Ageing Well – Admission Avoidance

Introduction: Home First – Prevention & Avoidable Admissions

- Home First Programme – Key focus on Discharge to Assess pathways '*centred on reducing the length of stay for people in acute care, improving people's outcomes following a period of rehabilitation and recovery, and minimising the need for long-term care wherever possible'.*
- However, need to ensure that we don't lose sight of our prevention and well-being agenda across both health and social care.
- Prevention – primary and secondary also needs to considered
- In Health, our current focus with regards to preventing unnecessary hospital admissions is on Ageing Well

Ageing Well Programme

Ageing Well

To support the Long Term Plan objective to transform 'out-of-hospital' care and fully integrate community-based care to support people with complex needs.

Enhanced Health in Care Homes (EHCH)

MDT

- Review of PCN plans to further develop MDTs for care homes

Falls

Conveyancing

- Care planning
- Training

Anticipatory Care

Draft Operating guidance released by NHSE:

Moderate severe frailty:

- Case identification
- Holistic Assessment
- MDT approach
- Co-ordinated care

People relying on unplanned care to manage their conditions:

- Risk stratification of cohort using population health approach

Urgent Community Response (UCR)

Crisis Response: 2-hour;

- By **March 2022** full geographical coverage required
- Aim of single point of access
- Services provided **8am – 8pm, 7 days a week**

Reablement Care: 2-Day;

- From Any referral source, except hospital wards.
- Interventions of less than, but up to 6 weeks.

End Of Life (EOL)

Palliative Care in the Community Project – scoping phase

- Development of a new model of care to support people to have a good death
- Anticipatory care aspect to start conversation with patients and family sooner and co-develop a care plan
- Increase capacity to support people to stay at home in times of crisis

Virtual Wards

Increase virtual ward 'beds' to 360 – 400 by December 2023

Virtual wards are both:

- Step up to support people staying at home
- step down from acute bedded care to support early discharge.
- Can be enabled with technology for remote monitoring where appropriate

Falls

Wider falls programme sits under the umbrella of Ageing Well.

Care Home Falls Project:

- Reducing the numbers of 999 / 111 call outs for non-injured residents
- To avoid long lies where a resident's condition will deteriorate the longer they lie on the floor

Enhanced Health in Care Homes (EHCH), conveyancing audit

Working with South West Ambulance Service (SWAST), we carried out an audit of 100 care home residents, conveyed to hospital and admitted, to understand:

- The suitability of the conveyance
- The reasoning behind the admission
- Assessment of the number of care plans in place and whether taken in to account
- Estimation of the number of bed day that could have been saved.

What did we find?

- 71% were appropriately conveyed, 25% inappropriately conveyed and 4% undecided
- Only 24 patients had a care plan in place and only 7 of these were documented as seen by SWAST
- 365 total bed days of which 116 bed days could have been saved

Enhanced Health in Care Homes (EHCH), conveyancing audit

What did we do with the findings?

- Findings were presented to many groups and discussions taken place around recommendations
- SWAST has introduced a training module on care planning and action to take
- Primary care focus on updating care plans for care home residents.

Other areas of focus with Care Homes is our Multi-Disciplinary model of care with both Primary Care Networks and Dorset Healthcare; NHS Mail – sharing information; Restore2; Falls project

Falls linking to Enhanced Health in Care Homes

Purpose:

- To avoid long lies where a resident's condition will deteriorate the longer they are on the floor
- Reduce the numbers of 999 / 111 call outs for non-injury fallers in care homes residents

Next Steps:

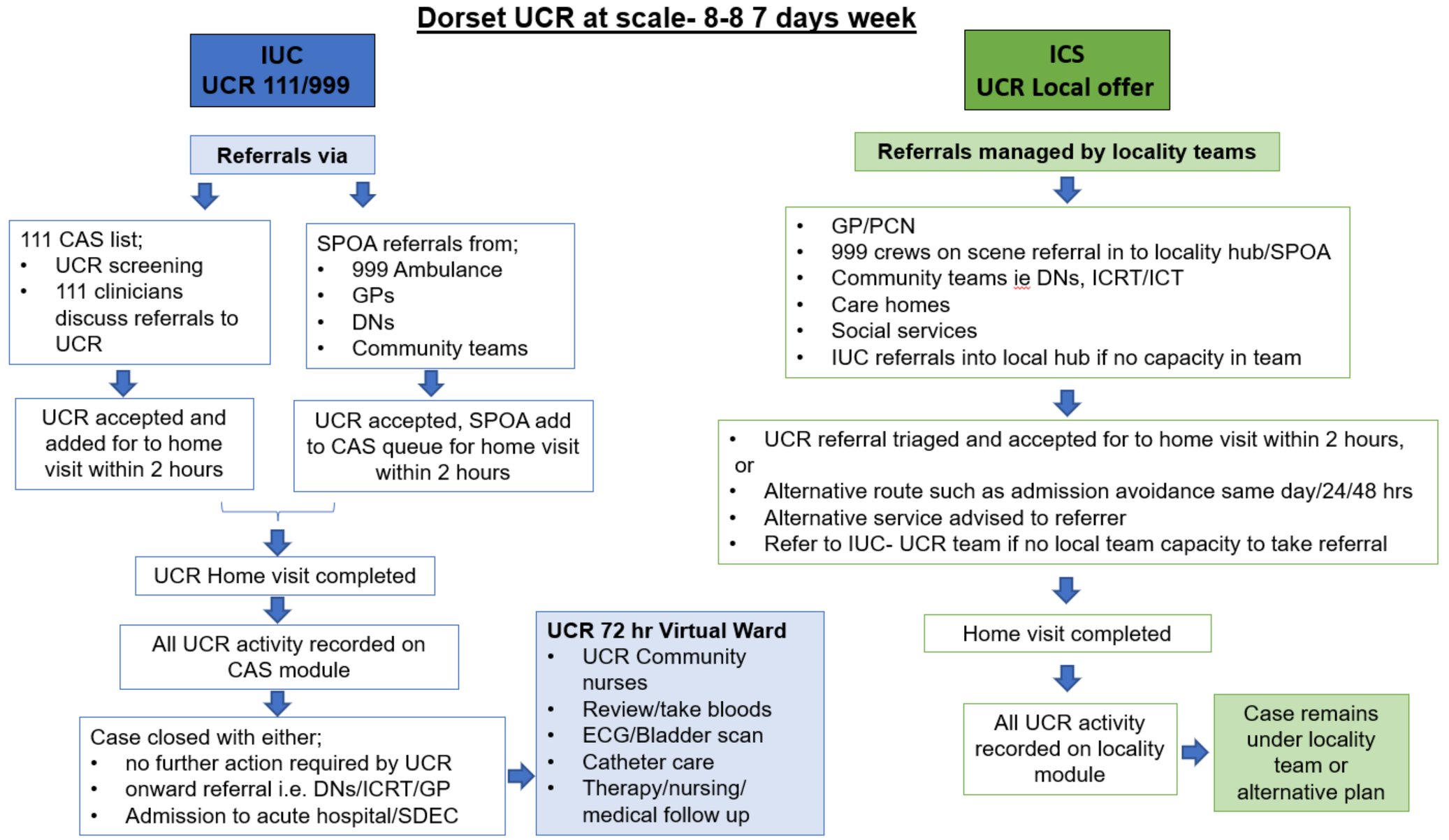
- Identify and establish collaborative working with other partners to ensure appropriate clinical support and governance to care homes post-fall, including pathways
- Identify and provide suitable lifting equipment and training to educate care workers to lift a resident safely after a fall, particularly those at greater risk, as well as understanding when not to lift because of risk

Urgent Community Response (UCR) - where are we?

At Scale 2-Hour Response

- Phased roll out across the county, with full implementation planned for end of March 2022
- Current provision is 8am – 8pm, 7 days a week
- Directly screening from Clinical Advisory Service to NHS111 and pulling suitable cases from the call stack
- Developed IT links with South West Ambulance Service Trust (SWAST) to refer calls directly to UCR
- SWAST has dedicated clinician for Dorset, triaging calls to refer to UCR
- Nurse led Virtual Ward under development to support people for up to 72-hours following intervention
- Pathway for referral for on going care in place.
- Welfare checks provided via a social care organisation for patients needing additional support following an intervention

Urgent Community Response Delivery Model



Urgent Community Response Next Steps

- Introduction of Primary Care Network 2-hour response offer
- Opportunity to bring together Out of Hours and UCR, moving to a 24 hour service
- Further development of the 2-day rehab and rehabilitation 2-day response

Anticipatory Care

Where are we are we?

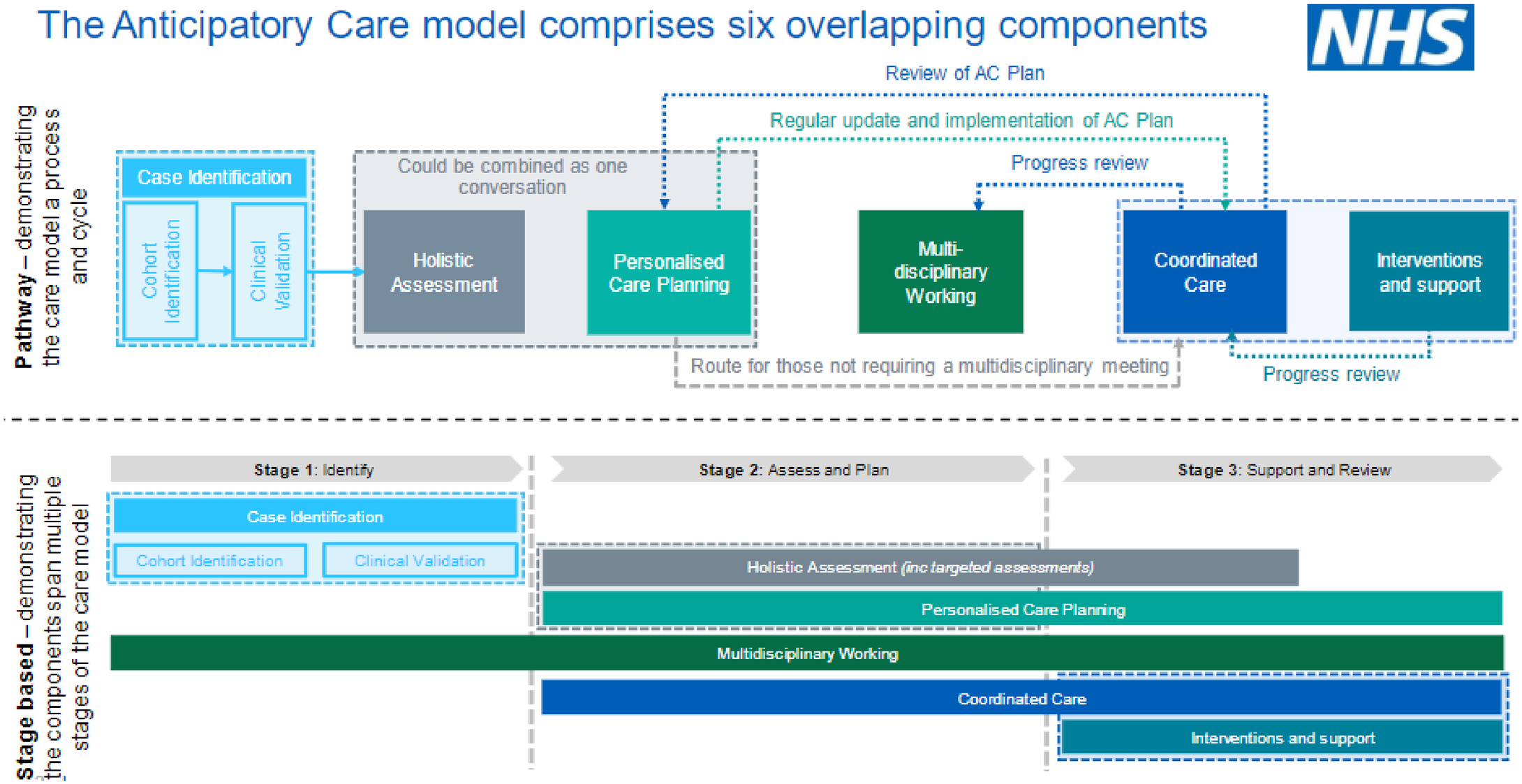
NHSE released the draft Operating Guidance document focusing on 3 key areas:

- Focus on Moderate and Severe frailty
- Health inequalities
- Focus on people who rely on unplanned care to manage their conditions.

In 2021 Dorset CCG used population health data to allocate funding to Primary Care Networks based on level of need with a focus on:

- Deprivation
- Rurality
- Frailty – mild, moderate and severe
- Risk of emergency admission within the next 12 months
- Risk of falls

Anticipatory Care, next steps



Virtual Wards

NHSE Ambition:

- 40 to 50 virtual ward ‘beds’ per 100,000 population by December 2023.

For Dorset this means:

- 360 to 400 virtual ward ‘beds’ by December 2023.

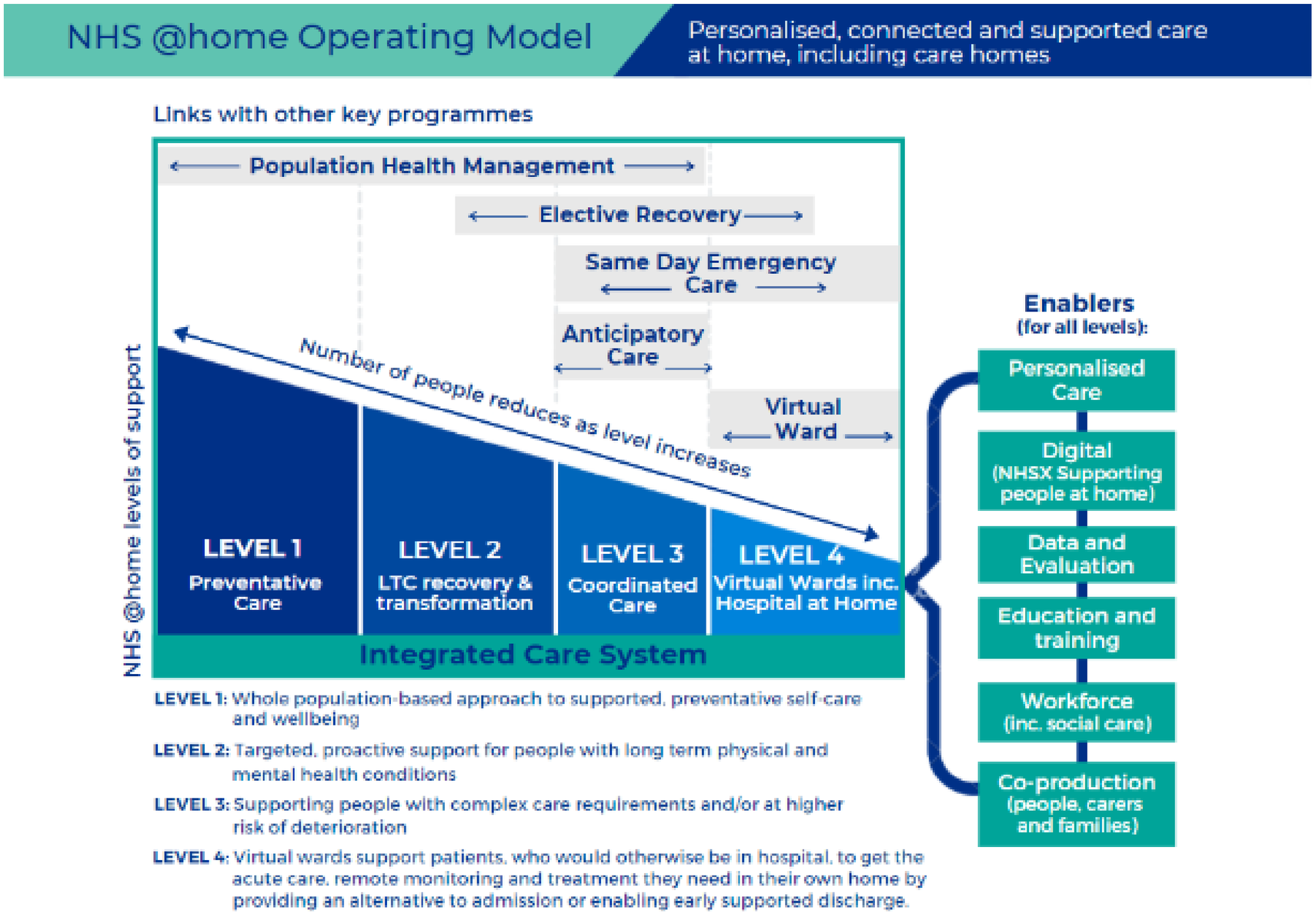
What is a virtual ward?

- A virtual ward is a safe and efficient **alternative to NHS bedded care** that is enabled by technology

- Virtual wards support patients who would **otherwise be in hospital** to receive the acute care, monitoring and treatment they need in their own home

- This includes either **preventing avoidable admissions** into hospital or **supporting early discharge** out of hospital.

Virtual Wards, understanding levels of care



Palliative Care and End Of Life Programme

Aims:

- Develop a model of care to support people to have a good death in the place of their choosing
- Reduce pressure on Out of Hours services, 999 and reduce avoidable admissions
- Support timely discharge of those who are end of life

Next Steps

- Increase capacity in the community and building resilience in family members to support people in their last weeks of life
- Strengthen links with the Voluntary (VCSE) to support people with their non-clinical needs
- Develop an anticipatory care approach to End of Life care by offering support to people at point of prognosis
- *Home to Die* pathway in West of County implemented 1 February, with an evaluation to inform longer term commissioning especially in relation to model of care across NHS and Local Authorities

Questions

Our Dorset
Your Local NHS and Councils Working Together