South Ayrshire Health and Social Care Partnership

REPORT

Meeting of South Ayrshire Health and Social Care Partnership
Held on 13 April 2017

Agenda Item 8

Title Acute Frail Older Peoples Pathway/Intermediate Care & Rehabilitation

Summary:
The Acute Older Peoples Pathway and enhancement of the South Intermediate Care & Rehabilitation Service has resulted in improvement to the quality and appropriateness of care for the over 65 patient group, with an associated potential resource saving in cost avoidance.

While this redesign is in early stages it is perceived and has proven to be a positive model that should be further developed alongside the South Ayrshire Health and Social Care Partnership (SAH&SCP) key priority areas of :Redesign of Biggart Community Hospital: Community Rehabilitation, Reablement and Anticipatory Care Planning in localities.

Presented by Tim Eltringham, Director of Health & Social Care

Action required:
The Integration Joint Board is asked to:
- Note the findings of this report
- Support and acknowledge the progress that has been made
- To consider and comment on proposed next steps

Implications checklist – check box if applicable and include detail in report

Financial ☒ HR ☒ Legal ☐ Equalities ☐ Sustainability ☒
Policy ☐ ICT ☐

Directions required to NHS Ayrshire & Arran South Ayrshire Council, or both

1. No Direction Required ☒
2. Direction to NHS Ayrshire and Arran ☐
3. Direction to South Ayrshire Council ☐
4. Direction to NHS Ayrshire and Arran and South Ayrshire Council ☐
1. PURPOSE OF REPORT

The purpose of this report is to brief Integrated Joint Board Members on a recent service redesign and implementation of a pathway for frail older people within University Hospitals Ayr, (UHA). This approach to improving older peoples acute care is part of the wider transformation of Enhanced Intermediate Care & Rehabilitation and the redesign associated with the pan Ayrshire Strategic Models of Care and Unscheduled Care Transformational Change.

2. RECOMMENDATION

2.1 It is recommended that the Integration Joint Board

- Note the findings of this report
- Support and acknowledge the progress that has been made
- Consider and comment on next steps

3. BACKGROUND INFORMATION

3.1 In May 2013, NHS Ayrshire & Arran were one of several NHS Boards to test a Frail Older Person Pathway (FOPP) in University Hospital Crosshouse and University Hospital Ayr. This pilot was undertaken in conjunction with Healthcare Improvement Scotland (HIS) and their data review and cost analysis demonstrated that multidisciplinary assessment (MDT) and comprehensive geriatric assessment (CGA) at the Acute front door can reduce admissions, readmissions, re-attendance and produce cost avoidance savings.

3.2 Over the past year the South Ayrshire Health & Social Care Partnership and University Hospital Ayr, Senior Management Team has worked closely to identify new models of care and areas of transformational change which would reduce unnecessary hospital admission, delayed discharges and care home admission but improve outcomes for the frail older person while making more appropriate use of Care of the Elderly Consultant time and use of Biggart Hospital rehabilitation. This work has been informed by the partnerships strategic priorities for Integrated Care, Delayed Discharges, Building for Better Care, (in particular the development of the Combined Assessment Unit) and a strategic Pan Ayrshire Programme of Transformational Change.

3.3 Following a “Day of Care Audit in 2015, Dr Anne Hendry National Clinical Lead for Older People was commissioned to undertake a “critical friend” review of existing processes and services within Acute and Community. Her review and recommendations identified that the adoption of a frail elderly pathway with a focus on comprehensive geriatric assessment, intermediate care, rehabilitation and rapid
care transition would improve outcomes for patients. In particular the advent of a new Combined Assessment Unit offered significant opportunity to identify patients who did not need admission but may need additional support to return home.

3.3 A small team led by Dr Christina McQuiston, comprising mainly Intermediate Care, Discharge Co-ordinators, Social Work and Care of the Elderly Consultant was established to test the implementation of this pathway using an action research methodology. The team were strongly supported by Senior Managers, Clinical Directors and Service Improvement Leads. This approach was taken to empower and support the team to make rapid change and improvement in day to day operational practice that would ensure adoption of the pathway and continual improvement and iteration.

4. REPORT

4.1 Key Timeline and Milestones

The following table highlights the key objectives and areas of redesign within the pilot:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>August 2016</td>
<td>ICT resource increased and coordinated MDT assessment provided to CDU, Geriatricians and Medical receiving and Acute Wards</td>
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<tr>
<td>September 2016</td>
<td>Scoping of the Acute Care of Elderly processes and patient flow in particular clinical decision making, assessment and referral to Geriatricians and Biggart Hospital.</td>
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<tr>
<td>January 2017</td>
<td>Dedicated carers resource integrated within Intermediate Care &amp; Rehabilitation enabling rapid crisis response and increase in caseloads and efficiency. Scoping District Nursing contribution to planned anticipatory discharge and transition of care.</td>
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<tr>
<td>February 2017</td>
<td>Scoping and agreement of appointment of Acute Care of Elderly Practitioner (ACE) in CDU and St 7, with rotation into ICT. Further development of workforce</td>
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<tr>
<td>March 2017</td>
<td>Embedding ACE into Station 7 Medical Receiving and ICT</td>
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<tr>
<td>April 2017</td>
<td>Agree discharge and ACE pathways (see appendix2) Embed DN contribution</td>
</tr>
<tr>
<td>May 2017</td>
<td>Opening CAU Scoping of Phase 2 redesign and TEC /ICT requirements</td>
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<tr>
<td>June 2017</td>
<td>Commence Phase 2 redesign and transformation</td>
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4.2 Preliminary Data
Data were collected retrospectively over a six month period to allow an assessment of the impact of the ACE pathway to be carried out. The cohort studied were all referrals to Care of the Elderly for assessment and rehabilitation. End Points in the pathway were identified to determine impact and outcome and these were agreed as:

- Length of time from initial Care of the Elderly referral, to discharge, either home or step down
- Length of time of above excluding outliers (those with excessive length of stay)

4.3 Summary of Preliminary Results

While data still continues to be collected and interrogated, it is possible to highlight and share some early preliminary findings.

- At commencement there were on average between 35-45 referrals per month to Care of the Elderly Consultants. At month 3 referral rates were showing a downward trend. Plan Do Study Act testing of the COE assessment and diagnostic tool also highlighted that clinical staff were referring right patients more appropriately
- Averages of approximately 15 days saved were identified in length of time from initial COE referral to discharge and/or step down. These are described in fuller detail in graph 2, within appendix 1.
- The average percentage of patients waiting greater than 10 days and those more than 30 days also demonstrated similar downward trends with an average reduction of 20%.
- Early supported discharge using ICT bed days saved and estimates of cost avoided in cumulative bed days were also calculated. Over the 6 month period an estimated 333 bed days were saved demonstrating potential resource savings from ICT interventions, length of stay and avoided admissions. Graph 3 and 4 in appendix 1 also describe this in more detail.

5. STRATEGIC CONTEXT

5.1 This report links to the following approved Strategic Plan Objectives and Policy Priorities:

(D) We will support people to live independently and healthily in local communities.
(E) We will prioritise preventative, anticipatory and early intervention approaches.
(F) We will proactively integrate health and social care services and resources for adults and children.

6. RESOURCE IMPLICATIONS

6.1 Financial Implications

6.1.1 In order to assess the complexity and ultimately the cost impact of this pathway of care for frail elderly patients a full economic business case in being developed. This will be included within the pan Ayrshire Intermediate Care & Rehabilitation (including Community Rehabilitation) Business Case that will be presented to NHS Scrutiny Panel in April 2017.

6.2 Human Resource Implications
There has been additional investment through Integrated Change Fund, Delayed Discharge and Acute monies in the Intermediate Care & Rehabilitation Service and Acute Care of the Elderly Pathway.

6.3 Legal Implications

6.3.1 There are no immediate or apparent legal implications

7. CONSULTATION AND PARTNERSHIP WORKING

7.1 This redesign has been developed in consultation and partnership with staff within Acute and Intermediate Care & Rehabilitation Service. There are also ongoing discussion with staff side representation and partnerships.

8. EQUALITIES IMPLICATIONS

8.1 There are none apparent at this time

9. SUSTAINABILITY IMPLICATIONS

9.1 Sustainability is reliant on implementation of transformational change programmes, workforce development and budget allocations.

10. CONCLUSIONS

10.1 This paper highlight the positive progress that is being made in developing and implementing an acute care of the elderly pathway built on existing resource at University Hospital Ayr and the South Ayrshire Intermediate Care & Rehabilitation Service. Further intersection and collaboration between Combined Assessment Unit, Intermediate Care and Rehabilitation and Care of the Elderly will ensure that patients receive the right care at the right time with a focus on prompt geriatric assessment, multidisciplinary working and enablement. The recommendations of the pilot will inform ongoing implementation and Phase 2 of the redesign.

REPORT AUTHOR AND PERSON TO CONTACT

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6th April 2017

BACKGROUND PAPERS
Appendix 1

Graph 1

Monthly referrals to COE

Graph 2

Average time to DC to Rehab
Graph 3

% Patients waiting >10 days and >30 days

Graph 4

Early supported DC by ICT Bed Days Saved