

# A&E Avoidance Schemes across London



A rapid review of good practice examples

November 2016

Natalia Proctor, Healthy London Partnership



# Key studies and their impact

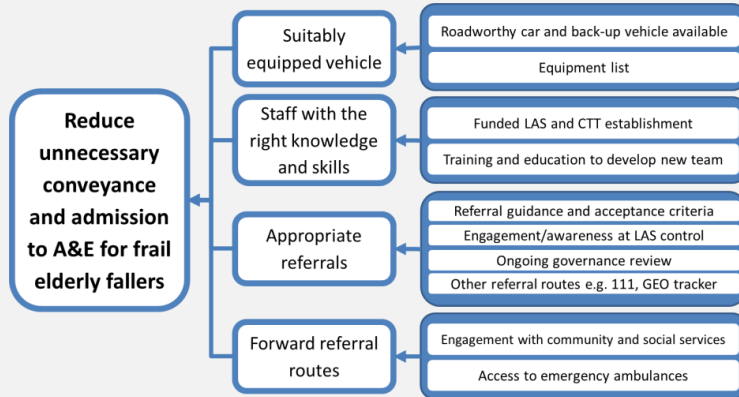
Study	Key Quantified Impact	Area
<p><b>Case Study 1: K466 Falls Specialist Response Car</b> A Falls Specialist Response Car, provided by the LAS and known as call sign K466, staffed with a Community Treatment team (CTT) nurse and a paramedic. LAS Control Centre identify the patient on criteria including the patient being over 65 and the service operates seven days a week between the hours of 07:00 and 19:00.</p>	66.5% of patient seen by the service were treated within their own home	Queen's Hospital – NEL
<p><b>Case Study 2: Solving the A&amp;E crisis using GP led triage and redirection:</b> GPs and nurses based in triage identify patients who could be managed more appropriately in primary care as soon as they enter the Emergency Department, and re-direct them back to primary care services.</p>	56% of patients were re-directed to their usual GPs	Care UK and St Georges Hospital – SWL
<p><b>Case Study 3: Rapid Access Doctor</b> A dedicated GP with a driver in a non LAS vehicle (provided by the existing Out Of Hours provider) commissioned to assess, diagnose, prescribe and treat in the home, without requiring a paramedic response.</p>	75% of all patients seen by the service were treated within their own home	Sutton CCG – SWL
<p><b>Case Study 4: Dedicated Community Nurse working with LAS</b> A LAS rapid dispatch car manned by a LAS Paramedic and a Rapid Response Nurse with advanced clinical skills to offer an alternative service to an ambulance dispatch for adults with particular needs where it was believed an A&amp;E attendance or hospital admission could be avoided.</p>	The addition of the nurse practitioner saw the percentage of non conveyance to A&E increase to 68.9% from 23.6%	LAS, Your Healthcare, Kingston CCG – SWL
<p><b>Case Study 5: Non-clinical navigators can ease pressures in A&amp;E</b> Four non-clinical patient navigators (2FTE) , working within Homerton University Hospital's A&amp;E, to educate patients about sources of healthcare and encourage GP registration.</p>	Average net monetary benefit of over £160,000 per year for each whole time equivalent navigator.	City and Hackney – NEL
<p><b>Case Study 6: Redirection of attendances from Queen's Emergency Department</b> A senior Consultant / GP at the Emergency Department (ED) front door redirecting patients to community and primary care.</p>	37.5% of patient were redirected away from the Emergency Department	Queen's Hospital – NEL
<p><b>Case Study 7a: Guy's &amp; St Thomas' and King's Hospitals Rapid Response</b> Short-term support and rehabilitation such as physiotherapy in the home after an event, a fall or short-term illness.</p>	4% reduction in the number of Southwark & Lambeth patients attending A&E	Guy's & St Thomas' and King's Hospitals – SEL
<p><b>Case Study 7b: Guy's &amp; St Thomas' and King's hospitals @home service</b> Provides acute clinical care at home that would otherwise have to be carried out in hospital.</p>	700-1400 bed days saved monthly	Guy's & St Thomas' and King's Hospitals – SEL
<p><b>Case Study 8: An integrated community team works with the LAS</b> A new care pathway between the LAS and the Integrated Community Response Service (ICRS) in North West London.</p>	A&E referrals to ICRS reduced by 64 % between June-September 2014 following the implementation of the LAS pathway	The Royal Marsden – NWL
<p><b>Case Study 9: Central and North West London NHS Foundation Trust: Rapid Response Service</b> Provides alternative care pathways in the community so that fewer vulnerable patients are admitted to hospital.</p>	Over 80% of referrals avoided admission	Camden's Rapid Response Service –NWL
<p><b>Case Study 10: Community Prevention of Admission Team</b> A multi-disciplinary team consisting of nurses and therapists and clinically led by a nurse consultant providing a service 7 days a week</p>	Less than 10% of patients assessed by the service are admitted to hospital while under the care of the service	The Royal Marsden – NWL

# Case Study 1: K466 Falls Specialist Response Car

## Background and Case for Change:

34% of all London Ambulance Service (LAS) conveyances to Queen's ED in Romford are patients aged 75yrs and over. A significant proportion of these attendances are due to falls, they don't need to be in hospital, and could have been better cared for at home.

This takes ambulances that could be attending elsewhere off the road, clogs up ED, and for the majority of this group of patients, results in an inpatient stay of at least one night.



## The Solution:

Using winter pressures funding, a learning collaborative of community nurses and paramedics was set up to try to reduce unnecessary ED attendances for frail, older people in North East London.

The collaborative sought to use their combined expertise to work together on setting up a service to respond to low acuity fallers, with the intention of assessing and treating on scene, with the aim of keeping the patient at home wherever safe to do so. They utilised the available funding to run a Falls Specialist Response Car, provided by the LAS and known as call sign K466, staffed with a Community Treatment team (CTT) nurse and a paramedic. LAS Control Centre identify the patient on criteria including the patient being over 65 and the service operates seven days a week between the hours of 07:00 and 19:00.

The scheme aims to keep 20 patients at home, per week to reduce attendance, admissions and ambulance conveyances to an ED.

## Impact

- From April 2015 to July 2016 the team visited 1,821 patients and managed to keep 1,211 at home (66.5%) avoiding the need for an emergency ambulance, A&E attendance and admission (where that would have been appropriate).
- Essex are looking to replicate the model and the team have presented their work to the executives and Trust.

***The Team won the international poster competition at the National Patient Safety Congress awards on 7<sup>th</sup> July – against over 200 other entries. They have also been shortlisted for an HSJ award.***

Performance:		2015/2016															
Month:	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Total
Calls attended	98	112	105	121	104	114	145	111	107	133	110	99	99	131	100	132	1,821
Pts kept at home (Plan):	80	100	80	100	80	80	100	80	80	100	80	100	80	100	80	100	1,420
Pts kept at home (actual):	57	72	79	97	76	81	106	76	79	95	77	- *	53	99	75	89	1,211

\*Note: information missing on actual patients kept at home for March – therefore the total is approximate and most likely lower than the actual figure.

Reference: <https://www.myhealth.london.nhs.uk/sites/default/files/20.%20K466-%20Falls%20Specialist%20Response%20Car.pdf>

# Case Study 2: Solving the A&E crisis using GP led triage and redirection

## Background and Case for Change:

It is well-documented that a large proportion of patients attending Emergency Departments could be managed safely in primary care—indeed many of these patients may receive better care from primary care services.

Care UK and St Georges Hospital devised an innovative new system where GPs and nurses based in triage identify patients who could be managed more appropriately in primary care as soon as they enter the Emergency Department, and re-direct them back to primary care services.

## The Solution:

Together with GPs and nurses, the redirection team includes an administrator who ensures that the patient has an appointment booked for the appropriate primary care service on that day.

The project was done as a prospective study of 150 patients over 5 weeks using a structured questionnaire.

- Of the 150 responses, 129 were from direct interviews and data from 21 patients had to be collected from their patient notes.
- The service operates between 9am and 5pm on weekdays.
- The total number of patients we navigated at that time was 277.

## Quantified Impact :

**56%** of patients were re-directed to their usual GPs, 32% to OOH services and 10% to walk-in-centres

## Key findings and Impact:

- 83% of patients were satisfied with their outcome and rated the redirection service as 'good' or 'excellent'.
- The most common reasons for patients attending A&E were as follows:
  - 1) They felt that their condition was serious and needed A&E treatment (19%)
  - 2) They could not get a GP appointment (18%)
  - 3) Waiting time for a GP appointment was too long (15%)
  - 4) Convenience (14%)
- The biggest category of presenting complaints was 'musculoskeletal' (22%) followed by 'dermatological' (14%). Within musculoskeletal, back pain was the most common symptom
- 56% of patients were re-directed to their usual GPs, 32% to OOH services and 10% to walk-in-centres.

**Reference:** Care UK and St George's University Hospital, London, [https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjB5JT4g-7OAhUIC8AKHZ0BBQ8QFggeMAA&url=https%3A%2F%2Fwww.myhealth.london.nhs.uk%2Fsystem%2Ffiles%2F30.%2520Solving%2520the%2520A%2520E%2520crisis%2520using%2520GP%2520lead%2520triage%2520and%2520redirection\\_0.pdf&usq=AFQjCNG-eOk\\_Cu8jNv2tS4vpHmq-de\\_wsw&sig2=wFGzHQ7H7y8yv4rJzCdJvA](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjB5JT4g-7OAhUIC8AKHZ0BBQ8QFggeMAA&url=https%3A%2F%2Fwww.myhealth.london.nhs.uk%2Fsystem%2Ffiles%2F30.%2520Solving%2520the%2520A%2520E%2520crisis%2520using%2520GP%2520lead%2520triage%2520and%2520redirection_0.pdf&usq=AFQjCNG-eOk_Cu8jNv2tS4vpHmq-de_wsw&sig2=wFGzHQ7H7y8yv4rJzCdJvA)

# Case Study 3: Rapid Access Doctor

## Background:

The System Resilience Group led by Sutton CCG was tasked, as part of winter resilience, to identify schemes that addressed the following themes:

- **Growing pressure on acute health services** against a background of falling resources and limited funding.
- An **increasing frail and elderly population with complex care needs** for whom hospitalisation is not necessarily appropriate and would benefit from an **experienced clinical assessment** at home.
- A requirement to be as effective or improve on current models, particularly with regard to being **patient focused**, timely and with **good clinical outcomes**.

## Case for Change :

The proposed scheme aimed to:

- **Improve care for patients** by:
  - Reducing unnecessary ambulance conveyances,
  - Reducing A&E attendances
  - Reducing unplanned admissions.
- **Improve quality and access** to the right service at the right time, improving patient health and wellbeing.
- **Increase capacity** for the London Ambulance Service to attend higher priority calls.
- **Make best use of resources** and generating savings to help address the financial gap.

## The Solution:



The existing Out of Hours provider was commissioned to provide a dedicated GP with a driver in a non London Ambulance Service vehicle (provided by the existing Out Of Hours provider). They responded to clinically appropriate Green (C3-C4) category triaged calls from 999 and were dispatched from the London Ambulance Service clinical decision making hub. Provided support to locally based Ambulance Crews.



The scheme operated between the hours of 15:00 and 0:00 Friday, Saturday, Sunday and bank holidays from December 2014 to the end of February 2015.



The scheme was commissioned to **assess, diagnose, prescribe and treat in the home**, without requiring a paramedic response, conveyance to hospital or subsequent admission. It also aimed to **improve patient access** to existing appropriate support services commissioned within the community.



## Impact:

The results from the winter scheme using the RCGP accredited audit tool demonstrated that:

- **75% of all patients were treated within their own home** leading to:
  - ✓ Increase in capacity within the London Ambulance service to respond to higher acuity calls.
  - ✓ **Reduction in non elective attendances** at the local acute trust.
  - ✓ **Reduction in admissions** at the acute trust
- A number of cases were identified from the audit where clearly the individual patient benefited from having care in their home, this is particularly so for vulnerable patients who could deteriorate with transfer.

## Lessons Learnt:

The scheme needed to ensure better access to appropriate support services reducing the risk of crisis in the future by:

- Linking to community services that can build a suitable package of care,
- Use of the mobile directory of services commissioned by NHS London
- Ensuring a more comprehensive induction for staff. Activity could have been higher, facilitated by:
- Increasing awareness within the Ambulance Service control Centre
- Running the service seven days a week and across SW London
- Agreeing a KPI for activity with LAS.

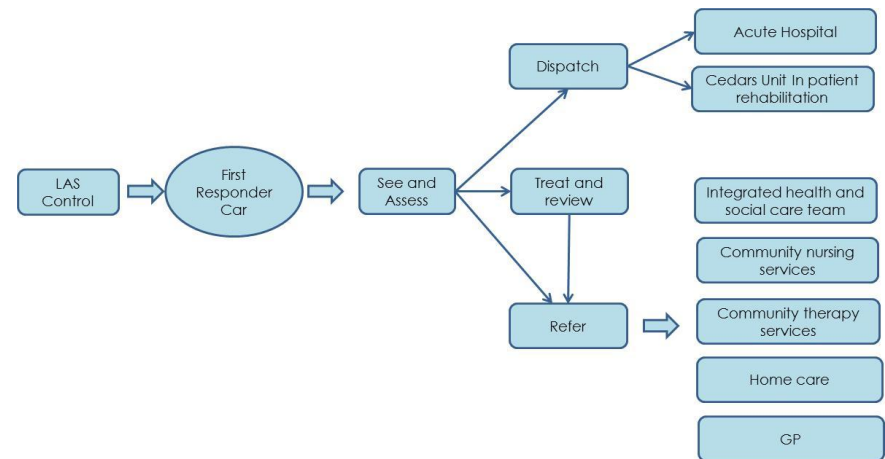
# Case Study 4: Dedicated Community Nurse working with LAS

## Background and Case for Change:

In autumn 2014 London Ambulance Service (LAS) and Your Healthcare (YH) Community Interest Company (CIC) worked in partnership with the Kingston Clinical Commissioning Group to develop a pilot service.

The service worked with a LAS rapid dispatch car manned by a LAS Paramedic and a Rapid Response Nurse with advanced clinical skills.

The pilot was created to offer an alternative service to an ambulance dispatch for adults with particular needs where it was believed an A&E attendance or hospital admission could be avoided.



## The Solution:

By working together the Nurse Practitioner and Paramedic were able to treat a person with complex needs at home and arrange medication and emergency equipment. As the Your Healthcare are an integrated health and social care service they were able to access additional community care services without delay to provide additional support at home, preventing an ambulance conveyance and A&E attendance.

This ensures that the service is able to not only see and treat people in their own homes but can refer into YH integrated adult community health and social care service which includes community nursing, physiotherapy, occupational therapy, rehabilitation, the falls service and home care support.

## Impact:

- The project duration was 7 months and in that time the team treated 557 category C patients and 384 remained at home.
- Historically the percentage of non conveyance with LAS alone is 23.6% with the addition of the nurse practitioner this percentage increased to 68.9%.

The long term impact is improvement and enhancement of future working with LAS. As an on-going improvement the LAS ambulance crews are referring to the Rapid Response if a patient needs on going assessment, treatment and review to prevent taking them to hospital. The rapid response team are also seeing primary care patients in A&E daily to allow senior A&E clinicians to see more serious cases promptly.

The Rapid response team take referrals from local GPs to assess patients at home within a 2 hour response time, seeing elderly patients with undifferentiated diagnoses and multiple co-morbidities and using clinical decision making, deciding to treat that patient at home or if a hospital admission is required.

# Case Study 5: Non-clinical navigators can ease pressures in A&E – City and Hackney CCG

## Background and Case for Change:

City and Hackney CCG has higher rates of A&E attendances than the average across all London CCGs, with about 10,000 patients going to an A&E department every month. 70% attend A&E at Homerton Hospital. The hospital has a primary urgent care centre within the department, to which 30-40% of primary care cases are diverted after seeing the assessment nurse. A significant number are not registered, however, and there are no walk-in centres elsewhere in City and Hackney.

## *Quantified Impact :*

**Average net monetary benefit of over £160,000 per year for each whole time equivalent navigator.**

## The Solution:

In February 2013, the CCG funded four non-clinical patient navigators (2FTE) , working within Homerton University Hospital's A&E, to educate patients about sources of healthcare and encourage GP registration, Their role was to approach patients in A&E waiting areas to:

- educate and inform patients who had been triaged by the assessment nurse as only needing non-urgent appointments/referrals about local services available;
- show unregistered patients how to register with a GP, including informing patients which practices in their area are taking new patients and liaising with GP practices about the enrolment process needed; and
- work with frequent attenders to help identify recurrent problems and signpost them to other services.

## Impact:

- 6% of patients left A&E to access alternative sources of healthcare after interacting with a navigator
- There was a 30% increase in people leaving the primary and urgent care centre without being seen.
- The number of City and Hackney CCG patients attending A&E did not increase significantly between 2012-13 and 2013-14, compared with rising attendances elsewhere in the country - this could be linked with the introduction and impact of navigators.
- 40% of people seen by a navigator registered with a GP - a much higher success rate than other known interventions
- Many interactions resulted in the correction of A&E electronic patient record details, including adding GP details - this led to a 20% reduction in the number of patients attending A&E who were then discharged with missing GP details.
- Navigators have become a valuable source of information about local clinics and services for which clinicians did not know specific details - A&E staff also felt they helped manage patient expectations about waiting times in A&E.
- City and Hackney has extended funding to increase the number of navigators to cover five whole time equivalent posts.
- Information collected by navigators showed there is an ongoing need for education about different sources of healthcare.

# Case Study 6: Redirection of attendances from Queen's Emergency Department

## Background:

During the Junior Doctor strike in April 2016, patients were re-directed to community and primary care by a senior Consultant / GP at the Emergency Department (ED) front door. This was to control the number of patients who required assessment by a reduced team. A decision was made to trial this on a normal working day to ascertain how many patients could be treated elsewhere in order to reduce the significant pressure on ED. A twelve hour trial period was run on 16 May 2016 (8am to 8pm). The trial included adult walk-ins from 8am to 8pm. Paediatric ED and ambulance attendances were excluded.

## Impact

The trial resulted in:

- 208 adult walk-ins from 8am-8pm
- 78 patients redirected from ED 8am-8pm
- 37.5% of patients were redirected in total
- 30% of the patient walk-ins were redirected to primary care

Three (5%) of the patients who were redirected to primary care environments have re-attended since. All three reported that they had not pursued the recommended option as they felt emergency care was more convenient. All three were discharged with advice or prescription only, following ED assessments that were in excess of four hours.

No patient that was redirected away from Queen's subsequently attended at King George Hospital.

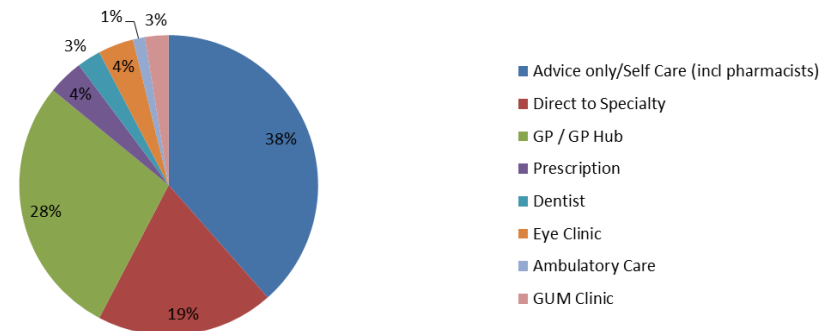
## Next steps:

1. Conduct a longer trial of the system to ascertain the impact of sustained redirect on both the acute and primary care sector.
2. Consider expediting some aspects of the UCC redevelopment plan to support the ED front door
3. Consider carrying out a similar trial for patients attending Paediatric ED.

## Destination:

5 patients went straight to Gynaecology as per the normal emergency pathway (albeit that they were identified more quickly than usual).

10 patients who would usually have had ED work-up then referral to speciality were sent directly to speciality. This was mainly ENT and General Surgery. By having a senior clinician review these patients quickly they were able to refer patients directly without the need for a lengthy diagnostic process. The destination of the patients is shown in the chart below:





# Case Study 7a: Guy's & St Thomas' and King's Hospitals Rapid Response

## Background and Case for Change:

The overall aim is to reduce unplanned admissions where possible, manage length of stay and ensure that discharge arrangements are as effective as possible to avoid unnecessary re-admissions.

There was a need to support vulnerable elderly people living alone who have become less mobile, sometimes because of a fall, to avoid admissions or long stays in hospital .

This service is also part of Lambeth and Southwark Integrated Care (SLIC) programme began in 2012, linking up services at scale across the local NHS and local authority social care and working together to deliver preventative, coordinated and community-based services.

## Impact:

As part of the overall impact of SLIC (2016):

- 4% reduction in the number of Southwark & Lambeth patients attending A&E
- Reduction in residential and nursing home placements
- Admissions for over 65s have remained stable unlike other boroughs where numbers have risen

## The Solution:

Provides short-term support and rehabilitation such as physiotherapy in the home. This may have been after an event, a fall or short-term illness, making it more difficult to cope at home.

The service can quickly visit and provide care and support to help patients remain at home and prevent hospital admission.

The teams consist of nurses, physiotherapists, occupational therapists, rehabilitation support workers, social workers and a geriatrician (consultant specialising in the care of elderly people).

## Acceptance Criteria:

- Patient would otherwise have to be admitted
- Must be 18 years of age or over and live in Lambeth or Southwark and be registered with a GP
- Patient must be able to transfer with maximum of assistance of one person or less (assistance of two people will be considered on a case-by-case basis)
- patient must currently be at home in the community (including care home residents) or have been in hospital for no longer than 48 hours
- patient must be home by 7pm for same day review.

## Exclusion Criteria:

- Primary reason for referral is a mental health or drug/alcohol problem.
- Referrals that can be effectively managed by standard social or health care services within the timeframe required.

## References:

<http://www.guysandstthomas.nhs.uk/our-services/community-rapid-response/overview.aspx>

<http://guysstthomashospital.newsweaver.co.uk/icfiles/1/14211/150535/5272827/pdf/News%20for%20GPs%20and%20primary%20care%20colleagues%20-%20April%202015%20-%20Print%20All%20Page.pdf>

[http://slicare.org/system/documents/files/000/000/068/original/SLIC\\_newsletter\\_FINAL\\_March\\_16.pdf?1459345392](http://slicare.org/system/documents/files/000/000/068/original/SLIC_newsletter_FINAL_March_16.pdf?1459345392)

# Case Study 7b: Guy's & St Thomas' and King's hospitals @home service

## Background and Case for Change:

This service was set up to reduce pressure on acute services, initially focussing on discharge processes, reducing delays, avoiding readmissions and improving patient experience and outcomes. It now also aims to reduce hospital admissions.

This service is also part of Lambeth and Southwark Integrated Care (SLIC) programme begun in 2012, linking up services across the local NHS and social care and working together to deliver preventative, coordinated and community-based services

The integration of @home with other supporting services was crucial to success as was developing a service that gave confidence to GPs, consultants and other partners, as well as staff, patients and carers for discharge and admission avoidance decisions.

## Impact:

- Currently achieving average of 285 accepted referrals monthly
- equating to around 700-1400 bed days saved monthly as these patients would otherwise be in a hospital bed
- Continues positive feedback form both patients and referrers
- Reduced acute attendance for patients seen on service
- Improved health outcomes and independence for patients due to MDT approach to holistic care (current research on going with Academic input)

## The Solution:

Key characteristics of the service:

- Provides acute clinical care at home that would otherwise have to be carried out in hospital
- Single Point of Access Referrals can be made between 08:00 – 23:00hrs; the service is open 24/7
- 2 hour response for urgent medical assessment
- Patients must reside and be registered with a GP Practice within in Lambeth or Southwark
- Patients can be treated at home for IV Therapy, Blood Monitoring, Anticoagulation Therapy, Cannulation and care, PICC & Hickman lines, Complex Wound Management, Palliative and Respiratory Care, Observation and Vital Sign Monitoring
- About 25 clinical pathways which include COPD, Cellulitis, Gastroenteritis, Dehydration, Infected foot ulcers, Diabetes, Pyelonephritis, Post Surgery, Heart Failure, Viral Illness, UTI
- Shared or total medical responsibility for patient
- Domiciliary visits by consultant or @home GP when required
- Referral pathway with the London Ambulance Service (LAS) so they can assess people in their homes and refer them to @home for treatment, or to refer to a rapid access 'Hot Clinic' rather than taking them to A&E (particularly for falls and CGA).

## References:

- [http://slicare.org/system/documents/files/000/000/068/original/SLIC\\_newsletter\\_FINAL\\_March\\_16.pdf?1459345392](http://slicare.org/system/documents/files/000/000/068/original/SLIC_newsletter_FINAL_March_16.pdf?1459345392) (2016)
- <http://www.guysandstthomas.nhs.uk/resources/patient-information/community/at-home-service.pdf> (2014)
- <http://www.guysandstthomas.nhs.uk/news-and-events/2015-news/march/20150305Hospital-care-at-home-helps-local-patients.aspx> (2015)
- [http://guysstthomashospital.newsweaver.co.uk/files/1/14211/150535/5131226/dc0ed6fccc78b97472e3bb66/\\_home%20poster%20final%20170314.pdf](http://guysstthomashospital.newsweaver.co.uk/files/1/14211/150535/5131226/dc0ed6fccc78b97472e3bb66/_home%20poster%20final%20170314.pdf)
- <http://www.tandfonline.com/doi/full/10.1080/17571472.2016.1211592> (2016)
- Business Case for the implementation of Homeward across Lambeth & Southwark(2013)

# Case Study 8: An integrated community team works with the LAS

## Background and Case for Change:

The UK National Health Service's initiative to move more care to the community to provide quality and cost-effective intervention has been a key focus of its strategy for the last ten years. This has seen the establishment of the integrated community multidisciplinary team (MDT) and the development of emerging roles for allied health professionals. Physiotherapists are now playing active roles as members and leaders of MDTs in emergency, pre-hospital and urgent care settings

## The Solution:

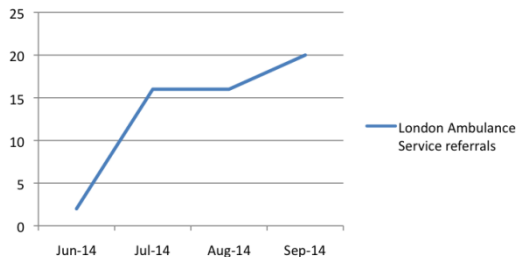
A new care pathway was established in June 2014 between the London Ambulance Service (LAS) and the Integrated Community Response Service (ICRS) in North West London. It was set up with the philosophy that an integrated care team with enhanced clinical skills should be able to successfully manage appropriate (non-life threatening) LAS cases in the community. Enhanced clinical skills may include: non-medical prescribing and advanced imaging training. Clinical members of the ICRS spent observation days with the LAS and discussions between members took place before 'going live'.

Referrals are received via telephone 7 days a week between 7am and 7pm. Once the referral is accepted, the ICRS responds within a 2-hour window and provides clinical intervention and management for approximately 7 days.

## Impact:

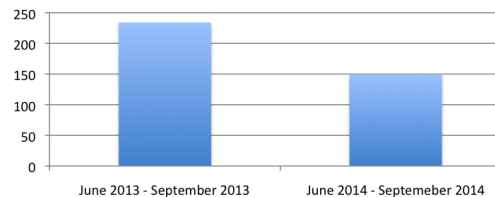
Considering case examples the physiotherapist demonstrated autonomy in assessment, intervention and case management (e.g. advanced assessment, analgesia prescribed and rehabilitation followed). Each LAS referral received and then managed by the ICRS revealed that only patients with acute serious illness were admitted to hospital.

**London Ambulance Service referrals**



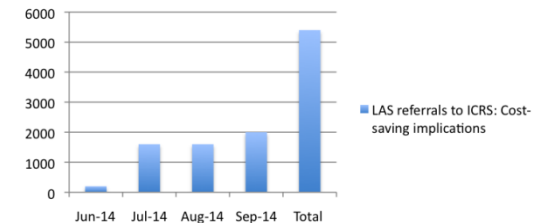
Referrals received from the LAS between June and September 2014.

**Accident and Emergency referrals decreased following implementation of LAS pathway**



Accident and emergency referrals to ICRS reduced by 64 % between June-September 2014 following the implementation of the LAS pathway.

**LAS referrals to ICRS: Cost-saving implications**



Every Accident and Emergency visit costs minimum of £100 (+/-). This graph highlights the cost-saving since implementing the new pathway.

In conclusion, an LAS case can be referred to an integrated community team and managed accordingly. The LAS and the ICRS have successfully demonstrated that they can collaboratively work together in managing acute patients. In addition, there is an emerging role for physiotherapists in emergency and pre-hospital care and in response to an appropriate LAS referral. Further research is required to determine the direct impact of the physiotherapist.

# Case Study 9: Central and North West London NHS Foundation Trust: Rapid Response Service

## Background and Case for Change:

Camden's Rapid Response Service (RRS) provides alternative care pathways in the community so that fewer vulnerable patients are admitted to hospital.

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

From October 2013, the trust used winter resilience money to create a single RRS. Integrating schemes brought benefits of sharing resources and better management of peaks in demand. The service was designed collaboratively with CNWL clinicians and managers working with staff at local acute trusts and the ambulance service, as well as nursing and residential homes, the voluntary sector and patients.

## The Solution:

The service offers short-term intensive support including nursing and therapeutic assessments and social care for up to 10 days, after patients are referred on to other appropriate services.

The service is for adults over the age of 18 who live in Camden, are registered with a Camden general practitioner (GP) and who require immediate intervention to prevent a possible hospital admission. Admission criteria is broad; the service is unsuitable for people who are medically unstable or where mental health is the main problem.

There is a single point of access. The service accepts referrals from:

- GPs and other health and social care staff including sheltered housing managers
- London Ambulance Service
- Acute services, if the patient has deteriorated once discharged home
- Carers and families (self-referrals)

The service is available 24 hours a day, seven days a week. Most patients are frail older adults. This particularly benefits frail elderly people, for whom hospital admission is associated with a risk of deterioration.

## Impact:

In September 2015 there were 80 hospital admissions a month with over 80% of referrals avoiding admission. A local acute trust's data for the last 6 months of 2013 and 2014 showed a 10.4% reduction in total inpatient spells for Camden patients. For residents from selected nursing and residential care homes, inpatient spells reduced by 35.1%. While this cannot be directly attributed to the enhanced RRS, the trust believes it has been pivotal in reducing avoidable admissions.

## References

<http://www.cnwl.nhs.uk/service/camden-rapid-response-admission-avoidance-service/>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/459230/Case\\_study\\_collection\\_-\\_Admission\\_avoidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459230/Case_study_collection_-_Admission_avoidance.pdf)

# Case Study 10: Community Prevention of Admission Team

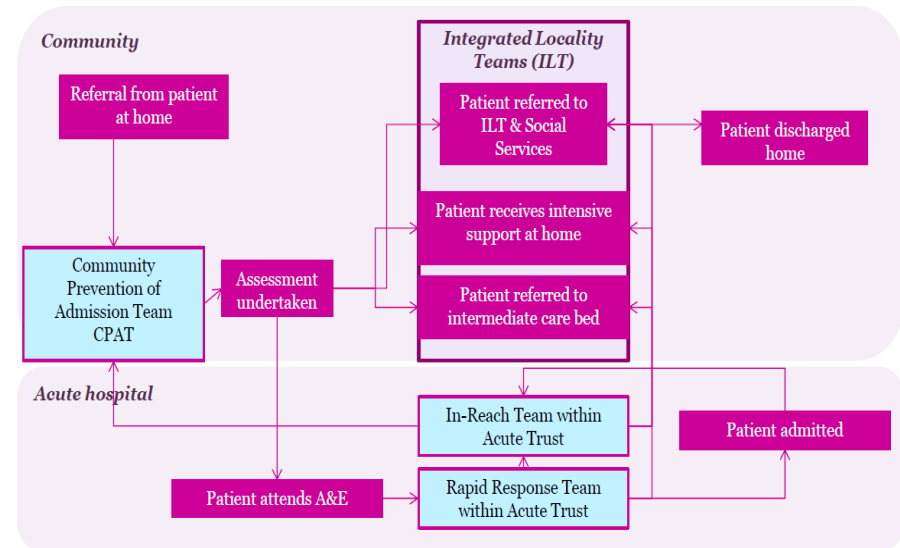
## Background and Case for Change:

With increasing pressure on local A&E and acute services as well as across the whole local health economy, the existing community and primary care services had limited capacity to enable the provision of a responsive service to support unplanned care over a 7 day period. The gap identified that in order to prevent avoidable A&E attendances and subsequent acute hospital admissions, patients require high quality rapid holistic assessment and clinical intervention in the community; where their presenting condition could be managed within an enhanced health care package alongside existing services. The aim of the service is to reduce the number of avoidable attendances to A&E and admissions to hospital and thereby provide more effective care pathways closer to home in the community.

## The Solution:

A multi-disciplinary team consisting of nurses and therapists and clinically led by a nurse consultant providing a service 7 days a week. The service aims to respond within 2 hours and provide intensive intervention for up to 5 days as an average, in order to prevent a hospital admission or to support a patient discharged from A&E to stay at home. The service also provides Intermediate Care to patients requiring a period of up to 6 weeks rehabilitation following an acute event leading to reduced independence for the patient. The service works through an integrated approach with the Integrated Locality Teams and services within our Model for Planned Care to provide a seamless transfer of care as required.

- **Inclusion criteria:** New unmet health need or acute worsening of known health need, Imminent risk of an avoidable hospital admission
- **Exclusion criteria:** Sepsis/stroke or other emergency requiring admission, Age < 18, Primary mental health presentation



## Impact:

- Enhanced support to patients in the community with an exacerbation of their long term conditions, sudden event leading to reduced mobility, urinary tract infections and post falls.
- Less than 10% of patients assessed by the service are admitted to hospital while under the care of the service
- Provide crucial support to nursing home residents to prevent hospital admissions and to support post discharge from A&E.