

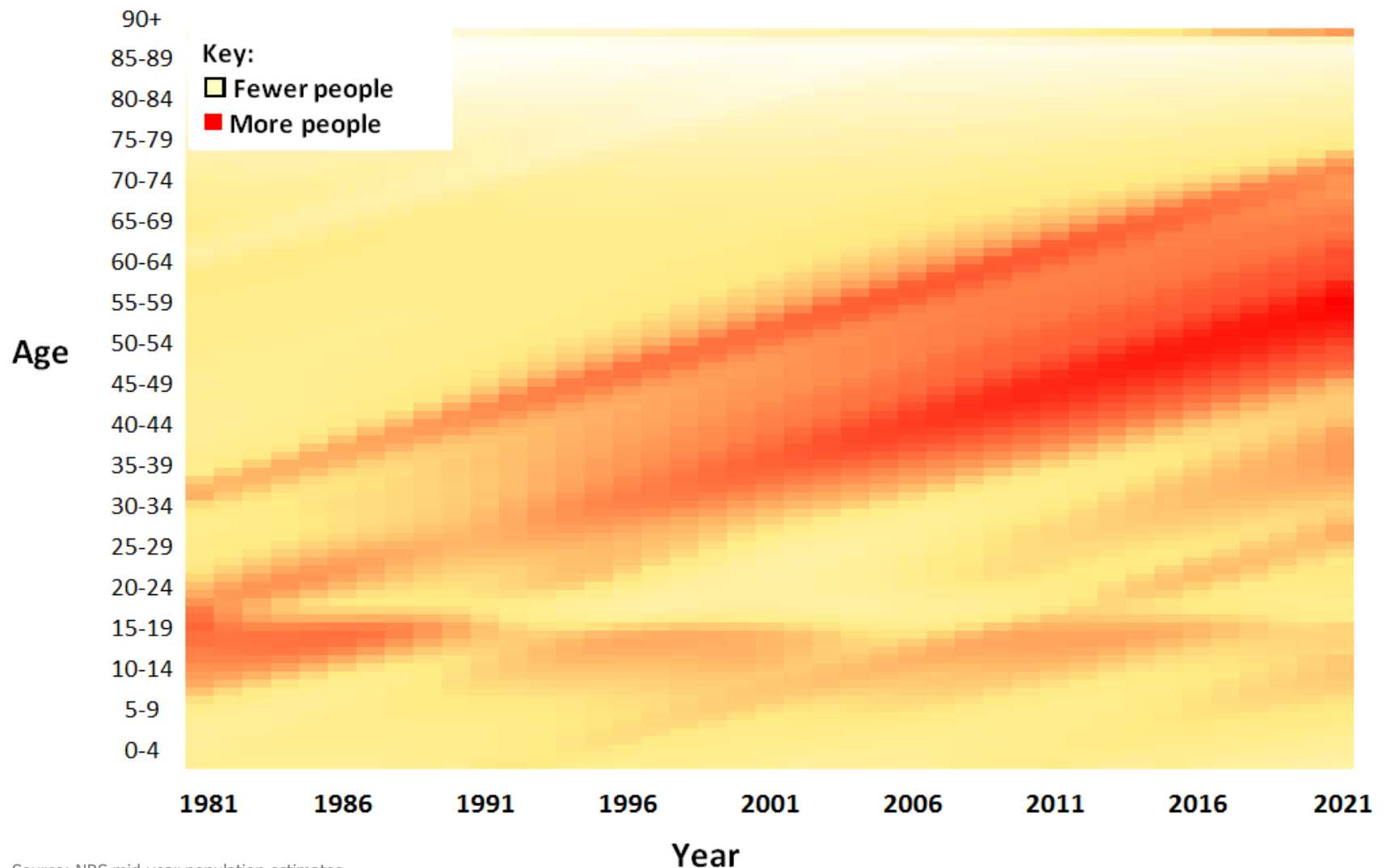


# Recommendations

- **Note progress to date against the programme of work outlined and funded under the Older People's Strategic Delivery Plan 2022 – 2025;**
- **Request an update in twelve months' time;**
- **Endorses the intention to evaluate the impact of the IJB investment in the Older People's Strategic Delivery Plan, and for the outcomes to be fed into the budget setting processes for 2024 – 2027.**

# Perth and Kinross Health and Social Care Partnership

## Key Challenges: population transformation



Source: NRS mid-year population estimates

# Key Challenges

- **Increasing population of older people;**
- **Increasing complexity and frailty;**
- **Workforce recruitment and retention.**



## What have we achieved: early intervention

- Continued collaboration with key stakeholders;
- Continuing success of Going for Gold;
- Increasing participation in Live Active exercise programmes;
- Increasing volunteering activities in communities / community circles;
- Further funded and working with Support Circles to enhance their existing work and a brokerage model of delivery;
- Ongoing work and investment in rural communities to ensure equitable service provision;
- Activity workers embedded in PRI, Murray Royal and St Margaret's;
- Enhanced support for care homes.



### Go 4 Gold 2023



### Paths for All BCH

## What have we achieved: shifting the balance of care

- Continue to develop Locality Integrated Teams and development of locality integrated bases;
- Supporting culture change: What Matters To You links to P & K Offer;
- Launch of Hospital @ Home model of care (August 2023) supported by HIS;
- Development of urgent care pathways;
- Implementation of clinical standards across P&K, and integration across professions and teams (including the HIS frailty project).

**The role of Advanced Nurse Practitioners within developing Urgent Care home visiting model in Perth & Kinross**  
Amy W...

**“There’s no place like home...”**  
“Older people with frailty are at particular risk of being affected by institutionalisation and delirium. Some 30% to 56% have been shown to experience a reduction in their functional ability between admission to hospital and discharge”

**Hospital At Home**  
Development of a Perth City Hospital at Home Service  
Careen Mullen-McKay, Nurse Consultant

**passionate Integrated to Support End of Life at Home**  
Lee Allan, Shona McLean, Andrew Parker

**Measures**  
The number of GP visits to support urgent care at home development opportunities.

**GP Data**  
As the Perth & Kinross population continues to grow and age, to meet the response to meet possible urgent care needs in the community setting. This site will be a strategic contact focused on supporting general practice sustainability through the expansion of the current primary care multidisciplinary team. With this strategy, Advanced Nurse Practitioners offer clinical leadership and expertise, and to facilitate access to appropriate services alongside improved outcomes in a timely manner.

**Small improvement group engaged with a number of GP practices to explore the role of Advanced Nurse Practitioners in supporting GP House Calls.**  
- Conducted GP home visits to explore suitable Advanced Nurse Practitioner Service criteria  
- Develop efficient GP referral processes.

**Benefits**  
- Enabled on-site communication with an emphasis on team working  
- Agreed on the vision and outcomes  
- Took time to understand each other’s roles  
- Tailored demand and capacity data for home visit and patient and staff feedback.

**Key learn**  
- Willingness to deliver an alternative approach  
- Flexibility in response  
- Carrying on  
- Improvements identified  
- Evidence of continuous home visits

**Perth & Kinross Health & Social Care Partnership Values and Behaviour Framework**  
everyone

**Fictional Patient Example**  
The lovely Mrs Meggin is 82 years old, she loves her new burgundy and family. She has just come home from hospital and doesn’t want to return. She has tipped over her rug and fell. Luckily, she hasn’t broken anything. She has been in bed and not feeling great since. The GP arrives and thinks she is not very well so arranges for her to go into hospital.

Mrs Meggin is well looked after by the nurses and doctors but unfortunately, she gets COVID from the patient in the next bed. She is quite small and it takes her a long time to recover. When she eventually gets home, she needs space to help her with many tasks that she used to be able to do for herself. She has lost a lot of confidence and doesn’t feel as capable as she used to.

**Hospital at Home Patient**  
The lovely Mrs Meggin is 82 years old, she loves her new burgundy and family. She has just come home from hospital and doesn’t want to return. She has tipped over her rug and fell. Luckily, she hasn’t broken anything. She has been in bed and not feeling great since. Hospital at Home is a service that can help her. The team check her blood and find that she has COVID. They give her a lot of antibiotics, get her bed, get her some help for meals, make sure she gets up and back to her usual and check on her several times a day so she isn’t getting any worse.

**After this session, people will be aware of:**

1. What is Hospital at Home and why we need it
2. Early success of Perth City HGH service
3. Benefits of MDT community care as an alternative admission

**Key Reference Material**

1. <https://hhs.scot.nhs.uk/media/9928/2020205-hospital-at-home-principles.pdf>
2. <https://hhs.scot.nhs.uk/media/9904/hospital-at-home-rigs>
3. <https://hhs.scot.nhs.uk/asset/booklets/hospital-at-home/hghp>

**Outcomes**

Integrated team on a daily basis allowed for quick response. The direct care support was transformed to a service user to spend their final days at home.

**what matters to you?**

**Improvement Methods**  
PDCA improvement cycle at patient level was used, to identify which issues are appropriate, what needs, and what are the barriers and enablers to patients who wanted to remain at home.

Thanks to a multidisciplinary person-centred approach, we were able to prevent hospital admission and support the patient’s family. Staff reported very positive feedback from both the patient and the family.

**The team can therefore demonstrate the ability to provide the same quality of treatment and care that would be traditionally carried out in a hospital environment.**

While we are still in the preliminary stages of development, the delivery team’s continuous improvement approach to protocols and pathways is proving invaluable in shaping the Hospital at Home service for the future.

Contact: careen.mullen-mckay@hhs.scot.nhs.uk

## Culture change & quality improvement

## What have we achieved: optimising capacity & flow

- Implementation of strategic Discharge without Delay programme, including new pathways from hospital to home;
- Integrated team from PRI and localities implemented a quality improvement approach;
- Integrated frailty pathway from hospital to community, and opening Frailty Unit at PRI;
- Enhanced integration of PRI discharge hub and hospital discharge team.

**FRAILITY @ THE FRONT DOOR**

**APRIL 2022**

- Frailty Team is created across AMU/POD and is coordinated led by PRI
- Frailty Patients identified into downstream wards with correct bed made during POD
- Discharge request raised across while MDT to provide service requirements
- Senior Nurse appointed

**MAY 22**

- MDT visit to Kinross AMU/POD and Kinross led by PRI
- Agreed vision and area of FRID
- Engagement with Wider MDT
- Escaping exercise begins with all ward teams
- 500/500 day plan in place

**JUNE 22**

- Level 4 bed allocation completed
- AMU transfer to 5 day mode leaving start date

**JULY 22**

- Established Care Board approved
- Further discussions with transferring care

**AUGUST 22**

- Interim 500/500 plan in place
- Process mapping commences
- Appointment of Frailty SOH

**SEPT 22**

- Further MDT Process Meeting and engagement commences
- MFI consultant appointment
- Plans for Virtual morning

**OCT 22**

- Virtual Day continues
- Stations work underway to
- Team Planning Meeting 20/10/22
- Following conclusion of

**NOVEMBER 22**

- Commitment of Virtual Frailty Day
- Frailty Bed 6 Change from 500/500
- Move to Physical bed
- Plan towards 7 day mode

**NEXT**

**Frailty @ The Front Door Pathway**

PATIENT ADMITTED TO AMU/PRI COMPLETE CLINICAL FRAILITY SCORE

- POSITIVE CLINICAL FRAILITY SCORE AND SOLICITING SPECIALITY CARE**
  - TAKEN OVER BY MFI / FRAILITY TEAM AND COMPREHENSIVE GERIATRIC ASSESSMENT COMMENCED
  - FRAILITY PATIENT - POD 0-7 DAYS (IDENTIFIED BY GREEN Y ON BED BOARD)**
    - TRANSFER TO ACUTE FRAILITY UNIT
  - MFI PATIENT - POD MORE THAN 7 DAYS**
    - TRANSFER TO DOWNSTREAM MFI WARD (N/1, TAY OR COMB HOSP) BASED ON LOCALITY
- NEGATIVE FRAILITY SCREENING OR REQUIRES SPECIALITY CARE**
  - DISCONTINUE FRAILITY PATHWAY
- IF THERE ARE NO IDENTIFIED FRAILITY PATIENTS WITH POD OF LESS THAN 7 DAYS TO TRANSFER TO THE ACUTE FRAILITY UNIT, IDENTIFY MFI PATIENT WITH POD OF 7 - 30 DAYS TO UTILISE THE BED**

**Frailty at the Front Door**

1. We are working towards a 7 day Frailty unit on level 4 PRI. The aim is to build up the current frailty team and embed the current transfer service working to develop some of the more complex actions such as infrastructure changes and recruitment to meet goals to allow 7 day working in a new specialised area.
2. The first steps in taking forward this vision are:
  - Mapping of current processes
  - Appointment of a frailty nurse
  - Appointment of a SCN
  - Identification of where frailty beds
3. Over the Month of September, we will be looking to identify 6 beds as frailty beds as a starting point in AMU with the intention to expand this in time across 2 Bays on level 4.
4.
  - Caroline Doan has been appointed as SCN to support the frailty team for a 6 month secondment.
  - Interviews for the frailty nurse (band 6) will happen this month.
  - Band 5 adverts for frailty will be submitted to HR this month.
5. Next steps... We will be engaging with AMU and downstream wards on the future plans for frailty. Any stakeholders have been invited to an engagement event on 14th September to plan our development over the next few months.

Frailty service





## Focus on transformation

1. Optimising independence and quality of life for people living at home;
2. Enhancing capacity in dementia services;
3. Developing a person-centred approach to rehabilitation and reablement.

## Next Steps

- Considerable progress in year 1 towards whole system integration with investment approved from IJB;
- Ongoing implementation of Integrated model of care across P&K and evaluation of individual projects;
- Consolidation of learning from year 1 and what are we taking forward into budget review;
- Developing training on the EFIA process to support staff to make equitable decisions when redesigning or transforming services;
- Focus on Transformation.

**THANK YOU: ANY  
QUESTIONS?**

