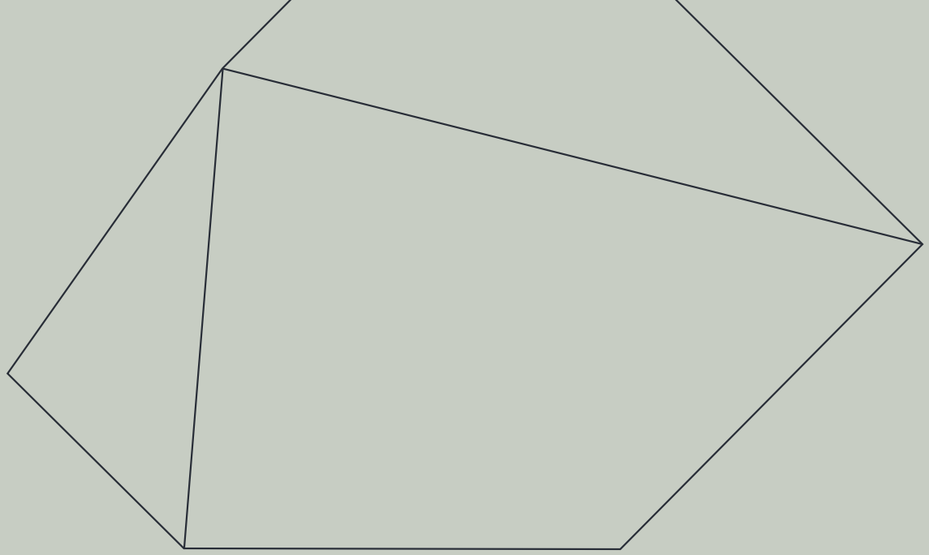
Newton

Helping older people stay independent for longer

Integrated care across Northamptonshire - the iCan programme

CASE STUDY



SUMMARY

In Northamptonshire, health and care system partners have been working together, with Newton, to improve the quality of care on offer for older people in the county, supporting them to stay independent for as long as possible.

The iCAN collaborative has brought together over 15 organisations and system partners in the design and delivery of services. The programme is focused on three pillars designed to help people choose better, stay well and age well at home, ultimately delivering better outcomes for the people of Northamptonshire.

THE PROGRAMME HAS ACHIEVED*:

9%
reduction in over 65s hospital attendances

9%
reduction in hospital admissions

1%
reduction in acute Length of Stay (LoS) since 2019, in a time where the national average increased by 18%

24%
24% reduction in post medically optimised for discharge (MOFD) LoS during an extremely challenging winter

250
Over 250 people supported by virtual wards in the community

20%
reduction in falls-related acute attendance due to an improved rapid response unit

50
Frailty model consistently delivering over 50 avoided admissions per month

50,000
bed days saved per year

£15M
The programme has also delivered £15m of annualised cost avoidance benefit in the Northamptonshire health and care system.

*in the 18 months up to March 2023

The challenge

In 2020, the Northamptonshire health and care system commissioned a diagnostic to look at how health and social care was working for its residents. The system recognised that it could be achieving better outcomes for its growing elderly and frail population. The results of the diagnostic showed that a full system transformation would be beneficial for residents, staff, and finances alike.

The iCAN programme

Together, teams across the system and Newton embarked on iCAN, a transformation programme aimed at improving outcomes for residents and staff.

The three key areas that make up the iCAN programme are:

- **Community Resilience:** Supporting older people to live independently within their community.
- **Flow and Grip:** Reducing the amount of unnecessary time spent in hospital and ensuring that residents are equipped with the right information and right support when they leave hospital.
- **Frailty Escalation and Front Door:** Ensuring that residents are assessed swiftly and treated effectively when needed, to allow them to remain independent.

Aligning the system and focusing on Community Resilience

The community resilience pillar of the iCan programme involved many interrelated projects. A few of the changes made were:

Connecting the 2-hour Rapid Response team to EMAS to support people at home and reduce hospital admissions

A pathway now exists for East Midlands Ambulance Service (EMAS) to directly refer a Rapid Response team to calls without sending an ambulance. The response team takes over 800 calls per month, with 80% of the calls being seen within two hours of the call (the national target is 70% within two hours). Only 55% of falls-related EMAS calls now result in acute attendance; 98% of non-injurious falls referred by EMAS to Rapid Response have been successfully treated at home and do not result in an admission to hospital.

Reducing delays to discharge by providing rehabilitation equipment in the community

The introduction of equipment stores, which hold a stock of key items, at community hospitals has allowed for patients to be discharged when they are ready. Prior to these changes discharge was often delayed due to individuals waiting for equipment to take home for rehabilitation. Equipment is now available at the point of discharge ensuring that individuals are not in hospital for longer than necessary due to equipment delays.

A truly integrated, nationally recognised, community-based Age Well team, bringing together health, social care, and the voluntary sector, providing a strengths-based approach to support older and frail people in the community

A frailty model has been adopted across all Primary Care Networks (PCNs) in Northamptonshire. GPs are leading extended reviews with over 120 patients and carers per month allowing for proactive, preventative care plans to be put in place with the support of multi-disciplinary teams. The PCN Age Well team members proactively reach out to patients in the community to provide practical support to over 300 newly identified people per month.

Improving access to frailty services and preventing avoidable admissions

Enabling Northamptonshire residents with frailty concerns to access the services they need, prevent avoidable admissions, and allowing people to input into the care they receive has been an important pillar of the iCan programme.

Same day emergency care and frailty teams made up of geriatric medicine experts proactively support older people coming into the front-door of the hospital. This specialist team has increased the number of people assessed at hospital front doors, allowing more patients to go home without admission. The introduction of this service helps frail patients by reducing the harm which can be caused by unnecessary hospital admission, whilst helping to ease winter pressures faced by acute hospitals every year.

“I feel confident to go out in my garden on my own.”

“I feel like I am learning new things each week and I can understand why I need to do the exercises to keep me healthy.”

Attendees at a strength and balance class in Northamptonshire

A digitally enabled way to improve flow and grip

Patient Time Matters is a dashboard providing hospital leaders and managers with visibility of patient flow through the acute hospitals in the county and the things which impact that flow.

The dashboard shows, in real time, an accurate view of LoS for pre and post medically-fit patients which is helping to drive performance around length of stay. This data can be broken down by patient cohort, admission type or even by ward, enabling leaders to identify and address challenges affecting specific pathways or parts of the hospital.

The dashboard also provides live and detailed data about various factors which can impact hospital flow. For example, a set of principles for effective board rounds were agreed with clinicians. Board rounds are scored against these principles and the resulting data is accessible on the dashboard. This provides a view of how well board rounds are going and enables any problems in specific wards to be identified and addressed. Similarly, the dashboard also incorporates data on other factors which can impact a patient’s LoS such as diagnostics and IV antibiotics.

In a time of unprecedented NHS pressures and workforce issues, the introduction of this dashboard has helped to drive a 14% reduction in LoS for over 65 non-elective patients in both the pre-MOFD and post-MOFD and a reduction of 24% in the LoS for post-MOFD alone.

A digital solution to system-wide visibility of the complex discharge process

The Complex Discharge Dashboard gives leaders and managers across the whole Northamptonshire health and care system better visibility of what is happening to patients once they are medically fit and awaiting discharge and crucially, a detailed view of what is causing delays.

The dashboard shows a live and complete view of everybody in the hospital with no reason to reside, and how many people are on each discharge pathway. Leaders can easily identify the number of stranded and super stranded patients in the system, visible at system, hospital, ward, and patient level.

There is also a detailed view of how long people are spending at different stages of the discharge process, from submission of discharge referral paperwork right through to a Provider being sourced and the discharge taking place. For the first time, staff have the data and insight they need to identify and address blockages. Improvement can be driven from all parties involved across the wards and the care providers. For example, the dashboards have enabled staff across the system to work together to halve the time taken for discharge referrals to reach the complex discharge hub.

At a system level, leaders are able to view discharge performance over time – enabling them to keep track of how well the overall service is working and anticipate and intercept a downturn in performance before it becomes a problem.

Delivery at a time of unprecedented pressure

The iCAN programme was delivered at a time where health and care systems were increasingly challenged due to the pressures of emerging from the pandemic. The programme has involved making changes in the community, changes to how Northamptonshire are supporting their frail patients, and addressing how to manage flow and discharge through and out of acute settings. The changes implemented to date through the iCAN programme have improved the experience of staff and are providing better outcomes for the residents of Northamptonshire.

“This is honestly a total game changer. I have been working blind for months before this came out.”

Chief Operating Officer, Acute Hospital

Newton

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