The EHCH framework
– learning from vanguards & ICS

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Where did this start?

1	Health & wellbeing gap	Radical upgrade in prevention
2	Care & quality gap	New models of care
3	Funding & efficiency gap	Efficiency & investment

"The NHS will provide more support for frail older people living in care homes."

Addressing real challenges

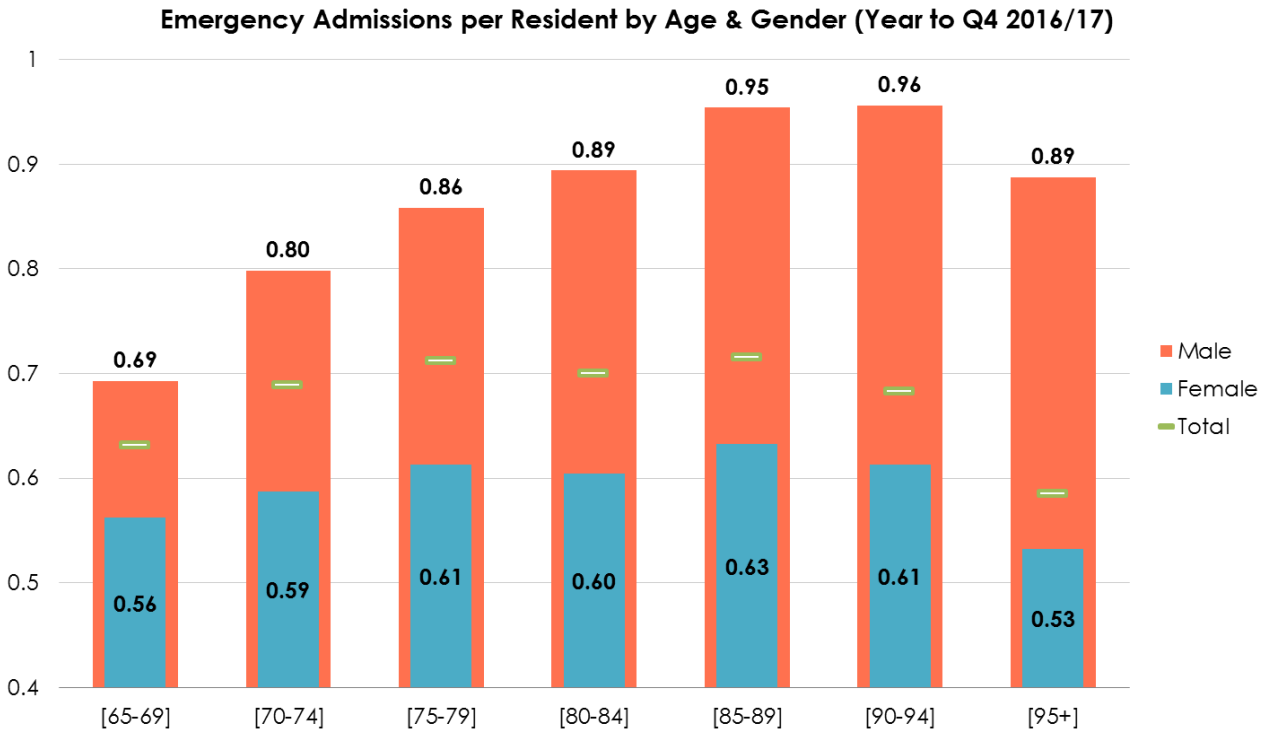
- Care homes residents are a frail, vulnerable population with increasingly complex needs & dependency
- England 3x as many beds in care homes as there are in the NHS but reduction in numbers of nursing home beds this year + increase in care home closures
- Social care facing significant financial pressures
- Hospital-based interventions have limited effectiveness for this population
- Ageing population with 1 in 7 over 85 living in a care home
- Need to provide personalised and technology-enabled care

Analysis of hospital activity from care homes

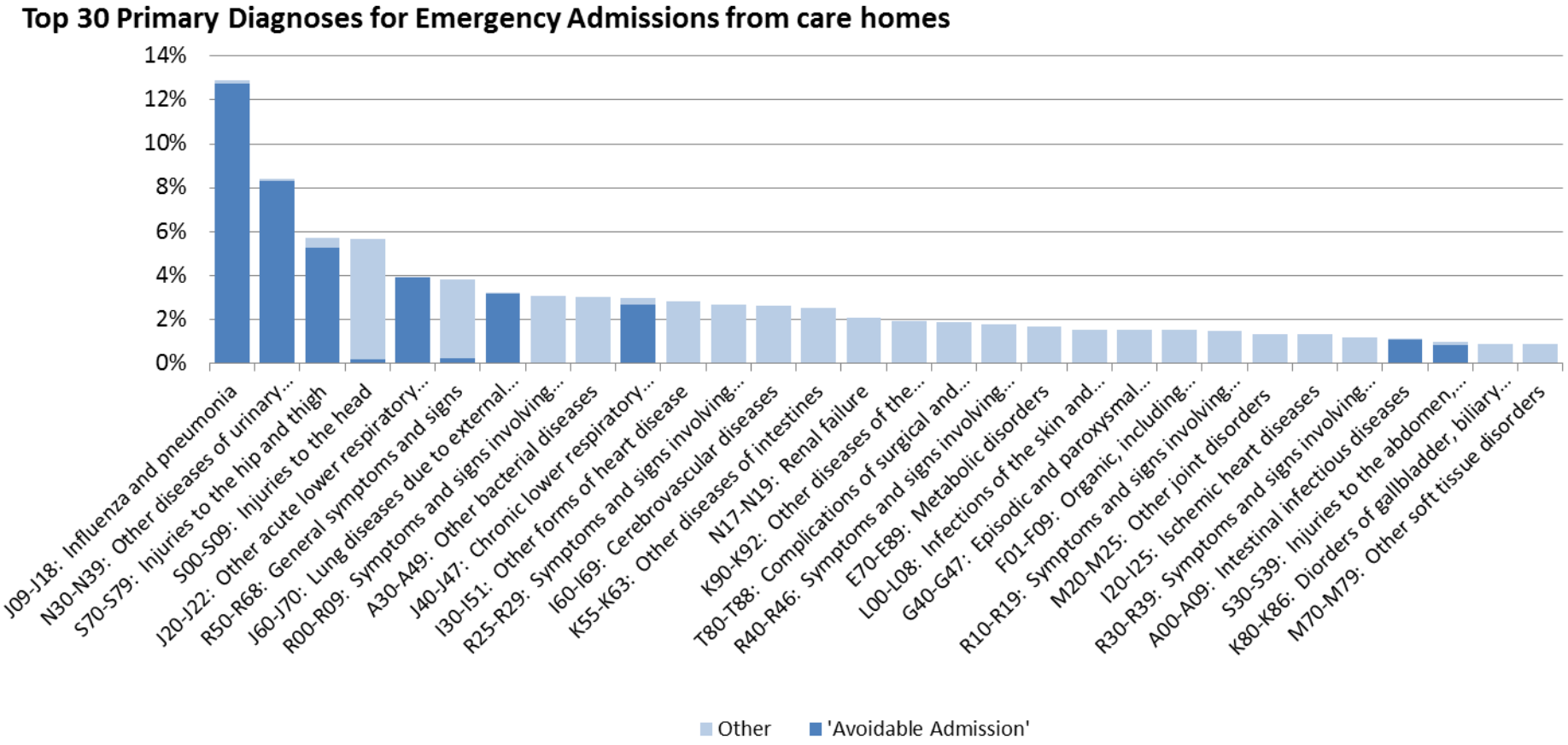
We have investigated the demographics of care home residents and how the rate of emergency admissions vary across different demographics.

The graph shows that **men have a higher rate of emergency admissions compared to women**, and **emergency admissions broadly increase as the age of the care home resident increases**.

Other findings included that **care home residents** in **more deprived areas** have **higher rates of admissions** and those in **residential homes have higher rates than those in nursing homes.**



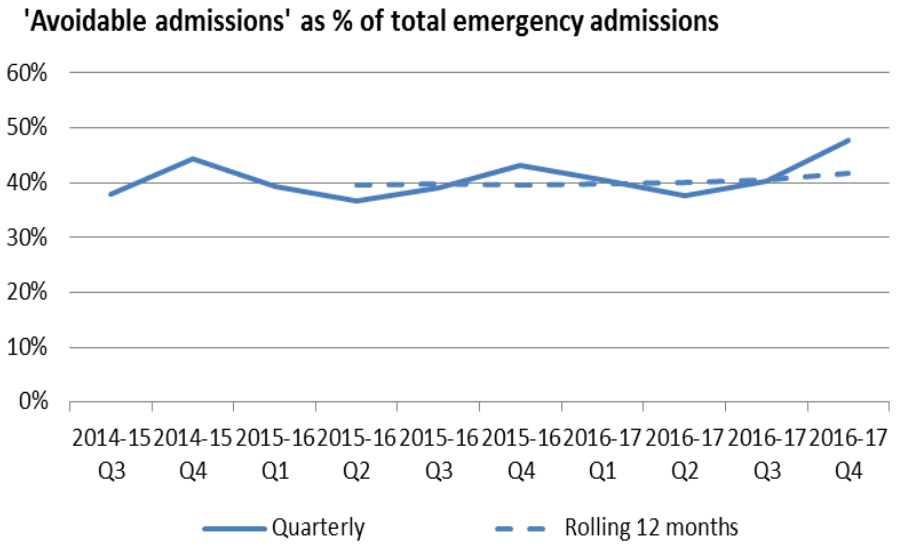
10 primary diagnoses account for over 50% of all older people emergency admissions from care homes

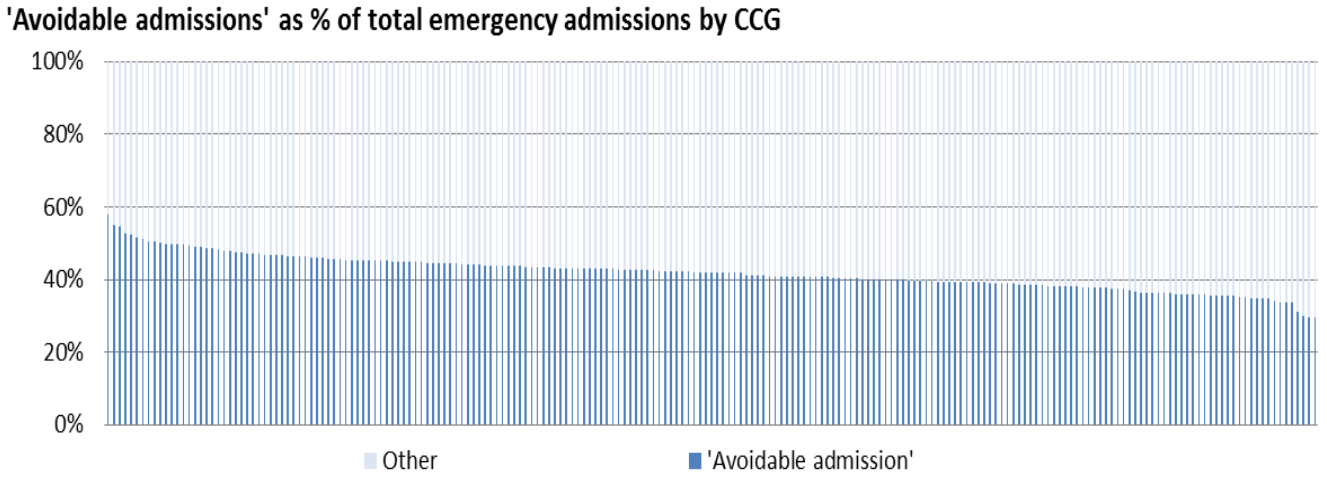


*https://cqc.org.uk/sites/default/files/documents/state_of_care_annex1.pdf

‘Avoidable admissions’ account for around 40% of all emergency admissions from care homes

- National ‘avoidable admissions’ have remained approximately constant at 40% of all emergency admissions
- For 70% of CCGs ‘avoidable admissions’ account for between 35% to 45%





Aims of the EHCH programme of work

- Nationally replicable models of care
- More accessible, more responsive and more effective health, care and support services
- Fewer trips to hospitals
- Care closer to home
- Better co-ordinated support
- 24/7 access to information and advice
- Access to urgent help easily and effectively, seven days a week

EHCH framework – elements and time to implement

Care model element	Sub-element	Time to implement
Clinical elements		
1. Enhanced primary care support	Access to consistent, named GP and wider primary care services	< 1 year
	Medicines reviews	< 1 year
	Hydration and nutrition support	< 1 year
	Out of hours/emergency support	< 1 year
2. MDT in-reach support	Expert advice and support for those with the most complex needs	1 year – 2 years
	Helping professionals, carers and those with support needs to navigate the local system	1 year – 2 years
3. Reablement and rehabilitation to promote independence	Aligned and effective rehabilitation and reablement services	< 1 year
	Developing community assets to support resilience and independence	1 year – 2 years
4. High quality end of life care and dementia care	End of life care	< 1 year
	Dementia care	< 1 year
Enabler elements		
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes	< 1 year
	Shared contractual mechanisms	1 year – 3 years
	Access to appropriate housing options	1-5 years
6. Workforce development	Training and development for care staff	< 1 year
	Joint workforce planning	1 year – 2 years

EHCH Care Model Framework

- The Enhanced Health in Care Homes (EHCH) framework was published September 2016
- Based on the common coordinated interventions being delivered in the vanguards
- Significant research base to support the model
- Aims to describe the care model and describe plan for spread
- Care model has seven core elements and 18 sub elements
- Clear signal to spread the care model

The vanguards have started to demonstrate how integrating services improves care for patients

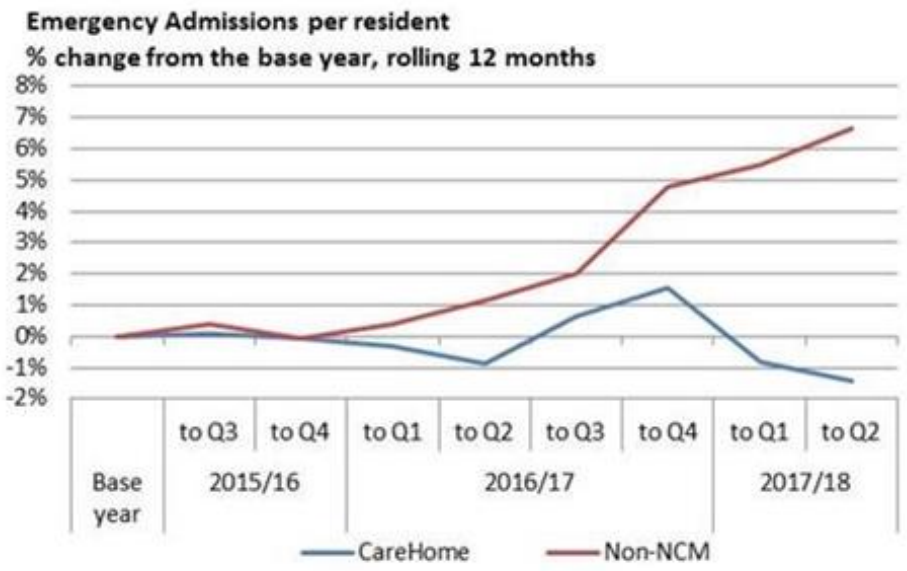
Yorkshire Integrating care teams across organisational boundaries	• In Wakefield, multi-disciplinary teams have been formed between care homes and primary care to manage the needs of residents in 27 care homes and 6 supported living facilities. • Local analysis showed that ambulance call outs have been reduced by 9% and bed days have reduced by 26% from the 2015/16 baseline.
Isle of Wight Collaboration between health and care systems	• A new care model 'My Life A Full Life' was introduced in 2014 as a collaboration between the CCG, local council and local acute trust. • The service is designed to support patients aged 65+ to avoid admission to hospital, offer more services in people's own homes & the community.
Sutton A improved pathway of care for people with complex needs	• The 'Hospital Transfer Pathway' (the 'Red Bag') started in October 2015. • The bag contains standardised information about a resident's general health, an escalation form about the changes to their condition and information about their medication. • This intervention has helped to reduce hospital length of stays and delayed transfers of care for patients.

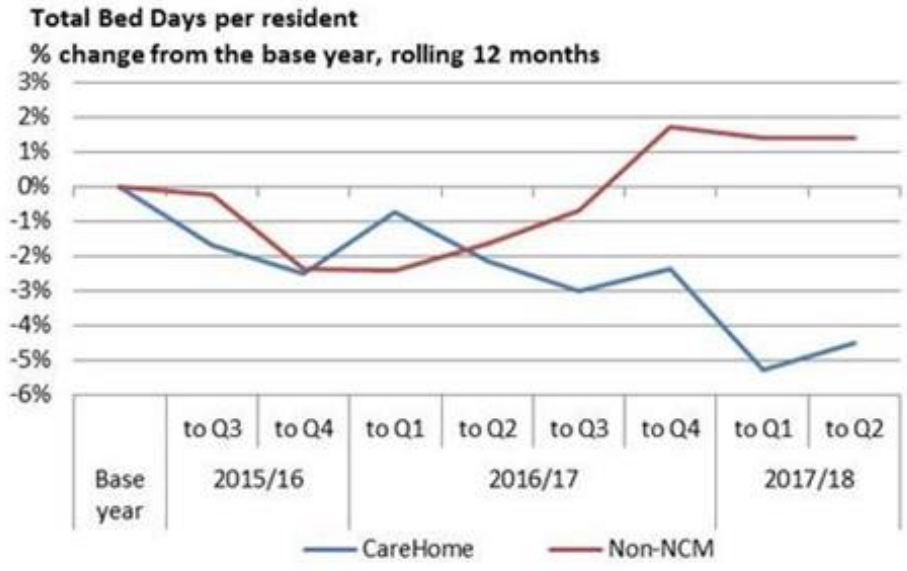
Enhanced Health in Care Homes – were they successful?

We now have…

- 6 exemplar sites across the country
- Providing joined-up primary, community and secondary health and social care to residents
- Better relationships between commissioners and providers
- Improved access to NHS services for care home residents
- Provider improvements for staff and organisations

"There has been a consistent and sustained trend in the performance of care home vanguards"





What have we learned from the care home vanguards?

- **Person centred** approach essential and focus on the **populations** health
- Build **collaborative system leadership** and relationships around a shared **vision** for the population
- Care homes are a **critical** partner in the work at all stages
- Able to see very quick benefits for **residents, providers** and **wider system**
- Not one change that makes a difference, requires a **coordinated approach** to improvement as isolated initiatives may create unwanted consequences
- Opportunities to apply the care model **wider than just care homes** with homecare, extra care housing and wider complex care needs management adaptable to the model
- Can **drive and develop better relationships** between commissioners and providers
- Great work goes on all over the country, but it needs **building upon and coordinating**

What support was needed to implement the model?

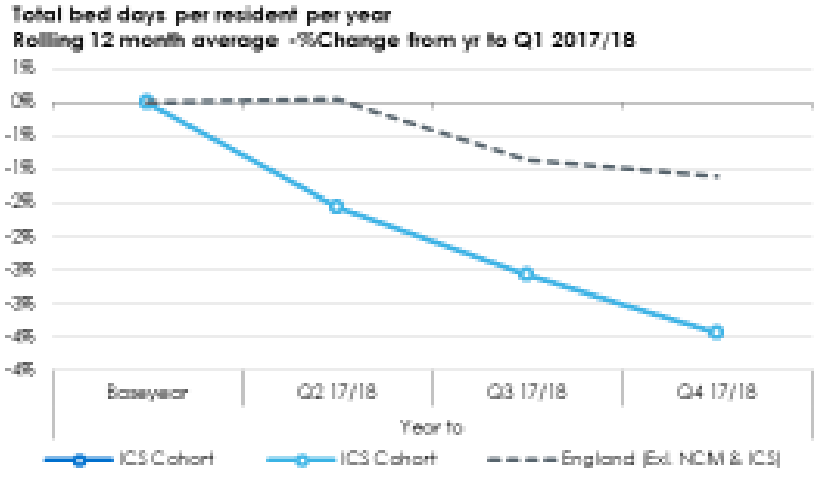
A. Getting started support	• Help to understand what it is you are planning • Helping make those plans real • Bringing people together
B. Materials	• Access to tools and resources to help deliver the work
C. National policy	• National policy support on areas that support delivery of the model • Decluttering the policy landscape • National framework
D. Site support	• Named contact in national team and signposting to national and regional expertise • Central team to support and coordinate
E. Network learning	• Calls/ webexes with national or regional team • Connections and networking support to link sites with wider ALB colleagues • Fortnightly call • Quarterly community of practice
F. Bespoke local support	• Quarterly reviews • Bespoke local work to develop solutions

Learning guides to support spread

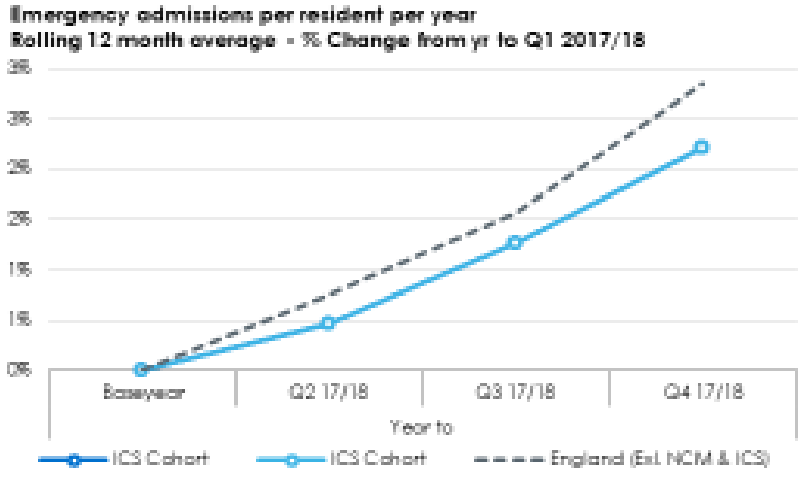
- Co-produced with clinicians, commissioners and project managers from across CCGs and local authorities, with input from NHS England expert teams.
- Provide detail on how the care model element supports the model, vanguard service models and innovation, things to consider and avoid, a ‘to do’ list, and how these interventions benefit care home residents, staff and the wider system.
- Include links to a wide range of service specifications, job descriptions, vanguard tools and other materials.
- Aligned with ‘Quick Guides’ produced by NHSE Hospital to Home team (formerly OHUC).
- A range of Learning from Vanguards guides now available on Kahootz for all to access.
- We also have a ‘Low Cost/High Impact’ guide in development which outlines quick win’ interventions from the Enhanced Health in Care Home vanguards that can be implemented rapidly and with little to no funding.

Supporting adoption in Integrated Care Systems

- The Integrated Care Systems (ICSs) have been our first and most intensive cohort for spread.
- Our support offer is part of, and aligns with, the wider offer to ICSs with a range of resources and tools and network learning opportunities.
- We have produced data packs, analysis and recommendations for the ICS sites who have shared completed benchmarking tools.



ICS Cohort	0%	-2%	-3%	-3%
England (Exl. NCM & ICS)	0%	0%	-1%	-1%



ICS Cohort	0%	0%	1%	2%
England (Exl. NCM & ICS)	0%	1%	2%	3%

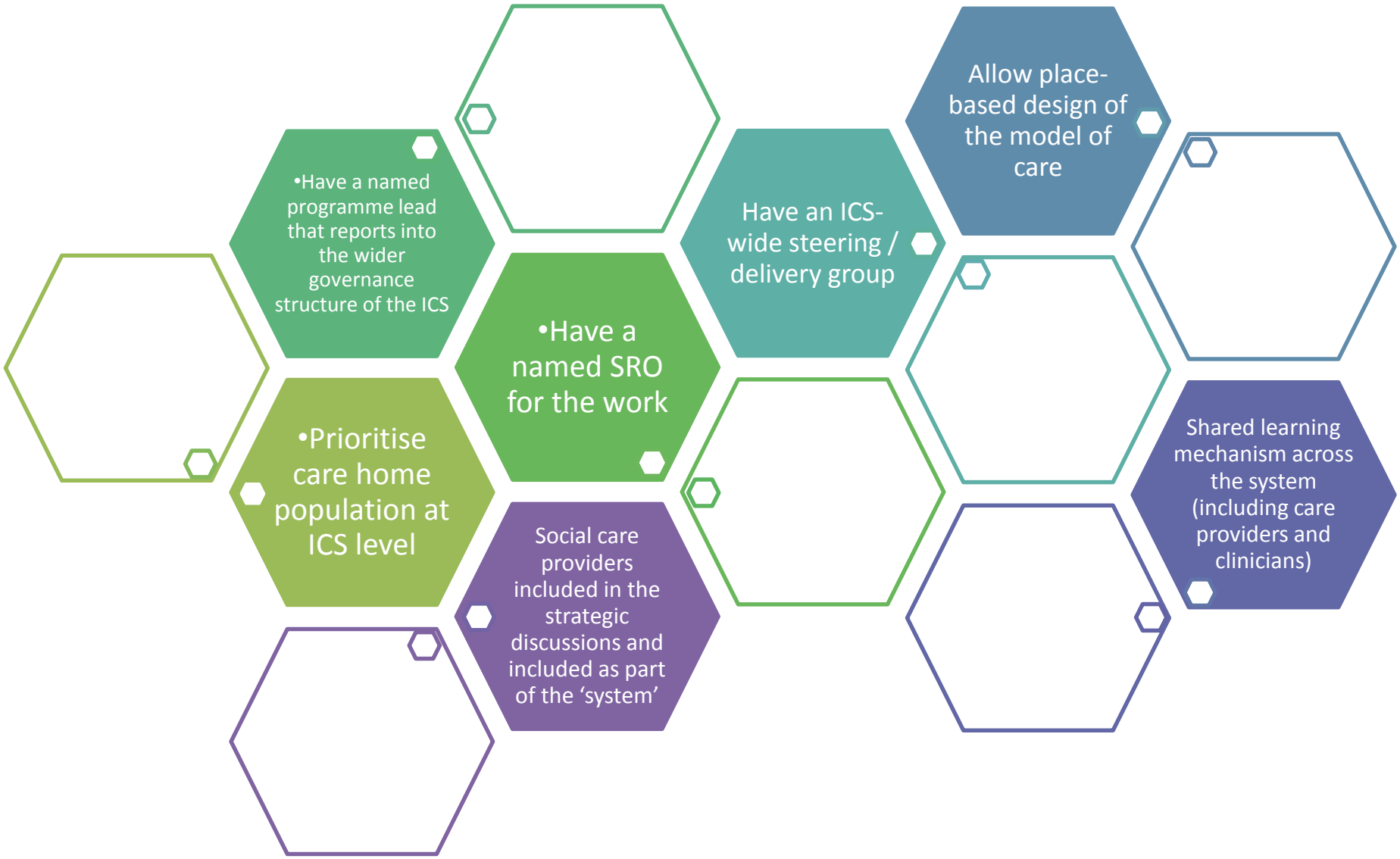
Learning from Spread

What have we learnt from trying to spread the model?

- There is a **huge appetite** to spread the model wider
- Many local areas have **strong foundations** on which to build
- The **care elements** of the model are **more widespread** then the enabler elements
- **Care home provider engagement is variable** nationally
- **Coordination** of multiple initiatives appears to be key locally
- **Learning and sharing** in communities of practice is an **essential** part of the process

Learning from Spread

What are the key 'ingredients' systems need to implement the EHCH model?



Case Study 1: **Admission Avoidance Initiatives NHSE**

Rachel Fox – Independent Care Sector Lead, NHSE