APPENDIX B

OLDER PEOPLE AND END OF LIFE CARE

Introduction

1. This is the Final Report of the Older People and End of Life Care Task and Finish Review Group to consider the Older People and End of Life Care workstreams of County Durham and Darlington NHS Foundation Clinical Strategy.

Membership of the Review Group

2. Councillors J Taylor (Chair), Francis and Macnab.

Acknowledgements

3. The Task and Finish Review Group acknowledges the support and assistance provided in the course of their investigation and would like to place on record their thanks to the following :-

   County Durham and Darlington NHS Foundation Trust –Nicola Allen, Clinical Services Manager; Lisa Cole, Head of Service, Stroke and Elderly Medicine; Dr Bernard Esisi, Clinical Director, Consultant in Stroke and Elderly Medicine; Jane Haywood, Clinical Director Adults and Integrated Services/Programme Manager; Carol Robinson, Service Integration Manager/Allied Health Professionals Lead and Denise Slark; Clinical Services Manager.
   Darlington Borough Council – Christine Forsyth, RIACT Manager, Wendy Lyons and Warren Tweed, Strategic Commissioner Older and Disabled People.
   GOLD – Claire Llewelyn and Terry Taylor,
   St Terea's Hospice – Victoria Ashley, Clinical Services Manager and Jane Bradshaw, Chief Executive and Abbie Metcalfe, Democratic Officer.

Methods of Investigation

4. The Task and Finish Review Group has met on seven occasions and the notes of each meeting have been regularly reported to the Health and Partnerships Scrutiny Committee and are attached as **Appendix 1**.

5. At the first meeting, Members received an informative and detailed overview of the Older People and End of Life Care workstreams. The key issues discussed included the Dementia Collaborative, integration of Community and Acute Services, training issues across all Organisations, Patient Choice, Integrated Care Plans, the Surprise Question, Amber Care Bundle, screening and prevention work, Health Improvement Team, Readmission Avoidance Scheme, Care in the Community and Integration of Multi-Disciplinary Teams.

6. Given the extensive remit of this Group, Members agreed to give further thought as to how best to approach this piece of work.

7. Members agreed to focus their work by exploring specific areas, as follows:-

   (a) Older People

      (i) Prevention and screening
      (ii) Improve integrated partnerships across all health and social care providers
      (iii) Training

   (b) End of Life Care
      (i) St Teresa's Hospice
      (ii) Pilots – Surprise Question and Amber Care
      (iii) Training

8. Members have received progress updates from County Durham and Darlington NHS Foundation Trust Officers in respect of the selected areas of interest which has led to more questions.

Older People – (a) Prevention and screening and (b) Improve integrated partnerships across all health and social care providers

9. Members have been fully briefed on the Readmission Avoidance Scheme and are pleased with its impact, the reduction of unnecessary admissions and the additional support at the point of discharge. This scheme has identified a significant number of patient readmissions during the night and investigations are being carrying out to ascertain why.

10. Members are aware that people with long term conditions, live alone and are sometimes isolated, often call their GP during the night and end up being admitted into hospital and the Trust are taking steps to address this. Consideration is being given to 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. While remembering that some patients will not want any support from community services as some people like being admitted into hospital.

11. Consideration is also being given to the introduction of a Single Point of Access. This will be beneficial to the community, the Emergency Department and GPs in the first phase with plans to roll it out to cover all aspects of the Trusts' business.

12. Preventing unnecessary hospital admissions through working closely with Care Homes is beginning to make a difference and the Trust have committed to working to up skill Care Home staff with fundamental training being required. It was noted that a high proportion of patients admitted from Care Homes die within 48 hours of admission to hospital and work was needed to address this. The Community Matrons role will assist in combating this and training is high on their agenda. Members see the role of the Macmillan Educator as integral to the Team

13. The introduction of the Gold Standard Framework (GSF) in Care Homes should drive up care quality and standards, which ultimately impact on hospital admissions and deaths.

14. Members met with members of Growing Older Living in Darlington (GOLD) to discuss their involvement in the GSF. GOLD volunteers are fully trained to carry out evaluations of the GSF in six of the Care Homes signed up to participate in the scheme over a three year period.

15. Seven GOLD Volunteers have visited the Care Homes to meet with staff, managers, family and residents. Interviews have been carried out with a variety of staff including caretakers and kitchen staff allowing volunteers reassurance that all staff are familiar with the policies and protocols in place. The information gathered has been reported that each individual Care Homes by way of a confidential report and an overview report has also been produced and circulated more widely. The same exercise has been repeated for 2012 and will commence again in the summer of 2013 for the final time.

16. Members welcomed Care Homes being evaluated by older people and thought it was a very positive step forward and hope that more Care Homes will sign up to be part of the GSF. Members believe that this would only be beneficial to them and drive up standards of quality of care.

17. Two pilots currently operating in County Durham around Care of Elderly Programme (CoPE) and Older People's Assessment Services (OPAS) Members believe could be very beneficial to Darlington as they contribute to the work of RIACT very nicely. However, both pilots will be included in the Intermediate Care Review which is currently on going within the Trust.

18. RIACT combines the following services, Rapid Response, Rehabilitation Service, Reablement Service and Recovery Services and the RIACT service operates with a multidisciplinary Team.

19. Members are pleased that RIACT and Readmission Avoidance Scheme (RAS) Teams are working together and becoming more integrated, with the aim of creating a Single Point of Access for all clients. RAS is very much part of the discharge planning and as part of that process the team to consider whether the patients conditions can be successfully managed at home, whether they understand their medication, offer reassurance to carers and assess people who require additional support, which is often a sensitive issue.

20. Members look forward to receiving updated figures of further reduction of avoidable Hospital admissions as a result of the RAS being in place.

End of Life Care – (a) St Teresa's Hospice

21. Members have met with Chief Executive and Clinical Services Manager form St Teresa's Hospice and undertaken a visit of the facilities and are extremely impressed by the enormity of services offered by the Hospice.

22. Members welcome how the services over the years have developed to include Hospice at Home, Day Care (now Day Therapy), In Patient Unit, Family Support and Bereavement Services.

23. The Hospice has also strengthened its Management Team to include a Financial Services Manager, Clinical Services Manager and newly appointed Nurse Consultant. This enables the Hospice to remain current and ensures that the services provided are relevant for those who need them.

24. Members are pleased that following a review of Clinical Services, services have evolved in response to the level of need for example, improvements to Day Therapy Services. The focus of the Day Therapy Model is based around palliative rehabilitation rather social interactions with individuals being able to live as independently as possible, for long and comfortable as they possibly can. This builds on the ethos of care closer to home and what the Council, Darlington Clinical Commissioning Group and County Durham and Darlington NHS Foundation Trist are aiming for.

25. The Hospice is also able to care for patients with complex needs and staff are fully trained to administer intravenous drips, antibiotics and blood transfusions at the hospice instead of transferring patients to hospital. The Blood Transfusion Service at the Hospice has been extremely well received by both local GP's and patients. GP's are able to refer directly to the Hospice, preventing a hospital admission into Hospital and allows the patient to receive their treatment in an appropriate, comfortable and calm environment.

26. Members are delighted that GPs have established a positive relationship with the Hospice and that GP Palliative Care Leads Group meetings are convened at the Hospice. The Hospice plays an important role in facilitating good links with all GP Practices, disseminating topical information and developing action plans and GPs have welcomed the support.

27. Members acknowledge that benefits of St Teresa's remaining an independent charity as the Hospice is able to be responsive to need and adaptable. The aim is to ensure all of the services are integrated with any state provision to avoid duplication and ensure what is best for the patient. Being independent the Hospice is able to work in partnerships with the Foundation Trust, Marie Curie, Adult Social Care and Macmillan Nurses.

28. It was noted that Rapid Response Team works in partnership with Marie Curie and County Durham and Darlington NHS Foundation Trust and that the services are available 24 hours 7 days a week and usually within the hour. Palliative care is

delivered at home whenever possible to avoid a hospital admission and the scheme is working well.

29. The Nurse Consultant is able to provide specialist advice for patients with complex symptoms in both the community and Hospice settings. Non-Medical Prescribers within the team ensure that patients receive necessary medication in a prompt and timely manner. Staff continue to develop their skills and are committed to further developing palliative and end of life services.

(b) Pilots – Surprise Question and Amber Care

30. Members met with Clinical Director Adults and Integrated Services/Programme Manager and Clinical Services Manager to discuss the above pilots.

31. **Surprise Question –** 'Would I be surprised if this patient died in the next year?' The surprise question asks Consultants to have honest and open discussion with the patient and instigate a discussion around the patients' options and way forward and management of conditions.

32. Members were interested to note that this pilot was unsuccessful with the Trust Clinicians and after a short period of time was no longer being piloted.

33. Members acknowledge that there was a clear need to identify those patients who are in their last stages 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.

34. Clinicians believe 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.

Amber Care Bundle

35. The Amble Care Bundle has been developed to improve the quality of care of patients whose recovery is uncertain.

36. It was reported that the Trust were 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.

37. In March 2013, Members have been informed that the Amber Care Bundle is being piloted on one ward at Darlington Memorial Hospital and the first step was to undertake an audit prior to the pilot. The second step is underway which includes training and the development of ward staff. Members are pleased that the specialist palliative care team is supporting the Ward with the initiative.

38. Members look forward to receiving the outcome of the Pilot in the near future.

39. 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.

40. 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.

(c) Training

41. Members have enquired about training and are pleased that Council staff are trained on a rolling programme and training does include some mandatory elements. Such issues as reablement awareness have been carried out jointly with health colleagues to build relationships and allow staff to support each other.

42. Work continues with the Trust and working arrangements with Macmillan Specialist Nurses and the education they deliver to those who provide the majority of palliative care both in acute and community settings.

43. 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.

44. However, Members are disappointed that the recruitment to the Macmillan Educator role was unsuccessful and the job description is currently being reviewed by the Trust.

45. Members would like to see this post recruited to as quickly as possible, as they believe this to crucial for training to be expanded and built on.

46. The funding for the post is for 24 months from recruitment and if the initiative proves to be successful the Trust have sought a commitment from Darlington CCG to give consideration to continue the provision of this, when the funding runs out, with the aim being to establish on going funding for the role.

47. Training is also undertaken in Care Homes and the Trust has committed to working with Care Home staff to upskill them to prevent unnecessary Hospital admissions and this has worked well.

Conclusions

48. Members acknowledged that end of life care is not an easy conversation to have with someone and applaud staff for handling this difficult subject sensitively.

49. Members have welcomed the opportunity to work with Officers from the Trust and St Teresa's Hospice and have been interested to learn how services are integrated services.

50. Members are delighted with the variety of services provided at St Teresa's Hospice and believe a continuation of integrated working would achieve successful outcomes.

51. Members are pleased that a focus on end of life care appears to be at the fore front of Clinicians minds when treating older people and ensuring that they have the opportunity, should they wish to, to plan for their end of life.

52. Although, in light of recent press articles, Members are disappointed that the Surprise Question was dropped and would like to know what else is in its place.

53. Members recognise the work of volunteers from GOLD and the Care Homes in achieving the GSF and welcome the accreditation of individual Homes in due course.

54. Members understand the financial difficulty that this Council and NHS organisations are facing but believe continued integrated services will avoid duplication to drive efficiencies and make savings.

55. Members are assured that potential opportunities will arise from integration such as shared training and initiatives which ultimately will benefit providers, however, Members believe that continually seeking to explore opportunities will be advantageous.

56. Members also recognise the challenging time the NHS is going through and the emergence of the Clinical Commissioning Groups which brings challenges to the process of integration.

57. Members applaud the Trust for continually seeking to develop services through the number of pilots that the Trust are participating in and share the belief that ultimately this will benefit patient care and make efficiency savings.

Recommendations

58. That promoting interagency working and engagement with Partners will ensure a seamless end of life pathway of care.

59. That every opportunity be explored to work more closely with St Teresa's Hospice to potentially share services.

60. That every contact counts and every opportunity be used to enable all medical professionals to have discussions with patients about this treatment and end of life care to enable people to have a choice and allow them to die with dignity.

61. That the Gold Standard Framework should be promoted within Care Homes to encourage take up.

62. That training continues to be high on our Partners agendas to ensure high quality care and patient safety is key to the service provided.

63. That Officers be thanked for their attendance at the Task and Finish Review Group meetings.

64. That Members receive a progress report in 12 months' time.

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

Appendix 1 (a)

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

18th May 2012

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

Officers: - Nicola Allen, Lisa Cole, Dr Bernard Esisi, Jane Haywood, Carol Robinson and Denise Slark.

Members received on overview of the areas of work that Officers are involved in. Discussion ensued and the following points were raised:-

- The vision of an Integrated Trust (Community and Acute Services) is a positive step forward and of benefit to patients, as patients simply wants a seamless transition of care. The Integrated Trust can develop improved integrated pathway of care and specifically for older people.

- In relation to end of life care and palliative care the Trust works with a number of partners including Marie Curies, Hospices and Macmillan nurses, etc. The service must be seamless for the patient and carers as with this pathway there is only one opportunity to get it right.

- Training issues – Southern Cross has carried out training with the care homes across Darlington and staff have been 'up skilled' in respect of end of life care. End of life care training and development for care home staff has been discussed with the Local Authority and there has also been some pump priming of funding into Eden Cottages with staff from Macmillan. The Trust is considering more training for care homes staff and also the 'informal carer' role.

- Dementia Collaborative – the work undertaken as part of the dementia collaborative includes end of life care

- The Trust are working with the Hospices to consider out of hours admissions and it was explained that it was quite a challenge to get patients admitted to hospices 24 hour 7 days a week or access to a palliative care consultant, but funding has been secured to assist with this provision.

- The Trust have 24 Macmillan specialist nurses that work with District Nurses and the care homes have access to those nurses too. St Teresa's Hospice and Macmillan provide a rapid response palliative and end of life care crisis service which enables some adjustment time to access specific carer of the patients choice.

- It was noted that services are continuing to develop, particularly around integrating services with joint providers, consultants are keen that the service offered in reality matches patients expectations, as sometimes the service actually received in practice is not as good as it should be.

- The needs of patients tends to be the same across the patch and therefore the level of provision needs to be the same regardless of where the service is provided and integration is key to achieving this. (It was noted that commissioning of such services will soon fall to the CCG).

- Older people access a vast number of services and there needs to be joining up of pathways and improved communications and engagement across the patch.

- Patient Choice – importance needs to be put on patient choice and patients need the right level of information to enable them to make the right decision for them.

- Integrated Care Plans – do these actually work in practice? There was a mixed reaction to this question.

- Surprise question – “Would I be surprised if this patient died in the next year?" The surprise question asks consultant to have honest and open discussion with the patient and instigate a discussion about the patients’ options and way forward and management of conditions. This has been run as a pilot and within the first six months the question was only asked once. It was acknowledged that this was a difficult discussion to have with elderly, frail patients but one that needed to be had. Consultants need to be more open about end of life care and the options that are available to them, especially those with long term conditions as it makes it easier to plan if patient discuss the treatment and care they want. It would be helpful if this could be rolled out to GP’s too.

- Amber Care Bundle – Pilot – This is a new package of care that helps to identify hospital patients with end of life care needs at an early stage and supports staff to produce a clear plan of care and start conversations about uncertainty and the possibility of death. This allows patients and carers time to prepare and consider their options. The Trust is operating the Amber Care Bundle as a pilot and is encouraged by the results of readmission avoidance that has been achieved as a result of this.

- Multi-Disciplinary Team (MDT) approach enables the whole medical team to have an input into a patients care. It doesn’t matter to a patient who delivers the care they receive as long as it is received appropriately.

- Screening and prevention work – The age of older people depends when screening processes are applicable, traditionally screening was targeted at 75 years and older such as dementia and falls assessment. However, it was noted that as the population is ageing and people are living longer there is the potential to screen more people sooner. It was suggested that there needs to be a series of questions that sit across primary and secondary care as part of older people’s regular health checks to assess any potentiation triggers of needs as every interaction should be used as an opportunity to ask such questions.

- Health Improvement Team – Work has been undertaken with colleagues across older people and end of life care regarding to drug and alcohol abuse to ensure that every contact allows staff and informal carers to discuss matters of concerns

relating to addictions with the patients. Work is undertaken to improve a patient's mental health to change their behaviours.

- It was explained that a paracentesis (a procedure involving needle drainage of fluid from a body cavity, usually the stomach) bid has been submitted to create an option for patients to have more choice around carrying out paracentesis procedures in community settings.

- Caring for older people in the community – It was noted that more needed to be done as keeping active both physically and mentally was highly beneficial to people as they get older. It was agreed that 'we' as a community need to get better at caring in the community for older people, as social isolation is one of the biggest problems.

- There is a big challenge for the Foundation Trust given the limited non recurrent funding that is available and given the financial pressure facing every organisation the Trust are forced to work differently to deliver services. Unfortunately working in collaborations takes time to have open discussions but this will improve as the culture changes. Finance should be secondary to driving services forward – but this isn't always the case.

Agreed:-

- That Officers be thanked for attending the meeting.

- That the following issues be specifically explored by the Task and Finish Review Group:-

    - Older People
        a) Prevention and screening
        b) Improve integrated partnerships across all health and social care providers
        c) Training

    - End of Life Care
        a) St Teresa's Hospice
        b) Pilots – Surprise Question and Amber Care
        c) Training

Appendix 1 (b)

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

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**

a) 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.

b) 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 who's 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 paitents. 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.

c) 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 .

Older People

- **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.

o **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.

o **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.

o **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.

o **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.

Appendix 1 (c)

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

29th November 2012

Present: - Councillor J. Taylor (in the Chair).

Officers: - Victoria Ashley, Clinical Services Manager and Jane Bradshaw, Chief Executive St Teresa's Hospice and Abbie Metcalfe, Democratic Officer.

Ms Bradshaw provided a in brief history of St Teresa's Hospice stating that the charity opened in 1986 and over the years the services have developed to include Hospice at Home, Day Care(now Day Therapy), In Patient Unit, Family Support and Bereavement Services. The Hospice has recently strengthened its Management Team to appoint a Financial Services Manager and Clinical Services Manager and a Nurse Consultant will be in post by late December 2012. This enables the Hospice to remain current and ensures that the services provided are relevant for those who need them.

Ms Ashley reported that improvements have been made to the Day Therapy Services following the review of Clinical Services, advising that the services have evolved in response to the level of need. The focus of the Day Therapy Model is based around palliative rehabilitation rather social interactions with individuals being able to live as independently as possible, for long and comfortable as they possibly can. Ms Ashley advised that recently the Hospice has introduced Tripudio, which is movement with a focus on the fluid systems of the body, including the lymphatic system and the cardiovascular system. All services are available for people over the age of 18 and any end of life illness is supported. There are also services for carers and family members. Day services are provided for up to 20 patients a day, four days week, every week and inpatient services provide care for up to six people, 24 hours, 7 days a week with the average length of stay being two weeks.

Ms Ashley was pleased to announce that the Hospice are looking to recruit a physiotherapist which will enable onsite physiotherapy services to be provided. Services are provided on a 12 week basis and then patients are assessed to consider whether it is still an appropriate level of care for them to receive. If an individual has made some improvements they may be discharged or alternatively the level of care may continue to be altered as necessary. The Hospice has finite resources and therefore patients are regularly assessed to ensure they receive the most appropriate level of care. For example, day therapy services would not be appropriate to be carried out for someone with a terminal condition if they live for a number of years.

The Hospice also offers diversion therapies which includes emotional support and art therapy. Hospice at Home services provides services for people at home, such as befriending services and social interactions. Ms Bradshaw added the volunteers play a role on providing Hospice at Home services and a number of volunteer drivers are also used. However, some care is provided by Health Care Assistants. There are currently 400 active volunteers working for the Hospice. Hospice at Home provides approximately 2,000 hours of care each year and there has been a reduction in support following the introduction of the rapid response support.

The appointment of a full time Nurse Consultant will also enable the development of a new medical model of care, the will ensure that the Hospice provides tiers of medical cover ensuring safe services to enable more pioneering work to be undertaken through research and offer support to other health care organisations and professionals. This will include GPs working in the Hospice in a sessional basis and it is hoped that eventually a Community Palliative Care Consultant will be appointed. Councillor Taylor was delighted to note that blood transfusions can now be carried out at the Hospice and it was hoped that management of coronary heart disease and breathlessness management programmes would soon be provided.

Ms Ashley reported that GP Palliative Care Leads Group meetings are convened at the Hospice and that the Hospice plays an important role in facilitating good links with all GP Practices, disseminating topical information and developing action plans and GPs have welcomed the support.

Ms Bradshaw reported that the Rapid Response Team works in partnership with Marie Curie and County Durham and Darlington NHS Foundation Trust and that the services are available 24 hours 7 days a week and usually within the hour. Palliative care is delivered at home whenever possible to avoid a hospital admission and the scheme is working well.

Ms Ashley added that the family support available also includes children and workshops have been held for teachers, social works, vicars, etc. regarding how to encourage children to talk about such issues and there is also an emphasis on schools. People should be supported through their workplace and bereavement policies are usually in place.

It was noted that St Teresa's have been working together with Health and Social Care Officers from the Council and Clinical Commissioning Group. The Education Manager is now coordinating supporting the care home who has registered to achieve the accreditation under the Gold Standards Framework. (Members will discuss GSF with DBC Officers at their next meeting).

Ms Bradshaw outlined the benefits of St Teresa's remaining independent as the Hospice is able to be responsive to need and adaptable. The aim is to ensure all of the services are integrated with any state provision to avoid duplication and ensure what is best for the patient. Being independent the Hospice is able to work in partnerships with the Foundation Trust, Marie Curie, Adult Social Care and Macmillan Nurses. The Hospice shapes its services around patient needs while adhering to national movements and are keen to position the Hospice as a centre of excellence. St Teresa's Hospice are also involved in the North East Cancer Network.

Ms Bradshaw reported that funding is always a challenge, whilst ensuring that the services remain patient led and ensuring that funding does not drive services. It was noted that networking is crucial and takes up a lot of time, but the Hospice needs to ensure that they mix with the right people at the right level to maintain effective partnerships. There are also ethical challenges and in response to a question, it was stated that excellent palliative care avoids that the need for assisted suicide. The

Hospice ensures that there is patient choice and unnecessary hospital admissions are avoided.

Actions:-

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

- That the contact details of Officers be shared with any Groups that the Hospice could be networked into.

Appendix 1 (d)

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

18th January 2013

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

Officers: - Christine Forsyth, RIACT Manager, Wendy Lyons, Warren Tweed, Strategic Commissioner Older and Disabled People and Abbie Metcalfe, Democratic Officer.

Christine Forsyth explained that RIACT is an Intermediate Care Service which involves a range of services designed to help people recover from an illness and prevent unnecessary admission to hospital. The service also assists people returning home from hospital. The service is for people over the age of 18, who live within the Borough of Darlington and/or are registered with a Darlington GP practice.

RIACT combines the following services:

- Rapid Response Service – Supports people home from hospital/helps to prevent avoidable hospital admissions into hospital by providing rapid assessment of needs followed by access to short term therapy / reablement, nursing support and personal care in the patients own home.
- Rehabilitation Service – provides a short term programme of therapy and reablement in a person's own home or a local residential care home. The service for people who are medically stable but need some support to enable them to return safely to their own home. The support may also follow a stay in hospital after an illness or an operation, or may sometimes follow deterioration in the patient's condition in their home.
- Reablement Service – gives people the opportunity and confidence to regain some of the skills they may have lost because of poor health, disability or impairment, following a stay in hospital or problems at home.
- Recovery Services – Enables people time to regain independence following a period of ill health or deterioration in an existing condition.

The RIACT Team is based at Hundens Lane and provides services which include:

- Physiotherapists - help patients become as fully mobile and active as possible.
- Occupational Therapists - help and encourage patients to regain independence in their daily lives.
- Nurses - address patients nursing needs, eg. wound care, nutrition, pain control and medication.
- Community matron – supports people with complex needs.
- Awaiting confirmation for a start date for a pharmacy technician to support with medication.
- Care Managers - assess the patients Social Care needs.

- Support Workers, either based in the community or residential care homes, help with the rehabilitation/reablement/recovery programme. This may include assistance to enable patients to manage their mobility, personal hygiene, dressing, meals and domestic chores.

The RIACT service is hugely popular and current the service is exceeding its capacity with between 30 – 50 new people accessing the service each month for conditions a variety of conditions including stroke, neurological and intermediate care. RIACT is available between 8am – 8pm, seven days a week. This includes Social Workers and there is also an evening service which allows people to have night sitters.

Members were pleased to hear that RIACT and Readmission Avoidance Scheme (RAS) Teams are working together and becoming more integrated, with the aim of creating a Single Point of Access for all clients. RAS is very much part of the discharge planning and as part of that process the team to consider whether the patients conditions can be successfully managed at home, whether they understand their medication, offer reassurance to carers and assess people who require additional support, which is often a sensitive issue. Part of the RIACT service includes a call back to a patient if they have refused care to check that they are alright and managing if they live alone.

Patients are triaged via the telephone when they call RIACT and this is well received and prevents hospital admission. If people present to Accident and Emergency with falls or black outs that has not resulted in a fracture is known as a 'near miss' and more often than not are followed up with telephone interviews. The aim is to have holistic approach and make every contact count and avoid unnecessary hospital admissions. It was noted that patients are readmitted based on need not want.

It was noted that the service RIACT provides has a long term benefits and that financially it is more cost effective, however, if admissions to care homes decrease the need for equipment increases, but overall the cost per episode is lower. The average numbers of people who use RIACT leave requiring no services or further health or social care intervention and continue to live independently despite their acute episode.

It was noted that there are a number of Telehealth pilots running in Durham and that Jane Haywood from County Durham and Darlington NHS Foundation Trust was leading on that work. Members commented about the previous Telehealth Pilots that were running in Darlington Care Homes and it was noted that the results were not as expected. Although, a positive outcome was that staff has become educated and familiar with individuals conditions, are able to reassure patients and carers and check readings and monitor conditions ultimately avoiding unnecessary admission to hospital. The two Care Homes in Darlington were Eden Cottages and The Gardens; Members were interested to note that Eden Cottage was the only Care Home that was continuing with the equipment.

The Gold Standard Framework (GSF) in Care Homes have been offered to all Care Home in Darlington and only 16 out of 22 care homes have signed up to attend the four workshops. Part of the contract arrangements includes a penalty clause for nonattendance at the workshops. Mr Tweed reported that realistically only 12 out of the original 16 would successfully achieve the GSF. Now a facilitator has been appointed it

was hoped that care homes would move through the programme more quickly and as clusters. The funding for the GSF comes to end an in 2013 and continuation will depend on whether the CCG intend to continue to invest funding. Part of the GSF includes End of Life Care training is undertaken in this area.

Publically GSF is an attractive achievement as people want to put their loved ones in Care Homes with the GSF standard and it also signifies a change in culture. Care Homes tend to look after people aged between 80 - 90 and their average length of stay is two years, therefore End of Life Care becomes very important. Part of the GSF involves staff being trained in End of Life Care and being able to assist people in planning for their death and personalise their individual pathway of care. GOLD have been asked to carry out some evaluations of care homes in Darlington to establish standards. The care homes visited were taking part in a national training programme GSF, which has a strong focus on dignity in care and care at the end of life. GOLD will visit different care home throughout the process and prepare reports after each visit.

There has been a significant rise in home equipment loans and adaptations allowing people to remain in their own homes for longer. It was noted that there are between 80 - 100 new clients every month across County Durham and Darlington. As a result resources are stretched and it was not always possible to meet clients' needs exactly how they would wish. An example quoted was availability of continence pads with clients only receiving up to four pads a day when ideally they would require more.

Members were pleased to note that Dr Matt Sawyer is the CCG lead for Intermediate Care and holding discussions with GPs, regarding aligning GP surgeries to Care Homes or having specific GPs available for Care Homes to call upon.

Members enquired about training and were pleased to hear the Council staff were trained on a rolling programme and training did include some mandatory elements. Such issues as reablement awareness have been carried out jointly with health colleagues to build relationships and allow staff to support each other. Officers discussed the benefits of having a Community Matron aligned to RIACT and how they can often act as a conduit with the Hospital. Officers stated that transforming community services has established the firm integration of the team. A single contact number for the RIACT service has proved to be very successful. Members were reassured that relationships were between health and social care are extremely positive and that there was a uniqueness in Darlington where people are always willing to share ideas and learn from each other to provide the best services, budgets aside.

Officers were delighted to announce that the Team had been shortlisted for a Local Government Intermediate care Award and agreed to share the outcome with Members as soon as possible. Members bestowed their best wishes to them.

Actions:-

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

- That the contact details of Officers be shared with any Groups that the Hospice could be networked into.

Additional Information:-

Funding to create create care environments for people with dementia

Health Secretary Jeremy Hunt has announced dedicated funding to create care environments for people with dementia that help reduce anxiety and distress, and help people feel safe.

Up to £50 million will be available to NHS trusts and local authorities, working in partnership with care providers, to help tailor hospitals and care homes to the needs of people with dementia. The care providers involved will need to sign up to the Dementia Care and Support Compact, which commits them to providing first rate care and support for people with dementia and their families.

Research by The Kings Fund demonstrates that good design can help with the management of dementia. People with dementia are calmer and less likely to get lost or become distressed in an environment designed with their needs in mind.

Organisations that bid successfully for money will be able to adapt care homes and hospitals using design principles tested in The King's Fund pilots. Specially designed rooms and spaces could include features such as:

- hi-tech sensory rooms using lighting, smells and sound to stimulate people's senses
- large photos of local scenes from the past to prompt people's memories
- specially adapted outside space to prevent people from wandering, by helping them keep busy and active with activities such as gardening
- technology such as day/night clocks and controllable mood lighting to emulate day and night, which can help with sleep patterns, orientation and safe movement
- calming colours, non-reflective surfaces, large-print signs and the creation of zones to help people know where they are and find their way back to their rooms

Every project will involve people with dementia, their families and carers, to make sure the designs meet their needs. The projects will form part of a national pilot to showcase the best examples of dementia friendly care environments. The lessons learnt from the projects will advise local Health and Wellbeing Boards on how to create better environments for dementia care.

The criteria for applying for funding and the deadline for receipt of applications will be announced shortly. The successful projects will begin from April 2013.

Social Care Capital Funding Applications: Improving the environment of care for people with dementia

Dear Sir/Madam,

Darlington Borough Council is committed to driving up standards of practice and care for older people with dementia. We have been working towards making a real difference to their lives by improving their living environments so that they can enjoy meaningful and stimulating activities. A large scale multi agency programme called the Dementia Collaborative was set up in Darlington in 2010 to improve the quality of life for people with dementia. It saw a number of practical environmental changes being made, as well as eliminating waste and improving quality and productivity.

The Capital Grant Funding programme will further support and progress the work that was undertaken locally as part of the Dementia Collaborative which involved major system changes across the four main statutory organisations. We wish to build on the firm foundations laid by our partner organisations, Tees Esk and Wear Valley Mental Health Trust, County Durham and Darlington Foundation Trust, and Durham and Darlington Primary Care Trust by continuously improving the environmental changes for people with dementia. This funding will provide a real opportunity and investment to further expand on this area of work.

The local hospital trust was the main target for the initial system changes which saw significant improvements made within the hospital environment, i.e. nursing stations being removed which encouraged staff to be more visible, changing the colour of crockery and the trays they were being served on and making the signage more clear and meaningful for people with dementia.

We support the applications from the key stakeholders in the community (Residential and Day Care Providers) and wish to invest by way of grant funding in this crucial, previously often neglected area of work. The reason we have submitted individual applications as opposed to one collective application was due to the nature of the different and unique proposals being put forward, which will not only provide improved stimulating and homely environments but give individuals real choice, and meet a wider range of needs.

Darlington Borough Council will ensure that there is a commitment at the highest level from those organisations bidding for grant funding, by applying European procurement rules and principles to support progress towards the changes that are proposed to improve environments for people with dementia .

As part of the Procurement Process we will ensure that for any changes that occur, an Equality Impact Assessment will be carried out to understand how people will be affected by any environmental changes, and as a result if any changes to policies are made, are appropriate and services continue to be accessible to all and meet different people's needs. This ensures that the L.A. continues to comply with its Public Sector Equality Duty.

The local Action Plan that was developed from Durham and Darlington's Older Person Mental Health Strategy which focuses heavily on dementia, categories the challenges and actions under the outcomes specific to the 'Dementia Care and Support Compact'. The Local Authority will sign up to the Compact, however it will take this a step further by making this a requirement under contractual arrangements with our Providers.

Our commitment to the Department of Health will be to share the learning and good practice that will evolve from these initiatives, by ensuring through the 'Contract Agreement' with Providers that we have clear and measurable outcomes relating to individuals health and wellbeing. Contract compliance will be monitored as part of the Contract period for the capital funding however the established performance management tools we currently use will continue to be utilised beyond the contract period for this investment to capture the benefits and outcomes following the changes to the environment.

We will endeavour to ensure via contract monitoring all Providers deliver their outcomes by 31st March 2014

Should ongoing development of environmental changes for people with dementia be required we will aim to champion initiatives locally for further investment by showing evidence for the need to redesign individuals' surroundings. We will also continue with the political support for the development of dementia services and environments, making sure dementia features in the plans of the new devolved administrations of the CCGs; and prioritising within health and wellbeing boards.

Please see attached applications from the following organisations:

Age UK Darlington.

Darlington MIND Ltd

Wilton House Care Home

Ascot Care - The Gardens Care Home

Four Seasons Healthcare - Grosvenor Park Care Home

Four Seasons Healthcare - The Grange Care Home

Manor Care Home Group

Yours sincerely,

Ada Burns and Paul Wildsmith, 16th January 2013

Appendix 1 (e)

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

8th March 2013

Present: - Councillor J. Taylor (in the Chair); Councillors E.A Richmond and S. Richmond.

Officers: - Abbie Metcalfe, Democratic Officer.

GOLD: - Claire Llewelyn, Community Development Worker for GOLD and Terry Taylor, Volunteer.

Claire Llewelyn explained that the Gold Standards Framework (GSF) is a national training scheme which aims to 'enable a Gold Standard of Care for all people nearing the end of life.' The GSF Care Homes Training programme also include improved co-ordination and collaboration with GPs and reduced hospitalisation to enable more people to live and die at home and thereby improving cost effectiveness.

Volunteers from GOLD were approached by Warren Tweed and asked if they would like to carry out research to evaluate standards over the three year period of the training. The three year period commenced in 2011 and the evaluation carried out between July and September 2011 was shared with Members. The 2012 evaluation report was still being produced and would be shared with Members in due course.

Mr Taylor described the intense training sessions that the volunteers undertook prior to visiting the Care Homes. There are seven volunteers involved in the process and they have made several visits to six Care Homes to meet with staff, managers, family and residents. Interviews have been carried out with a variety of staff including caretakers and kitchen staff allowing volunteers reassurance that all staff are familiar with the policies and protocols in place. The information gathered has been reported that each individual Care Homes by way of a confidential report and an overview report has also been produced and circulated more widely. The same exercise has been repeated for 2012 and will commence again in the summer of 2013 for the final time.

Mrs Llewellyn reported that the Care Homes were purposely chosen to reflect a mix of high and low number of residents, whether urban or rural, whether privately owned or Council run and its registrations. Pre meetings were held with the Care Homes prior to the visits commencing to ensure they understood the process of evaluation and all agreed. The feedback received from the Homes has been positive and it is acknowledged that older people evaluating Care Homes is first Nationally.

Warren Tweed has previously briefed Members on GSF and Members are aware that not all of the Care Homes have signed up to the GSF and some that originally had, have now dropped out. Members commented about the value of undertaking the GSF and thought that Care Homes should want to achieve that standards as it would be positive promotion tool and certificates could be displayed within the Care Homes.

Discussion ensued about the results of the first year's evaluation and recommendations included issues around safeguarding, communications between staff and residents, medicine management, how friends and family can influence Care Plans and how the homes are run, interior decoration of the Care Homes, hygiene, cleanliness and smell of Care Homes and choice of activities offered. The results collated from year one would be compared to year two and subsequently year three. Members were pleased that Care Homes were reacting positively to the recommendations that the volunteers from formulated and hoped that adequate steps had been taken to implement changes to address them.

Members were interested to note that Care Homes selected residents for the volunteers to talk too and that it was sometimes difficult to engage with families. Lots of feedback was gathered around activities that people undertake in the Care Homes and the variety offered. Comments around whether activities did stimulate residents ensued and all agreed it must be difficult for staff to manage. Members would like to see a variety of activities offered in Homes to enable every resident the opportunity to be engaged and involved if they can. Members believe that staff should find out about individuals and learn about the types of interests and activities they would like to participate in. Members questioned whether there were areas (smaller lounges) to enable people to sit on their own and enjoy the peace and quiet if they chose too.

It was noted that work was being undertaken for the GSF to be rolled out in Hospices and Hospitals. Once the GSF is awarded, GSF inspectors will monitor the Care Homes and visited and rechecked every three years. Particular reference was made to dignity and how staff have a large role to play in treating residents with dignity and Members were pleased to note that dignity is now part of the Hospitals Standards.

Members thanked Mrs Llewelyn and Mr Taylor for their attendance at the meeting.

Appendix 1 (f)

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

26th March 2013

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

Officers: - Jane Haywood, Clinical Director Adults and Integrated Services/Programme Manager and Abbie Metcalfe, Democratic Officer.

Members received an update from the Clinical Director in respect of the areas of interest within Older People.

Older People

Readmission Avoidance Scheme – Ms Haywood reported that the post evaluation of the Readmission Avoidance Scheme (RAS) had been undertaken and there had been some really positive feedback from patients and has been extended to run until June 2013. MS Haywood reported that there had been an independent review of intermediate care undertaken in Co Durham with the evaluation report due to be presented to the Chief Officers Group on the 27th March and therefore the outcome would be known after Easter. Ms Haywood offered to share a report with Members in providing more detail in respect of RAS.

The Clinical Director shared her thoughts about stream lining the patient journey from admission to discharge. She believes that a mapping exercise of the whole services and pathway needs to be undertaken and elements of RAS could run though the make-up of the staff teams. This work is currently underway, the aim of which will me to reduce the acronyms and streamline services.

Discussion ensued as to whether the RAS has been successful and Ms Haywood believes that it has helped reduce readmissions although the actual figure has only reduced by 55 for 2011/12 for RAS but in terms of avoiding admissions the figure was much more positive . There were no comparative figures to baseline against and it is difficult to state whether without RAS the activity would have been much greater and therefore the pressures on Acute beds even more pressing.. The development of the Front of House (integration of Urgent Care Services) at Darlington Memorial Hospital (DMH) would make a difference is reducing hospital admissions and the Trust are keen for this to happen as soon as possible.

o **Community Matrons** – Ms Haywood reported that there are 3.9WTE Community Matrons in Darlington. There is a high percentage of admissions of older people into hospital from Care Homes and the Trust are currently using Community Matrons to work with Care Home staff to up skill them to prevent unnecessary admissions. There is an issue with high percentage of staff turnover as the fully trained staffs often leave in the Care Homes.

Community Matrons workloads also include specialist cases, brief intervention and early support once the diagnosis of long term conditions has been made. Ms Haywood

commented it would be desirable to have more, although, their rolehas not in the past been clearly defined. It was noted that GPs are piloting the use of advanced Care Practitioners in Sedgefield and these have the same skill set as Community Matrons.

o **Single Point of Access (SPA)** – Discussion ensued about how useful having a SPA would be and comparisons were made about the success of the RIACT service. Ms Haywood reported that the Trust are giving consideration to providing a SPA which would be beneficial to community, emergency departments and GPs in the first phase with plans to roll it out to cover all aspects of the Trust business.

o **Training** – It was noted that within the CQUIN targets for 2013/14 there is a requirement to train specified role specific nurses on non-medical prescribing . This will be a pressure as the course lasts six months and is for two days a week. The mandatory staff training figures remain at 95% compliance and training is not an issue for the Care Closer to Home Group in respect of Mandatory training .

There is still a significant number of patients admitted from Care Homes who die within 48 hours of admission to hospital. It was acknowledged that more work and training was needed to combat this and this would be part of the Community Matron role.

Members made reference to the Gold Standard Framework in Nursing Homes which should drive up care quality and standards, which ultimately impact on hospital admission and deaths. Members expressed their disappointment that Care Homes are dropping out of the schemes.

o Care of Elderly Programme (COPE) and Older People's Assessment Services (OPAS) – Ms Haywood reported that both COPE and OPAS re included in the Intermediate Care Review and work was continuing to streamline the pathway of care. Both services are only provided in the North of the County due to historical funding arrangements

o Telehealth Pilots –

Warfarin – Ms Haywood explained that patients can self-test blood levels at home, submit the figures, to initiate an automated phone call. The patient then answers a series of questions. The results are checked by a nurse and the following day a further automated call is made to the patient advising of the revised warfarin level to take. Patients would still be offered the choice of attending warfarin clinic but for patients that work this would be an ideal solution.

100 patients are required to participate in the pilot across County Durham and Darlington and the initial work is encouraging. The aim is that eventually nurses will not check the results and system will make the adjustments automatically.

The Trust will provide 100 machines initially but if this proves a resounding success patient may be required to purchase their own machine costing £350 currently. Which could be a real investment and this would be a huge debate for patients in the future. The Trust is the first Trust in the Country to do this and therefore it is hoped to commercially sell the model; to generate income.

Nutrition in Care Homes – Patients who are discharged with nourishment drinks their activity will be monitored remotely.

Bariatric – This is a six months pilot and focuses on the six months prior to surgery and is an electronic coaching programme, with the outcome being prolonged graduated weight loss and being more engaged with health eating. The aim is to reduce hospital visits and reduce the risk factor of long term conditions from being obese. The vision is to roll a childhood obesity programme out in schools if this proves to be successful, run via an interactive Wii type progamme.

Ms Haywood reported that GOLD have invited her to attend a meeting of their Health Group to demonstrate the telehealth kit and suggested that Members of the Scrutiny Committee may also like to attend.

Actions:-

- That the Democratic Officer be chase Denise Slark for an update on end of life care to enable members to complete this piece of work;

- That the Democratic Officer contact GOLD to ascertain when the GOLD Health Group meeting will be held to discuss Telehealth; and

- That the Clinical Director be thanked for attending the meeting and for her time and supporting of the duration of this piece of work.