuring manageable case loads
- Specialist support should ordinarily sit outside the core MDT BUT must actively support and enable to MDT
- Community Geriatricians will be critical and should provide a named link to each MDT
Core MDT functions

- Comprehensive and holistic assessment – ideally a single process
- Wrap care around the patient through care coordination
- The Care Coordinator role is a key function and must be performed by the right team member who might be non-clinical or a carer with the ability to advocate and influence
- Care planning and the planning of care, is owned by the patient and their carer
- Care delivery is single and integrated
- Support patients when admission is required, by in-reaching to specialist and urgent care services
- Support patients to be safely ‘discharged’ from acute hospital

Who, or what professionals are in the MDT?

- GP Champions
- Practice Nurses
- Community Nurses and Matrons
- Therapists
- Mental Health Workers
- Social Care Workers
- Generic Care Assistants / Workers
- Care Coordinators or Case Managers
- Administrators
- Managerial support

The right skill mix is key. Effective leadership is vital in these teams, but the lead professional might be different in each team. Access to equipment is a key enabler

Geriatric service

Consultant Community Geriatricians should,

- Follow the patient into and out of the acute hospital back into the Community, bridging the entire urgent care pathway
- Provide a key leadership role in the system
- Provide training and education for the system

Workforce

- Must plan for a shift of workforce from acute to community setting
- Engagement with grassroots staff will be key
- Staff must be up-skilled and given appropriate training

Organisational Form

- Form MUST follow function
- Must remove barriers to ensure staff can work effectively
Managing System-Wide Change

Creating a system of care for the frail/elderly population as described in this document means transformational change across the system. In realising such change we need to apply the following principles of large scale change,

- Be prepared to identify high leverage key themes that explain the need for change and describe it in a way that people can understand e.g. the need for integration because patients experience fragmentation.

- Spend time with people, ensuring that change processes provide the opportunity to frame and reframe issues actively because different people and groups see things from different perspectives and will have different receptors for change.

- Support massive and active engagement of stakeholders.

- Create momentum through early, pragmatic and mutually reinforcing changes across multiple systems and processes to gather “champions” and spread different ways of working e.g. develop Pioneer Sites to drive excellent practice.

- Take risks and live with what we have. We must be prepared to work on the basis of faith, courage, intuition and proceed forward with an incomplete evidence base.

- Celebrate success!

Governance

Good clinical and corporate governance will be a key enabler in any change, and to ensure delivery we,

- Must have robust clinical governance across the pathway
- Must maintain momentum through a programme management structure
- Must ensure clear clinical and managerial leadership across the system
- Must have clear baseline data
- Must have up a local frailty/programme board
  → CEO level, health and social care
  → Meet at least monthly
  → Sit within a pre-existing sub-structure if possible
  → Report into NHS Sussex
- Must have accountability agreements with agreed milestones between all partners
- Must have one set of system wide metrics with system wide data sharing
- Must develop a common language between health and social care

Contracting and Finance

We must incentivise the system to work collaboratively through,

- Agreed milestones which are reflected in contracts and which hold the system to account
- Local prices
- Planning for re-provision costs and allowing for pump priming
• Consideration of pooled budgets with risk and reward sharing

**Technology**

Technology will be a key enabler. This will support all professionals to share information in order to achieve,

• Effective Risk stratification tools to identify patients by drawing on data from the whole system
• Shared patient records
• Real time performance data
• The whole system on one email system, for example nhs.net

**Sussex Added Value**

To enable local deliver, NHS Sussex will commit to:

• An ‘expert’ team who will:
  ✓ Create a network
  ✓ Ensure the spread of ideas
  ✓ Drive change and maintain momentum
  ✓ Support local delivery but not lead or manage. They will “parachute in” when asked
  ✓ Collate and share best practice
  ✓ Share detailed local work eg service specifications, accountability agreements
  ✓ Problem solve
  ✓ Provide professional expertise eg champion geriatricians
• Agree Sussex wide frail/elderly local prices
• Lead IT solutions and achieve economies of scale
• Enable integrated health and social care working
• Hold the system to account
## Outcomes and milestones

### Outcomes

This work will deliver a high value service with good clinical quality at an affordable and sustainable price. Measures aligned to outcomes to consider include:

- 30% reduction in non-elective admission for those over 65 years
- 30% reductions in length of stay for those over 65 years
- Significant reduction of admissions for LTC in all age groups
- Significant reduction in readmissions
- Increase in people dying in their place of choice
- Significant Reductions in people in long-term residential placements
- High satisfaction scores in patient and carer experience surveys

### Milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>now</th>
<th>By 01.04.12</th>
<th>By 01.06.12</th>
<th>By 01.08.12</th>
<th>By 01.10.12</th>
<th>By 01.04.12</th>
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<tbody>
<tr>
<td>Put break clauses in current contracts</td>
<td>X</td>
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<tr>
<td>Set up extranet site (to build a database of useful material)</td>
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<tr>
<td>Establish Senate (its project teams, and governance arrangements)</td>
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<td>Local frailty boards exist</td>
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<tr>
<td>Frailty network formed and functioning</td>
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<tr>
<td>Delivery plan costed agreed and ready</td>
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<td>X</td>
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<tr>
<td>Baseline data produced and fit for use</td>
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<tr>
<td>Accountability agreements in place</td>
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<tr>
<td>Pioneer schemes start</td>
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<td>X</td>
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<tr>
<td>System fully operational</td>
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<td>X</td>
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