Monitor
Making the health sector work for patients

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

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

the team. Unlike the original service, ERRS employs more advanced practitioners capable of enhanced assessment and treatment.

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.

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

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 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.

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).

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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This is one of a suite of case studies designed to increase awareness of the impact of moving healthcare out of hospital. For more materials see Moving healthcare closer to home