Gateshead BCF Scheme Review – Overall Achievements, Challenges & Next Steps

BCF Scheme	Overall Achievements /What has worked well?	Challenges / What has not worked so well?	Key Next Steps to progress / re-focus work?
BCF 1: Single Point of Access	• Culture of inter-professional learning established and maintained (aiming for consistent decision making regardless of the call received and the needs identified). • Team Nurse now funded in a full time post within single point of access for a further 12 month contract. • Training needs analysis for SPOA has been carried out by Team Manager and Team Nurse, a training plan has been identified and training is to be carried out on a weekly basis. • Nurse has access to hospital information system [Medway] which supports efficiency in terms of SPOA staff time when contacting the hospital for information whilst also increasing quality in referral processing and safe patient / client outcomes. • The Rapid Response Service (BCF 7) receives all referrals through the SPOA and continues to work	• The SPOA is central to the overall reshaping of Care and Wellbeing services. There are challenges in managing the transition to new service models. • Linked with this is the associated challenge around ensuring staff are suitably trained to make the most of opportunities presented by the SPOA.	• Ongoing staff training and development (including education re health issues and conditions from team nurse). • Preparation ongoing for Multi-disciplinary working within SPOA to deal more efficiently with calls following restructure of Adult Social Care. • Nurse now full time and a member of the Vanguard Pathway of Care work stream with a view to exploiting opportunities for sharing education and training beyond SPOA team e.g. in relation to care home workforce development • Mobilisation and transformation of community services procurement process. The successful re-procurement of community health services will support the further development of the SPOA given the partnership provider arrangement formally established between primary and secondary care with the local authority.

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	closely with the team managers to ensure the single point is an effective route of access and the client gets to the right service first time. • Promotion of SPOA and Rapid response service to Primary care colleagues via Team Nurse and Team Manager.		
BCF 2: Alignment of locality based teams/frailty	This group focused on locality working attached to GP surgeries, for older person services. The plan was agreed by all parties as part of our original review of services and was awaiting an implementation date agreement to discuss further with staff members.	The challenges were: • Changing the present way of working; • Change of environment; • Change to mental health co-locality working; • The re-procurement of community health services.	In light of the revised service model we will need to re think how we will work in localities. Consider the scope to have locality working at the "front door". Now that re-procurement of community health services has been completed, once the new provider is out of the mobilisation phase and into the transformation phase we can expect to make progress. The model is for locality based integrated health and social care teams to work closely with a group of practices formed in response to the Transformation of Primary Care agenda.
BCF 3: Frailty co-ordinator role & alignment of hospital based frailty	A geriatrician has tested the model one day a week for a period of 3 months and outcome audit data suggests that it is possible to discharge 20-30% of older people providing responsive community services are	• Difficulty in recruiting a lead geriatrician. • Development of frailty nurse posts challenging because of community services re-procurement but now should progress in line with those	The model was for a multidisciplinary team to work in A&E and the assessment unit at QEH while also exploring the introduction of a frailty assessment unit. This will need to be reviewed in light of the challenges noted and the transformation of community

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	available. The frailty nurses have also recently sought to introduce their role and have undertaken a clinical audit which needs to be concluded.	developments.	services planned. Clinical audit by frailty nurses to be completed.
BCF 4: Enhanced Dementia pathway	• Dementia is a specific workstream in the Gateshead Newcastle Care Homes Vanguard (which will influence care in a much wider population than care homes alone). • Service review underway within Old Age Psychiatry in GHNFT aiming to improve pathways in conjunction with primary care. Aim for pre-diagnosis to death support for people with dementia and their families via primary care, secondary care and the third sector working in partnership. • Diagnosis rates continue to improve across the borough. • Challenging behaviour in dementia teams from GHNFT and Mental Health Concern are now clinically working in partnership. • Dementia nurse specialist appointed for Queen Elizabeth Hospital and now in post.	• Ongoing fragmentation of diagnostic and treatment pathway between Memory Protection Service (NTW) and Old Age Psychiatry (GHNFT). • Going forward, there is the challenge around how the new ASC model will meet the demand for older people's mental health assessments. This will need to be monitored to ensure mental health assessment needs are met.	• Continue Vanguard workstream. • Continue GHNFT service review and aim for clear timescale for implementation. • Agree future direction of Memory Protection Service in Gateshead.

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BCF 5: Expansion of Ambulatory Emergency Conditions pathways	A successful pathway has been developed so that patients can safely leave hospital (step down) for continued administration of intravenous antibiotics for a range of conditions (not just patients with cellulitis).	It has been challenging to develop similar arrangements for community administration of intravenous antibiotics (step up) due to community access to some drugs not being readily available, and community staff being employed by a different Trust to the hospital pharmacy team which meant access to the drugs could not be facilitated in this way.	NETS The North East Transformation System (NETS) team have been commissioned to review current work of the Ambulatory care service and then to scope the potential for expansion of work (surgical pathways) which will include the accommodation , workforce and equipment requirements. NETS has started to do this work with the Ambulatory Care team. The Rapid Response task and finish group of the Care Home Vanguard project will expedite the development of community administration of intravenous antibiotic pathways (supported by the successful re-procurement of community services as described above).
BCF 6: Enhanced 24/7, seamless palliative care	EOL Strategy signed off by the long term conditions group, Dec 2015. The benefits of EoL supportive social care being easily available has been identified and agreed by the strategy group and access to this needs to be incorporated into the further development of the SPOA in BCF 1.	Clarity regarding what is required in terms of SPOC and access/availability of social and supportive personal care .	The Care Home Vanguard project has established a task and finish group for end of life care. As a result, the EoL strategy group will revisit its TOR and composition to look to include its work into this work stream if feasible. Dr Sarah Louden is now the CCG lead in this area and is a member of both groups. A bid was previously submitted by the EoL Strategy Group seeking to improve access to supportive personal/social care and the

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			progress of this needs to be fed into the Vanguard Care Home group for further consideration.
BCF 7: Establish an urgent response domiciliary support service	Since the commencement of the Rapid Response service in April 2015, the service has exceeded the KPI of preventing 0.2 admissions per day, supporting 465 individuals in a crisis situation, preventing 105 hospital admissions and possessing an average response time of 54 minutes. The service has effectively developed excellent relations with NEAS, A&E and ECC in preventing unnecessary hospital admissions and facilitating hospital discharges. The Social Work Navigator role employed within the Rapid Response service has proved a great founding for operational practices within the new Enablement service.	Uptake from GPs to maximise step-up preventions in respect of the service has been under continual review. The acquisition of transport in order to step-down people from the hospital wards has been difficult to secure. The hospital supportive discharge team is separate as is the reablement service which may cause fragmentation in seeking to facilitate rapid and most timely hospital discharge. The separation of the services means that more work needs to be done to fully understand approaches to service delivery.	Continual operation of the service, accentuating the high standard of the service provision. The presence of the service within the Queen Elizabeth Hospital's ECC and A&E department is paying dividends with individuals being seamlessly discharged back to their own homes (as opposed to spending time on an acute ward) from support by the Rapid Response service. Consequently, the service will preserve this arrangement seeking to further enhance relations with both QE and Community Nursing and Therapy teams. Gateshead Council's Adult Social Provider service continues to scrutinise the number of PIC emergency admissions in line with referrals into the Rapid Response service to ensure that individuals are being supported in their own homes as much as possible. 69 of the 465 referrals (15%) made into the service have been from GPs. In light of a predominant objective of the service to provide an alternative resource for GPs to

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			use people's homes as opposed to a residential setting to prevent a hospital admission , this is a figure that needs to be continually evaluated. The transformation of community health services following the mobilisation period provides an opportunity to streamline all prevention of admission and facilitation of timely discharge services.
BCF 8: Alignment of discharge support teams	A working group focused on aligning hospital discharge with community matrons/district nurse/social work teams. Early meetings were being used as learning sessions which proved helpful.	Maintaining the momentum of the working group.	This will be further developed in line with the Transformation of Community Services expected from October 2016 and BCF 7.
BCF 9: Expansion of intermediate bed based care services	Eastwood has established a community beds model providing recovery, rehabilitation and reablement support to facilitate timely discharges from hospital and prevent unnecessary hospital admissions. The centre has an 'admit to assess' ethos in which an MDT will seek to achieve the primary objective of discharging people home to continue independent living. The Intermediate Care beds	A review of planning meeting functions was required within the centre. Handover times were modified and a handover tool produced to enhance the channels of communication between social and health care practitioners. Anecdotal evidence suggests that the admit to assess criteria may not be as effective as first thought with a number of patients being	The future of intermediate care beds in Gateshead will be progressed through the Care Home Vanguard Pathway of Care team. Clinical audits are currently underway reviewing patients admitted or readmitted to hospital and those being discharged from Eastwood into their own home in light of the anecdotal evidence identified. Further information will be gathered from

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	have a 89.4% occupancy rate, with 181 individuals using the 15 IC beds with a 73% home discharge rate.	readmitted or admitted to hospital.	analysing the review of Eastwood service users within weekly MDTs.
BCF 10: Expansion of Gateshead Care Home initiative	The programme has continued to develop through the integration with the Care Home Vanguard Programme. Pathway of Care Group established that is considering aspects of care of the over 65 population living in residential and nursing care homes while also considering now those living in their own homes. MDT is more structured and now has support from a MDT Co-ordinator.	IG issues around transfer and holding of personal identifiable information that supports the MDT. Confirmation is awaited of an indicative budget allocation of £1.6m linked to the delivery plan for the care home Vanguard programme. As the indicative allocation represents 40% of the 'ask', this will represent a challenge going forward.	Secured funding for 2016/17 will enable the continued development of the programme and will specifically ensure that further older person nurse specialists can be employed to support the roll out of support into residential care. A review of intermediate care services are underway linked to Gateshead Council's funding position. Baseline audits are currently being undertaken to seek learning that can inform best practice standards for the care home 'ward rounds', and Community MDT 'virtual ward'. The Pathway of Care Group will become members of Gateshead's Older People's Partnership Board and Malnutrition Alliance so as to reduce the risk of duplication and further enhance integration.
BCF 11: Enhanced Falls service	Two days Programme Lead for Older	Patients requiring vestibular rehabilitation	Support further collaborative working and,

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	People resource from Public Health Department developing the collaborative approach to falls prevention and older people agenda. This post works in an integrated approach to managing the falls prevention strategy (two days per week). This staff resource is in addition to the BCF funding. Development of a Falls Pathway for Gateshead, in agreement with the local falls prevention strategy group. Reviewing/ increasing membership of the falls prevention strategy group to increase representation from key stakeholders. Recruitment of Falls Educator/ Co-ordinator. Development and delivery of standardised falls awareness training to Gateshead Council staff . Plans developed to include other staff groups e.g. care homes and members of the public. Mapping of strength and balance	are required to access services in Sunderland/ Newcastle - there is a gap in vestibular rehabilitation services in Gateshead. Two nurses and an occupational therapist have received training in this approach, however there are inadequate links to ENT and a lack of specialist equipment to implement this at present. Anecdotal evidence suggested that some patients referred to specialist services could have been referred to other falls prevention and management services instead. A new pathway was introduced streamlining the referral process in 2014. This needs to be evaluated. Linking in with Leisure Services to provide evidence based falls prevention exercise classes.	as part of this, consider how it will be resourced. Support further collaborative working/ integration between specialist fall team and other providers such as social care, NHS staff, care homes, primary care, etc. Development of an action plan for falls prevention in Gateshead. Ensure greater collaboration between NEAS and specialist services. Review quality of falls prevention initiatives being utilised within A&E. Work with specialist nurses to evaluate management of falls within care homes in order to support development of : - Policy - Practice - Education - Care planning Develop a formal strength and balance network with opportunities for all those over 65. This will involve increasing delivery of evidence based options such as Tai Chi, Otago and Postural stability to be provided in both 1:1 and group settings. It will also

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	opportunities in relation to the needs of the population. This will link with the social prescribing agenda allowing health care staff to navigate patients to appropriate classes Utilising data from NECS/CCG/ Trusts to inform where focus for change is required. Development of preventative strength and balance opportunities, including : - Tai chi classes deliveredat Older People's Assembly; - Postural stability instructor employed through Older People's Assembly (external/ independent funding) to deliver 4 classes per week across Gateshead; - Otago course hosted for 16 local staff to enable 1:1 and group provision within reablement/ community therapy/ day centres/ specialist services/ voluntary sector. Trialling of RCP guidelines/ post-fall bundles outside of acute hospital (within promoting independence		require forging stronger links between leisure and private providers to develop maintenance options that are self- sustaining and appropriate. Provide a data base for all Falls Prevention Exercise classes in Gateshead to enable the staff and public to be aware and access the classes most benifical to them. Broaden falls training package to primary care, voluntary sector, care homes and the public. Work collaboratively with the fire service to develop falls screening as part of their Home Safety Checks. Consider applicability of RCP guidelines/ post fall bundles within care home settings. Look at options to 'join forces' and develop a joint strategy for falls across Newcastle and Gateshead. Review and evaluate the falls prevention service offered by the LA for minor adaptations. Work closely with the new Adult Social Care service to ensure falls prevention is

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	centre). Reviewing assessments offered in the community through the specialist falls service to ensure they are comprehensive and in line with NICE guidance. Continuation of the Fall Prevention Scheme provided through Gateshead Council, offering free minor environmental /home adaptations in private properties.		embedded into the new service. Work will be taken forward with the community service provider to use the evidence base to influence the delivery of the service.