Preventative Services to reduce Hospital admission and keep people at Home

1) **UCR**
2) **NHS@Home (Virtual wards)**

Health Select Committee February 2024

National context

- The NHS Long Term Plan published in January 2019 set out a programme of phased improvements to NHS services and outcomes, including several strategic priorities for community health services which would transform ‘out of hospital’ care and fully integrate community-based care to support people with complex needs. In 2021/22 planning guidance set out a requirement for local services to roll out a 2-hour crisis community Health and Care response.

- In October 2023, a national ambition to build 40-50 virtual ward beds per 100,000 population was outlined in planning guidance to offer a safe and efficient alternative to NHS bedded care that was enabled by technology. The specification was these patients would otherwise be in hospital and included preventing avoidable admissions into hospital or supporting early discharge out of hospital.

Definitions of Urgent Community Response (UCR) and NHS@Home, Virtual Wards (VW)

- UCR teams consist of health and social care professionals who provide urgent health care and rapid care triage to people in their homes within two hours. This is often used for patients who are frail and in crisis, where a quick intervention by a range of community staff attending a person's home will avoid having to call the ambulance and admitting them to hospital. For example, a blocked catheter which could be relieved and treated, a fall where someone needs help to get back on their feet, or a rapid response where an informal carer has sadly become unwell, and the person they care for needs to be looked after to be safe.
- Anyone can refer to urgent community response, and in Wiltshire the local authority, Medvivo and the Community hospital work together to make sure the response is coordinated and meets the needs of the patient or the Carer.
- Our virtual ward service is called NHS@Home Wiltshire. The term 'virtual ward' is misleading, as patients are seen face to face by an expert team of health professionals. This service provides a safe alternative to hospital care for people with acute, hospital care needs associated with frailty or respiratory conditions. Patients are assessed in their place of residence (which could be their home or care home) by a clinician for example a Nurse or Doctor; and their treatment is delivered by a range of healthcare staff for up to 14 days. Treatments could include receiving IV fluids, medication, blood tests, an ECG or being monitored daily by either a clinician or remote monitoring technology (we use a service called Doccla). For patients who require an X-Ray or scan this can be arranged with the Hospital as a day case or 1 night stay.
- UCR and VW are distinct yet complementary services with unique roles in community services.
- In Wiltshire both UCR and VW work closely alongside the Community Nursing and Therapy teams.

The main difference between UCR and VW is that patients in a VW are **acutely ill** and would normally require treatment in hospital.

UCR and VW: Staff type and capabilities

Typical UCR delivery

Types of staff:

- A range of Nurses, Physiotherapists, Occupational therapists, Social workers, health and care support workers and domiciliary care staff. This is a collaborative and partnership approach between Wiltshire Health and care, Wiltshire Council and Medvivo.

Skills and competencies:

- Urgent support for a variety of health emergencies such as catheter care, diabetes, palliative or end-of-life care and urgent equipment provision
- Rapid response for (non-injury) falls
- Support for informal carer breakdown, which if not resolved, will result in a 'social' admission to hospital.
- This service can provide temporary care or be used as an emergency assessment for a longer-term solution, signposting to established services. This aim is to prevent an inappropriate admission to hospital wherever possible and keep people safe and independent at home.

NHS@Home delivery

Types of staff:

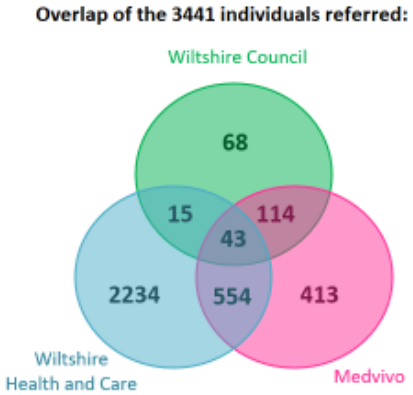
- A named Consultant Practitioner leads the service and is responsible for all patients on the 'virtual ward'. There is access to timely specialist advice and guidance from a range of Consultants in hospital. The team consists of Nurses, Physiotherapists, Doctors, Pharmacists, Mental health Nurses, and health care support workers.

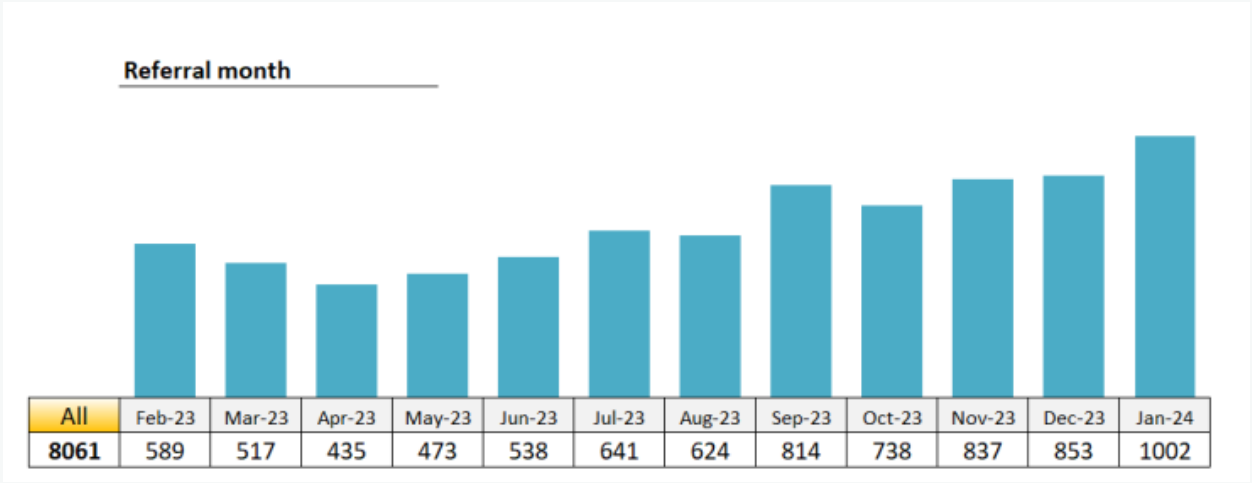
Skills and competencies:

- Specialist skills in treating patients who are acutely unwell at Home
- Daily review of patients for up to 14 days.
- Management of monitoring equipment and use of remote technology to monitor patients (Doccla)
- Access to diagnostics in hospital i.e. scans, this could be as a day case to hospital therefore avoiding the emergency department
- Links to community services on discharge to encourage and promote management of long term conditions

Urgent Community Response data

Referral source*	
111/OOH/ambulance service	2194
Access to Care	647
Adult Social Care	190
Community Team	251
GP/Care co-ordinator	1607
Hospice	115
Hospital ward/A&E	64
NHS at home (Virtual ward)	36
Other service	25
Self/relative/carer	2932
All sources	8061





All	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
8061	589	517	435	473	538	641	624	814	738	837	853	1002

Referral reason	
Carer breakdown	613
Catheter / bladder / bowel	3581
Decompensation of frailty	126
Delirium / cognitive problem	8
Diabetes	23
End of life support / pain control	1542
Equipment provision	174
Fall / accident / injury	735
IV / central line care / indwelling device	9
Other condition specific support	11
Reduced function / mobility	118
Testing / monitoring	157
Wound / skin / ulcer	819
Other (no longer used)	145
All reasons	8061

- The top referrals are for urgent catheter and bowel care and for end-of-life pain relief for those who chose to die at home. 70% of patients are seen within 2 hours of referral and treatment can be provided in their own home.
- Did you know that a ‘Social Care admission’ is someone who comes in the ambulance to hospital because their carer is unwell and there is no other place of safety for them to be? The emergency rapid response for carer breakdown is supporting 40 residents at any one time per month to prevent this happening.
- The cost of a care package for live in care at home is approximately £185 which is significantly cheaper than a hospital bed.
- Only 1.6% of patients are admitted to hospital after being seen by this service.

An example of an Urgent Community response

- Maggie, a carer aged 75 years old phoned for help. Her husband (who she cared for) had become progressively confused and was being aggressive, threating to harm her, and she was frightened to be alone with him in their home.
- The Urgent Community Response service responded to assess her situation within 2 hours.
- Expert Nurses diagnosed her husband with an infection, and prescribed medication. A social worker put in place live in carers who are used to working with people who are confused, to help with daily activities such as washing and dressing.
- Due to significant concerns for Maggie's welfare, it was agreed that she should stay with family whilst he was receiving treatment.
- After a few days, treatment had not had the expected impact and her husband was still paranoid and distressed. Therefore, the service referred for an urgent assessment with a Mental Health specialist clinician who visited and adjusted his medication.
- Care remained in place for 3 weeks until his confusion resolved, and condition settled. Maggie was then able to return home to care for her husband.

People who have acute confusion called delirium often become more aggressive when in an unknown environment. This can be difficult to manage in a hospital ward, and very distressing for a patient and everyone around them. Enabling him to stay at home to receive his treatment will have had a positive impact on his mobility, independence and well-being. Providing respite and a place of safety for Maggie was important too.

An example of an Urgent Community response

- Andrzej was admitted to hospital for emergency surgery on his knee.

- Andrzej is the main carer for his wife Maria who had a stroke 4 years ago. They live together in a 2-bed house, and each day he helps her to get up in the morning for personal care, move around the house and prepare meals.

- Their daughter lives in Sheffield, works part time and has a young family to care for. She came as soon as she heard the news but could not stay for longer than 2 days to support her mother.

- The Urgent Community Response team were called for carer breakdown. The team arranged carers to visit 4 times per day, for four weeks, until Andrzej had been discharged from hospital and was fit enough to resume caring for his wife.

As a Carer, it is such a difficult time when you become unwell. You must cope with your own illness or injury whilst worrying about what will happen to those you care for in your absence.

This service enabled Maria to stay in the comfort of her home. It also gave reassurance to Andrzej so he could concentrate on his recovery.

NHS@Home (virtual wards)

Referral source	
111/Out of hours	14
A&E	1
Ambulance service	0
Community team	24
Community service - other	6
GP	29
Inpatient ward - GWH	29
Inpatient ward - RUH	37
Inpatient ward - SDH	3
Inpatient ward - other	0
SDEC	3
Urgent Community Response	0
All sources	**146**

Primary referral reason	
Accident / trauma	4
Bladder / bowel / continence	6
Cancer	1
Cardiac / circulatory conditions	7
Cellulitis / ulcer / skin condition	2
Cognitive / mental health problem	3
Decompensation of frailty	76
Diabetes	0
End of life support	0
IV / Central line care	0
Pain / symptom control	8
Reduced function / mobility	1
Renal problems	0
Respiratory condition	37
Stroke / neurological condition	1
Other	0
All reasons	**146**

NHS@Home is a new service- giving patients who are unwell the CHOICE to receive their acute care at home.

- We currently have community specialist staffing to support 56 patients on any given day at home across Wiltshire and will be increasing to 90 over the next few months.

In January 2024;

- We supported 146 patients so they could have hospital level treatment at home.
- Referrals came from a range of providers- 50% of patients were referred to prevent admission to hospital, 50% of referrals were to get people out of hospital to continue treatment in the comfort of their home.

When patients with frailty are admitted to hospital, they often stop moving and completing daily tasks that they would do at home.

Evidence from virtual wards shows that when you have your care at home rather than in hospital you are
5x less likely to acquire an infection and
8x less likely to have a decline in your mobility and strength.

An example of an NHS@Home patient

- Sylvia was 85, she had a heart condition but had been coping well, living alone independently with her dog and watching the birds from her conservatory in her garden.

- She phoned her Doctor as she had been experiencing some pain and was not generally feeling well.

- The Doctor had told her that she needed some investigations. Sylvia did not want to go into hospital as she did not want to leave her dog and was worried that she would not have any visitors due to the distance from her home and lack of transport available.

- The Doctor referred her to NHS@Home. A specialist Nurse clinician went to see her at home and took some bloods and sent them to hospital. The results showed that she needed urgent treatment for heart failure. It also indicated that she might not recover from this episode.

- The staff spent some time with Sylvia talking to her about her treatment choices. It was important that they understood her wishes, the way she wanted to receive her care and what she wanted to happen if her treatment no longer worked, planning for how she might die. Often when patients quickly become unwell, there is no time to have difficult conversations, and decisions are made for them about their care. Many people die in hospital, away from loved ones, in an unfamiliar environment because they did not make an advance care plan known as a ‘Respect plan’. Sylvia was pleased to sit and have a conversation. She was keen to take control and make plans so that she could chose to die at home. She wanted to be in her place of comfort and safety. The notes were written up and she kept them at home with her.

- Sylvia was visited daily for 10 days by a team of Nurses, Physiotherapists and health care support workers to monitor her treatment and condition, until the acute symptoms resolved. She was pleased to be in her home, where she could move independently, eat the food she enjoyed, and receive visits and help from friends and neighbours. On this occasion Sylvia improved, however, she has a condition which needs long term monitoring, so she was referred to the Heart Failure outpatient team for ongoing management.