Monitor
Making the health sector work for patients

Moving healthcare closer to home case studies: Admission avoidance and length of stay reduction

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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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[1] and four community hospitals,[2] 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.

[1] Central Middlesex Hospital, Ealing Hospital and Northwick Park and St Mark's Hospital.
[2] 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.

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.

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.

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.[3] 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.

[3] 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.

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.

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.

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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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