Making it better

Supporting older people to stay well in Sheffield

The last two years have seen some fantastic partnership work between health, social care and voluntary teams to make real differences to the lives of older people living with physical or mental illnesses in our city.

It is the beginning of a journey which has already started to prevent older people having to be admitted to hospital and instead be supported to stay living independently at home. The place we all would want to be as we get older if at all possible.

This newsletter outlines just some of the changes which have happened and how they are helping our patients, service users and in many cases of course our own family members to stay well, supported and living independently.

Thank you for all your continued hard work, it is really making a difference.

Shaping Sheffield

Over 60 organisations in Sheffield have joined together to commit to a single plan called 'Shaping Sheffield' for improving health and wellbeing in the city.

'Shaping Sheffield' brings together and joins up the work we are all doing across the city, as well as looking at new ways of working to improve care and make services sustainable.

We already work together closely in many ways but this will rub out the boundaries between our organisations and mean managing our resources for health and care is a more joined up approach. Priorities for 2017 to 2019 include preventing ill-health, helping people back to work, community support to promote independence and self-care, primary care and tackling inequalities by greater investment into our communities with greatest needs.

Work is continuing to agree how this will look, including regular planning events with partners and local community groups.

Sheffield ageUK · Sheffield Teaching Hospitals NHS Foundation Trust · NHS Sheffield Clinical Commissioning Group · voluntary action sheffield · Primary Care Sheffield · Sheffield City Council · NHS Sheffield Health and Social Care NHS Foundation Trust · healthwatch Sheffield

It's all about healthy Neighbourhoods

A new neighbourhood approach is helping people to stay well and get the care they need as close to home as possible. GP practices have joined together to form 16 groups across the city – known as neighbourhoods – along with their 'neighbours' from hospital, community, mental health, social care and housing services, and local voluntary groups. Each neighbourhood covers a population of around 30-50,000 people.

The practices work together to coordinate health and social care for people in their area, and consider how services should best be provided. The aim is to make the best use of resources for local communities, tackling the biggest health and social challenges facing their particular area. There is also a strong focus on reducing unnecessary hospital admissions and supporting people to keep well and to remain at home where possible. Whilst still in development, early successes are already happening in some neighbourhoods.

The benefits?
People won't have to go into hospital unless they really need to as more clinics and services become available in the community. More people will be supported to take control of their own health and wellbeing through closer working between GP practices and the voluntary sector.

Vulnerable patients given the support they need to return home safely

Elderly people who live alone are being given support on their return home from hospital by a charity working in partnership with Sheffield Teaching Hospitals, the Council and Sheffield Clinical Commissioning Group.

Sheffield Churches Council for Community Care (SCCCC) are providing a rapid response service to support older people who may not have family or friends available at the time they are ready to be discharged from hospital.

Within an hour of receiving a call from the hospital, a trained volunteer will take the patient home, ensure the heating is switched on, make them a snack and drink and provide emotional support until the arrival of family, friends or a care agency.

The charity can also make referrals to other organisations like the fire service or Community Equipment Loan Service, where they believe a patient may be in need of further support.

Hospital to Home Coordinator at Sheffield Churches Council for Community Care, Sarah Wigston, said: "This is a highly personal service which helps support older vulnerable people in Sheffield. It means that after a stay in hospital, patients have someone to help them get settled back at home, to have a cuppa and a chat until family or other support arrives. As well as supporting the patient to return home safely and confidently, it also enables the hospital bed they may have been waiting in, to be used for another patient. It is a win win solution which we are delighted to support."

How 'Active Recovery' made 108 year old Jane very happy.

The Short Term Intervention Team (Social care) work alongside community health services to provide an 'Active Recovery' service in Sheffield. The two teams support people to be discharged from hospital and assess their needs at home. They provide a short term service to help people recover and recuperate, before transferring on to long term care if they need it. In most cases people are able to become independent again. The service also supports people in crisis to avoid the need for them to be admitted to a care home or hospital.

108 year old Jane is just one of the many people who Active Recovery have supported in the last year. Jane is very deaf and communicates by writing on a board. She was admitted to hospital with concerns about confusion. She had fallen twice at home and bruised her face. She was diagnosed with an infection. Therapy staff were concerned about her returning home because she was very frail and had poor mobility and high risk of falls.

Jane was able to understand the concerns about her wellbeing, but was desperate to return home. She did not wish to be placed in a care home. Discharge Planning Team social workers listened to what Jane wanted and after carefully assessing the situation they were able to arrange for an increased support package, and further assessment of Jane's long term needs so that she could return home instead of going into a home. A year later and Jane is still very happy at home with the same package of care in place.

Rapid response for mental health

Sheffield Health & Social Care's Dementia Rapid Response and Home Treatment Team provides community based NHS assessment, care and treatment to people with dementia and who are experiencing some degree of crisis or difficulty. There is no age limit. The teams work in a person's own home (this may be a nursing or residential home), to provide prompt interventions aimed at resolving the individual's immediate difficulties and improving the situation. The focus is on admission avoidance to ensure that people are supported to remain in their own home.

The Rapid Response team is also working with the Functional Intensive Community Service to provide short term intensive home treatment to older adults over 65 who have functional mental health problems. The aim is to prevent hospital admission, supporting people to remain in their own homes. The average length of involvement by the service is up to ten weeks depending on the circumstances and needs of the individual. The Functional Intensive Community Service also provides discharge support to help people return to their own homes following hospital admission. Further investment in the service over the last year has meant weekend provision has been extended.

Nursing home residents benefit from early health intervention thanks to new technology

A new project in some of the City's care homes is testing how the integration of new technology combined with partnership working between community health professionals, care homes, hospital teams and GPs can prevent older people from having to go into hospital.

The digital care home project being run by the Perfect Patient Testbed is using a range of digital devices, including a blood pressure monitor, pulse check and weigh scales as a package that can help an individual or a carer keep a regular check on their health. The data that is gathered from the devices is sent live to the Single Point of Access community health team at Sheffield Teaching Hospitals who are then able to identify any irregularities in the patients' health data. The team can then follow up any potential concerns by calling the local care home team to offer advice or suggest a further appointment with a health professional if required, and therefore preventing further deterioration of a patient's health. It is hoped this rapid response will help keep care home residents well and reduce hospital admissions by enabling preventative measures to take place earlier.

Liza Murphy, Manager at Balmoral Care Home said: "This is a really exciting project for us to be involved in. It will enable us to provide an enhanced healthcare service to our residents.

The technology is easy to use, the residents don't mind using them at all, and if the solution enables the health professionals to identify even the smallest signs of deterioration in our residents, which we wouldn't have been able to spot ourselves through visual observation, it will be a great way to keep our residents well and out of hospital."

To date over 50 residents have avoided the need to be admitted to hospital after the need for early intervention was identified from the data transmitted through the new way of working.

Did you know?

The Perfect Patient Pathway Test Bed, based in Sheffield is one of 7 national NHS Testbed programmes. It aims to bring new benefits to patients with multiple long term conditions. This will be achieved through the combination and integration of innovative technologies and pioneering service designs, keeping them well and independent and avoiding unnecessary hospital attendances.

Perfect Patient Pathway

Why not home? Why not today?

Every winter right across the NHS we hear about the number of patients whose discharge is delayed for one reason or another. In Sheffield it is no different but what is different is the work underway by all the main health and social care organisations to do things differently and reduce the number of times when a patient's transfer from hospital to home or the next stage of their support is delayed.

During last year, Sheffield's Teaching Hospitals, the City Council and Sheffield Clinical Commissiong Group teamed up to do an assessment of the reasons why we continue to have large numbers of people in hospital beds facing a delay to their discharge .

The results of this assessment focussed our priorities towards three pieces of work.

Help more people get home, faster (If not home, the next best, most independent, place).

Increase the capacity in community teams so that we can look after more people more quickly.

Help more people receive their assessments at home or in Intermediate care.

Our shared commitment to our older service users: When you need hospital treatment, there is no better place to be than in hospital. Once hospital treatments are completed, research suggests that you will do better at home, so getting you back there without delay is important. We will ensure that our services work together, are simple to use and will be available when they are needed, so that you have the help and support to get you home.

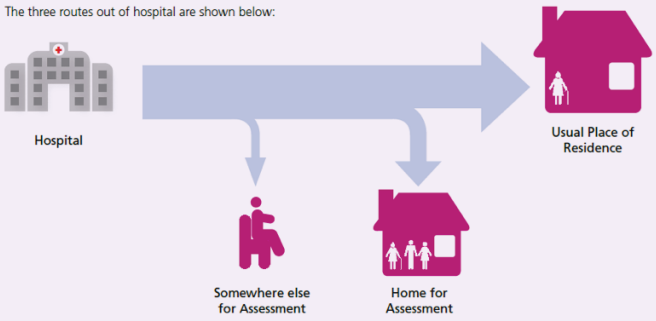
Home first assessment changes mean patients leave hospital more quickly

One of the key priority areas is how we can get more people who no longer need acute medical care home quicker (or if not home, the next best, independent place for them) and a significant change to the way in which people are assessed for their support needs is already having an impact on reducing the time it takes for someone to be discharged.

Most patients who leave hospital are able to return home with little or no support. Others may need help for a short time until they get back to normal, or may need help on a long term basis.

Traditionally patients have been assessed for their ongoing care needs whilst in hospital. However it is recognised that this environment is not a true reflection of how a person may be able to function when they are in the familiar surroundings of their own home.

Also waiting for the various assessments or indeed decisions about the most appropriate next place of care can mean patients wait longer than they need to in hospital when they no longer need acute care. As well as the potential risks of infection, falls or loss of mobility for the patient, it also means that their hospital bed cannot be used for any other patient who needs acute care.



With this in mind the usual discharge process has been tipped on its head and patients who are ready to move on from acute care no longer wait in hospital. They either go home where appropriate and are met by a team of specialists who assess what short or long term support they need to stay living independely. Or they move to an intermediate care facility where they are assessed for short term rehabilitation or indeed the need for a care or nursing home placement.

Laura Evans, Head of Therapy Services at Sheffield Teaching Hospitals NHS Trust, said: "The new process of assessment and discharge is showing early signs of success and that is thanks to the partnership between health and social care teams and by devising new ways of working."

First Contact team help Florence feel safe

First Contact is a new way of accessing social care services. A new team of social workers, care managers, prevention workers and occupational therapists are now available to support people contacting adult social care. The teams' aim is to provide an immediate response, manage crisis and offer prevention advice. The multi-disciplinary team also offers signposting, helps to avoid delays and reduce the number of hand offs between different services.

The First Contact team helped Florence. Florence was referred by the Fire Service because they had been called out 13 times to break her door down because she had fallen. Florence has arthritis in her knees, and most falls had occurred due to falling out of bed.

Florence was rolling out of bed because her king size mattress was on top of her double bed frame. Her key safe was not working. The First Contact team arranged a handyman to repair her key safe and recode it. They also sourced a double bed base and new mattress to fit properly. Florence is feeling safe in her home now and there have been no further calls to South Yorkshire Fire and Rescue.

Doris goes home sooner after surgery

A partnership between staff in the Surgical Assessment Unit and Geriatricians at Sheffield Teaching Hospitals is enabling elderly patients to return home from hospital more quickly.

Consultant Geriatrician Dr Rosie Lockwood said: "A lot of elderly patients come in to hospital with a surgical problem, but once they are surgically fit for discharge they end up remaining in hospital because of perceived problems about their ability to cope at home or outside of hospital. By working together with our geriatrician collegues to quickly identify these patients t we can get the support in place to enable them to leave hospital sooner."

The approach enables patients to return to the comfort of their own home much sooner, while ensuring hospital beds are not occupied for longer than necessary. The change is part of a wider partnership between general surgery and geriatric medicine, which has seen a reduction in length of stay (by 2.5 days on average) and an increase in the proportion of patients returning to their usual place of residence (up to 92% from 72%).

Doreen Norris, 86, of Fulwood, Sheffield, was assessed on the Surgical Assessment Centre after being admitted. After treatment she was able to return home just three days later having being given help to arrange support at home.

Virtual ward helps older people stay out of hospital

For a person with complex health conditions, a virtual ward is a way of offering targeted support. In Sheffield the electronic frailty index is used in combination with local clinicians' knowledge and experience of their practice population to identify patients who are most likely to benefit from a more intensive and proactive approach. The Virtual ward model is designed to bring together community professionals; health, social care and voluntary sector, to work in a person centred and holistic way. Virtual ward provides care and support to keep the most frail people well at home, promotes better self-care, self-awareness and increases patients' and carers confidence, which helps to make best use of the resources available.

For GP practices, a virtual ward provides a consistent, co-ordinated and proactive approach to caring for people with the most complex medical and social needs in the community, avoiding unnecessary interventions and admissions.

Dr Iolanthe Fowler, GP and Clinical Director, Primary & Community Services at Sheffield Teaching Hospitals NHS Foundation Trust, said: "Frail patients with long-term illnesses have complex needs. The virtual ward brings together GP's, community nurses, and therapists and links to wider community and specialist health, social care and voluntary sector services who will jointly coordinate care for people on the virtual ward.

In many instances other professionals such as pharmacists, local community support workers, Age UK, and/or advocacy workers are also invited to attend the virtual ward. There are good links between the professionals on the virtual ward and hospital specialists, particularly in care of the elderly. Conversations between community and hospital specialists are facilitated through our Single Point of Access (SPA). We are seeing more coordinated, patient owned care plans, with real benefits for patients.

What does a virtual ward actually look like?

The term 'virtual ward' suggests there's a physical building with a full team inside doing ward rounds but it merely mimics a hospital ward hence the term 'virtual.' It's a team of health, care and community professionals who work together virtually to coordinate the best wrap-around care for their most vulnerable patients."

How does a virtual ward differ from community nursing?

Community nurses care for housebound patients; patients with multimorbidity and complex needs, some of whom are very old/ frail. Patients on the virtual ward may be housebound and need community nursing along with other services too. The virtual ward ensures these services are coordinated to reduce duplication, improve continuity and patient's care.

What are the benefits of virtual ward to a person?

Not having to repeat your story. Knowing what to expect in terms of your care. Having the same team of professionals involved in your care who know what 'well' looks like to you personally, and understanding what matters most to you. So for example when Derek has a flare-up of his respiratory problems and has trouble talking, another healthcare professional can see from his 'OK to stay' (see below) care plan that this is 'common' for Derek and given a 'bit of time' and one of his inhalers, he can safely stay and be treated at home where he prefers, rather than go into hospital unnecessarily.

'OK to stay' plans developed in Sheffield

Rebekah Matthews is an Integrated Pathway Manager at Firth Park Clinic. Her role involves managing one of Sheffield's four localities of community nursing teams.

In July 2015 I developed the concept of the Okay to Stay plan to help us enable and support patients with complex long-term conditions stay at home and avoid unnecessary days in hospital, and help facilitate earlier discharge home. I wanted to see if we could find a better way to support patients at home, even if they become unwell. It all started with a workshop I arranged with geriatricians, ward matrons, hospital and community therapists and nurses, GPs, social services and the Yorkshire Ambulance Service.

Everyone was enthusiastic and during the workshop we started to develop the plan, which has been developed and operationalised by an ongoing steering group. We also involved patients and their families in the development of the plan from the outset.

The Okay to Stay plan has developed into simple document drawn up by a community matron with the patient. As well as including vital medical information, it paints a picture for any visiting health professional of how the patient manages at home, who supports them and what medication they need, including rescue medications if they become unwell. It also helps the patient to recognise an exacerbation of their condition and when/how they need to take their emergency medications.

The plan is completed on SystmOne (our clinical patient record), and is accessible via our Single Point of Access service based at the Northern General Hospital. The patient and/or their family retain a printed copy, which they are then able to share with paramedics, the ambulance service or emergency department staff.

The Okay to Stay plans encourage the development of a holistic action plan to help in the event of the person becoming more unwell. When completing the plans it adopts an enabling and self-help approach, and aims to increase confidence for patients and carers to manage their own conditions and access expert help at the appropriate time.

More recently we have started working closely with independent living advisors from AgeUK, who work closely with the community matron to complete the more social aspects of the plan with the patient. This has proven beneficial for the patients, as they have been able to identify and resolve issues such as finances, benefits, heating and social isolation.

Patients have said they feel more confident and supported, and are more aware of when they needed to go to hospital and when they could stay at home with support. It wasn't just the piece of paper that gave them the confidence; it was their interaction with the nurses and other professionals involved.and other professionals involved.

Mick's story

Mick was one of over 7,000 people in Sheffield who benefitted from a social prescription last year to help tackle the root cause of their ill-health.

Social prescribing is a 'prescription' for non-medical support or services that address a wide range of social, emotional or practical needs that can affect people's health and wellbeing.

Coping with bereavement, trying to find a new job or struggling with carer's responsibilities can all impact on someone's health. In these situations, people often turn to their GP for help but usually, it's a 'more than medicine' approach that's needed. GPs and other primary care professionals can refer people to a range of local, non-clinical services, which are often provided by voluntary and community organisations.

Mick's GP referred him to Sheffield's Community Support Worker Service as she was concerned around the 73 year old's mobility and that this could lead to falls. The community support worker worked with Mick to tackle his mobility problems, including sorting aids and adaptations for his home and helping him use community transport so he could get to the supermarket. Thanks to social prescribing, Mick has regained the independence he loves. His risk of falling is much lower and he feels far less isolated, both of which have helped to prevent further health issues or an avoidable hospital admission.

Sheffield Memory Service

Sheffield has a dementia diagnostic rate of 79.6% which is significantly higher than the national benchmark of 66.7%, which means people in Sheffield are far more likely to access support with memory problems than elsewhere in the country. More people are receiving ongoing support and treatment appropriate to their specific needs as it provides a bespoke service of support and education for both the service user and their carer which is tailored to the needs of the individual.

The current waiting time for referrals is 0-2 weeks. This means that for people in the community with worries about their memory, referral to diagnosis and treatment is between 6-8 weeks in total ensuring access to timely advice and support for both service users and their families and carers.

The Sheffield Memory Service has received the highest level 'accredited as excellent' status from MSNAP (Memory Services National Accreditation Programme), part of the Royal College of Psychiatrists

Mental health Liaison Service offers round the clock support to older people

We know that research shows that untreated mental health issues can lead to people spending longer than needed in hospital and also contribute to poorer physical health outcomes. By working closely with staff at the Hallamshire and Northern General Hospitals, Sheffield Health & Social Care's recently expanded 24 hour Liaison Service is making sure that patients in hospital or attending A&E get the right help, at the right time, in the right place. The Liaison Service offers a high-quality intervention, assessment and discharge process that covers all aspects of mental health - including drug and alcohol use and self-harming. The Liaison Service also gives advice on clinical management of patients and, if needed, can make referrals to other relevant services.