**East Lothian Home Visiting Service (ELHViS)**

**Service Model for delivery of Nurse-led Home Visiting**

**1 Background**

1.1 The PCIP considers several options to deliver Home Visits for patients. Paragraph 18.3 specifies the possibility of deploying an Advanced Nurse Practitioner, augmented with a Band 6 Nurse Practitioner, with any required training being hosted within the CWIC service.

1.2 District Nursing are currently training new staff in Clinical Decision Making and prescribing and are a workforce already clinically assessing patients in their home environment

1.3 As a current test of change, SAS are currently working within the Musselburgh Model

1.4 There remains the possibility of exploring an AHP-led home visiting model focussed on management of frailty crises

1.5 At present there is no one clear preferred strategy for expansion of Home Visiting services in East Lothian. This proposal focuses on nurse-led home visiting.

**2 Description of Service**

2.1 The service would be delivered across a number of practices. For the purpose of the test period, those practices would require to be those that have expressed an interest in developing new services for home visiting, some having already stated that current home visiting arrangements are satisfactory for patient needs.

2.2 Patient access to the service should be through a well governed process of care navigation.

2.3 For the purposes of the test phase, the service would be staffed by one WTE Band 7 Advanced Nurse Practitioner, and one WTE Band 6 Nurse Practitioner.

2.4 The service would be based in suitable premises with access to transport and equipment. Telecommunication and IT infrastructure should be fit for purpose. This would include the use of existing Primary Care records, with consultations being recorded on those records.

2.5 The service should link seamlessly with other ELHSCP services, including District Nursing, Hospital @ Home, and Practice Pharmacists. The service should also be expected to link with Social Care services, especially in the context of admission avoidance.

2.6 When necessary, admissions to secondary care would be arranged directly through usual admission pathways.

2.7 The service will aim to support early discharge from hospital by offering clinical review where necessary

2.8 The service may open up the possibility of clinical staff developing a portfolio role by working in other ELHSCP nursing services.

2.9 The service would focus on delivery of unscheduled care. These are likely to be home visits for acute illness, or acute on chronic illness. It should be expected that frailty crises will also present to this service with ill health being the trigger for contacting Primary Care, and the service should be equipped to deal with these scenarios.

2.91 The potential need for staff training to deploy existing skills in a new clinical context is recognised, especially with reference to anticipatory care planning and end of life care.

**3 Constraints**

3.1 IT. ELHSCP are continuing to work with partners in NHSL eHealth to seek support for implementation of a fit for purpose IT solution to provide a seamless exchange of information between GP Practices and ELHSCP services. While a solution has been proposed, this has not so far been progressed

3.2 Telephony. Until an agreed route of care navigation has been designed, requirements of a telephony solution cannot be defined. The PCIP is committed to improving access experience for patients.

**4 Project Timescale**

4.1 The project will commence in XXXXXX and be evaluated over one year

**5 Strategic Context**

5.1 This model should seek to meet the IJB strategic objectives for 2019-2022

5.2 Access for housebound patients seeking unscheduled care should be prompt and proportionate to need

5.3 The model should ensure excellent anticipatory care planning and support early intervention and prevention of crisis

5.4 The service will be designed to minimise the need for unscheduled hospital admission, and to support early discharge from hospital

5.5 The service will allow those patients whose need for clinical care can only be delivered in their home environment can have that need met

5.6 Pathways for patient care will be integrated with existing Health and Social Care Services, and with GP Practice Independent Contractors

5.7 Clinical decision making and care planning will based around patient wishes

5.8 The service will aspire to reduce health inequalities, particularly those associated with access to Primary Care Services

**6 Evaluation**

6.1 It should be noted that existing data locally on home visiting is limited

6.1 Patient and carer experience

6.2 Admission data may be useful, though over a short period of one year this may be difficult to interpret in a small service

6.3 Prescribing data should be considered, but may be difficult to separate from whole practice date, and may lack comparative data

**7 Initial Steps**

7.1 Identify suitable GP Practices. One practice may be sufficient. Several practices in East Lothian have already stated that they are not looking for extra support with home visits. Those that have can reasonably be expected to have higher rates of unscheduled home visit requests

7.2 Recruit staff for service delivery. It is likely that these roles will be housed with the existing CWIC service allowing job variety for individuals and ease of training

7.3 Agree suitable clinical IT systems. At present it is hoped that NHSL eHealth will support East Lothian’s overall IT strategic needs, but this is still under discussion

7.4 Agree access pathway. This will be developed as part of the overall operational discussions