Item 11 (c)

Older People and End of Life Care – Task and Finish Group

Tuesday 2nd October 2012

Present: - Councillor J. Taylor (in the Chair), Councillors Francis and Macnab.

Officers: - Jane Haywood, Clinical Director Adults and Integrated Services/Programme Manager and Denise Slark, Clinical Services Manager.

Members received an update from Officers in respect of the areas of interest they selected from the first meeting:-

- **End of Life Care**

  - **St Teresa's Hospice**

Councillor J. Taylor reported that she had made contact with the Chief Executive of St Teresa's Hospice and a meeting with Members would be arranged in due course.

Ms Slark reported that the Trust have undertaken a staff skill mix for staff based at St Teresa's Hospice, to ensure that that staff are most effectively utilising existing capabilities and developing a comprehensive nursing team that delivers the highest quality palliative and end of life care. Some staff have been up skilled to enable them to fulfil their roles. Given that the Hospice receives a number of complex need patients that require specialist care, staff are fully skilled to administer intravenous drips, antibiotics and blood transfusions at the hospice instead of transferring patients to hospital. This will be the direction of travel for the next 12 months and the Trust are keen to establish a pathway of care to avoid day cases and admissions as well for Hospice patients. The Trust are looking at delivering pathways to enable intravenous drugs to be administered at home or in community settings.

  - **Pilots – Surprise Question and Amber Care**

Surprise Question – Members were reminded that there is a clear need to identify those patients who are in their last year of life, to enable an appropriate package of support to be agreed with the patient, families and carers, as well as the professionals caring for them and assist in planning their future care in advance. The implementation of the Surprise Question with consultants within the Trust had not taken off and was not longer being progressed.

It was felt that these types of discussions do happen throughout the provision of end of life care and work is being undertaken in respect of Advance Care Planning, Do Not Resuscitate CPR and Deciding Right initiatives. Deciding Right is a North East initiative and the first in the UK to integrate the principles of making advance care decisions for all ages. It brings together advance care planning, the Mental Capacity Act, cardiopulmonary resuscitation decisions and emergency healthcare plans. Deciding Right identifies the triggers for making care decisions in advance and formalising the arrangements.

Amber Care Bundle – Members were reminded that the Amber Care Bundle developed to improve the quality of care of patients whose recovery is uncertain. It was

reported that the Trust are looking to pilot the Amber Care Bundle in January 2013, on one or two Wards and discussions were being undertaken with Dr Esisi, as Lead Clinician for Older People Services. It was anticipated that the Amber Care Bundle could be used as a measuring tool, to plan care packages in advance, although, it was noted that staff would need to be trained in the use of the tool and the benefit for patients. Members were advised that the Trust has a shortfall of Palliative Care Consultants which has implications on the Trusts ability to deliver palliative care in the community.

- **Training**

Ms Slark reported that work continue working arrangements for the Macmillan Specialist Nurses and the education they deliver to those who provide the majority of palliative care both in acute and community settings. The Trust was successful in a bid to attract money from Macmillan to recruit to a Macmillan Educator, this initiative will strengthen the provision of palliative and end of life care education across the county. If the initiative proves to be successful the Trust have sought a commitment from the CCG to give consideration to continue the provision of this, when the funding runs out, with the ultimate aim being to establish on going funding for the role.

Discussion ensued regarding current duplication of provision of services and Officers agreed that it was often confusing for patients as to which organisation is delivering their care. Ultimately as long as the service is of high quality and seamless, the patients are not interested in who provides the service. Members were reassured that the Trust is working in Partnership with the CCG to address this issue. It was acknowledged that GPs and District Nurses, Care Homes, Hospitals and Specialist Nurses play a pivotal role in delivering to end of life.

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- **Readmission Avoidance Scheme** – Ms Haywood reported that the readmission avoidance scheme has been successfully running for a number of months and would continue until March 2013. The aim is provide patients with additional support at the point of discharge to avoid them being readmitted. The question Clinicians have to ask themselves is “Would I be surprised if this patient was readmitted within 30 days?” Patients that potentially might be readmitted are identified, their history is tracked for three months and are monitored for three months to establish how many readmissions occur related to a single issue. This scheme has identified a significant number of patient readmissions during the night and investigations are being carrying out to ascertain why. It was known that people with long term conditions, live alone and are sometimes isolated, often call their GP during the night and end being admitted into hospital. To address this issue, the Trust are considering extending the opening hours of the contact centre to enable the service to be 24 hours, seven days a week and offer the provision of night sitters (Health Care Assistants) to avoid people being readmitted into hospital. It was noted that some patients will not want any support from community services as some people like being admitted into hospital. Ms Haywood offered to share a report with Members in providing more detail in respect of the above.

- **Community Matrons** – Ms Haywood reported that the highest percentage of admissions of older people into hospital is from Nursing Homes and the Trust have committed to working with Nursing Home staff to upskill them to prevent unnecessary admissions. This was working well, although, some fundamental training that was

required. There is an issue with high percentage of staff turnover as the fully trained staffs often leave. It was noted that a high proportion of patients admitted from Nursing Homes die within 24 hours of admission and work was needed to address this. Ms Haywood advised that the introduction of the Council's Gold Standard Framework in Nursing Homes should drive up care quality and standards, which ultimately impact on hospital admission and deaths. Ms Haywood offered to share a report with Members in providing more detail in respect of the above.

- **Care of Elderly Programme (COPE) and Older People's Assessment Services (OPAS) –** Ms Haywood reported that further discussion was underway with Dr Esisi to roll out initiatives that are running in the north of patch, across the whole patch. This would include GPs with specialist interest in older patients assessing them quickly and ensuring that they receive the appropriate care quickly. This work also links into the RIACT Programme and Intermediate Care Pathway.

- **Kaiser Permanente** – Ms Haywood reported that the Trust are considering the Kaiser Permanente model of care which originates from America and is based on a data collection agency model. The model also draws upon the pyramid of care model which identifies a population of patients with long term conditions into three distinct groups based on the level of need. The purpose is to improve the health and quality of life of those with long term conditions by providing an appropriate level of care and support. The model has to be rolled out across a large population to have the most positive outcomes and enable a forecasts and improvements to be made. Durham County Council is very interested in this model, as the aims is to be able to make predictions to target reablement services on certain patients with long term conditions.

- **Telehealth – Healthcall Pilot** – Ms Haywood provided Members with an update on the Telehealth Pilot that the Trust has been running working with InTechnology, called Healthcall Hub, to cover a wide range of applications and patient cohorts. The model has been agreed and pathways and processes are being developed and work is progressing to implement services in respect of complex long term conditions. Patients have been identified with a long term condition that is unstable which has resulted in frequent unplanned hospital attendances and admissions. A programme of training and awareness sessions has been run for staff, providing them with an opportunity to learn about the Healthcall Hub and identify suitable patients to use the service.

Clinicians will recommend what equipment is needed and patients will take daily measurements of their vital signs. The clinicians will view the data via the secure web based service and track trends over a period of time; as a result this should enable them to provide intervention in a timely and appropriate manner. The monitoring centre will also respond to any alerts daily and ensure any clinical intervention needed is directed to the appropriate team.

It was noted that some of the anticipated benefits that could be achieved would include: a reduction in unplanned hospital bed days; a reduction in prescribing, a reduction in the demand for GP appointments, a reduction in patient transport costs, an increased self-motivation and patient awareness, more increased data to assist with prevention and deterioration and more support for patients with newly diagnosed ill health conditions.

Work streams have been formed to ensure the smooth implementation of all services and applications, the processes are being developed that will enable us to reach large numbers of patients within the 3 levels of the service model.

Healthcall Hub – Automated service using Bluetooth to send messages direct to Telehealth record. This includes patients with complex COPD and HF, there would be approximately 150 across County Durham and Darlington. Hubs will be installed into patients home and monitored over 12 weeks. After 12 weeks patients have the option to remove the Hub or continue for another 12 weeks. NHS Direct Manage the service and deflect any unmanaged alerts and if a alert occurs NHS Direct will ring the patients if an alert is flagged and if a true alert, nurses will act.

Healthcall Plus – Involves a number of differing schemes using a device and manual input to collect measurements via IVR including preeclampsia, INR, long term conditions including type two diabetes and stroke patients.

Healthcall – An outcomes tracker with coaching provision via a response to a questionnaire using an automated telephone response is available for example Post-Surgery Telephone Questionnaires to Reduce Avoidable Readmissions and Pre-surgery Bariatric Coaching.

Actions:-

- That Officers be thanked for their attendance at the meeting.

- That a meeting be arranged in November 2012 with representatives from St Teresa's Hospice.

- That a meeting be arranged with Officers from this Council in January 2013 to discuss working relationships with the Trust.

- That further meeting be arranged with Officers of the Trust in February 2013 for a further update of how the pilots and matters above are progressing.