Appendix 2

Reducing Non- Elective Admission - Update January 2016

Long Term Conditions

People with long term conditions continue to see variation in care and services. The current system fragments care for individual patients and the lack of continuity often leads to poorer outcomes and hospital admissions. There is limited proactive care and the standard of care is inconsistent across practices, there are multiple access points for patients, a level of inappropriate admissions and delayed transfers of care in a system where it is difficult to navigate between health and social care. Care is often only provided in response to a crisis or cry for help and there is poor access to information and data. The aim of this work is to:

- increase prevention and early identification of those at risk of developing a Long Term Condition
- standardise high quality care, reduce variation and ensure consistency across LTC management in all practices
- develop and implement SystmOne templates to support practices to manage patients with Long Term Conditions and improve quality and consistency of care

A number of templates have been finalised and were launched at a Long Term Conditions Conference in October.

End of Life Care (EoL)

The objective of the initiative is to avoid hospital admissions. This is done by East of England Ambulance Service Trust (EEAST) not conveying EoL patients to hospital (where appropriate) and instead working with the Partnership in Excellence for Palliative Care (PEPS), which is a single point of access for patients, carers and professions to co-ordinate care for the patient in their own home. The benefits of this initiative will be to patients who wish to remain in their own homes for EoL care. Through the PEPS service, patients receive a coordinated timely response that is appropriate to their needs. 42% of EEAST frontline staff have been trained on the End of Life Pathway/PEPS service and this initiative is showing reduction in non-conveyance. Actual numbers of non-conveyance has increased from 15 in April to 34 in August 2015.

Falls

The project aims to reduce the number of emergency admissions for falls by ensuring the opportunities for avoiding hospital admissions are maximised in the current pathway and by ensuring that Falls Prevention training is provided to high risk populations to both prevent falls and reduce the harm caused due to falls. It will identify populations at high risk of falls with proactive response through training to Care Homes and Domiciliary Care Providers and the extension of the Council's Urgent Home and Falls Response Service into Care Homes. A Falls prevention and awareness training programme is being offered to all Care Homes in Bedfordshire. The launch event for Care Home

training took place in September and representatives from 25 care homes attended, 34 people including EEAST, Complex Care Team and SEPT representatives. Further training is planned. Each Care Home will be asked to identify a falls Champion and a falls support/service director will be developed for Care Homes.

Care Homes

To ensure improved and consistent quality of care to care home residents with timely input to prevent/reduce inappropriate hospital admissions. Following a review of ambulance data, the Council and CCG are undertaking joint visits to care/nursing homes with high numbers of ambulance conveyancing to ensure they are getting appropriate support and accessing all services available to reduce the number of people transferred to hospital. PEPs is also being extended to provide information and advice to all Care Homes, so that patients and family members can be supported with enquires and decisions on preferred place of death for patients, avoiding unnecessary conveyance to hospital. PEPs are also delivering 5 Step EOL training to Care Home staff, designed to not only improve EOL care but assist with best interest decision making on preferred place of death.

This initiative will also identify any gaps in providing good physical healthcare, as well as promoting access to falls service, diagnosis for dementia and the End of Life pathway. An extension of the Council Urgent Falls and Homes Response Service into Care Homes is also being piloted.

In addition to these projects work is also under way, in view of **Winter Pressures**, to review bids for winter schemes to facilitate discharge. Systems Resilience Group is reviewing the proposals to meet winter challenges. £1.3m of funding has been allocated for winter pressures schemes across the Bedfordshire health system. It will support the following:

- Hospital at Home
- Clinical Navigation
- Ambulatory emergency care
- Discharge assessor