south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership Held on:	Integration Joint Board 15th November 2023
Agenda Item:	11
Title:	Hospital at Home

Summary:

The purpose of this report is to provide an update on the progress of NHS Ayrshire and Arran Hospital at Home Team and outline proposed expansion with projection on how this shall be accomplished.

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Recommendations:

It is recommended that the Integration Joint Board

- **i. Note the achievements made thus far by the hospital at home team**
- **ii. Agree with the proposed expansion plans and means to realise this.**

Route to meeting:

Directions:		Implications:	
1. No Directions Required	☐	Financial	☐
2. Directions to NHS Ayrshire & Arran	☐	HR	☐
3. Directions to South Ayrshire Council	☐	Legal	☐
4. Directions to both SAC & NHS	☐	Equalities	☐
		Sustainability	☐
		Policy	☐
		ICT	☐

HOSPITAL AT HOME

1. PURPOSE OF REPORT

The purpose of this report is to provide an update on the progress of NHS Ayrshire and Arran Hospital at Home Team and outline proposed expansion with projection on how this shall be accomplished.

2. RECOMMENDATION

It is recommended that the Integration Joint Board:

- Note the achievements made thus far by the hospital at home team
- Agree with the proposed expansion plans and means to realise this.

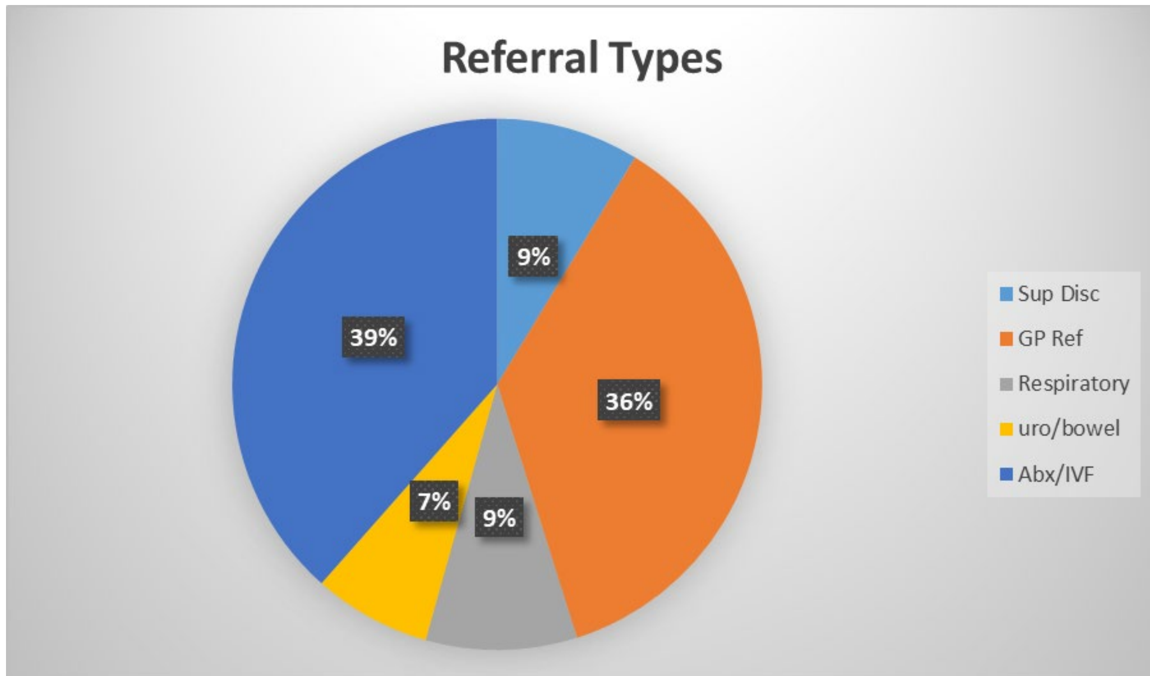
3. BACKGROUND INFORMATION

3.1 Hospital at Home is an alternative to hospital admission, offering short term targeted acute care to individuals in their own home or homely setting. The service treats older frail patients, this is because studies show they are more likely to be affected by delirium and institutionalisation. With 30-56% of older people experiencing a reduction in functional ability between hospital admission and discharge.

3.2 Hospital at Home provides acute care in the patient's own home, which is equivalent to that provided in a hospital. This includes investigations, treatments and referrals. It is a patient centred approach to care focussing on the values of realistic medicine. Each patient receives a comprehensive geriatric assessment (CGA) which the BGS recognises as the gold standard for caring for older frail people.

3.3 Hospital at Home in Ayrshire and Arran was established in January 2022, starting with a geriatrician, nurse consultant and ACE practitioner. It has grown to encompass a team of 19 which includes Geriatricians, Nurse Consultant in frailty, Clinical Nurse Manager, Advanced Clinical Practitioners and Associate Practitioners. Patients within South and East Ayrshire are cared for in their own homes receiving a variety of treatments for individuals with high acuity and complex issues resulting from multiple morbidities and acute illness (see table below for common presentations within H@H).

Below information from Sept 1st 2023 to October 31st 2023. This shows the top 3 most common referrals and the type of referrals – Gp/supported discharge.



3.4 Hospital at Home interventions can include the following

- CGA by acute team experienced in dealing with complex frail older adults.
- Full clinical Assessment
- Access to Investigations on same time scale as in-patient (X-ray, Ultrasound, CT etc)
- IV drugs (antibiotics/diuretics/antifungals)
- IV Fluids
- Oxygen Therapy/ Nebulisers
- Review of polypharmacy +/- de-prescribing

4. REPORT

Scotland has an ageing population, by mid-2043, it is projected that 22.9% of the population will be of pensionable age, compared to 19.0% in mid-2018. Furthermore, the number of people aged 90 and over in Scotland will double between 2019 and 2043 from 41,927 to 83,335. While societies are ageing, associated comorbidities and disabilities are also going to increase. With unscheduled care of older adults increasing and hospital admissions causing safety concerns for older adults, who are admitted more frequently, experience longer stays and occupy more bed days in acute hospitals than other patient groups. The expansion of alternatives to hospital admissions would be beneficial to the people of Ayrshire and Arran.

Over the past 6 months there has been an increase in the virtual beds. In November 2023 we are aiming to have 19 Virtual beds.

Leading on, following a further bid to Scottish Government for Hospital at Home to create a further hub and an additional 12 virtual beds at present, the aim is to

incrementally increase the capacity within South and East Ayrshire to 36 virtual beds by April 2024.

5. STRATEGIC CONTEXT

Funding Bid 1 - Supported by Health Improvement Scotland - Sept 2023

Hospital at Home Team received non-recurring funding from HIS in Sept 2023 for the following.

- 1 x GP extended roles (2 sessions) in place
- 2 x B7 awaiting vacancy requisition to be sanctioned
- 3 x B5 awaiting vacancy requisition to be sanctioned
- 1 x B5 project co-ordinator awaiting to pass scrutiny

The roles above were to support further virtual beds, a test of change involving 2 band 5 Nurses at both hospital sites to help identify and refer individuals to the hospital at home team. The project co-ordinator was to reduce admin for clinical team members thus supporting increased face to face clinical time. Hospital at Home are unable to recruit to the above posts at the current time due to NHS Ayrshire and Arran having special measures in place. This has been escalated to Scottish Government as this would directly affect the impact the Hospital at Home team can make to support individuals to receive acute care in the right place at the right time by the right person.

Funding Bid 2

We are about to commence recruitment for the posts required once the official funding letter has been received by Scottish Government.

The 1st step in this change and are currently recruiting additional staff in the form of:

- 2 x GP with special interest (sessional work) to enable 5 day cover, 3 sessions each to support virtual bed increase.
- 1 x Band 8B Annex 21 Frailty Nurse Consultant to support development and virtual bed increase.
- 1 x Band 8A Clinical Nurse Manager to continue to support clinical and operational changes including setting up a second H@H hub and co-ordinate associated staff, workload, governance and development.
- 3 x Band 7 Advanced Nurse Practitioner to increase overall capacity and enable expansion.

- 2 x Band 5 Staff Nurses to increase capacity and enable expansion.
- 3 x Band 4 clinical support workers to provide increased care needs.

Data is available that shows the current progress being made by the Hospital at Home Team in regard to the overall numbers of referrals, accepted referrals, declined referrals and the length of stay of patients on the virtual ward.

From this we are able to predict that with further staffing/expansion of the existing team if capacity was increased to 36 patients the average number of bed days saved would be an additional 2900 over the year this equates to approximately 12 additional patients a week. Spend avoided full year would be 4,380 bed days @ £320 = £1,401,600. Surge Costs avoided estimated at 6 months = £700,800 Therefore showing the benefit expansion of the team would make to the local community

The overall recruitment process will take approximately 4 months. Within this time we will incrementally increase bed capacity as follows where possible, we are hoping to bank in short term to support flow/capacity.

Based on the capacity created please outlined the expected number of avoided/

Month	**Capacity + Additionality**	**Avg LOS** 7.06 (From avg of July/Aug/Sept) Estimated days saved per week	**Expected No of avoided/reduced admission per month** 60/40 spilt - Primary Care referrals - Supported D/C + OPAT
November 23	18 + 2 = 20	141.2	60/20
December 23	20 + 4 = 24	169.44	72/24
January 23	24 + 4 = 28	197.68	84/28
February 24	28 + 4 = 32	225.92	128/32
March 24	32 + 4 = 36	254.16	144/36
Total	Additional 560 patients		

The service and expansion will be monitored by data collection pertaining to patient admissions, patient acuity, discharges, length of stay, number of bed days saved, relevant staffing and finance data, source of patient referrals including Partnership locality, reason for patient's referral, reason for rejection of patient referral, onward patient referral and patient discharge from service destination.

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