Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Transforming care across northern and eastern Devon

Contents

Our vision:

We will deliver local integrated health and social care to support people to live as healthily and independently as possible, recognising the differing needs of our local communities across Devon.

Introduction

A series of initiatives across the Trust, from Axminster to Ilfracombe and Holsworthy to Exmouth, are helping patients benefit from care closer to home.

Although each is tailored to local conditions, the underlying themes are the same: Providing people with the right care, in the right place and at the right time.

Wherever possible, that means going into people's own homes with a range of support that cuts across health, social care and independent services.

It also means minimising, and preferably avoiding altogether, time spent in either the Royal Devon & Exeter Hospital or North Devon District Hospital. Early intervention to prevent deterioration, allied to rapid response and the use of new technology, are among the keys to success.

Multi-disciplinary teams are generally at the heart of the initiatives, providing the relevant skills for each patient, as rapidly as possible. Often, this can make all the difference between staying at home and ending up in hospital perhaps for a long period.

Partnership working is essential, especially with Devon County Council, as we continue to break down barriers between organisations and reshape the way we use resources for the benefit of patients. Often, that means single management, to make the most of the complementary skills of staff.

Many of the teams therefore include the council's social care staff, underpinned by the transfer of NHS money under Section 256 of the NHS Act 2006. A S256 agreement for 2012/13 commits NHS Devon and Devon County Council "to jointly plan the best way to use funding for prevention, early intervention and to facilitate seamless care for patients on discharge from hospital, to prevent avoidable hospital readmission and provide personalised services within their own home where appropriate".

The aim of the Trust is to make sure learning from all these initiatives is used to inform further developments across the entire area that it covers, bringing incremental improvements to the care and support that can be provided to people in their own communities.

Full outcome data is not available for all the projects described below. It will be added over time, as the projects evolve.

Onward care – smoothing the discharge of acute patients

Where: RD&E and its catchment area

The Trust's complex care teams in the RD&E catchment are taking greater responsibility for making sure 'their' patients are always being cared for in the right place.

They now have access to the RD&E's ward-based electronic whiteboard, so they can track known patients through the acute phase of their treatment. The CCT can then ensure not only that discharge from hospital is timely, but that the patient and their family are aware of all the options for community-based care before any decisions are taken.

Local teams have undergone training to support this approach to 'pulling' patients out of the RD&E. Taken as a whole, CCT patients can now be managed, wherever they are, via an electronic 'virtual ward'.

The system is underpinned by the Trust's multi-disciplinary Onward Care Team, based at the RD&E, which works closely with hospital staff and takes on responsibility for patients who are not known to CCTs.

The team's occupational therapists also work with hospital staff at the 'front door', in both Emergency Department and on the Acute Medical Unit, to identify and assess patients whose admission to the acute hospital can be avoided. They arrange equipment or support for patients to facilitate discharge or liaise with CCT colleagues in the community such as Rapid Assessment at Home, Mid Devon Pathways, Rapid Response services to ensure appropriate follow-up at home.

Outcomes:

Although yet to operate through the winter period, results from summer 2012 highlight the effectiveness of the approaches to both facilitating early discharge and avoiding unnecessary admission.

The table shows the numbers of patients supported through early discharge, highlighting the growing role of services – highlighted in this report - other than community hospitals:

Month	Discharges to community hospital	Discharges to other community services	Total
June 2012	225	40	265
July 2012	240	60	300
August 2012	210	60	270
Total	675	160	835

In terms of avoiding admissions, the Onward Care Team's OTs saw an average of 47 patients a week in August, of whom more than half (26) were able to go back home – with suitable support - rather than staying in the RD&E.

Extending Pathfinder into A&E

Where: Northern Devon

A pilot project in early 2012 saw the scope of the Pathfinder team at NDDH extended to A&E, to help ensure that pathway options were identified correctly for incoming patients – especially those already know to complex care teams (CCTs).

A Pathfinder team member was available to support A&E from 8am to 10pm on weekdays and from 8am to 8pm at weekends, working alongside a GP as well as departmental staff.

As patients arrived, Pathfinder input to triage helped screen out those patients who would better be directed to other services rather than being admitted to NDDH for non-medical reasons.

Those patients known to CCTs who did need admission could also be followed up by CCT/ Pathfinder to make sure they were discharged in a timely way.

Outcomes:

Data from the first five weeks of the project showed admission had been avoided for four patients. Pathfinder staff now visit A&E and the Medical Admissions Unit (MAU) on a daily basis and provide ongoing support in the discharge of patients.

Care closer to home

Where: Honiton, Ottery St Mary, Seaton, Axminster and Sidmouth

This project is about ensuring that patients can be cared for as near as possible to their own home: in a community hospital rather than the RD&E, and at home rather than in a community hospital.

A single point of access via a 'red phone' can be used by GPs and other professionals to trigger a two-hour response by nursing and occupational therapy staff to assess patients. Further staff were recruited to increase capacity in summer 2012.

As a result, home adaptations and domiciliary services can be lined up very quickly to support people outside hospital, speeding up and avoiding admissions.

In parallel, the aim is to create a much stronger 'rehab culture' in the community hospitals, with a training programme for ward-based nurses being rolled out in spring 2012, the development of therapy-led beds, direct discharge home rather than via intermediate care, and plans for more rehab work at home.

Outcomes:

At Seaton, one month saw 35 calls of which 23 were suitable. Thirteen called for rapid response, including five night-sits. Fifteen people needed equipment.

Twenty people required review in the 48 hours before being discharged, with the remaining three reviewed up to five days. Just two needed admission to the RD&E and one needed emergency placement.

The Sidmouth single point of access commenced in May 2012. From the first 17 patients referred, 16 were assessed within two hours; 16 admissions were avoided.

Hospital at Home

Where: Exmouth and Budleigh Salterton

The Hospital at Home project provides active treatment by health and social care staff, for a limited period of time, in the homes of patients whose condition would otherwise call for in-patient admission. It also enables earlier discharge from the RD&E and the two community hospitals. It covers people living in care homes.

Patients are either referred directly by their GP or are transferred from the RD&E following screening by the care of the elderly consultant who oversees the team.

The combined team includes nurses, therapists, care agencies, and can call for input from older people's mental health services. Together, they provide 24/7 care for up to 21 days, using shared as well as specialist skills.

A single point of access triggers assessment at home within two hours for patients who might otherwise need hospital admission, and four hours for those coming out of hospital.

Care is provided within a virtual ward, using an electronic whiteboard and daily 'ward rounds', with weekly multi-discplinary team meetings led by the geriatrician.

Outcomes:

The initial period from December 2011 to the end of April 2012 saw 108 patients cared for, with an average age of 84 and length of stay of 13 days. Around 80% were still in their own home at the end of their treatment.

Between December 2011 and May 2012, there was a fall from 2.7 to 1.1 in the average number of patients awaiting transfer from the RD&E to Exmouth Community Hospital.

Hospital at Home – how it works

Several Hospital at Home patients live in residential homes, but had been admitted to hospital following a fall and/or fracture. Previously, most of these would have either remained in hospital until they were back to their previous level of function or would have been transferred into nursing homes because their current home could not meet their needs.

Hospital at Home has enabled more patients to come back to their original care home and supplemented the care they usually get, with double-ups or night-sitters if needed, and nursing and therapy input until the situation stabilises.

This settles patients back with no increase in funding for the care home, no need to move them and, most importantly, giving a good outcome for the residents in terms of their abilities and independence.

Rapid Assessment At Home

Where: Exeter

The Trust's Exeter Complex Care Team has been piloting a Rapid Assessment at Home service for local people who suffer a fall or some other deterioration in their health.

Once referred, patients receive a full health and social care needs assessment in their own home within two hours. The team then develop a care plan with the patient and mobilise the right combination of support for that patient to encourage rehabilitation, maintain independence and avoid a hospital admission.

The multi-disciplinary team includes community matron, community nurses, care support workers, therapy assistants, physio, occupational therapists and community psychiatric nurse.

The team have access to night-sitters, rapid-response carers and a spot-purchase budget to meet the immediate needs of the patient while longer-term support is put in place.

Referrals come mainly from GPs, though the project is also open to referrals from district nurses and the RD&E, with the GP remaining accountable.

Outcomes:

The first five months of RAAH saw 175 referrals made, of which 145 (83%) were accepted, with patients ranging from 69 to 101 years of age.

Of those patients accepted:

- 95% avoided admission to hospital
- 97% were assessed within two hours
- Average length of intervention was 6.9 days

Follow-up at six weeks found 70% still at home, 8% in residential care, 8% in the RD&E, and 6% in Exeter Community Hospital or in intermediate care. The remaining 8% had died.

Patient satisfaction was high, with over 82% feeling completely involved in decisions (18% partly involved), and 100% feeling well cared-for, happy to be at home rather than in hospital, and that the RAAH team worked well together.

Mid Devon Pathways project

Where: Cullompton, Tiverton, Crediton, Moretonhampstead and Okehampton

This project was developed with staff and GPs to prevent hospital admission and promote timely discharge, using defined pathways to make sure patients were cared for at home wherever possible.

It is based around a Rapid Intervention Centre that takes GP calls and completes initial assessment forms for the local complex care teams. Each CCT Co-ordinator then has access to a rapid response team that picks up all urgent cases each day.

The team also works closely with hospital discharge facilitators covering Tiverton, Crediton , Moretonhampstead and Okehampton community hospitals and trainee assistant practitioners.

Outcomes:

Of 90 patients referred onto the pathway during March and April 2012, 79 remained at home. Of the remainder, seven went to a community hospital and four were admitted to an acute hospital (three to the RD&E and one to Musgrove Park).

Mid Devon Pathways – how it works

Mr B was referred on 29 March 2012, and discharged on 3 April. This elderly man, who lives alone in Tiverton and was previously independent, had a GP visit for a swollen painful wrist. He was taken as an out-patient to the community hospital for x-ray, which showed no fracture; he was returned home with increased analgesia and plaster cast.

The patient was struggling to cope with personal care, meal and drink preparations, mobility and confidence. His family were not able to arrange any support to start immediately. The rapid response team went in to provide the daily support required as above. The GP reviewed and discharged Mr B from the pathway on 2.4.12. His family arrived to stay and private care was arranged from the 3.4.12; the patient reported feeling much better and remained in his own home throughout.

Home from Hospital

Where: Northern Devon

The Trust is working with the Red Cross to provide patients with support at home with the aim to help them regain their confidence and independence and to prevent re-admission to hospital.

The service is running initially for 12 months, with Red Cross volunteers on hand for a period of up to six weeks for each patient; assisting with day to day tasks such as shopping, collecting prescriptions and generally helping patients rebuild confidence after an accident or illness.

Sometimes the support required is minimal, such as making sure there is food in the cupboards, or having a chat and a cup of tea, but even these can help sustain the patient at home, aid recovery and reduce isolation.

Suitable patients are be identified by the nursing teams while on the wards at NDDH or in one of the five community hospitals in northern Devon.

Outcomes:

Not yet available

COPD telecare

Where: Holsworthy and Torrington

The Trust, local GPs and NHS Devon have set up a project to support patients with Chronic Obstructive Pulmonary Disease (COPD) at home.

While specialist community nurses continue to provide care and treatment, they are now supported by Telehealth, an NHS-run service based in Cornwall that enables the patient to monitor their own condition on a daily basis.

This simply means wiring up at home to measure readings such as oxygen level and pulse rate, then transmitting them down the phone line to nurses on the control centre. Early signs of deterioration can be picked up and any necessary action triggered. It also reduces the number of false alarms, which would otherwise see the patient having to struggle along slow rural roads to NDDH for a check-up - often in A&E, out of hours.

This will help avoid unnecessary admissions as well as providing reassurance to the patient that help is available rapidly if needed.

Chris Axford from Holsworthy was one of the first patients to have the tele-monitoring equipment installed. He said: “The weekend after we received the equipment and were trained in its use, my health took a turn for the worse. Ordinarily I’d have ended up phoning 999 for an ambulance and been admitted to hospital. But because we could see the readings ourselves and knew they’d be reviewed elsewhere I felt able to take my meds and rest - just as they would have told me to do in hospital.

“First thing on Monday morning a nurse was on the phone to check on my progress. Wonderful.

“Being more in control of my health by having a better understanding of what’s going on has renewed my desire to look after myself and it’s given my wife so much more confidence by being a tool we can use when making decisions about my health”.

Outcomes:

Not yet available

Support for people with Parkinson's Disease

Where: Northern Devon

The specialist Parkinson's Disease nurse at NDDH now offers a rapid response service to enable patients to cope with their condition at home, rather than being admitted to hospital.

Acting on GP referrals, the aim is to go out to patients with Parkinson's who are entering a crisis and might otherwise need to go into hospital. This means visiting either the same day or the day after to carry out an assessment and arrange treatment plans.

The nurse typically visits each patient weekly for the next 6-8 weeks. Strategies for keeping patients at home include reviewing medication, dealing with non-Parkinson's-related ailments and supporting patients with their medication regimes.

If patients need other support, other members of the multi-disciplinary team at NDDH will visit, so any adaptations to the house or additional care can be discussed with both the patient and their carer. On some occasions the consultant visits the patient at home, when issues are particularly complex.

Outcomes:

During the first year of this project, 40 patients with Parkinson's were supported at home when they would otherwise have needed admission to hospital. By the second year, while some Parkinson's patients were admitted for other reasons, such as falls, none were admitted through not coping with Parkinson's.

The charity, Parkinson's UK, estimates that each avoided admission saves the NHS around £4,000.

Integrated pathway for end-of-life care

Where: Northern Devon

The pathway for patients who need palliative and end-of-life care has been redesigned to bring together NHS and independent provision, across acute and community settings.

The Trust's specialist palliative care team is now integrated with services at North Devon Hospice to support the wishes of individual patients and their families, in line with the national End of Life Care Strategy.

This means better coordination of care and improved quality of life for people, via a single 24/7 service, with far fewer avoidable admissions. District nurses, GPs and care homes are also closely involved.

Outcomes:

Access to palliative care and supportive care, discharge arrangements and end-of-life services have all improved, enhancing the experience of patients and their families and improving clinical outcomes.

Mobile technology supports community teams

Where: Northern and Eastern Devon

Community teams across the Trust are now using mobile technology for managing caseloads and collecting data while out and about seeing patients.

More than 1,000 staff have been trained on the new ComPAS system, using Samsung Galaxy tablet computers that tap into either 3G or wi-fi networks to download and upload data.

Although prompted by forthcoming national requirements to collect the Community Information Data Set (CIDS), the tablets go much further in terms of usefulness for a mobile workforce. The seven-inch screens are big enough to be easily readable as well as handy to carry around. The Samsungs also come with:

- GPS, which might be critical if an ambulance is needed for a patient
- Satnav
- NHS email connectivity
- Camera, so wounds could be shown to doctors at hospital for assessment, for example
- Built-in phone with bluetooth capability
- Teleconferencing capability, to tap into case conferences, for example
- Car chargers, to keep the devices operational on the road

Outcomes:

By September 2012, only a handful of small specialist teams had not adopted the new system, with more than 8,000 episodes of care being recorded each week.

The 'outcoming' of patient appointments - logging what happened, to keep the record up to date - was running at a rate of over 90%. This is well above Monitor's target minimum for Foundation Trusts of 50% for activity eligible for CIDS. Data quality has also improved, as staff enter information straight after each appointment, rather than at the end of the day.

Free training to care home staff

Where: Northern Devon

The Trust is piloting a scheme to provide free training and ongoing support to staff in nursing and residential care homes.

Community clinicians offer courses to local care homes on:

- Pressure damage and tissue viability
- Urinary tract infections and continence
- Diabetic care

The main aims are to reduce avoidable hospital admissions and to enable service users to stay in the comfort of their care home. In the last two years there have been 1,264 admissions to NDDH from care homes in northern Devon.

The service is available to care homes in Braunton, Lynton, Ilfracombe and South Molton. After the initial training, community clinicians will provide ongoing face-to-face, practical support.

Outcomes:

Not yet available

Recuperative care

Where: Northern and Eastern Devon

This project was set up to help patients recover in a nursing or residential home, easing pressure on beds at NDDH and community hospitals. It enables people to be discharged earlier or to avoid admission altogether.

Support is provided for up to six weeks, with the patient then expected to return to their own home at the end of the recuperative period. The Trust's Pathfinder team is the access point.

A typical case involves someone who is in a leg plaster, is otherwise medically fit to leave hospital, but lacks a carer at home to look after them. Physiotherapy and nursing staff might then go to the patient in the community, helping them move to elbow crutches and rebuild strength and mobility. This might not require daily visits.

Other patients might be eligible because they are awaiting home adaptations or equipment.

Latterly, patients have also been discharged to their own homes for recuperative care.

Outcomes:

An audit covering the six months to the end of March 2012 showed 24 patients had undergone recuperative care. Of these, 18 were still at home, four were still under recuperative care (less than six weeks), one had died at the end of their placement and just one had ended up permanently placed in a care home.

The average duration of recuperative care was 31.8 days, compared to 41 days the previous year.

Telephone referral to social care

Where: Northern Devon/NDDH

Ward-based staff at NDDH and community hospitals can now refer patients directly by phone to Care Direct Plus (CDP), if they need social care as part of their discharge arrangements.

CDP staff take initial details on a BICA form, then arrange discharge if the case is not complex. Complex cases come back to the Pathfinder team.

Handover by phone speeds up the system, tapping into schemes such as Rapid Response at Home and Recuperative Care (see above) if required but without calling for ward-based staff to understand their intricacies.

Outcomes:

Positive impact on ward staff and capacity, removing administrative tasks and strengthening communication by direct conversation with CDP staff.