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Working better together – A report which explores local authority approaches to avoid admissions to hospital

Produced July 2018 and commissioned by the Delayed Transfers of Care Network

Contents

1. Introduction and what we set out to achieve

The Delayed Transfers of Care Network commissioned a small piece of research in June 2018 to report on examples of best practice and resources across the region and outside of the region in relation to preventing hospital admissions. The network is keen to explore what others are doing well and to avoid duplication.

The examples provided not only look at admission avoidance to a ward once a patient reaches the Emergency Department but preventative approaches in the community which reduce, delay and prevent the need for more long term complex care and support which is a key objective within the Care Act 2014. Local Authorities were asked to provide case study examples (see Annex A for the proforma used to gather information via email or via telephone call direct to the lead) of such approaches and their view on what is working well, what could be improved and what support would help further. During May to July, we received examples from eight out of the eleven local authorities across the East which we have included in the report.

2. Disclaimer/Caveat

It should be noted that this report does not claim or aim to be complete and does not include a full picture of practice across the region. The level of detail reported is dependent on the information provided by the Delayed Transfers of Care Leads.

The report aims to be clear, concise, accurate and as up to date as possible; where written materials have been made available these have been used to best reflect the local area's own description of their work. The report has been agreed by the chair of the DTOC network chair for dissemination. However, any omissions or misunderstandings which may remain relating to any services or issues described are the responsibility of the author, and do not necessarily represent the views of the respective Local Authorities or their partners. If you are interested in the individual case study examples, please follow up with the contacts provided.

3. Signpost to national research and tools

This section of the report, signposts to national reports and research documents which are helpful to understand when assessing practice and flow. *Please click on the underlined report title to access the link.*

National Audit Report March 2018 – reducing emergency admissions

The latest of the research from the National Audit Report on reducing emergency admissions dated March 2018, sets out some important facts when researching and addressing admission avoidance, as follows:

- The cost of emergency admission reached £13.7bn in 2015/16
- There were 5.8m emergency admissions in 2016/17, they continue to increase gradually year on year
- We saw an increase in emergency admissions between 2015/16 and 2016/17 of 2.1%
- 79% of the increase in emergency admissions between 2013/14 to 2016/17 was caused by people who did not stay overnight
- 65% of hospital emergency bed days occupied by patients aged 65 and over in 2016/17
- 53% of the growth in emergency admissions came from people aged 65 and over between 2013/14 and 2016/17
- There was a 27% increase in people admitted and not staying overnight from 2013/14 to 2016/17
- 32% of local areas reported they had reduced emergency admissions by the target they set in their Better Care Fund plans for 2016/17

ADASS response to the NAO report

ADASS recognises the importance of reducing emergency admissions but this requires working together and having targeted resources to focus on keeping people at home as long as possible. ADASS Response to NAO report

Better Care Fund – joining up health and social care

The **Better Care Fund** (BCF) supports integration. It is a programme spanning both the NHS and local government which seeks to join-up **health** and **care** services, so that people can manage their own **health** and wellbeing, and live independently in their communities for as long as possible. Each local system has a two year plan and the Link to BCF website provides information about best practice.

Vanguards and Five Year Forward View – Supporting improvement and integration of services

In January 2015, the NHS invited individual organisations and partnerships to apply to become Vanguard Models for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View (published October 2014) and supporting improvement and integration of services.

High Impact Change Model (HICM) – managing flow

The High Impact Change Model and national work on delayed transfers of care recognises that it's not always safe and appropriate for a person to go to hospital or to be in hospital longer than required and promotes discharging to a safe and more appropriate setting as soon as possible. The high impact change model offers a practical approach to manage transfers of care and patient flow. It can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year. The biggest challenges for Adult Social Care in the East are in relation to implementing the patient choice policies consistently, understanding the impact of discharge to assess and trusted assessors and finally implementing 7 day working across services. Assessing against the HICM is a requirement of the Better Care Fund.

Safer Flow Bundle – smooth journey for patients

The NHSI has also published the Safer Flow Bundle to support a smooth journey for patients. This tool improves the effectiveness of ward rounds and is focused on inpatients.

The safer flow bundle sets out to not only explore early intervention and prevention in Adult Social Care but ways in which to avoid emergency admissions via the Emergency Department.

National Intermediate Care Audit 2017 – transitional services to prevent hospital admission

The National Intermediate Care Audit focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system. The audit shines a light on intermediate care and provides a stocktake of current service provision

CQC Area Review and CQC beyond Barriers Report – moving through the health and social care system

The CQC Area Review findings provides key learning from the review of 20 local health and wellbeing systems focusing on the care and support for people aged 65 and older. The CQC beyond Barriers Report June 2018 focuses on how people move through the Health and Social Care system and provides some really useful insight.

Up until now, there have been no CQC Area Reviews in the East but many councils are preparing for CQC Area Reviews in the future and need to be aware of the Key Lines of Enquiry used to support such a review. Qualitative feedback from patients following discharge is seen as a national area for development for example.

CQC State of Health Care and Adult Social Care in England 2016/17 report – looking at the future of care and the current complexities

The latest State of Care shows that the quality of health and social care has been maintained despite very real challenges. The majority of people are getting good, safe care, and many individual providers have been able to improve. However, future quality is precarious as the system struggles with increasingly complex demand, access and cost. The efforts of staff have largely ensured that quality of care has been maintained – but staff resilience is not inexhaustible, and some services have begun to deteriorate in quality. With the complexity of demand increasing across all sectors, the entire health and social care system is at full stretch.

SCIE report on Multi-disciplinary Teams (MDT's) – the benefits of an MDT approach

The SCIE report on MDTs shows the benefits of working in multi-disciplinary teams including providing some case studies to show examples of why the approach is successful.

Further resources *(please click on the underlined title to access the link)*

SCIE resources – learning from excellence

The Social Care in Excellence website provides a huge amount of best practice material including for example moving patients from hospital to home

Local Government data sources on delayed transfers of care

The LGA website provides some excellent resources to help track data performance by local authority area.

Hospital Episode System data

HES provides provisional monthly hospital episode statistics for admitted patient care, outpatients and accident and emergency data.

Public Health England Fingertips Data

This provides a range of data about people who use or have the potential to use Adult Social Care Services at Local Authority level. The profile is there to support commissioners and health professionals when making decisions about these people by bringing together a wide selection of indicators from different publicly available data sources.

The profile is broken down to Upper Tier Local Authority level, Region, and England to allow the user to interactively query and compare indicators related to Adult Social Care Services.

4. What you said worked well, what we could improve upon and support required?

What worked well?

Each Local Authority area were asked to provide feedback on what was working well, here are some examples (see overleaf)

- Multi-disciplinary Approach and Multi-disciplinary Teams including Clinicians working closely together and alongside Adult Social Care e.g. utilisation of Nurse Assessor role, good use of Occupational Therapists, and community navigators
- Access to good patient information and good communication
- Single Point of Access
- Integrated Triage
- Good access to interim services and capacity
- Dedicated timely response to equipment requirements
- Providing a response service to avoid unnecessary ambulance visits prior to admission
- Designated support to voluntary services for low level requirements

What could we improve on?

Each Local Authority area was asked to provide feedback on areas which were of challenge, here are some examples:

- Integrated **information systems**
- Additional **money and capacity** e.g. being able to source appropriate home care packages within a short time frame
- Improved working with **Transport** Services
- Close links with **housing**
- **Accessible information** about services outside of catchment areas
- Good support and information between locality and Emergency Department Teams
- Upskill care home staff to manage complex cases by using learning from the **Vanguards**
- Educating patients to use **assistive technology** rather than calling 999

What are the areas of challenge which the region could support with?

Each Local Authority area was asked what challenges may require regional support, here are some examples which have been responded to:

- Provide examples of admission avoidance work and strategies within and outside the region (best practice examples contained within this report)
- To provide more information regarding accessing My Care Record. *My Care Record allows health and care professionals directly involved in your care, access to information about you.*
  It is currently available for patients from west Essex and Hertfordshire attending health and care settings.
- To provide information about the JET service in Peterborough Link to info on JET. *Running since 2014, the Joint Emergency Team (JET) provides 24 hours urgent care provision as a support to the Admissions Avoidance Team (AAT) based within Peterborough City Hospital, Accident & Emergency Department.*

5. Local authority case study examples

Various examples of approaches contained within this section of the report have been provided by Local Authority areas and cover a range of early intervention and preventative approaches, such as:

- Learning from Enhanced Care Home Vanguard
- Multi-disciplinary and joined up approaches
- Single Point of Access
- Early intervention vehicles
- Crisis intervention and crisis response teams
- Focused work at the Emergency Department Front Door
- Equipment, assistive technology and falls prevention

5.1 Shared learning from the East and North Hertfordshire Care Home Vanguard – Enhancing Care in Care Homes

Delivering an enhanced model of health and social care to support frail elderly patients, and those with multiple complex long term conditions in the community in a planned, proactive and preventative way.

For further information, please click here: East and North Herts Vanguard

In East and North Hertfordshire there are 62 older people's care homes providing 3,475 beds. Of which, 37 are residential homes (1,786 beds), 23 nursing homes (1,550 beds) and 2 have dual registration (139 beds). 79% of homes are rated as "good" by the CQC, 19% are rated as "requires improvement" and 3% are rated as "inadequate". Hertfordshire County Council buys in total 34% of the East and North beds. East and North Hertfordshire CCG buys 2% of the beds for their Continuing Health Care (CHC) block contracts and 6 homes in total have been in serious concerns in the last 12 months.

The challenges identified:

- Disproportionate number of 999 calls from the over 65 age group
- Patients in care homes are more likely to be taken to A&E than those living at home
- Multiple hospital admissions of less than one day
- £2,626 average cost of a hospital stay for a patient who has fallen
- Care home patients on average take seven prescribed medicines
- Nationally, on any given day, 70% of patients experience at least one medical error

The vanguard has in place confident staff, multi-disciplinary teams, rapid response and effective technology through various schemes/services such as:

- Aligned GP contract
- Red bag
- Complex care training
- Home first/rapid response
- Impartial assessor
- Care Home Pharmacist
- End of Life Training
- NHS.net email
- Acute Frailty Service
- Assistive Technology

Some of the impact:

Through working in partnership across the Health and Social Care sector the Vanguard was able to deliver reductions in demand in a number of areas.

- There has been an 11.5% reduction in emergency admissions for the over 65 year olds
- 4.9% reduction in bed days
- The Vanguard undertook 9,164 interactions
- 50 care homes now have NHS.mail
- 1,616 admissions have been avoided
- 100% of care homes are aligned to GP surgeries
- 17,848 medicines were reviewed resulting in a saving in drug costs of £392,649
- 16% stopped unnecessary medication
- 65% stopped unnecessary nutritional supplements
- Early Intervention Vehicle has a 28% conveyance rate to hospital
- Estimated 670 bed days have been saved by the Impartial Assessor service, resulting in financial savings of £251,750 (based on the figure of £525/bed)

- 44% of care homes completed training
- 213 Care Home champions were trained
- 670 staff were trained by end of life nurses
- In summary: £13.4m was saved of which £1.05m was in avoidable A & E attendances; £818,840 in avoidable conveyances (through Ambulance services); £11.1m in avoidable emergency discharges and £392,649 on medicine optimisation. In total the programme saved £1,054,360 in cumulative savings in A & E attendances for those over 65 years old.

In total 14 projects were set up and delivered across East and North Hertfordshire, as well as a suite of tools to support care homes to navigate the health and social care system, including a 1 page contact sheet for localities and a clinical resource pack. The projects were not just focused on care homes, they also included the wider population of those over 65 years of age living in their own homes with the development of the Early Intervention Vehicle and roll out of Rapid Response.

Outcome:

The Vanguard Programme has been successful in having a positive impact on the population over 65 years of age. Through working in partnership across the health and social care sector the Vanguard was able to deliver reductions in demand in a number of areas. In quarter 3, 2017/18, there was an 11.5% reduction in emergency admissions for care homes. There has been a 4.9% reduction in bed days per resident.

The Vanguard programme has raised awareness of care homes in East and North Hertfordshire and has raised the profile and importance of the care sector across health and social care. This has led to a wider impact than just simply the projects that were funded as relationships and integrated working have formed. For example, HCPA are supporting the local 111 service to develop their clinical line to support care homes and were instrumental last year with raising awareness of the flu campaign to care homes and home care staff.

The Vanguard programme will now transition into the Sustainable Transformation Partnership for Hertfordshire and West Essex, where care homes have been identified as a sub group of the fragility project. This will allow the STP to use the learning from the Vanguard Programme and take forward further work to support care homes.

5.2 Hertfordshire Early Intervention Vehicle (EIV) – A joint initiative to keep people at home rather than admitting them to hospital

The Early Intervention Vehicle (EIV) is a joint initiative of health and social care professionals who respond to triaged 999 calls, with the primary aim of keeping frail people at home rather than admitting them to hospital. The Early Intervention Vehicle is staffed by a Senior Paramedic with an occupational health professional, physiotherapist or social worker responds to carefully triaged 999 calls from individuals to care homes. Staff undertake a holistic geriatric assessment, which takes around an hour. As well as assessing the patient's health and wellbeing, the home environment and any practical adaptations and increased care needs are considered. Changes to care packages and minor home adaptations and increased care needs are considered. Changes to care packages and minor home adaptations can be made there and then.

Case study:

The family of a 96 year old lady called 999 for an ambulance due to her not eating or drinking which raised the family's concerns over her deteriorating state of health. Rather than send an ambulance, the 999 call centre dispatched the EIV which completed medical and functional assessments. This ascertained that the lady was dehydrated but not in need of hospitalisation and there was a main concern that the lady's family were not coping well with her deteriorating health.

It was important to the lady to remain at home and in order to achieve her wishes the EIV assessed how care and support needs could be met in the home environment and avoid hospital admission. The team were

with the lady for two hours and in this time they were able to help her achieve her wish to remain at home and ease the burden on the family.

The EIV team contacted the lady's GP and the community rapid response team. The Rapid Response team is made up of nurses, physios, mental health, CPN's and social workers which support patients to avoid admission through case management or ongoing support. The rapid response team assessed the lady to and put in place a care package and practical aids to help maintain her hydration and well-being. This resulted in the lady not being admitted to hospital and she remained in her preferred home environment with her needs being met and easing the burden on her family also.

Outcome:

Had the EIV not been in place to assess this lady, there would have been no joint assessment of health and social care needs and it would have been far more likely to result in admission to hospital. This would have caused distress to the lady and her family, as well as being a greater cost to health and social care. The impact of the EIV was positive for both parties; the lady was able to remain at home rather than being admitted to hospital, which was in line with her wishes and avoided any stress and disorientation and maintained her well-being. The EIV team were able to carry out an assessment to support the lady to remain at home and avoid the need for an ambulance which could be used for more appropriate calls.

It is worth noting that the average cost of a hospital stay for a patient who has been admitted to hospital due to a fall is £2,646. Since the EIV inception in May 2016, the EIV has responded to 2,271 call outs, with an average non-conveyance rate to hospital being 72%. This has resulted in a gross saving of £1,086,560 and net saving of £182,046 as at April 2018.

5.3 Four examples of shared practice demonstrating the effectiveness of the Norwich Escalation Avoidance Team (NEAT) – Single point of access for urgent and unplanned health and social care needs

The Norwich Escalation Avoidance Team (NEAT) provides Norwich's single point of access for urgent, unplanned health and social care needs where co-located staff work together to coordinate an integrated response which supports and manages patients and carers safely in the community through a period of crisis, using the most appropriate level of intervention. NEAT is a professional referral line only.

Case study 1: An 89 year old man was referred into the NEAT team by GP. Mr B's mobility and ability can be poor and there is a history of UTI's and falls. He had been in hospital over Christmas. He had been at home for over week and half but since being home has had two falls. He is unwell with Diarrhoea but is medically stable and there are no signs of other infections. He hasn't been eating and drinking and he is unable to care for himself. Mr B has a good friend who offers informal help but is no longer available as much as he was. Mr B is struggling at home and struggling to mobilise to bathroom. His friend is looking into care home placements.

Outcome:

NEAT convened an MDT within 30 minutes of referral. Norfolk First Support reablement provided three calls per day starting the same evening for support with personal care, medication support and food preparation. Physio arranged for next day to review his mobility and falls assessment took place. Care home admission was avoided.

Case study 2: An 82 year old female referred into Norwich Escalation Avoidance Team by Community Matron. Mrs A has short term memory issues and is diagnosed with Alzheimer's; Granddaughter and daughter are her main carers. Mrs A has been diagnosed with cellulitis and was referred to case manager who is due to see her next week for an initial visit, case manager had also referred Mrs A for wound care. Mrs A has been started on anti-biotics, however, family are only available once daily to give tablets and personal care in the morning and then have work. Further 3 calls were needed.

Outcome:

NEAT convened an MDT in less than an hour of referral. NEAT Mental Health link nurse called patients granddaughter, there was significant confusion regarding medication and when it should be taken. NEAT contacted the surgery and family and ensured Norfolk First Support provided the calls that were needed. As an outcome of Integrated Care Coordinator in NEAT tracking the case up to 7 days after referral within 2 days of referral, the package of support from NFS was increased again to include support to get into bed.

Case study 3: An 84 year old female referred to Norwich Escalation Avoidance Team from Social Services. Mrs P has been unwell since yesterday, had a fall two days earlier and banged her head and swifts were called out and found that she had fallen. The GP was called the day before. Package of Care (POC_already twice a day. The daughter is worried and would like an increase in care. According to daughter Mrs P can't mobilise at present but if two people help she can get into bed but can't weight bear, appearing confused and 'off legs'. GP requested daughter bring in urine sample same day.

Outcome:

NEAT convened an MDT in less than an hour of referral. Community OT was arranged to assess same afternoon. NEAT questioned the increase in POC, more information to follow after OT visit and agency on stand by for double up. OT ordered Ross return and Transaqua Chair for delivery the next day and will follow up the possibility of a hospital bed needed. OT recommends double care social services who arranged double up support temporarily.

Day 2 NEAT review – Mrs P seen by community OT, Mrs P is anxious about falling and this limits her overall mobility. Advised that she still needs double up x 4 POC and social services arranged this using usual agency for continuity and to reduce anxiety during crisis period.

Day 7 NEAT review – Mrs P seen by community OT for follow up, assessed to only need support of 1 carer. Social services aware and reduced calls again. Daughter noted that Mrs P had improved and the equipment provided made a difference.

Case study 4: A referral was received because sadly Mrs A's husband passed away the previous evening, unexpectedly. He was the main carer for Mrs A who has limited mobility, but only has a frame to mobilise and no other equipment in place. Mrs A stated she was unable to transfer without full support and was not able to complete any personal care tasks independently and needed support with taking her medication. Mrs A has a bed in the living room as although there is a stair life in situ, she is not able to get upstairs. Following treatment for cancer, Mrs A is doubly incontinent and needs support to use her toilet.

A colleague from NEAT called Mrs A, the situation was clearly emotive and it was evident that the family was in distress. During the call information came to light that patient is a diabetic and had not taken any medications including insulin that morning.

NEAT called Mrs A's GP about Insulin dose as family and patient were not aware of what insulin should be taken, NEAT gathered information about the insulin needed and made a referral to community nurses for an unplanned visit to administer insulin. During NEAT's initial calls it was clear Mrs A's family were keen that she goes into residential care, however, NEAT was able to talk to the family about care in the home and the family and Mrs A agreed this was a good option. NEAT arranged for support from Homeward and Norfolk First Support.

Mrs A's daughter needed to leave her mum due to her own family commitments, but her son stayed with her. NEAT ascertained that Mrs A had mental health needs with past emergency admissions for psychosis and depression although there had been no recent concerns. Given her recent loss NEAT was able to ensure Mrs A and her family were aware of additional support for any changes with Mrs A's mental health.

Outcome:

NEAT was able to work with Mrs A and her family to build a wraparound package of support to help Mrs A through the difficult time. Mrs A's family administered insulin to Mrs A at lunchtime, and community nurses supported her with the evening dose. Homeward continue to liaise with the GP regarding insulin management. Mrs A was visited by a Social Worker and an Occupational therapist from health team and OT was able to discharge as Mrs A's mobility was better than first reported. Mrs A's social worker arranged a night sit to support Mrs A that evening, to give her family carers support and to gather more information of her needs. Care was provided by Homeward and Norfolk First Support as a joint package of support calling in four times a day to help with personal care, meals and medication.

Mrs A now has a long-term package of support from a care agency, and did not need to leave her home for residential care. An Integrated Care Coordinator in the community will monitor Mrs A's situation via monthly multi-agencies meetings as her GP practice until such time as her situation is settled. Community Nurses visit Mrs A at her home to support with insulin twice a day. No action was needed from Mental Health Services at this time.

5.5 Central Bedfordshire Community – Joined up discussions in partnership to avoid hospital admissions

Joined up discussions involving Adult Social Care Locality Team; Community Occupational Therapy; Local Authority Intermediate Care; Primary Care/GP and Community Mental Health Team to ensure the right support, in the right place and at the right time.

Case study: Mrs H had been referred to the community locality team following a period of falls within a short period of time that did not require hospital admission. Mrs H's GP was concerned at her increasing shortness of breath secondary to COPD and reduced mobility further to medication that she was taking to manage Bi Polar disorder and Osteoporosis. The frequency of falls coupled with increasing shortness of breath meant that Mrs H was on the cusp of requiring hospital admission.

Mrs H was finding it increasingly challenging to manage her personal care and had become increasingly anxious as a result of falls which had elevated the periods whereby her breathing was exacerbated. Mrs H was afraid to leave her home and took the view that if she were admitted to hospital, her long term conditions and anxiety levels would see her not leave the hospital.

Outcome:

As an alternative to hospital admission, it was agreed with Mrs H and the assessing Social Worker and Intermediate Care Therapist in a joined up discussion with her GP, that she would be referred to a Reablement

Step up bed from her home, with close monitoring and support being offered by her GP to complement the support and therapy provided by Intermediate Care. A referral was made by the GP in parallel to neurology as part of their management of frequent falls, her medication was also monitored by her GP as a further element of falls management.

Mrs H was able to avoid being admitted to hospital further to the coordinated support provided to her between the Local Authority and Primary Care, the most significant impact was that Mrs H was on the cusp of requiring acute hospital admission which in turn could have been detrimental to both her physical and emotional wellbeing. Mrs H received a period of assessment within a sub-acute setting to determine an appropriate care and support plan with her Social Worker and GP.

The cost avoidance relates to Mrs H requiring admission for further assessment of her circumstances within an acute trust setting alongside Mrs H not requiring a respite care home admission from her home given the associated risks to her remaining in her home.

5.6 Essex Rapid Intervention Service – short term rapid support

Short term support provided to support independence involving GP service, SPA (setting up service and reviewing), short term support service (care), customer and her family

For further information, please see the following link: Essex Rapid Intervention Service

Case study: A referral from GP for a 91 year old woman who had a chest infection was received. Antibiotics were prescribed. The lady had received 2 ambulance visits in 48 hours with low sugar episodes. She was not managing at home due to illness and not eating or preparing food.

It was important for the person to stay in her own home and having contact with her supportive neighbours and family as well as being able to get back to doing things as soon as possible.

Due to her acute illness she was not managing to get dressed, washed or prepare food and so was at risk of rapid deterioration. The lady wanted to get back to feeling well and getting back to doing what she wanted. An option would have been to manage her illness as an inpatient or to put in longer term support, however, this would not have been geared to reducing support as she is improving.

Outcome:

After provision of Short Term Support 3 calls per day at the end of three weeks the person was not requiring any support and was once again managing in the community with the support of her neighbours and family. Dossett box to assist with managing medication was provided.

Being able to remain in her familiar home was very important and so the person was pleased that the support had been offered. The lady reported that she was "doing alright" and with the support had the confidence to get back to completing the tasks she was doing previously. She had no break in her time at home and so was able to continue to remain in a familiar setting.

5.7 Essex County Council Community Therapists – providing equipment to support independence

Equipment support involving the family, customer, spa, equipment services, Hilton services, Community PT

Case study: Call received regarding a 75 year old gentlemen who had rapidly deteriorating functions and was not managing. Diagnosed with Multiple Sclerosis for 10 years but over the past 3 days had "gone off his feet". Not clear if this was due to MS or due to an infection.

He wanted to stay at home and did not want to be admitted to hospital. He was frightened that things had changed so quickly. He wanted to be able to get back to his life being able to do some work, being in control of his life. He lived with his wife who had a diagnosis of dementia.

He was unable to stand to transfer. He was taking 3 people to enable him to stand. There was evident family stress. He and his family wanted a safe way of assisting him to move and him and his wife to be able to manage at home. The options were to look at a variety of different types of equipment to enable transfer. He had not been admitted to hospital for a number of years. He was attending RLH as an outpatient for MS. He could have stayed in bed which would have been deconditioning.

Outcome:

No admission to hospital was necessary, no ongoing care and support was required and a better outcome was achieved. Provision of hoists/slings, profiling bed, shower chair and commode were arranged. Provision of Hilton service to assist with transfers until the family could source their own care was commissioned. Advice was given to the family regarding the need for minor adaptations.

The customer reported that he was happy with the service and that the equipment provided enabled him to have a way of getting out of bed and maintaining his dignity when he had a sudden change in his condition. Fortunately his abilities have improved and so he is now able to stand with support of his private carer. Speed of delivery of equipment enabled him to manage. After approx. 3 weeks his condition had improved and he was able to stand with maximum assistance of one. Referral was made to community therapists to look at improving his mobility.

5.8 Cambridgeshire - Technology Enabled Care

The value of technology and a 24/7 response service in avoiding admissions and other social care costs involving Enhanced Response Service, Technology Enabled Care Team and Telecall Call Centre

Case study: A referral was made to the Technology Enabled Care Team in October 2014 for an 89 year old Sofia with advanced dementia. The main risks identified by her daughter and referred to TEC by Reablement related to leaving the gas on and not taking her medications that instigated a referral. She lives alone in a semi-detached property. She has two daughters who are local and very supportive of their mother but both have constraints on their time due to working full time and being single parents. On assessment it was identified that she was disorientated and there was a risk of a fall. Sofia and her two daughters were keen that she could remain living at home although it was recognised she was at high risk of falls and that she needed frequent guidance and support. The possibility of needing to move to a care home was very real.

The Technology Enabled Care team organised a community Lifeline to be installed. A gas detector was installed linked to the Lifeline, a Pivotell medication remainder and dispenser was provided and a bed sensor. However, three months later Sofia had a fall at 4:30am. She did not activate her alarm nor did the bed sensor trigger an alarm as she had not got into bed to trigger the absence alarm. It was her neighbours who heard her calls and who summoned the Ambulance. She was admitted to hospital and found to have fractured her hip.

The concerns when planning her discharge were:

- Was the Lifeline any benefit given Sofia did not remember to press it?
- The bed sensor needed programming to have a “not in bed” alarm, previously declined by the family. What other technology could be considered?
- Would she be safe to return home or did she need increased support across 24 hours a day? She already had a care package of 4 calls a day.

Although, there were risks for Sofia to return home, this was the option preferred by Sofia and her daughters. It was agreed to install “Just Checking” for an assessment period to monitor Sofia’s level of activity across the 24 hours within the home and whether she went out. This had been discussed just prior to admission and was already due to be installed when she fell. The Just Checking assessment indicated:

- Sofia was quite active at night and often slept for periods in the day
- Sofia did not go out of the house on her own
- Sofia did go upstairs even though she had her bed downstairs and she would use beds both up and downstairs
- Sofia had irregular daily living routines

The Technology Enabled Care installed movement detectors both upstairs and downstairs. They installed multiple bed and chair sensors programmed to identify when not in bed or in the chair. The movement detectors and bed/chair sensors were programmed to trigger an alert if none of them were activated in 45 minutes. In this was the technology would detect a fall because none of the sensors would be activated in 45 minutes. The Tele Call Centre was closely involved in the plans for technology in Sofia's home and the plans for who to contact to respond. It was agreed the Enhanced Response Team would respond for all calls when daughters are not available especially night time when they cannot leave their own children.

The Enhanced Response Team have responded to many calls from the Telecall Call Centre. Many of the activations have turned out to be false alarms and Sofia is fine or is fast asleep. There can be multiple calls in one night, multiple calls in one week but then there can be no calls for a month. However, there are activations where the Enhanced Response Team have picked her up from the floor following a fall, have helped to re-orientate her temporarily and to settle her.

There is a constant cycle of liaison between the Enhanced Response team, the Technology Enabled Care Team, the Telecall Call Centre and the daughters to minimise the numbers of false alarms, and to refine and check technology in the home.

- Trying to encourage Sofia to speak to the Lifeline when she can hear the Telecall Call Centre Staff talking to her. This has been unsuccessful despite numerous attempts by her daughters and the services
- Problems with the bed sensors when used in combination with a pressure relieving mattress
- Sleeping in the wrong end of the bed
- The need to replace and re-programme sensors on a number of occasions in part due to heaving incontinence but also due to the complexity of the programming.

The patterns of activations is constantly monitored and remedial actions taken.

Outcome:

Since 2014, Sofia has had only one further admission into hospital for Pneumonia not responding to antibiotics. She has remained living at home with the same size care package. The Enhanced Response Service are able to meet her unpredictable and ad hoc needs that have avoided a 24 hour care package or care home placement. Although, she had had several falls over the last 4 years she has avoided the consequences of a long lie on the floor, hypothermia, dehydration and pressure sores that could have led to hospital admissions and an overall deterioration in her health and wellbeing.

Without the Enhanced Response Service operating 24/7 the Telecall Call Centre would have escalated to the Ambulance Service. An Ambulance Call out is approx. £240, however, the Enhanced Response Service is approximately half of this. In a 3 month period from Nov 17 to Jan 18, there were 37 activations. There were 6 activations for a fall or other personal care need. Over a 3.5 year period, it is possible to say that approx. 550 calls to the Ambulance Service have been avoided and of the 80+ genuine calls an unknown proportion of these have probably avoided an admission.

Sofia's case has been complex to work with and has stretched the services to problem solve and try to work together to get things right. This has also included further installations of the "Just Checking" kit to be able to monitor what is happening when the bed alarms are triggering to try and identify problems. It has also been a very rewarding case to work with as between the services, we have managed to keep Sofia at home. Sofia and her family, particularly her daughters have been very happy with and grateful for the service they have received and also feel this has had an essential impact on her ability to remain at home.

5.9 Cambridgeshire - Enhanced Response Service to provide one off interventions to avoid hospital admissions

One off intervention when they are needed to avoid admissions and other health and social care costs

For further information, please see the link: Cambridgeshire Enhanced Response Service

Case study 1: A woman who is tetraplegic and lives alone knocked her lamp and it was leaning against the curtains.

Outcome:

ERS was able to respond extremely quickly and pick up the lamp and reposition the woman to be comfortable in bed. This call avoided possible fire in the home.

Case study 2: ER was called to a Service User who was on the floor in the lounge following a fall. The service user was very short of breath due to COPD. A post falls assessment was completed, and no apparent injuries were sustained. The raiser used to assist the service user from the floor. The GP contacted and made a referral to JET – a 2 hour nursing response team (Information about JET).

Outcome:

From these actions a chest infection identified and antibiotics commenced. Without ERS responding to this call the underlying cause of the fall may not have been identified as early as it was and it lead to the antibiotics being started in a timely manner. This service user had a history of several admissions to hospital with chest infections.

Case study 3: ERS was called to a women living alone who was feeling unwell with both diarrhoea and vomiting. The response service was able to assist with personal care and hygiene and called her GP.

Outcome:

GP administered injection and prescribed medication. Although ERS needed to attend another couple of times in 36 hours they were able to encourage fluids, make sure drinks were easily available and provide personal care when needed. The interventions of the GP and ERS helped prevent the need for hospital admission.

5.10 Peterborough City Council - Collaborative working between different organisations and agencies

Supporting a person with COPD

Case study: Received a referral from Therapy Technician in the Emergency Department regarding a service user with severe breathing difficulties. The service user in a 2nd floor flat and was unable to get up and down the stairs. The service user had no food in the home and was very anxious about returning to the flat as he felt like a prisoner. The British Red Cross supported the service user with shopping to ensure he had adequate provisions to return home. The service then supported the individual to develop skills to shop online and supported with emotional support e.g. short term befriending.

The British Red Cross and Occupational Therapy liaised with Axiom housing by requesting a staff member from housing to do a home visit to assess the service users living conditions. Axiom Housing stated that this accommodation was unsuitable and moved the service user into a ground floor flat near the town centre where the service user had access to his long term friends. Previous admissions to hospital had occurred on several occasions.

The costs avoided included

- The cost of admission overnight
- Minimal care and support put in place via the British Red Cross to avoid the need of a more formal care and support package whilst other actions progressed (approx. £50 per week)

The support provided

- Support with shopping
- Emotional support
- Assistive technology
- Avoidance of social isolation
- Improved living conditions
- Adequate food provision
- Support to cope with COPD
- Help with on-line shopping
- Encouragement of social inclusion
- Support with housing needs

Outcome:

As a result, the service user's emotional well-being improved. This helped with his lifestyle so avoided more admissions. For the service user involved the words used were "I never thought this would happen. I feel like a king in my new home and can now visit my friends". The best part of this experience was the collaborative working of different agencies and not being admitted to the ward as the service user stated he was sick of hospitals.

5.11 Peterborough City Council Emergency Department Front Door Team Admission Avoidance Team – equipment delivery

To ensure timely and effective equipment delivery to avoid admission to hospital and support independence involving the Admissions Avoidance Team

Case study: Referral from the Social Worker in the Community Front Door requesting equipment delivery. The service user had excruciating back pain, she had suffered a back injury whilst on holiday 2 weeks prior. Service user was assessed in the emergency department and deemed unfit to go home without mobility aid equipment. Service user needed a toilet frame and perching stool. ED stated if the service user couldn't get the aids delivered she would have to be admitted to hospital until such time. The service user had not previously been admitted for this injury.

Outcome:

The British Red Cross was called by the Social Worker in the ED Community Front Door Team to see if they could deliver the equipment to the patient's home address and that the help would avoid an unnecessary hospital admission. The equipment was promptly delivered by the British Red Cross. The service user was able to go home and be able to access the toilet and use the perching stool when needed.

This needed a quick response as the British Red Cross were told that this needed to be in place in the next 10 minutes as hospital transport was ready to take the patient home and if equipment delivery was not done the patient would have to stay in hospital. The patient and her husband were extremely grateful that help was provided. The biggest impact was an avoided admission. This both benefitted the service user and Peterborough City Hospital.

5.12 Peterborough City Council – A collaborative approach to avoid hospital admission

Involving PCC, NWAT, CPFT, Admission Avoidance Team (Front door), ED medical team for investigations, admission avoidance social services for restart of care, Red Cross for befriending and shopping services, admission avoidance PT/OT assessment and OT equipment.

Case study: 83 year old lady admitted to hospital due to generally feeling unwell. Once ED medical team had assessed as fit and referred patient to admission avoidance team, information was sourced from PCC

system that patient was in receipt of services, therefore able to provide information for therapist to assess mobility and transfers and provide appropriate equipment to ensure safe return home. Patient was very keen to return home and on assessment from the therapist the person had difficulty mobilising with current walking stick and therefore the patient was identified as requiring walking frame for safe discharge.

Outcome:

Discussion regarding current level of care package and if additional support may be required e.g. reablement services/voluntary services for shopping and befriending until fully recovered/rebuilt confidence. Current package of care identified as sufficient, however due to no family presence patient accepting of Red Cross services for shopping and befriending. Patient had has 2 admissions within 12 month period.

Support provided: Restart of care was agreed; Red Cross support was provided and change of equipment for safe mobility

Differences

The person was able to feel confident to return home safely with appropriate care and support. A clear and precise plan within the team with minimal impact on the length of stay in ED (less than 4 hours) ensuring the patient was fully informed and aware of the support being offered with clear expectations throughout.

5.13 Luton Borough Council – rapid response with clear pathway for individuals

Luton operates a Discharge Assessment Reablement Team (DART) to provide a quick response and clear pathway for patients in collaboration with colleagues from Virgin Care

Within Luton Intermediate Care, the Social Care staff within the DART team work alongside colleagues from Virgin Care, reablement and community nurses to prevent admission.

The Luton Integrated Rapid Response pathway is for patients that need a multi-disciplinary approach to prevent admission to hospital. The referrals can only be accepted if made from another professional, generally a community nurse or a GP. It is a direct line for professionals to refer too. The pathway has been in place for a number of years now and has prevented a wide range of admissions. IRR in Luton

5.14 Suffolk County Council Reactive Emergency Assessment Community Team (REACT) – falls prevention and prevention of imminent admission to hospital

The REACT service is focused on multi-agency support and will consist of Nursing staff, Therapy staff, generic worker reablement support, social services, Suffolk Family carers and British Red Cross. The initial REACT response will be provided within two hours, where appropriate. The team will respond to referrals from the community where the risk of admission is imminent.

Case study: 76 year old lady referred by paramedics. They were called to the property as the patient had fallen on attempting to transfer to her wheelchair. This was the 5th occasion that the paramedics had been called to the patient this year due to a fall. They reported deterioration in her function and were concerned about her safety at home, therefore referred to REACT. This lady has a progressive hereditary spastic paraplegia.

An assessment was completed the following morning with two clinicians. The patient lives with her daughter who has the same condition and are both wheelchair bound. She has had REACT input approx. 6 months ago and is well known to the community services, having declined care on numerous occasions in the past. Following assessment, her transfer methods were deemed unsafe due to increased spasticity in

her lower limbs reducing strength and her ability to weight bear. The patient declined a step up bed at this point requesting to remain at home. That same day, therefore, a trial of different pieces of equipment including the SARA steady took place, but it was deemed a hoist was needed to ensure patient safety.

Hoist, slings, sliding sheet and wheelchair commode were ordered on a 4 hour delivery. A clinician and generic worker returned to the property later that same day to trail hoist transfer with the patient. This was deemed a safe method of transfer, however, the patient's bedroom was cluttered with furniture limiting space for hoist and wheelchair.

Outcome:

Following the above, QDS double up generic worker visits were put in to assist with personal care and toileting. The Red Cross input was arranged to assist the patient to declutter the bedroom environment to enable safe hoist transfer.

The REACT social worker put in a request for long term x 2 packages of care. The patient was discharged from the caseload once the care agency were in place and with a community therapy referral to determine if the patient had any rehabilitation potential to progress the transfer.

6. Case study examples from outside the region

We have also provided a number of examples from other regions which may assist Local Authorities with shared learning, please see below:

6.1 Leicester: A journey to improve discharge and avoiding admissions

Partners in Leicester have taken a five-stage approach to improving discharge and advoiding unnecessary admissions. The example shows how local areas are working together to implement overall system change to manage transfers of care.

For further information, please see the following link: Leicester

6.2 Lincolnshire: Hospital avoidance response team

The hospital avoidance response team (HART) service is delivered by members of the Lincolnshire Independent Living Partnership and takes referrals from secondary care discharge hubs. A & E in reach-teams, the ambulance service, primary care and community health providers.

For further information, please see the following link: Lincolnshire

6.3 Tower Hamlets: Admission avoidance and discharge service (AADS) and discharge to assess

A CCG-funded pilot was initiated in 2015, starting with 15 patients and running in parallel to other winter resilience schemes, including an admission avoidance team, hospital at home service and out of hour's social work.

For further information, please see the following link: Tower Hamlets

6.4 Surrey County Council: Enhancing Care in Care Homes

In 2014, East Surrey CCG embarked on a project to improve the medical care of residents of nursing and residential homes. This is a local initiative to support managing transfers of care:

For further information, please see the following link: Surrey

6.5 Wakefield District: Enhancing health in care homes vanguard

The programme aims to tackle loneliness and fragmented care by joining up services for older people in supported living schemes and care homes, to help people live longer, healthier lives at home and within their communities.

Wakefield

6.6 London Borough of Barking and Dagenham, Havering and Redbridge: Pilot allocating GPs to nursing homes

A £400,000 pilot scheme which allocates a GP, who visits the home each week has resulted in a 53% reduction in emergency bed days and 40% reduction in hospital admissions.

LB of Barking and Dagenham, Havering and Redbridge

7. Conclusion and next steps

There are some good examples within region and outside of the region reducing unnecessary visits or stays in hospital which we have shared within the report.

From the examples provided, it is evident that multi-disciplinary and partnership work with the sector including voluntary sector is key to the success and delivery of prevention and improving independence. Good practice includes:

1. MDT working including voluntary sector
2. Rapid Response to crisis
3. Strong presence in Emergency Department
4. Integrated triage of referrals so facilitate right response

There are a number of areas which the Delayed Transfer of Network could consider further work on, such as:

1. Closer links with Housing
2. Good use of Assistive Technology to aid early intervention and prevention
3. Integrated IT
4. Good engagement with Transport Services

We continue to work as a region via the Delayed Transfers of Care Network to share good practice as part of our approach to Sector Led Improvement and will share the report with network members and through our Sector Led Improvement monthly newsletter. We encourage staff to share and make use of the resources within the report.

8. Key Contacts

Here are the key contacts for the six local authorities who have provided case studies.

Local Authority	Key DTOC contact
Hertfordshire	Chris.badger@hertfordshire.gov.uk
Central Bedfordshire	Anthony.Prior@centralbedfordshire.gov.uk
Essex	Alexandra.Green@essex.gov.uk
Norfolk	Nick.pryke@norfolk.gov.uk
Cambridgeshire and Peterborough	Debbie.mcquade@peterborough.gov.uk
Luton	Jo.Towner@luton.gcsx.gov.uk
Suffolk	Gillian.clarke@suffolk.gov.uk

9. Annex A – Case study template

Local Authority		Contact Name	
Email address		Are you happy for us to share the information provided Y/N?	
In General – what do you think works well in your area to avoid admissions to hospital?			
In General – what are the barriers and challenges to avoid admissions to hospital?			
In General – Are there any research/examples of good work you'd like to know more about?			

CASE STUDY 1 Can you please provide a case study example of something that has worked well in your area highlighting what and how an admission was avoided and what difference it made to the individual?	
What is the case study title/theme?	
Who/which organisations/partnerships were involved?	
ACTIVITY – Why was contact made? What was important to the person? What was difficult? What did they want changing? What options were explored? What alternative options were available? Had this person been admitted to hospital previously?	
COST AVOIDANCE – By taking this approach, was there any cost avoidance and if so, can you provide an estimate?	
RESULTS – What support was agreed? What support was provided? What changes were made? What was different?	
EXPERIENCE – What was it like for those involved? What was the experience like for the person receiving support? What had the most impact?	

Reviewed By:	Name	Date:	Date
Approved By:	Name	Date:	Date