south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership	**Integration Joint Board**
Held on:	**15th February 2023**
Agenda Item:	**9**
Title:	**Hospital at Home Update**

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 UPDATE

1. PURPOSE OF REPORT

1 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

2.1 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.

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 13 which includes geriatricians, 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 often complex issues resulting from multiple morbidities and acute illness (see table below for common presentations within H@H).

Pneumonia	Acute Atrial fibrillation
Congestive cardiac failure	Gastroenteritis
Hyponatreamia and unstable metabolic conditions	Neurological disorders including Parkinson's Disease
Pulmonary embolism and deep vein thrombosis	Infected skin conditions such as cellulitis and infected ulcers
Urinary sepsis	Dementia and related complications
Complex falls	Anaemia
Acute functional decline due to underlying medical conditions	Upper limb fractures after initial assessment
Acute delirium	Influenza
Exacerbations of COPD and Asthma	Acutely unwell nursing home patients
Acute Kidney Injury	

3.4 Hospital at Home interventions can include the following

- CGA by acute team
- Access to Investigations on same time scale as in-patient (X-ray, Ultrasound, CT etc)
- Iv drugs (antibiotics/diuretics)
- IV Fluids
- Oxygen Therapy/ Nebulisers
- Review of polypharmacy +/- deprescribing

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.

Leading to our proposed expansion of Hospital at Home. With 12 virtual beds at present, the aim is to incrementally increase this to 28 within South and East Ayrshire.

5. STRATEGIC CONTEXT

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

- GP with special interest (sessional work) to enable 5 day cover and additional sessions to support virtual bed increase.
- 1 x Band 8A CNM/Team leader to drive forward clinical and operational changes including setting up a second H@H hub and co-ordinate associated staff and workload.
- 3 x Band 5 staff nurses to increase overall capacity and enable expansion of OPAT services
- 5 x Band 3 clinical support workers to provide increased care needs in rural areas and where emergency social care is problematic at short notice.

  The overall recruitment process will take 3 months, therefore in the first instance it will take 6 months to recruit, induct and integrate new staff into the service. This will involve input from the lead consultant, Frailty Nurse Consultant, Divisional General Manager, Head of Unscheduled Care, QI Team and H@H Team members. Within this time, we will incrementally increase bed capacity as follows:

Date/Month 2023	Capacity /virtual bed increase
Feb to April	Remain at 12
May	16
June	20
July	24
August	28

5.2 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 patients referral, reason for rejection of patient referral, onward patient referral and patient discharge from service destination.

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