Monitor
Making the health sector work for patients

Moving healthcare closer to home: Case studies

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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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1. Admission avoidance

Telehealth Hub: Airedale NHS Foundation Trust

The Airedale NHS Foundation Trust Telehealth Hub provides remote support to patients and carers via a video link, with the aim of reducing attendances to A&E and admissions into the hospital. The service provides remote support and advice to patients, and co-ordinates referral to other services where required. Important features of the service are delivering at scale, the use of technology and working with partners.

Airedale NHS Foundation Trust provides acute, elective and specialist care over 700 square miles across Yorkshire and Lancashire, for a population of 200,000 people.

Aims

Airedale NHS Foundation Trust's Telehealth Hub is a team of clinicians providing remote triage and advice via video link to patients in their homes, in nursing homes and in prisons. The team provides clinical consultation and inward referral to the most appropriate care setting where necessary.

The scheme aims to support patients in their usual place of residence to manage their condition themselves or to co-ordinate the most appropriate care. By doing this it aims to avoid unnecessary admissions, A&E attendances and GP appointments.

Origins

In 2006 Airedale NHS Foundation Trust set up the Telehealth Hub to deliver remote telehealth services to patients in prisons. In 2009 the service expanded to individual patients with long-term conditions, and in 2011 to nursing and residential homes.

The trust chose to follow international examples of healthcare delivered via video. It recognised that healthcare delivery needs to change to meet the predicted growth in demand from the changing population and healthcare needs. Its three-year strategy states: "we needed to alter our hospital dominated delivery model to one based on diversified, integrated

Characteristics

- triage and advice via video link
- 24-hour service
- led by senior nurses
- access to advice from acute consultants
- co-ordinating care with local services

services, designed with our partners, delivered at the most appropriate point for patients enabled by technology”.[1]

Structure

Providing services across England All telehealth services are run centrally from the Telehealth Hub at Airedale Hospital. It provides services via a video link to around 250 care homes, 13 prisons and 100 patients in their own homes (at June 2015).

24/7 service The service provides a hotline so that patients can access medical advice 24 hours a day, seven days a week.

Senior nurse led The central hub is staffed by senior nurses (bands 6 and 7). An acute consultant advises when required.

Conditions treated

- chronic obstructive pulmonary disease
- heart failure
- anxiety
- diabetes
- urinary tract infections
- dementia
- breathing difficulties
- skin rashes
- foot ulcers
- end-of-life care

How patients benefit

Patients at home, in care homes and in prisons can call into the telehealth hub 24 hours a day to talk to a senior nurse. The nurse discusses their symptoms with them and carries out an assessment using the video technology to focus on particular areas to diagnose where necessary.

The majority of Telehealth Hub patients access the service from care homes. Airedale has developed relationships with care homes and local authorities across the country.

Enabler: technology

High quality and reliable video connections allow nurses to visually assess patients, eg the nurse can perform a visual stroke assessment or look closely at wounds or rashes. The system uses an encrypted video link to maintain confidentiality.

Linked patient records allow detailed patient history to be viewed during remote triage. The hub relies on linked patient records between primary and secondary care.

In care homes staff help patients to contact the service via the video link. Nurses at the hub advise nursing home staff on support and treatment where appropriate.

In prisons, patients and prison staff can book consultations. Consultations can be booked between

[1] www.telecare.org.uk/webfm_send/950

a consultant, the patient and a member of the healthcare team in prison. The complexity of transferring prison patients to hospital for treatment means it is particularly helpful to avoid attendances at hospital.

Patients who are identified as at high risk of exacerbation of long-term conditions have access to the video link from their own homes. The service works with local GPs to identify patients who could most benefit from the service.

Staff at the hub can refer patients to local services. The service can direct patients to their GP, and in some cases where strong relationships have been developed, GPs are able to prescribe based on hub recommendations. The service also refers patients to local community services based on a solid understanding of what services are available where patients are located. The hub can provide a full handover to other services, which means that patients or carers do not have to deal with referrals themselves.

Enabler: relationship with care partners and knowledge of local health economies

Building partnerships with other care organisations and developing trusted relationships is at the heart of providing care remotely.

Hub staff work hard to engage staff from ‘on the ground’ teams (out-of-hours GPs, district nurses, etc) who may receive referrals from the hub, and care home managers and owners whose staff use the services.

Where virtual triage indicates that a patient needs to move to acute care, this is co-ordinated from the hub. The hub has strong relationships with some local hospitals, where it can facilitate referral directly into inpatient wards and pass on clinical knowledge to staff in the hospital.

The hub also operates ‘Gold Line’, an end-of-life service providing telephone advice and support for patients and carers, co-ordinating with other end-of-life services, and supporting those who are bereaved. Patients and carers can access clinicians in the hub and in some cases also have a video link connection. It was launched across Airedale, Wharfedale and Craven in November 2013 and extended to the Bradford district last March with funding from the Bradford City and Bradford District clinical commissioning groups on a trial basis until March 2015. Currently there are more than 500 patients registered.

Enabler: scale

As this is a 24/7 service there are high fixed staffing costs involved in ensuring staff are available to meet patients’ needs. However, because it is a telehealth service it can operate across the country and build up a significant patient base to cover these costs.

Hub clinicians visit patients and institutions to train them in how and when to use the technology. This is important to the success of the service. Meeting

patients and nursing home staff gives hub staff a chance to build relationships and confidence in the service. Patients and staff from nursing homes and prisons must be willing, comfortable about using the technology and confident that conditions will be adequately assessed via the video link.

Impact

Analysis of patients in care homes using telehealth showed a reduction of about 35% in emergency admissions between 2012 and 2014 (the first two years of receiving the service) compared to the two years before, and over 50% reduction in attendances to A&E. As elderly patients have longer stays in hospital, these reductions represent significant savings in resources and staffing.

In the case of patients in prisons, there are also significant savings in supervising patients while they are in hospital.

Challenges

Reliance on effective referrers

Having staff members in care homes or prisons who are knowledgeable and enthusiastic about the service is crucial. Effective training, with hub staff visiting in person and demonstrating the technology, helps to build confidence in the service but there are still a number of care homes that make very few calls to the hub. Care homes have a very high turnover of staff and some staff appreciate the ease of referring patients to hospital. This places pressure on hub staff to repeat training and rebuild staff confidence.

Service funding

In addition, care homes do not directly commission the Telehealth Hub services. This can mean they do not have confidence in the benefits of the service when it is first installed, and may not have incentives to use the service appropriately. The hub works closely with staff to communicate the benefits to the care home and the wider healthcare system.

More information

Airedale telemedicine

Airedale Gold Line

Immedicare

Airedale NHS Foundation Trust

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Annex: Patient story

The Gold Line service at Airedale enabled breast cancer patient Mrs D to die in a way that was important to her.

The team acted as a 'clinical advocate' to ensure that Mrs D was as comfortable as possible and received the support she needed to be able to go back home. Gold Line organised the adaptation of her house, a special bed and commode and made sure she had extra pain relief when she needed it. It also arranged for clinical care, including draining her abdomen to enable her to hug her children.

It was important to Mrs D to keep different healthcare professionals out of the house; Gold Line supported this in providing a single point of contact. Mrs D's partner said: 'Everyone I spoke to knew about [our family] and what was going on. I didn't have to keep explaining my situation to different people'.

The 24-hour telephone support also provided reassurance to her partner. He said: 'I knew I could ring Gold Line any time about anything … I didn't have to use the service very often but it was important to me to know it was there… The nurses explained things so that I wouldn't panic'.

After Mrs D died, the Gold Line team called out a GP to certify her death, advised on contacting the undertaker and kept in touch with her partner later to make sure he was coping.

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.

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

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
- 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.

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

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.

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.

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

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

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.

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.

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.

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.

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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Rapid Response Service

CareLink

Central and North West London NHS Foundation Trust

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Emergency Ambulatory Care Service: Countess of Chester Hospital NHS Foundation Trust

The Emergency Ambulatory Care Service enables patients with some conditions (see below) to be treated in a specialist unit without the need for admission or an overnight stay in hospital. Important features of the service include rapid diagnosis by a senior clinician and ongoing development to expand the number of clinical pathways that the service can support.

The Countess of Chester Hospital NHS Foundation Trust is a large district general hospital in Chester with over 600 beds, providing services at an acute hospital site and at an intermediate care site.

Aims

The Emergency Ambulatory Care Service aims to transfer care out of the inpatient setting by providing rapid clinical assessment, diagnostic services and treatment planning to patients at hospital in the designated Ambulatory Care Unit (ACU). Patients receive the same medical treatment they would previously have received as an inpatient, and return to the hospital with a planned follow-up appointment if further treatment is required. This enables them to avoid admission to hospital and maintain their independence at home.

Origins

The trust began work to move activity from the hospital into the community in 2011/12. Drivers for this included increasing pressures on A&E, inefficient use of hospital beds, and an organisational commitment to improving patient experience by delivering care to patients where they want it most – at home and not in a hospital bed. The ACU opened in 2013 and since then the service has seen over 5,000 patients.

Characteristics

- focus on rapid access to diagnostics and treatment planning
- patients treated as an emergency day case
- focus on senior medical input
- rapid assessment and diagnostics
- no beds

Structure

Operational six days a week The service is open Monday to Friday from 9am to 10pm and on Saturdays from 10am to 6pm.

Multidisciplinary team The service includes advanced nurse practitioners, therapists and two community geriatricians. A number of GPs are employed on a sessional basis.

How patients benefit

Referrals are received from primary care and via the trust's A&E. When a GP sees a patient and knows they need specialist care at the hospital but should not need to be admitted overnight, they can send the patient to the ACU as an emergency day case rather than direct to A&E. Similarly, when people present at A&E and need tests, these can be done immediately in the ACU rather than admitting them to hospital, unless absolutely necessary. In this way, patients can be treated and go home the same day. Approximately 65% of referrals come from GPs; others are redirected from A&E and a few are from other departments in the trust, to support workflow and performance across the hospital.

Conditions treated

- cellulitis
- chest infections and chest pain
- abdominal pains
- low risk gastrointestinal bleeds
- low risk jaundice

Certain conditions can be treated in the ACU. The trust plans to increase the number of surgical and medical pathways being managed by the ACU to cover a wider variety of patients with a greater range of needs, and therefore widen the scope of admission avoidance activity.

Assessments can be done immediately by senior consultants. The ambulatory care model deploys senior doctors to ensure rapid diagnostics and robust assessment. This is a critical factor in enabling patients to go home on the same day. Patients receive specialist input, spend less time waiting, spend less time in the unit (two to five hours depending on the diagnostics required), and can be discharged to the community the same day, with further outpatient follow-up appointments if necessary.

Patients are able to go home and return to the unit with a planned follow-up appointment if further treatment is required. In the past, a person with cellulitis needed up to a seven-day stay for a full course of intravenous antibiotics. Now, patients can come to the ACU each day to receive their antibiotics.

No beds The trust considers that the psychology and ideology behind the unit are significant aspects of improved patient experience and the

Enabler: changing working practices

A crucial success factor for the service was changing the default behaviours of A&E practitioners. Rather than admitting patients, senior consultants in A&E are now asked to send them for treatment in the ACU.

To assist senior doctors in A&E to diagnose patients for this service, there is a directory of emergency ambulatory care which outlines 49 clinical scenarios in which it is appropriate for patients to be sent to the ACU. The trust has an ongoing training programme for staff in the ACU and A&E.

service's success. There are no beds, only chairs. The ACU is designed to look and feel like an outpatient centre: patients talk about going home, not about being admitted.

Community outreach The ACU is able to arrange nurses to visit people at home if this is the most appropriate response.

Strong relationships with primary care The trust runs awareness-raising sessions and training programmes among local primary care practitioners. These have led to an increase in referrals from primary care. The unit employs GPs for sessional work, which has the added benefit of sharing learning back into primary care.

Challenge: new ways of working

The aim is that people should not have to wait for diagnostics in ACU. This has had an impact on the working hours of those in clinical diagnostics.

The trust is aware of this and is working to support staff by creating new working patterns.

The ACU procedure shows trust staff how the trust sees the strategy for future care services: **senior review, good diagnostic, plan, and home.**

The trust is currently working towards a scenario where 'all cases should go to ACU unless they shouldn't'. This will require the development of further medical pathways through ACU. The unit plans to build capability to take on more surgical pathways delivered through 'hot clinics' in the near future.

Impact

The service enables patients to be cared for closer to home. Service data show that 75% of patients are discharged from ACU on the same day, generating a zero length of stay, and only a small proportion need to return for follow-up care. Approximately 25% of patients are admitted for inpatient care.

The service is calculated as avoiding 138 admissions every month, and activity is rising every month. The trust has been monitoring patient experience throughout, and over 95% are satisfied or very satisfied.

The scheme appears to have financial benefits for the trust. Although this cannot be attributed to the ACU service alone, the trust has recently closed two wards over an 18-month period as a result of saving bed days and increasing the number of patients who do not need to be admitted. Ward closure has helped the trust to achieve its cost reduction goals.

More information

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The Countess of Chester Hospital NHS Foundation Trust

healthcareclosertohome@monitor.gov.uk

Enhanced Rapid Response Service: Kent Community Health NHS Foundation Trust

The Enhanced Rapid Response Service (ERRS) helps patients in crisis avoid a stay in an acute hospital where clinically appropriate. After initial clinical triage, the service assesses the patient in their own home where medical, nursing and therapy support is then given. Important features of the service include leadership by the consultant geriatrician, who manages a team of specialty doctors and enhanced practitioners, and an engagement programme with primary care, the mental health trust, social care and the ambulance trust to boost uptake of the service.

Kent Community Health NHS Foundation Trust provides care to 1.4 million people in their own homes, nursing homes, health clinics, community hospitals, minor injury units, walk-in centres and mobile units.

Aims

The service brings together a medically led community team to treat patients at or closer to home. It aims to avoid unnecessary A&E attendance and emergency admission to an acute hospital.

The service also facilitates timely hospital discharge for patients who need a short stay in an acute bed, and can admit patients to a community hospital bed.

Origins

The service began as a pilot in November 2013, funded through short-term winter pressure money from commissioners. This enabled the trust to upgrade the existing rapid response nursing service by investing in a wider range of skills within the team. Unlike the original service, ERRS employs more advanced practitioners capable of enhanced assessment and treatment.

Characteristics

- part of a 24-hour service, covering seven days a week
- assessment in patient's home within two hours of referral where appropriate
- introduction of a consultant geriatrician, specialty doctors and enhanced practitioners for enhanced assessment and treatment
- multidisciplinary team
- recruitment of 13 whole-time equivalent staff
- single point of access
- care largely in patients' homes
- step up directly to community hospital beds

Structure

7-day service The ERRS team works from 9am until 10pm receiving referrals from a range of professionals and enabling patients to be treated for sub-acute conditions in their own homes.

Community hospital based
Multidisciplinary team review meetings, led by the consultant geriatrician, take place twice a week at the community hospital in Tonbridge. Although most care is provided in patients' homes, some is step-up care in community hospitals and residential care homes.

Multidisciplinary team A geriatrician leads the team, which includes specialty doctors, paramedic practitioners, senior nurses and therapists. An administrative team takes referrals via a central referral unit.

Referral sources

- GP
- ambulance trust
- mental health trust
- out-of-hours provider
- community nursing team
- A&E
- acute hospital ward
- social services
- hospice
- community hospital ward
- intermediate care team

How patients benefit

Referrals from multiple sources through a central unit ERRS receives referrals directly from primary care, the ambulance service, A&E and hospital discharge teams. From November 2014 to March 2015 the trust received 119 referrals a month on average. GPs made most referrals – 69% – followed by community health services at 14%. The ambulance trust made 6% and acute services (hospitals and A&E combined) 7%.

How soon a patient is seen after referral depends on their clinical acuity established at triage. Most are seen within two hours.

Patient-focused, short-term intensive support Using an assessment tool to calculate risk, the team decides whether the patient can be managed at home or needs a short stay in a community hospital. If they can be managed at home the patient is admitted to a 'virtual ward', receiving short-term care and support at home. The team's consultant geriatrician will treat the patient in a community hospital if that is the most appropriate place for the patient.

Conditions treated

- acute confusion
- acute heart failure
- acute urinary retention
- administration of intravenous antibiotics
- cellulitis
- chronic obstructive pulmonary disease and asthma
- dementia crisis
- end-of-life care
- acute loss of mobility in frail elderly
- gastroenteritis
- higher level tube feeding
- hypoglycaemia
- non-fracture falls
- other conditions requiring enhanced service
- recovery from injury or surgery
- sudden reduced mobility
- urgent provision of nursing intervention
- urgent provision of personal care
- urinary tract infections causing falls or acute confusion

ERRS's advanced competency practitioners enable it to support patients through a wide range of clinical pathways, including intravenous antibiotics, cellulitis pathways and others that require prescribing. Protocols are now in place to enable this to happen outside the hospital.

Service development to meet patients' needs Ongoing case review, internally at the trust and jointly with commissioners, has led to developments to ERRS. Currently there is no joint commissioning of social workers for the service but the trust hopes to work with the local authority to recruit social workers to the multidisciplinary team and to act as case managers.

Patients can remain on the rapid pathway for seven days. After discharge from ERRS, patients are often transferred to social care or case management within the trust's wider services, such as the complex care nurse caseload, or back to the care of their GP. Health and social care co-ordinators help patients progress in a timely manner, providing access to information and referral or directing them to other services or the voluntary care sector. The care co-ordinators are named individuals with whom the patient or carer can communicate to ensure access to seamless care.

The trust is currently working with about 70 primary care practices, promoting their continued use of ERRS and working with those not regularly using it. The trust found the service is

Enablers

- senior clinical leadership
- staff engagement, motivation and readiness for change
- staff training
- use of key performance indicators to demonstrate change in practice
- building understanding with local commissioners

Enabler: electronic patient record

ERRS has used an electronic patient record since November 2014. This has enabled it to collect rich service data that demonstrate the complexity of the patients looked after and the variety of interventions they receive.

Data show more use of step-up beds in community hospitals for ERRS patients, fewer referred to acute services and fewer re-referred to the ERRS service within seven days (for the same clinical reason).

popular among GPs, and referrals from primary care are increasing. GPs particularly appreciated being able to contact ERRS quickly through the central referral unit's telephone number.

Impact

The service has high patient satisfaction. The trust found that patients' preferred option is to stay at home when they have the chance. Patient satisfaction among those completing a survey averaged 99% in 2014/15, while 96% felt able to cope because of ERRS's interventions.

The scheme may be avoiding admissions for patients who might otherwise have been treated in hospital. Data show that between November 2014 and March 2015, 342 referrals were recorded as being made to avoid admission. Of these, 94.4% of patients were discharged to their usual place of residence, avoiding an admission. Therefore the scheme could potentially reduce pressure on local acute services and save money.

Challenges

Recruitment

The trust had to recruit staff from outside its own workforce to set up ERRS. Its marketing programme described how the service was innovative, and targeted individuals through NHS Jobs and recruitment days on site. The short time for implementation posed a challenge. The trust initially employed temporary staff, gradually replacing them with permanent employees.

Discharge targets

The trust discharges most patients within seven days, either to their GP or to other services. The main challenge to this is the availability of social care packages.

More information

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Emergency Multidisciplinary Unit: Oxford Health NHS Foundation Trust

The Emergency Multidisciplinary Unit (EMU) at Abingdon Community Hospital provides an urgent assessment and treatment step-up service to reduce A&E attendances and admissions to acute hospitals. Important features are rapid diagnostics, a multidisciplinary team and a seven-day service.

Oxford Health NHS Foundation Trust provides community health, mental health and specialised health services across Oxfordshire, Buckinghamshire, Berkshire, Wiltshire, Swindon, and Bath and North East Somerset. In Oxfordshire it is the main provider of community health services in community and inpatient settings, including eight community hospitals.

Aims

EMU aims to offer an alternative to A&E attendance and acute admission by providing rapid multidisciplinary assessments, diagnosis and treatment for patients in the community. It can provide comprehensive medical, nursing, therapist and social care assessment supported by 'point-of-care' diagnostic technology. It can treat patients with multiple, often complex problems, many of whom are frail and elderly.

Characteristics

- 7-day admission avoidance service
- step-down care from acute settings
- multidisciplinary team including senior geriatricians and social worker
- access to rapid diagnostics
- rapid treatment planning
- effective triage and can escalate patients to co-located short-stay beds if necessary
- joint acute and community provider staffing model
- partnership working with hospital-at-home service

Origins

EMU was set up in 2010 to create a credible alternative to acute admissions.

Most adult medicine patients in crisis have a mix of medical, social and psychological needs. They require a rapid response to a particular crisis, but may not need a hospital bed or outpatient unit. The service was therefore designed by Oxford University's Department of Primary Care Health Sciences, Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Trust and Oxfordshire County Council to provide rapid acute care in the community.

Structure

Multidisciplinary team The team includes consultant geriatricians, GPs with acute elderly care experience, healthcare assistants, a physiotherapist, an occupational

therapist (OT) and a social worker. Staff have the skills and experience to treat a wide range of conditions.

7-day service EMU operates from 8am to 8pm on weekdays and 10am to 4pm at weekends.

Community-based EMU is co-located with Abingdon Community Hospital. Most patients are treated during the day and return home overnight. EMU has access to six short-stay inpatient beds on the community hospital's rehabilitation pathway, which patients can occupy for 72 hours. This has the additional benefit of avoiding transporting patients to other sites.

How patients benefit

Patients are referred by their GP, the ambulance service or community district nurses. EMU escalates care for patients having an acute crisis and provides a step-down service for patients from acute services.

Open referral criteria EMU focuses on frail elderly patients (the average age is 80) but has open referral criteria for all patients over 18 in a population of 140,000. The trust says restrictive criteria would prevent uptake of the service. EMU will accept any patients who are not hyper-acute – that is, patients with suspected heart attacks, strokes, head injuries or those who may need surgery.

Enabler: multidisciplinary team

The service relies on the capabilities and working attitude of its multidisciplinary team, which draws on experience from a range of specialisms. With senior clinical decision-makers' support, the team can deliver care effectively and mitigate the risks of caring for patients outside an acute hospital.

Transport is available if patients need it. EMU can bring patients into the unit using its dedicated patient transport service, which can transfer patients in wheelchairs. Transfer takes one hour on average after referral, and the service's independence means EMU can make sure patients are diagnosed and treated rapidly following referral.

Patients are treated in an ambulatory setting. Patients are assessed on a hospital bed but transferred to a chair if appropriate. If they are expected to return home, they remain in their own clothes. To avoid patients deteriorating, EMU tries not to turn attendances into 'inpatients'. Some patients already have care packages in place, which the OT assesses to ensure they meet the patient's needs.

EMU operates with specialist senior clinical decision-makers so it can treat quite severely ill patients. It has a consultant geriatrician and a clinical nurse with acute service backgrounds and the experience to diagnose patients, assess risks and determine treatments rapidly.

Point-of-care diagnostics give rapid results, enabling patients to be treated within half an hour of arrival. They allow patients to receive intravenous treatments and fluids quickly. As EMU is located alongside the community hospital, it also has access to more intensive diagnostics such as x-ray. The service cannot provide more advanced diagnostic services such as MRI, but can access these rapidly at the John Radcliffe Hospital.

Enabler: point-of-care diagnostics

EMU uses handheld point-of-care diagnostic machines that can give results within minutes for a range of blood tests. This helps rapid decision-making, allows appropriate management of risk and enables patients to be treated as early as possible.

Clear pathways and escalation processes ensure patients are treated in the right location. If their condition worsens, they can be transferred to the acute trust, where they are admitted directly to a hospital bed and avoid the A&E pathway. EMU treats most patients using ambulatory pathways, although 16% are initially stabilised then transferred for ongoing care at the John Radcliffe Hospital; 2.8% need their care escalated after initial ambulatory treatment in EMU due to clinical deterioration and are admitted to the acute hospital or a community bed.

EMU offers support to patients and carers. EMU assesses the risks of patients being at home, and supports carers to minimise the additional burden that may result from out-of-hospital care. EMU staff discuss care plans and expectations with patients and carers, and tell them about EMU's advantages: patients receive appropriate care while being able to sleep in their own beds in comfort and familiarity.

Enabler: seven-day service

EMU says it would not be a credible hospital avoidance service without operating seven days a week. A seven-day service ensures continuity of patient care, avoiding admissions throughout the week. Seven-day availability encourages confidence from other parts of the local health economy that depend on reliable services.

Although EMU operates shorter hours at the weekend, it believes that it reaches most patients who would benefit from the service.

Acute and community services work together to deliver care closer to home. Within EMU, clinicians from the local acute trust, occupational therapists and other staff from the community provide medical care. EMU can jointly employ staff with its acute partners, allowing it a more flexible staffing model.

While the EMU model concentrates care in one location, it does work with a hospital-at-home nursing service also run by Oxford Health. The service gives patients further short-term treatment if required. This provides extra oversight to share and cover

risks. If patients deteriorate following discharge they are returned to EMU or can be directly admitted to the acute trust geriatric service.

Impact

EMU allows patients to be treated more quickly and closer to home and to return home as soon as possible. Feedback from patients suggests EMU sees them more quickly than A&E, as EMU staff can make rapid decisions. The service says that consultants, registrars or GPs make decisions with the same level of confidence, as they all have a concentrated caseload throughout the unit.

More information

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Annex: Patient story

Mr B is 81 and lives alone. He takes warfarin for atrial fibrillation and rarely visits his doctor. His younger sister helps him go shopping. Over two weeks he becomes increasingly breathless and can't leave home. He finds it harder to get around the house too, and notices his ankles have swollen.

His sister visits him and calls the GP, who comes that day. Mr B refuses to go to hospital but realises he needs more tests and treatment than his GP can offer him at home. The GP calls EMU, which collects Mr B, who is on the unit within an hour.

Within five minutes a healthcare assistant assesses him and carries out blood tests chosen by the EMU doctor, who has spoken to Mr B's GP. Five minutes later the test results are back. A senior doctor examines Mr B for 20 minutes and suspects heart failure with a pleural effusion. A chest x-ray 20 minutes later confirms a right-sided pleural effusion. Although this has a number of causes, which staff discuss with Mr B, they start initial treatment for heart failure with intravenous diuretics on the unit. Two hours later, Mr B begins to feel better. EMU staff plan a care pathway for the next few days, involving daily visits to the unit for intravenous diuretics and monitoring Mr B's kidney function through point-of-care blood tests.

Five days later, Mr B feels much better and is getting out by himself. His treatment is changed from intravenous therapy to oral tablets. The pleural effusion has almost cleared up, and further cardiac investigations are organised with ongoing follow-up from Mr B's GP and community heart failure nurses.

Single Point of Access: South West Yorkshire Partnership NHS Foundation Trust

Single Point of Access (SPA) is an engagement, triage and assessment service, helping users of mental health services keep well in the community and avoid unnecessary hospital admissions. Important features include high quality patient assessments, delivery of interventions to reduce distress and provide practical help, and signposting some patients to voluntary sector and primary care services.

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services across Barnsley, Calderdale, Kirklees and Wakefield. It also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber. Over 98% of services are delivered in the community.

Aims

SPA is a pilot project in the trust's acute and community transformation programme. SPA receives all urgent and routine referrals to secondary mental health services, including service users considered to be at risk of admission.

Previously assessment teams managed referrals for adult community mental health teams (CMHTs) only, but SPA manages all referrals to adult and older adult CMHTs and primary care mental health services. Some specialist services continue to take direct referrals (memory services, improving access to psychological therapies (IAPT) and early intervention in psychosis), but SPA may triage and can help ensure rapid access to these services.

Characteristics

- aims to see service users within three days where urgent needs are identified
- staffed by a multidisciplinary team
- medical leadership and input
- referrals from primary and secondary care and self-referrals
- 7-day service available until 8pm weekdays
- part of the trust's transformation programme – a key component in improving community mental health services by streamlining referral and assessment

Origins

Developing a single point of access to secondary mental health services is a strategic priority for the trust and a local priority for commissioners and users of mental health services. In particular, local GPs asked for quicker, simpler pathways to specialist mental health services and for mental health assessment to be available when they needed it.

Until this pilot, referrers and service users had to rely on psychiatric emergency services (crisis team and accident and emergency liaison) after 5pm and at weekends. This placed a burden on these services, on GPs and other referrers. It was linked to delay in patients accessing specialist mental health services, both community and hospital-based. This led to increased demand for acute services, particularly from patients with mental health deterioration presenting at A&E.

Structure

Clinical commissioning group winter resilience funding has allowed SPA to extend its operating hours. It is now a **seven-day service**, receiving referrals from 8am to 8pm Monday to Friday, with shorter opening hours on Saturday and Sunday.

SPA is run by a **multidisciplinary team** of mental health nurses and social workers, and includes staff experienced in primary care mental health and care for older adults. A consultant psychiatrist works with the team providing medical leadership, rapid access to medical assessment and offering advice and consultancy to referrers. Specialist psychological advice is available to the team from the host CMHT.

How patients benefit

SPA receives referrals from primary and secondary care, **and people can refer themselves**. The team accepts and triages routine, urgent and crisis referrals of mental health service users.

The SPA team accepts and triages crisis referrals on behalf of the home treatment team and can undertake joint assessments with it. This makes referral simpler and safer as **there is only one number for GPs to call 24/7** for mental health crises. It also allows SPA to divert or quickly escalate people who in fact need an urgent rather than crisis response.

Enabler: high quality assessments

One of SPA's key tasks is to assess people presenting with risk of self-harm and suicide. By developing its practice in this field, and by offering extended assessments to people with identified risks, the team aims to expertly manage this challenging dimension of mental healthcare.

All service users are contacted on the day of referral to find out how urgent their needs are. SPA can respond on the same day to the most urgent, with a commitment to see all non-routine referrals within three days. It assesses routine referrals within 14 days.

SPA conducts a **face-to-face assessment** wherever possible. After referral, a team member contacts the service user, determines urgency of need and arranges an appointment in the user's place of choice – sometimes at their GP surgery, sometimes at the team base and often in their home.

Enabler: supportive interventions

SPA can see service users several times in a short period. This may be to complete an extended assessment or to provide 'brief interventions'. These aim to reduce levels of distress and anxiety, provide practical help and advice (eg with debts) and increase family/carer resilience through support and education. The approach can be highly effective, partly because help is provided quickly and at a time of stress when people can be more receptive to making changes. Brief interventions have been found to substantially reduce the number of service users requiring referral to secondary services.

The team works with the patient to **agree a care plan, action any referrals and signpost the patient to self-help groups** and activities, including the local Recovery College. Patients with identified mental health needs may be referred to CMHTs, the primary care mental health team, trust specialist services or IAPT services. The service user and assessor sign the agreed care plan and share it with the patient's GP, so they are aware of what services the patient will be receiving and can monitor progress. The service user keeps a copy for their own records.

Multidisciplinary working that involves social workers in the team ensures that SPA properly understands and addresses social dimensions of mental ill-health.

Challenge

Changing ways of working

It was a challenge to convince CMHTs and other receiving teams to stop managing referrals in favour of a centralised specialist team. The trust is doing this by demonstrating the value to the organisation of a single point of access and assessment. The trust has reduced its 'Did Not Attend' rates for appointments, reduced CMHT waiting lists and increased opening hours. The team regularly discusses referrals with staff outside the single point of access to maintain trust and accountability across wider teams.

Impact

The trust reports quality improvements since SPA's introduction:

- **improvements in the timeliness and nature of patients' care –** centralised referral and assessment enable the team to triage service users effectively and direct them rapidly to the right parts of the system for care that is most appropriate for their immediate and future needs
- **improved ability to manage growing demand –** the streamlined referral and assessment process has helped the trust meet growing demand

- **shorter time between referral and first appointment,** therefore reducing waiting times for patients
- **increased capacity to care for patients in the community –** SPA has increased throughput, and the CCG's investment in staff has enabled expanded operating hours
- **reduced waiting lists for CMHTs** as the new approach to triage means only appropriate referrals are passed to secondary services.

SPA rapidly assesses and directs people to the right part of the system according to their needs. By reducing pressure on crisis services and redirecting people who do not need specialist mental healthcare, the local health and social care economy could benefit from improved efficiency. The trust reports that SPA helps deal with growing demand, and by reducing missed appointments it can make a considerable contribution to cost-effectiveness, despite no direct evidence yet that it saves money.

More information

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Midhurst Macmillan Palliative Care Service: Sussex Community NHS Trust

The Midhurst Macmillan Palliative Care Service ('Midhurst Macmillan') provides acute-level care at home to patients nearing the end of their lives. Important features are personal case management to co-ordinate all aspects of care, a seven-day service and cross-skilled staff.

Sussex Community NHS Trust is a large community healthcare provider serving a population of about 1 million people. It provides medical, nursing and therapeutic care to over 8,000 patients a day.

Aims

The Midhurst Macmillan consultant-led multidisciplinary team provides hands-on care at home and in other community settings seven days a week. The service is based on the Motala model[2] in Sweden and aims to:

- enable patients with complex needs to be cared for at home
- allow patients to die in the place of their choice
- prevent avoidable admissions to hospital.

Characteristics

- care at home for end-of-life patients
- ability to provide acute level care
- co-ordinating other end-of-life services
- multidisciplinary team
- 7-day service

Midhurst Macmillan differs from traditional hospice models by focusing on care at home and proactively identifying patients earlier in their end-of-life pathways.

Origins

The Midhurst Macmillan Palliative Care Service was set up in 2006 in response to the closure of King Edward VII Hospital and its 20-bed inpatient palliative care unit. The NHS and Macmillan Cancer Support had jointly funded the unit. The hospital's closure prompted local stakeholders to consult on an alternative solution for palliative care. The local health economy already had good hospice bed provision, so the service focused on developing a more interventionist approach, providing acute-level care at home.

[2] Beck-Friis B, Strang P. The organization of hospital-based home care for terminally ill cancer patients: the Motala model. *Palliative Medicine* 1993; 7 (2), 93–100.

Structure

Multidisciplinary team A single team provides medical, nursing and psychosocial support to its patients.

Community-based Midhurst Macmillan has an administrative base at a local community hospital but provides all care in the patient's home.

7-day care The core service operates between 8:30am and 8:30pm daily. It also provides night-time advice to healthcare professionals and respite care.

Staffing

The team's caseload is around 300 patients a year from a population of 156,000. The team comprises:

- approximately 2 whole-time equivalent (WTE) consultants/associate specialists in palliative medicine
- 0.5 service director/joint clinical lead team leader
- 10 WTE clinical nurse specialists/registered nurses
- 4 WTE healthcare assistants
- 1 WTE counsellor/family therapist
- 1 part-time physiotherapist and occupational therapist
- 1 to 2 WTE administrative staff and volunteer co-ordinator
- more than 70 volunteers.

How patients benefit

Referral from GPs and hospital inpatient wards Midhurst Macmillan encourages referrals soon after diagnosis of a life-limiting condition. Around two-thirds of referrals are from GPs. One-third come from within hospitals, where Midhurst Macmillan staff join multidisciplinary meetings with acute hospital palliative care teams to identify patients who could benefit from the service. The Midhurst Macmillan team also proactively calls acute wards and palliative care teams in local acute hospitals to arrange patients' early discharge.

End-of-life care Midhurst Macmillan accepts referrals for patients over 18 with complex cases of cancer or life-limiting chronic progressive disease. These represent around 25% of end-of-life patients locally. Most Midhurst Macmillan patients have terminal cancer but growing numbers are receiving care for non-cancer conditions, including motor neurone disease, chronic obstructive pulmonary disease, heart failure, multiple sclerosis and other neurological conditions.

Palliative interventions the team can provide in or close to a patient's home

- blood/blood product transfusions
- parenteral treatments
- intravenous (IV) antibiotics
- IV bisphosphonates
- fluids
- paracentesis
- spinal analgesia

Patients are usually seen on the same day. If a patient is in crisis on referral, a clinical nurse specialist treats them in their home on the same day. The clinical nurse specialist also assesses patients not in crisis at home. The team discusses and assesses all patients at daily multidisciplinary team meetings, and allocates support services based on the level of intervention needed.

Clinical staff are allocated to specific patients to enhance care continuity. Each clinical nurse specialist holds a caseload of about 50 patients. In addition, a clinical nurse specialist is able to pick up cases and respond quickly to urgent needs. Clinical nurse specialists do not usually provide hands-on care; this is done by trained nurses or healthcare support workers.

Single assessments Patients are assessed for psychosocial, medical and social needs at the same time. Single assessments help reduce stress and accelerate care planning. Counsellors work with patients and families before and after bereavement.

Working closely with the community Medical and nursing staff visit patients at home. Midhurst Macmillan also supports nursing homes and community hospitals. Skills transfer to staff in nursing homes and community hospitals may benefit patients not directly referred to Midhurst Macmillan.

Enabler: care co-ordination and clear leadership

A clinical nurse specialist co-ordinates care for each patient. This enables staff to build relationships with patients, GPs and district nurses. Relationships are enhanced by the same team seeing patients from diagnosis, with hands-on nursing for more complex procedures in the patient's home.

The Midhurst Macmillan team co-ordinates complex care across a range of providers, placing the patient at the heart of the plan, reducing duplication of effort and covering for other services where necessary.

Consultant presence Consultants visit about 30% of patients. Typically a third of these require a single consultant visit and two-thirds need more frequent visits for specialist medical procedures. Outside these visits consultants are kept updated and provide oversight through weekly multidisciplinary team meetings. The patient's GP remains accountable for patient care but Midhurst Macmillan consultants are able to perform specialist procedures without the GP's prior approval.

Access to inpatient beds if necessary If patients require a short-term inpatient stay or procedures that cannot be carried out in their home, inpatient beds are available in local hospices and community hospitals.

Impact

Allowing more patients to die in a place of their choice In 2013, 84% of Midhurst Macmillan patients were looked after and able to die in their preferred place of care.

Enabler: seven days a week cover

The service operates seven days a week. This allows Midhurst Macmillan to respond to a patient crisis, avoid the patient going into hospital and treat more patients at home.

In addition, Midhurst Macmillan has an increasing bridging role providing care when community nursing teams are not available (eg over the weekend), allowing patients to leave hospital faster.

Enabler: cross-skilled staff

The team treats patients when and where they need it, using competency-based care. Nursing grades or therapy specialisms do not restrict the care that staff can deliver.

A study of the Midhurst Macmillan service notes the importance of flexible working relationships[3] and tasks being performed by the nearest competent professional. Team members are willing to learn from each other.

Midhurst Macmillan also has a large pool of volunteers who fulfil many important roles within the service and support patients through activities such as shopping or gardening.

In the UK, for those who expressed a preference reported by their relatives, most people preferred to die at home (81%), although only half were able to.[4]

Identifying patients early prevents inpatient admissions. Most patients in the Midhurst Macmillan scheme are referred before an inpatient admission, resulting in fewer emergency attendances and over two-thirds fewer inpatient hospital days compared to patients who are referred to a hospice. Most hospice patients have at least two inpatient admissions before referral. Avoiding

[3] Noble B et al (2014). Can comprehensive specialised end-of-life care be provided at home? Lessons from a study of an innovative consultant-led community service in the UK. *European Journal of Cancer Care*. ISSN 0961-5423 (in press).

[4] ONS National bereavement survey 2012 www.ons.gov.uk/ons/dcp171778_317495.pdf

hospital admissions is a welcome outcome for patients, leading to consistently positive patient feedback.

The scheme may save money. Some evidence suggests this service could cut the total health economy cost of care in the last year of life by 20%.[5] Evaluations indicate the Midhurst Macmillan service is about half the cost of hospice care. Savings are largely due to the earlier referrals to Midhurst Macmillan, particularly if they avoid additional inpatient admissions. However, other parts of the health system incur higher costs as Midhurst Macmillan involves greater co-ordination to provide care with other out-of-hospital services.

More information

Midhurst Macmillan

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[5] Noble B et al (2014). Can comprehensive specialised end-of-life care be provided at home? Lessons from a study of an innovative consultant-led community service in the UK. *European Journal of Cancer Care*. ISSN 0961-5423 (in press).

2. Admission avoidance and length-of-stay reduction

Short-Term Assessment, Rehabilitation and Reablement Service: London North West Healthcare NHS Trust

Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) provides acute-level care in the patient's home. It avoids admissions and enables early discharge from acute hospitals by responding rapidly to referrals from GPs and identifying patients for discharge from A&E departments and inpatient wards. Important features are cross-skilled staff and integration within the acute hospital.

London North West Healthcare NHS Trust brings together acute and community services across Brent, Ealing and Harrow. It serves a population of 850,000 and employs more than 8,000 staff. The trust comprises three acute hospitals[6] and four community hospitals,[7] providing services in over 30 community sites.

Characteristics

- patients treated at home
- rapid response within two hours
- referrals from GPs and ambulance service
- an admission avoidance team based in A&E
- dedicated team to identify patients who can leave hospital with support

Aims

STARRS is a suite of initiatives:

- a rapid response service for patients in crisis or at urgent risk of hospital admission: patients are given a comprehensive clinical assessment at home within two hours of referral and are treated at home
- an admission avoidance team based in A&E to identify patients whose treatment could be managed out of hospital
- early supported discharge for hospital inpatients: a dedicated team identifies patients who can leave hospital with support from a hospital-at-home service
- general and neurological rehabilitation provided in the community within 72 hours of referral.

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[6] Central Middlesex Hospital, Ealing Hospital and Northwick Park and St Mark's Hospital.
[7] Clayponds Rehabilitation Hospital, Denham Unit, Meadow House Hospice and Willesden Community Rehabilitation Hospital.

STARRS seeks to:

- keep patients out of hospital where possible
- achieve earlier discharge for those who are admitted
- enable patients to be more independent through co-ordinated support, and prevent premature use of long-term residential care
- improve patients' transition between acute hospital and community services
- increase awareness of other support services in the community.

Origins

Brent first explored early supported discharge in 1995 to counter increased pressure on capacity following the closure of a 25-bed inpatient ward. Rapid response services were included in 2009, and Brent Primary Care Trust commissioned the STARRS programme in 2010.

The scheme expanded to Harrow in March 2012, taking over from four separate services previously provided by the acute discharge team, healthcare and rehabilitation team, falls team and the physical disability support team.

Structure

Multidisciplinary team The STARRS team includes nurses, therapists and consultants with support from the SPA (single point of access) team that manages administration.

7-day care STARRS' rapid response and admission avoidance teams in A&E operate seven days a week.

Acute-based Two acute-based STARRS teams work independently in two of the commissioning areas covered by London North West Healthcare NHS Foundation Trust. Both STARRS teams are based in Northwick Park Hospital, with a satellite early supported discharge team for Brent based at Central Middlesex Hospital.

STARRS team

- consultant physician
- nurses
- physiotherapists
- occupational therapists
- social worker
- paramedics
- administrators
- dietician
- speech and language therapist
- therapy technicians
- patient transport driver

How patients benefit

Patients are referred to STARRS rapid response team by GPs or from community and social care.[8] The SPA team facilitates rapid response admissions avoidance, discussing the referral over the phone with support from a clinician. The service takes referrals from 8am to 6pm on weekdays and sees patients until 8:30pm. It is open from 9am to 6pm at weekends and bank holidays.

Enabler: based within the acute hospital

STARRS is led and mainly staffed by nurses and therapists from the acute hospital, where it is based. This enables:

- **access to diagnostics** for faster testing, results and diagnostic imaging, as if patients were on acute pathways
- **consultation with clinical specialists** in the acute hospital when advice is needed
- **immediate admission** to the hospital if patients deteriorate
- **acute staff to contribute a high level of clinical discussion and decision-making,** vital to STARRS' success
- **easier staff recruitment** and repurposing if needed.

The STARRS team feels that integrating rehabilitation services into STARRS means **whole-system pressures** can be detected and managed, leading to improved flows.

STARRS rapid response team diagnoses and treats patients in crisis at home. The team aims to visit patients with deteriorating conditions at home within two hours. Clinical staff (usually a senior nurse and a therapist) carry out a comprehensive clinical assessment in the patient's home. The team can do tests during initial assessments, including full blood tests. The service has rapid access to diagnostics in the acute hospital, getting results within one hour. The team, consultant and GP discuss a management plan for the patient, which is implemented on the same day.

Patients are also identified by the STARRS admission avoidance team, which operates in A&E to assess patients throughout the day. The team operates in Northwick Park Hospital's A&E department from 8am to 10:30pm, 365 days a year. The team screens for appropriate patients on arrival, generally assessing them before or in parallel with A&E doctors. Patients who have attended A&E overnight are referred to the STARRS team during the morning clinical handover. The team sees overnight referrals by 9am to help mobilise and discharge them back home from A&E areas.

[8] Referral criteria here: www.brentstarrs.com/pdf/Referral_Criteria_Guidance.pdf

Typical STARRS care packages

Rapid response

- average time with service is 3 days
- conditions include urinary tract infections, falls and reduced mobility, chest infection, chronic obstructive pulmonary disease, heart failure, cellulitis, deep vein thrombosis, pain management, social issues/programme of care, diabetes, etc

Early supported discharge

- average time with service is 5 days
- conditions include elective orthopaedics, gynaecology and breast surgery, optimisation of INRs, intravenous antibiotics and IV furosemide, complex wound management and some bridging of care

Reablement

- average time on service is 6 weeks
- services include falls assessment and neurological rehabilitation

Patients in the observation area for less than 24 hours are considered to be a short-stay admission.

The STARRS team helps patient flow through A&E. Once patients are identified in A&E as suitable for STARRS, they are discharged to the STARRS assessment lounge (avoiding breaches in A&E targets). Assessments and treatments can be completed here, after which STARRS is responsible for transporting the patient home and the team organises follow-up visits and care packages.

The STARRS early supported discharge team identifies patients for whom an early supported discharge is appropriate. This service runs from 8am to 6pm on weekdays. The team 'in-reach' to wards to identify suitable patients and take referrals from wards. The team aims to transfer patients home within 24 hours after referral.

The STARRS early supported discharge team puts in place care packages to enable patients to leave hospital earlier. For both elective and non-elective care, early supported discharge teams can act as a 'clinical bridge', enabling patients with complex conditions to be discharged from the acute hospital earlier than would otherwise be appropriate.

Staff in the STARRS teams rotate between each of its three main functions: rapid response and A&E admission avoidance, early supported discharge and community rehabilitation. The team highlights the importance of including community rehabilitation in this rotation.

Care for all patients is co-ordinated by virtual ward rounds. A nurse or a consultant leads virtual ward rounds twice daily. Webcasting technology facilitates meetings across sites. In general there are 35 to 40 patients in the virtual ward every day. During the virtual ward rounds the multidisciplinary team discusses patient treatment, diagnostics, discharge or escalation.

Patients are visited up to twice a day by nurses and therapists from the team.

STARRS also provides short-term rehabilitation services. Therapists, technicians and rehabilitation assistants provide therapy in a patient's own home. The team aims to visit patients within 72 hours of referral. A suite of services to reduce inpatient bed days, including rapid rehabilitation services, is crucial for maintaining flow through the system.

Enablers to delivering rapid care

- technology enables liaison with consultants from patients' homes via video calls
- nurse prescribing
- e-prescribing by consultants out of hours
- pre-packs of medication available

The STARRS team collaborates closely with social services and continuing care teams. The STARRS team, GPs and consultants in the acute hospital liaise closely to agree care plans. These can include rehabilitation and social support for a patient's future continuing care.

The STARRS team have access to short-term beds. A step-up service is available for patients who are unable to remain at home but do not require acute care. Patients can receive intensive therapies in a location staffed by nurses and junior doctors.

A driver facilitates patient transfers. STARRS employs its own driver. This enables patients to return home promptly from the hospital and be brought into hospital for treatment or testing that cannot be done at home.

Enabler: multidisciplinary teams with competency-based nursing rotation

Team members are mainly recruited from an acute background as staff need to be able to deliver acute levels of care.

The service functions through competency-based nursing: STARRS nurses must be confident and able to make autonomous decisions on patients' care.

Rotations ensure community teams maintain their acute skills and relationships.

GPs remain in charge of the clinical governance of patients referred to the rapid response service. This requires significant trust between GPs and the STARRS team. The team found that GPs became more confident about referring directly to STARRS as the service grew and evolved. In some areas GPs lack this confidence and provide few direct referrals.

Early supported discharge patients remain under the clinical governance of their acute inpatient consultant. The acute hospital monitors the patient's condition until they have reached their goals and are declared ready for discharge from the scheme.

Impact

Patients see STARRS as having benefits, and they provide positive feedback. The service allows interventions to take place in the patient's home, avoids a potentially lengthy A&E process and limits the need for patients and carers to travel. The STARRS team has not yet had the opportunity to conduct a full clinical review of benefits.

Challenges

Workforce

The service takes healthcare professionals out of traditional working practice, which has led to recruitment difficulties.

Nurses must have the confidence to make autonomous decisions on patients' care and be willing to learn new skills beyond their own specialty. They must also be prepared to work long shifts across seven days and be able to drive.

Consultants running the service are subject to unique risks. With no direct responsibility for patients, and often no direct contact with them, some consultants can be reluctant to take on the responsibilities of overseeing STARRS.

Commissioning pressure

STARRS is commissioned on a block contract, based on the clinical commissioning group's activity assumptions. It is difficult to achieve the level of referrals needed to meet the contract's admission avoidance target. The team is trying to increase referrals – for example, by building relationships to encourage referrals from the London Ambulance Service and from care homes.

More information

Harrow Council progress update on implementations of Harrow STARRS

Brent STARRS early supported discharge pathway

A&E pathway to STARRS

STARRS rapid response pathway

healthcareclosertohome@monitor.gov.uk

Care Navigation/Telehealth Care Services: South West Yorkshire Partnership NHS Foundation Trust

Telehealth monitoring in patients' homes in Barnsley helps reduce hospital readmissions and length of stay by enabling patients to better understand their illness and take more responsibility for managing their long-term conditions at home. Important features include remote data-monitoring and close partnership working with the local authority.

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services across Barnsley, Calderdale, Kirklees and Wakefield. It also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber. Over 98% of services are currently delivered in the community.

Aims

Care Navigation/Telehealth Care Services support people in Barnsley to be active participants in their care and maximise their potential for independent living. Telehealth is intended mainly for people with one or more long-term conditions, and aims to monitor patients' vital signs/symptoms from their home on a daily basis. The service also educates patients to understand and manage their conditions.

Characteristics

- around 235 people in Barnsley have access to a telehealth unit in their home
- operates Monday to Friday 9am to 5pm, Saturday and Sunday 8:30am to 4:30pm
- a person's condition is monitored and observed from their home
- integrated with the community matron service, the heart failure specialist nursing service and the community chronic obstructive pulmonary disease (COPD) specialist nursing service
- patients who use this service require monitoring, ie vital signs, assistance with medication titration, symptom management

Structure

A telehealth unit is installed **in the patient's home** and they are trained to upload daily data on their vital sign readings, including blood pressure, concentration of oxygen in the blood and weight.

An office-based multidisciplinary team of staff nurses, all band 5 NHS-trained community nurses, monitors the data. The service is located at Mount Vernon Hospital.

The service operates **seven days a week** from 9am to 5pm Monday to Friday, and from 8:30am to 4:30pm on Saturday and Sunday.

Telehealth is publicised as a **non-emergency service.** Patients are advised to ring their GP or dial 999 in an emergency.

How patients benefit

Risk stratification Patients are selected using a risk stratification tool, or following referral from their GP or specialist nursing service.

Remote data monitoring The patient-reported data and records of physical symptoms, health knowledge and health behaviours are transmitted daily to the Telehealth Care Service, where care navigators review them to identify clinical trends. Patients are categorised on a daily basis as green, amber or red, indicating their risk status.

Patients have a named staff nurse who monitors their data and provides 'telephonic care'. Staff nurses build up an understanding of the patient's 'norms' and are able to spot signs of deterioration. They direct the patient to other health, social care and third sector services, such as stop smoking services. Diabetes and heart failure referrals are made electronically through SystemOne, helping patients navigate the most appropriate care. Patients or their carers can contact care navigators on a freephone number.

A patient's care can be escalated for a short-term intervention. If a patient is in danger of deteriorating, staff nurses pass their data to community matrons or a relevant specialist nurse, who would schedule a visit.

This is a 'step-down' service, and how long patients use it depends on the individual. Usually patients spend about six months with the service, although this can be extended if staff nurses and the patient deem it appropriate. The community matron or specialist nurse decides when to remove the home-monitoring kit and discharge the patient.

Enabler: partnership working

Telehealth is integrated with the local authority's Independent Living at Home service and aims to provide seamless social care as well as healthcare. For example, staff nurses can liaise with the Independent Living at Home service to arrange grab rails or other home equipment to be fitted.

Joint working Telehealth monitoring is part of an integrated range of services provided by the trust. Patients can access one or more of these depending on their needs. They include:

- care navigation – patients receive advice, information and support to stay well; care navigators direct them to the most appropriate services to help them manage their long-term condition
- health coaching – using motivational interviewing, staff nurses teach behaviour change techniques to patients to help improve their care and self-manage their condition

- post-crisis support – staff nurses contact the patient on discharge from secondary care to discuss the reason for admission and offer telephone support to reduce the chance of the patient being readmitted.

Patients over 18 years old and with at least one long-term condition can access any combination of these services. The referral criteria for telehealth monitoring are based on the patient being known to a community matron/specialist nursing service for the management of their long-term condition.

Impact

The service is measured against key performance indicators, including reductions in:

- hospital admissions
- GP appointments
- visits from community nursing services.

The service may support patients to effectively self-manage their conditions by giving them the right equipment and helping them to understand their conditions. The trust reports that the service reduces anxiety among patients with long-term conditions, and anecdotal evidence from staff suggests it improves self-management. Around 45% of patients using the service said they were visiting their GP less.

Trust service data, based on provision to 235 patients, indicate that the Care Navigation/Telehealth Service has decreased users' demand for services such as accident and emergency and community nursing:

- fewer hospital admissions since installation of the Telehealth equipment
- improved patient outcomes from preventing more intrusive and expensive services further along the care pathway
- about 45% fewer GP attendances among those accessing care navigation, health coaching interventions
- about 20% fewer GP attendances among those accessing telehealth technologies.

The trust reports the service has enhanced its other community-based care schemes – for example, by creating capacity among other community teams. The Care Navigation/Telehealth Service benefits community matrons and specialist nursing services by providing daily advice and support. This enables teams to 'step down' patients from their caseload and concentrate on the more severely ill. Patients are supported in a less resource-intense way, enabling community matrons and

specialist nurses to manage larger caseloads and visit patients needing face-to-face intervention.

More information

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South West Yorkshire Partnership NHS Foundation Trust

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3. Improving acute pathways

Older Persons Assessment and Liaison team: Ashford and St Peter's Hospitals NHS Foundation Trust

The Older Persons Assessment and Liaison (OPAL) team provides early comprehensive geriatric assessment (CGA) in the acute hospital to prevent avoidable admissions to inpatient wards and remove barriers that can lead to longer stays for older patients. Important features of the service are senior clinical leadership and working with partners.

Ashford and St Peter's Hospitals NHS Foundation Trust is a multi-site acute trust operating across Surrey; it serves a population of more than 380,000. St Peter's Hospital offers a full A&E service with all major specialties, including major trauma and resuscitation, while Ashford Hospital has a walk-in centre for non-urgent care and a range of medical and day-surgery services.

Aims

The OPAL team is a multidisciplinary, multi-agency team of geriatricians, nurses and therapists operating in St Peter's Hospital. Rather than providing care for patients in alternative settings, the OPAL team aims to improve the quality of care in the acute hospital for frail older patients with complex conditions to support the trust in meeting its operational objectives.

Characteristics

- aims to improve in hospital pathways for frail older patients
- staffed by a multidisciplinary team
- 7-day service

The service aims to:

- appropriately divert patients when they arrive at hospital
- intervene as early as possible to prevent lengthy hospital stays.

Origins

The OPAL service was set up in October 2013 when the trust identified high pressure on its inpatient emergency services and began to engage closely with the local community care provider, Virgin Care, to consider different ways of working.

Their top priorities were to:

- help meet the four-hour A&E target
- improve the emergency care pathway
- help ensure the efficient and safe discharge of patients from hospital into the community.

The scheme does not have an explicit aim to close beds or reduce workforce commitments.

They identified older patients as a target group partly because once admitted to hospital, older people frequently stay longer and are more likely to be readmitted.

The trust's chief nurse was tasked with developing a care model to meet the challenge outlined by the 'Silver Book' – providing specialist time and resource at the start of an older person's episode.

'Silver Book' quality care for older people with urgent and emergency care needs

The 'Silver Book', published by the British Geriatric Society,[9] sets a challenge for trusts to prevent hospital admissions, reduce length of stay and facilitate earlier and safe discharge.

It suggests four elements for a new model of care:

- **a frailty syndrome assessment** on initial assessment in the medical admissions unit (MAU) or A&E following referral to the medical team
- a **frailty unit** located in bays on existing wards
- **an older persons assessment and liaison team**
- **comprehensive geriatric assessment** (CGA).

OPAL supports wider hospital staff in conducting frailty syndrome assessments and CGAs. The trust did not create a frailty unit because of estate constraints.

Structure

Dedicated resource, multidisciplinary team The team members are all experienced in the care of older people and work solely in the OPAL team.

Acute-based The team is based and mainly operates in the MAU of St Peter's Hospital, and also provides follow-up in the medical short-stay unit. It has recently started maintaining a constant presence in A&E. The scheme does not provide care to the patient in alternative settings.

7-day service The team operates seven days a week between 8am and 6pm. Consultants work from 8am until 4pm.

[9] www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

Staffing

- consultant geriatricians
- clinical nurse lead
- senior nurse
- clinical nurse
- physiotherapists
- therapy assistant
- dietician
- pharmacist
- in-reach community nurse

Enabler: strong leadership from geriatricians

The trust identified the importance of leadership by consultant geriatricians to the success of the scheme. The consultants have also adopted flexible working patterns to enable the delivery of the service.

How patients benefit

Patients are referred to OPAL if they are identified as frail. All patients over the age of 85 are automatically referred to OPAL. All patients aged between 75 and 85 are screened by an OPAL nurse or therapist using a frailty syndrome assessment in A&E or MAU, and if they are identified as frail and need medical assessment are referred to OPAL. Patients under 75 are not eligible.

CGAs are carried out with an OPAL team geriatrician. All patients referred to OPAL have a CGA, which informs the care they receive while in hospital and supports safe and effective discharge planning from the beginning of the patient's acute episode. The process involves relatives, carers and other health and social care professionals known to the patient.

Patients either remain in the MAU with clinical responsibility held by the OPAL consultant or are transferred to a specialty bed within the acute hospital.

Patients are sent home before they have fully returned to their clinical baseline with plans in place for continued care from community nursing and to address social and mental health issues. OPAL can identify additional components to care that will address patients' overall needs and help prevent readmission.

Working with partners to implement care planning The team works closely with care homes and residential homes, and refers patients to support services to minimise their risk of readmission. It also develops care plans to help primary and social care teams support patients. The service aims to prevent readmissions by using the OPAL team's specialist skills to support community colleagues.

Enabler: engagement with community and social care partners

The scheme has engaged closely with partners from community, social care and care homes. They have worked together to design the service and develop systems for the smooth transition of care.

The community provider, Virgin Care, also provides a community in-reach nurse as part of the OPAL project team. Their role is to facilitate and expedite the discharge of patients into community services.

Enablers: clear objectives and key performance indicators

It is critical to have clear objectives that hold the scheme to account.

The trust found that it was beneficial to carry out a baseline audit and set key performance indicators (KPIs). However, it suggested that future projects should have these in place before implementing service redesigns.

The process of developing KPIs should involve the whole project team, including clinical leads.

OPAL provides dedicated post-discharge support. On discharge, patients and relatives are given access to a dedicated telephone support line. This allows patients to contact clinicians who understand their needs and with whom they have developed a relationship.

The OPAL team supports other hospital-based admissions avoidance initiatives. When referring patients, GPs can get advice from nurse navigators, and OPAL clinicians feed in specific guidance on the needs of older patients. The OPAL team does not provide a dedicated advice line for referring GPs, as this would require significant additional resources.

Challenges

Funding arrangements restricting service flexibility

The business case for establishing the OPAL service was part of a whole-system patient reablement model and was predicated on investment from the clinical commissioning group (CCG). Its design was therefore restricted due to parameters established by the CCG, which was not involved in creating the OPAL project.

Staffing

OPAL has struggled to maintain the long-term staff needed to operate consistently. Posts have been vacant for significant periods, and bank and locum staff have been needed to limit negative impacts on the service.

Senior clinical buy-in

The trust's executive team supports the OPAL project, but there was little engagement and support from senior clinicians when it was established. As a result, it was difficult to drive through service change.

Impact

In its first year of operation, from October 2013 to November 2014, over 2,600 patients were referred to OPAL – around 220 patients a month.[10] The introduction of the team has coincided with improvements in a range of trust operational metrics.

In its first six months (October 2013 to April 2014) there were improvements in performance indicators for the target cohort of patients (aged 85 or over). These included:[11]

- an increase in the number of patients being discharged directly from the MAU, with admission to inpatient wards falling from 90% to 81%
- a reduction in the length of stay for patients admitted via the MAU by one day from 10.1 to 9.1 days
- a reduction in the percentage of patients readmitted within 30 days, dropping by almost a quarter from 20.7% to 15.3%
- a reduction in the crude mortality rate for the patient cohort from 11.1% to 10.8%.

More information

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OPAL

Ashford and St Peter's Hospitals NHS Foundation Trust

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Annex: Patient story

Mr J is 92 years old. He lives alone following the death of his wife and takes medications to manage pre-existing medical conditions including heart failure and diabetes. After a fall, despite no obvious injuries, Mr J was taken to A&E because of ambulance crew concerns that he was confused and unable to manage at home.

On arrival a member of the OPAL team identified Mr J as requiring a comprehensive geriatric assessment, which was completed with him and by telephone with his daughter. The assessment identified that he had an underlying cognitive impairment and chronic pain in his right foot. These were affecting his ability to manage his medication, make meals and get around independently.

[10] Source: ASPH OPAL team database.
[11] Abstract book; British Geriatrics Society Autumn Scientific Conference 2014.

The OPAL pharmacist came to speak to Mr J about his medication and arranged a dosette box. The nurse initiated the reablement service to support him at home. The geriatrician ruled out an acute illness or injury from the fall; advised on suitable analgesia for his chronic pain and requested that his GP refer him to the memory clinic. The physiotherapist issued Mr J with a stick to improve his stability and arranged an urgent community falls assessment.

This thorough and prompt assessment enabled Mr J to return home that afternoon and gave him and his daughter confidence in future support. His daughter contacted the team a couple of days later to advise that he was well at home and getting on very well with the carers from the reablement service.

Rapid Assessment Interface and Discharge (RAID) Service: Birmingham and Solihull Mental Health NHS Foundation Trust

The Rapid Assessment Interface and Discharge (RAID) team provides an in-reach psychiatric liaison service to prevent avoidable admissions to inpatient wards and mitigate longer lengths of stay associated with mental illness as a co-morbidity to physical conditions. Important features of the service are a rapid response and 24-hour, seven-day service.

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental healthcare to over 1 million people. It offers inpatient, community and specialist mental health services including rehabilitation, home treatment, community mental health services, assertive outreach, early intervention, inpatient services, day services and mental health wellbeing services.

Aims

The service provides rapid response assessment and management of mental health conditions for patients attending hospital due to physical health conditions. RAID is based in the A&E departments of five acute hospitals as an in-reach service.

The RAID team aims to:

- improve outcomes for patients with mental health conditions receiving acute care
- divert and discharge patients from A&E
- promote effective and appropriate early discharge from general wards
- reduce readmissions.

Characteristics

- based in A&E
- senior clinical leadership
- 24-hour care
- integrated into the acute hospital
- mental health staff help acute staff to manage mental health needs
- referral to community mental health services

Origins

In December 2009 Birmingham and Solihull Mental Health NHS Foundation Trust launched the RAID service as a pilot project to improve outcomes for patients in the acute hospital who also have mental health conditions.

Co-occurrence of physical and mental health conditions often leads to poorer health outcomes, longer hospital stays and higher readmission rates. Early detection of mental health problems can enable rapid and appropriate interventions, as well as help with discharge planning from acute wards.

Co-occurrence of physical and mental health conditions lead to poorer health outcomes:

- patients with mental health co-morbidities generally have longer stays, more frequent readmissions and higher incidence of institutionalisation[12]
- 12% of A&E attendances and 40% of acute admissions result from alcohol and substance misuse[13]
- two-thirds of inpatient beds are occupied by older people and 60% suffer from, or will acquire, a mental disorder during an admission[14]
- patients who have long-term conditions and mental health co-morbidities generally cost 45% to 75% more to treat than those with physical health needs only[15]

Research has shown that a significant proportion of patients attending A&E or being admitted to an inpatient bed have mental health issues as a co-morbidity. Rapid assessment to identify mental health conditions when a patient is admitted and 'in-reach' into inpatient wards may therefore have a demonstrable impact on patient outcomes and hospital flows.

Structure

In-reach service Birmingham and Solihull Mental Health NHS Foundation Trust operates and administers RAID in five hospitals (in three acute trusts) across Birmingham. Mental health trust staff integrated with the acute trusts' clinical teams deliver care. The team is based in A&E, with staff outreach to other wards.

24/7 care The service operates with 24-hour nursing cover in each hospital. Consultants are present at each site between 7am and 9pm, and a team of senior clinicians including a consultant is on call outside these hours.

Managing mental health conditions RAID clinical staff do not provide treatment for mental health conditions. Instead, to improve treatment outcomes, they help acute clinicians manage the mental health needs of patients presenting with physical conditions, and refer patients to community services for mental health treatment.

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[12] Singh et al (2013) *The Rapid Assessment Interface and Discharge service and its implications for patients with dementia.*
[13] *National Indicators for Local Authorities and Local Authority Partnerships* (2009).
[14] Tadros et al (2013) Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model, *The Psychiatrist* (2013), 37, 4-10.
[15] The King's Fund (2012) *Long-term conditions and mental health. The cost of co-morbidities.*

How patients benefit

The RAID team is a **single point of contact** for mental health services in acute hospitals.

The team enables all patients referred to the scheme to be:

1. assessed
2. treated for their acute care needs
3. signposted to community care
4. referred for treatment in the community.

Referrals come from both A&E and inpatient wards with a rapid response approach. RAID aims to respond to referrals from A&E within an hour (and usually within 20 minutes). From their base in A&E, RAID nurses also outreach to wards when patients are referred. RAID's target is to respond to wards within 24 hours and it usually does so well within this time.

Enabler: integration within the acute hospital

RAID nurses are based in A&E:

- positioned to respond to cases directly without the need for calls and delays
- able to monitor all patients in A&E and pick up cases at an early stage
- able to quickly identify patients referred by A&E staff who are already being effectively managed in primary care
- able to outreach to wards across the hospital.

Working within the acute hospitals, the trust gains an in-depth understanding of its impact across the wider health system. This integration facilitates more rapid referrals from the acute to mental health services by breaking down barriers in patient handover.

Patients are treated by nurses with advice from consultants available 24 hours a day.

The team trains acute hospital staff to better identify, treat and refer patients with mental health needs. It helps acute staff to understand mental health needs and focus on them as part of their role and responsibility. This means RAID benefits all acute patients with mental health conditions, as well as patients it interacts with directly, reinforcing its impact across the hospital. It also enables the RAID team to concentrate on supporting patients with the most complex needs.

RAID enables faster access to mental health services. Before RAID, if acute patients had mental health needs, staff had to be called in from community mental health services. This made community services less effective and caused long waits in the acute hospital, particularly for patients who arrived out of hours.

Enabler: rapid response 24/7 service provision

RAID offers a rapid response service 24 hours a day, with on-call consultant back-up. This means that the service is able to meet patients' needs at any time of day.

In addition, as a constant presence in the trust, the RAID team gives other staff confidence to treat patients with mental health issues. Clinicians are better able to manage risk, as they have senior mental health professionals available to help if they need to escalate patients.

Enabler: consistent senior leadership and integration within the acute hospital

The same two consultants have led the service since its first pilot, giving it strong and consistent leadership.

They designed RAID to be different from their previous experiences of psychiatric liaison, in which fragmented services working limited hours were located in the 'bowels' of acute hospitals.

Being integrated within the acute hospital facilitates rapid referrals to mental health services by breaking down barriers in patient handover.

Impact

RAID has an impact on operations across the entire acute trust, because the RAID team trains staff as well as supporting patients directly. Economic assessments of RAID during its pilot phase and roll-out across multiple hospitals[16] indicate benefits for patients who directly interact with RAID staff and for patients with mental health conditions treated across the trust. RAID's benefits include:

- fewer admissions from A&E and the emergency medical unit to inpatient wards
- shorter average length of stay for inpatients
- twice as many elderly patients discharged to their own homes
- identifying more people with mental health conditions, with more patients being given an MH diagnosis code after RAID's introduction, suggesting the service is addressing previously unmet need.

The scheme may reduce costs in the acute trust by reducing admissions and length of stay, but it will divert more patients to existing community mental health services.

[16] Parsonage M, Fossey M (2011) *Economic evaluation of a liaison psychiatry service*. London: Centre for Mental Health 2011. /www.centreformentalhealth.org.uk/evaluation-liaison-psychiatry
Central Midlands Commissioning Support Unit (2012) *Rapid assessment interface and discharge liaison: economic evaluation of the Birmingham and Solihull roll out*.

Challenges

A yearly commissioning cycle

This can lead to greater uncertainty over the future of services because it:

- places a burden on the trust to continually review and highlight the scheme's impact to maintain funding
- causes a lack of clarity and stability for long-term investment to improve cost-effectiveness
- makes it difficult to recruit to senior roles, with staff lost to more secure jobs in similar schemes.

Pressure of A&E targets

Some A&E leads at trusts can be quick to apportion blame where delays and target breaches affect patients being treated with a RAID intervention. The team suggests this is often due to referrals to the RAID team coming late in the A&E pathway.

Differences in service specification

The trusts in which RAID operates use slightly different service models from each other. If they were more consistent, more efficiency gains would result.

Enabler: service delivered across Birmingham

RAID is commissioned across Birmingham as a whole, which brings economies of scale. Staff move across the five sites, making the service flexible and meaning it needs fewer staff than it would otherwise, bringing cost savings.

Because the service can offer benefits across the local health economy, hospitals commissioning services in combination may enjoy a higher level of provision overall than those commissioning in isolation.

More information

RAID service

Birmingham and Solihull Mental Health NHS Foundation Trust

Dementia in acute hospitals

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Acute Care of the Elderly Service: Croydon Health Services NHS Trust

The Acute Care of the Elderly Service (ACE) provides a comprehensive assessment of treatment needs for older people arriving at A&E. It aims to avoid admission or to help the patient move rapidly through the hospital and back into the community. A key feature is the comprehensive geriatric assessment (CGA) completed by a consultant-led multidisciplinary team when the patient presents at A&E, facilitated by access to rapid same-day diagnostics.

Croydon Health Services NHS Trust provides acute and community healthcare across the borough of Croydon for a population of over 380,000. The trust includes Croydon University Hospital, a district general hospital with more than 500 beds.

Aims

ACE supports older people with deteriorating and complex health needs to avoid further deterioration or crisis. Hospital specialists in elderly care work alongside primary and community services to manage the patient journey and make sure frail older patients get specialist treatment in the right place at the right time.

The service aims to:

- rapidly and comprehensively assess older patients who have come into A&E
- facilitate packages of care to support patient recovery at home where possible
- improve hospital efficiency to shift the care of older patients closer to home, safely and seamlessly.

Characteristics

- multidisciplinary team
- consultant-led
- comprehensive geriatric assessment as close to patient presentation at hospital as possible
- integrated with acute teams, rapid response team, ambulatory care, primary and social care
- GPs and community teams can speak to an ACE consultant for advice and referral from Monday to Friday between 9am and 5pm.

Origins

Croydon University Hospital Trust set up ACE in November 2012 to meet the needs of frail older people. The service is funded internally as part of the trust's whole-system transformation, improving the management of older patients.

Underlying ACE is the recognition that frail older people can reach crisis rapidly and unpredictably. Accurately diagnosing, managing and treating them can be challenging, so they need easy and rapid access to specialist geriatric assessment and treatment.

Structure

Acute-based The ACE team is based at two main locations within the acute hospital: the observation ward, next to A&E, and an outpatient rapid assessment setting.

7-day service The service operates seven days a week, 9am to 7pm.

Senior multidisciplinary team The team includes five consultants in elderly care, a specialist nurse, physiotherapist, occupational therapist, social worker and voluntary sector representatives.

Enabler: rapid access to diagnostics

- Early consultant-led CGAs for frail older adults improve care quality, patient satisfaction and patient flow, and reduce length of stay.
- Rapid access to same-day diagnostics makes the CGAs possible.
- The ACE team managed this change of focus by working closely with diagnostic departments from the outset to secure senior commitment.
- Diagnostic departments have been highly responsive to this way of working. They particularly appreciate the consultant-to-consultant discussions about patient care.

How patients benefit

There are two components to this service: 'in-reach into the emergency department' and the 'fast-track rapid assessment clinic'.

Older patients are assessed as soon as they arrive at the hospital. The 'in-reach' element looks after complex frail patients who have presented at the front door of the hospital as an emergency or patients who are entering crisis. The consultant-led, multidisciplinary team provides early **comprehensive geriatric assessments** of frail older patients, with a view to managing and treating them so they can return safely to the community and to their own homes.

The service initially delivered care in the A&E observation ward, where most of these elderly patients were being admitted. It has now extended further into A&E, liaising with a number of hospital teams to identify suitable patients.

The service is primarily for patients over 80 years old, but the ACE team will see younger patients if their needs are suitable for the service.

Enabler: communication with primary care

Apart from being able to follow up patients rapidly if necessary, the fast-track assessment clinic mainly aims to provide primary and community teams with an opportunity to refer patients for same-day care as an alternative to emergency admissions.

GPs can directly speak to the ACE consultant on call for advice and/or referral to the clinic, Monday to Friday 9am to 5pm, on the ACE consultant mobile number.

The consultant-led MDT administers a CGA and treatment plan. The CGA assesses the patient's medical, nursing, mobility, functional and social needs. Physiotherapists assess mobility and risk of falls, and recommend community mobility programmes and other rehabilitation pathways as required. Occupational therapists assess patients' ability to manage daily tasks at home, and refer to social services teams or rehab teams as required. Social workers arrange or optimise home care for patients, assist with respite care or arrange for a patient to have an interim care home placement, as well as addressing any safeguarding issues.

ACE aims not to admit patients if there is no medical reason to do so. Rather, the ACE team completes a comprehensive assessment of the patient and sets up ongoing care packages to support them in the community. The trust reports that without the ACE service these patients would have been admitted and therefore exposed to the risks associated with an acute inpatient stay.

The CGA supports timely patient flow through the hospital if a patient does need to be admitted to acute medical units or hospital wards. Early consultant geriatric review and multidisciplinary review can lead to better outcomes for patients, as well as assisting with patient flow.

Out-of-hours patients are seen the next morning by the ACE team. Outside operating hours, patients who previously would have been referred to the on-call team and admitted to a ward or acute medical unit, are admitted to the observation ward and seen by the ACE team the following morning.

Fast-track rapid assessment clinic The second element of the ACE service is the fast-track rapid assessment clinic. Patients may need to return to this clinic for follow-up following discharge from the in-reach element of the ACE service. It is run by a consultant in elderly care and staffed primarily by the ACE team, although routine clinic staff also provide support.

This clinic is both a hotline and a treatment centre. GPs, community teams, rapid response and intermediate care teams can call this clinic if the condition of patients in the community is deteriorating, as an alternative to referring them to the emergency department. The ACE consultant takes all the calls so specialist advice can be given as well as referrals to the service accepted. The consultants carry a designated ACE mobile phone and pager. Patients can be seen within 24 to 48 hours of referral. If they are well enough to go home the same day, they are discharged from the unit straight home.

Enabler: dedicated area

- fast-track assessment clinic based in a quiet area of the hospital, dedicated to assessing and treating patients aged 75 and over and staffed by staff with specialist skills
- looks and feels like an outpatient centre, with four clinic rooms and three beds
- offers a better experience for patients who do need to be admitted
- designed to be dementia friendly

Onward care Once patients are discharged from the ACE service, ACE nurses can provide follow-up calls, and the service directs patients towards other community pathways as appropriate, such as reablement services, day centres, rapid response, or the intermediate care team.

The ACE team works particularly closely with the trust's rapid response service, a 24/7 scheme that provides intensive nursing and therapy interventions in the home to prevent and manage crisis among high intensity hospital users and avoid unnecessary admissions. The ACE and rapid response services support each other to provide care for older adults with patients being referred between the two teams.

Impact

The ACE service can improve quality of care for older patients. The immediate provision of CGAs by a skilled multidisciplinary team as soon as frail older adults arrive at the hospital is widely regarded as best practice. It increases the likelihood that conditions such as dementia, falls and stroke are recognised and appropriate treatment plans are put in place. This can improve patient health and reduce the time the patient has to spend in hospital.

This scheme may be important in alleviating operational pressure at the trust caused by increasing demand. The trust reports that ACE has contributed to reductions in length of stay at the trust. Since November 2013 the average length of stay across elderly care wards has reduced by five days and 84 inpatient beds have been closed. Since ACE began, there have also been fewer admissions into hospital from the A&E observation ward at Croydon University Hospital for patients over 80 years of age. This is despite increasing attendance at A&E and admission to the observation ward among this age group.

Reductions in length of stay and fewer admissions suggest potential for the service to deliver cost savings, if fixed costs can be taken out.

Challenges

ACE needs capacity to cope with increasing numbers of referrals, particularly in the fast-track clinic.

There are demands on the workforce due to increasing demands on the service. The trust has responded by:

- investing in greater consultant input
- providing nursing staff with ongoing training to develop their specialist elderly care skills
- recruiting a full-time social worker to be part of the team.

More information

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Older People's Assessment and Liaison (OPAL) Service: Gloucestershire Hospitals NHS Foundation Trust

The Older People's Assessment and Liaison (OPAL) Service at Gloucestershire Hospitals NHS Foundation Trust ensures that older people presenting at the trust's A&E receive comprehensive clinical assessment and care planning from a consultant geriatrician. An important feature is the OPAL consultants' close working with the integrated discharge team to facilitate supported discharge and recovery at home.

Gloucestershire Hospitals NHS Foundation Trust serves a population of 612,000, runs two district general hospitals and employs more than 7,400 staff. Its doctors and nurses also treat patients at clinics, other smaller hospitals and through outreach services in the community.

Aims

The service aims to reduce the number of people over 80 years old who are inappropriately admitted to hospital. The immediate assessment aims to meet patients' needs while avoiding hospital admission – for example, by co-ordinating a package of community support. For patients who are admitted, care planning and treatment start immediately.

Origins

The trust has a range of initiatives to support patients being treated in the most appropriate location. It developed OPAL after recognising that older patients deteriorate once in hospital, which can lead to a longer stay and a risk to their health. Most patients prefer to stay independent and in their own homes, rather than be admitted to hospital.

Characteristics

- senior geriatricians at the front of the hospital in A&E
- joint working with integrated discharge teams
- originally funded by commissioners on a non-recurrent block contract basis; now recurrent

Structure

Acute-based The service has operated from the Gloucestershire Royal Hospital (GRH) site (since October 2013) and from Cheltenham General Hospital (CGH) since October 2014.

Multidisciplinary team The service is consultant-led, with several consultants (including geriatricians) contributing to the rota at each site. GRH currently has one full-time specialist nurse, and there is a part-time GP at CGH. The teams work alongside the integrated discharge team, which includes therapists and nurses but no social worker.

Monday to Friday service OPAL currently operates five days a week, 9am to 5pm at both sites; this does not necessarily align with hospital admission patterns.

How patients benefit

Geriatricians carry out thorough assessments at the front of the hospital with the aim of turning patients around without an admission. Early comprehensive geriatric assessment (CGA) means that senior geriatricians can decide diagnoses, avoiding admissions and ensuring that more patients are supported in their own homes or move to 'intermediate' care/community hospitals for rehabilitation. For patients who are admitted, early CGA means they receive specialist care, which should improve the quality of their care and reduce how long they stay.

Enabler: high quality leadership

High quality leadership and service management by committed senior consultants have been crucial. The most successful model for the service was where existing geriatricians moved from the wards into OPAL and locums took their place on the wards, rather than hiring temporary practitioners to staff the OPAL service.

An ambulatory approach to short-stay admissions In some instances, a short-stay admission will be necessary for an intense period of hospital treatment. However, these short-stay facilities do not have beds; they look and feel like an outpatient clinic. The philosophy and focus are about maintaining the patient's independence.

Many patients are seen and discharged either without staying or with just a one-day stay. Patients are transferred to appropriate primary and community care teams to complete their recovery outside hospital.

OPAL, supported by nurses from the trust's integrated discharge team, supports patient discharge and transfers patients to community teams, activating access to reablement, sit-in services or other services that the patient needs to be kept well at home. Some patients are also transferred into community hospitals. The OPAL and integrated discharge team nurses can follow the patients into the community and carry out home visits if necessary.

Enabler: synchronisation of projects within the local care trust

As service models change, there is increasing overlap between the two organisations. It is essential that services are lined up for patients to receive high quality integrated care.

The consultant geriatricians have close working relationships with community teams and they attribute OPAL's success to the close positive working between its practitioners and community teams.

Community teams can phone the consultant geriatrician directly if they are concerned about a patient**.** GRH consultants carry a mobile phone, partly for this reason. CGH does not offer this service currently because of resource constraints but hopes to in future.

Impact

Reduction in older people being admitted to acute wards The trust reports that the number of people over 80 admitted to the hospital in 2014/15 is lower than in previous years, even though admissions in all other age cohorts are rising. This has improved flow through the hospital, helped the trust reach its access targets and ensured beds are available for acutely unwell patients.

Monitoring quality improvement The trust has developed an internal set of metrics based on data collected by the OPAL team, including an analysis of patient cohort by age band and the Rockwood Clinical Frailty Scale.[17] Other monitoring covers length of stay, readmission and mortality rates for the patients seen by the OPAL team compared to all 'frail' patients (locally defined). The trust is also working with the Acute Frailty Network, which provides technical support and a 'measurement for improvement' tool.

Challenges

Recruitment

- Developing OPAL took longer than expected, partly because a lack of available applicants meant it took time to recruit staff.
- Competition for staff also brings issues of negotiating pay rates and reliance on locums or agency workers.

Capacity

- There are pressures on existing staff who are being asked to develop and run a service simultaneously.
- The trust has concerns that the current OPAL staff resource may not be sufficient to meet current and growing demand.

[17] A global clinical measure of fitness and frailty in elderly people ranging from Very Fit to Terminally Ill.

More information

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4. Enabling early discharge

Early Supported Discharge Service: Countess of Chester Hospital NHS Foundation Trust

The Early Supported Discharge (ESD) Service enables acute hospital patients to be discharged in a timely way by making sure care packages are in place to support their rehabilitation at home. An important feature of the service is the strong partnership with the local community trust.

The Countess of Chester Hospital NHS Foundation Trust is a large district general hospital in Chester with over 600 beds, providing services at an acute hospital site and at an intermediate care site.

Aims

ESD aims to allow patients to be discharged from hospital earlier and receive the rehabilitation they need in their own homes. By increasing the patient's functional independence at home, ESD also aims to help them avoid readmission. It is one of several schemes designed to support the trust's A&E performance.

Characteristics

- 7-day service
- nurse and therapy led
- patients stay up to 14 days on the ESD pathway and are referred to social care if applicable at day 3
- serves up to 90 patients a day
- supports 14 new discharges a day

Origins

The foundation trust and the local community trust set up ESD at the Countess of Chester acute site in November 2012 as a joint service for adult patients. Many patients aged over 65 were occupying Countess of Chester beds despite being able to receive care and support outside hospital.

Structure

Multidisciplinary team The team comprises nurses and therapists, including occupational therapists and physiotherapists, as well as a social care assessor. Increasing numbers of community support workers can provide care, rehabilitation and support in the patient's home while awaiting social care packages. Staff are employed by an integrated community and acute therapy service.

Acute-based Multidisciplinary meetings take place daily at the acute hospital to discuss patients on the ESD pathway and plan their care.

How patients benefit

The service takes patients who are medically stable but need further therapy. Patients are referred from A&E and intermediate care, and identified from medical wards. A typical patient has been hospitalised following a fall.

Enabler: single therapy lead across the locality

ESD relies on downstream services being available to which patients can transfer from the ESD pathway. The trust reports that joint working with the local community trust has enabled patient flow through the service. One person is responsible for therapy services across the local community and acute providers, which has particularly helped develop successful working relationships.

MDT meetings take place daily at the hospital where staff discuss patients on the virtual ward. The hospital-at-home team provides additional medical support to ESD.

Short-term input ESD can care for 90 patients in the community each day, offering therapy, bridging social care support and providing short-term medical care at home. Patients stay with the service 10 days on average, receiving a maximum of three visits a day before transferring into community care (eg ongoing community services, integrated care teams run by the local partnership trust, or primary care). Social care assessment is made on day 3 for patients who the team predict will need ongoing care.

The trust has responded to increasing demand on the service. Since it was set up, the service has supported 4,000 hospital spells and 3,000 unique patients. The trust has invested in additional staff for the service. ESD's length of stay has shortened due to the development of pathways with social care, which enable increased throughput.

Impact

The trust says ESD helps it cope with the pressures of increased demand. Specifically, it helps shorten length of stay, freeing beds for patients with acute health needs and relieving pressure on A&E.

ESD could save money as the trust, in partnership with the community trust, is now looking after three times as many patients in the community as it was in the acute hospital, for the same cost. The trust achieved this by reinvesting in community teams the savings made from bed closures.

More information

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Discharge to Assess: South Warwickshire NHS Foundation Trust

The Discharge to Assess (D2A) service enables patients to be discharged earlier from acute inpatient wards by co-ordinating care in alternative settings. Important features include the trusted assessment between health and social care, in-house reablement and rehabilitation, and care co-ordinators to support patients and their families throughout the discharge process.

South Warwickshire NHS Foundation Trust became an integrated trust in 2011. It provides community services across the whole of Warwickshire and acute services to south Warwickshire at Warwick Hospital.

Aims

Patients on a D2A pathway are discharged from hospital into nursing or residential homes, community hospitals or their own homes with care and rehabilitation support for up to six weeks. The service derives its name from its focus on assessing patients for ongoing care needs outside the acute hospital rather than patients waiting in acute beds to be assessed. The local health economy's shared vision for the service is that no decision about long-term care needs will be made in an acute setting.

The service aims to:

- support timely discharge from hospital
- maintain patients' independence where possible
- reduce requirements for long-term care packages
- have a net neutral impact on social care spend.

Characteristics

- assessment for care and therapy needs at home, not in hospital
- three pathways for three distinct cohorts of patients – but no patient is excluded
- multidisciplinary team assessing and providing patient care
- patients referred on within four to six weeks
- discharge care co-ordinators facilitating patient journey

D2A aims to minimise hospital stay and maximise independence by taking longer than usual to assess patients for ongoing care needs outside the acute hospital and providing care at home wherever possible.

Origins

Pressures to improve patient flow across the hospital included accident and emergency underperformance, high levels of delayed transfers of care, suboptimal health outcomes and bed crises.

South Warwickshire Foundation Trust's plan for system transformation began in 2012/13 and comprised initiatives on ambulatory emergency care, a community integrated health and social care team, frailty services, trusted assessment and early supported discharge. Implementing the D2A model has been a significant part of the system transformation.

The trust worked with the local authority, including NHS continuing healthcare (CHC) and the local clinical commissioning groups (CCGs) to set up the service.

Structure

Care seven days a week The multidisciplinary team can provide 7/7 care in the patient's own home and 24-hour care in residential settings for patient rehabilitation. This allows the patient to leave hospital and complete their recovery at home or in the community when they no longer require acute hospital care.

Assessments for continuing care needs take place at home or in residential care. Assessing the patient at the right time for them and in the right environment reduces delayed transfers of care, allows more time to assess them for ongoing care and reduces overall spending on continuing healthcare.

Multidisciplinary team The care co-ordination team comprises mostly nurses but includes occupational therapists (OTs) and social workers. The rehabilitation and reablement teams include GPs, nurses, OTs, physiotherapists, social workers and support workers.

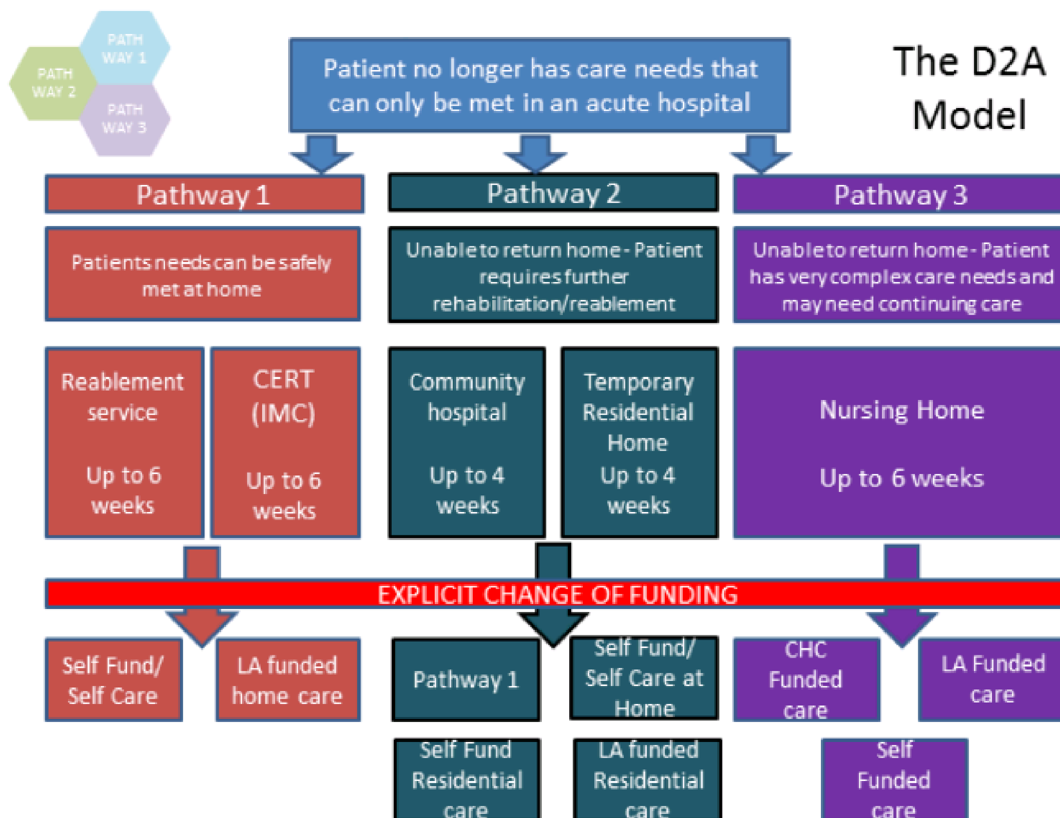
Enabler: care co-ordinators

D2A runs on the explicit assumption that the pathways are only for six weeks; after that, the way the patient's care is funded must change. Care co-ordinators are crucial to achieving this. They follow the patient through the pathway and complete ongoing care assessments at the end of the pathway. These practitioners ensure continuous and appropriate care for patients. By December 2014, only one patient out of 300 who had been through the service had been significantly delayed.

How patients benefit

Three pathways enable patients to be discharged from hospital in a timely way and support patients to rehabilitate fully in their own home or the community.

The average age of the service's patients is 80 years old.



Pathway 1 is for patients on a hospital ward who can return home with additional support from the Community Emergency and Response Team (CERT) or reablement service. They receive ongoing support at home through CERT and Warwickshire Reablement Service, and stay on the pathway up to six weeks.

The ward multidisciplinary team completes a single assessment for ongoing care needs in the patient's home, which is shared between social care and community health teams (trusted assessment). CERT or the reablement service provides care and therapy at home to support patients' recovery to independence. The intensity of the service depends on patients' needs: they can be seen up to four times a day.

The trust discharges about 40 patients a week through this pathway.

Pathway 2 is for patients who cannot be discharged home directly but could return there with additional rehabilitation. Patients are discharged to temporary residential care or community hospital settings for up to four weeks. About 23 patients a week are discharged through this pathway.

Pathway 3 is for patients likely to need ongoing care in a residential setting, who may be eligible for continuing healthcare funding. The hospital-based multidisciplinary team has assessed these patients as having very complex care needs and likely to require continuing care in a residential home for the rest of their lives. Around 40% of these patients have dementia. This pathway takes patients into a residential home, where the assessment for their ongoing care need is completed. About five patients a week follow this pathway.

The trust has access to 30 temporary community nursing home beds. Patients on Pathway 3 are discharged from Warwick Hospital to one of these for up to six weeks. The beds are funded by the CCG, commissioned by the local authority and case-managed by the trust. The local authority commissioned beds from providers it deemed capable of high quality care under the intensity of developing such a complex pathway.

D2A pathways have built-in links with primary care. Two GP practices have been commissioned to provide clinical input to these 30 nursing home beds. GP cover for nursing homes is deemed critical to high quality care and to enabling the patient to move along the D2A pathway within six weeks.

The average length of stay on the pathways is four to six weeks. Following discharge from the pathway, patients move under their GP's care or to self-funded care, local authority funded care or funded CHC.

Enabler: trusted assessment between health and social care

- trusted assessment enables direct referral to reablement without the hospital social work team's involvement
- assessments are sent electronically to the service to which the patient has been triaged, facilitating timely discharge
- trusted assessments are helped by eCAT (an in-house technology solution for trusted assessment referrals)
- the trust reports this has enabled improved flow through the hospital

Enabler: working with Warwickshire Reablement Service

Joint working with the local authority has been essential to developing D2A. Close collaboration allows for a rapid and smooth transition between different services, avoiding delays as patients await social care packages or a nursing home place.

The transformation of the local authority's traditional domiciliary care service into a reablement service was crucial to developing Pathway 1. Over 200 staff were retrained to change their way of working – from doing things *for* the patient to doing things *with* the patient, for six weeks. The aim was to reduce the cost of expensive long-term care packages and help patients live independently in their own homes.

Before this, a typical patient's domiciliary care package was about 14 hours a week. Now, support initially intensifies during the six weeks of the reablement package, although by the end patients on average need only 10 hours of care a week. Those who need ongoing home care support average five hours a week, with 51% of patients needing no home care one year after reablement. Savings are shared among the trust, CCG and local authority commissioner.

Impact

The service offers patients the choice of returning home and D2A has not led to an increase in readmissions despite earlier discharge home.

The trust reports that streamlined internal processes have produced more effective services and enabled it to improve A&E performance against rising activity. Increasing the number of D2A beds ensures that acute medical beds are more often used only by patients who need acute clinical care.

From 2011 to 2014, the trust believes that D2A and other work areas resulted in:

- improved A&E performance
- shorter length of stay for emergency inpatient adults
- shorter length of stay for people over 75 from:
    - fewer emergency readmissions
    - fewer patients affected by three ward moves.

The scheme may save money for the local health economy. For instance, the trust reports that 2014/15 data show the proportion of patients on Pathway 3 receiving CHC funds has fallen from 40% of eligible patients to 20% in a year (when

compared to patients who refused the pathway). The trust's service statistics show that the proportion needing CHC funding after a D2A programme is half that of the group who do not use D2A.

Challenges

Waiting times for community nursing home beds can be two to three days. This results in:

- excess hospital stays for some patients who cannot be discharged to a community bed on the day they are clinically able to be so
- some patients still having decisions about their long-term care needs made in hospital.

D2A has a 27% refusal rate by patients. The trust believes this may be due to the geographical location of the Pathway 3 nursing homes; the families of some patients with dementia may not want them to move.

More information

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These case studies are part of a suite designed to increase awareness of the impact of moving healthcare out of hospital. For more materials see Moving healthcare closer to home