

Moving healthcare closer to home case studies: Admission avoidance

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

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

¹ www.telecare.org.uk/webfm_send/950

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 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.

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.

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.

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.

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.

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.

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.

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

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.

How patients benefit

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

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

Enabler: stakeholder engagement

Open communication channels with GPs

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

Engagement with acute care colleagues

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

Referral sources

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

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

Patients are supported to remain at home.

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

Patients can be referred from acute wards,

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

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

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

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

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

It values clear discharge planning and onward referral. Patients stay in the care of the rapid response MDT for up to 10 days. The team then transfers patients to alternative and continuing care as appropriate: eg district nursing or community

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.

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.

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.

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

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.

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

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.

Conditions treated

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

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

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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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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Kent Community Health NHS Foundation Trust

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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.

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

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

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.

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.

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.

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.

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.

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.

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.

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.

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

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 model² 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.

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.

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.

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 relationships³ 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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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](#)

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).