NHS Board Meeting
31st March 2021

Lanarkshire NHS Board
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SUBJECT: HOSPITAL AT HOME SERVICE

1. PURPOSE

This paper is coming to the Board:

For approval	☐	For endorsement	☐	To note	☒

2. ROUTE TO THE BOARD

The paper has been:

Prepared	☒	Reviewed	☐	Endorsed	☐

by the Service Manager for the Adult Health Services Unit, North H&SCP

Prepared	☐	Reviewed	☒	Endorsed	☐

by the General Manager for the Adult Health Services Unit, North H&SCP

3. SUMMARY OF KEY ISSUES

3.1 Background (Dec 2011 – Nov 2019)

Hospital At Home (H@H) was a service introduced into NHS Lanarkshire in December 2011.

Published and on-going research & studies at that time evidenced that elderly patients who were admitted to hospital and not discharged within 72 hours were likely to end up as an inpatient for a prolonged period of time and need additional intervention prior to discharge. It also evidenced elderly patients rehabilitated better in the familiarity of their own homes than they did in a hospital setting. In addition to this there are the clinical risks associated with being in hospital, such as hospital acquired infections. All of these factors combined with the opinion that elderly patients just didn't want to be in hospital, directed the drive for alternative ways of providing care to the elderly community.

NHS Lanarkshire's Reshaping Care for Older People programme worked towards finding new processes to avoid hospital admission and to drive elderly care patient services out into community settings, and consequently reduce hospital bed numbers. As part of this strategic agenda, NHS Lanarkshire closed 26 community beds at the Roadmeetings site and transferred the recurring budget into the Hospital At Home service.

NHS Lanarkshire was one of the first Health Boards in the UK to have a functioning Hospital At Home service. This service was designed to provide acute medical care, equivalent to that of Acute hospital wards, delivered in the patient's own home. Set up within one central location in Coathill Hospital, the service was composed of a multi-disciplinary team, Consultant led, and employing Consultant Geriatricians, Nurse Practitioners, Assistant Practitioners, AHPs and Admin staff, and

serving the over 65-year-old patients of North East and North West sectors of Lanarkshire. By 2015, the proven on-going success of the service in the North localities combined with the Glasgow boundary changes, led to the South H&SCP invested some recurring monies into the service and a second H@H hub was opened up based within University Hospital Hairmyres. This hub and staff were to serve the Hamilton & East Kilbride localities within the South H&SCP area. In 2017, the service had grown again and a third H@H team was founded and based within University Hospital Wishaw. This cohort of staff was to serve the Wishaw, Motherwell & Bellshill areas of the North HSCP, while the original Coathill hub remained to serve the Airdrie, Coatbridge and Cumbernauld localities.

The clinical criteria for the patients was determined by analysing the typical presentations of the over 65-year-old patient cohort being presented to Acute Hospitals, and assessing what hospital treatments/interventions they required that could safely be carried out in the patient's own home. It was agreed that H@H would be made available to patients aged over 65 years, living within one of the funded locality areas (as detailed above), presenting to their GPs with symptoms of frailty, respiratory & influenza conditions, frailty DVTs, UTIs, and other infections requiring medical treatment. There were clinical exceptions such as cardiac presentations and also strokes. GPs were able to refer to the service via the Emergency Receiving Centre hub, the referral would be triaged and if it met the H@H criteria, and member of the team would present to the patient's home within a one-hour timeframe.

NHSL H@H operates 7 days per week from 8am to 6pm. The service is open to accept GP referrals from 8am to 4pm on weekdays, and also accepts patient referrals from the Scottish Ambulance Service at weekends.

Current substantive virtual bed capacity within the service is 64. This is split as follows:

- UHM catchment – 24 beds
- UHH catchment – 24 beds
- UHW catchment – 16 beds

The service continued to evolve and grow as service demand increased. Under the guidance of a Senior Nurse and Clinical Lead, referral rates and patient numbers increased. The service made strategic adaptations throughout its journey to adapt to changing needs of the over 65 population it served. It also enhanced the clinical service it was able to provide, including being able to deliver IV antibiotics, IV fluids, blood transfusions, catheterisation, ECGs and bladder scans within the patient's own home, with all clinical guidelines & governance followed. Collaborative working with community services such as DNs and Social Work ensured a full comprehensive geriatric service was provided as it would be within the Acute wards. However, adversely, within these evolutions, the H@H service found itself becoming an unofficial supported discharge service as Acute wards had started discharging patients from hospitals into the service. While these patients did meet the clinical criteria for the service as they still required Acute clinical intervention, with no additional resource to manage these patients, this reduced the capacity for GP patient referrals, and consequently some GP patients would need admitted to Hospital.

3.2 Scottish Government National Strategy

In February 2019, Jeanne Freeman, Cabinet Minister for Health & Sport, visited the H@H team in NHS Lanarkshire to observe the functions and service provision of the team. She complimented Lanarkshire on its success and its status as a leading Board in Scotland for its H@H service. Later in that year, Jeanne Freeman announced a national initiative whereby the Scottish Government pledged £1m from the 2020/21 budget to ensure all Scottish Health Boards could establish a functioning H@H service.

3.3 Existing Service Model (Nov 2019 onwards)

By November 2019, due to growth, expansion, and other governing factors, (including a reported £110k overspend, a high staff turnover, and high sickness rate), an Operational Service Manager was appointed to the H@H service within NHSL. This allowed more robust HR, financial, and clinical governance to be implemented to the existing service to ensure the staff and processes were stable to allow further growth for the service, while ensure patient care & safety was the highest priority.

Present service resources include a funded establishment of 37.58 wte staff, and an annual budget of £2,146,745.

A review of the implementation of HR policies; a full workforce review; the introduction of a workforce planning model; combined with rigid financial governance and strict financial planning; has supported the overall performance of the H@H service to improve. In the 12-month period to November 2020, the H@H service was reporting a break even financial position, with CRES savings identified and implemented, sickness was reduced by 3.9%, and staff turnover had reduced by 20%. In addition to this, referral rates had increased by an average of 45 per month, a 20% average increase compared to the previous year. Average daily caseloads consistently exceed the 72 currently funded beds.

Currently the accommodation provided on all 3 Acute sites is insufficient to meet the needs of the service. Office space is not compliant with social distancing measures and temporary workarounds have had to be adopted. This is not feasible in the longer term, and prevents the expansion of the service. Storage facilities are not adequate and have been raised at the North H&SCP hygiene meetings.

3.4 Response to Covid-19

In March 2020, the unprecedented Covid-19 global pandemic impacted on healthcare services around the world. H@H had to redesign some aspects of care provision to accommodate the change in demand for the service. Service improvements during this period included:

- In response to the pandemic a virtual "Step Down" ward was created which was intended to create a direct flow from Acute wards into H@H and back into Community to help increase bed availability on Acute sites. This was staffed by Shielding Care Of The Elderly Consultants and designated H@H Practitioners. The benefits have included:
    - Created capacity within Acute sites to aid flow and create bed space
    - Ensured Ward supporting ward discharges did not impact on admission avoidance and capacity to accept GP referrals helping keep patients out hospital completely
    - Full Utilisation of Acute Consultants unable to do direct inpatient care
    - Helped create and devise full virtual processes for managing an Acute COTE caseload safely & effectively
    - Collaborative working with Community Pharmacy
    - Collaborative working with Community AHPs & rehabilitation teams, including Direct referrals in and out service
    - Collaborative working with District Nursing & Community Teams
    - More comprehensive assessments for patients being transferred from Acute into Community to comply with Continuing Care & Frailty strategy

- Within 10 months (May 2020 – Feb 2021) the following statisticss were recorded in the Step Down Pilot:
    - 256 patients admitted to service from Acute wards
    - 1341 Acute bed days saved
    - Average LOS = 5.72 days per patient

- Temporary increase to UHW hub to allow them to safely increase capacity to 24 virtual beds, increasing funding to 72 virtual beds. Average activity can often exceed this.

- Extended service provision to Care Homes, including patient swabbing and diagnosis, direct Consultant access for telephone advice, advice, conversations and completion of DNACPR processes where required, Advanced Practitioner reviews on "mass" patient groups for facilities with outbreaks, advice on clinical care planning for patients who are sick but do not require admission to H@H or Acute wards, and provision of Home Oxygen where required.

- Collaborative working with Community Respiratory and OOH teams to provide oxygen to patients in community settings to avoid admissions

- Collaborative working was undertaken with IRT & ICST teams to improve the flow of patients between the 2 services. This has proven successful and helped avoid hospital admission

- Collaborative working was undertaken with District Nursing to ensure the swifter transition of care from Acute to Community services, and reduce the LOS within our service, consequently creating increased capacity to accept more patients

- Assistance with Urgent Blood transfusions for dependant Haematology patients who could not attend the MDBU as normal due to Covid-19

Referral rates from Feb 2020 to Feb 2021 are as follows:

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
UHM	80	90	119	92	112	50	90	77	85	86	92	88	88
UHH	66	69	71	72	70	75	62	64	75	82	75	71	70
UHW	40	36	67	49	49	51	55	42	52	54	49	53	52
Stepdown	0	0	0	19	24	32	28	17	21	27	23	34	33
Service Total	**186**	**195**	**257**	**232**	**255**	**208**	**235**	**200**	**233**	**249**	**239**	**246**	**243**

Feb 20 - Feb 21 Increase:

	Referrals	%
UHM	8	10%
UHH	4	6%
UHW	12	30%
Stepdown	33	100%
Service Total	**57**	**31%**

Average Increase in Referrals since Covid:

	Pre-Covid Avg	Post Covid Avg	% Increase
UHM	85	89	4%
UHH	67.5	72	6%
UHW	38	52	27%
Stepdown	0	23	100%
Service Total	**191**	**236**	**19%**

3.5 Future Model

In January 2020 a short life working group was commissioned to agree the strategic direction of the H@H service going forwards, on a pan-Lanarkshire basis. The group commenced, but was placed on hold due to the onset of the Covid pandemic in March 2020.

Given the significant changes experienced over the last 12 months, it is proposed that the group reconvenes, but the terms of reference are refreshed to reflect the new landscape, with an update report coming back to the Board in 6 months.

Part of the review will incorporate the requirements around pharmacy to assist with polypharmacy, medicines reconciliation and community pharmacy interfaces.

3.6 Finance

As per all information above, detailed business and operational proposals would need to be complete, with full input from finance colleagues.

3.7 Next Steps

- Re-establish the H@H short life working group, with all key stakeholders represented to agree the future strategic direction of the service and thereafter service changes required to deliver the agreed model;
- Provide an update report to the Board in 6 months' time;
- Engage with Acute Senior Management regarding accommodation provision to support service provision.

4. STRATEGIC CONTEXT

This paper links to the following:

Corporate objectives	☒	AOP	☒	Government policy	☒
Government directive	☒	Statutory requirement	☐	Achieving Excellence/ local policy	☐
Urgent operational issue	☐	Other	☐		

5. CONTRIBUTION TO QUALITY

This paper aligns to the following elements of safety and quality improvement:

Three Quality Ambitions:

Safe	☒	Effective	☒	Person Centred	☒

Six Quality Outcomes:

Everyone has the best quality of life and is able to live longer healthier lives; (Effective)	☒
People are able to live well at home or in the community; (Person Centred)	☒
Everyone has a positive experience of healthcare; (Person Centred)	☒
Staff feel supported and engaged; (Effective)	☒
Healthcare is safe for every person, every time; (Safe)	☒
Best use is made of available resources. (Effective)	☒

6. MEASURES FOR IMPROVEMENT

A Short Life Working Group will develop a measurement plan that relates to performance and will illustrate criteria such as referral rates, LOS, readmission, mortality, and quality of patient outcome.

7. FINANCIAL IMPLICATIONS

As mentioned above, the SLWG will provide a full illustration of the financial investment and implications.

8. RISK ASSESSMENT/MANAGEMENT IMPLICATIONS

The services will continue to be operationally managed within the Adult Health Services Unit and governance arrangements will be through the AHSU SCCG forum, escalating via the NH&SCP SCCG forum to HQAIC.

9. FIT WITH BEST VALUE CRITERIA

This paper aligns to the following best value criteria:

Vision and leadership	☒	Effective partnerships	☒	Governance and accountability	☒
Use of resources	☒	Performance Management	☒	Equality	☒
Sustainability Management	☒				

10. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Any future model will be subject to a full Equality and Diversity Impact Assessment.

11. CONSULTATION AND ENGAGEMENT

A SLWG will be commissioned to engage in a process with a wide variety of key stakeholders to discuss, propose & approve plans for expansion/extention of H@H services within NHSL.

12. ACTIONS FOR THE BOARD

The Board is asked to:

Approve	☐	Endorse	☐	Identify further actions	☐
Note	☒	Accept the risk identified	☐	Ask for a further report	☒

The Board is asked to:

1. Note the progress made in developing the service to its current status and towards the five HIS standards;

2. Note the plans to reconvene the short life working group to agree the future strategic direction of the service; and

3. Request an update back to the Board in 6 months' time.

13. FURTHER INFORMATION

For further information about any aspect of this paper, please contact:

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