

Rapid Response Service: Central and North West London NHS Foundation Trust

The Rapid Response Service enables patients who are entering crisis to remain supported in their home or the community, rather than be admitted to hospital. The service also helps patients who have been admitted to hospital to return home as soon as possible. Features include overnight staffing and the service's interdependencies with other trust teams to meet patient needs.

Central and North West London (CNWL) NHS Foundation Trust provides integrated health and social care services for 3 million people in the south east of England. Over 98% of its care activity takes place in the community.

Aims

Camden's Rapid Response Service provides alternative care pathways in the community so that fewer vulnerable patients presenting at accident and emergency departments are admitted to hospital.

The service offers short-term intensive support for up to 10 days, including nursing and therapeutic assessments and social care. Care is provided mainly at home, enabling patients to safely regain independence as quickly as possible. After 10 days, the team supports the referral of patients to other appropriate services.

The service aims to:

- rapidly respond to admission avoidance referrals
- reduce the number of short-stay admissions
- improve patient flow along the emergency care pathway

Characteristics

- admission avoidance referrals received 24/7
- single point of access
- four-hour response time for face-to-face assessment
- supported discharge referrals taken seven days a week
- broad referral criteria
- overnight staffing
- multidisciplinary team (MDT)
- nursing and therapy led
- interdependencies with other CNWL teams to meet patient needs
- supported by CareLink, providing therapy-focused reablement
- patients referred on after 10 days

- accelerate therapy-led discharges so that patients receive care closer to home
- bring financial benefits to the local health and care economy at large.

Origins

The trust had a therapy-led rapid response service for some years. Two staff ran it from Monday to Friday, and it could carry four or five patients on the caseload at a time.

From October 2013, the trust used winter resilience money from Camden Clinical Commissioning Group to expand and integrate its existing rapid response, rapid early discharge and hospital-at-home services to create a single Rapid Response Service. Integrating schemes brought benefits of sharing resources and better management of peaks in demand. This increased the trust's capacity and ability to avoid hospital admissions while supporting timely discharge, particularly at weekends.

The service was **designed collaboratively** with CNWL clinicians and managers working with staff at local acute trusts and the ambulance service, as well as with nursing and residential homes, the voluntary sector and patients. The Rapid Response Service began in November 2013.

Structure

Single point of access Referrals are received 24 hours a day, seven days a week at a single point of access, and nursing or therapy staff prioritise them. Within four hours, the rapid response service completes a telephone triage and a healthcare professional will visit the patient at home.

Nurse and therapy led A senior nurse manages the team, which consists of band 7 clinicians able to work autonomously. The team includes nurses, occupational therapists, physiotherapists, a pharmacist, a rehabilitation assistant and healthcare assistants. Doctors are not currently part of the team. However, links with acute trust consultants and GPs have been stronger since expansion.

Conditions treated

- urinary tract infections and complex bladder care requiring bladder scans on a regular basis
- chest infections
- exacerbations of chronic obstructive pulmonary disease
- dehydration
- uncontrolled diabetes
- decreased mobility and falls
- severe pain
- palliative care
- patients requiring intravenous therapy
- patients with post pulmonary embolism and deep vein thrombosis

24/7 care The service is staffed until 9pm but the trust's overnight nursing service has been co-opted into the rapid response team so it effectively operates 24 hours a day, seven days a week. If a referral is received outside core working hours, one of the team's overnight nurses will immediately assess the patient at home, stabilise them and arrange for a therapist to visit at 9am to complete a full assessment and care plan.

How patients benefit

The service is primarily for **patients with physical health needs**. The main referral criterion is that patients have been assessed as medically stable but would not be safe to stay at home without further support. Most patients are frail older adults.

Most referrals come from primary care. Since the service expanded, the proportion of referrals from non-GP sources has increased significantly, reflecting the trust's engagement with stakeholders in acute care and the local health economy.

Enabler: stakeholder engagement

Open communication channels with GPs

The trust has positive feedback from most of the 38 local primary care practices. GPs say they appreciate the open communication channels: for example, being able to speak to a senior clinician immediately and decide together what is best for the patient.

Engagement with acute care colleagues

Staff from local acute trusts have opportunities to shadow CNWL community teams, including the rapid response teams, to enhance colleagues' understanding of whole pathways and encourage appropriate referrals.

Referral sources

- GPs
- London Ambulance Service
- acute services
- other health and social care staff including community teams and sheltered housing
- carers, friends, family
- self – if they have used the service previously

Patients may also refer themselves – directly to a clinician – if they have used the service before.

Patients are supported to remain at home. Once a patient has been referred to the service by their GP or the ambulance crew and has consented to join the rapid response pathway, a nurse will triage them by phone and an MDT member will conduct a face-to-face assessment in the patient's home. MDT members design a care plan with the patient, with the aim of restoring the patient's independence as quickly as possible.

Patients can be referred from acute wards, including the trust's own inpatient facility at St Pancras, via the Rapid Enhanced Discharge Support (REDS) team. The combined REDS and Rapid Response Service can facilitate patients' discharge within 24

hours. Permanent members of the REDS and rapid response team build relationships with ward teams to ensure referrals are made as promptly as possible.

Admissions criteria are inclusive. The team tries to serve as many patients as can be cared for safely, rather than viewing the assessment criteria as a tool for exclusion. The team knows the conditions under which the service can and cannot care safely and effectively for the patient in their home.

GPs maintain medical accountability for the patient on the rapid pathway. Accountability for community referrals, especially admission avoidance, remains with the GP and the Rapid Response Service clinicians. All changes in treatment pathways are discussed with the referring GP. The discharging services – eg REDS and Rapid Response Service – often refer back to the discharging consultant for medical guidance and always update each GP surgery before or on discharge.

The service can adjust according to patients' acuity. The number of patients the service sees depends on their acuity at any one time. The service has a capacity of over 40 patients per day depending on casemix.

It values clear discharge planning and onward referral. Patients stay in the care of the rapid response MDT for up to 10 days. The team then transfers patients to alternative and continuing care as appropriate: eg district nursing or community therapy. Relationship building with primary care, adult social care and mental health services is an important aspect of providing a seamless service to patients.

Enabler: working closely with other initiatives – CareLink

The Rapid Response Service relies for its success on close working relationships with other local initiatives, says the trust. For example, CNWL provides a home-based service in Camden called CareLink, which works closely with the Rapid Response Service. This provides six weeks of home-based care for reablement. The trust can introduce a CareLink package to give more intense care and reablement to patients on a rapid pathway: a healthcare professional might visit the patient two or three times a day instead of once. A nurse and a therapist will conduct many home visits jointly. If they identify a need for ongoing care, CareLink staff will support the application for this.

CareLink is provided in-house (12 permanent healthcare assistants and bank staff as required). Care packages often take up to five days to organise through the local authority, but as an in-house service with extended working hours CareLink allows reablement to begin immediately after discharge. It also makes it less likely that care provided will overlap unnecessarily.

CareLink and the Rapid Response Service are located together, which helps them communicate. They benefit from each other's experiences, and joint working brings economies of scale.

Developing pathways to improve care for all patients is important. Pathways are also being developed for people who are not suitable for rapid response services – for example, because they only have a social care need – to ensure they pass through the system seamlessly.

The trust has recently secured **recurrent funding** for the service, enabling it to attract experienced and skilled staff.

Impact

The service is helping to avoid inappropriate hospital admissions. This particularly benefits frail elderly people, for whom hospital admission is associated with a risk of deterioration.

The trust reports that it is avoiding around **80 hospital admissions a month** with over 80% of referrals avoiding admission. Inappropriate referrals are few and decreasing due to engagement with referrers and collaborative working.

A local acute foundation trust's data on emergency admissions among patients in Camden for the last 6 months of 2013 and 2014 showed a 10.4% **reduction in total inpatient spells**. For residents from selected nursing and residential care homes, inpatient spells reduced by 35.1%. While this cannot be directly attributed to the enhanced Rapid Response Service, the trust believes it has been pivotal in reducing avoidable admissions.

More patients can be treated where they choose. The service helps vulnerable people remain at home, reducing the risks of hospital-acquired morbidity or deconditioning, and promoting independence. The service has a high patient satisfaction rate, reflected in a recent CNWL-wide patient survey.

The trust reported that the scheme could make savings from:

- fewer hospital admissions
- shorter lengths of stay for older patients at University College London Hospitals and the Royal Free Hospital
- fewer A&E attendances
- reduced average length of reablement packages
- fewer local authority reablement packages of care.

Challenges

Effects of higher acuity patients in the community Demand for other community services is increasing, as are the complexity and acuity of patients being treated in the community. Community teams are caring for patients they might previously not have come across. The trust is aware that this may have implications for the capacity and skill level of community-based teams in future.

MDT skills mix Medical input into the MDT would enhance the scheme's impact, enabling more acutely ill patients to stay at home. But moving consultants into the community would significantly affect the cost of the service and capacity in the rest of the organisation.

More information

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