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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
9 JANUARY 2024

HEALTH AND CARE SYSTEM PLANS TO REDUCE INAPPROPRIATE ADMISSIONS TO HOSPITAL

Summary

1. The Health Overview and Scrutiny Committee (HOSC) has requested an update on health and care system plans to reduce inappropriate admissions to acute hospital care and to support patients to be cared for in the most appropriate setting.

2. Representatives from NHS Herefordshire and Worcestershire Integrated Care Board (ICB), Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) and Worcestershire County Council (the Council) have been invited to attend this meeting to respond to any questions the Committee may have.

Background

3. At its meeting on 7 December 2023, the Committee focused on **in** hospital patient flow including an update on the new Emergency Department at Worcestershire Royal Hospital.

4. This report is intended to provide the HOSC with an update on progress within the 'pre-hospital' health and care economy which aims to offer the right care to local residents in the right place at the right time.

Pre-Hospital Programme

5. The Pre-Hospital Programme is coordinated by the Urgent & Emergency Care (UEC) and Community & Ageing Well programme teams within the ICB. The Pre-Hospital Programme is delivered in collaboration with system health partners through the Pre-Hospital Steering Group which meets monthly. Members include clinicians and executives from Primary Care Worcestershire, Worcestershire Acute Hospitals NHS Trust (WAHT), HWHCT and the ICB. The senior responsible officer and chairperson is Sarah Dugan, Chief Executive of HWHCT.

6. The Pre-Hospital programme aims to support a number of the 10 key priorities within NHS England's UEC Recovery 10-point action plan and is underpinned by the Herefordshire & Worcestershire Integrated Frailty Strategy 2023-2028 and NHS England (NHSE) National policy and guidance.

7. As listed in NICE Guidelines, there is an increasing evidence base to support the treatment of some medical illnesses in a person's own home following a clinical assessment. There is recognition that not all patients benefit from receiving hospital bed-based care due to functional decline and many other influencing factors. The pre-hospital agenda does not look to 'keep people out of hospital' but rather to clinically assess where a person could receive the appropriate model of

care, with a holistic view of support networks, family, safety, and housing too. Prevention and early intervention are key aspects of this work.

8. The Pre-Hospital Programme focuses on key workstreams including and not limited to:
    a. Urgent Community Response (UCR)
    b. Care Navigation Hub / Single Point of Access
    c. Virtual Wards
    d. Primary care access
    e. Minor Injury Units
    f. Frailty and falls prevention
    g. Care Homes

A Patient Journey

9. A person who feels unwell can:
    - contact their GP, local pharmacy or NHS 111 via telephone or app for advice, support and appointments.
    - If someone has a minor illness/injury then they can self-present at their local Minor Injury Unit (MIU)
    - If they are unable to leave their home, they may access health care via their Primary Care Network or Neighbourhood Team which consists of community nurses, pharmacists, and more.
    - If someone has a fall in their home and they have a pendant alarm, then a community falls responder can attend to help someone up off the floor and do a wellbeing check. If a person is injured from a fall, then the Urgent Community Response (UCR) team or a paramedic can attend to either treat and remain at home or convey to hospital if in need of specialist acute care.
    - A person can be referred to their Neighbourhood Team, UCR or virtual ward.
    - If a person calls 999, their call will be logged and triaged - if appropriate then an ambulance will be dispatched, but the ambulance service can also refer to these alternative community services if it is deemed in the person's best interest.

10. The pre-hospital programme looks to identify appropriate alternatives to attending the emergency department (ED) where possible.

Progress

11. **Urgent Community Response (UCR):** this service is delivered by HWHCT via the Neighbourhood Teams (NTs) and provides people in their home with urgent assessments, care, and treatment where possible to avoid unnecessary hospital admission. An assessment is usually completed within two hours and personalised support is provided within 24 hours. The team is multi-skilled and includes a variety of professionals such as call handlers, advanced clinical practitioners (ACPs), community nurses, and therapists with access to GP oversight and support. Referrals are made via local GPs, Primary Care Networks (PCNs) and neighbourhood Teams which can relieve pressure on primary care. Residents may also call 999 in an emergency which West Midlands Ambulance Service (WMAS) in collaboration with the UCR team can then clinically triage and

pass appropriate patients over to the team to support people being treated in their home and to potentially avoid an unnecessary conveyance and admission to hospital.

12. In November 2023, 50% of referrals made into UCR were directly taken from WMAS which saw 349 cases responded to by community clinicians as opposed to ambulance dispatch. Prior to the UCR service launching, those 349 people would have been waiting for an ambulance or gone straight to Emergency Department. Appendix 1 (Illustration A) shows UCR performance data.

13. The Worcestershire UCR team consistently meet or exceed the NHSE standards and continue to excel in partnership working with the rest of the health and care system. It is an excellent example of partnership working and is deemed a great service nationally. The service continues to grow and adapt to the needs of the system including a recent initiative where the UCR team goes into the ED at Worcestershire Royal Hospital and redirects patients that can be treated at home to avoid unnecessary admission.

14. **Care Navigation Hub (CNH) / Single Point of Access (SPA)**: the vision is a team of teams working together for the safe and timely coordination of care and support. It is a single point of contact for health providers, offering clear escalation and unblocking issues. The Hub facilitates admission avoidance and discharge to support patients in receiving the right care in the right environment. It brings together, acute, community, primary care, voluntary, community and social enterprise (VCSE), mental health, homeless liaison and social care supported by transport, safeguarding and equipment services. The SPA went live on Monday 4 December 2023.

15. **Virtual Wards**: also known as hospital at home, allows people to receive hospital level care safely at home, helping speed up their recovery, prevent functional decline, whilst freeing up hospital beds for patients that need them most. In Worcestershire there is a ‘step up’ Frailty virtual ward in the Wyre Forest with the second phase expanding to Evesham, Bredon, Broadway, Inkberrow, and Malvern in the new year. The programme team have been working closely with system partners to establish a longer-term plan for upscaling virtual wards across the county to ensure equity in the frailty provision. The vision is to have a Virtual Hospital where speciality virtual wards can be layered onto a strong infrastructure between Acute and Community providers. This winter will also see a respiratory virtual ward launched in partnership with WAHT. With a fully functioning virtual hospital, there will be options to escalate and discharge patients between community and acute settings with a virtual ward option in the middle to enhance the admission avoidance offer.

16. **Primary Care Access**: although elements of primary care access are included in the pre-hospital programme, it is paramount to acknowledge that there is a separate Primary Care Access Recovery Plan (PCARP) with its own governance in operation. Routine GP services data show booked appointments are above pre-pandemic levels and Herefordshire and Worcestershire continue to perform in the top three ICBs in the Midlands against the Plan. The ration of appointments to population at 0.61 continues to be the highest in the Midlands, by a significant

margin, with the national rate at 0.50. This equates to 609 appointments for every 1000 patients. There are several other schemes being driven by PCARP and reported into NHSE including the implementation of 'self-referral' routes in seven named pathways including falls, audiology, community equipment services and tier two weight management, to further reduce pressure on primary care.

17. **Minor Injury Units (MIUs):** Since the pandemic, activity in local MIUs has significantly increased and continues to year on year. Activity is shown in appendix 1 (illustration B). MIUs offer another alternative to attending the ED and ease pressure on the system. The opening hours at Princess of Wales Community Hospital, Bromsgrove have been expanded to facilitate this increase in activity and HWHCT (with service partners) is looking to improve how MIUs operate in the next financial year. Hours at Kidderminster MIU reduced during the Covid pandemic and now the opening hours are more equitable across all MIU sites, with better take-up during the opening hours, signalling improved resources optimisation.

18. **Frailty and Falls Prevention:** Worcestershire has a very engaged multi-disciplinary Falls Network which meets bi-monthly to bring together health, social care, housing, VCSE and public health. The prevention offers available through local authority and VCSE services are showcased in this forum and linked in with redesign of NHS falls pathways and services. This work feeds into pre-hospital care and is a significant part of the Frailty Strategy priority of prevention. There are services commissioned to respond to non-injured fallers which eases pressure on UCR and Ambulance services. They all work in partnership to ensure the right service is dispatched to care for a person who has fallen.

19. The Integrated Strategy for people living with Frailty (2023-2028) was published in October 2023 and a local delivery plan has been developed. Engagement with system partners including social care, public health and primary care has been exemplary and there is now a shared vision on how to deliver the best care and support for people living with Frailty. This will help people receive appropriate care in the community rather than hospital admissions. Work with Worcestershire County Council (the Council) will be key to maximising people's independence and keeping them well at home. This is a link to the use of the Better Care Fund.

20. **Care Homes**: The ICB commission 66 Care Homes with nursing across Worcestershire. Each of these homes receives a regular quality assurance visit by the ICB Nursing and Quality Team alongside the Council partners, using a joint Quality Framework. An integral part of 2023/2024 winter plans is to drive the improvement of care across Herefordshire and Worcestershire. This will be achieved by working closely with Care Home colleagues and ICS partners offering support with digital innovations, training of staff and having a named nurse for every Care Home with nursing that is commissioned. In October 2023, the Care Home Deterioration pack was successfully launched across Herefordshire and January 2024 will see the roll out of Worcestershire's Deterioration pack across all Care Homes and Domiciliary Care providers. The Care Home Deterioration Pack is a locally produced resource which supports care homes to identify deterioration in a resident's health earlier in the process to reduce a health crisis. The resource also provides a wealth of guidance and local signposting with clear escalation routes if a resident is unwell. The concept should build confidence of care home colleagues in decision making which in turn may reduce the number of calls to

999 and admissions to ED.' The Care Homes Quality Network was launched this winter and meets bi-monthly with an aim to provide dedicated training to care home staff, delivered by guest speakers on key areas such as Sepsis, management of falls, and respiratory conditions etc. It has been very well attended to date with excellent feedback.

21. An audit is currently underway to review Care Home 999 activity, exploring the number of calls, reasons for 999 calls, and how many of the calls resulted in a resident being conveyed to an Emergency Department. Supportive meetings with Care Homes demonstrating high 999 usage are underway to better understand issues and offer holistic support. Any areas that identify opportunities to offer training, boost primary care/community support or review staffing challenges can be addressed. This work is in conjunction with the ICB Care Homes Digital Team and ICS partners and has been well received by care homes to date. This work will continue over the winter period whilst the impact of the actions are monitored to build a longer term integrated plan.

22. **County Council support through social care and the Adult Front Door**: The Adult Front Door is the way in which customers can access services to support their care and support needs including social care. Worcestershire County Council's Adult Social Care provides social work services to support all residents who require advice and information and support to prevent, reduce and delay the need for services, enabling people to live independently. Keeping people safe, is key and under the Care Act 2014, the Council provides advice and information via the Adult Front Door, and for those who may be eligible for support, offer a full assessment, usually within 28 days to assess a person's needs. In order to support its health partners and compliment their services, the Council recognises the need to work at pace to prevent an admission to hospital. To do this, a duty social work service is provided, with a response within 2 hours, working closely with Neighbourhood Teams.

23. Examples of specific schemes and services that support the avoidance of hospital admissions are as follows:

<u>Admission Avoidance for people with Learning Disabilities</u>

24. The Dynamic Support Register (DSR) is a register of people with Learning Disabilities and Autism. Managers from Adult Social Care and the ICB, attend fortnightly meetings to discuss individuals with learning disabilities and autism at risk of an acute Mental Health hospital admission. Discussions capture an update on the person's current needs and a multi-disciplinary decision is made on their current risk of admission. Multi-Disciplinary Team (MDT) meetings are held with the Community Learning Disability Nursing Teams and Social Work Teams, on a monthly basis, to discuss individuals and their presenting health needs. They are a mechanism to discuss individuals who are at risk of hospital admission and ensure there are plans in place for joined up care and support on discharge.

<u>Reablement</u>

25. When people have been discharged from hospital into the Reablement Service, there may be occasions where their health deteriorates during their recovery. In this instance the service works alongside the Urgent Community Response Service (provided by HWHCT) to obtain a rapid clinical assessment, with the purpose being to prevent re-admission to hospital by providing co-ordinated

support to meet all health and social care needs. Daily conference calls also take place between the Council's Reablement Service and the Neighbourhood Teams, which enables discussion of complex cases and the ability to share resources to ensure both health and social care needs are being met. This also ensures capacity is retained in Neighbourhood Teams to respond to urgent health requirements in the community, which contributes to admission prevention. The Reablement Service and Neighbourhood Teams also hold 'buffer stock' of some items of equipment which is located across the six districts of the County. When there is an urgent equipment need to prevent hospital admission, any of these teams is able to respond to this by visiting the person and assessing and fitting equipment.

Service of Last Resort

26. Adult Social Care can provide a Service of Last Resort, which is delivered in house to support people at home in a crisis, in the short term. The Council also provides Emergency Replacement Care, for a person to receive care and support in a residential/nursing home setting for a short period until they have recovered. This is often due to short-term health needs such as UTI's, falls etc where they need 24/7 support to avoid further deterioration in their health and well-being.

Services under development

27. In the Adult Front Door, the Council is focussing on factors contributing towards admission avoidance and working on the following areas:
    - Targeted Adult Support Team (TAST) are working with people at an earlier stage
    - Developing a paper for the Integrated Commissioning Executive Officers Group to secure funding to work with people who hoard, to be able to offer supportive interventions
    - Work with Public Health on frailty and reducing muscular degeneration
    - Use of Assistive Technology for falls prevention
    - Discussions regarding the role of the Adult Front Door in the Care Navigation Hub are in the first stages.

Challenges

28. The Worcestershire system has experienced significant pressures in urgent and emergency care despite the innovative and coordinated admission avoidance schemes that have materialised in recent years.

29. The challenges for admission avoidance schemes can be grouped into four key areas:
    (1) Attracting or growing a workforce with the appropriate skills is one of the most fundamental challenges that limits the admission avoidance schemes capacity.

    (2) The use of technology as a lever to improve communication and sharing of information across organisations to be able to work together and introducing digital interventions into the community. Some of this may need resourcing.

    (3) Targeting admission avoidance schemes at people at a higher risk of need urgent or emergency requires a risk stratification approach, based on health and the wider determinants of health. At the present time, Worcestershire

does not have an agreed risk stratification approach across Primary Care and Community Services.

(4) The system is operating in a financial deficit, limiting resources for scaling up pilots or transformation. Work is underway to explore making investments in areas that have robust evidence-base or can demonstrate a return-on-investment.

Purpose of the Meeting

30. The HOSC is asked to:

- consider and comment on the information provided; and
- determine whether any further information or scrutiny on a particular topic is required.

Supporting Information

Appendix 1 – Performance Summary

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance), the following are the background papers relating to the subject matter of this report:

- Agenda and Minutes of the Health Overview and Scrutiny Committee on 7 December, 11 September, 15 June, 10 February 2023, 1 December, 17 October 2022, 18 October 2021

  Health Overview and Scrutiny Committee Agendas and Minutes are available here