Citywide Locality Engagement Forum: Maximising Independence and Hospital @ Home Report on 6 December 2022

Introduction and Welcome

Robert Smith, Chair of NW Locality Engagement Forum, welcomed participants to the Citywide Locality Engagement Forum session with presentations on the Maximising Independence Programme and Hospital @ Home 'test of change' project.

Maximising Independence (Marion Ballantyne, Maximising Independence – Communications)

Marion began her presentation (attached) the HSCP definition of 'Maximising Independence' in this programme. It is 'supporting people who can and want to, remain living at home safely for as long as possible with the right support in place for them, and their carers if they have them'. Marion described work undertaken to date, explained why the HSCP are talking about Maximising Independence, who it would benefit and progress so far. It was noted that progress had been hindered in the beginning due to it being seen as a stand alone programme. This position has now changed and is seen integral to the way the HSCP works.

Any type of change programme in a large organisation is difficult to achieve due to the size of the task so the work was broken into five specific workstreams – Workforce and Culture, Communication and Engagement, Health and Equalities,Commisioning and Communities.

Marion described the role of the LEF members in this work, future plans and highlight examples of good practice already operating in the community including WOW, Knightswood Connects, Walking Groups and examples being progressed by HSCP staff. Such as the greater use of technology to support people in their own homes and Home care staff using a buzzer/door bell so that people who are able to have the opportunity to maintain mobility by answering the door therefore encouraging elderly people to stay active.

Robert noted that the time allocated for Homecare visits are really tight especially if a person takes a long time to answer the buzzer. He wondered if making older people walk unneccesarily may also increase the risk of trips and falls. He commented that if you want people to get involved with Maximising Independence the HSCP need to change the way they communicate with them and start listening to what people want from health and social care services.

It was clarified that no one was being expected to walk to a door to answer a buzzer, this example was based on advice from physios that where the person being supported had capacity to maintain mobility, this was a good small everyday activity that might be of use to maintain wellbeing and prevent decline.

Marion agreed that impoving communication with the public was crucial as well as looking at new ways of providing information and using less jargon in order to reduce barriers to accessing services. We also need to be more effective in reaching 'easy to ignore'

individuals and communities to be able to gather and reflect their views. We want to find out 'what matters to you?' rather than 'whats the matter with you?'

One member commented that Maximising Independence should not be afraid of testing change – 'if it doesn't work then change and start again – listen to families, carers and services users because they are the experts'.

Another member of the audience worried that care and support would just shift to carers and families. If carers are over burdoned then their health is a risk.

Some audience members felt that Maximising Independence 'put all older people in the same category implying that everyone over a certain age had dementia or have difficulty understanding basic information or needed help' This is not the case as many older people contribute to community, provide supports and activities/services plus doing things for themselves and are self reliant.

Comments from audience:This progamme aims to involve and give the the third sector a bigger role in providing services. This could be a problem as the 3rd Sector are stretched to the limit and they do not have any spare capacity to take on extra work without increasing their resources. It was felt that the HSCP provide £1 funding to the 3rd Sector but expect £2 worth of support and care services.The 3rd sector and community projects need resources and funding to provide care and support services in the community. The HSCP should fund trusted 3rd sector organisations for longer period of time – rather than one off and one year grants. Marion advised that this message had been heard loud and clear in a number of forums.

There was a discussion highlighting that both the HSCP and 3rd sector projects were experiencing difficulty in recruiting and retaining staff which hindered providing services.

The final discussion on Maximising Independence centred on when this change on how the HSCP deliver services will make an impact and improvement to individuals lives. It was hoped it would not take years.

Marion advised it sometimes takes a long time to see change or improvement in services due to the size and diversity of the Glasgow population but it was important to give regular updates and keep people informed about changing services. It is hoped that the LEF will have an important role in circulating information to service users and in the community.

Hospital at Home Dr Jude Marshall (GP) and Chris Rowley (Service Manager)

Dr Jude Marshall began by explaining that the Hospital at Home, test of change project, is a short-term targeted intervention that provides hospital care in an individual's own home that is equivalent to that provided within a hospital. It began in 2021 and is now delivered by twenty HSCP/Health Boards in Scotland.

Hospital at Home is person centred, personalises care and value based care, home is often where people would like to be and prevents patients from hospital 'harms' such as deconditioning, disconnected from family, delirium, infection and falls because people are unfamiliar with their surroundings.

This is a year long test of change project which started taking referrals in January 2022 in Glasgow City and will be evaluated closely with a lot of learning. The project started with 3 beds and is now up to 10 beds with ambitions to aim for 25 beds. Jude advised that the beds are close to being full most of the time and is a dynamic service changing to meet the needs of referrals.

Hospital at Home service:

- Patients and GP must have postcode in Glasgow City
- Test of Change covered all of Glasgow City - South by end June 2022
- Extended referral to include Drumchapel and Yoker in September 2022
- Operates 08:00-20:00 7 days a week
- Accept referrals 09:00-15:00 Monday to Friday (excl Public Holidays)
- Out of hours covered by NHS24 and GP Out of Hours
- Accept referrals from GP's and the Queen Elizabeth University Hospital
- Work closely with community teams such as Community Rehab Team and Respiratory and Heart Failure teams

The service aims to provide a:

- 2 hour turnaround of blood results
- 2 hour notice to increase care package
- Fluids, Antibiotics and other medication by drip
- ECG on admission
- Bladder scanner
- Oxygen can be given if safe
- Hospital level response to Xrays and CT Scans
- Provide OT equipment

The service is person centred finding out what is important to a patient, understanding of current situation and future illness, listens to patient wishes and empowers them and their family. This leads to more meaningful/trusting/open relationships with shared decision making and helps patients get the right treatment for them

The Hospital at Home Team is:

- Advanced Nurse Practitioners (ANP) led service employed by HSCP
- Nurse Consultant
- Nurse Team Lead and a Lead Nurse
- Trainee ANP/Staff nurses and health care support workers
- Occupational Therapist
- Pharmacist and Pharmacy technician
- GP sessions – 3 days a week
- Responsible Medical Officers – Consultant's at QEUH (Dr Moylan/Dr Anderton and Dr Jamieson)
- Service Manager giving operational support

The nursing staff work 12 hour shifts with consultants working alternate weeks supporting the team. The team meet every morning to review safety and plan visits - patients usually get 2 visits per day. Support is also provided during the day from coordinator/GP/Consultant and multidisciplinary team.

The patients are all aged over 65, acutely unwell and either need or at high risk of hospital admission plus their family and patient willing to have H@H involved as there is quite a lot of ‘traffic’ in the patient’s home in first couple of days

The criteria for the service is acute decline due to underlying health conditions, acute multiple medical problems; worsening of COPD/Asthma/Heart Failure; acutely unwell nursing/care home patient; severe infections - pneumonia, UTI or cellulitis; delirium; recurrent falls with no injury likely due to underlying acute illness; dehydration and acute presentation of suspected advanced cancer.

The service is unable to treat people who are felt to be 'unsafe at home', stroke, heart attack, gastrointestinal bleed, head injury or hip fracture

Hospital at Home so far have treated 219 patients, with an average length of stay of 5 days. The age range of patients is from 65-100 years old with an average age is 83 and an average Frailty Scoring of 6 - living with moderate frailty.

Jude finished off the presentation with a couple of case studies to illustrate the service. The cost of the project is presently being met by the Scottish Government but it will be up to Greater Glasgow and Clyde Health Board if it is to continue after the project evaluation. This evaluation will be presented to the GGC NHS Board as well as Chief Officers of each of the six HSCPs

Q: How many referals do you get eack week?
A: The number of referrals depends on the Teams capacity to deliver the service.

Q: Will the savings from this new way of working be retained in the service?

A: This is a test of change project with extensive monitoring of a number of factors including the overall performance of the service, costs, patient and family views, which have been very positive, before the GGC NHS Board decide whether Hospital at Home will continue. Jude also agreed with comment that patients with this project could contribute to tackling bed blocking.

Closing Remarks

Robert thanked all the speakers for their presentations and willingness to answer some challenging questions. Both projects are positive and innovative developments and should improve services for patients and families