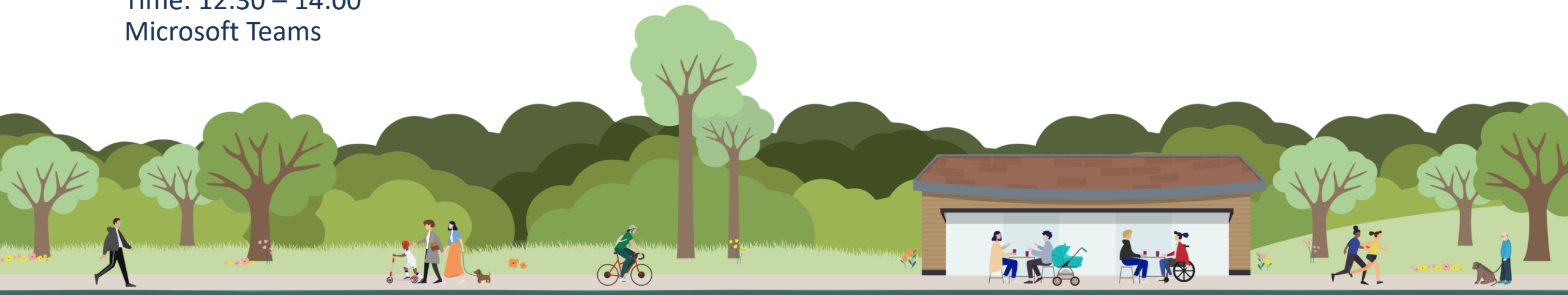
Leeds Health & Care Partnership

Care Home & Enhance Frailty Peer Support:

Date: Thursday 14th December
Time: 12:30 – 14:00
Microsoft Teams



#TeamLeeds

Care Home & Enhance Frailty Peer Support: Thursday 14th December at 12:30

Leeds Health & Care Partnership

Item No	Lead / Organisation	Title	Timing
1.	**Sue Wilkinson – ICB** **Chair** Senior Pathway Integration Manager	Welcome and Introductions	**12:30 – 12:35**
Main Items			
2.	**Jacqueline Tunnard** Project Manager – Virtual Ward, Frailty	Enhance Care at Home – Home Ward (Frailty)	**12:35 – 13:00**
3.	**Sue Wilkinson** Snr Pathway Integration Manager - ICB	Proactive Care – Update of national scheme	**13:00 – 13:15**
4.	**Dr Gill Pottinger** GP and Clinical Lead for End of Life care	Proactive work - looking at earlier identification of patients approaching EOL and a general refresh on developments with planning ahead	**13:15 - 13:45**
5.	**Sue Wilkinson**	AOB & Close Dates for 2024/25 and any items you'd like to see	**13:45 – 14:00**

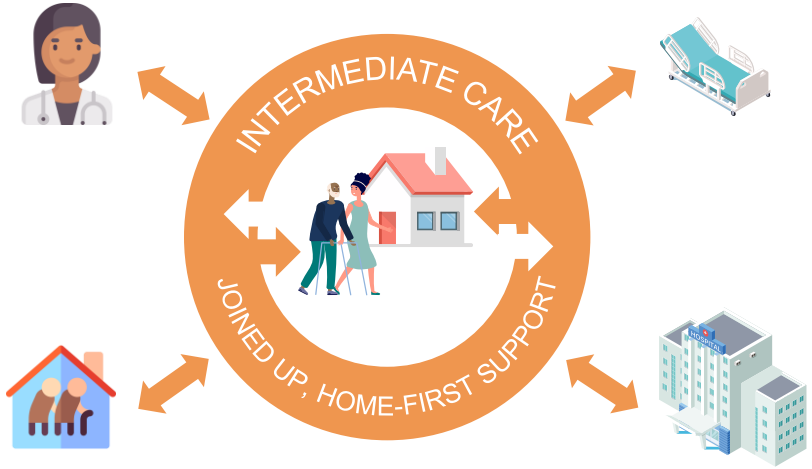
Home First Programme Overview including Enhanced Care at Home project (ECaH):

Care Homes &
Enhance Frailty Peer
Support Group

HomeFirst Programme | Leeds Health & Care Partnership

HomeFirst Programme Vision

A sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence



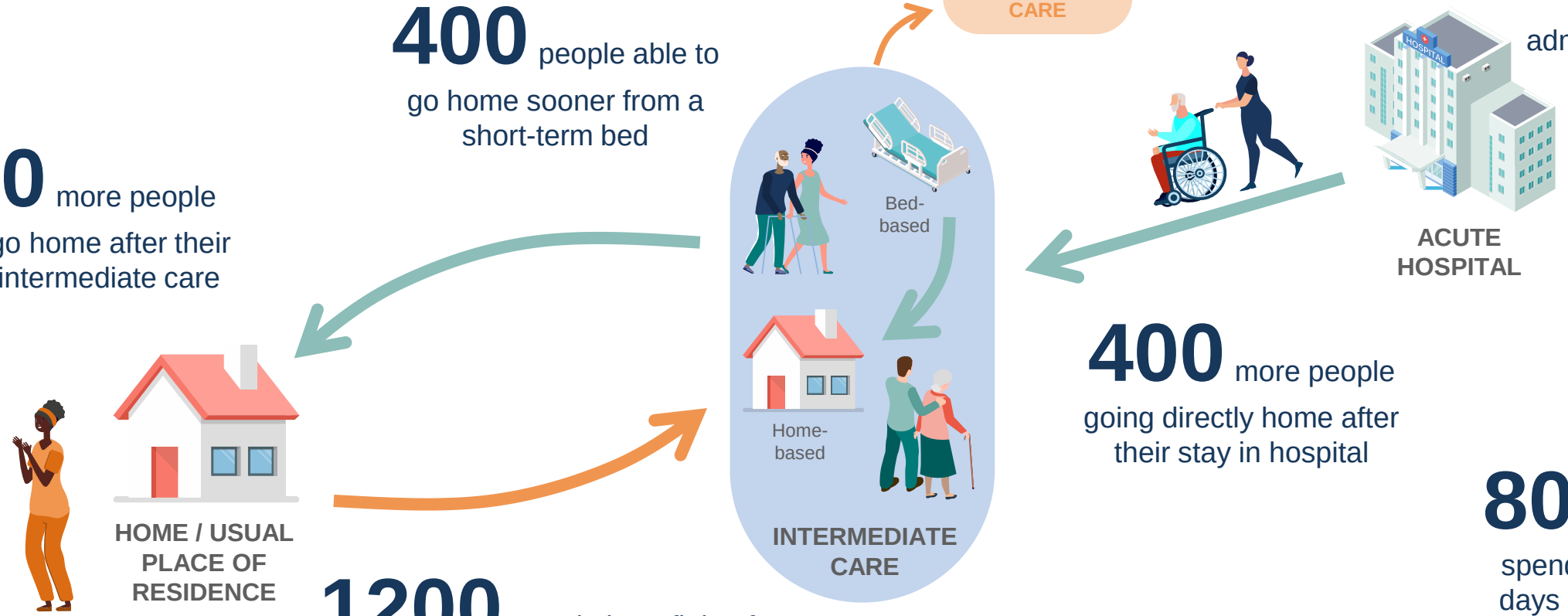
Programme Aims (Outcomes)

Based on the evidence gathered in the diagnostic, each year we could see…

400 people able to go home sooner from a short-term bed

100 more people able to go home after their time in intermediate care

1,700 fewer adults admitted to hospital



400 more people going directly home after their stay in hospital

800 people spending fewer days in hospital

1200 people benefitting from a more rehabilitative offer in their own home

The proposed scope and plan is designed specifically to deliver these benefits

5 Interdependent Projects

What is Enhanced Care at Home?

Enhanced Care at Home is a partnership between:

- West Yorkshire Integrated Care Board
- Leeds Community Healthcare NHS Trust
- Leeds Teaching Hospital NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds City Council
- Leeds GP Confederation
- Age UK Leeds

The Enhanced Care at Home partnership is proud to bring together health and care providers from across the city to deliver fast and effective care outside of a hospital setting for adults in Leeds.

This will help people, who may not need to go into hospital, stay at home where they are most comfortable and support others to return home more quickly after receiving care in hospital.

You may have previously heard it referred to as Enhanced Community Response.

What is Enhanced Care at Home?

Enhanced Care at Home includes six main health and social care offers which we call:

- **Quick Response**
- **Emergency Cover for Carers**
- **Rapid Response to Falls**
- **Home Ward**
- **Remote Health Monitoring**
- **Home Comfort**

Quick Response

Quick Response provides assessment, care, and support to people at home over the age of 18. It is for people who are experiencing a health or social care difficulty and who are at risk of needing to go to hospital within the next two to 24 hours. The team aim to respond within two hours. A multi-disciplinary team from across the partnership supports the Neighbourhood Teams to provide this urgent care. You may have previously heard this referred to as Urgent Community Response or Rapid Response.

How do I refer?

Out of Leeds referrers such as Yorkshire Ambulance Service and 111 should call Single Point of Urgent Referral (SPUR) on 0113 843 2291.
GPs and community health and social care practitioners can refer directly to the appropriate Triage Hubs: North (0300 300 2999), South (0300 300 3050), West (0300 300 0940).

More information on the areas covered by each Triage Hub can be found here: www.leedscommunityhealthcare.nhs.uk/our-services-a-z/neighbourhood-teams/

Emergency Cover for Carers

Emergency Cover for Carers supports carers and patients to prepare plans to use in the event of an emergency and action them quickly, to reduce the impact on the person who needs care if their usual carer is unable to care for them. Leeds Telecare will store this plan on a database to support easy access. They can also support individuals and their carers to find alternative carers if needed. If a healthcare need is identified, our **Quick Response** team will be contacted. You may have previously heard this referred to as Emergency Carers Support. The management of this moved to Leeds Telecare in April 2023.

How do I refer?

You can find out more information about how to register an emergency care plan with Leeds Telecare on www.carersleeds.org.uk/emergencyplanning/ or you can call Carers Leeds Advice Line on 0113 380 4300.

Rapid Response to Falls

Rapid Response to Falls helps people who have fallen and who have been identified by the ambulance service as having a minor injury or no injury and who do not require an ambulance to take them to an emergency department. It is provided by Leeds Telecare who respond quickly to avoid the person who has fallen having to wait longer for someone to come and check that they are safe and comfortable. All adults in Leeds are eligible for this support. This offer launched in December 2021.

How do I refer?

Patients can only be referred by the Yorkshire Ambulance Service.

Remote Health Monitoring

Remote Health Monitoring uses digital equipment to remotely check a patient's vital signs from the comfort of their own home and alert them and healthcare professionals when needed. It can support those who would benefit from having their health monitored but who do not need to be in hospital, for example those who are on the **Home Ward**. It can also support people to return home sooner after a hospital stay. Patients can contact health professionals easily and will have regular opportunities to speak to their healthcare team. It may be part of a wider package of care and patients may need to attend hospital on occasion. We aim to launch this offer by the end 2023.

How do I refer?

Updates will follow as the offer develops.

Home Comfort

Home Comfort provides emotional and wellbeing support rather than clinical care. It is available to adults in Leeds aged 60 and above, aged 55 and above living with frailty and those aged 50 and above who live with severe frailty. The Home Comfort team work with people and their healthcare team to make flexible short-term plans to support the person's needs. This support can include checking someone's safety, sign posting to warmth schemes, providing food packages, doing shopping and picking up prescriptions. This existing service is provided by Age UK Leeds and has been developed to support and compliment other areas of Enhanced Care at Home.

How do I refer?

Call their dedicated coordinators on 0113 389 3012.

Home Ward

Home Ward is the collective name for our Home Ward (Frailty) and Home Ward (Respiratory). Both wards are there to provide support and care to people who become suddenly unwell but can be safely cared for in their own home. They can also support people to return home from hospital sooner. They work in a similar way to a hospital ward; a multidisciplinary team with different specialisms work together to support patients effectively.

Home Ward (Frailty) is led by the Neighbourhood Teams with support and specialist input from across the partnership. It is there to assess and provide clinical support to people over the age of 65 who live with moderate to severe frailty.

Home Ward (Respiratory) is there for people of any age with chronic obstructive pulmonary disease (COPD) care needs and is led by the Community Respiratory Service. You may have heard them referred to as the Virtual Ward (Frailty) and Virtual Ward (Respiratory), or Hospital at Home.

How do I refer?

Home Ward (Frailty) - Healthcare practitioners in Leeds can contact 0113 843 2291. Home Ward (Respiratory) - Healthcare practitioners in Leeds can call 07739 970 431.

Home Ward (Respiratory) – Referral Criteria

- GP Referrals: Acute Exacerbation Chronic Obstructive Pulmonary Disease (COPD)
- LTHT Referrals: Acute Exacerbation Chronic Obstructive Pulmonary Disease; COPD with pneumonia (stable and on oral antibiotics); COPD with Bronchiectasis (+/- CIVAS); Bronchiectasis (+/- CIVAS) COPD/Asthma overlap
- Patient has a Leeds-based GP /registered with Community Resp team past or present/ confirmed diagnosis
- Care episode expected to be completed within 2 weeks of admission to Home ward Respiratory
- Patient needs can be managed safely at home with an enhanced package of care up to 4 times a day
- Care needs are temporary as there is an expectation the individual will recover from the episode of ill health

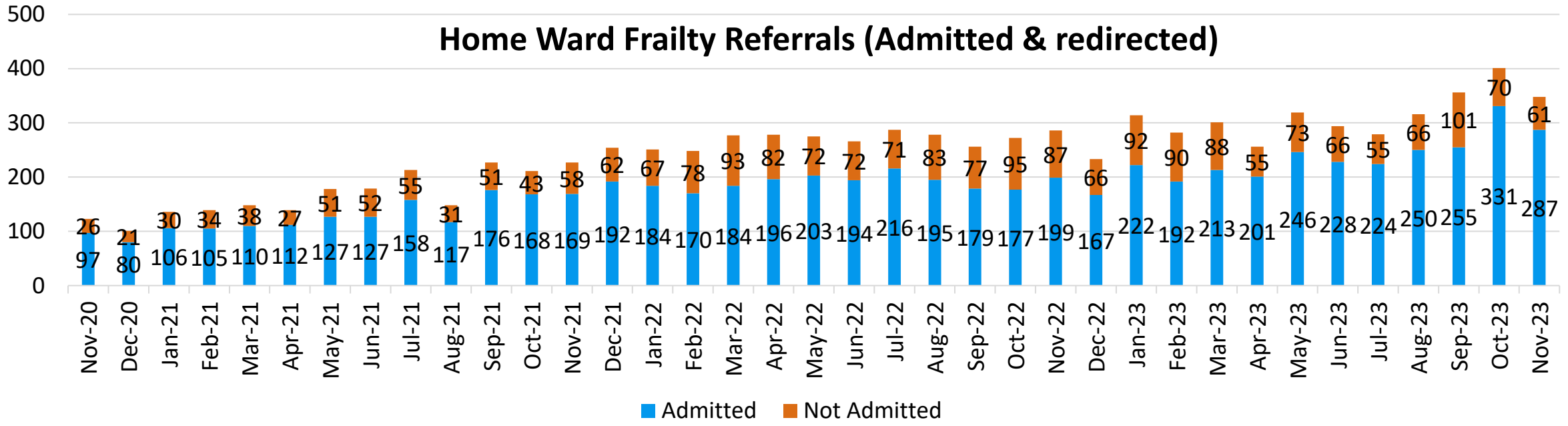
Home Ward (Frailty) – How it works

- 24/7 as an enhanced offer of the Neighbourhood Teams/Neighbourhood Night Service
- Referrals taken 8am-8pm via SPUR (0113 8432291), referrals received after 5.30pm will be seen the next day
- Referrals received before 5.30pm will be seen within 2 hours if clinically required
- Clinician to clinician discussion re appropriateness of referral
- Decision to accept for assessment or decline
- Community Matron assesses, bloods taken and processed within an hour of being received at the lab
- 24/7 medical cover OOH

Home Ward (Frailty) – Referral Criteria

- Patients must be registered with a Leed GP
- Age 65 or over
- Moderately/Severely frail (Efi/Rockwood 5 or more)
- NEWS2 5 or less (dependent on baseline/3 in one parameter)
- Patients not displaying signs of acute episode that requires hospital attendance /admission e.g. MI, stroke, DVTs, sepsis , surgical emergencies, fractures etc

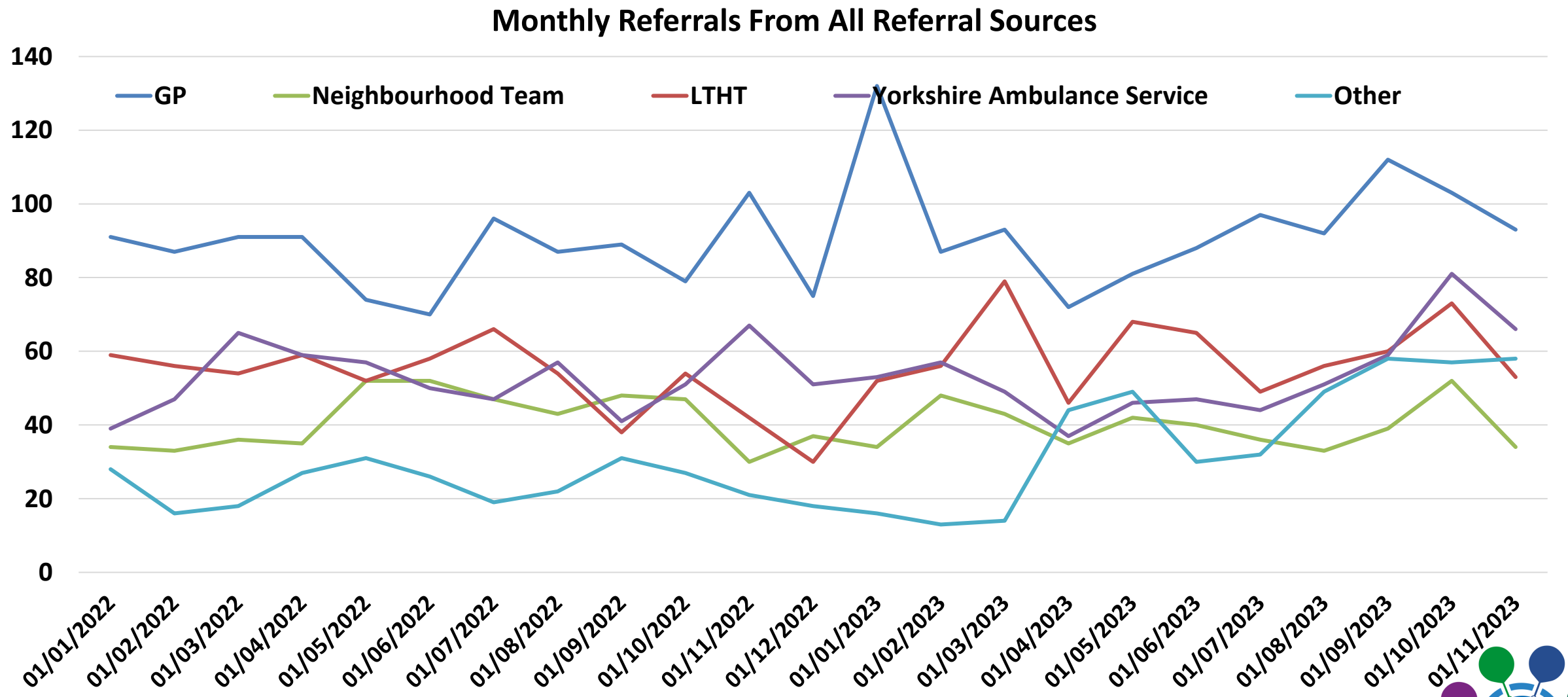
Home Ward (Frailty) Performance Information



Top 5 referral reasons	
Falls	12%
Heart Failure	10%
Chest Infection	9%
General Deterioration	8%
UTI	7%

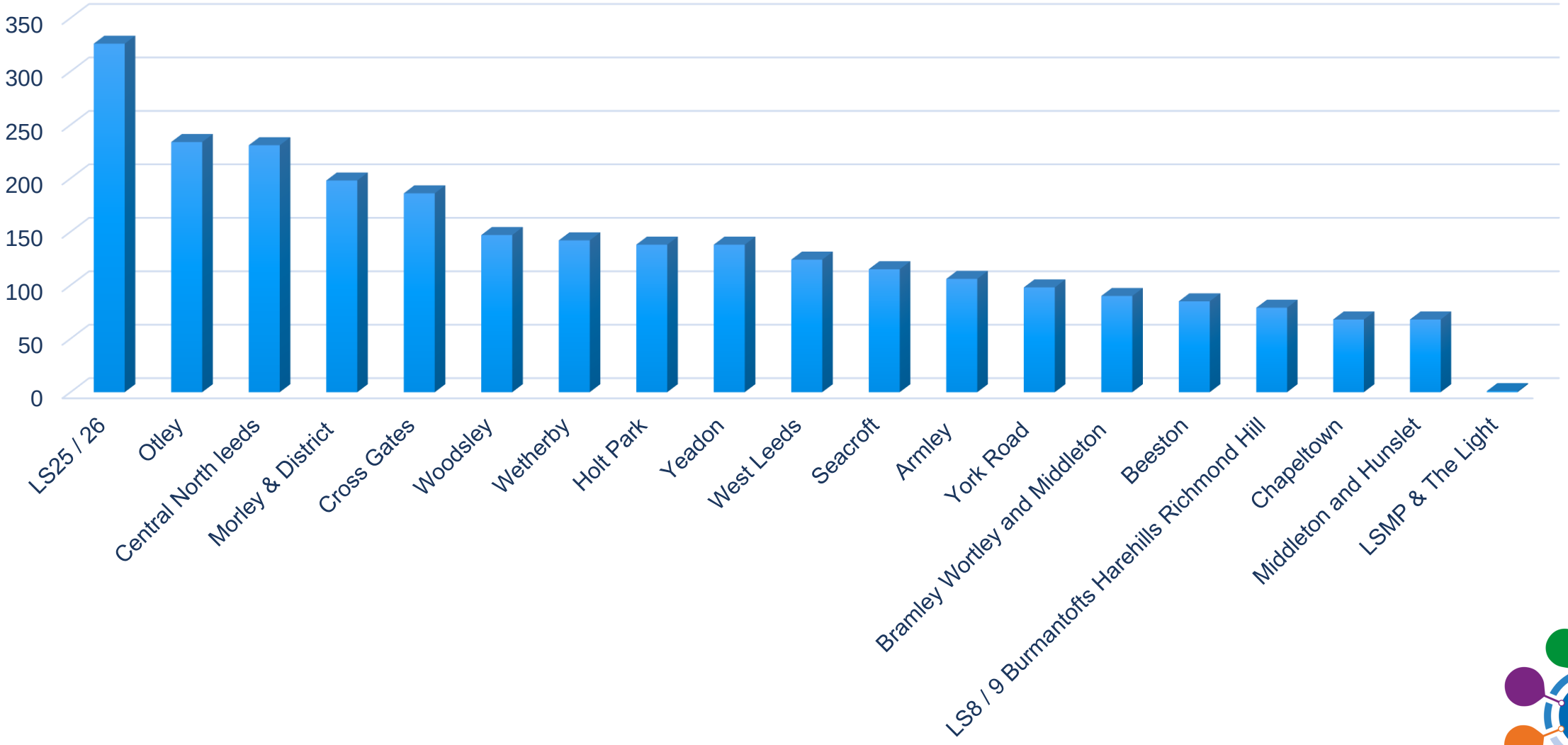
Data Measure	Total	%
Total Referrals to Home Ward Frailty Nov 2019 - Nov 2023	9545	
Top 5 referrers		
GP Practice	3151	33%
Yorkshire Ambulance Service	1562	16%
Neighbourhood Team	1553	16%
Elderly Medicine Ward	1323	14%
SDEC (Same Day Emergency Care) - Older Person	418	4%
Emergency Department	346	4%

Home Ward (Frailty) Performance Information



Home Ward (Frailty) Performance Information

Home Ward Frailty PCN Referrals Nov 19 - Oct 23



Home Ward (Frailty) Performance Information

Top 10 GP referrers over past 6 months

NT	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	
Chevin Medical Practice	6	3	9	5	10	5	**38**
Colton Mill Medical Centre	5	7	4	9	4	6	**35**
Ireland Wood Surgery	5	4	8	1	6	7	**31**
Oulton Medical Centre	2	8	1		9	2	**22**
Garforth Medical Centre	3	4	3	3	3	5	**21**
Boston Spa Surgery	1	7	3	4	3	3	**21**
Windmill Health Centre	1	4	1	4	4	2	**16**
The Street Lane Practice	2	1	1	8	3	1	**16**
Lofthouse Surgery	2	2	2	4	4	0	**14**
Shaftesbury Medical Ctr.	2	4	1	3	0	3	**13**

Next Steps for the Home Wards

- Continue expanding the capacity of the Home Ward by December 2023
- Reviewing referral pathway to ensure both Home Wards can be accessed through the same access point.
- Point of Care Blood Testing
- ICE system into the 13 neighbourhood teams

How you can help us decrease hospital admissions further

- Cascade information on Enhanced Care at Home offers and Home Ward (Frailty) referrers leaflet to your colleagues
- Inform us of the best communication routes with yourselves
- And inform us on how we can support more referrals from Primary Care

Where can I get more information?

- Home Ward (Frailty)- online referral information for health and care professionals

- Leeds Health and Care Partnership website: HomeFirst

- HomeFirst Highlights: Look at previous issues of our monthly newsletter here
- (Each issue includes a brief introduction to each project)

- Or go straight to December's update

Send us an email and/or join our mailing list for updates:

You can contact wyicb-leeds.homefirst@nhs.net for more information, to sign up to HomeFirst Highlights, and receive information about our next Q & A session online.

Proactive Care Updates:

Leeds Health & Care Partnership

Proactive Care:

- National Proactive Care Framework
- Healthy Leeds Plan
- Enhanced Health in Care Homes Framework

National Proactive Care Framework:

- The initial focus is on people with MLTCs **at risk of unplanned care**, living with frailty, reliant on **unplanned care** for their planned care needs and experiencing **health inequalities**

- **PCN DES 2022/23** : Anticipatory Care* NHS England » Network Contract Directed Enhanced Service (DES)

  - ICSs have a responsibility to design and plan Anticipatory Care for their system

  - PCNs must contribute, working with other providers with whom Anticipatory Care will be delivered jointly, to ICS-led conversations on the local development and implementation of Anticipatory Care

*now Proactive Care

National Proactive Care Framework:

- National Proactive Care Framework final draft- expected in NHSE Operational Guidance for 24/25
- PCNs key partners in delivering Proactive Care alongside Integrated Neighbourhood Teams
- Proactive Care – Frailty Test & Learn project – 7 areas trial of searches developed by DQT- to inform implementation in Leeds
  - Testing clinical searches, age bands from 50+, including ED/Admission/Discharge codes/ moderate and severe frailty
  - Feedback from trial mid February to inform implementation 2024/5
- BGS Proactive Care Group - engagement

Healthy Leeds Plan goals

Leeds Health & Care Partnership

<table>
<tr><td colspan="3">Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest</td></tr>
<tr><td colspan="2">Goal 1
Reduce preventable unplanned care utilisation across health settings</td><td>Goal 2
Increase early identification and intervention</td></tr>
<tr><td colspan="3">Focus on the 26% of people in Leeds living in the 10% most deprived areas nationally</td></tr>
<tr><td colspan="2">Leeds to achieve a 25% reduction in preventable, unplanned utilisation for those in IMD1 by 2028, against a 2022 baseline</td><td rowspan="4">To be determined</td></tr>
<tr><td>Frailty and Cancer Populations
Injury / Fracture</td><td>Children and young People
Respiratory Disease</td></tr>
<tr><td>People living with 3+ LTCs and SMI</td><td>End of Life
Respiratory Disease</td></tr>
<tr><td colspan="2">HomeFirst Programme</td></tr>
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Population Planning

Enabling the LHCP to set the population goals that it wants and is required to achieve

Transformation

Making the change and innovation happen to deliver these goals

Partnership management, development and coordination

Supporting partners, building and maintaining relationships and creating the conditions that enable the LHCP to deliver greater person-centred integrated care

....Through strong clinical and professional leadership

Ensuring clinical and professional leadership across the place is at the heart of planning, transformation and integration, and integrating clinical functions into place

National Anticipatory Care Framework

Draft for Discussion

Anticipatory Care will provide proactive and personalised health and care for individuals with multiple long-term conditions (MLTC), delivered through multi-disciplinary teams in local communities.

What are the aims of Anticipatory Care?

Anticipatory Care aims to optimise use of the health and care system for individuals with MLTC, by intervening earlier, proactively, and more holistically, whilst the patient is at home. This should:

- Reduce use of avoidable unplanned care by ensuring patients have access to the planned health and care support they need in the community
- Reduce avoidable exacerbation of ill health, reducing the need for more costly health and care provision downstream

AC will also contribute to the shared Community Care aims of: (1) reducing health inequalities (2) delivering a better patient experience, (3) further developing the evidence base for integrated care and (4) improve staff retention and satisfaction.

Who will be offered it?

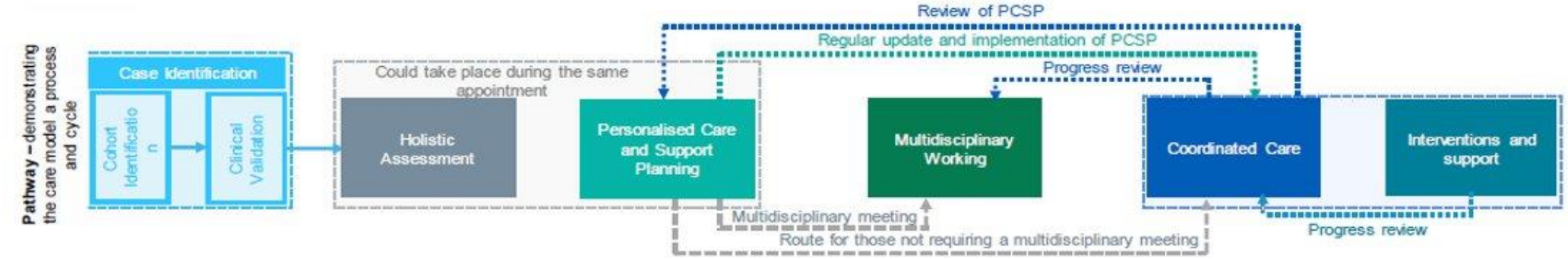
Anticipatory Care targets **individuals living with multiple long-term conditions, who also: (1) live with frailty, (2), experience health inequalities, as defined by Core20PLUS, and (3) are reliant on unplanned care services to meet their routine care needs.**

The people who should be offered Anticipatory Care first are those who are either at risk or admission, or have been admitted twice or more, in the last 12 months. This will allow us to prioritise individuals who are most at risk of adverse health outcomes.

What will their care look like?

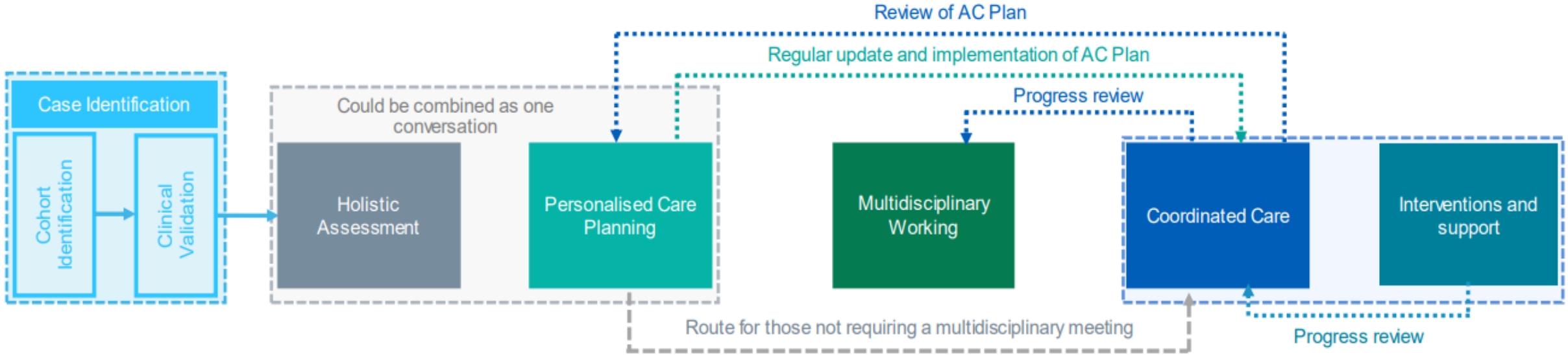
Individuals who are prioritised for Anticipatory Care will be offered:

- A **holistic assessment**, to understand their health and care needs which will be documented in a **Personalised Care and Support Plan** which is coproduced to ensure it outlines what matters to them, and their ambitions.
- **Multidisciplinary input** into their care, to reduce treatment burden and duplication of clinical and professional input, with the MDT suggesting appropriate **interventions and support** to help the individual achieve their goals.
- **Care coordination** from a single named contact, ensuring the individual is supported to make decisions about their health and understands their options.



The Anticipatory Care model comprises six overlapping components

Pathway – demonstrating the care model a process and cycle

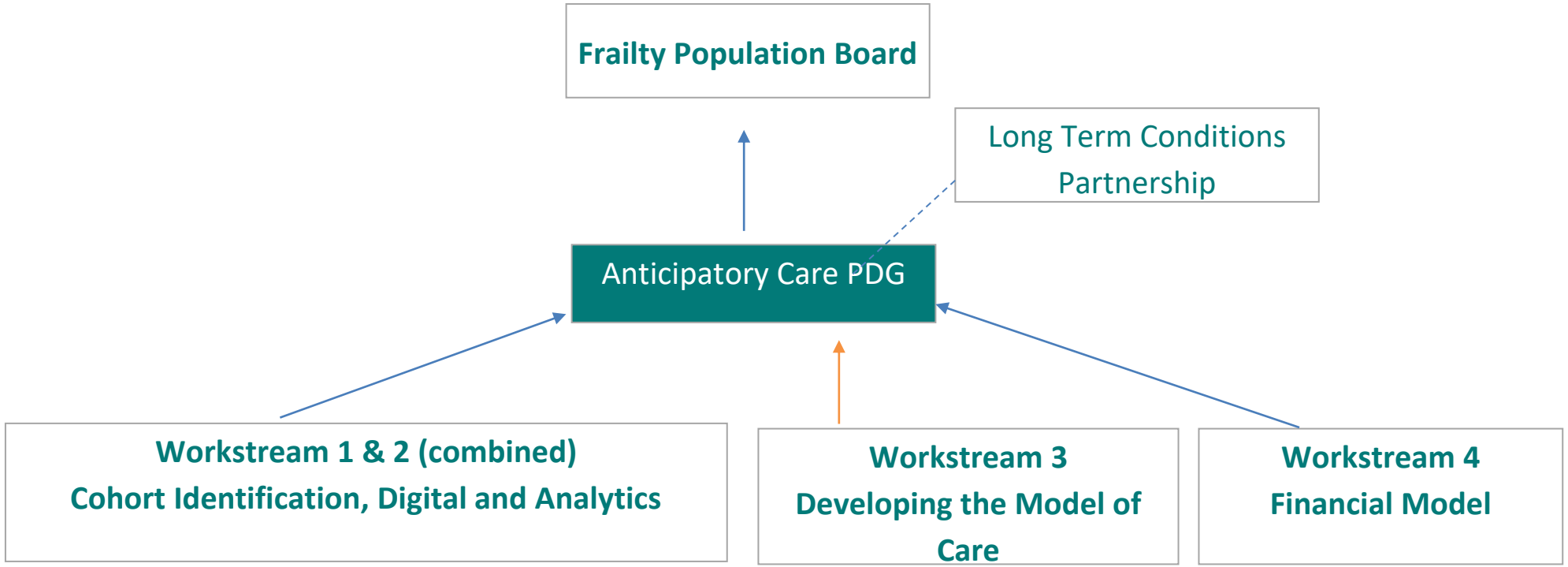


Case Identification	Holistic Assessment	Personalised Care Planning	Multidisciplinary working	Coordinated Care	Interventions and support
Data driven approaches will be used to identify individuals eligible for Anticipatory Care. Providers must clinically validate individuals as appropriate for AC before inviting for an assessment. Dynamic case lists must be maintained by the providers to allow for individuals to be added and removed as required.	Individuals who accept the offer of Anticipatory Care are invited to undertake a Holistic Assessment in a timely manner. The Holistic Assessment identifies the health, social and self-care needs of the individual. It covers details about the individuals personal circumstances, health history and current needs	Individuals should be empowered to take an active role in making decisions about their care through facilitated conversations. An Anticipatory Care Plan (ACP) must be coproduced with the individual. The Operating Model will set out the minimum content which must be included.	Multi disciplinary teams (MDTs) will recommend, and deliver care. The membership will be tailored to the needs of the individual. Multidisciplinary meetings (MDMs) will review the individual's progress, at a frequency based on the individual's needs and make recommendations for the individual's care.	All individuals will have a named coordinator assigned – either an ARRS role or a member of their MDT. The named coordinator should support the individual to understand the recommended interventions for their care and provide regular reviews of their progress and updates of their ACP.	MDTs will recommend clinical and/or non-clinical interventions which will be tailored to the individual's needs and preferences. The AC Interventions Framework will help areas establish AC, provide a common approach, be comprehensive and promote integrated personalised care

Progress in Leeds: Proactive Care Framework

- Leeds HomeFirst programme
- Primary Care Enhanced Frailty Scheme (Severe Frailty) - 3 year Scheme
- Plan for phased implementation aligned with HomeFirst & learning from existing proactive frailty teams in the city
- Identification of Proactive Care local cohort and opportunities – Test & Learn project
- Frailty education & frailty teams best practice films
- Multidisciplinary team (MDT) Survey

Leeds Proactive Care Programme Groups & accountability



Frailty Involvement Network

Leeds Carer Partnership Board

Health Inequalities
Tackling Health Inequalities Group (THIG)

NHSE released the draft national Anticipatory Care framework Aug 2022 at https://future.nhs.uk/CommunityHealthServices/view?objectID=143366053

Enhanced Health in Care Homes:

- Enhanced Health in Care Homes – refresh published 29 November 2023 ; NHS England » Providing proactive care for people living in care homes – Enhanced health in care homes framework
- The refresh of the EHCH Framework introduces more detailed guidelines, emphasising:-
- Holistic, integrated approach to care
- A shift towards digital integration
- Proactive healthcare strategies, and comprehensive, personalised care planning with a continued focus on SMRs and falls prevention and management.
- Primary Care seeking comments on the refresh – for further review in January 204
- No contractual changes or changes to indicators in this refresh – no proposals re 24/25
- Likely NHSE Regional Benchmarking exercise Spring 2024

Questions or Comments

Planning Ahead (ReSPECT/EPaCCs) Template

NHS
Leeds
Clinical Commissioning Group

AIM

To have one template to record and share advance care planning (ACP) discussions and decisions irrespective of prognosis or diagnosis

Produced collaboratively by:

LCH, Hospices, GP's and LTHT (with Resus Council)

Why?

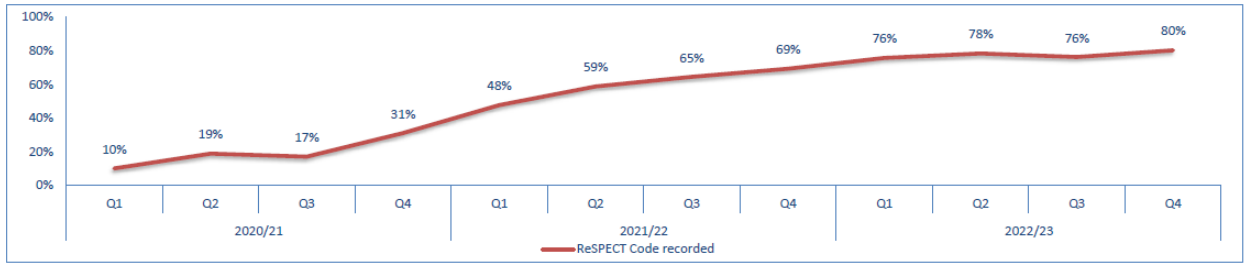
NHS
Leeds
Clinical Commissioning Group

1. Moving away from just End of Life Care
2. Include “What Matters to Me” to support personalised care
3. One location for ACP outcomes
4. Includes the updated Version 3 of ReSPECT

Part 2 - Leeds Health & Care Partnership EoL Data
2022/23 Report (Q1-Q4)

C2.7 Deceased EPaCCS patients who have ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Code recorded on the system.

Patients with ReSPECT Code	Q1		Q2		Q3		Q4	
ReSPECT Code recorded	533	76%	520	78%	611	76%	596	80%
ReSPECT Code not recorded	170	24%	143	22%	189	24%	146	20%
Total	703		663		800		742	



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ReSPECT Signatory requirements

NHS Leeds Clinical Commissioning Group

- Senior clinician
- Pre-requisites – development matrix
- Attend ReSPECT Training
- Planning Ahead Template training video
  - LPCN website / Final tab of the template
  - ‘My LCH’ intranet on Planning Ahead training page
- Advanced comms skills training
- Mentor support (experienced senior clinician)

Key messages

NHS
Leeds
Clinical Commissioning Group

- Unable to share ReSPECT across all clinical systems
- Risk around knowing the most up to date version
- Paper copy still needed, in particular for YAS
- ReSPECT must be completed within S1 via the Planning Ahead template
- Good communication between professionals essential – re changes / who best place to review etc

Frequently asked questions?

NHS
Leeds
Clinical Commissioning Group

- When should an existing ReSPECT form be reviewed?
- When should the form be returned to the patient?
- Can LTHT see a community ReSPECT form?
- What if the patient already has a ReSPECT form created outside SystmOne?
- What if there are discrepancies between versions of the ReSPECT form, or previous versions are unavailable?

Any other questions?

NHS
Leeds
Clinical Commissioning Group

Contact details

- gill.pottinger@nhs.net Primary Care
- sarah.mcdermott@nhs.net LCH

Website links

- Planning Ahead / ReSPECT Training Resources | Leeds Palliative Care Network

PLANNING AHEAD (ReSPECT/EPaCCS) TRAINING

Leeds Health & Care Partnership

- New ReSPECT signatories
- Existing ReSPECT Signatories who would like a refresher.
- Who work in: Leeds Hospices/ Leeds Community Healthcare Trust/ Leeds Primary Care
- Do you require training to become a new ReSPECT Signatory?
- Are you an existing ReSPECT signatory who has not attended any previous DNACPR or ReSPECT signatory training or would like a refresher?
- Do you support patients and those important to them to start to think about their care and future wishes as they become less well? Then this training is for you.

PLANNING AHEAD (ReSPECT/EPaCCS) TRAINING

Leeds Health & Care Partnership

Dates and times: (choose only one date and time)

Date	Time	Venue
Wednesday 21st February 2024	**09:00-12:00**	**Shine**
Tuesday 14th May 2024	**13:00-16:00**	**Bridge Community Church Conferencing**
Wednesday 18th September 2024	**09:00-12:00**	**Bridge Community Church Conferencing**
Monday 2nd December 2024	**13:00-16:00**	**Bridge Community Church Conferencing**

Facilitators: Palliative Care Clinicians from Leeds.
Booking: – To book onto one of these sessions please email: **LPCNcourses@st-gemma.co.uk**
All training will be held face to face and held at the venues indicated on the table. Once you have booked on you will be sent further information on the rooms and locations.
If you have any questions, please email: LPCNcourses@st-gemma.co.uk

Date and time of next meeting

Thursday 14th March 2024 12:30 – 14:00

Proposed Dates

Wednesday 26th June 2024	Click here to join the meeting
Wednesday 18th September 2024	Click here to join the meeting
Thursday 12th December 2024	Click here to join the meeting
Thursday 20th March 2025	Click here to join the meeting

Any items you'd like to see covered at future meetings??

Contacts:

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#TeamLeeds