REPORT 1

FRAIL OLDER PEOPLE
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Vision

To develop and deliver a whole system integrated model that aims to enable people to live healthy and independent lives engaged in their community. A model that offers people choice and control over their lives and the support they receive.

Our model for Frail and Older people’s care recognises people as individuals. Therefore, the model is made up of a range of pathways all of which aim to promote independence, prevent avoidable crisis, and inappropriate admission to hospital or long term care.

In this model hospitals will be for those experiencing acute illness or in need of medical or other interventions that can only be provided in hospitals and not in alternative settings.

This model will involve frail people, their families and/or carers, community and primary care providers, secondary care, local authority staff/services and third sector providers and organizations.
Principles / Parameters

Principle 1
Dignity, respect, privacy must be at the heart of our model for Frail and Older people.

Principle 2
To develop a “Whole System Model” for Frail and Older people where all parts of the system link from self care, through community services, to services that should be provided in hospitals to enable people to live healthy and independent lives.

Principle 3
To deliver higher quality services for Frail and Older people will require improved communication and co-operation between the community and the hospital, and between health and social care.

Principle 4
Reducing health inequalities. That all our communities receive the best care, more control, and improved choice ensuring that no one is disadvantaged in access and patient experience due to their postcode.

Principle 5
Localise where possible, centralise where necessary. Routine healthcare should take place as close to home as possible. Some care can only be provided in hospitals. Specialised care should be concentrated in fewer centres to ensure it is carried out by the most skilled professionals with the most cutting edge equipment.
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Principle 6
“24-7” Our Patients and carers should expect 24/7 consistent and rigorous assessment of their need and an appropriate and prompt response in an appropriate location, in or near to their home wherever possible.
Objectives

• Instill a culture of independence and empowerment through self care and condition management supported by family, carers, community.

• Develop greater anticipatory and preventative care and risk stratification of Frail and Older people.

• Integrate services between health, social care and voluntary sector services, including where appropriate pooling of staff and budgets, sharing of information between sectors of care and greater use of combined records and assessments.

• Review current pathways and ensure that they are integrated pathways. Clearly define specialist services for Frail and Older people care patients/service users in the community.

• Establish a single point of access for services.

• Improve medicines management for Frail and Older people across acute, intermediate and community settings.

• Improve medicines management for Frail and Older people.

• Services must be proportionate and responsive to the needs of individuals including for example provision of step down resources, and crisis intervention teams.
• Integrate appropriate mental health services for older people with Community Resource Teams, to address the needs of the Frail Older People and people with both dementia and other age related conditions.

• Ensure that Frail and Older people only stay in an acute hospital when they are acutely ill and require treatment / interventions or where rehabilitation is available only in that setting.

• Increase the use of tele-care and monitoring with Frail and Older people.
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Current Frail Older People Model

All 3 localities have acute hospital based consultants in care of the elderly. Intermediate care teams supported by local/community hospitals and a range of community services often working in conjunction with voluntary and third sector organizations.

• Frail and Older people are admitted electively or as emergencies, to 3 acute hospitals in ABM. Each acute unit has their own pathways for ensuring that patients are referred on to the specialists in elderly care.

• Community hospitals have existed to support the slow stream reablement of patients requiring further rehabilitation or therapy.

• In most areas there are Day hospitals in operation to provide a supporting role and bridge between secondary and community care, offering “hot” clinics, mdt assessment and treatments, “falls” clinics and rehabilitation, although this is not consistently provided across the Health Board.

• Each locality has a community resource team with a range of different components and specialist services, these encompass the intermediate care teams.

In Bridgend there is an Integrated Referral Management Centre developing as a single point of access for all community health and social care services. Early and 24 hour mobile response services underpinned with Telecare, and an enabling home care service BridgeStart, and a selective Reablement service, which includes a residential reablement unit Community Independence and Well being
Frail Older People

team. There is also, Community Occupational Therapy service, Integrated community network teams comprising social workers district nurses and community occupational therapists. A new service Bridgeway is being developed to work in an enabling way with people with dementia.

**In NPT the team** incorporates the Early Response Service, the Reablement service, joint assessment of patients in LAC and MAU, Home IV anti-biotic therapy, nursing home pilot, joint work with WAST /NHS Direct re falls intervention.

**In Swansea the fully integrated team has:**

- An Early Response Service.

- A Reablement service.

- A large hospital discharge support service.

- Geriatrician “hot” clinics.

- Links to A&E and WAST Pathways.

- Links with Social Services for emergency care placements.

- Incorporates specialist nurses for continence, dementia care, palliative care and HSSE .

- A GP Champion Project.

- Home IV antibiotic therapy when underwritten by patients physician.
Various Medicines Management initiatives, including improved Medicines Management in domiciliary care, technician support to CIIS and outreach models have also recently been developed. Such schemes aim to enable safe medicines management including re-enabling and administration of medication in domiciliary settings.

There are common elements to the services, but they have been developed to different degrees across all 3 localities; Therefore there are a number of gaps in services across ABM. Although some services are in place they are not all fully resourced and do not give full coverage.

The development phase of Changing for the Better has identified key deficits in the current model these can be summarised under 4 headings.

• Quality and Safety of services
• Workforce
• Inequalities in Health
• Finance

This report will not go into the detail of each of the deficits identified within the current model as these were identified in some detail in the “part 1 Case for Change document” this document is included as annex 1.

What is essential is that any future model of unplanned care is not only developed in line with the principles identified in section 4, but that a future model also addresses the deficits identified within the Case for Change document.
The following provides a summary of what will be included in each part of the ABMU Health Board Model for Frail Older People.

**Universal / Enabling**

When considering the self care / prevention elements of the Frail and Older peoples model there will be specific cross over to the Long Term Conditions work stream, staying healthy work stream and unplanned care work stream.

Key elements for development:

- Work in partnership with 3rd Sector and Local Authorities to develop local Community brokerage models of support, based on mutuality and/or reciprocity to help older people with high support needs live well in later life. Evidence shows these models are valued greatly and achieve significant outcomes for individuals, and that they work well when they build on and link to other services, networks and systems.

- Assessed and supported to have healthy foot care, oral Health, nutrition, continence support.

- Assessed and supported to ensure high quality medicines management including safe systems for administration of medicines in the domiciliary care setting where required.

- Work in Partnership with 3rd Sector and Local Authorities to implement a Community Falls Prevention model.
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• Work in Partnership with 3rd Sector and Local Authorities to develop / enhance housing adaptation programmes, home maintenance / cleaning / shopping social enterprises.

• Fully implement carers strategy to enable carers to maximise their health and wellbeing.

• Work with Public Health Wales to increase levels of Screening and vaccination programmes.

Specifically:

• Flu and pneumococcal vaccines.

• Regular eye and hearing tests.

• Bowel cancer.

• Screening breast and cervical screening where indicated for women in at risk groups.

Train relevant individuals with the community to roll out early identification of dementia programme.

Agree with the principles of C4B but needs to be done in collaboration with Local Authorities to develop use of Leisure centres, schools, libraries and community centres as part of encouraging people to take responsibility for their own health and wellbeing.

Community Network – engagement response 2012
Frail Older People

Specialist Prevention Services

- Place community networks at the heart of our prevention services to co-ordinate, develop and respond, to the population they serve this will include:

- Further develop Risk Registers in Primary Care to enable anticipatory care of Frail Older People.

- Work in Partnership with 3rd Sector and Local Authorities to implement a consistent Life After Stroke model across the Health Board following best practice Public Health / NLIAH guidelines.

- Access to equipment & transport To enable a person to access and use assistive technology, community equipment, aids and adaptations which enables them to continue to live within their home and perform daily tasks irrespective of the limitations imposed by their frailty or disability.

- Provide specialist services such as Falls Clinics, Continence Services, and podiatry services.

- Increase use of Tele Care to support Frail and Older people independent in their own home and to provide additional confidence and support for carers.

- Medicines Management -To increase focus of appropriate medicines management at all tiers of care, to ensure maximum benefit and minimum harm. This will include medication review, medicines reconciliation, clinical pharmacy services, assessment of patient’s ability to manage their own medicines, education, provision of compliance aids, domiciliary support services etc.
• Work in partnership with providers of the **National Exercise Referral scheme** to ensure the programme is integrated into the model of services for Frail and Older people and to ensure that older people have effective graduation routes from the scheme.

• **Active case management** of high risk Frail and Older patients.

• **Development of Telecare** - established evidence base supporting telecare as highly effective in maintaining the independence of people with health and social care needs in the community, and reducing costs in other parts of the health and social care system.

It would be useful to have a clearer view of where and how vulnerable older people who do not attend Primary or secondary care can be identified before a crisis occurs.

*NHS Member of staff - engagement events 2012*
Frail Older People

Intervention

- **Development of Telehealth** - established evidence base supporting telehealth as highly effective in maintaining the independence of people with health needs in the community and reducing costs in other parts of the health system.

- **Expand the GP champions project**, where interested and motivated GPs work with geriatricians to help with demand, gain insight into allied services e.g. CRT and enthuse their GP colleagues regarding new and better ways of working with older people.

- **Develop ICT governance and processes** that enable effective sharing of records, real time communication between primary, secondary, community health and social care.

- **IT staff Management** develop electronic call monitoring and call rostering for community resource teams.

- **Consultant Medical Resource** replicate the consultant medical input that has proved effective in Swansea and in Neath across the Health Board Footprint.

- **In reach service (Hospitals & Care Homes)** - Prevent crisis through early and intensive intervention.

- **Integrated Palliative & End of Life Care** - work with Local Authorities and the 3rd / private sectors to develop models of care with the care home sector to enable effective deliver of end of life care to residents without requiring an inappropriate hospital admission.
• **7 day working** from all staff groups within the Community Resource Teams.

• “**Hot”/Rapid Access** clinics established so that patient exacerbations can be managed in community with access to specialist intervention the following day in an ambulatory setting rather than admission.

• **Rapid Assessment Access** either at home or at initial point of contact linked to unplanned Care Model.

• **Help line/easy access phone advice** specialist advice lines established so that CRT and GPs can access specialist opinion from hospital based staff.

• **Develop ‘Step up step down’ beds in the community provided by health or social care – flexible beds that can provide short term reabling, respite, recovery and transition with direct access from the community.**

• Provide an active **reablement service** for people who are medically stable but who, because of the need for supervision beyond that which could be provided in an individual’s own home, especially overnight, or because of difficulties within their home environment are unable to return home from hospital.

• **Rapid response** – By the Community Resource Team.

• **Comprehensive geriatric review and assessment** via appropriate medium and in an appropriate setting e.g. “**Hot”/Rapid Access Clinics / Help line/ easy access phone advice to whom professionals public etc?”
• Specialist medicines management support and assessment services to ensure optimum management of chronic conditions, safe monitoring/administration of high risk drugs and medicines review for patients following recurrent admission e.g. falls review

Better Community Care is to be welcomed to keep elderly people in their own homes - but all treatment must be undertaken with dignity of the patient paramount.

*Member of the public, engagement event 2012*
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**Specialist Intervention**

- Comprehensive geriatric review and assessment completed by appropriate professional within hospital setting.

- One acute medical intake site serving Swansea & NPT based on the Morriston site.

- One acute medical intake site serving Bridgend (site based on outcome of South Wales Programme).

- Appropriate level of medicines management support.

- Ward based medicine to include Care of the elderly wards.

- Appropriate Nurse and therapies staffing ratios.

- 7 day working from Medical & therapy staff (allied health professionals).

- Bed occupancy to be planned not to increase above 90%.
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Single Point of Access, Internal Transport, LA Integration, IT integration