

Right time, right place: Urgent community-based care for older people



1 Introduction

The British Geriatrics Society (BGS) is committed to improving healthcare for older people, in the most appropriate setting for the individual. In recent years there has been an increasing focus on the healthcare that is provided outside the acute hospital environment, either in the patient's home or in a community setting. Various models have emerged, particularly for the provision of urgent care out of hospital.

This document outlines the offers and services currently delivered across the country in pursuit of a broadly similar aim to provide appropriate, timely, high-quality care when an older person experiences a crisis or urgent need. The BGS does not advocate one particular approach and instead we have set out principles which we believe should be fundamental in ensuring older people's needs are met. There is significant inconsistency between the different urgent care offers available, both in terms of what they deliver and the language used to describe them, and this can lead to confusion. We acknowledge that this is a constantly changing environment and that there is a lack of consensus around definitions of services and provision in different parts of the country. We are calling for coordination and consistency in the clinical process of care so that older people can be supported as close to home as is possible with reliable high-quality appropriate

care which meets their needs and wishes. We also recognise the importance of considerations of cost-effectiveness in a context of limited resources.

This document aims to describe the role of urgent care within the ecosystem of older people's care and details some examples of how urgent care can be provided outside the hospital environment. It provides tips for BGS members who want to start providing this type of care to their older patients and calls on commissioners and governments to make the provision of care at or near to home easier for healthcare professionals and patients.

While the BGS is a four-nations society, we have taken the decision to focus on England in this document, although some of the themes are likely to be relevant to colleagues in other parts of the UK. This is an area where the situation is significantly different across the four nations. For example, plans are underway in England as part of the NHS operational and planning guidance for 2021/22 to put in place an 'Urgent Care Response' (UCR) to a two-hour target across all Integrated Care Systems (ICSs) by April 2022, while Health Boards in Scotland are required to establish Hospital at Home (H@H) services. 'Acute care at home' services have been introduced in Northern Ireland while '@Home' services provide similar care in Wales.



2 Our vision for urgent care

Older people wish to lead healthy, independent and active lives for as long as possible. With the process of ageing, more people develop long term conditions, frailty and other impairments such as dementia. The BGS believes that with the right assessments, diagnoses, care and support, these conditions can be managed and even, in some cases, reversed. This is particularly so at moments of crisis or urgent need when a timely effective response can make the difference between someone being able to stay at home or being admitted to hospital.

Our vision is for older people to receive the care that they require in a setting that is appropriate to their needs and wishes. Patients may have a preference regarding where they receive treatment, depending on their personal priorities, continuity of care and their goals to improve their function and wellbeing. In all localities, options should exist for older people to receive high-quality urgent care without hospital admission.

3 Principles for urgent care

- Care should be delivered at or as close to home as possible, enabling older people living with frailty or other conditions to stay in or return to the comfort and familiarity of their usual place of residence as quickly as possible, balancing the risks and benefits of hospital admission with the risks and benefits of care at home.
- Any additional support required for acute care based in the home must be provided.
- Urgent care response services should complement and connect to other services seamlessly, so that older people experience joined-up care rather than fragmented services. Healthcare, social care and the voluntary sector should be integrated to provide person-centred care.
- Appropriate urgent responses should be delivered in a prompt timely manner.
- Multidisciplinary teams (MDTs) provide the range of skills and competencies to deliver urgent care and should include doctors or advanced practitioners who have the ability to assess, diagnose and treat in an urgent care setting.
- First responders such as ambulance services and NHS 111, local community services, carers and older people themselves should be made aware of what urgent care services are available in an area with simple single point of access referral processes, including self-referral, put in place.
- Urgent care services should be available to all older people, including those living in care homes.
- Patient records such as Comprehensive Geriatric Assessments, Advance Care Plans and Treatment Escalation Plans should be made available so that urgent care teams have access to the information they need to diagnose and treat, and all parties involved in older people's care have access to accurate, up-to-date patient information.

4 The case for a range of options

Well-designed systems for assessment, diagnosis and treatment through services provided at or closer to home supported by point of care or near patient testing or using hospital-based same day emergency care (SDEC) can provide a credible alternative to hospital admission for managing acute illness and ensure that ongoing care is put in place swiftly.

Situations of course remain where admission to hospital is clinically indicated and offer the patient the best chance of treatment and recovery. There will also be situations where patients need to visit hospital as outpatients, particularly to access diagnostics which are not available in a non-hospital setting. Some patients may also prefer to be admitted to hospital for a variety of reasons including the impact on people they live with, not wishing to medicalise their home or a belief that the treatment they receive in hospital will be better. Older people should continue to be offered hospital admission if this is considered clinically appropriate and is the patient's preference. Patients admitted to hospital should be offered Comprehensive Geriatric Assessment (CGA) in hospital as this is evidence-based and improves outcomes.

However, for some older people, hospital admission brings the risk of deconditioning, delirium and hospital-acquired infection as well as risking prolonged separation from the people who are most important to them. Older people often require additional care upon discharge from hospital and delays in making arrangements for this care can mean that they remain in hospital for longer than medically necessary. Research shows that in appropriate clinical and service circumstances, CGA leading to care in a H@H setting leads to similar outcomes to hospital care and decreases the likelihood of an older person being admitted to residential care within six months.¹



5 Options for alternatives to hospital

This section aims to briefly outline the main models currently in existence providing urgent care in England outside an acute care setting. This list may not be exhaustive as additional models may exist for specific patient groups or in specific localities. Each description sets out the features of the model and the benefits and limitations. While these descriptions specifically discuss individual models, it is important to note that there are increasing overlaps and hybrid models being developed with elements of H@H and UCR. These are often pragmatic responses to the demands of different localities and availability of resources, and have similar aims to provide alternative options to hospital admission.

a. Hospital at Home (H@H)

H@H services are multidisciplinary teams with the ability to assess, diagnose and treat conditions within the patient's own home. These services can be led by professionals from across the team including geriatricians, GPs, advanced care practitioners or community matrons and involve other specialists as appropriate (for instance, patients with heart failure being treated in H@H services should have a cardiologist involved in their care). The H@H team aims to provide hospital-level care for acute conditions that would normally require admission to an acute hospital. While H@H usually covers the full adult population, it can be particularly applicable to older adults with frailty.

Advantages of H@H services can include older people having specialist care in a home environment which is less disruptive for them and those around them. However, for areas setting up a new service, H@H can appear to be very resource-intensive, requiring initial investment with savings likely to manifest some time later. They provide short-term intensive interventions, usually of between one and 14 days. They do not provide care for ongoing needs but often link with other services.

More details can be found at: www.hospitalathome.org.uk

b. Urgent community response (UCR)

Building on the priorities in the NHS Long Term Plan, UCR teams aim to respond in a timely manner to people with an urgent health or social care need, typically being able to assess need and provide an appropriate short-term intervention within two hours.² The aim of UCR teams is to provide short-term support to diagnose and treat conditions as well as to provide appropriate equipment and care to the patient in order to prevent a hospital admission. The teams may be part of the wider provision of care in a locality, so that any emergency responses connect into the ongoing care of an individual. UCR is one of the NHS's priorities for 2021/22 and a key commitment of the NHS Long Term Plan. As such, funding may be available for local health and care systems to implement this model. Geography remains a challenge to UCR teams, especially in rural areas, and interventions delivered are time-limited, typically lasting up to 48 hours.

More details can be found at: www.england.nhs.uk/community-health-services/urgent-community-response

c. Same Day Emergency Care (SDEC)

The SDEC approach can allow specialist senior clinicians to care for patients on the day they arrive at hospital as an alternative to admission, removing delays for patients requiring investigation and/or treatment. Patients with relevant conditions, such as frailty, can be assessed, diagnosed and treated without being admitted to a ward and, if clinically appropriate, return home on the same day. Where clinically appropriate, some episodes of care may require follow-up for review and/or treatment to eliminate the need of overnight admission. SDEC can provide an opportunity to embed the acute frailty pathway within an Acute Trust. This may be particularly effective when linked with integrated frailty services. These services include integrated primary and acute care models (GPs working in hospital or interface geriatricians working in A&E departments) or community models with neighbourhood health and social care teams wrapped around GP practices.

The NHS England mandate is for 70 hours per week of acute frailty services.

More details can be found at: www.england.nhs.uk/urgent-emergency-care/same-day-emergency-care/

d. Frailty Assessment Units (FAUs)

FAUs aim to provide frailty-specific health and social care assessment at the front door of a hospital and link with services out of hospital. FAUs can avoid the need for older people to wait in emergency departments to be seen, and ensure that they get the right care from the right department within the hospital as quickly as possible. FAUs may work as a component of a SDEC service, with separate or shared use of space and resources.

Details of an example of a Frailty Assessment Unit can be found at: www.kch.nhs.uk/Doc/pl%20-%20814.1%20-%20frailty%20assessment%20unit.pdf

e. Virtual wards

Virtual wards support patients who would otherwise be in hospital to get the acute care, remote monitoring and treatment they need in their own home. This may mean providing patients with support to use equipment or digital technology to provide regular readings for healthcare professionals to support recovery. Multidisciplinary teams may also provide clinical care in people's homes or in care homes as a component of a virtual ward model. This can allow patients to remain at home safely while still getting the care they need in a timely way.

NHS England and NHS Improvement are working to develop a frailty virtual ward model. This is an integrated model of care that is supported by a range of services delivered both in person and remotely, put in place to provide acute-level personalised care for a person with frailty at home. This could include in-home visits from health professionals and social care workers and is supported by robust digital tools to support high-quality patient care.

Access to a frailty virtual ward would be via a range of entry points such as paramedics, hospital emergency departments or SDECs, including hospital-based acute frailty teams. Frailty

virtual wards utilise hand-held and wearable technology to enable remote monitoring by a multidisciplinary team and provision of district nursing as required. The frailty virtual ward model can help to enable an interface between primary and secondary care, allowing clinical responsibility for an episode of care to sit with the secondary-based care team or to be shared between primary and secondary care.

6 Supporting structures

The models outlined all share a common aim – to offer older people with frailty a viable high-quality alternative to hospital admission, minimising the time they spend in hospital and/or delivering processes of care in community settings that have previously only been available in hospital. These models are linked to the NHS Long Term Plan, the work of NHSX and the work of the Acute Frailty Network. However, these models cannot exist in isolation and enablers such as the following are required in order to deliver a comprehensive out-of-hospital service for older people with frailty.

a. MDT-led Anticipatory Care

Anticipatory Care is a proactive care model being introduced as part of the NHS Long Term Plan. The NHS operational and planning guidance for 2021/22 builds on this Long Term Plan commitment by implementing population health management and personalised care approaches to improve health outcomes and address health inequalities.³ It is targeted at people living with frailty, multi-morbidity and/or complex needs to help them stay independent and healthy for as long as possible at home or the place they call home, focussing on what is important to the individual. Urgent care services delivered out of hospital will work best when older people living with frailty are already 'known' through proactive anticipatory care support. This can help to stave off the risk of emergency episodes and facilitate an integrated response.

b. Enhanced health in care homes (EHCH)

Another strand of the NHS Long Term Plan, the Enhanced Health in Care Homes (EHCH) programme aims to ensure that everyone living in a care home has a similar level of care and that this should be the same as the care they should expect to receive if they were still living in their own home. This model relies on increased integration between care homes and primary care, community care and mental health services. The EHCH model aims to better align GP practices with care homes and provide care home residents with healthcare support delivered by a multidisciplinary team.⁴ It is anticipated that this better integration of services will enable early identification of care home residents at risk of deterioration.

c. RESTORE2 and other early warning systems

RESTORE2 is an example of an early warning system which could help carers to communicate effectively with healthcare professionals and alert them to the need for urgent care. It aims to support staff in care homes to proactively recognise and manage physical deterioration in order to improve residents' experience and outcomes and reduce admissions to hospital. A project using RESTORE2 was initially developed in West Hampshire as a partnership between GPs, care homes, ambulance service, secondary care and the Academic Health Science Network and is now in use in 16 Clinical Commissioning Groups (CCGs).



7 Tips to get started

Some parts of the country have well-developed services providing out-of-hospital care for older people with frailty while others do not have any of these services in place. It can be daunting to begin the process of redesigning services. This section provides colleagues with practical tips for getting started:

1. Plan the **right service for your area**. None of the services outlined are intrinsically more suitable than the others – consider what will work best for your population, the geography of the area you serve, the services you already have in place and the capacity available. You may well develop a hybrid model most suited to your locality. Assessments such as those offered by Getting It Right First Time (GIRFT) visits may be helpful in providing an understanding of what might need to be developed.
2. Be **realistic about funding and resource**. Work with the resources you have, to maximise the use of current services and personnel. Additional funding may not be available so you may need to repurpose the working of existing multi-disciplinary teams. Aim to provide a good service for many, not an excellent service for only a few. This may mean building gradually towards some of the more resource-intensive options.
3. **Engage with all colleagues providing frailty-based care, including your acute hospital colleagues**. These services work best when community services work in partnership with colleagues in acute hospitals.
4. **Don't forget the communications**. Whatever you do, make sure that when developing a new service, you involve others who need to know about it, from first responders such as ambulance services and NHS111 through to voluntary sector agencies.
5. **It doesn't end with you**. Whatever service is implemented, it is unlikely that the individual's needs will have been met entirely. It is crucial that the service links with other services that can provide ongoing support and monitoring as needed.

8 What is needed to make this a reality?

While implementing services to provide urgent care at home requires dedicated local capacity, support is needed from central bodies and ICSs to make this a reality across the country. In order to make this happen, we call for:

1. Commitment to implementing the principles set out above to deliver a high-quality person-centred experience of urgent care for older people.
2. Coordination and linkage of services to enable delivery of coherent and efficient services for people living with frailty.
3. Sharing of good practice, so that all regions and local areas are supported to learn from each other, coalesce around a common language and avoid duplication and fragmentation of services.
4. Communication between providers so that proactive and reactive services are joined up, and patient records are shared with appropriate information governance in place.
5. Appropriate resources to be identified to ensure all people living with frailty have clear, effective and sustainable alternatives to hospital admission where appropriate.
6. Investment in technology to ensure excellent communication between primary, secondary and community care.

This is just the start of the conversation around urgent care and admission avoidance for older people. If you could like to get in touch with us and share suggestions, feedback or experiences please email us at policy@bgs.org.uk

9 Conclusion

The BGS believes this vision is within reach if there is the will to make it happen. 90% of the deaths from COVID over the last year were in people aged over 65. As services gradually resume post-COVID and the long-term effects of the pandemic become apparent, now is the critical time to 'build back better' and seize the opportunity afforded by the NHS Long Term Plan, with its focus on delivering more care for older people closer to home. Ensuring that the urgent care initiatives described above are coordinated will reduce duplication and enable older people living with frailty to receive assessment, diagnosis and treatment appropriate to their urgent care needs.



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