



# **Travel & Transport Group**

Care Closer to Home

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01/11/2017



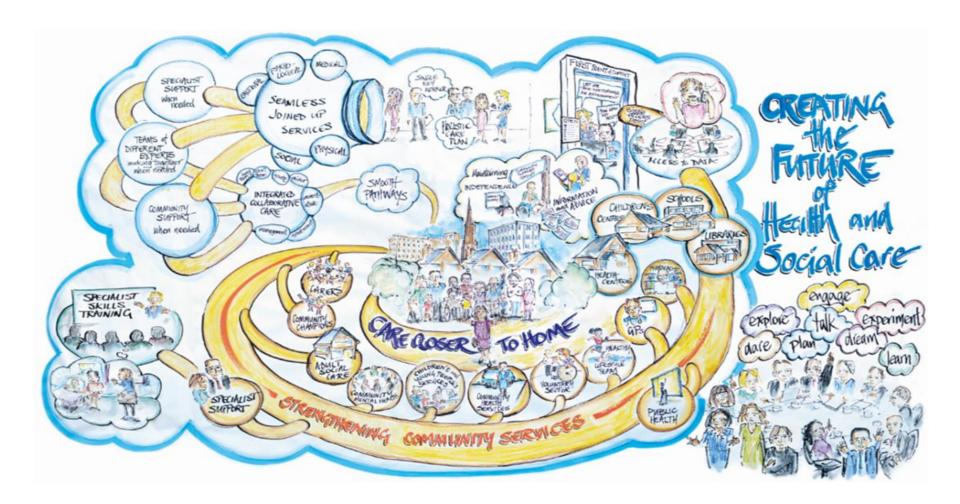


## **Calderdale Community Services**

- What community services are currently provided
- What shift will there be in the future for services including scale
- What is the time frame in the context of reconfiguration and 5 year forward plan







For full animation: http://www.calderdaleccg.nhs.uk/your-health/care-closer-to-home/





## **Community Services Provided by CHFT**

Community Nursing	Specialist Nursing	Intermediate Care	Community Therapies	Out Patient Therapies	Community Equipment Store
District Nursing teams & OPAT	Respiratory and Pulmonary rehab	Intermediate care bed base	Community Therapy	MSK single point of access	Community Diabetes Service
Out of Hours Nursing	Heart failure and Cardiac rehab	Virtual ward	Speech and Language Therapy	MSK	Community Midwifery
Community Matrons	Lymphoedema	Community Place	Nutrition & Dietetics	OP Physio	Community Paediatric
Quest Matrons	ТВ	CIT	Orthotics and Patient Appliances	Children's Therapy	Services
End of Life/Palliative	Parkinsons  Continence		Podiatry		Out Patient Clinics Todmorden
care	Multiple Sclerosis		Diabetic Foot screening		Safeguarding Team  – children, Domestic  Violence Hub
					Looked After Children's Team





### Integrated approach

### **CALDERDALE ADMISSIONS AVOIDANCE TEAM**

This will be a combination of the following integrated health and social care teams:

- Crisis Intervention Team
- Virtual Ward (Frailty)
- Hospital Avoidance Team
- Intermediate Care beds
- Reablement
- Falls Response Team
- **Community Place**

### CALDERDALE DISCHARGE SUPPORT **TEAM**

This will be a combination of the following integrated health and social care teams:

- Crisis Intervention Team
- Virtual ward
- Intermediate Care Beds
- Reablement
- **Community Place**
- Community Therapy
- Falls prevention team

#### Skillset available across the two teams

- **Physiotherapists**
- **Occupational Therapists**
- Qualified nurses
- Mental health practitioners

- . Assistant practitioners
- . Reablement support workers
- . Patient flow coordinator
- . Pharmacist

Social work

Members of the wider team will be allocated roles in either sub-team dependent on demand





## **Frailty Pathway**

**Equipment provision** 

Early support

Mobility

Care Package at Home



Falls prevention

Medical intervention

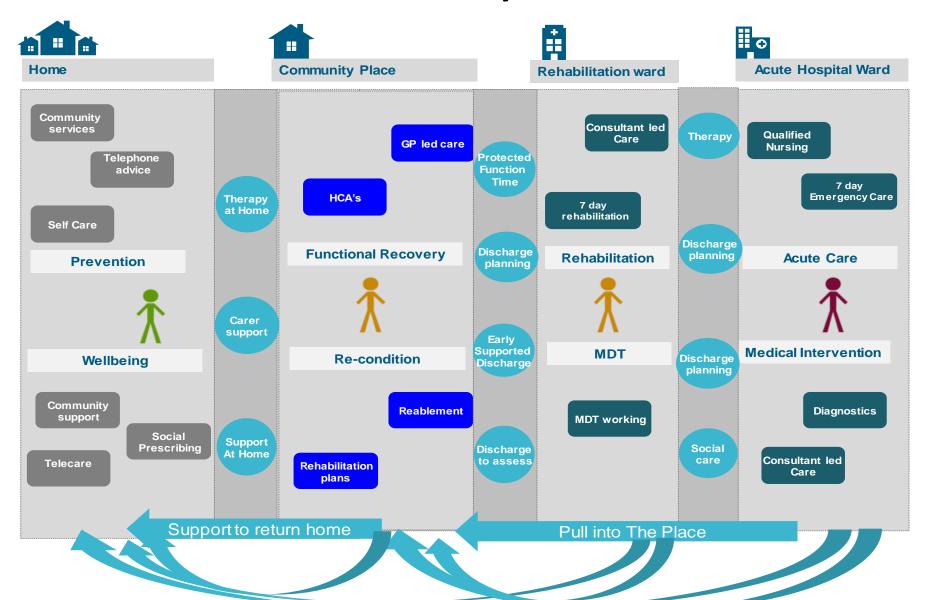
Intermediate Care

In first 3 weeks – 61 people seen, 25 people returned home within 72 hours, 9 hospital admissions avoided





### **Community Place**





# Care Out of Hospital Rehabilitation and Huddersfield

IMC + (phase 2)	IMC Beds	Recovery at Home	Community Place
24 hour nursing support	BBV - 24 hour nursing care provided by Four Seasons	Person at home and offered regular visits to maximise independence and recovery	24 hour care from Clinical Support Workers
Specialist therapy input (working across IMC beds and recovery at home)	FL- 24 hour social care provided by Social Services	Care plan developed by Therapist or assistant practitioner	Allocated Social Worker
Daily Physio and Occupational therapy	Daily Physio and Occupational therapy	Up to 4x daily visit from reablement worker to assist with functional activities and deliver therapeutic interventions within care plan	Therapy input while waiting for discharge destination
Allocated social worker	Allocated social worker	Weekly review by therapist or assistant practitioner	Social activities promoting independence
Mental Health Practitioner available	Mental Health Practitioner available	Link to mental health practitioner within team	
Up to 6 weeks rehabilitation	Up to 6 weeks rehabilitation	Individual care plans	
Individual care plans	Individual care plans	Care delivery in own home	
		Night calls available – call out service	
		Community nursing input to support nursing needs	





### **Quest for Quality in Care Homes**

Support to care home staff in managing complex conditions



Fnd of Life care

Pharmacy review of medications

Identifying and managing people in deteriorating health

Telehealth support to care homes

Guidance for care homes on managing falls risks in residents.

Supporting care homes who have been identified as requiring improvement by CQC





### Working in partnership to reduce falls

#### What did we do- Collaboration with the Fire and Rescue Service

Worked with the Fire Service, initially in Calderdale, but then across the whole of West Yorkshire, to develop their Safe and Well check so that it included questions about falls and falls risks.

Developed and delivered training to the fire crews about falls and falls risks.

Pilot of new Safe and Well check completed in Todmorden in January-March 2017.

### Why?

The NHS England Five Year Forward View makes it clear that sustainability of the NHS and associated social care services will only be achieved if there is a radical upgrade in prevention and public health. As experts in prevention and community engagement, fire and rescue services have a recent history of acting as a prevention agent on behalf of all health and care partners whilst continuing to reduce demand relating to fire.

#### **Results**

61 new Safe and Well checks completed during the pilot, resulting in 12 referrals to the Falls Pathway for a more detailed Multi-factorial falls risk assessment, and strength and balance intervention when appropriate. Less admissions to CHFT hospitals due to falls between Jan-March 2017 than Jan-March 2016. Overall admissions due to falls remains static, despite an aging population, and reduced excess bed-days in fallers. Ongoing training of Fire Crews, and Safe and Well check being rolled out across Calderdale.



# Finding Your Feet -



Strength & Balance Exercise Class

What is Finding Your Feet?

- It's a specialist exercise class programme which concentrates on improving overall strength and balance
- It improves confidence and the ability to carryout everyday activities for longer
- Who can attend?
- Anyone over the age of 50. They must be registered with a Calderdale GP and live in the local area
- Have a history or fear of falling, and/or problems with their balance
- Be generally fit and mobile and able to exercise independently

How is improvement measured?

By 3 functional protocols, which are:

- √ Timed Up & Go (TU&G)
- √ 4 Stage Balance Scale
- √ Functional reach







"The 13 week course has improved my mobility enormously and given me back my confidence"

"I have used a walking stick for the last 2 years
This course has reduced my need to only
use a stick when walking over rough ground"

"The team are very helpful, friendly and caring and helped improve my confidence"

"I am now able to do things that I haven't been able too for a long time"



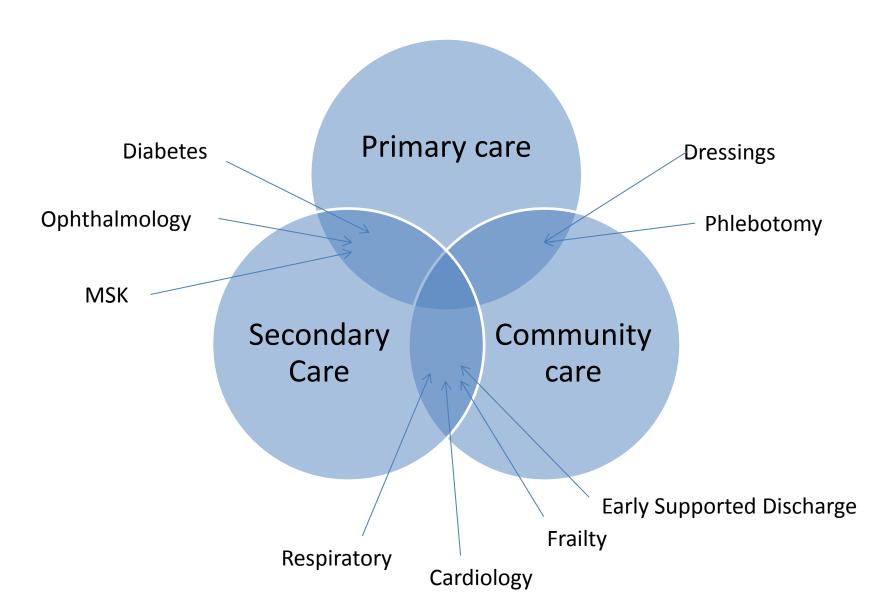
**Exercise Class** 

90% of patients said "they wished the course could be extended"





## **Integrated pathways**







### **Our future focus**

