	Unscheduled Care Model Development Update Report	Project Stage **Define**

Project Name	Unscheduled Care	**Date**	11/02/2019
Project Reference No.	TBC – joining Acute Care at Home and West Visits Business Cases	**Governance Programme Board(s)/ IJB**	TCPB EPB IJB
Project Manager/ Author	S McNamee	**Date of Programme Boards/ IJB**	

1. Summary of Project

This project seeks to establish an approach to delivering Unscheduled Care within Aberdeen City which builds on learning taken from the INCA, West Visits project and the Acute Care at Home (AC@H) project. This project requires re-allocation of existing resource including alignment of existing Business as Usual (BAU) teams, AC@H and West Visiting teams, to deliver a coordinated response to Unscheduled Care needs. In the main, these unscheduled needs will be identified by GP / practice who will refer for further assessment / diagnostics and/or the delivery of a treatment and/or care plan. Who completes this assessment will develop and expand as MDTs develop in localities.

The project will include the implementation of enabling operational structures such as:

- A single point of contact / referral / triage (SPOC) for receiving and tasking of referrals (whether this is a city-wide SPOC or smaller locality SPOCs is to be determined)
- A Multi-Disciplinary Team (MDT) approach to the identification and management of appropriate cases for early preventative intervention (proactive case finding using the

electronic frailty index[1] and High Health Gains predictor – via SPIRE (Scottish Primary Care Information Resource – aligns with Silver City approach)

- An MDT approach to case management[2][3] and delivery of treatment and/or care (MDT working in localities / Enhanced Community Support / including the use of the Living Well in Communities (LWiC) MDT framework for good practice.)

2. Business Need

[1] https://ihub.scot/media/1370/20180222-efrailty-care-coordination-poster.pdf
[2] https://www.kingsfund.org.uk/publications/case-management
[3] https://www.kingsfund.org.uk/publications/montefiore-health-system-summary

Why is this project needed?

Unscheduled Care is usually undertaken in response to the onset of an acute illness or the rapid decline in function of someone living with an existing condition(s). Responses to need for different levels of treatment or care can be broadly categorised in terms of a stepped care approach described in the diagram below.

Unscheduled care across Aberdeen City is currently un-coordinated, often characterised by services working in isolation from each other. This leads to poorer outcomes for those requiring care and inefficient use of resources. The existence of many separate teams with different referral systems and multiple handovers is evidence of the lack of coordination and in-built inefficiency within the system. There are currently higher levels of hospital admissions than could be achieved through a more coordinated approach. A more synchronised approach across 7 days where care could be stepped up and down in response to the needs of an individual would allow for more people to be treated / supported in the community thus avoiding hospital admission.

Initial approaches to resolving these issues (Acute Care at Home - ACH) have been challenging to deliver due to workforce challenges. The completion of assessment and diagnostics through a home visit on behalf of GPs (West Visits) has proven to be of value to GPs and a more effective use of resource and is similar to the initial assessment at home that ACH patients would get. The model articulated in this update report builds on learning from ‘pathfinder’ projects:

- Acute Care at Home
- West Visits
- Integrated Neighbourhood Care Aberdeen (INCA)

The model of care articulated in this report sees existing community teams using the skills they already possess, or could be supported relatively quickly to develop, to adopt the best bits of the transformative approaches already tested. By embedding them as approaches within a stepped care approach delivered by existing community teams we connect all activity in a pathway that sees all citizens get the right level of support at the right time by the right person.

This project aligns with Partnership strategy as it both enables and relies on connected partnership working. This project also aligns with national strategic direction in shifting the balance of care from hospital to community settings.

What problem does the project seek to resolve? (Admission data)

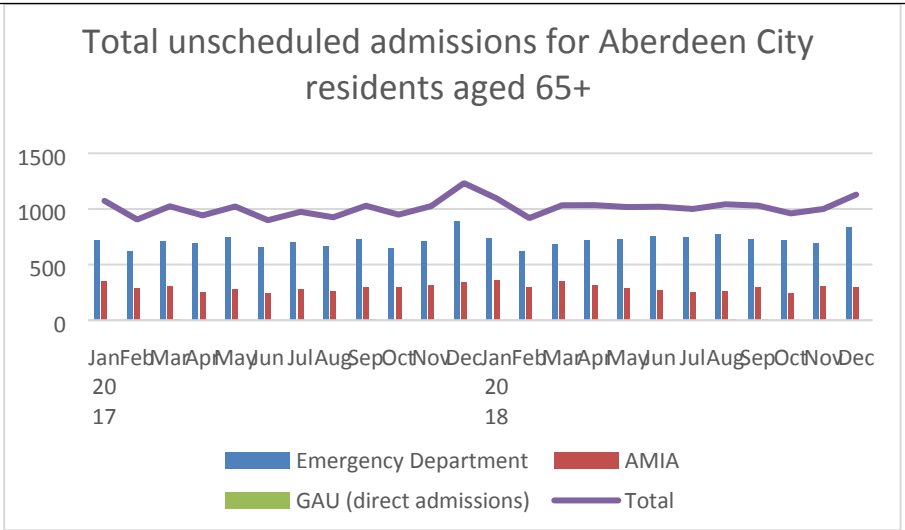
[*In this update report a focus has been placed on Older Adults, however in the final Business Case there will be a wider look at all admissions to give assurance that we are focussing our resource at the segment of our patient base that will make most impact***]**

Predicted demand is modelled on previous demand. Reliable admissions data is taken from discharges recorded on acute systems.

The table and graph below chart all unplanned admissions for Aberdeen City residents aged 65+ for 2017 and 2018. The data shows two things of interest:

- ✓ Generally Unscheduled admissions sit around 1000 per month through Emergency Department (ED) or Acute Medical Initial Assessment area (AMIA)with a very small number admitted through Geriatric Assessment Unit (GAU);
- ✓ Unscheduled admissions generally spike in December

Discharge from	2017											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	719	619	712	687	742	655	697	663	731	648	711	892
AMIA	351	284	308	252	279	242	274	262	294	298	314	337
GAU (direct admission)	3	2	4	3	1	2	3	0	4	3	1	3
Total	1073	905	1024	942	1022	899	974	925	1029	949	1026	1232
Discharge from	**2018**											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	733	615	680	716	727	752	745	773	731	721	694	834
AMIA	361	300	350	317	289	268	254	263	294	238	304	293
GAU (direct admission)	1	3	3	1	1	0	1	6	5	1	2	2
Total	1095	918	1033	1034	1017	1020	1000	1042	1030	960	1000	1129



Impact of admissions from Care Homes

The data above can be further broken down to identify of those admissions how many came from care homes, i.e. known to have a higher need for care and thus more predictable. The table and graph below detail the numbers of admissions form care homes and the percentage of overall admissions to either Emergency Department (ED) or Acute Medical Initial Assessment area (AMIA).

<u>Emergency Department</u>

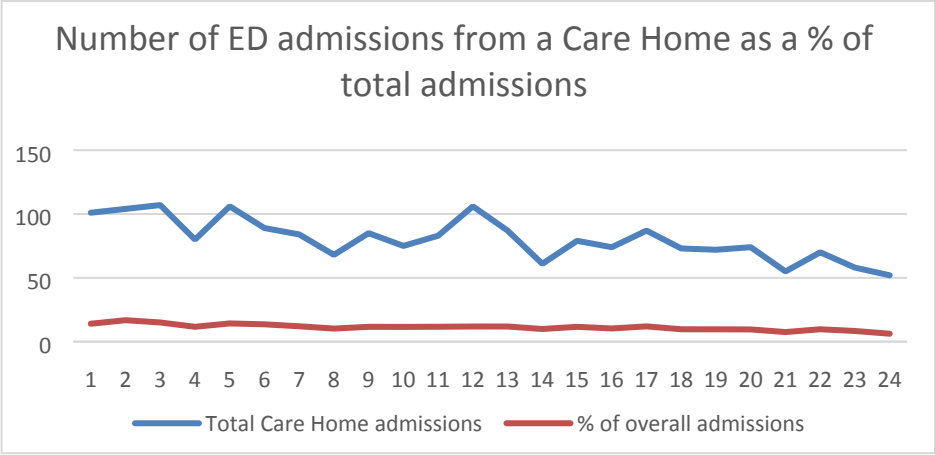
Admissions data to the Emergency Department suggests that:

- ✓ As a percentage of overall admissions to ED the number of admissions from Care Homes has been continually reducing over the last two years.

We know from above that the overall admission figures are relatively stable year on year so there is definitely something different happening in care homes – an improvement. This may be caused by

a number of factors but points to **successful preventative activity having an impact.** If similar strategies are employed for those other patients (Care at Home recipients, people identified at higher risk of admission, those living with multiple morbidities, etc.) then it is fair to assume we can expect to have a similar improvement on admission rates.

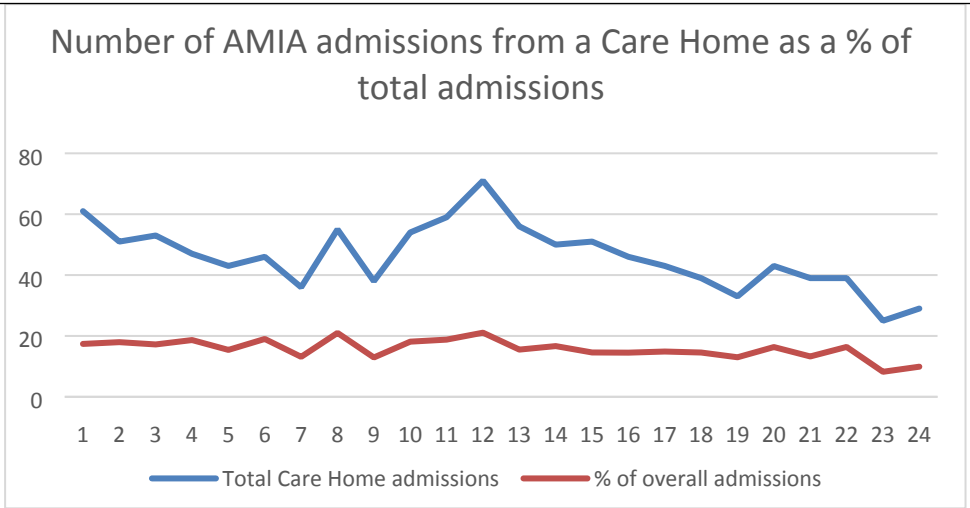
Discharge from	2017											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	719	619	712	687	742	655	697	663	731	648	711	892
Total Care Home admissions	101	104	107	80	106	89	84	68	85	75	83	106
% of overall admissions	14	16.8	15	11.6	14.3	13.6	12.1	10.3	11.6	11.6	11.7	11.9
Discharge from	**2018**											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Emergency Department	733	615	680	716	727	752	745	773	731	721	694	834
Total Care Home admissions	87	61	79	74	87	73	72	74	55	70	58	52
% of overall admissions	11.9	9.92	11.6	10.3	12	9.71	9.66	9.57	7.52	9.71	8.36	6.24



AMIA

If a GP wishes to admit a patient to hospital (in-hours during GP working hours) the admission route will generally be to AMIA rafter than ED. The table and graph below shows, similar to the ED admission data, AMIA has also experiences a downward trend in admissions from Care Homes though this improvement trend is less stable. This supports the hypothesis that system is getting better at reducing unplanned admissions from Care Homes – most likely through the work of GPs, Link Geriatricians, Community Geriatric Nurses, Community Nursing and AHP Teams and Care Home staff.

Discharge from	2017											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMIA	351	284	308	252	279	242	274	262	294	298	314	337
Total Care Home admissions	61	51	53	47	43	46	36	55	38	54	59	71
% of overall admissions	17.4	18	17.2	18.7	15.4	19	13.1	21	12.9	18.1	18.8	21.1
Discharge from	**2018**											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
AMIA	361	300	350	317	289	268	254	263	294	238	304	293
Total Care Home admissions	56	50	51	46	43	39	33	43	39	39	25	29
% of overall admissions	15.5	16.7	14.6	14.5	14.9	14.6	13	16.3	13.3	16.4	8.22	9.9



Summary of Problem

We don't have a coordinated approach across services to Unscheduled Care. If we did, we would have the potential to impact on admissions numbers to both ED and AMIA. Two clear areas where improvement can be targeted is admissions of people aged 65+ and also admissions from care homes. In order to do this, we need to have a joined-up approach across community teams to both planned and unscheduled care which will become preventative when successful.

Unscheduled Care

Unscheduled Care is usually undertaken in response to the onset of an acute illness or the rapid decline in function of someone living with an existing condition(s). Responses to need for different levels of treatment or care can be broadly categorised in terms of a stepped care approach described in the diagram below.

This project aligns with the Partnership's strategy as it both enables and relies on connected partnership working. This project also aligns with national strategic direction in shifting the balance

of care from hospital to community settings.

There is a difference in service level available in-hours on Weekdays and Out-of-Hours (evenings and weekends). In general, there is a much-reduced availability of workforce to continue care in evenings and weekends and this is often covered through an out-of-hours rota system staffed by those working in-hours in community teams. There is also the Grampian GMED service which covers out-of-hours for urgent cases.

To have any hope of moving to a much more preventative and planned-care approach we need to have service provision that covers 7 days. It is also clear from the INCA, West Visits and Acute Care at Home projects thus far that stand-alone or 'double-run' services are not sustainable or scalable. In order to have good chances of success we need to ensure that **existing community teams** deliver care which can be rapidly stepped up or down in line with the needs of the individual.

This will require some changes to how the current system operates to implement a stepped care approach which is:

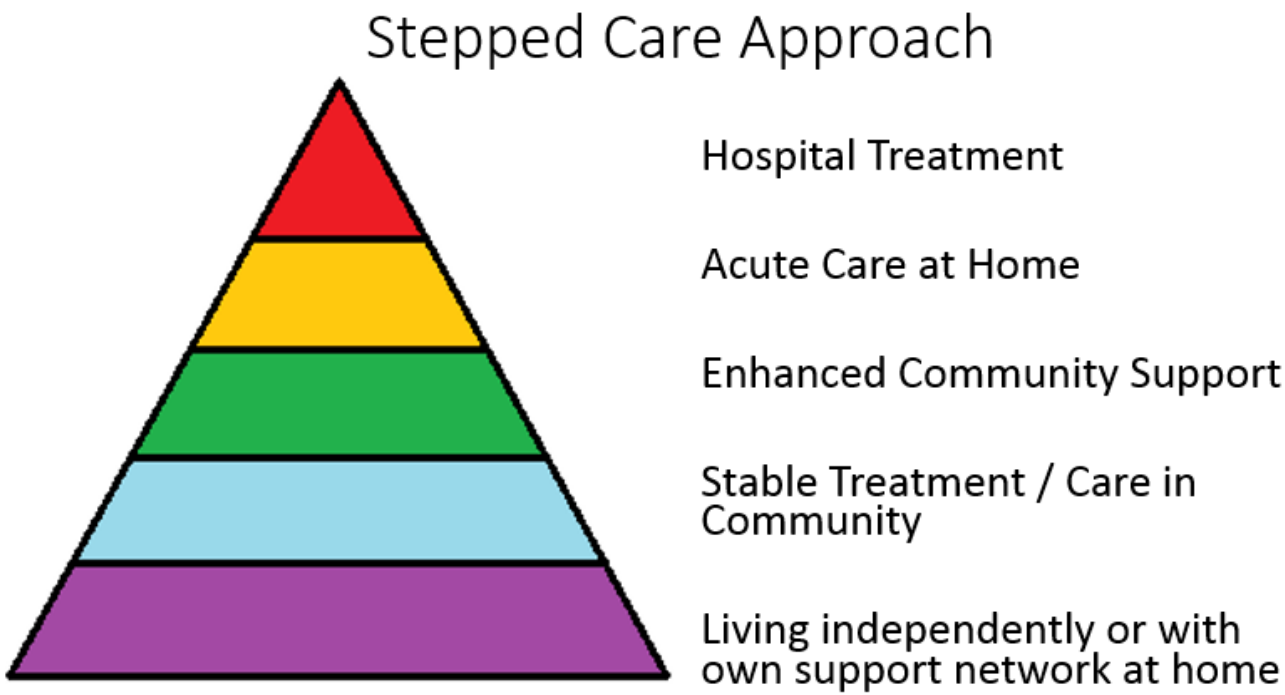
- ✓ Led and run by MDTs made up of **existing skilled and experienced staff** in localities / sub-localities (geography / practice aligned);
- ✓ seamless for the patient – **same staff group providing Urgent / Acute Care at Home, Enhanced Community Support and stable / planned treatment / rehab / support** thus ensuring continuity of care.

Stepped Care Approach

This project will establish a coordinated unscheduled care response serving all localities and GP practices in the city. The service will primarily aim to reduce hospital admissions by providing rapid assessment and diagnostics within the community enabling a decision to be made whether treatment and care can be delivered at home or whether hospital admission is most appropriate for the individual. This project will also enable the earlier discharge of patients from hospital for a short period of 'Active Recovery' post-discharge. There are two different approaches that will enable us

to maintain the person in their own home rather than admission to and treatment in hospital:

- Acute Care at Home
- Enhanced Community Support



In cases where treatment and care at home is deemed suitable (pre- or post-admission) then this care will be delivered by a multi-disciplinary community team comprising members as required by the treatment / care plan. The MDT shall include (but not limited to):

- GPs

- Trainee GPs
- Physician's Associates
- Social Workers
- Advanced Practitioners (e.g. Nurses, AHPs)
- Pharmacists / Pharmacy Technicians
- Community Nurses
- Community Physiotherapists
- Community OTs
- Health Care Support Workers
- Care at Home Workers

Acute Care at Home

This model provides rapid assessment and access to diagnostics to enable decision making on whether the person would be better treated in a hospital setting or in their own homely setting. A range of factors will influence this decision such as:

- Acuity of illness of person being assessed
- Level of required medical / therapeutic support available for delivery of treatment plan
- Suitability / safety of homely environment for delivery of treatment plan

If the person is suitable for treatment, then a treatment plan will be developed and delivered by the acute care at home team in partnership with existing community teams. This will facilitate the stepping down and continuation of care by community teams as the individual returns to baseline levels of function / wellness. In this manner all treatment and care will be delivered as part of a seamless patient focused pathway.

It is true to say that these patients would previously have been treated in hospital by medical, nursing and AHP teams and now they will be treated and supported in the community – this will be an additional workload. It is envisaged that by reducing / eradicating the need for referrals and in some cases duplicated assessments between MDT colleagues that we can release capacity to service this increased demand.

In addition to this, some of our community teams currently do not have basic equipment required to complete observations when out in people's homes in the community. Part of this costings of this project would ensure that community-based staff have the required equipment needed to assess patients and allow them to escalate any deterioration professionally (NEWS equipment – pulse oximeters, tympanic thermometers, etc.). This will also strengthen trusting professional relationships within the community MDT and facilitate the fast, accurate passing of information required to diagnose or manage treatment / support plans.

Workforce

Difficulties have been experienced in the current delivery of the Acute Care at Home Project. This was due to an inability to recruit to Consultant Geriatrician posts on which we relied on for medical input. General Practitioners were a possible alternative for medical input but GPs are also experiencing demand pressure. The positive experience in the West Visits project which utilised Advanced Nurse Practitioners to conduct home visit assessments on behalf of GPs pointed to a possible solution.

There are also however limited numbers of ANPs available, and a lack of a framework for consolidation of learning. Current community nursing teams have DNs qualified to and working at Advancing Practice level. There is scope to develop some of those community nurses to Advanced Nurse Practitioner / Advanced District Nurse Practitioner level which would give additional qualified diagnostic capacity within localities. The training and consolidation of skills and competencies of the current advancing practitioners within existing community nursing teams would take a period of 9-18 months to see them become competent Advanced District Nurse Practitioners in line with our

Partnership need and further embed the stepped care approach within those teams.

The challenges experienced by the Acute Care at Home project in obtaining medical input and competent advanced practitioners has led to a wider exploration of how we could obtain these inputs for assessment, diagnostic and treatment planning which would not further pressurise GP or Geriatrician workloads.

A potential solution has been found to allow the Unscheduled Care project to 'go-live' whilst at the same time bringing required numbers of community nurses and therapists up to advanced practitioner level. Proposals are currently being worked up to access three types of roles:

- Career Start GPs
- Clinical Development Fellows (CDF)
- Trainee GPs
- Physician's Assistants

Career Start GPs are newly qualified GPs and therefore able to undertake all the assessments, diagnostics and come to a diagnosis as a qualified medic. Clinical Development Fellows (CDF's) are doctors after their foundation 2 years who aren't quite ready to commit to a specialty. They are not GPs but they are doctors who we could encourage/enthuse to become GPs. They have to do a certain amount of GMED plus some Acute plus some element of project work. We are currently working up a specification for a primary care CDF to be included in / enhance our service. An appropriate support and supervision structure would need to be agreed and implemented.

Enhanced Community Support (ECS)

This model provides a same day or rapid response to escalation of identified need to medically-fit patients, determined by a General Practitioner / Advanced Practitioner. Older people may be

identified for Enhanced Community Support (ECS) at any time by a range of community practitioners, members of the MDT or by house call or other GP contact.

Older people can also be discharged home to ECS and managed by the team for a short focused period of time. ECS is intended to be a short 7-day (approx.) escalation of care during which time the patients care is coordinated by a Case Management role (e.g. locality District Nurse / Nursing Team Leader / Community Geriatric Nurse / Care Manager) who has access to dedicated social care hours but would not be delayed by having to undergo a SW assessment.

We are working on a solution where by the hours being 'saved' for people in hospital can be used – it won't allow for specific times but will give access to already available and paid for care at home hours across a range of providers. This is a key element to be tested and implemented in the new Bon Accord Care SLA from 1 April 2019 and it is envisaged this approach will be rolled out to all other providers in 2020.

To be 'admitted to' ECS older people are referred through a Single Point of Contact / Referral (SPOC).

The key difference between the normal workings of the MDT model and ECS are:

- Patients are discussed daily by GP & key professionals involved in the older person's assessment (this builds on learning from 'Virtual Ward' approach in Aberdeenshire and elsewhere)
- Assessments are escalated
- Patients are reviewed at a **weekly** ECS MDT meeting

The same MfE Link Geriatrician Consultant will be available to localities and team for advice and support including access to diagnostics, clinic or admission. Consultants will input to weekly ECS MDT meetings.

During an 'admission to' ECS every older person will be offered:

- A Comprehensive MDT Geriatric Assessment, as indicated
- A review or completion of an ACP
- A review or reconciliation of medicines

On 'discharge' any ongoing assessment will be continued through mainstream services and existing community teams.

Preventative work in Care Homes
In analysing data for the Acute Care at Home project admissions to hospital from care homes were identified as an area for improvement. Testing of a version of an ECS-type model has taken place through the current Acute Care at Home project and alignment of Community Geriatric Nurses to localities. CGNs and the ACH team have been reviewing patients on a weekly basis, refreshing / developing Anticipatory Care Plans (ACPs) and intervening early to prevent decline in residents identified as at risk.

Preventative Work in GP Practices
Building on the already successful "Silver City" model of Geriatrician and GP supported MDT reviews in practices, an 'enhanced model' of preventative care is currently in development. Currently, primary care MDT members can bring any patients for whom they have early concerns for a full MDT discussion/review as part of a regular structured meeting – tasks/interventions are then put in place to support the patient in question. In addition to this, the Partnership is currently working with iHub to utilise data from GP systems to flag up cohorts of patients for discussion/review who are **not yet** presenting to MDT members, but are at risk of transitioning to higher levels of frailty etc. This will further expand the early intervention possibilities in primary care, and will allow for work to be undertaken with 'at risk' patients before they present in a crisis scenario.

Out-of-hours and Weekend Cover

Existing Out-of-Hours teams would continue in their role but would have added support over weekends from the 7-day rota staff under this model. Further work needs to be completed to scope

need and impact of this.