Royal College of General Practitioners

British Geriatrics Society
Improving healthcare for older people

Integrated care for older people with frailty

Innovative approaches in practice

Foreword

The British Geriatrics Society and the Royal College of General Practitioners are delighted to have been able to work together to produce this report. An ageing society and the rising prevalence of frailty are game changers for the health and social care services, and our collaboration is designed to support GPs and geriatricians in responding to these significant new challenges.

That people are living longer than ever before is in part testament to the success of the NHS. However, nearly 70 years after its foundation, the needs of the UK's population are considerably more complex. Caring for older people is expensive, particularly when they are presenting at times of crisis and when there is no viable alternative to remaining in hospital. Fundamental changes in the way that services are commissioned and provided are needed to support holistic approaches to the care of older people with frailty that are sustainable in the face of rising demand.

GPs and geriatricians are leading the way in instigating these changes, as evidenced by the fantastic response we received to our call for case studies for this report. Working with colleagues right across the health and social care services, our members are developing new and creative solutions that specifically support older people with complex health needs. We would like to take this opportunity to thank everyone who generously offered up their experiences to share with their colleagues – there were many more excellent case studies we could have chosen.

Our aim has been to harness the local pockets of enthusiasm and disseminate best practice to support GPs and geriatricians in delivering integrated care in their locality. The examples in this report show what an integrated health and social care system looks like in practice and the positive impact it can have. A fully integrated system will require a culture change within the NHS, and we hope that practitioners will take away inspiration and ideas, and that policymakers will recognise the need to invest in general practice and geriatric medicine so that these excellent initiatives can be translated into normal working practice on a wider scale.

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Executive Summary

Introduction

The role of GPs and geriatricians is more important now than ever given the complex healthcare needs of the UK's rapidly ageing population, and will only increase in the years to come.

The prevalence of multimorbidity is on the rise, with 44% of people over 75 now living with more than one long-term condition.[1] Around 10% of people over 65 will also be living with frailty, a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves, putting them at greater risk of adverse outcomes after apparently minor events.[2]

GPs and geriatricians are uniquely suited to lead the response to the challenges of caring for this group. As generalist disciplines, general practice and geriatrics look at the whole person and consider care within the context of the patient's family, carers and the wider community. They take continuity of responsibility for care across many disease episodes and over time, and coordinate care across organisations.[3] These shared holistic values provide opportunities for collaboration between the two specialisms, and this should be at the forefront of the future design and delivery of care for older people.

However, in the past, service development has all too often taken place in isolation, leading to the creation of services in silos. Not only does this fragmentation have a detrimental impact on patient experience and outcomes, there are also negative consequences for service efficiency and effectiveness.

This has been particularly true at a national level and, in this respect at least, little has changed. However, improvements are being made at a local level where GPs and geriatricians are providing clinical leadership in spite of the organisational barriers they face. This report has been designed to showcase examples of these new approaches that are putting the positive talk around integration of care into practice.

The case studies were all selected as examples of collaboration between GPs and geriatricians that provide innovative and interesting ideas about the care of older people. They were also chosen to cover a range of locations across the UK, including urban and rural populations, and a range of settings, including services based in the community, in GP practices, in care homes and in hospitals. While the majority are led by GPs or geriatricians, the initiatives were selected to illustrate the vital role that many other professionals play, including nurses, therapists, pharmacists and social workers.

The case studies have been grouped into three areas:

- **Ageing well and staying well**
- **Extending primary and community support**
- **Integrated care in acute settings**

The three areas cover the whole frailty trajectory, from keeping people healthy and independent right through to supporting them in hospital. One possible version of a full strategy for the care of older people with frailty is a strategy that is built on these three pillars.

[1] Royal College of General Practitioners, *Responding to the needs of patients with multimorbidity: a vision for general practice*, September 2016. Available at: www.rcgp.org.uk/policy/rcgp-policy-areas/integration-of-care.aspx
[2] British Geriatrics Society, *Fit for Frailty*, June 2014. Available at: www.bgs.org.uk/index.php/fit-for-frailty
[3] Royal College of General Practitioners, *Medical Generalism: why expertise in whole person medicine matters*, June 2012. Available at: www.rcgp.org.uk/policy/rcgp-policy-areas/medical-generalism.aspx

Common themes and key messages

The schemes are at different stages in their development: some are pilots that have begun in recent months, such as case study I in North West Surrey, or are now planning a wider roll-out across a local area, such as case study XI in Rushcliffe. Others, including case studies IV and V in Southampton and Ullapool, have been established as part of normal working practice for many years. However, there are many common themes and these give an indication of the keys to their success:

- **Person-centred care.** A recurring theme in the efforts to deliver person-centred care is the emphasis on patient involvement and choice to support a positive patient experience. Case study II in North Wiltshire provides a striking example of how this can work: by knowing that the patient's preference was to avoid medical interventions, the simple step of sharing information about a patient's pre-existing history of fainting regularly saved unnecessary and unwanted intervention.
- **Continuity of care.** The value of strong professional relationships across the primary and secondary care interface underlies many of the models. Some of the initiatives here have taken the joined-up approach a step further by designating a care coordinator, such as the role of the well-being coordinator in case study I in North West Surrey, to support patients in navigating complex care pathways.
- **Proactive approaches.** The three main elements of delivering more proactive care in this report are risk stratification, conducting Comprehensive Geriatric Assessments, and creating care plans for multiple eventualities[4]. The initiatives in both West Yorkshire (III) and Leeds (XIII) are using the electronic Frailty Index to identify patients at risk of frailty. Developing care plans takes time, but many initiatives have seen the benefits of this investment. For those under extreme time pressures, Lothian (VIII) provides a simple but effective template for kick-starting the care planning process.

- **Collaboration and communication.** Strong communication links between GPs and geriatricians is the cornerstone on which their collaboration is built. Whether it is by email, telephone or through dedicated face to face sessions, immediate access to expert advice is crucial. Case studies V and VII in Ullapool and Wakefield are leading the way by using a mixture of all three.

- **Multidisciplinary working.** In the initiatives in this report GPs and geriatricians often provide clinical leadership for integrated, multidisciplinary teams which draw together professionals from right across health and social care services. In case study VI in Midlothian, for instance, others involved include speciality trainees, advanced nurse practitioners, physiotherapists, occupational therapists and a community psychiatric nurse.
- **Professional development.** One of the real successes of many of the case studies has been the benefits for the clinicians involved. This impact can be tangible – for example, in case study VII in Wakefield, part of the scheme has been to expand workforce skill-sets so occupational therapists have been trained in clinical assessments, clinical observations and phlebotomy, and nurses have received environmental and cognitive assessment training. One of the most interesting ideas to support working across the interface is in Rushcliffe (XI), where GPs and geriatricians have invested time in shadowing each other on ward rounds and in surgeries, in order to support relationship-building by gaining a better understanding of different roles, responsibilities and skills.

[4] Information on the Collaborative Care & Support Planning programme available at: http://www.rcgp.org.uk/care-planning

- **Community resources.** Many of the initiatives are part of the drive to expand provision of services in the community. This means improving both the provision of integrated urgent care, such as in many of the case studies in section 2, and the awareness of local resources so that patients are signposted to the appropriate service. The case study in Southampton (IV) has been particularly successful in this regard, developing links with a local Anglican minister specifically for older people, and working with Age Concern to develop healthy walks based around GP surgeries.

- **Shared records.** Effective collaboration often relies on access to shared electronic patient records. The Islington scheme (X) uses EMIS Community which also enables clinicians to add notes to the record, while in Rushcliffe (XI) SystmOne is also used to send messages to the GP on discharge with follow-up actions and details of continuity of support required. This has proved so useful that standard desktop connectivity to SystmOne has been rolled-out on the hospital wards as a permanent resource.
- **Technology.** As one of the primary enablers of integrated care, use of new technology, which also requires investment in training staff to use systems, is a frequent theme. South Sefton (IX) is particularly advanced in its use of technology to support the delivery of integrated urgent care and enable patients to remain in their own homes. The initiative includes a virtual ward, an urgent care team equipped with tele-video technology for remote assessment and support, and secure NHS video conferencing facilities in care homes.
- **Implementation.** Rather than trying to start with a big bang, many of the schemes in this report have undergone a phased development. This has meant services can be built around patients and clinicians and learnings can be incorporated. Guidance was created for using Lothian's (VII) revised three-part questionnaire to support care planning in response to user feedback, while the 'Hospital at Home' service in Midlothian (VI) was developed as an enhancement to a successful Rapid Response Team.
- **Outcomes.** Evaluation plans have been built into most schemes. While it is too early to draw firm conclusions, there are promising indications that, under the right conditions, services can be developed that deliver both better outcomes for older people with frailty and financial savings. While many report a decrease in demand on acute services, some of the most striking statistics are in Leeds (XIII), where the conversion rate from A&E attendance to hospital admission fell from 74% prior to the introduction of the geriatrician service to 39% during the times when the geriatrician is in the department. Islington (X) have also calculated that the reduction in bed days amounts to around a £300,000 saving to the local health care economy in the two years since their service was established.
- **Investment.** None of the innovation in this report would be possible without sufficient investment, and it is notable that the schemes that are the most developed and the longest established, such as case study VI in Midlothian, have benefited from ongoing, ring-fenced funding. However, this financial commitment tends to be from local decision-makers or specific schemes such as NHS England's vanguard programme. This needs to be combined with metrics that demonstrate potential savings for the whole system and greater national investment to support those shaping and planning health services if these models are to be adopted more widely.

1

Ageing well and staying well

The ideal scenario for patients and health professionals alike is supporting older people with frailty to stay well and out of hospital. People want to continue to lead their normal lives for as long as possible. Remaining at home is a critical part of this, and has a profound impact on their overall well-being and health outcomes. Proactive care to support early identification, prevention and forward planning is also vital for a cost-efficient NHS.

The five case studies in this section are at very different stages in their development. While the initiative in Southampton (IV) has been running for over 15 years, North West Surrey's project (I) was only launched in December 2015. Common to them, however, is the emphasis on strong communication across the primary and secondary care interface and cross-organisational working in order to support patients to remain in the community.

I

Multi-agency health and social care hubs – North West Surrey

Background

Almost half of the 31,000 people in North West Surrey who are over the age of 75 are either frail or at significant short-term risk of becoming frail. The area has one of the lowest levels of premature mortality in England, and this means a significantly higher proportion of the population is living longer into old age.

The pressures this puts on the urgent care system has made it difficult to develop proactive approaches to care. It has also led to delays in reactive care, causing patients, especially older people with frailty, to have a poor experience of care, worse clinical and social outcomes, and more rapid deterioration than would be otherwise expected.

Getting started

The aim was to establish a fully integrated, patient-centric frailty service led by GPs. This would promote independence and physical and mental well-being, prevent patient deterioration and carer breakdown, and safely deliver appropriate acute care in the community. It was also important to eliminate duplication across services in order to ensure a more efficient and effective use of resources.

In order to achieve this, North West Surrey CCG sought input from primary and secondary care, community, social and mental health services, local government, the voluntary sector and, crucially, patients themselves in designing Locality Hubs, the first of which – Woking Hub – was launched in 2016. The programme is funded by North West Surrey CCG.

Key features

The Locality Hubs are physical buildings next to a community hospital which operate in a network alongside GP practices and their services. The Hubs are staffed by multidisciplinary teams drawn from a multitude of health and social care providers. These teams are supported by a robust communications plan, with all stakeholders receiving a weekly progress update by email.

Patients, who are identified using a predetermined clinical algorithm, are all over the age of 75 and suffering from multiple long-term conditions. They live in either their own homes or in care homes, and the Hubs have outreach teams to visit those in the latter.

Every patient is allocated a well-being coordinator who conducts an initial assessment focusing on their social situation, their daily lifestyle, and the support they have at home and in the community. A holistic assessment is then made in order to develop a care programme that is tailored to the individual patient's needs and draws on available community services. Support plans, which are completed by patients with their well-being coordinator, facilitate effective ongoing assessment, care coordination and planning. They include provisions for both proactive (for stable) and reactive care (for exacerbation), and the focus is on prevention, encouraging self-care, and the identification and early management of risk factors. The plans are supported by an integrated care record.

The Hub itself organises evidence-based tasks and activities, such as creative seated dance, that are delivered in a co-located setting by a team that includes carers and volunteers. Patients are able to make frequent, regular appointments to ensure they derive the maximum benefit from the service, and transport is provided for people who would otherwise struggle to attend.

Impact and results

"People who are elderly with complicated needs are difficult to sort out in the restricted time that is available in general practice. One of the things that happens in a consultation is that you will only have enough time to deal with the immediate problem, whereas at the Hub we have a bit more opportunity to talk to people and we can identify the key problems – there is often more than one". *GP*

"These patients come to hospital because their social and function needs are not met in the community and hence they pitch up in A&E as an emergency admission. In this Hub setting, specialists and generalists work well together, removing that divide between primary and secondary care". *GP*

"I recently saw a 75 year old patient as he has chronic obstructive airway disease with recurrent admissions. He first came to the Hub in mid-January, and since then (we are in mid-February), this patient has not been to hospital and has been able to remain in his own home. He now has a community matron and a well-being coordinator who are monitoring his progress, which helps to keep him out of hospital". *GP*

"Thank you so much for the care and help shown to me. I was given time to talk about my problem, shown kindness, had tests done and was given time in explaining how they can help me. Thank you so much". *Patient*

The initiative has been discussed at voluntary sector events and local authority meetings because of the results that the scheme has delivered, and the positive engagement by patients and professionals that it has generated.

Data is currently being collected on the patients seen at the hub and evaluation plans include looking specifically at the number of GP visits, emergency attendances and hospital admissions, as well as the social care packages patients are receiving. Data is also being collected from patients' friends and families as part of the evaluation.

Future plans

The Woking hub has seen 429 new patients in the last five months, and the next phase will go live in September 2016. The locality hub scheme will be expanded to the other two localities in Ashford and Weybridge towards the end of the year.

II

Improving continuity through use of care plans – North Wiltshire

Background

Although person-centred approaches to care have clear benefits for patients, problems can arise when there are decisions to make about the appropriate level of medical intervention. When people are acutely ill these decisions need to be made rapidly, and it is at precisely this time that they are unable to share their views and preferences.

This can slow decision making, lead to unwanted interventions, and delay the start of patient involvement in discharge planning. This issue is exacerbated by segregation between primary and secondary care services.

Getting started

The aim was to develop a primary care-centred initiative focusing on older people with frailty that would support patients to live as independently as possible at home, while also involving people in the consideration of possible future care before a health deterioration occurs.

A critical part of this was facilitating direct communication across the primary and secondary care interface by developing a GP-led service with daily access to a geriatrician, which would both strengthen cross-organisational working, and ensure that the patient's wishes are known, shared and implemented.

Key features

Care plans are integral to the project, providing the basis of quick and effective communication between patients and professionals across the health services. Vulnerable adults who would benefit from an extended GP assessment are identified by practice staff and GPs will typically spend half an hour with them, working together to produce a succinct care plan. This process encourages proactive thinking between the patient and the primary care team. The summary is placed on the TPP computer system, which can be accessed by out of hours services and local secondary care hospitals. The plan therefore also provides primary and secondary care professionals with a resource to support clinical and social planning and continuity of thinking.

The plans are designed to be accessed and read in less than a minute and contain two key paragraphs at the top. The first paragraph expresses the patient's own view of their care and what they would like to happen in the event of deterioration. The second can contain very specific information which may be helpful in the event of a sudden change in health, such as idiosyncratic responses of individuals to standard treatments.

Although the model is GP-led, multidisciplinary working is fundamental to its success. Each practice runs regular meetings linked to the extended GP assessment which are attended by community teams and geriatricians. The community geriatricians provide a daily advice line, with email advice for less urgent matters, and care home liaison. Geriatricians also conduct reviews of patients at home, in rapid assessment clinics or in intermediate care settings, and support patients transitioning into community hospitals.

Wiltshire CCG has allocated the Transforming Care of Older People funding to this initiative, while the adult community health provider has received extra funding from the CCG to fund the geriatricians' time.

Impact and results

An 89 year old woman, who has several long-term health problems, was deemed at high risk of deterioration in her health. A care plan was discussed with her and she clearly said she was not keen on future medical interventions and under no circumstances did she want to go to a care home. She was also noted to faint frequently and the problem was fully investigated.

The woman unexpectedly developed acute abdominal pains and, due to other existing problems, was unable to cope alone. She was transferred to A&E during the night, where she fainted. However, as this was now expected, no additional action was needed. Her request for little intervention was backed up by her previous statements, and so investigations were kept to a minimum. Her other existing conditions were noted but left alone.

In the morning, the geriatrician spoke on the phone to the GP and a plan for low-key investigation was made with an aim for early home transfer with support from the community team. Her symptoms in fact resolved quite quickly and she went home with support. She is immensely pleased not to have been pushed into additional investigations, and the secondary care team are pleased to have had prior thinking in place to help their acute decision-making.

The scheme has led to improved working satisfaction for community teams, GPs and geriatricians and an increase in confidence in community staff to manage cases at home. Clinical staff, especially those with less experience, also now have a better understanding of older people's views on their own future care.

The introduction of the care plans has been associated with a reduction in the number of district general hospital bed days required for acute care of the elderly. The admission levels for urgent care for those aged over 75 has stabilised, despite an increase in the population of that age. Allowing for demographic growth, this equates to a 5.1% reduction in acute admissions.

Future plans

Over the next year geriatricians will start visiting each larger practice to discuss patients and conditions directly, rather than have patients referred to a traditional outpatient clinic. The expansion of the geriatrician's role will also mean there is increased provision to support patients transitioning into community hospitals or intermediate care beds, and will enable the introduction of virtual acute community beds. In addition, further development of ambulatory care models in community hospitals is planned, which will support admission avoidance.

	2014/15					2015/16				
Activity	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Spells	1,717	1,636	1,760	1,706	6,819	1,606	1,581	1,684	1,710	6,581
Bed Days	18,899	17,790	19,132	20,237	76,058	19,291	17,180	18,135	18,808	73,414
Average length of stay	11.0	10.9	10.9	11.9	11.2	12.0	10.9	10.8	11.0	11.2

III

Developing a Frailty Pathway – North East Yorkshire

Background

Hambleton, Richmond and Whitby (HRW) CCG covers a particularly rural area of over 1,000 square miles. The area has an ageing population, and local systems of healthcare have been disease rather than patient focused. Patients were unhappy with the existing services as they were often referred to multiple agencies leading to multiple appointments, and GPs and geriatricians were keen to improve the situation which was having a negative effect on patients' health and well-being.

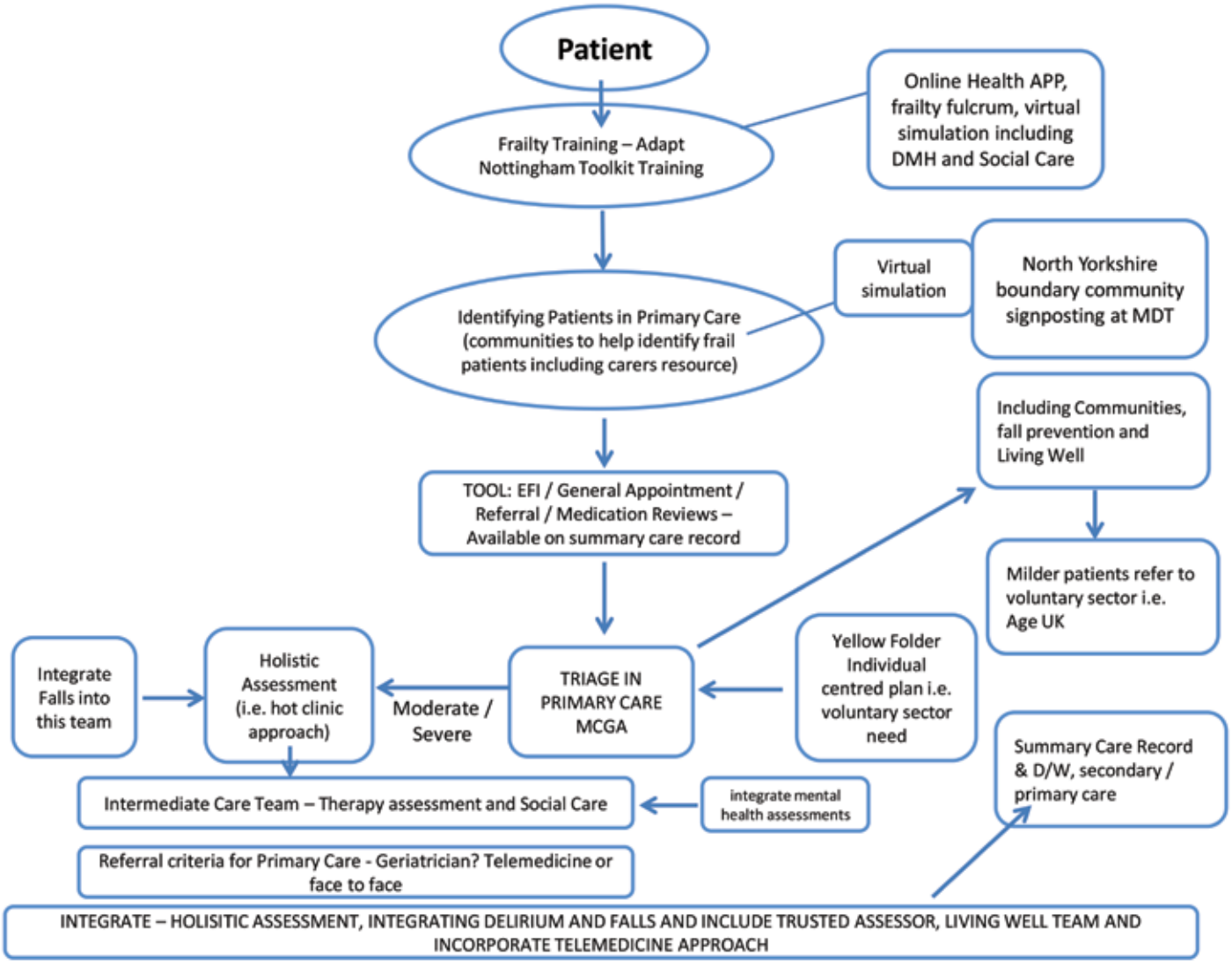
HRW CCG together with Heartbeat Alliance (HBA) were successful in gaining funding from NHS England to deliver ten pilot schemes to meet increased demand for primary care.

Getting started

The intention was to develop a frailty pathway drawing on these pilots that would incorporate existing services from all care sectors to ensure an integrated model of care with benefits for patients and the health economy. Design of the frailty pathway was informed by the British Geriatrics Society's *Fit for Frailty* guidance.

The aims were to support patients with frailty with non-specific symptoms that often end up in acute crises and require urgent and emergency care, and to reduce avoidable admissions and crises. Initial work was led by a team from the CCG and the HBA with input from the Improvement Academy and Falls team. Primary care was built into the wider pathway development.

Mapping a frailty pathway



Key features

The electronic Frailty Index (eFI) was used within the GP clinical system, SystmOne, to proactively identify patients at risk of frailty. Patients were divided into two cohorts, an intervention and a control group. The intervention group received a Modified Comprehensive Geriatric Assessment (MCGA) by a practice nurse within their home which included:

- holistic chronic disease management of patients regardless of their residence;
- screening for dementia, depression, chronic widespread pain and insomnia;
- use of self-supported management, including involvement in IT and care plans which include discussions of 'what matters to me' and anticipatory care planning;
- avoidance of over-medication and improved prescribing through the use of the STOPP/START Toolkit and Community Pharmacist (21st Century Care Pilot);
- a template was designed on SystmOne to facilitate data entry.

Impact and results

The use of the word 'frail' was negatively received by some patients and led to an alternative explanation to patients based on the 'Frailty Fulcrum' from the Nottingham Toolkit by Dr Moody.[4]

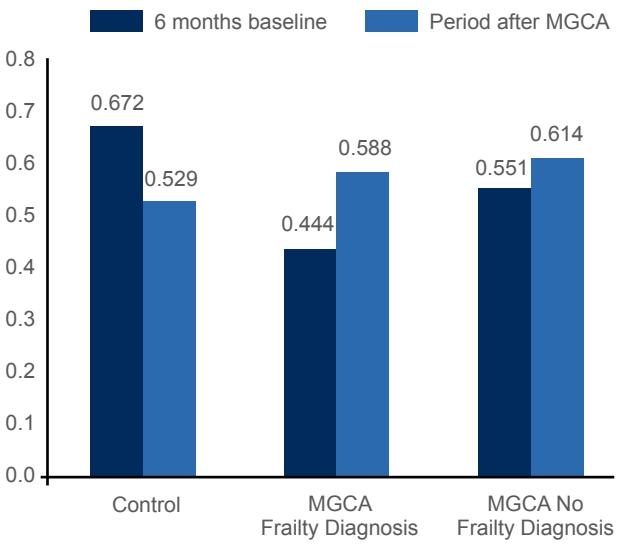
Feedback from patients has been largely positive with housebound patients in particular feeling they had regained contact with allied health professionals from the surgery.

> "It highlighted problems which might otherwise be considered as not worth bothering the doctor with". *Patient*
>
> "Having someone with medical knowledge and access to other professionals visit is preferable in some instances to visiting a surgery". *Patient*
>
> "She was referred to the memory clinic which enabled all parties involved to assess her and put in place anything she required to make life easier". *Family member of patient*

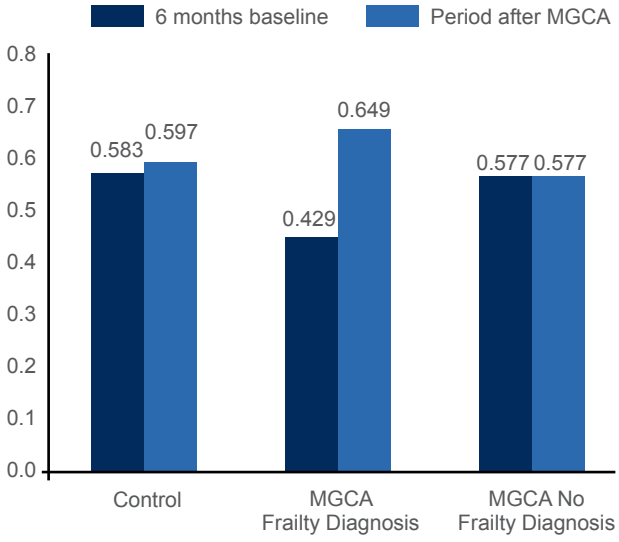
Workshops were held to review and develop the overall pathway and involved input from Heartbeat Alliance, the CCG, the Improvement Academy, the Falls Team, the Community Matron, the Integrated Care Team and a secondary care clinician from South Tees NHS Trust. The NHS Foundation Trust mental health providers and county council social services, together with Living Well Practitioners, also participated.

There were initial challenges with the change of mindset from reactive to proactive working, developing confidence in visiting patients at home, the use of mobile IT and in the assessment itself. Some staff raised concerns regarding the perceived impact on QoF and chronic disease appointments and targets, but an audit of appointments demonstrated that there had been little change in availability due to the employment of a Health Care Assistant to free the practice nurses from more simple tasks.

Nurse Appointments Per Month



GP Appointments Per Month



[4] http://www.frailtytoolkit.org/frailty-fulcrum-animation/

Although the early data demonstrates an increased rather than reduced demand on primary care services, the hypothesis is that this demonstrates unmet need in this population which is often housebound. The six and twelve month data will provide further insight.

Further outcomes to be evaluated include patient satisfaction and quality of life; improved recognition and diagnosis of frailty; reduction in the number of GP consultations, out of hours consultations and disease-specific secondary care referrals; increase in referrals to social services and the third sector; and evidence of de-prescribing amongst patients with a frailty diagnosis.

Partial data was collected at three months with full data to be collected and interpreted at six and twelve months, after which the control group will receive the intervention. An economic evaluation is to be performed by the York Health Economics Consortium.

Future plans

The next phase of the project will be to consolidate the work done to date by systematising the use of the eFI tool across primary care and implementing a programme of education in primary care to support the change to the proactive care model. In addition, the CCG will begin to look at how to commission all the services that contribute to the frailty pathway in an integrated way, such as through the emerging Multispecialty Community Provider (MCP) care model.

IV

Joint working to develop Comprehensive Geriatric Assessments – Southampton

Background

The need for health and social care amongst Southampton's ageing population is almost double the national average. In 2011/12, 213 older people per 1,000 received social services in Southampton, compared to a national average of just 113.5 per 1,000.

People are expected to make complex decisions that require a detailed understanding of their diagnoses, prognosis and the options available to them. This is a huge demand for many, in particular older people with frailty and their families, who need significant professional support. Sometimes this need is not known to the health and social care services until a crisis occurs.

Getting started

Older people with frailty were already known to community services, GPs and social services but what was needed was a more proactive approach to managing their risk of an acute crisis.

The idea of the community geriatrician was born out of a desire to see people earlier. The role began in 2000 with a consultant geriatrician dedicating sessions to support the community rehabilitation team, supported by an initial £1 million investment of non-recurring funds from Southampton City CCG, and has grown ever since, although financial constraints and difficulties in carrying out a systematic evaluation of the role have threatened the sustainability of the community geriatrician.

Key features

The aim is to identify people who would benefit from a Comprehensive Geriatric Assessment (CGA) and the development of an advanced care plan. A CGA identifies and manages physical, psychological, social and cognitive issues concerning patients. It is undertaken by a multi-professional team, drawing on the collective knowledge of many including GPs, community nurses and social workers.

The use of CGAs has enabled the development of person-specific management plans. Care is then coordinated by the most appropriate person and negotiated across all parties involved, including the patient, their family, their GP and hospital consultants. Very often, management plans utilise local resources. For instance, Southampton has an Anglican minister specifically for older people, and Age Concern has helped to develop healthy walks based around GP surgeries.

Patient-centred decisions are fundamental to the process of assessment, engagement and the behavioural change required for lasting benefits. For example, if a person is reluctant to undertake an investigation due to anxiety, support from an occupational therapist using psychological interventions can enable the patient to take the test.

The geriatrician provides specialist knowledge on an individual patient level, working collaboratively across all of these professions and organisations. In practice, this means conducting joint assessments and case conferences, and being available to provide advice. There are currently three community geriatricians working across Southampton based within community rehabilitation and matron teams, with a strong focus on relationship-building, including with GPs. This flexible approach is not constrained by fixed sessions or disrupted by the pull of hospital work.

Impact and results

In the 15 years since this approach was first developed, GPs in the area have become better equipped to manage complex frailty and negotiate the transition of patients with conditions such as severe dementia, end-stage heart failure or lung disease, into a comfortable death at home. Families welcome this opportunity and value the support they receive.

In Southampton there has been a 2% reduction in non-elective admissions in those aged over 65 in 2013/14 compared with the previous year. There has also been a 14% reduction in delayed transfers of care, a 6% reduction in injurious falls and a 7% reduction in the age standardised rate of admissions compared over the same period.

"There is improved confidence within primary care to support people in the community for longer knowing that help from a community geriatrician is readily available". *GP with special interest in geriatrics*

"The key to the role of a community geriatrician is respect for other people's point of view, whether it is a patient, carer, therapist, social worker, nurse or GP. This means having the ability to change one's own mind about a course of action. It also means encouraging others to feel safe to voice an opposing viewpoint. Working closely with social workers has taught me to think in terms of risk and how to quantify and modify it, as well as embracing alternative viewpoints which is so important when planning for someone's health and well-being. These skills require practice, but once established enable clinicians to recognise a clinical pattern which is more effective and efficient". *Community geriatrician*

V

Integrating care for older adults in a remote, rural population – Ullapool, Scottish Highlands

Background

Ullapool Medical Practice is located in a small coastal village in the North West Highlands of Scotland looking out over the Atlantic towards the Outer Hebrides. The community is a rural one, with remote outlying areas such as Achiltibuie, Dundonnell and Scoraig.

The practice area covers a region of approximately 30 miles by 20 miles, with a population of 2,500. There is little deprivation and 2014 figures show 9.3% of the population is over the age of 75. Many are retired people who have lived there all their lives and have families living locally. In 2010 the practice had 219 patients over 75 and in 2016 it has 233. Most patients live independently at home, but there are also patients in the local nursing home or residential home. Most also live in the main village, but there are some who are part of crofting communities up to an hour's drive away. There is a strong sense of community and a willingness to help out, with lots of people benefiting from the informal support of neighbours and friends.

On the other hand, the location poses a number of unique challenges, including a minimal public transport system, one track roads and limited grocery supplies in outlying areas. Healthcare provision is limited, for example home carers, day services, and specialist provision such as Speech and Language Therapy and Occupational Therapy. Lengthy journeys makes it difficult to access secondary care. The nearest hospital requires a 110 mile round trip.

Getting started

There was a clear need to develop close links with secondary care colleagues in order to move provision of acute services, where possible, closer to the patient's home. The aim was to develop a multidisciplinary, multi-agency model of care hallmarked by regular planned proactive interaction of GPs, geriatricians and other health professionals.

The initiative started in 2007 when a consultant older adult physician developed a strong link with the practice and the primary care team. A specialist clinic was established in the practice and held every six months, and the physician is also available to give advice by telephone and email. Since then a powerful partnership has evolved based upon respect for each other's skill set and with the interests of the patients at its heart.

Key features

The clinic is run by the consultant in a GP consulting room and decisions about the clinic list are made with input from both primary and secondary care. GPs fund the use of the consulting room and the logistics of arranging the clinic, while the consultant sessions and travel are funded by secondary care.

After the clinic there is a multidisciplinary meeting where each case is discussed and a management plan made. At the meeting there are contributions from the GPs, the district nurses, an occupational therapist, a physiotherapist, a social worker, nursing home managers and staff, and the Care at Home manager.

Another element of the initiative is building robust communication links between the GP and the consultant. The consultant is able to provide advice, usually the same day, which can be put into effect immediately because they already know many of the patients. If the consultant does not know the patient then they have rapid access to relevant information from the GP, clinic letters and investigation results.

Impact and results

By sharing knowledge of the patient's clinical presentation and home setting, and by working collaboratively across a multidisciplinary team, rapid interventions are possible which improve treatments, quality of life, outcomes and help maintain patients in their own homes in the community. It may also avoid hospital admissions or shorten hospital stays. Crucially there is consistency of care, because the same consultant has done the clinic for several years and so has excellent relationships with both patients and clinicians in the community. This clear and rapid access to specialist advice despite the distance involved has helped the local team work to their maximum potential.

Most of these people have worked together for many years and work from the same building, meaning that interprofessional communication is easy, friendly and usually in person rather than in writing or by phone. Some of the benefits of this are a strongly patient-centred model of care, which minimises hospital admissions and stays, and enables terminal care to be provided at home when requested by the patient and their family.

The advantages of the model are reflected in the admission rates, occupied bed days and place of death.

Ullapool rate admission >75s per 1,000		Type of Hospital				Ullapool % difference
Financial Year	Community	Raigmore District General Hospital	New Craigs Psychiatric Hospital	Grand Total per 1,000 75s	CHP* average	Ullapool % difference
2008/9	18.3	251.1	18.3	287.7	326.7	-12%
2009/10	13.7	196.3	-	210.0	306.8	-31%
2010/11	13.7	210.0	-	223.7	357.7	-37%

* Community Health Partnership

Ullapool OBD use per 1,000		Type of Hospital				Ullapool % difference
Financial Year	Community	Raigmore District General Hospital	New Craigs Psychiatric Hospital	Grand Total per 1,000 75s	CHP* average	Ullapool % difference
2008/9	1,196	2,611	1,333	5,140	5,570	-8%
2009/10	1,447	2,479	721	4,648	5,812	-20%
2010/11	854	2,453	393	3,699	5,216	-29%

* Community Health Partnership

Year	Total deaths	In community	In hospital	% in community
2006/07	23	15	8	65
2007/08	19	11	8	58
2008/09	38	24	14	63
2009/10	26	19	7	83
2010/11	22	18	4	82
2011/12	35	29	6	83
2012/13	30	27	3	90
2013/14	26	21	5	81
2014/15	19	10	9	53
2015/16	28	23	5	82
Average over 10 years				74

"My husband has attended the medicine for the elderly clinic on a regular basis for the last few years to discuss developments in his health due to Parkinson's disease.

Because of the debilitating effects of this disease he is no longer fit to attend Raigmore Hospital's outpatient clinic. He finds the journey to Inverness exhausting and is not fit for a reasonable consultation on arrival. He is also very uncomfortable in an unfamiliar environment. In the past we have occasionally found it impossible to get a wheelchair for him to use while at the hospital which has resulted in him having to walk painfully and slowly down lengths of corridor to see his consultant. When he is expected to attend an appointment at an Inverness clinic, he finds it impossible to sleep the night before the clinic as he is too stressed by the thought of going.

The Parkinson's specialist does need to see him regularly to examine his physical and mental condition, to offer helpful advice on dealing with the condition as he monitors its progress and to review medication. Without the clinic in Ullapool we would be without the help and advice we very much need in order to let my husband have the best quality of life possible for him". *Wife of patient*

Future plans

This is a simple, uncomplicated, patient-centred system, and the aim is to continue to support its delivery.

2

Extending primary and community support

Older people with frailty are susceptible to health crises and need acute care when a crisis occurs. They want to remain at home if they possibly can, and developing urgent care responses delivered at home or in a community setting often delivers better outcomes than in hospitals. Successful delivery requires collaboration across a wide range of health, social and voluntary sector organisations, working together with patients, families and carers. The interaction between the GP and geriatrician is pivotal in helping this collaboration to work well in practice.

The importance of developing strong relationships across the interface is a common theme in the five case studies in this section, which all show how much can be achieved in the community when communication and joined-up working is established at the outset of a new initiative. The Midlothian 'Hospital at Home' initiative (VI) shows how acute care can be delivered in a patient's home instead of on a hospital ward. The Wakefield vanguard (VII) and the Islington schemes (X) show the clear benefits for older people living in care homes when they are able to access high quality health care from a multidisciplinary team. The other case studies, from Edinburgh (VIII) and Merseyside (IX), demonstrate the benefits of developing anticipatory care plans, and the extent to which high levels of acute care can be delivered in the community, including through the development of a 'virtual ward' which has all the same clinical input as a hospital ward.

VI

‘Hospital at Home’ – Midlothian, Scotland

Background

Midlothian is a semi-rural community to the south of Edinburgh. It is in a region which has significant areas of social deprivation, and some of the population are biologically older than their age. People aged 60 and over make up 24.4% of the Midlothian population, which is slightly higher than the average in Scotland of 24.2%. A successful Rapid Response Team has been in place for many years, with therapists, a falls service and in-house carers integrated across health and social care.

In 2014 a consultant geriatrician was appointed to set up an enhanced service with medical and nursing input to support people with significant health needs. A team of Advanced Nurse Practitioners was also appointed to provide day-to-day medical and nursing care in the community for patients who would otherwise have had to be admitted to hospital. This service has been fully operational since summer 2014, and has provided care seven days a week since October 2015.

Getting started

The additional new component of the service is known as ‘Hospital at Home’. In Scotland the term ‘hospital at home’ is used to refer to ‘an episode of specialist care delivered at home as an alternative to being treated in an acute hospital environment and where the care is overseen by a consultant/ equivalent specialist’.[1]

The Rapid Response Team was renamed the Midlothian Enhanced Rapid Response & Intervention Team (MERRIT). Patients who would previously have been admitted to acute hospital care are now able to be cared for at home. The service is funded by the Midlothian Health and Social Care Partnership, administered by an Integrated Joint Board, and the funding is established and ongoing.

Key features

GPs make the majority of referrals to the team and although medical responsibility transfers to the geriatrician there is close liaison, especially when patients are being discharged back to GP care. Some patients are also referred from the local emergency department and others from the ‘Front Door Geriatrician’ in the Medical Admissions Unit of the local teaching hospital. They are admitted to a virtual ward on the hospital-based computer system and are assessed and treated in the same way as if they were in hospital, but instead they remain in their own home or care home. They have the same access to investigations that other inpatients have.

The service provided to patients is fully integrated across specialisms and sectors. Medical input by the consultant geriatrician is provided through six sessions per week, with additional input from speciality trainees when attached to the team. Five Advanced Nurse Practitioners assess the patients daily and administer intravenous or subcutaneous medication and fluids if needed. Physiotherapy and occupational therapy can be provided in-house by the Rapid Response Team. There is regular liaison with the Red Cross and other third sector organisations to provide support for the patients. There is a Community Psychiatric Nurse attached to the team and the Old Age Psychiatry service is co-located adjacent to the Hospital at Home office. This means care packages can be provided at home for patients who need additional care, which is one of the biggest benefits of being an integrated team providing health and social care.

The majority of patients who access the service are elderly and frail. Many have significant comorbidities such as heart or renal failure, and dementia and delirium are common. Some referrals are for younger patients who are biologically older than their years, and care has also been provided for some patients with a variety of disabilities who are young but have complex needs. Patients are generally living in their own homes, though they may also be living in care homes or supported housing. In addition, Midlothian has a number of social care beds available in a community facility for ‘Step Up/ Step Down’ care which can be used for any patient requiring short-term additional care or rehabilitation.

[1] www.knowledge.scot.nhs.uk/chin/intermediate-care/hospital-at-home-services.aspx

Impact and results

Developing a Hospital at Home service has been a successful enhancement to a well-established Rapid Response Team. Recruiting team members from a range of backgrounds across primary and secondary care has brought a good blend of skills to the team. There is now a very real alternative to hospital admission for this group of older patients with frailty when they require urgent care. Ring-fenced funding from an integrated Health and Social Care Board has been key to success.

Patients are grateful to have the opportunity to remain in their own home. In a patient survey in 2015, 100% of 28 respondents stated they had confidence in the team and 100% said 'definitely yes' that they felt valued as an individual.

> "I cannot thank them enough for the excellent service and care I received". *Patient*
>
> "I firmly believe that having treatment at home has accelerated my recovery". *Patient*
>
> "All staff took time to explain everything clearly and listened at all times. All very professional". *Patient*

In 2015, 302 patients were referred, of whom 87% were accepted. Of these, 84% were referred by their GP, and 15% by acute hospitals to support early discharge. The majority were elderly, with 77% over 75 years. Patients had a variety of problems, including acute infection (20%), cardiac problems (12%) and respiratory illnesses including COPD (12%). Many patients have multiple issues, such as falls, delirium and musculoskeletal problems.

The average length of stay in the 'virtual ward' is around eight days. Approximately 20% of patients are admitted to hospital for acute care, but of these, many can be 'retrieved' the next day and return home with support. At 28 days after discharge from Hospital at Home, around 75% of the original cohort of referrals are still (or back) in their own home. Around 10% patients die either under the team's care or within 28 days of discharge; these deaths are usually expected and appropriate. The team are able to facilitate this to happen in a place of choice, either at home or in the local community hospital.

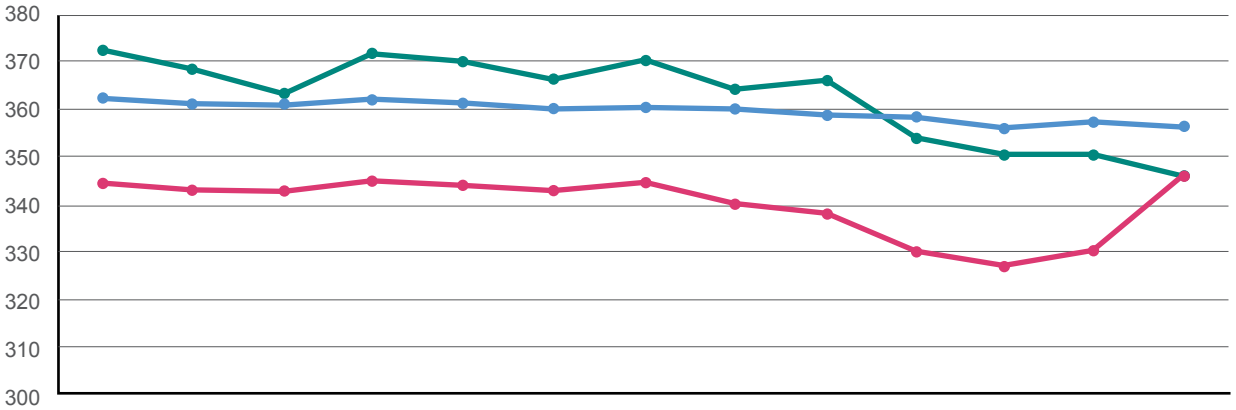
GPs and geriatricians are all delighted with the service. In many cases the GP simply does not have the time to sort out the complex issues presented, and they have found the service very helpful in providing more intensive support for their patients over a short time period.

The table below shows how emergency admissions in Midlothian for people aged 75 and over compares with the rest of Scotland. The data refers to admissions and not to individuals.

Future plans

An experienced GP has now been appointed to join the team in 2016 to work alongside the consultant physician. This will be a tremendous bonus and facilitate greater understanding and cooperation between the Hospital at Home team and the wider GP community.

75+ Emergency Admissions Per 1,000 Population



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Midlothian	372	369	363	371	370	366	370	364	366	354	350	350	346
Lothian	344	343	343	345	344	343	344	340	338	330	327	330	346
Scotland	362	361	361	362	361	360	360	360	359	358	356	357	356

VII

Connecting care for residents in care homes – Wakefield

Getting started

In March 2015 NHS England announced the first of its new care model vanguards. The Wakefield District, Connecting Care vanguard is one of six enhanced care vanguards which aims to offer older people in care homes better joined-up health, care and rehabilitation services. The vanguards are designed to break the mould for older people in care homes, tackle social isolation and move from fragmented to connected care. The service is funded by the vanguard and Wakefield CCG.

Key features

The older person is at the heart of the design and delivery of services which have been developed to meet a full range of needs. Figure 1 shows the key components.

When someone first moves into a care home they are assessed quickly, and the care home is able to access a full range of care from community health, social care and voluntary sector professionals, as well as shared records and advice.

GPs, health workers and specialist voluntary workers work together to make sure residents in care homes and supported living schemes have their health and social care needs met, and a multidisciplinary team provides personally tailored care plans to targeted vulnerable patients. The team comprises a Matron for Care Homes, a Registered General Nurse, a Mental Health Nurse, Dietician, Speech and Language Therapists, a physiotherapist and occupational therapists. They are supported by a geriatrician who provides two dedicated sessions a week.

Figure 1

Going into care and living well

- Proactive and holistic assessment and care planning
- Access to community and activities
- Primary care led models of proactive intervention (currently in pilot/prototypes)

What if I'm at the end of my life?

- Advanced care planning including do not attempt resuscitation (DNAR) led through primary care models (pilots)
- Additional wraparound support from primary and community services
- Shared record

What if I have health needs?

- Proactive primary care support (prototypes)
- Connecting Care teams – integrated community health, social care and voluntary community sector (VCS) repsonse
- Support and advice from secondary care
- Shared record

What if I'm admitted to hospital?

- Rapid assessment for frail/elderly (REACT)
- Communication with the care home
- Early supported discharge with wraparound support for additional needs
- Shared record

What if I need urgent help?

- Yorkshire ambulance service (YAS) yellow care plan
- Emergency care practitioner (ECP) response 'see and treat'
- Conveyance to hospital

What if I become unwell?

- Primary care urgent call-outs
- Connecting Care teams urgent response (community)
- Support and advice from secondary care (REACT)

The team proactively provides continuity of care through case reviews which help improve medical management and quality of life. This includes the facilitation and provision of advanced care planning in liaison with GPs and district nurses to ensure that each care plan is delivered in a timely and appropriate way. When urgent care is required the response is coordinated by the Yorkshire ambulance service which has access to an individual's 'yellow care plan' (this is an approved ambulance care pathway that has been drawn up prior to an acute event). If a patient needs to be admitted to hospital, they will undergo a rapid assessment for frailty. Acute care workers will communicate with the care home to facilitate early discharge with support for additional needs wherever possible. End of life care is based on advanced care plans, which are implemented with input from primary and community services, and again facilitated by shared records.

A key part of the team's role is to facilitate improvements in communication between healthcare professionals. They also provide support and training to care home staff to enable them to deal with patients' medical needs in the most appropriate manner, and a monthly newsletter is published to share stories and opportunities for learning, as well as 'top tips' on important health and social issues. 'Ageing Explained' sessions are also now underway for residents, relatives and staff, ensuring better understanding of issues faced by people living in 24-hour care settings.

Impact and results

Evaluation of the work within the Wakefield care home vanguard is ongoing but initial results are very encouraging. When compared with a control group over the same time period, there has been a 6% reduction in emergency admissions and a 6% decrease in the number of emergency department attendances. There is also a 16% overall reduction in ambulance call outs based on the expected number of ambulance attendances during the same period, and 34% fewer ambulance call outs than the control group.

"It is so refreshing to have people be honest about my husband's health. I now know what to expect and feel reassured if my husband has to go into hospital that the doctors will also care about getting him home as soon as possible". *Wife of patient*

"This innovation truly is improving residents' health and building on their life experience, based on the things that we know make the most difference to well-being in older age: somewhere to live; something to do; someone to love". *Programme Commissioning Director Integrated Care*

"This approach allows us to ensure residents have the best possible care. By making pragmatic decisions with residents or their relatives, we can ensure that people living with frailty are treated with respect and dignity". *Community and acute geriatrician*

Future plans

The work is currently being carried out in 12 care homes and two extra care schemes, and has been rolled out to further homes. Ultimately, this model will be delivered in all the care homes and extra care schemes in Wakefield.

VIII

Anticipatory care planning in three questions – Lothian, Scotland

Background

When the Care Home Enhanced Service started in Lothian in 2008, St Triduana's Medical Practice had almost 300 care home residents, of whom approximately 95% have either dementia or cognitive impairment.

The care home residents required anticipatory care plans (ACPs), but it was clear that some of the ACPs being created contained vague and general statements that were unlikely to have a significant impact on patient care. However, there was already good evidence from other areas that high quality ACPs could support the provision of integrated urgent care and reduce inappropriate admissions.

Getting started

ACPs that were working well had been developed during lengthy face to face meetings between GPs or nurses and the patient.

Instead of face to face meetings, GPs at St Triduana's developed a plan for a simple, short form to be given out by care staff to relatives of new care home residents, the majority of whom lack capacity to make informed decisions concerning their welfare. It was anticipated that as well as making a potentially daunting task more efficient, the answers to the questionnaires could be used to ensure that the care plans included specific and meaningful guidance to support GPs and consultants caring for residents when they were seriously ill.

A separate questionnaire was designed to be answered by new care home residents who do have the capacity to make decisions about their care. The development of the questionnaire was funded as part of the Care Home Enhanced Service.

Key features

The questionnaire uses three questions to facilitate a discussion with families about how a patient would like to be treated in the event of a serious illness:

- If your relative had a stroke which meant that they were unable to communicate at all what do you think they would wish to happen?
- If your relative had a serious infection which was not improving with antibiotic tablets what do you think they would wish to happen?
- If your relative was so unwell that they could not eat or drink what do you think they would wish to happen?

Within each scenario there are three options:

1. Admit them to hospital for invasive treatment.
2. Discuss with a family member as soon as possible to decide whether to admit them to hospital.
3. Keep them comfortable and relieve any distressing symptoms in the environment that is familiar to them.

The information from the questionnaire responses is combined with personal data and information about a patient's functional status to create a detailed and robust ACP. This is recorded in an electronic Key Information Summary (KIS) that is shared with the out of hours GP service, ambulance control and secondary care. The KIS also includes a medical history, drug history, resuscitation status and next of kin details. A copy of this KIS is printed off, discussed with care home staff, and added to the resident's notes.

Impact and results

Using funding from Marie Curie, a Steering Group was formed in order to design and conduct a small project to evaluate the use of the questionnaire in two contrasting care homes in Edinburgh. In particular, its effectiveness and reactions to its use were assessed, and both barriers to and benefits of its use were identified. An audit of acute clinical events was conducted over a six month period and by interviewing relatives, care home staff and GPs. Thirty Lothian Unscheduled Care Service GPs were also invited to a focus group to discuss a range of scenarios that typically occur in a care home setting.

The care planning process was found to be broadly acceptable. Some people thought the questionnaire was clear and helpful, while others thought it needed to be modified. Feedback from both staff and relatives was that it would be helpful to have a short explanatory leaflet about the process and the decisions to be considered, in addition to staff providing information.

The questionnaire has now been revised, and accompanying guides have been produced. The fundamental principle used for developing the original questionnaire was followed which ensured it was no longer than one side of A4 with only three questions.

A key learning point from the project was that anticipatory care planning should start before care home admission and be a coordinated, ongoing care process tailored to individual needs and embedded in the routine procedures of the care home. There was evidence that having clear electronically recorded plans in place ensured most acute clinical events were handled appropriately. 58 out of 69 acute events were handled either in accordance with the ACP or appropriate decisions were made by out of hours doctors. Times when the system worked less well and was most vulnerable were when protocol-driven decisions were made by NHS call handlers.

Although it was recognised that an ideal ACP cannot be achieved with three questions, the questionnaire has formed the basis of robust and specific ACPs in a care home population.

> "Key Information Summaries are really helpful because they are so easy to transfer over. I work in out of hours as well, and I think it's useful because it's such a clear plan. It's very specific, it answers the questions you want to know, such as what are the patient's wishes, what are the family's wishes, and do I need to admit this patient? And it's quite nice, I think, because it gets families thinking about these issues too". *GP*
>
> "It's very self-explanatory, it sets out in very detailed terms what people will be admitted for, what they won't be admitted for, and people can decide at the time they're coming in because usually that's the best time to establish what's expected of us as well, in terms of them going to hospital". *Care Home Staff*
>
> "I think you need it because, at the end of the day, they're your relative and they need a spokesperson, and I just know how my mum felt about life". *Relative*
>
> "I think it's an excellent idea. I know being asked beforehand can be upsetting for some people, but you do really need to know, so I completely agree with this approach". *Relative*

Future plans

There is currently active discussion on how best to roll out this programme across Lothian.

IX

Designing holistic care for frail older people – South Sefton, Merseyside

Background

South Sefton is an urban area of Merseyside with a population of 155,000. It has an 11 year variation in life expectancy, with neighbourhoods covering some of the highest levels of both frailty and deprivation in the country. Over the next five years South Sefton is projected to have a 20% increase in the number of older people with frailty.[5] The majority of older adults with frailty in the area are female, have multiple long-term conditions, live alone and require support with personal care.

The overarching goal of the Frailty Community Care Model was to provide care closer to home for mild to moderate illness in older people with frailty, and care for end of life patients in their usual place of residence. A secondary goal was a reduction in unplanned hospital attendances and admissions.

Getting started

In 2013, in the light of the demographic changes and their anticipated clinical impact, the CCG made frailty a strategic objective. A GP led on the design of a community care model that is integrated, proactive, responsive and holistic in meeting patients' needs. The aim of the model was to facilitate coordinated care across organisational boundaries, to fill the gap in community urgent care and instil a culture of continuous improvement. Another GP led on the design of a programme for care homes. The CCG worked closely with the local community provider, Liverpool Community Health South Sefton, to implement the model.

A community geriatrician was recruited in early 2014 and plays a pivotal role in providing oversight, giving GPs confidence in the clinical model, and offering senior clinical expertise to healthcare professionals who look after older people with frailty outside a hospital setting. The model is supported by active work streams and joint governance structures, with quality improvement as a key driver. The South Sefton CCG provides the funding for the service in its entirety, including the role of the community geriatrician. Patients referred to the scheme can be seen in their own home, a care home or community clinic, whichever is most suitable for them.

Key features

The relationship between the GP, community geriatrician and nursing staff is strong. Within this community care model there are three main programmes :

i. **Virtual ward.** The vision for this programme is 'maintaining happy independence for frail and elderly people'. One of the features that is critical to success is the multidisciplinary team or 'virtual ward round', which facilitates coordination. Led by virtual ward (VW) coordinators, these integrated teams include four organisations working together. Community matrons, district nurses, therapists, social workers, health and well-being trainers and mental health liaison officers meet at 'virtual ward rounds' to discuss cases. The GP and community matron have immediate access to the expertise of a community geriatrician for advice and, when necessary, to review a case.

   Most staff have access to a common IT platform. The virtual ward screens patients for medication issues, falls, dementia and nutritional status. The community matron meets regularly with the GPs in her allocated practices. Together they identify older people with frailty who are at high risk of a crisis, in order to enrol them in a programme that can last up to three months.

   Virtual ward staff are able to call on a wide range of services, from voluntary organisations to specialist nurses, to assist in the management of patients' care. Strong links to local voluntary organisations have been developed by health and well-being trainers.

[5] https://www.sefton.gov.uk/media/728987/SSNA-2014-Older-People.pdf

ii. **Urgent Care Team.** The second programme is the Urgent Care Team, which works to avoid admissions for sub-acute patients. The team operates out of a community walk-in centre and consists of a community geriatrician, advanced nurse practitioners, therapists, healthcare assistants, social workers and administrative and call centre support. GPs make referrals for older people with frailty who would otherwise have been sent to hospital. It is connected to the GP out of hours service, which supports the ambulance service by providing alternative transport. In addition, the local hospital A&E staff can access the team through dedicated A&E link nurses. A clinical coordinator brings together a holistic response which may include specialist nurses.

   Staff are equipped with tele-video technology for remote assessment and support. The target response time is within two hours, but the majority of cases are usually reviewed within an hour. The community geriatrician is available for advice and queries regarding clinical issues, but the nurses have clinical examination competencies and can prescribe medications. The community geriatrician provides both home visits for housebound or care home residents and a clinic in the hub, with referrals seen within a week. They can be contacted by the GP directly by mobile or email for clinical advice or a second opinion.

iii. **Care Home Innovation Programme (CHIP).** The third programme is the CHIP, which supports 32 care homes in the South Sefton area (about 1,200 residents). Community matrons work in collaboration with their allocated care homes within localities, and the patient's GP ensures that a care plan is in place including, where appropriate, advance care plans and orders relating to cardiopulmonary resuscitation. Crucially, both the GP and community matron have immediate and direct access to the expertise of a community geriatrician for advice and review of a case. Each care home (except for one which declined) have had a secure NHS video conferencing facility installed, which links to the community matron and community geriatrician during office hours, and remotely to a senior nurse 24/7 for out of hours. CHIP is supported by standardised protocols, a bi-monthly quality improvement collaborative, in-reach by pharmacists and a GP acute visiting scheme.

Impact and results

There has been a 40% improvement in self-reported scores across the virtual wards.

South Sefton CHIP has contributed to a 23% reduction in North West Ambulance Service conveyances. Care homes that have fully engaged in the programme have seen a 40% reduction in conveyances compared to control care homes in other parts of Merseyside who do not have the same input as those in South Sefton. Of all the cases seen by the urgent care team, just under 10% need to be transferred to hospital.

Patient reported satisfaction for this service consistently exceeds 95%.

"I was feeling very alone, it felt like an endless tunnel. The physiotherapist came out and gave me exercises, the occupational therapist arranged some bath aids, and the health and well-being trainer pointed me towards a community program called 'go with the flow'. They soon lift you and you go home feeling miles better. Thanks to their hard work, they gave me my life back". *Patient*

"Despite trials with [standard therapies] we weren't really making much progress. The VW holistic care has really given [the patient] the skills to manage her conditions better. She comes into my room now with a smile on her face". *GP*

"The support my father received from the urgent care team and the district nurse was excellent and enabled him to have his final wish, which was to die at home with those he loved". *Daughter of palliative patient cared for by the urgent care team*

"One of our residents suddenly became critically ill, becoming increasingly agitated and distressed as his breathing started to become laboured. Liaising with a senior nurse on the tele-video, the staff were able to treat the patient in the comfort of his own familiar environment, surrounded by familiar faces, and support him to make a full recovery. Prior to CHIP and the introduction of telemedicine at our care home, this would have been a typical 999 call ending in hospital". *Care home manager*

Future plans

The next phase is currently being developed. It will include implementation of a collaborative partnership with other community specialty teams such as respiratory, diabetes and cardiac services. It will link up with the acute frailty unit in the local hospital and provide more capacity in the 'step up' intermediate care facility.

X

An integrated community ageing team – Islington, London

Background

Islington, in North London, has ten dual-registered care homes within its borough, with approximately 500 residents. In the year April 2013 - April 2014 there were 607 ambulance call outs from these care homes. 86% of these were transferred to hospital, resulting in 44 acute admissions per month from Islington care homes.

The ten care homes are run by five different private organisations, each with different governance structures. There was already some input into care homes from palliative care, mental health and specialist nursing teams. However, these services were from different community provider and acute trusts and each team worked on different IT systems. As a result, there was very little communication and sometimes duplication. There were also challenges in supporting the educational needs of care home staff, the majority of whom do not have nursing training, and there is often a significant turnover of staff.

Getting started

Recognising the need for change, an Integrated Community Ageing Team (ICAT) was commissioned in March 2014. This built on some existing good practice where specific GP practices supported specific care homes in Islington according to locally set standards. Despite this, with the medical complexity of care home residents increasing each year, it was felt some more specialist input was needed.

From the outset, ICAT aimed to:

- work alongside GPs and other community services to provide high quality, integrated care for patients from care homes in the most appropriate setting according to their wishes and needs;
- improve communication between secondary and primary care for patients;
- maximise the number of days spent within the care home through comprehensive geriatric assessments and planning for treatment escalation;
- work closely with allied GP practices and care home staff to support ongoing professional development in complex geriatric case management.

Key features

The team comprises a group of clinicians with uniquely blended roles. Three consultant geriatricians from the two acute trusts in the borough work together to provide sessions in the community and acute sectors. This allows continuity of care and timely transfer of relevant information for care home residents when they are admitted to or discharged from hospital. A local GP with a special interest (GPwSI) in geriatrics contributes two sessions per week into the service spread across the hospital and community. Having a service that combines the experience of both geriatricians and a GPwSI has been invaluable for the establishment and running of the service.

Two pharmacists work with the team, supporting safe and appropriate prescribing in care homes and liaising closely with GP practices and the hospitals. The pharmacists also have named care homes and they see all new residents to the home and any residents who have recently been discharged. They review issues around polypharmacy, safe prescribing and appropriate use of medication, as well as training staff on appropriate use of medications such as inhalers.

Each care home has a named geriatrician/GPwSI who carries out monthly visits to review residents and conduct comprehensive geriatric assessments. They hold monthly multidisciplinary care home meetings with the named ICAT clinician, together with the named GP, care home staff, palliative care and mental health teams. When care home residents are admitted to hospital an in-reach service is offered in order to ensure continuity, offer additional insights based on prior knowledge and support a safe, timely discharge. A telephone advice line is also available Monday-Friday from 9am-5pm, for GPs to discuss residents of concern with a consultant geriatrician or GPwSI.

It was crucial to use shared IT systems; ICAT uses EMIS Community. This gives the team direct access to full GP records, including the ability to update them and to see previous diagnoses, investigations and management, which facilitates informed decision-making and reduces duplication of investigations.

ICAT is funded as a block contract from Islington CCG and Whittington Health NHS Trust is the provider, working in partnership with University College London Hospital. The subsequent expansion of the ICAT service is funded by the Better Care Fund.

Impact and results

Since ICAT started its service the average number of admissions from care homes to Whittington Hospital in Islington has decreased by 26%, resulting in an 18% reduction in bed days from care homes. This reduction has been sustained since the service was established two years ago. This means there is an average of 87 fewer bed days per month, which is the equivalent to around three fewer hospital beds needed in the last year, amounting to around a £300,000 saving to the local health care economy to date. The average length of stay has increased from 13.9 to 19.7, which probably reflects the complexity of the patients still requiring admission.

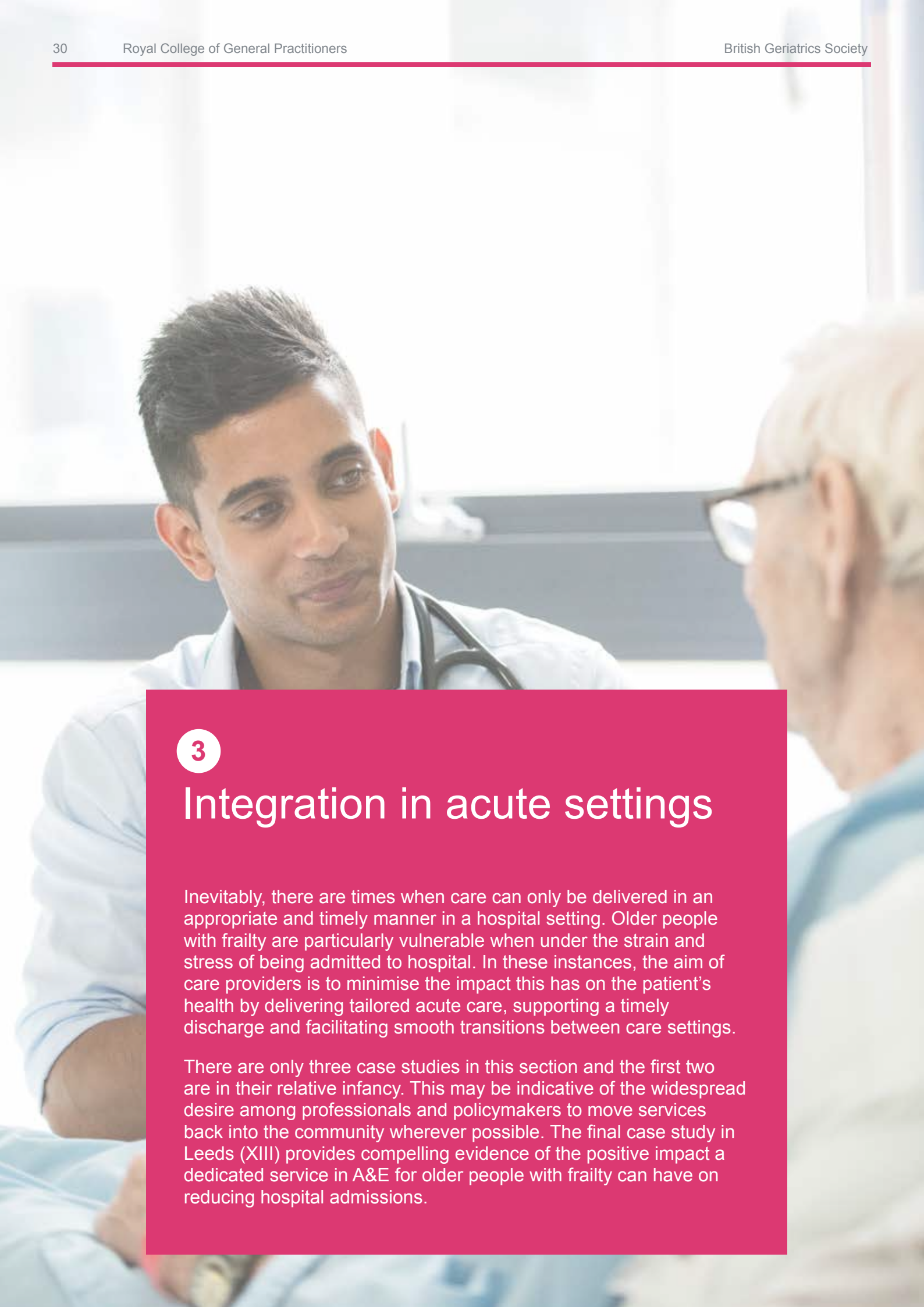
"They listened to me and took account of what I said. Yes, I did have control over the decision and I told them that I did not want the dose of the medicine increased and they said fine and it was my decision". *Care home resident*

"She knew dad and he knew her, there was no need to repeat his story; there was continuity of care". *Daughter of care home resident*

Islington CCG also commissioned Heathwatch Islington to undertake a qualitative evaluation of the service in care homes, obtaining views from the residents, relatives and staff. The comments were very positive and they highlighted the improved continuity of care and an enhanced feeling of shared decision-making.

Future plans

Now that the care home service is established, ICAT has started to develop an equivalent service for community-dwelling older people. This is also a multidisciplinary service which brings together the expert knowledge of both GPs and geriatricians, and includes the provision of comprehensive geriatric assessments within the patient's home. Islington CCG has implemented the electronic Frailty Index (eFI) and ICAT are considering how they can utilise this screening tool as part of their service.



3

Integration in acute settings

Inevitably, there are times when care can only be delivered in an appropriate and timely manner in a hospital setting. Older people with frailty are particularly vulnerable when under the strain and stress of being admitted to hospital. In these instances, the aim of care providers is to minimise the impact this has on the patient's health by delivering tailored acute care, supporting a timely discharge and facilitating smooth transitions between care settings.

There are only three case studies in this section and the first two are in their relative infancy. This may be indicative of the widespread desire among professionals and policymakers to move services back into the community wherever possible. The final case study in Leeds (XIII) provides compelling evidence of the positive impact a dedicated service in A&E for older people with frailty can have on reducing hospital admissions.

XI

GPs in hospitals – Rushcliffe, Nottingham

Background

Rushcliffe CCG faced several challenges in the provision of care on the Health Care of Older People (HCOP) wards at Nottingham University Hospitals Trust (NUH). These included a high number of unplanned admissions, significant readmission rates, delayed transfers of care and a common assumption among patients and professionals that hospital was the only viable option for end of life care.

Getting started

The overarching aim was to build trust between professionals working across the primary and secondary care interface, initiating a culture change that would promote collaborative working now and in the future. In so doing, the initiative sought to improve understanding of the management of older people with frailty following an acute admission, communication and information sharing, and awareness of the community services available to support discharges. For patients this would mean a reduction in lengths of stay and readmissions, and a more positive experience of care and discharge for patients, carers and families.

Following collaboration between the CCG and NUH, the CCG commissioned a ward-based community team to support acute colleagues and the 12 month pilot started in December 2015. The service is funded by the Principia Multispecialty Community Provider Vanguard.

Key features

Since its inception, the service has supported around 200 patients, all of whom are registered with a Rushcliffe GP. The majority are over 70 and have been admitted to HCOP wards via their GP (20%) or the emergency department (80%).

The ward-based community team consists of a full-time community matron who is supported by four Rushcliffe-based GPs offering three sessions a week across the HCOP wards. The community matron and GPs work closely with the medical and nursing teams, and allied health professionals on the ward.

Access to shared records has been at the heart of the initiative. Remote access to GP and community electronic records via SystmOne, and EPACCS (Nottinghamshire's shared end of life care online tool) is now available on HCOP wards. This means hospital staff can view a patient's pre-admission history, prior discussions about treatment and preferences for end of life, including DNAR status and preferred place of death. This has reduced duplication, thereby freeing up staff time. On discharge a message is now sent to the patient's GP via SystmOne with follow-up actions and details of the continuity of support required. This has proved so useful that standard desktop connectivity to SystmOne has been rolled-out on the wards as a permanent resource.

A new pathway was developed to support clinical decision-making and give confidence to primary and secondary care colleagues that the transition of care will be smooth and safe; meaning everything a patient needs will be in place when they arrive home including syringe drivers, medications, care support and district nursing. The community team's knowledge of local services, such as rehabilitation services at home and a 'step up' or 'step down' facility, has been an invaluable resource in identifying available and appropriate opportunities for transitions.

Impact and results

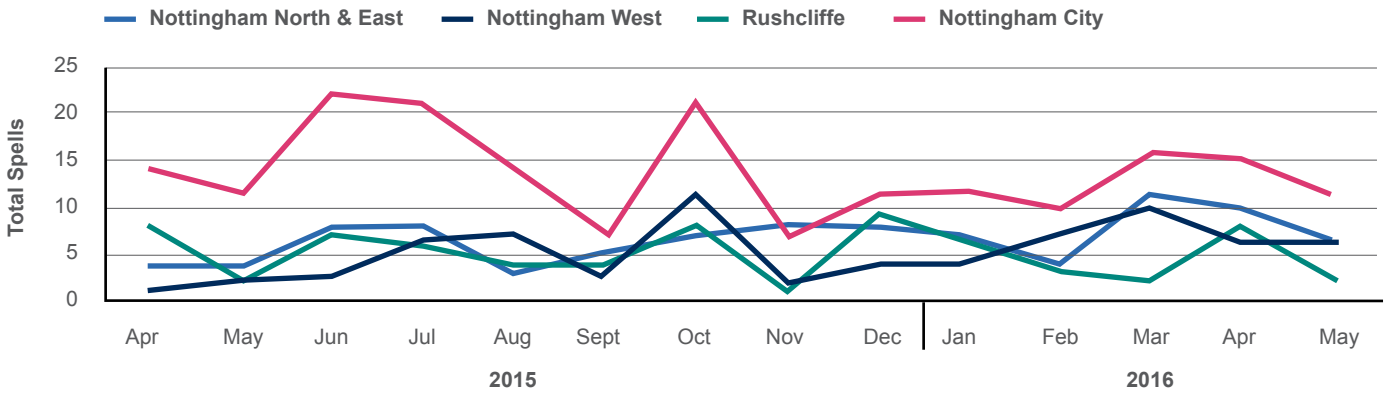
The most significant and immediate effect on improving care, patient experience and timely discharge has been around end of life care planning. Sensitive and informative conversations between the community matron on the ward and patients and families about options for end of life care have increased patient involvement and choice.

GPs, geriatricians and other consultants have spent time shadowing one another on ward rounds and in surgeries. This has helped both acute and primary care clinicians gain a real insight into the day-to-day pressures and challenges faced across the health services. Moreover, it has also led to a better understanding of what each service offers.

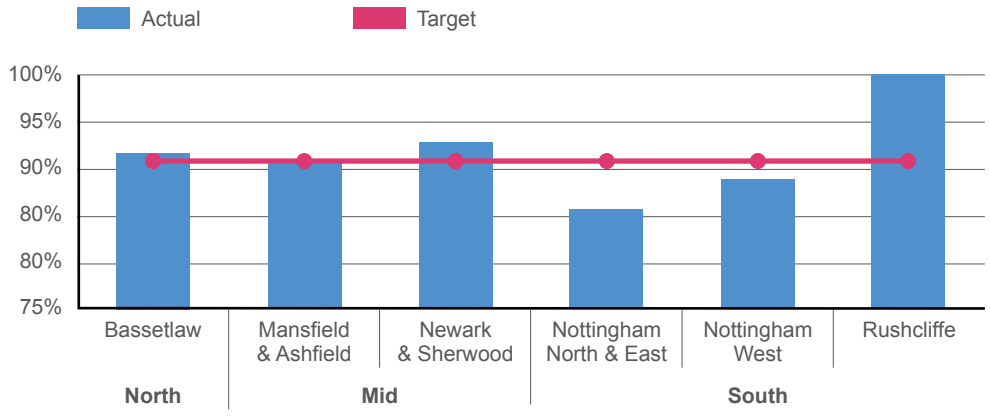
Readmissions of patients aged over 65 have been reduced by 8.7% in Rushcliffe since December 2015, whereas there has been an increase in readmissions for the other three neighbouring CCGs in recent months.

The Better Care Fund metric, which assesses the number of older patients that remain at home after 91 days after being supported by re-ablement and intermediate care services, shows that, as of March 2016, 100% of patients had avoided readmission.

NUH Emergency Readmissions - Over 48hrs, 3 South CCGs - 65+ years



Proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - CCG and Unit of Planning split March 2016



"Thank you for your support and kindness at such a difficult time, and also for recognising Dad's needs – you made a real difference to us". *Family member*

"You have helped us as a family and given us peace of mind along the way in getting him home, where he really wants to be. We found it especially useful that we could directly contact the community matron by phone – she was always able to give us consistent and reliable information regarding his condition and his pending discharge. A very efficient and necessary service". *Family member*

"This isn't just about improving discharge and preventing readmissions for the sake of easing pressure on the NHS. It is also about patient experience. Hospitals are simply not the best place for many older people with frailty to recover from illness or injury. The disruption to their routine is known to increase confusion or cause delirium. They tend to move less and eat less when in hospital, and this can lead to a loss of muscle mass, contributing to slower rehabilitation and an increased risk of hospital acquired infection. Our community matron often sees patients in the hospital whom she has nursed previously in the community. Her knowledge of their situation and relationship with them, and their families, has often meant discharge is quicker and easier for everyone involved. Patients are able to leave hospital with confidence that ongoing care has been planned around their individual needs and will be in place before they get home". *GP and member of the community team*

Future plans

Monthly operational meetings to review the pathway and pilot are attended by GPs, consultants, hospital managers, and CCG and community nursing representatives.

Plans to roll out the HCOP model across the three neighbouring South Nottingham CCGs are now underway, as are plans to develop an Acute Frailty Pathway at NUH. The HCOP pilot will be a guide to maximising the potential of the GP and community matron skill sets. For example, the GP may be best placed to support clinical decision-making in emergency departments, supporting patients admitted on trolleys, and/or on the admission wards, while the community matron may be better placed on a base ward supporting complex discharge planning.

From September, measures are being put in place within the community to have technicians and paramedics working alongside community nurses to reduce conveyances to emergency departments.

XII

GPs and geriatricians working in a single team – Fylde Coast, Lancashire

Background

The proportion of the population across the Fylde coast aged over 65 is expected to rise between 31% and 35% by 2028. As a seaside resort with lots of inexpensive accommodation there is a large transient population. This, coupled with high unemployment and rising prevalence of long-term conditions, has led to significant levels of deprivation and health inequalities that rank among the worst in the country.

Blackpool has the worst life expectancy in the country for men and the third worst for women. People in Blackpool also spend a smaller proportion of their lifespan in good health and without disability. In the most deprived areas of the town, disability-free life expectancy is around 50 years. Although 57% of the population in Fylde and Wyre live within two of the most affluent quintiles, there are still more than 16,800 people living in neighbourhoods that are classified as being among the fifth most disadvantaged areas in England. Men die on average 10 years younger than those in more affluent areas, while for women, the difference is six years. A higher percentage of people in Fylde and Wyre are affected by long-term health problems than the national average.

Getting started

It was widely recognised that local CCGs, the hospital trust and local councils needed to collaborate to develop new models of care to support the population, in particular older patients with complex health needs, including multiple long-term conditions, who are high utilisers of healthcare services. The aim was to design a service that would lift these patients out of normal primary care for a period of time and provide them with individualised care.

The first step was the clinically-led development of a service blueprint involving both primary and secondary care, with input from a range of stakeholders. The Extensive Care service then launched in June 2015 under the remit of the Blackpool Teaching Hospitals NHS Foundation Trust, with funding from the Fylde Coast NHS Vanguard. The service provides care across two local CCG footprints – Fylde and Wyre, and Blackpool.

Key features

Extensive Care provides patients with a single point of access to support proactive, coordinated care in order to reduce the need for unplanned hospital admissions and out of hours contacts. The service operates from four geographical hubs across the Fylde Coast. Three are located in primary care centres – Lytham, Moor Park and South Shore – and one in a local authority civic centre in Poulton.

The Extensive Care team is led by a consultant geriatrician with support from GPs, two of whom are directly employed while others are contracted from GP practices. The team also includes nurses, physiotherapists, occupational therapists, pharmacists and primary care assistants. One of the initiative's objectives has been to widen the skill-set of this workforce. For example, occupational therapists have been trained in clinical assessments, clinical observations and phlebotomy, and nurses have received environmental and cognitive assessment training. Non-clinical support is provided by Well-Being Support Workers, who act as a point of contact for carers and relatives. They also have excellent knowledge of the local community and so can signpost patients to appropriate voluntary and social care services.

To be eligible for the service, patients must be over 60 years of age with two or more of the following long-term conditions: coronary artery disease; atrial fibrillation or congestive heart failure; chronic obstructive pulmonary disease; diabetes; dementia. Patients are referred to the service by their GP and an initial comprehensive multidisciplinary assessment is then carried out with the patient in the hub or their own home. Once a patient joins the service, lead responsibility for the coordination of their care is transferred to the Extensive Care team from their GP practice (this is similar to the way in which care is provided when a patient is admitted to hospital).

The service is designed to encourage the patient to self-manage their own conditions and lifestyle as far as possible. Each patient is assigned a Well-Being Support Worker who helps the patient, in conjunction with their carer, to develop a comprehensive 'My Plan' care plan. The plan sets out a number of goals for the patient to work towards, and also outlines the triggers that define when a patient's condition has worsened, and the action to take to support and stabilise them. Well-being measurements and patient activation measures are used to drive changes in behaviour. The ultimate aim is to help patients reach a point where they no longer need the intensive support of the service.

Impact and results

The Extensive Care service has now been operating just over a year, and evaluation is ongoing, based around ten key KPIs, which include caseload, time in service, referrals, A&E attendance, non-elective admissions and outpatient appointments. Initial statistical work performed by the Commissioning Support Unit has shown that there have been significant reductions in A&E attendance, non-elective admissions and outpatient activity. Latest activity figures for the service population reveal:

- 19% reduction in A&E attendance
- 22% reduction in non-elective admissions
- 13% reduction in new outpatient appointments
- 18% reduction in follow-up outpatient appointments

"Fantastic care from Extensive Care. Could not ask for any better. Have all worked well to keep me out of hospital". *Patient*

"I've never been able to talk to people involved in my medical care the way I can talk to the Extensive Care Service team. Without them I would never have felt able to get going with losing weight and living a healthier lifestyle. It was exactly the support and encouragement I needed". *Patient*

"I feel great in myself since joining Extensive Care. It's great knowing I can just phone up if I have a problem and someone always gets back to me to offer advice or support. It boosts my confidence". *Patient*

"I think that the service I've received up to now is excellent and a far better service and care package I've received than previously. I now feel safe". *Patient*

"I am enjoying working in this role very much and when I have done occasional GP locum sessions over the past few months I have found it very difficult to re-adjust to trying to see such complex patients in a ten minute slot. Over the past seven months I have seen huge differences made to patients' lives from making simple changes – even with the most sick, most complex patients, the contact with the Well-Being Support Workers and Care Coordinators is what makes the most impact for many patients". *GP*

"Our aim is to keep patients at home and out of hospital. We are giving patients confidence as they know who to contact and, as we are a team of multi-skilled professionals, we can manage most problems and avoid referrals and subsequent delays in management". *Clinical Care Coordinator*

Future plans

Statistical analysis work is starting to indicate which sections of the population (dependent on their risk of non-elective activity) benefit the most from the service. In future this will allow a better targeted population approach to intervention from Extensive Care.

XIII

From the hospital's front door to your front door – St James's Hospital, Leeds

Background

Leeds Health and Social Care Transformation Board was conscious of the need to consider alternatives to hospital admission for older people with frailty presenting in crisis. There was an awareness of the evidence of the effectiveness of comprehensive geriatric assessment (CGA) in reducing the risk of hospital readmission and increasing the likelihood of the patient being alive and living in their own home six months after the assessment (Stuck et al, 1993), and of the relative lack of evidence for the effectiveness of other interventions (Purdy, 2010).[6 7]

Getting started

The aim was to develop a service whereby colleagues across primary and secondary care could share knowledge and skills for the benefit of the patient to agree the most appropriate pathway.

Agreement was reached to invest in 'interface geriatricians' who would work in the A&E department assessing older people with frailty, and in the community alongside integrated neighbourhood health and social care teams wrapped around GP practices.

The initial funding came from pump priming funding from the Better Care Fund. Subsequently the acute trust incorporated the A&E component by remodelling job plans and the CCG agreed to continue to fund the community elements.

Key features

Leeds has 13 integrated neighbourhood teams comprising district nurses, community matrons, social workers, occupational therapists and physiotherapists, each supported by one session per week of consultant geriatrician time. They work closely with GP practices to support patients with frailty and those with complex health and social care needs. Patient selection has been based on risk stratification tools, the GP's '2% list', clinical knowledge and latterly the electronic Frailty Index (eFI). The community geriatricians also work in the acute trust where they provide A&E interface sessions, on acute admissions wards or on general elderly care wards, and care for patients in rehabilitation beds in the community.

The interface service in A&E currently operates on weekdays from 1-5pm. In general, the service focuses on those patients presenting to the 'majors' stream (i.e. not those with a simple single problem or those presenting as extremely unwell who are seen in the resuscitation part of A&E). Common diagnoses include falls (with or without fractures), urine or chest infections, perhaps with some element of delirium, cellulitis and heart failure. Patients living in care homes are assessed and supported in the same way as those living in their own homes.

The consultant geriatrician in A&E provides the expert medical assessment including a medication review, working with the Early Discharge Assessment Team (EDAT) to assess function and risks around discharge home. A key part of the geriatrician's assessment is to ascertain the person's wishes and expectations and to support them in considering the options available to them. Family members are often present at the time of assessment in A&E; if not they are contacted (with the patient's consent) and involved in planning. Together the consultant geriatrician and the EDAT provide a smooth pathway back home (or to a rehabilitation or interim bed) for patients who require some support for safe discharge, and who would otherwise be admitted because of concerns about the safety of a return home. Support from the community teams can be provided up to four times a day. This includes aids and simple adaptations or, in selected cases, a night sitter may be provided for a short period.

Leeds is fortunate to have the Leeds Care Record which allows a clinician in secondary care to see a full list of a patient's medication and recent changes as well as information such as allergies. Changes in treatment or other aspects of the management plan are communicated to colleagues in primary and community services by telephone or written communication in order to facilitate continuation of person-centred care planning. This may be as simple as ensuring that appropriate documentation regarding resuscitation status is conveyed back to a care home, with a request to a practice to consider a patient for the Gold Standards Framework, or it may be much more complex. For example, there may be a need for a GP or community matron to continue a conversation about the consequences of problems with eating and drinking in a frail patient with dementia or another degenerative neurological condition.

[6] Stuck AE, Siu AL, Wieland GD, Adams J, Rubenstein LZ. (1993). 'Comprehensive geriatric assessment: a metaanalysis of controlled trials' in The Lancet 342(8878):1032-6

[7] Purdy S. (2010). *Avoiding hospital admissions: What does the research evidence say?*, The King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy- December2010.pdf

Frequently there is discussion between the geriatrician and the GP regarding the most appropriate plans, including follow up. Sometimes the primary care physician will suggest a follow up home visit by the practice, for example to monitor progress where an older person has an infection but where discharge is still considered appropriate. In complex cases the geriatrician in A&E may agree that the community geriatrician will work with primary care to continue the CGA in the patient's own home.

In addition to the 'hands on' role of the geriatrician in A&E, the consultant also offers telephone advice to colleagues in primary care, either at their request or at the suggestion of nursing staff who have been trained to take and screen calls for direct hospital admission. Options may include admission, urgent investigations or outpatient assessment, home assessment by the community geriatrician, or a plan for management and follow up to be enacted by primary care. Where additional support from nursing, social care or therapy colleagues is needed this can be accessed.

Impact and results

A before and after assessment of the impact of the A&E interface service showed that for the over 75 year olds who attended A&E in the 'majors' stream, the conversion rate from attendance to admission fell from 74% prior to the introduction of the geriatrician service to 39% during the times when the geriatrician is in the department. Overall, 27% were admitted because of acute medical reasons with an additional 12% admitted because of lack of capacity in the community bed base. The readmission rate after discharge from A&E was similar to that for the Medicine for the Elderly department's overall rate.

Feedback from colleagues in A&E and primary care has been extremely positive. Patients and their families have also expressed satisfaction with the care, and delight in being offered an alternative to admission.

An 85 year old man had been visiting his wife in a care home and collapsed on leaving. He had previously had several short-stay admissions, and on this occasion he attended A&E via 999. It was his third recent attendance at A&E.

Medications were reviewed in the light of previous postural hypotension. He appeared low in mood and tearful. He was referred to the community matron from the emergency department who arranged for him to have a hot meal at the care home, a joint visit with a social worker, and subsequent telephone follow up. The outcome was better quality of life, improved mood and health, and he has not presented again to the Emergency Department.

A 91 year old woman living in a residential home was approaching the end of her life. A Community Do Not Apply CPR was in place, and advance care planning was being considered. She then presented to A&E following a seizure. Reversible causes were excluded. The next of kin, care home manager, GP and social worker were all involved in identifying ongoing care needs and addressing concerns about seizures and pain. The woman was discharged from A&E with increased anti-epileptics, analgesia, PRN rectal diazepam, and an advanced care plan in place.

Future plans

Work is now underway to estimate the impact and cost effectiveness of extending the hours of the interface service. Consideration is also being given to how much impact a community based urgent care response might have so that some patients need not attend A&E at all.

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