Background

A proportion of Change Fund monies from The Scottish Government’s Reshaping Care for Older People Programme have been used to develop and implement a new Integrated Community Assessment and Support Service (ICASS) in Fife.

ICASS comprises Hospital at Home, Intermediate Care and Reablement and aims to improve the quality of care and outcomes for older people whilst allowing them to remain independent within their own homes or communities. Anticipated outcomes include:-

- Providing an alternative to emergency hospital admissions for older people but will progress to also reduce the number of people requiring long term institutional care.
- A reduction in the length of stay will be facilitated for those who require hospital admission.
- Enable older people who are maintained at home to achieve and sustain their maximum potential.
- Providing care and support that is both financially and practically sustainable.

A proposed programme of evaluation of ICASS was presented to and approved by the ICASS Partnership Project Group on 12th January 2012. It should be noted that there are some evaluation questions which cannot be fully answered given the early stages of implementation of services such as Hospital at Home. However, other areas of evaluation have been progressed in order to identify and share lessons learned to assist the ongoing implementation of ICASS across Fife. In particular work has been progressing in order to answer the following evaluation questions:

a) Compared to previous ways of working, what is ICASS and how does it compare to other existing models?

b) What perceptions do staff, patients and their carers have about ICASS and whether it will achieve its aims and objectives?

This is the first in a series of reports highlighting findings and key learning points from the early evaluation of ICASS and covers the evaluation work carried out between January and July 2012. These initial findings are presented in order to facilitate learning to be shared across all areas implementing ICASS in Fife.

Methodology

A combination of methods are being used to date in the evaluation of ICASS:

1) A review of published and grey literature was undertaken to identify and provide background knowledge to existing models of care similar to those provided via ICASS.

2) To document how ICASS works, and how it differs to previous models of care in Fife, a review of key ICASS documentation was undertaken in addition to a series of qualitative interviews with key stakeholders between January and July 2012. Additional information around ICASS has been collected through attendance at relevant meetings between January and July 2012.
3) As part of the qualitative interviews, key stakeholders were asked to identify any early lessons which could be used to assist future implementation of ICASS services across Fife.

4) Descriptive statistics summarising the activity of the first three months of the Hospital at Home service in Dunfermline & West Fife locality were prepared by analysing the data collected by the local Point of Access to Community Teams (PACT) office, through which all referrals for Hospital at Home are routed.

5) A series of Case Studies of Hospital at Home patients, involving a review of case notes and qualitative interviews, in DWF have been undertaken in order to:
   a. Document the timeline of their journeys through Hospital at Home and, where appropriate, the wider ICASS service in order to understand how ICASS and its component services work.
   b. Identify any issues raised by patients, their carers and/or family members as well as staff involved in their care, and seek views on the extent to which the objectives of the Hospital at Home service are being met.
   c. Establish the effectiveness of Talking Points as a patient focussed approach in capturing the experiences of people involved in the Hospital at Home service.

This work will be reported in a separate paper.

6) In order to determine how ICASS services affect hospital activity in Fife, a series of quantitative measures have been established and work to gather baseline data for these has been ongoing. The first report detailing the Quantitative ICASS Measures is provided in Appendix 1.
Key Findings to Date January - July 2012

What is ICASS?

ICASS stands for Integrated Community Assessment and Support Service and is the overarching term used to describe a group of services in Fife whose aim is to improve the quality of care and outcomes for older people with the intention of allowing them to remain independent within their own homes or communities.

Although there is no one overarching Fife-wide document detailing what ICASS is or is not, presentations on ICASS identify three core areas of work that make up ICASS: Hospital at Home, Intermediate Care and Reablement. Each of these models of care has been or will be implemented throughout each locality in Fife. These models are summarised in Box 1 below.

<table>
<thead>
<tr>
<th>Box 1: Core Components of ICASS in Fife as Detailed in ICASS Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital at Home</strong></td>
</tr>
<tr>
<td>Hospital at Home provides services traditionally provided in a hospital setting in the patient's home comprising assessment, investigations, treatment, care and discharge. The service is aimed at people aged 75 and over. In Fife, Hospital at Home provides hospital-level specialist geriatric care within the community in order to prevent unnecessary admissions to a hospital setting and reduce length of stay for those patients who do have to be admitted to hospital. The service is led by a consultant in elderly medicine working with a team of specialist nurses and healthcare support workers.</td>
</tr>
<tr>
<td><strong>Intermediate Care</strong></td>
</tr>
<tr>
<td>In the broadest sense, Intermediate Care Services provide support to prevent unnecessary admissions to and discharge from a hospital setting. These services can be provided in a hospital setting or in a person's home. In Fife, teams providing such services include, but are not limited to, Integrated Response Teams, Community Rehabilitation Teams, Enhanced Healthcare Teams and the Rapid Assessment and Discharge Team. Fife also has Intermediate Care Housing options that people can access.</td>
</tr>
<tr>
<td><strong>Reablement</strong></td>
</tr>
<tr>
<td>Reablement is a &quot;short-term, specialist home care based service providing personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves&quot;. Reablement differs to traditional home care services in that it helps people ‘do things for themselves’, rather than ‘having things done for them’.</td>
</tr>
</tbody>
</table>

In addition to the core ICASS services detailed above, each locality also has one point of access where all referrals for the various ICASS services are routed. In Dunfermline/West Fife this is known as PACT – Point of Access for Community Teams, whilst in both Glenrothes/North East Fife and Kirkcaldy/Levenmouth, this is known as SPOA – Single Point of Access.

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1 Hospital at Home Protocol, April 2012  
2 As defined in the Models of Care Group: Care of the Elderly report, 27.4.11  
3 Fife Intermediate Care Demonstrator: Final Report, August 2010  
4 As per Home Care Redesign Presentation, February 2012
Local Variations in ICASS across Fife Localities

In addition to the core models of care detailed above, each locality in Fife has additional aspects of ICASS which reflect local circumstances. Table 1 details those services listed as being part of ICASS in each of the locality areas of Fife, as taken from relevant local documentation relating to ICASS.

Table 1: Local variations of ICASS across Fife

<table>
<thead>
<tr>
<th>Dunfermline &amp; West Fife&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Glenrothes &amp; NE Fife&lt;sup&gt;6&lt;/sup&gt;</th>
<th>Kirkcaldy &amp; Levenmouth&lt;sup&gt;7&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital at Home</td>
<td>Hospital at Home (scheduled to start 27.8.12)</td>
<td>Hospital at Home (not started yet)</td>
</tr>
<tr>
<td>Intermediate Care Services</td>
<td>Intermediate Care Services</td>
<td>Intermediate Care Services</td>
</tr>
<tr>
<td>including Intermediate Care</td>
<td></td>
<td>including Intermediate Care</td>
</tr>
<tr>
<td>Housing at Dollar Court</td>
<td></td>
<td>Housing at Lismore Place</td>
</tr>
<tr>
<td>Reablement</td>
<td>Reablement</td>
<td>Reablement</td>
</tr>
<tr>
<td>Intermediate Care Beds in QMH</td>
<td>Community Hospital Inpatient Beds to support prevention of admission and supported discharge</td>
<td>Community Hospital Inpatient Beds to support prevention of admission and supported discharge&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td>Day Assessment, Treatment</td>
<td>Integrated Services for</td>
<td></td>
</tr>
<tr>
<td>and Rehabilitation Service</td>
<td>Dementia &amp; Frailty</td>
<td></td>
</tr>
</tbody>
</table>

ICASS in Dunfermline & West Fife

In Dunfermline and West Fife, ICASS comprises Hospital at Home, Intermediate Care Services, Intermediate Care Housing at Dollar Court, Home Care Reablement and Intermediate Care Beds at Queen Margaret Hospital, Dunfermline. Dunfermline and West Fife were the first locality to implement Hospital at Home with the service going "live" on 16th April, 2012. The early lessons learned around Hospital at Home in this locality will assist the other localities when they begin implementing Hospital at Home in the coming months.

ICASS in Glenrothes & North East Fife

In Glenrothes and North East Fife (GNEF), ICASS comprises the three core ICASS services of Hospital at Home (due to start on 27th August, 2012), Intermediate Care Services and Home Care Reablement. In addition to these, an Intermediate Care Sheltered Housing unit is currently being established in this area along with the Day Assessment, Treatment and Rehabilitation (DATR) Service which is being proposed as an alternative model of care to the current Day Hospital model (further details are provided in Box 2). Community hospital inpatient beds are also included in ICASS in GNEF and provide support for prevention of admission to and supported discharge from an acute setting. Staff from the Intermediate Care Service in Glenrothes/North East Fife provide support to all patients whether in an inpatient or community setting.

In addition to those services detailed above, there has been recent work in GNEF by Fife Council to establish Intermediate Care Housing within a sheltered housing complex in both Glenrothes and Cupar which will be available for people who are waiting for adaptations etc on

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<sup>5</sup> As presented at DWF Reshaping Care for Older People Event, November 2011
<sup>6</sup> As presented at GNEF Protected Learning Time Session, 7th February 2012
<sup>7</sup> As detailed in K&L ICASS Newsletter, March 2012
<sup>8</sup> Suitable when the complexity and intensity of care means the patient cannot be managed at home, but nor do they require acute hospital care. The care in the Community Hospital inpatient beds is part of a continuum of care from care in the patient’s own home to acute hospital care.
their own home. This will facilitate that person being discharged from hospital and so facilitate hospital beds being used more appropriately.

A Reablement Unit based in a care home setting is also being established by Fife Council and this will provide eight places where people can receive reablement support following discharge from hospital and prior to going home.

**Box 2: Day Assessment, Treatment and Rehabilitation Service in Glenrothes/North East Fife**

The DATR service aims to provide rapid access to assessment, diagnosis, treatment and rehabilitation for patients with intermediate care needs and it is proposed that the service is established at St Andrews Community Hospital and Glenrothes Hospital, with a satellite unit providing treatment and rehabilitation only.

**ICASS in Kirkcaldy & Levenmouth**

In Kirkcaldy and Levenmouth (K&L), ICASS again comprises the three core ICASS services of Hospital at Home (due to start in coming months), Intermediate Care Services (including access to Intermediate Care Housing at Lismore Place) and Home Care Reablement. Similar to GNEF, community hospital inpatient beds in K&L are also utilised as part of ICASS. K&L also has Integrated Services for Dementia & Frailty as part of the ICASS model, a service that is unique to this area at this point in time. Further details of this service are provided in Box 3.

**Box 3: Integrated Services for Dementia & Frailty in Kirkcaldy/Levenmouth**

The community infrastructure in Kirkcaldy and Levenmouth will be enhanced through adding and aligning a range of new roles and relationships, to provide care that is centred on the person and their family, and specifically orientated to the needs of those with dementia and frailty.

The service will put the person first and not the disease(s), it anticipates, responds and empowers to ensure wellness is central to care. Care that is wide ranging, integrated and includes specialist health care is provided in the persons own home, with hospital avoided or only used for short stay.

The four components of the model are:

1. **Care Manager and Care Co-ordinators** – aligned to Primary Care Teams in each local area in Kirkcaldy & Levenmouth.

2. **Specialist Nurse Practitioner for Dementia and Frailty**. These posts will link to the GP’s and Acute Hospital and provide enhanced clinical skills to assess and support patients, either prevention of admission or early discharge, as well as education and support. This component part will be included within Hospital @ Home as part of the wider ICASS.

3. **Additional home based support hours** – approx 200 hours per week anticipated.

4. **Clinical Psychologist, part-time** – their main role is their clinical caseload for patients with difficult behaviours as well as staff support, education and advice.

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How does ICASS compare to previous ways of working?

Data gathered through a combination of qualitative interviews, attendance at relevant ICASS meetings and reviewing relevant ICASS documentation and presentations has identified that ICASS is different in a number of ways to how services for older people in Fife were provided previously. These differences are summarised below.

Closer working of ICASS services through co-location of teams

In order to facilitate services for older people in Fife working closer together to better support older people, and their carers or families, one major change in ways of working has been to co-locate teams so that they are physically housed closer together in one working area.

In speaking to senior staff, they report teams being overall positive about coming together to work under the ICASS "banner". As time has progressed, teams have gained a better understanding of what each other does and are starting to see things from a more global point of view i.e. not only from their own team's point of view. This has led to some changes in the way staff work as being together means staff are more aware of other teams’ workloads etc and can see where they can help out if need be.

It is acknowledged there is some way to go before teams become fully integrated and also that having teams working in a fully integrated fashion will bring it's own challenges such as ensuring that when a patient is accepted by a team, there is clarity around which team accepts clinical responsibility for that patient. It was also reported that when ICASS teams work in a more integrated fashion, it is important that professional roles are not diluted and that staff retain clarity around their own role and place within the bigger team in order to feel valued.

However, even taking the above challenges into account, to have such progress in teams working closer through being co-located is one of the key positive findings from the evaluation of ICASS to date.

New ways of working

There were several instances of teams working together differently to how they did before ICASS.

In one example, the staff in Kirkcaldy and Levenmouth have implemented a new way of working aimed at reducing the waiting list for assessments to be undertaken. A timetable has been established to allow professionals to focus solely on assessments at a given time in the working week. In this way, they are able to schedule their clinical commitments and assessment commitments better and so the waiting list for assessments has reduced.

Additionally, a new "screening tool", based on one used in Dunfermline & West Fife, is now being used to determine if the patient is suitable for an ICASS service as opposed to completing the Single Shared Assessment which can be a lengthy process. By completing the screening tool, the patient can be accepted onto the service and the Single Shared Assessment can be completed over the next few days. This has again contributed to the waiting list for assessments being reduced.
New models of care

In terms of new models of care being introduced in Fife, there are several features of ICASS which differ to previous ways of working – the key ones being the development and implementation of the Hospital at Home and Reablement models of care throughout all localities in Fife in addition to the proposed DATR in GNEF and Integrated Services for Dementia and Frailty in K&L. Details of these new models of care are provided above.

Hospital at Home

The Hospital at Home service began accepting patients on 16th April 2012. The service is led by a Consultant and nursing input is provided by a combination of Band 6 Nurse Practitioners and Band 5 nurses, supported by several Healthcare Support Workers and administration staff from PACT. A GP with Special Interests has also been funded to provide backfill for the Consultant for two sessions a week.

Referrals are received by the PACT staff who then pass the referral over to a Nurse Practitioner who will undertake an assessment of the patient, liaising with the Consultant for medical input in agreeing an appropriate plan of care. At the time of "going live", only one member of the Hospital at Home nursing team were qualified to undertake assessments, whilst the other Band 6 nurses are currently undergoing a programme training and consolidation of competencies to allow them to undertake assessments.

Descriptive statistics on Hospital at Home activity in the first three months of implementation

Descriptive statistics, obtained through analysing quantitative data collected about Hospital at Home from 16th April 2012 – 4th July 2012, are presented in Table 2 to illustrate Hospital at Home activity in the first three months following implementation.

From the data presented in Table 2, it can be seen that, as at 4th July 2012, the majority of patients being admitted to Hospital at Home were admitted in order to prevent admission to an acute hospital setting. These patients have been referred from one of twelve GP practices in the Dunfermline & West Fife area. There have also been three referrals in which support has been requested for patients who have either a Hickman or PICC line to allow them to be cared for a home as opposed to a hospital setting.

Patients accepted by Hospital at Home have had a variety of diagnoses ranging from Respiratory problems, Pain Control, Cellulitis and Urine Infections. These diagnoses are in line with the list of “Suggested suitable conditions” detailed in the Hospital at Home Protocol which has been circulated to those GP practices referring to Hospital at Home.
Table 2: Descriptive Statistics of Hospital at Home Activity, 20th April – 4th July 2012

<table>
<thead>
<tr>
<th>Total number of referrals received</th>
<th>41</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients</td>
<td>39 (1 patient referred 3 times)</td>
</tr>
<tr>
<td>Male : Female Ratio</td>
<td>12 males : 27 females</td>
</tr>
<tr>
<td>Age profile</td>
<td>All</td>
</tr>
<tr>
<td>Age range</td>
<td>53 - 93</td>
</tr>
<tr>
<td>Average age</td>
<td>80</td>
</tr>
<tr>
<td>Median age</td>
<td>84</td>
</tr>
<tr>
<td>Referred from:</td>
<td>GP Practice (x12)</td>
</tr>
<tr>
<td></td>
<td>34</td>
</tr>
<tr>
<td>Reason for referral:</td>
<td>Prevention of Admission</td>
</tr>
<tr>
<td></td>
<td>38</td>
</tr>
<tr>
<td>Accepted v not accepted</td>
<td>From 41 referrals, 3 were not accepted (1 was ?stroke, 1 was thought to be cellulitis but was not, 1 was more suitable for CRT referral), 35 were accepted and 3 are pending (as at 4th July)</td>
</tr>
<tr>
<td>Diagnoses for those patients accepted to Hospital at Home</td>
<td>Respiratory x7</td>
</tr>
<tr>
<td></td>
<td>Pain Control x3</td>
</tr>
<tr>
<td></td>
<td>Invasive Lines x3</td>
</tr>
<tr>
<td></td>
<td>Blood Chemistry Imbalance x2</td>
</tr>
<tr>
<td></td>
<td>Falls x2</td>
</tr>
<tr>
<td></td>
<td>Cardiac x2</td>
</tr>
<tr>
<td></td>
<td>Cellulitis x2</td>
</tr>
<tr>
<td></td>
<td>Renal Impairment x1</td>
</tr>
<tr>
<td></td>
<td>Other x4</td>
</tr>
<tr>
<td></td>
<td>?DVT</td>
</tr>
<tr>
<td></td>
<td>Low Hb (4.7)</td>
</tr>
<tr>
<td></td>
<td>Generally Failing</td>
</tr>
<tr>
<td></td>
<td>Lethargic, Mobility &amp; Appetite have deteriorated</td>
</tr>
<tr>
<td>Length of Stay in Hospital at Home</td>
<td>From a total of 35 patients treated and discharged to 4th July 2012 (including 2x Invasive Lines):</td>
</tr>
<tr>
<td>Length of Stay (all patients)</td>
<td></td>
</tr>
<tr>
<td>Average length of stay = 9 days (range = 1-42 days)</td>
<td></td>
</tr>
<tr>
<td>Median length of stay = 7 days</td>
<td></td>
</tr>
<tr>
<td>Length of Stay (minus 2x Invasive Lines)</td>
<td></td>
</tr>
<tr>
<td>Average length of stay = 7.4 days (range = 1-19)</td>
<td></td>
</tr>
<tr>
<td>Median length of stay = 6 days</td>
<td></td>
</tr>
<tr>
<td>Total bed days</td>
<td>Total of 263 bed days for those accepted to and discharged from Hospital at Home</td>
</tr>
<tr>
<td></td>
<td>Total of 200 bed days for those accepted to and discharged from Hospital at Home (minus Hickman Lines)</td>
</tr>
</tbody>
</table>
Homecare/Homecare Re-ablement

Table 3 provides an overview of the number of older people aged 65 and over receiving homecare and the number of hours that are provided for 2010/2011 and 2011/2012. Due to changes in the service, previous years would not be comparable. At the present time, work is ongoing to extract this data for people aged 75 and over.

This information is a snap shot as at week containing 31 March in the following financial years and is in line with the homecare definition used in the Scottish Government annual homecare return and home care statutory performance indicator.

Table 3: Homecare provision for people aged 65 and over in Fife

<table>
<thead>
<tr>
<th>Fife Council</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 65+ receiving homecare</td>
<td>3202</td>
<td>3125</td>
</tr>
<tr>
<td>Number of people aged 65+ receiving homecare per 1000 population</td>
<td>50.9</td>
<td>48.7</td>
</tr>
<tr>
<td>Total number of homecare hours for older people (65+)</td>
<td>26367</td>
<td>26749</td>
</tr>
<tr>
<td>Total number of home care hours provided per 1000 older people (65+)</td>
<td>419</td>
<td>417</td>
</tr>
</tbody>
</table>

Table 3 shows that there has been a 2.4% decrease from 2010/11 to 2011/12 in the number of older people in receiving a homecare service however there has been a 1.4% increase in the number of hours provided to people aged 65+

The rate of home care hours provided for people aged 65+ has dipped slightly in 2011/12 as there was a 1.9% estimated population increase.

Graph 1: Number of people who have received Homecare – Reablement

Dunfermline & West Fife CHP commenced Nov 2011
Kirkcaldy & Levenmouth CHP commenced Jan 2012
Glenrothes & North East Fife commenced April 2012
Graph 1 shows the Homecare Reablement activity in the different localities in Fife since the service began and shows that there has been an increase of approximately 47% in the total number of people receiving Reablement in July 2012 compared to the baseline month of June 2012.

Staff perceptions of Hospital at Home: Key findings from interviews

Through interviewing staff who either work as part of the Hospital at Home team in DWF or GPs who have referred to Hospital at Home, a series of important points were raised and are noted below.

Delays in training programme for senior nursing staff

- It was fed back through interviews that Hospital at Home is probably 6-12 months behind the original project timelines due to a suitable programme of training and consolidation of skills not being in place prior to the Hospital at Home service being rolled out as per the original project timescales.

- In DWF, this has resulted in only one specialist nurse who is fully trained to undertake assessments at the present time (as opposed to the full team comprising nine additional nurses who are either currently undergoing training or will be trained in the coming months). This has in turn meant the caseload capacity of the team and the roll out to further GP practices has had to be limited.

- In addition to the delay in training for senior nursing staff, backfill for the Consultant input to Hospital at Home has been an issue and so "hands-on" Consultant input to the service has been limited.

Types of referrals to Hospital at Home

- GPs referring to Hospital at Home reported using the service to provide support for people who refuse to go into a hospital setting but whom GPs know would benefit for some more intensive input than that provided in the community. Hospital at Home is able to provide such additional support in the person's home, meaning the patient did not have to be admitted to hospital. Admitting to Hospital at Home, with consultant input, was also seen as an appropriate alternative for patients whose needs are quite complex but not acute enough to be admitted to hospital.

- In terms of patients who might not be referred for Hospital at Home, patients who have support networks in place alongside District Nurse input were reported as having sufficient input so did not need Hospital at Home support.

- In terms of how referrals to Hospital at Home are being recorded on the electronic system MIDIS, at the present time, the only options available relate to patients being admitted to hospital - not being discharged with support. As Hospital at Home is providing support to facilitate an early discharge from hospital, this cannot be recorded at this stage on MIDIS. Although the MIDIS system is being developed further at the moment, details about Hospital at Home referrals are being recorded on a local system to ensure the data is captured at this stage and as an interim measure until the e-Health systems are fully developed to deal with the requirements of the Hospital at Home service.

Referral process

- In DWF, referrals to Hospital at Home should be directed through the PACT office to allow key demographic data be collected before being handed over to the Hospital at
Home team. However, in the early stages of Hospital at Home, clinicians have been calling the Hospital at Home team directly in some instances in order to ask advice on whether the referral is appropriate, reflecting some of the challenges associated with implementing a new service, as referrers try to "learn" what referrals would be classed as being inappropriate. Although this was not felt to be a major issue, when Hospital at Home begins working to full capacity, this may have implications for the Hospital at Home team having to spend time discussing appropriateness of cases as opposed to actually assessing the patient and, where appropriate, start a treatment plan.

- GPs who have referred to Hospital at Home fed back that having some way of "re-activating" a Hospital at Home admission quickly within a short period of time following discharge (say thirty days) would be helpful as there had been one instance of a patient having to be referred via PACT before being accepted by Hospital at Home again. In a similar instance, Hospital at Home staff reported that it would have been helpful if they could have put a patient's Hospital at Home admission “on hold" as this would have allowed a patient to be admitted to an Intermediate Care bed for a few days before being discharged back into Hospital at Home care. As it was, the patient had to be recorded as being "discharged" from Hospital at Home before being re-referred via PACT. If the e-Health systems could have option to either “re-activate” or “put on hold” an admission, this would have been helpful. At the present time, e-Health systems only record whether a patient is being admitted to hospital as an "emergency" or as a "planned/elective admissions".

Care Groups Suitable for Hospital at Home

- As Hospital at Home is a new service, the team in DWF have had to "learn" about the clinical conditions the service can support out of a hospital setting.

- In one example, the care needs of a patient began as being "palliative" but rapidly changed to become “end of life” during the Hospital at Home admission. Given the range of other services that care for people near the end of their life (e.g. Marie Curie Nurses, MacMillan Nurses and District Nurses), the Hospital at Home service did not originally anticipate caring for people nearing the end of their life. However, in this instance, the team were concerned that withdrawing the Hospital at Home service might be seen as being insensitive to the patient's and family's support needs.

- However, the family fed back to the patient's GP that whilst they were happy with the care provided during the Hospital at Home admission, they felt that once the patient's care needs had changed to becoming “end of life”, this could have been taken on board quicker by the Hospital at Home team. The family also fed back that, with regards to continuity of care at the end of their loved one's life, there was a lot of people coming and going as part of the Hospital at Home service and they felt this wasn't appropriate in these circumstances.

- The GPs involved in this case queried whether there would be scope for the Hospital at Home service to work with GPs and/or District Nurses in a shared care model when a patient's care needs become "end of life", as this would assist the person remaining in their own home in the final days of their life. The GPs felt such a model would also facilitate continuity of care for such patients as GPs and District Nurses would still be involved.

- It was also noted that GPs referring to the service are also “learning” what patients are suitable for Hospital at Home and that it would be beneficial, in these early stages to either be able to speak directly to the Hospital at Home Team Leader or have feedback from the Consultant in charge as to whether the referral is/was appropriate.
Communication between Services

- GPs who have referred to Hospital at Home in DWF have described their experience as being very positive to date and feel that Hospital at Home is a good model which is very well liked by patients and their families. However, they highlighted some areas where communication between services could be improved and have fed these back to the Hospital at Home team in DWF in order that these could be resolved.

- **NB: Although the majority of these issues have indeed been resolved, it is important to present them in this report in order to aid the implementation of Hospital at Home in other localities in the coming months.**

- GPs reported it would be beneficial to receive notification on whether the referred patient had actually been accepted by Hospital at Home as soon as possible as this would allow alternative arrangements to be made quickly if the person has not been accepted by Hospital at Home.

- It was also reported that it is important to be clear about which service has clinical responsibility for a patient once a patient is referred to Hospital at Home. In the example given, a patient admitted to Hospital at Home was subsequently, and unexpectedly, admitted to hospital when attending for an investigation. The discharge documentation from the hospital was forwarded to the original GP as opposed to Hospital at Home which led to confusion as to whether the patient had actually been discharged from Hospital at Home. It was noted that Hospital at Home had not informed that the patient had been admitted either. In order to resolve this issue, the Hospital at Home team in DWF now use name wristbands on each patient to show that person is under the care of Hospital at Home should they be seen by another service. Similarly, if a patient is receiving a particular medication (such an anti-coagulant) as part of their Hospital at Home care, a red wristband is used to alert other services to the fact they are receiving that medication.

- There were different opinions of whether the referring GP should be kept informed once the referral had been accepted by Hospital at Home and it was highlighted that families still call the GP practice for updates as opposed to calling Hospital at Home. However, at the present time, there is no way of GPs and Hospital at Home teams sharing information electronically via electronic systems both staff groups can access. Instead, keeping GPs informed would involve the Hospital at Home team e-mailing updates to individual GPs, which, again, would take them away from spending time caring for patients. In relation to the above point, not having one e-Health system that all services can access to share information about patients was reported as being a major issue.

- Communication between the different services involved in a patient's care was also noted as being important. The example given related to a home care manager having been asked to provide urgent input to a particular patient and subsequently found out that person was currently under the care of Hospital at Home but was unaware whether this impacted on the need to provide home care for that person. It would therefore be helpful to ensure the various services are aware of Hospital at Home and the implications of a person being admitted to the service.

- Another example was around letting the patient's pharmacist know the patient is now under Hospital at Home care as this would allow ongoing dispensing of medicine to be managed in conjunction to the medicines prescribed by the Hospital at Home service. It was suggested it would be beneficial to collect details of the patient's pharmacist to allow any change in medication to be passed on to the pharmacist. At the present time, as per the Hospital at Home protocol, the CHP Pharmacy Technician is informed that the person has been admitted to Hospital at Home whilst, on discharge, the Key Worker informs the Community Pharmacist and GP of any changes to medication.
Accessing ambulance services for transferring patients for investigations

- At times, the Hospital at Home needs access to some investigations that can only be carried out in a hospital setting due to the equipment being based there e.g. a Doppler scan. In trying to arrange for patients to receive such investigations, Hospital at Home have encountered challenges with accessing ambulances to transfer patients to the hospital setting. Although a "workaround" to the issue has been identified, it has highlighted another challenge in establishing a new service.

Discharge Information

- GPs highlighted that it would be beneficial to have further information as to whether the referral was appropriate and also feedback from the consultant in charge on why a certain course of action was taken and advice on what to do if the same situation occurred. This would assist the GP in managing the patient in the future and assist in determining which patients were suitable to be referred to Hospital at Home in the future.

- On a related point, it was also reported that that it would also be good to have feedback as to why patients are not accepted to allow GPs to become more aware of which patients might be appropriate for referral to Hospital at Home.

Out of Hours prescribing

- At the present time, only the Team Leader of Hospital at Home in DWF is trained and has build up appropriate levels of competencies to prescribe in the Hospital at Home setting. As the Team Leader covers the core Hospital at Home hours, there is an issue around prescribing out of hours.

- If need be, doctors on the QMH site can be asked to prescribe until 8pm but if a prescription is required after this time, the Hospital at Home team have had to phone the medical registrar on-call at VHK and arrange prescriptions via e-mail. However, this has issues in itself as if prescriptions are provided via e-mail, a written prescription is required within 72 hours. Given the medical registrars are based at VHK, this has the potential to cause issues in getting written prescriptions to QMH (where Hospital at Home team are based) within 72 hours.

Recording of Hospital at Home Patients

- In Scotland, patients receiving acute care in a hospital setting are recorded using the SMR01\textsuperscript{10} system. Although Hospital at Home patients might not fit into the traditional category of "inpatients", they are still receiving an episode of acute care, albeit in their own home and NHS Fife require to report on this.

- Work has therefore had to be undertaken to put systems in place to ensure these episodes of acute care are recorded appropriately, with accurate coding. NHS Fife are using a readily available inpatient Patient Administration System to capture this data as it is key to have "admission" "diagnosis" and "discharge" dates recorded electronically. Hospital at Home data is not submitted to Information Service Scotland (ISD). We treat and analyse the data captured separately - treating as new data and taking time to understand accuracy and completeness. This then allows NHS Fife to able to measure the outcomes desired from the new service. This work is ongoing at the present time.

\textsuperscript{10} Scottish Morbidity Record for General / Acute Inpatient and Day Cases
Key Learning Points

In undertaking initial evaluation work, a series of key learning points have been identified and are presented.

- When co-locating staff in order for ICASS teams and services to become more integrated, consider how best to:
  - Record and communicate which team/service accepts and retains clinical responsibility for that patient.
  - Ensure that members of a larger ICASS team are clear about the role they play in that team in order that people feel their role is valued.
  - Ensure that, despite working closer with other teams, professional roles are not diluted.

- When establishing a new Hospital at Home service:
  - Consideration should be given to ways of sharing learning points between referrers and the service in the early stages so that both referrers and the Hospital at Home team establish which patient groups are best suited to Hospital at Home. The example given was around Hospital at Home working with other services in a shared care model for people nearing the end of their life
  - Consideration should be given to what processes should be put in place to ensure prescribing out of hours is facilitated.
  - Consideration should be given to how best to alert other services that a patient is under the care of Hospital at Home.
  - Consideration should be given to what procedures need to be in place to facilitate transfer of patients to hospital settings to receive investigations which can not be undertaken at home.
  - Consideration should be given to developing existing e-Health systems to allow a Hospital at Home admission to be either put "on hold" to allow an admission to an intermediate care bed or allow a recent referral to be "re-activated" to allow a referral for a person who recently discharged from H@H to be expedited.
  - Consideration should be given to how best to work with other services to respond out of hours - at the moment, PCES will only accept a person under H@H care if they present with something not related to their reason for H@H admission - can this be developed?

- In terms of global learning points:
  - Consideration should be given to further developing e-Health systems to facilitate the sharing of information about a Hospital at Home patient's ongoing care between all relevant services.
ICASS Evaluation
Reporting Period July 2012

Authors:  S. Halcrow
          M. Gilmour
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## Introduction

This report looks at some of the quantitative measures identified for the ICASS Evaluation work. The core measures, along with their development status, are as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Detail of Measure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of emergency hospital admissions for people aged 75 and over</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>2</td>
<td>Rates of emergency hospital admissions for people aged 75 and over</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>3</td>
<td>Total emergency bed days for people aged 75 and over</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>4</td>
<td>Rates of emergency bed days for people aged 75 and over</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>5</td>
<td>Number of re-admissions for people aged 75 and over</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>6</td>
<td>Rates of re-admissions for people aged 75 and over</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>7</td>
<td>Length of continuous inpatient stay in acute and community hospital setting for people aged 75 and over admitted as an emergency to hospital(^{11})</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>8</td>
<td>Number and percentage of weeks in delay for people aged 75 and over who have been admitted as an emergency to hospital</td>
<td>Measure under development</td>
</tr>
<tr>
<td>9</td>
<td>Number of people aged 75 and over admitted to care homes</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>10</td>
<td>Number of people aged 75 and over admitted to hospital from home and discharged to a care home from a hospital inpatient acute setting (Acute and Community)</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>11</td>
<td>Rate and proportion of new entrants to care homes admitted from home, hospital and respite care (Social Work)</td>
<td>Baseline data presented</td>
</tr>
<tr>
<td>12</td>
<td>Number and rates of people aged 75 and over with complex needs (defined as receiving 10 hours or more of home care) receiving care at home</td>
<td>Measure under development</td>
</tr>
<tr>
<td>13</td>
<td>Measure of dependency: before and after homecare</td>
<td>Measure under development</td>
</tr>
<tr>
<td>14</td>
<td>Number and rates of people aged 75 and over receiving home care changes following the implementation of ICASS</td>
<td>Measure under development</td>
</tr>
<tr>
<td>15</td>
<td>Experience measures and support for carers from the Community Care Outcomes Framework (Community Care Benchmarking Network)</td>
<td>Measure under development</td>
</tr>
</tbody>
</table>

\(^{11}\) Acute length of stay and the total length of stay following an emergency hospital admission to account for people transferred to a community hospital
Measure 1: Number of emergency hospital admissions for people aged 75 and over

Commentary:
Chart 1 shows the emergency admissions per month with a 3 month rolling average.\textsuperscript{12}
NHS Fife has shown a steady increase in emergency admissions for people aged 75+ between Apr 2008 and Jan 2012. There are peaks in the winter periods of December and January, and in 2010 and 2011 there appears to follow a decrease in February and March, followed by a sudden increase between April and June. The mean average for emergency admissions from April 2008 - January 2012 is 766.

Chart 1: Number of emergency hospital admissions for people aged 75 and over, April 2008 - January 2012

Source: ISD Scotland (Acadme)

Methodology: An emergency admission is defined as being a new continuous spell of care in hospital where the patient was admitted as an emergency. Admissions are based on month of discharge.

\textsuperscript{12} A rolling average smoothes out short-term fluctuations and highlights longer term trends or cycles.
Measure 2: Rates of emergency hospital admissions for people aged 75 and over

Commentary:
Chart 2 shows the crude rate and 3 month rolling average per 1,000 population of emergency hospital admissions for people aged 75 and over.

NHS Fife has one of the lowest rates of emergency admissions in Scotland. Since April 2008 it has been consistently below the national rate and it is comparable to NHS Tayside and NHS Forth Valley. The peaks and troughs are similar to that of NHS Scotland.

Chart 2: Rates of emergency hospital admissions for people aged 75 and over, April 2008 - January 2012

Source: ISD Scotland (Acadme)

Methodology: An emergency admission is defined as being a new continuous spell of care in hospital where the patient was admitted as an emergency. Admissions are based on month of discharge.
**Measure 3: Total Emergency Bed Days for People aged 75 and Over**

**Commentary:**
Chart 3 shows the total number of bed days per month and a 3 month rolling average. NHS Fife’s total emergency bed days has remained close to the mean average over the last three years, with peaks occurring around January and troughs around October. The winter of 2012 saw an increase in bed days, but this increase was less than previous years and below the mean bed days between Apr 2008 and Jan 2012. The mean average bed days per month between April 2008 and January 2012 was 10,354.

**Chart 3: Total emergency bed days for people aged 75 and over**

Source: ISD Scotland (Acadme)

**Methodology:** An emergency admission is defined as being a new continuous spell of care in hospital where the patient was admitted as an emergency. Emergency bed days are counted as the time in a continuous spell of care, from the date of emergency admission to the date of discharge i.e. to home, care home, etc. Bed days are attributed to month of discharge.
Measure 4: Rates of Emergency Bed Days for People aged 75 and Over

Commentary:
Chart 4 shows the emergency a 3 month rolling average rate per 1,000 population. Bed days are attributed to month of discharge.

NHS Fife’s emergency bed day rate has shown a steady decrease since Apr 2008; this is largely due to an increase in the 75+ population whilst the total number of bed days has remained consistent (see chart 3).

NHS Fife has one of the lowest reported bed day rates in NHS Scotland, although there are some issues with counting community bed days (Geriatric Long Stays) from the national dataset. NHS Fife will include previously defined geriatric long stay (GLS) beds from Community Hospitals. This is not officially counted in national statistics yet, but local analysis shows including these patients will increase NHS Fife’s emergency bed rate by approximately 19.5%.

Chart 4: Rates of emergency bed days for people aged 75 and over

<table>
<thead>
<tr>
<th>Month</th>
<th>Bed Day Rate per 1,000 pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-08</td>
<td></td>
</tr>
<tr>
<td>Jul-08</td>
<td></td>
</tr>
<tr>
<td>Oct-08</td>
<td></td>
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<tr>
<td>Jan-09</td>
<td></td>
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<tr>
<td>Apr-09</td>
<td></td>
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<tr>
<td>Jul-09</td>
<td></td>
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<td>Oct-09</td>
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<td>Jan-10</td>
<td></td>
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<td>Apr-10</td>
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<td>Jul-10</td>
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<td>Oct-10</td>
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<td>Jan-11</td>
<td></td>
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<tr>
<td>Apr-11</td>
<td></td>
</tr>
<tr>
<td>Jul-11</td>
<td></td>
</tr>
<tr>
<td>Oct-11</td>
<td></td>
</tr>
<tr>
<td>Jan-12</td>
<td></td>
</tr>
</tbody>
</table>

Source: ISD Scotland (Acadme)

Methodology: An emergency admission is defined as being a new continuous spell of care in hospital where the patient was admitted as an emergency. Emergency bed days are counted as the time in a continuous spell of care, from the date of emergency admission to the date of discharge i.e. to home, care home, etc.

NB: It is advisable not to compare NHS Fife emergency beds to other boards as there are inconsistencies across NHS Scotland as how bed days are measured i.e. some boards include all geriatric long stays, whilst other include some and others do not include any.
Measure 5: Number of Re-admissions for People aged 75 and over

Commentary:
Chart 5 shows that the number of readmissions within 28 days has changed pattern since April 2008 from short and sharp variations of peaks and troughs to more sustained periods. The 3 monthly rolling average, which smoothes out short-term fluctuations and highlights longer term trends or cycles, demonstrates this.

Chart 5: Number of re-admissions for people aged 75 and over

Source: ISD Scotland (Acadme)

Methodology: A readmission is defined as an admission that takes place within 28 days from the previous date of discharge. It includes both elective and emergency admissions.
Measure 6: Rates of Re-admissions for People aged 75 and over

Commentary:
Following on from Measure 5, Chart 6 shows that the rate of re-admissions per 100,000 population, within 28 days has changed pattern since April 2008 from short and sharp variations of peaks and troughs to more sustained periods. The 3 monthly rolling average, which smothes out short-term fluctuations and highlights longer term trends or cycles, demonstrates this.

Methodology: A readmission is defined as an admission that takes place within 28 days from the previous date of discharge. It includes both elective and emergency admissions. Crude rates are per 100,000 population.
Measure 7: Length of continuous inpatient stay in a) acute and b) community hospital setting for people aged 75 and over admitted as an emergency to hospital

Commentary:
Chart 7a shows that the average length of stay in acute hospitals has been continually decreasing since Apr 2008. The average length of stay in acute hospitals for each financial year was 12.08 in 2008/09, 11.75 in 2009/10 and 11.64 in 2010/11. Between Apr 2011 and Jan 2012 the average length of stay was 11.21.

Chart 7a: Length of continuous inpatient stay in acute hospital setting

Source: Oasis, PIMS and Acadme

Chart 7b shows that the average length of stay in community hospitals has also seen a general decrease, with the exception of 2010/11. The average length of stay in community hospitals for each financial year was 49.58 in 2008/09, 47.74 in 2009/10 and 50.96 in 2010/11. Between April 2011 and January 2012 the average length of stay is 44.62 days.
Chart 7b: Length of continuous inpatient stay in community hospital setting

Source: Oasis, PIMS and Acadme

Methodology: Average length of stay is calculated as the total length of stay per month divided by the total number of monthly admissions. Month is defined by date of admission.

A rolling average smooths out short-term fluctuations and highlights longer term trends or cycles.
**Measure 9: Number of people aged 75 and over admitted to care homes**

**Commentary:**
Chart 9 shows the number of publicly funded admissions to care homes between April 2008 - January 2012 and shows there was a sharp increase in the in Jan 2009 and Apr 2009. Since then, the 3 monthly rolling average has fluctuated around the mean average.

**Chart 9: Number of publicly funded care home admissions, April 2008 - January 2012**

Source: Fife Council, Contracts Data Information (CODI)

**Methodology:** Only care home admissions that are funded by Fife council are included in this analysis. Publicly funded residents amount to 70.9% of all Fife care home residents, as at March 2011.
**Measure 10: Number of people aged 75 and over admitted to hospital from home and discharged to a care home from a hospital inpatient acute setting**

**Commentary:**

Chart 10 shows the number of people admitted to an inpatient acute setting from home and discharged to a care home and shows this has continually decreased between 2008/09 and 2009/10, from a mean average of 14 to 8. It has increased slightly in recent years, from a mean of 6.4 in 2010/11 to 6.8 in 2011/12.

**Chart 10: Number of people aged 75 and over admitted to hospital from home and discharged to a care home setting from an acute setting**

![Chart 10](chart.png)

**Source:** Oasis, PIMS and Acadme

**Methodology:** Average length of stay is calculated as the total length of stay per month divided by the total number of monthly admissions. Month is defined by date of discharge.

A rolling average smoothes out short-term fluctuations and highlights longer term trends or cycles.
Measure 11: Rate and proportion of new entrants to care homes admitted from home, hospital and respite care

Commentary:
Table 10 shows the average number an percentage of new entrants to care homes admitted from home, hospital and respite.

The majority of admissions to care homes are from hospital, whilst the proportion of admissions from home have declined from an average of 21% in 2008/09 to 15% in 2011/12. The largest increase has come from ‘Other’, which is used when placement information is not available.

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>%</td>
<td>Mean</td>
<td>%</td>
<td>Mean</td>
</tr>
<tr>
<td>Care Home Adms</td>
<td>67 -</td>
<td>86 -</td>
<td>85 -</td>
<td>85 -</td>
</tr>
<tr>
<td>admitted from home</td>
<td>14 21%</td>
<td>16 19%</td>
<td>15 17%</td>
<td>13 15%</td>
</tr>
<tr>
<td>admitted from hospital</td>
<td>33 49%</td>
<td>37 43%</td>
<td>40 47%</td>
<td>39 46%</td>
</tr>
<tr>
<td>admitted from respite</td>
<td>8 12%</td>
<td>7 8%</td>
<td>8 10%</td>
<td>12 13%</td>
</tr>
<tr>
<td>admitted from other</td>
<td>12 18%</td>
<td>25 29%</td>
<td>22 26%</td>
<td>22 26%</td>
</tr>
</tbody>
</table>

Source: Fife Council, Contracts Data Information (CODI)

Future reports
The graphs in this report have been developed using historical data from April 2008 to January 2012 in order to provide background information around the various quantitative ICASS Evaluation measures. Work to develop some of the measures is still ongoing due to data not being readily available in the required format at this point in time.

Future reports will present the quantitative measures using the most up to date data in addition to twelve months previous data to allow comparison of data on a twelve monthly basis. This timeframe is as recommended by the Data Management Group at it's meeting on 27th July 2012.
Additional Information

Weekly Emergency Occupied Bed Days

Commentary:
The pattern of weekly emergency occupied bed days has been consistently lower in 2011/12 than in the previous year. The mean weekly average for 2011/12 was 1,865. It reached its highest point of 2,303 admissions on the week 6th – 12th January.

Methodology: An emergency occupied bed day is captured by the days that an emergency inpatient is in hospital between admission and discharge date. For example, if patient x was admitted on 1st April 2011 and discharged on the 4th April 2011, the occupied bed days would be 1st, 2nd and 3rd April (the date of discharge is excluded as they are discharged before midnight). Only emergency inpatients’ with a length of stay greater than 0 are included in this analysis.

This analysis only includes patients (all Fife residents) admitted to Adamson Hospital, Cameron Hospital, Glenrothes Hospital, Lynebank Hospital, Netherlea Hospital, Queen Margaret Hospital, Randolph Wemyss Memorial Hospital, St Andrews Community Hospital, Victoria Hospital and Whytemans Brae Hospital.

This analysis does not show the whole population of Fife, as in calendar year 2010, approximately 16.6% of emergency admissions for Fife residents aged 75+ took place outside of NHS Fife (14.4% NHS Tayside; 1% NHS Lothian; 0.9% NHS Forth Valley; 0.3% other).

Source: Oasis