Future Hospital Programme | Development sites

Phase 1: Frail and older people

East Lancashire Hospitals NHS Trust

Aim

To deliver better, personal, effective care for frail and older people closer to home where safe and appropriate.

Outline

The Future Hospital development site work at East Lancashire is a core component of the Pennine Lancashire Transformation Programme ‘together a healthier future’. As one of six health improvement priorities and part of the trust’s emergency care system transformation programme, the project team set out to:

1. develop integrated community care teams to support frail older people
2. implement a rapid frailty assessment for frail older people attending hospital as an emergency
3. embed holistic care planning for frail older people approaching the end of their lives
4. learn from the experiences of patients and families to improve services.

Key messages

- **Adaptability** to local changes, and embedding the work within them, 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.
- Recognising that the prominent culture of **care is a continuum** that may include hospital care. This has been exemplified through this work and has influenced organisation and **system culture.**
- Establishing the measures for the process and outcomes of care at the start of the programme or project, alongside robust **project management**, may bring earlier results.
- Keeping **patients at the centre** and embedding your work in the organisation’s everyday business.
- By **raising the profile of vulnerable patient groups**, multiprofessional staff are now better coordinated to meet families’ needs, and improvements in care are progressing fast.

Methods

1. Developing integrated community-based teams

These teams were developed to support frail and older people within their homes, either preventing admission to hospital or provision of continuing care following initial assessment and care in hospital. This included the following:

- Integrated neighbourhood teams (INT): a case-management approach for high-need individuals, linked to multidisciplinary teams.
- Intensive home support service (IHSS): an urgent multiprofessional support at home to prevent or reduce hospitalisation.
- Intermediate care allocation team (ICAT): a multiprofessional team who coordinate referrals, care planning and packages and monitor service capacity.
- Integrated discharge service (IDS): to signpost, coordinate and progress throughout the patient discharge pathway, acting as a central point of referral, assessment and information, thereby actively reducing length of stay (LOS) in the acute setting.
- 'Home first': a discharge-to-assess approach which was piloted across Pennine Lancashire.

2. Rapid frailty assessment for older people attending hospital as an emergency

A frailty specialty doctor was appointed in August 2016 to lead and provide the medical input for rapid frailty assessment. The multiprofessional team assesses those patients highlighted by emergency department coordinators or who have been 'screened' in the department.

Milestones

- Jul 2013: East Lancashire Hospitals NHS Trust (ELHT) enters special measures.
- Jul 2014: ELHT taken out of special measures.
- Sep 2014: Appointed as an FHP development site.
- Feb 2015: Frailty MDT piloted in medical assessment unit.
- Oct 2015: Expansion of acute medical unit (AMU), to AMU A and AMU B with 82 beds.
- Dec 2015: IHSS and ICAT services commence.
- Feb 2016: IDS commences.
- Mar 2016: Hosted learning event for phase 1.
- Aug 2016: IHSS fully operational. Frailty specialty doctor appointed to lead rapid frailty assessment.
- Oct 2016: Specialty doctor begins working as part of the front door team in the emergency department at Royal Blackburn Hospital.
- Jan 2017: ELHT rated 'good' in Care Quality Commission (CQC) inspection.
- Mar 2017: Pilot of 'discharge to assess' system.

Outcomes

1. Admissions due to falls or poor mobility

There has been a **reduction in admissions to hospital** as a result of falls and poor mobility. This initially coincided with the development of IHSS and INTs, with a trend to further reduction since January 2017. The increase in November 2014 is thought to be due to changes in clinical coding.

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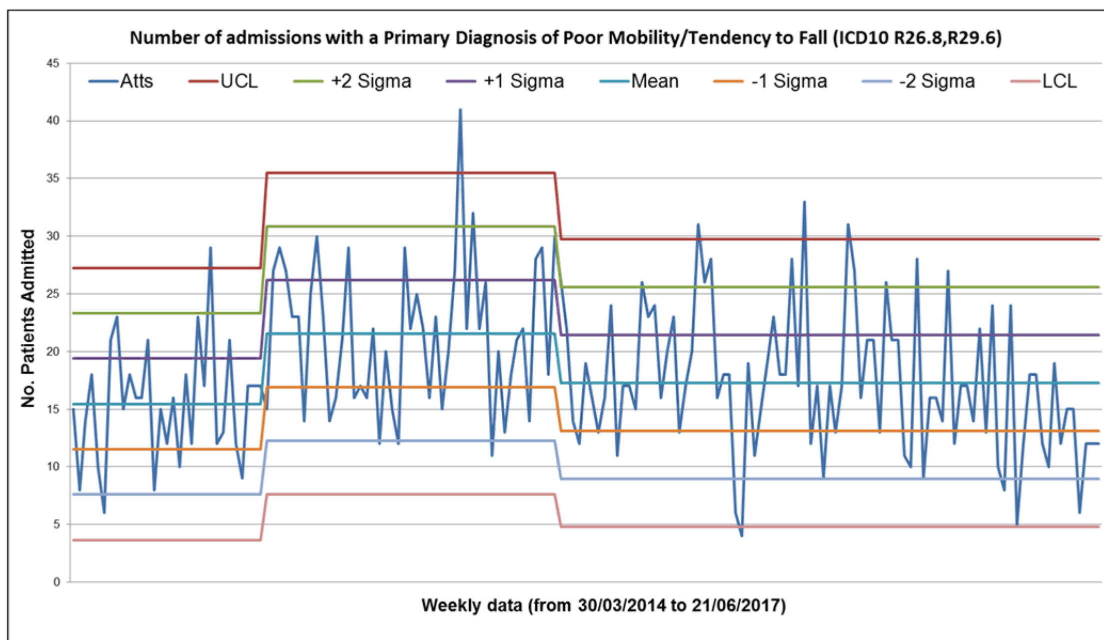


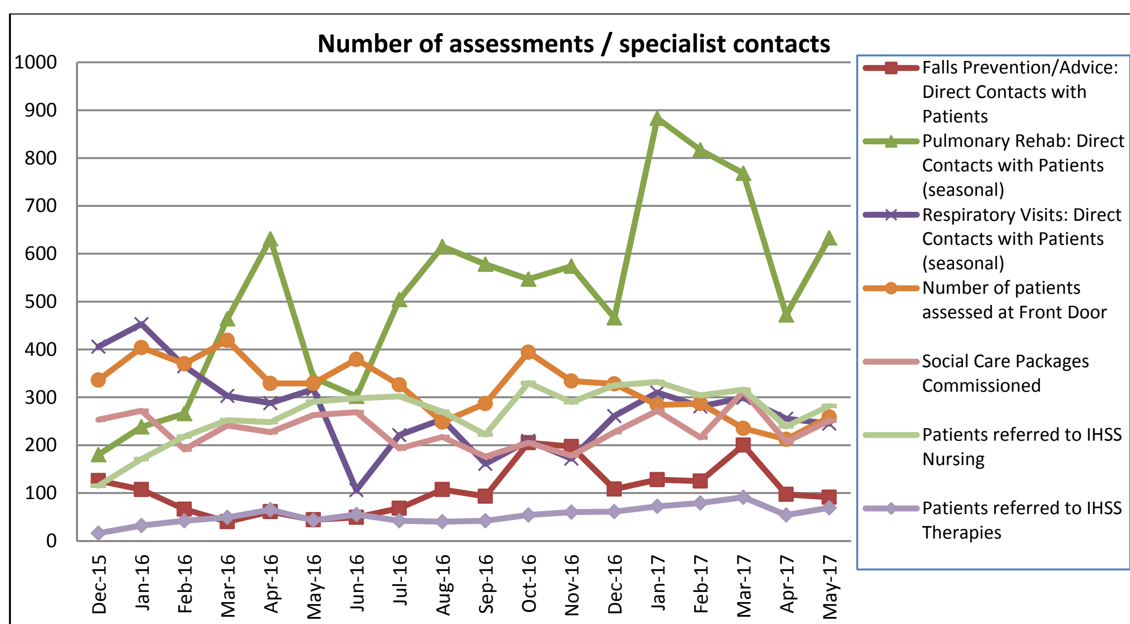
2. Patient experience

Strong themes that emerged from patient experience reporting have been:

- the need for improved information about what care to expect
- the need for greater involvement of families and carers in care
- the importance of other services, eg community pharmacy, ambulance services and voluntary sector
- the importance of good end-of-life care.

3. Impact on community services

Community services have responded to patients' needs, not only those referred from the emergency department, but also patients referred directly from community services, including INTs. A notable **increase in falls prevention advice** and input, together with **fewer but more complex assessments by the 'front door team'**, have been seen.



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4. Staff engagement

The introduction of a frailty specialty doctor (FSD) to the front door team has had a **positive impact** on many staff in the emergency department.

- *'The FSD gives me confidence of a safe discharge. They have time to go into detail that I will never have. The team have a familiarity with support services.'*
  Emergency department consultant
- *'The FSD gives us confidence to make higher risk decisions and 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

Successes and challenges

Successes

- ✓ A new approach to using patient experience through structured interviews about the whole experience of care.
- ✓ Standardised patient stories used by teams and leadership to guide and invigorate continuous improvement.
- ✓ Better conversations and care planning have been major outcomes.
- ✓ Improvements in care and experience for frail and older people in their own homes, when attending hospital and during and following a hospital admission.
- ✓ Reduced admission rates for people with mobility problems
- ✓ Consistent use of improvement methodology of small-scale testing and adaptation moving to wider scale implementation.
- ✓ CQUIN (quality funding incentive) negotiated, thanks to status as FHP development site.

Challenges

- Challenging to coordinate and involve multiple stakeholders working across a number of internal and external programmes of work.
- East Lancashire has a complex health and social care economy, with two clinical commissioning groups (CCGs), two community providers and two local authorities.
- Having the workforce resources to deliver the project was not always possible and at times it was demoralising.
- Difficult to retain volunteers to deliver the patient experience elements of the project.
- Issues around governance and competing priorities for the patient experience team and clinical and managerial leads.

Read the full report from East Lancashire's development site team at **www.rcplondon.ac.uk/delivering-the-future-hospital**

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