FRAILTY

NHS NATIONAL AWARD

A west Suffolk project which has reduced the number of avoidable hospital admissions from care homes and improved patient care has scooped the award for NHS Outstanding Collaborative Leadership for Health and Social Care at the NHS Leadership Recognition Awards 2016.

The West Suffolk Care Home Model is a partnership between WSCCG, West Suffolk Hospital, St Nicholas Hospice Care, GP practices, out-of-hours, Care UK, the ambulance service and care homes. The model delivers better support to care home residents and their families by talking with them about planning for an emergency and discussing in detail their future care wishes. The development of individual Personalised Care and Support Plans as part of the My Care Wishes (Yellow) folder process means everyone involved in caring for an individual knows what to do in an emergency.

For further information on this project, please contact 01284 758039 or email: trisha.stevens@westsuffolkccg.nhs.uk

FIT FOR FRAILTY

By Caroline Ratcliff, Project Manager, West Suffolk CCG

Frailty is being increasingly recognised as a marker of poor prognosis in later life. People with frailty have a reduced functional reserve compared with non-frail people of the same age. This means that minor events, such as an infection or change in medication can cause a dramatic adverse outcome for those living with frailty.

In June 2014 the British Geriatrics Society published ‘Fit for Frailty’, a best practice guidance document for the care of older people living with frailty. The key elements of the guidance are:

Assessing frailty: making every contact count by using appropriate assessments such as ‘timed up’ the ‘go’ test, PRISMA questionnaire and gait speed

Undertaking Comprehensive Geriatric Assessment: an holistic detailed assessment which identifies a person’s health, social and environmental needs

Ensuring frail elders have personalised shared care and support plans: these should include treatment goals, management plans, plans for urgent care and, if appropriate, end of life care plans

Sharing health information between primary care, emergency services, secondary care and social services: systems need to be established to allow the sharing of health information

Developing local protocols and pathways for older people with frailty: these need to include pathways for indicators of frailty such as falls, delirium, sudden immobility and unexplained weight loss

Recognising that frail older people in a crisis manage better in their own home only with appropriate support systems.

Over the past year an integrated frailty model led by WSFT through the clinical leadership of the Interface Geriatrician service has been developed in west Suffolk. This model, underpinning the management of complex patients, is based on the key elements of case finding, clinical assessment, care co-ordination and case management as outlined above.

DYING DOESN’T WORK 9 TO 5

By Jo Marshall, Centre Director, Sue Ryder – The Chantry

Ensuring that the last days and hours of a person’s life meet their needs and wishes can have a huge impact on them and those around them. Most obviously, we know that most people would like to die at home, but all too often this is not possible due to a lack of support.

The End of Life Coalition has published “On the brink: The future of end of life care”. This new report encourages action by Government nationally and also urges real improvement in end of life care at a local level. It calls for systematic recording of care preferences, support for carers, involvement of those important to the individual in discussions about care, 24/7 support for people dying outside hospitals, and named lead clinicians and care co-ordinators to allow people’s wishes to be met as fully as possible.

Over 220,000 of the 470,000 people who died in 2014 died in hospital, yet death in hospital accounted for only 3% of stated preferences. This can be deeply upsetting for patients, but it can also be damaging to the NHS. If more people were properly supported to die at home, there would be fewer hospital admissions, and fewer beds occupied by people who would rather be spending their last days somewhere they felt comfortable, as well as saving the NHS money.

Supporting dying people to have real choice about how they are cared for as they leave this world makes sense. We hope this report helps to keep this important issue on the agenda.
URINARY TRACT INFECTIONS

By Georgina Wilson, Consultant Urologist, West Suffolk NHS Foundation Trust

Urinary tract infection (UTI) is the most common infection in residents of care homes. Although most infections may have no symptoms, do not make the resident unwell or need treating (‘asymptomatic’), there are also episodes of symptomatic infection that do contribute to illness in these residents. Older adults at greater risk for getting an UTI include:

- Those who require a catheter in the urethra and bladder
- Those who are diabetic
- Anyone with kidney stones
- Previous UTI
- Those using incontinence pads

Prevention of UTI for frail individuals is imperative, so here are some additional simple ways in which care providers can decrease the risk of recurrent UTIs:

- Good fluid intake. During the summer months an increase in fluid is vital to compensate for perspiration and to flush through the bladder regularly. In care homes, cold jugs of water changed every few hours for each resident is essential and encouragement to drink a glass of fluid every hour is important. This fluid intake will also help decrease the risk of constipation.
- Regularly emptying the bladder. Regular toileting must be encouraged so that urine is not allowed to stagnate in the bladder. Whilst wiping, it is also important to remember to always wipe bacteria away from the bladder, i.e. front to back.
- Change pads often. Incontinent patients it will be important to change their pads more often as the concentrated urine and warmth will provide a great environment for bacterial growth.
- Avoid use of feminine products near the vagina. Avoid the use of feminine products such as wipes, talc’s etc. in the genital area as these can irritate the urethra increasing the risk of UTI.
- Shower rather than bath. This avoids any soaps etc. being left in contact with the delicate genital area.

All of these interventions are simple and with your help can make a difference in the risk of UTI.

INTRODUCING MY CARE WISHES

By Dawn Barrick-Cook, Clinical Transformation Lead, West Suffolk CCG

A great scheme has been given an important upgrade to help clinicians and patients alike plan for the future.

The My Care Wishes folder (MCW) replaces the Yellow Folder to help people plan for the care pathways they want in place, much earlier than before.

The Yellow Folder initiative was originally implemented to support individuals in the last 12 months of life only and held key information such as the DNACPR and Advance Care Planning documents.

MCW extends this planning to much earlier in someone’s life, starting vital conversations earlier in an individual’s care pathway to allow patient/resident and family/carer to make choices around their preferred place of care and death. MCW also provides clear guidance on how an individual would like to be cared for in an emergency situation.

MCW would also capture patient/resident wishes around further ‘active’ treatment and hospitalisation versus remaining in their usual place of residence and receiving palliative care/symptom control. To capture all of this key information a new document has been introduced into the MCW (yellow) folder called a ‘Personalised Shared Care & Support Plan’.

A MCW Folder supports choice around ‘care wishes’, so that all frail elderly individuals, those with long term conditions and/or mental health/dementia and their families have opportunity to be fully involved in their care. It does more than consider how someone wishes to die well.

The MCW should ideally remain with the patient/client. This is particularly important in out of hours emergency situations as it means relatives/carers will have all key information in one place.

The implementation of the Personalised Care and Support Plan and MCW Folder has been developed by the CCG in partnership with WSFT Interface Geriatricians, Suffolk County Council Adult Community Services (SC ACS), Suffolk Community Healthcare (SCH), Primary care GPs and St Nicholas Hospice Care staff.

For further information please contact dawn.barrick-cook@westsuffolkccg.nhs.uk or telephone 01284 758031.
JIGSAW - THE EXTRA PIECE

CARER’S WEEK 2016 - MONDAY 06 TO SUNDAY 12 JUNE

By David Cunliffe, Health Manager, Suffolk Family Carers

There are 6.5 million people caring unpaid for an ill, frail or disabled family member or friend and in the UK, 6,000 people take on a new caring role every day. By 2037, it’s anticipated that the number of carers will increase to 9 million.

Carers help with personal things like getting someone washed and dressed, turning them in their sleep, helping them move about or administering their medication. Carers also help with things like shopping, laundry, cleaning, cooking, filling in forms or managing money.

Over 3 million people juggle care with work, however the significant demands of caring mean that 1 in 5 carers are forced to give up work altogether.

People providing high levels of care are twice as likely to be permanently sick or disabled

- 625,000 people suffer mental and physical ill health as a direct consequence of the stress and physical demands of caring.
- Over 1.3 million people provide over 50 hours of care per week.

**Carers Week will take place from Monday 6 to Sunday 12 June 2016.**

West Suffolk CCG working with Suffolk Family Carers support initiatives to help keep family carers healthy and able to cope with the demands of their caring role.

- The GP adviser service visits every GP surgery in West Suffolk, and helps the practices to identify carers, offers one-to-one appointments for those who need it and provide Family Carer groups in some locations.
- The Respite on Prescription service allows GP’s to enable carers to have the hospital visits they need whilst providing care for those they normally care for.
- The Moving & Handling training service ensures Family carers move the person they care for safely and without endangering their own health.

HEADWAY SUFFOLK

By David Crane, Hub Manager, Headway Suffolk

Headway Suffolk’s service is all about empowerment and promoting independence for those left with physical, sensory and cognitive impairment following an acquired brain injury, stroke or a neurological condition.

Our team of rehabilitation staff and clinical therapists support typically 250 people every week throughout the county.

Our person-centred approach works with the client on their aims and goals, empowering them to have choice and flexibility over their support package.

Clients are assessed and reviewed by our occupational therapist, physiotherapist, speech and language therapist, clinical nurses and counsellors.

At our main hubs in Bury St Edmunds and Ipswich, and at various outreach hubs (including Haverhill and Mildenhall), there is a range of activities to help with skills, cognition and concentration, such as crafts, music, fitness, cookery and IT, aimed at having positive outcomes.

Our community team provides support in an individual’s home and in their local community, delivered at a time and place to suit the client, with staff given time to deliver quality care.

We facilitate support to enable greater independence for the client, such as to go shopping, access leisure activities, engage in a hobby, return to work, help with personal care, medication, appointments and money management.

A hospital co-ordinator provides emotional support, advice and information to patients on the stroke and neurology wards at Ipswich Hospital, as well as signposting after discharge.

Our Brainy Dogs help clients with companionship, therapy and dexterity skills through grooming.

We provide regular ‘understanding brain injury’ courses for free for clients and newly-diagnosed persons.

More information and a referral form is available at www.headwaysuffolk.org.uk.

SEEKING HOSPICE NEIGHBOURS

Information sessions:
Wednesday 25 May, 1530 or 1730; Hyndman Centre, Old Hospital Road, Bury St Edmunds
Or 1000; Community Room, Burton Centre, Haverhill.

Hospice Neighbour training:
Friday 10 June, 0930, Burton Centre, Haverhill or Saturday 11 June, 0930, St Nicholas Hospice Care, Bury St Edmunds

Volunteers need to attend both the information and training session. To book a place either email Kay.newman@stnh.org.uk or telephone: 01284 719638

FEEDBACK

Did you know Jigsaw is also available as a hardcopy newsletter?

Please click here to request a hardcopy to be sent to you.

Do you have an idea or would you like to write an article for a future edition?

If so, please click here to email your suggestion.

To view previous editions of Jigsaw, please click here.