Older Peoples Clinical Services Plan

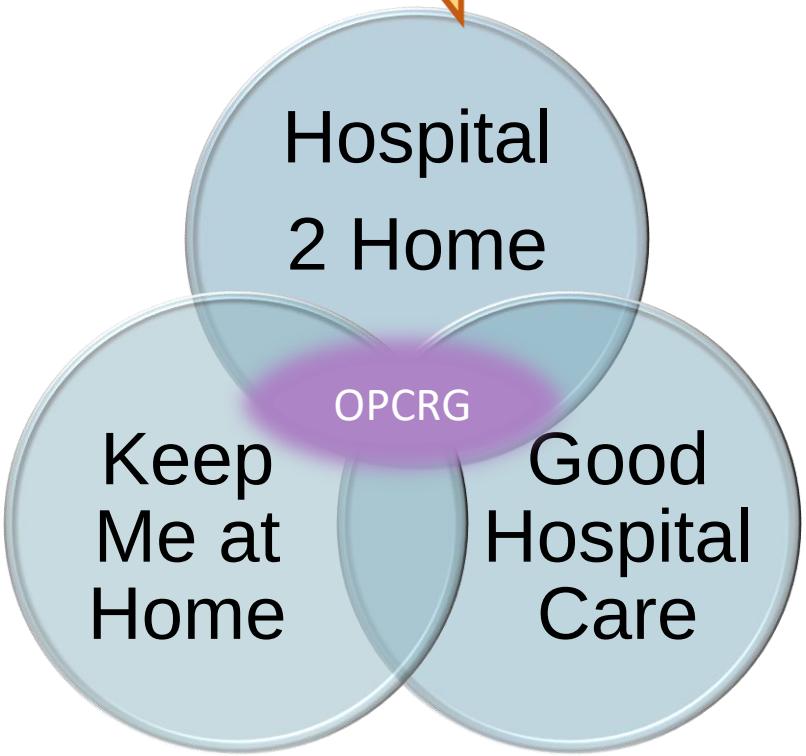
Our ambition is to provide genuinely integrated care, embracing the principles of comprehensive geriatric assessment required to meet the needs of older people.

Clinical Services Plan : 10 components for delivering excellence in older peoples care (Kings Fund,2014)

1. Healthy active ageing and supporting independence	2. Living well with simple or stable long terms condition	3. Living well with complex co-morbidities, dementia and frailty	4. Accessible, effective support close to home at times of crisis	5. High quality person centered acute care when needed	6. Good discharge planning and post discharge support	7. Effective rehabilitation and re-ablement after acute illness or injury	8. High quality nursing and residential care for those who need it	9. Support, Choice and control at end of life	10. Integration to provide person centered integrated care

Older Peoples Clinical Redesign Group

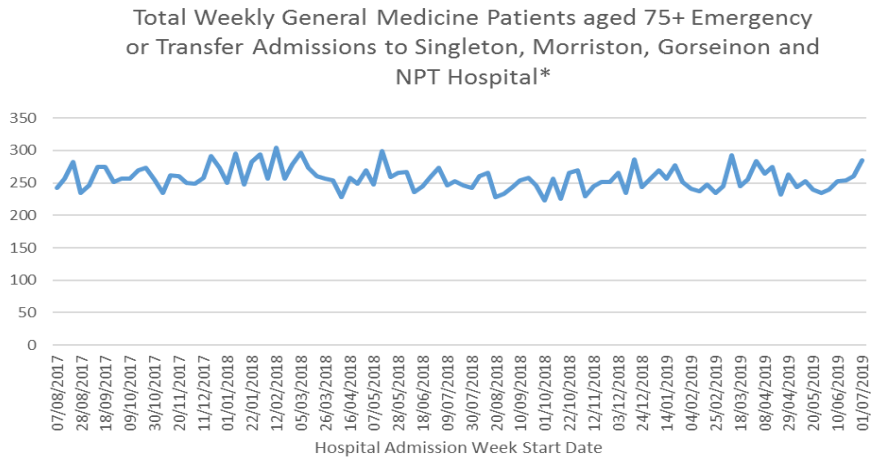
Home 2 Home
Integrated Pathway for Older People

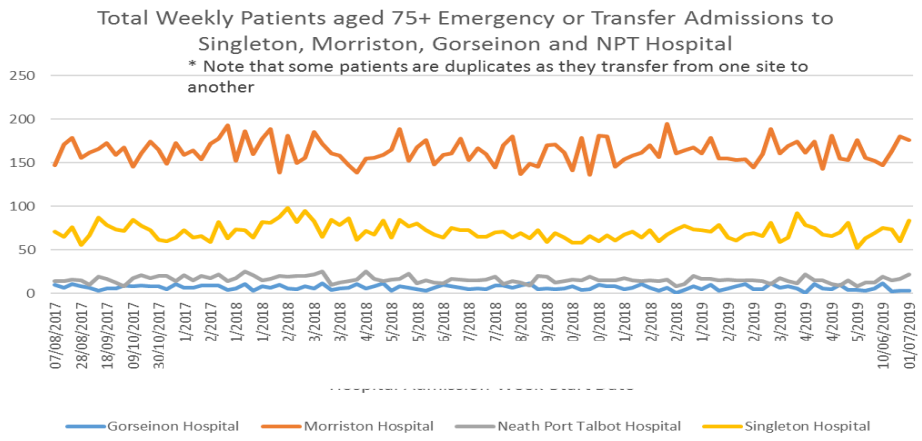


Multidisciplinary approach to Leadership

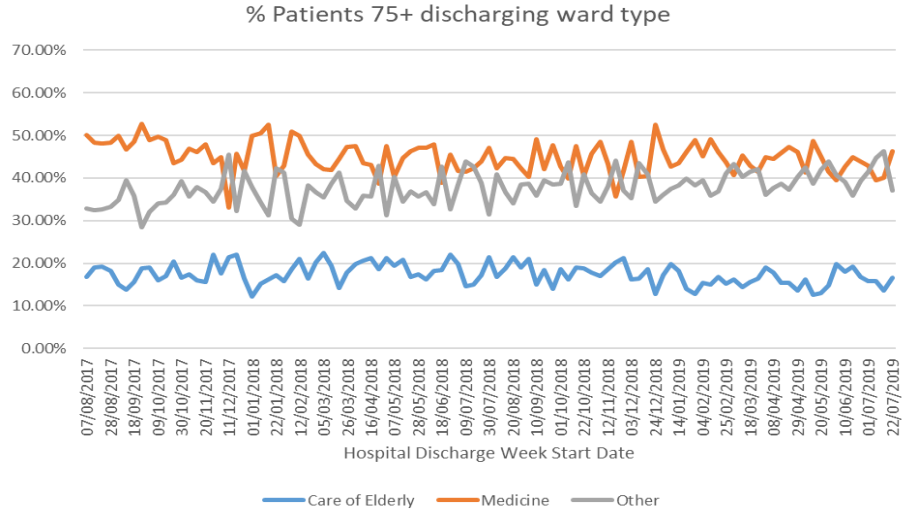
Clinical Lead	Rhodri Edwards
Planning Lead	Nicola Johnson and Marie-Claire Griffiths
Management Lead	Hilary Dover (H2H and KM@H) Jan Worthing (GHC)

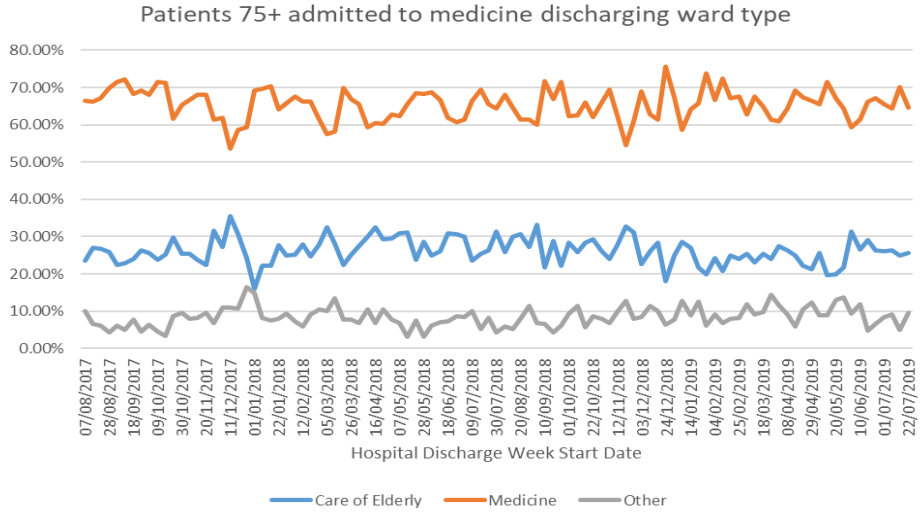
Older People's Admissions





- The weekly admissions are variable but generally around 250 per week, 150 to 180 of these are to Morriston
- The median weekly admissions are about 150 for 75-84 years olds and 100 per week for 85+



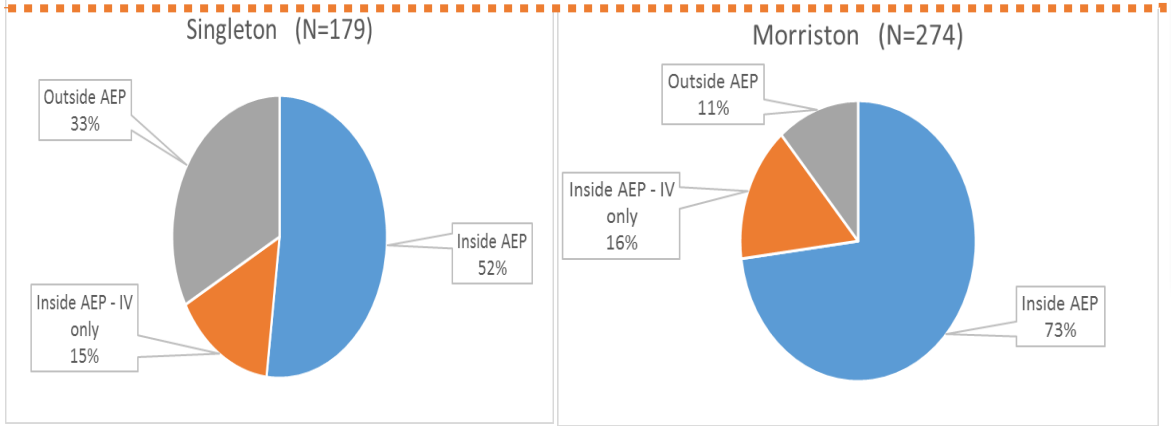


- Those discharged from a care of the elderly ward is around 17% per week
- 45% are discharged from medicine wards an 40% from other wards.

Right Place Right Care Review

757 patients surveyed predominantly in General Medicine (63%) and over the age of 65 (80%)

Morriston 73% met the clinical criteria for admission
Singleton 52% met the clinical criteria for admission

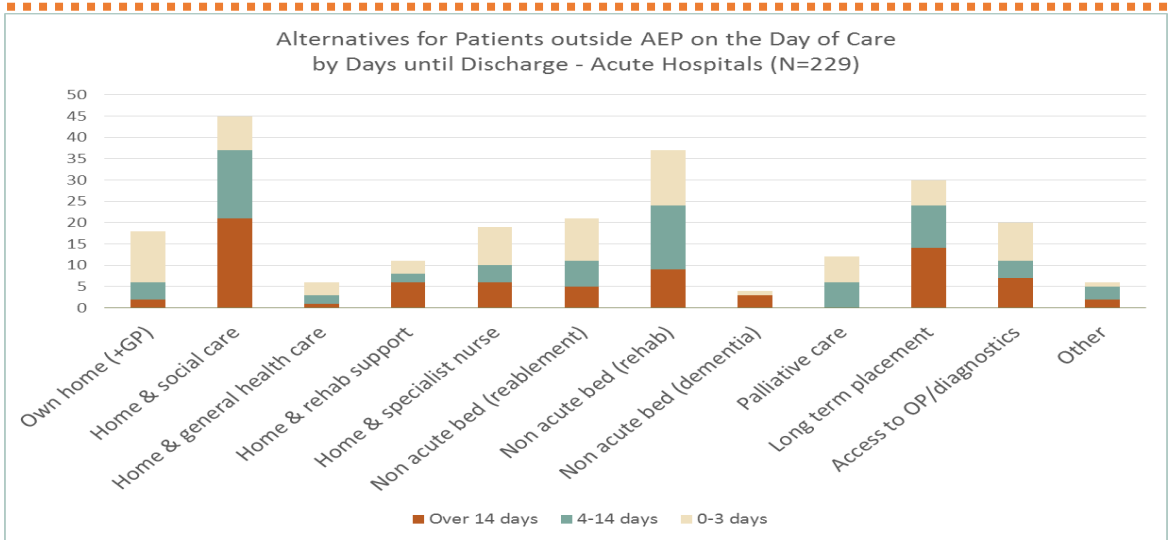


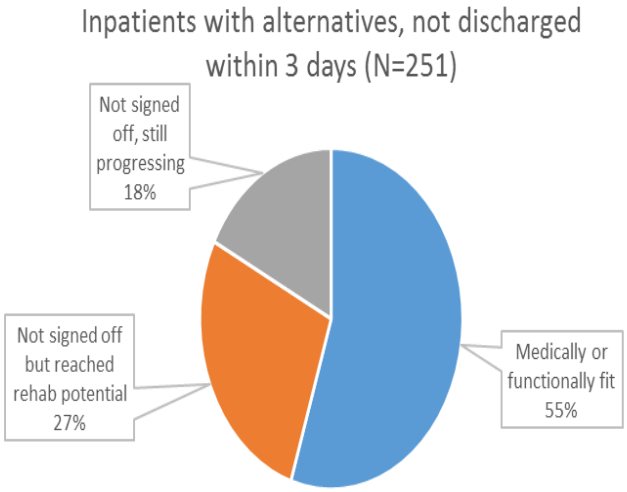
Themes

- ❑ Maximise capacity in partnership
- ❑ Whole system approach
- ❑ Support Frail patients to receive the right care in the right place

55% of patients fully recovering in hospital - medically or functionally fit.

Morriston 40% met the clinical criteria on the day of care
Singleton 32% met the clinical criteria on the day of care





CSP Deliverables for Older People

- Single Frailty Model across Swansea and Neath Port Talbot
- Increase the capacity and responsiveness of our existing community based integrated Acute Clinical Teams.
- Admission avoidance including taking direct referrals from Welsh Ambulance stack
- Focus on Care Home Medicine
- Embed Comprehensive Geriatric Assessment across hospital pathways
- Standardise Acute Frailty Services across the Health Board
- Develop policy and guidelines covering the major frailty syndromes including falls, delirium, dementia, urinary incontinence and polypharmacy
- Address the findings of our Right Place Right Care Review (2018)
- Establish a Hospital2Home as a re-ablement model of discharge

Quality Priorities

- SAFER patient flow ✓
- Comprehensive geriatric assessment ✓
- Reducing harm from falls ✓
- Improving outcomes following stroke
- Improving cancer outcomes
- Improving end of life care
- Improving surgical outcomes
- Reducing Pressure Ulcers ✓
- Reducing Healthcare Acquired Infections ✓

Home 2 Home
Integrated Pathway for Older People

Unscheduled Care Annual Plan Actions

1. Ensure Timely Access to Urgent or Emergency Care through implementing assessment recommendations for vascular, Fractured neck of femur, Acute Medical Assessment Unit (AMAU) and ED pathways, maximising use of Medicine Neurology and Respiratory Hot Clinics and flexible beds.
2. Reduce patient risk through reduction in avoidable delays and prolonged hospital stay through Implementing the NHS Wales Delivery Unit complex discharge audit recommendations and Right Care Right Place review recommendations.
3. Rebalance medical bed capacity at Morriston through maximising the use of Early Supported Discharge for COPD patients at Morriston and Singleton, and the use of community hospital frailty beds, pathway coordinators (funding dependent), Green to Go ward relocation (funding dependents) and implementing OPAS pus (funding dependent).
4. Draft Transformation Fund Bid for Hospital2Home service including new discharge to assess and recover model, expansion in reablement at home, expansion in acute clinical teams & Single Point of Access.
5. Centralise the Acute Medical Take at Morriston and align with continued planning for the HASU (subject to any engagement/consultation requirements).

Programme Title / Annual Plan Action	Our Neighbourhood Approach West Glamorgan	A Whole System Approach	Keep Me at Home	Good Hospital Care (2)	Hospital 2 Home (4)	Dementia
Programme Board	Integrated Transformation Board Chair: Siân Harrop-Griffiths		Adult Transformation Board Chair: David Howes ⇔ Unscheduled Care Programme Board Chair : Chris White		Adult Transformation Board Chair: David Howes	Adult Transformation Board Chair: David Howes
Partnership Governance	Neath Port Talbot JPB Swansea JPB				Neath Port Talbot JPB Swansea JPB	
Clinical Leadership		8 Cluster Leads meeting. Clinical Lead : Dr Anjula Mehta/Dr Richard Tristham	Older Peoples Clinical Redesign Group Clinical Lead : Dr Rhodri Edwards			
Project Board	TITLE TBC Implementation Group Chair: TBC	TITLE TBC Implementation Group Chair: TBC	Keep Me at Home Implementation Group Chair: Hilary Dover	Good Hospital Care Implementation Group Chair: Jan Worthing	Hospital 2 Home Implementation Group Chair: Hilary Dover	Dementia Plan Implementation Group Chair: Stephen Jones
Sub Group					DTOC Chair : Jason Crowls	
Aims			Standardise ACT model around best practice and right size capacity for rapid response Work closely with WAST to prevent admission Development of community IV service Improve diagnostic access within the community to prevent admission Develop a Single Point of Access	Standardise Frailty model. standards of care and ways of working on all sites Comprehensive Geriatric Assessment embedded across in hospital pathways Analysis of the required capacity for Ortho geriatrics and surgical liaison to reduce length of stay. Embedding good pratice of flow - SAFER, EDD and Board Rounds Documentation that is transferable across all parts of the patient pathway - mobilisation in hospitals	Hospital 2 Home is an agile service to assess, care and reable patients at home maximising independence and ensuring care packages are right sized John Bolton Model used as a best pratice model for implementation Trusted assessor model where assessment does not take place in a hospital bed. Strength based assessments not "need" assessments taken place when patient is not in crisis	Implement best practice in caring for patients with dementia across all settings Implement National Dementia Plan Agree common standards, protocols and ways of working
IPOP Component	1. Help me choose and age well	2. Support me to stay well	3. Assess and Monitor Me Closely 4. Step Up My Care and Keep Me at Home	5. Give Me Good Hospital Care	6. Get Me Home Safely and Step Down my Care	