

## 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<sup>1</sup> and four community hospitals,<sup>2</sup> providing services in over 30 community sites.

### 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

### 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

<sup>1</sup> Central Middlesex Hospital, Ealing Hospital and Northwick Park and St Mark's Hospital.

<sup>2</sup> Clayponds Rehabilitation Hospital, Denham Unit, Meadow House Hospice and Willesden Community Rehabilitation Hospital.

- general and neurological rehabilitation provided in the community within 72 hours of referral.

### 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.**<sup>3</sup> 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.

<sup>3</sup> Referral criteria here: [www.brentstarrs.com/pdf/Referral\\_Criteria\\_Guidance.pdf](http://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.

**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.

### 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

### 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](#)

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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](#)