York Teaching Hospital NHS
NHS Foundation Trust

Health and Adult Social Care Policy and Scrutiny Committee – 19 April 2017

Delivering Home First: Re-Providing Archways Intermediate Care Unit Update Report

This paper was requested by the Health and Adult Social care Policy and Scrutiny Committee following a discussion regarding the closure of Archways Intermediate Care Unit at its meeting held in September 2016.

The paper identifies the background to the decision to close Archways Intermediate Care unit and reinvest the resources into an expanded range of community services. The proposal also identified the need to maintain and deliver some of the in-patient functions delivered at Archways by distributing those function to other in-patient community units. Data is presented to clarify the impact of the closure and the success of the measures planned and implemented.

Michael Proctor, Deputy Chief Executive of York Foundation Trust will be attending the Committee to present the report and answer questions.

Recommendation

The Health and Adult Social Care Policy and Scrutiny Committee are asked to note and discuss this report.

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1. Introduction and Background

Archways Intermediate Care Unit consisted of 22 beds (arranged over two floors) and was based at Clarendon Court, York (this represented 2% of York Teaching Hospital NHS Foundation Trust (YFT) bed stock). Typically, 350 patients were managed via the unit annually, of which 270 of these were over 75 years old. It was established over twelve years ago as an intermediate care unit; typically providing short term rehabilitation and support to adults who need a period of rehabilitation, recovery or reablement after a stay in hospital or because of 'a crisis' which means that they can't remain at home (or their usual place of residence).

YFT has, over the last twelve months, participated in the national Emergency Care Improvement Programme (ECIP). The ECIP aims to support local health and social care systems to review and improve the way that emergency care services are delivered. As part of this programme, the national ECIP team have undertaken audits across all YFT community units. This audit work determined that many of the patients being managed at Archways could, in fact, be supported at home if alternative services were available. In addition, emerging national evidence suggests that elderly patients suffer from the harmful effects of deconditioning relatively quickly, following admission into a hospital bed. After 24 hours, muscle power reduces by 2-5% and circulating volume by up to 5%. At 7 days, this has deteriorated even further with a reduction in muscle power of 5-10% and circulating volume of up to 20%. In many cases this isn't reversible. Therefore, minimising hospital stays (or avoiding admission altogether) is essential.

On this basis, a plan was developed to close Archways and reinvest the resources released into an expanded range of community services. This meant that only those patients who cannot be managed at home (or in their usual place of residence) with support are admitted into an inpatient bed. This proposal to enhance and re-provide these services form part of the Vale of York CCG and YFTs out of hospital strategy that sets out an ambition to deliver care closer to home.

However, for some patients remaining at home with support may not be clinically appropriate and for these people 'bed based' intermediate care remains available at other community units such as either Whitecross Court [23 beds] or St Helen's [20 beds] rehabilitation units. These units are located on Huntington Road and Tadcaster Road respectively. Admission to these units is based on individual clinical need.

This approach is consistent with the learning from conversations that the Vale of York CCG has held with the public about 'what good care or services looks like'. People have told them that they would prefer to be supported at home by coordinated health and social care services that are tailored to meet their own individual needs. When asked, the local community has told us that they want to tell their story once and they want to receive treatment and care at home, in their own familiar surroundings.

Reinvesting the resources released from closing Archways into community based services is providing an alternative for those people/patients who do not need to be in a hospital bed. The services previously delivered from Archways are being provided through an expanded York Community Response Team and other appropriate support services enabling a greater number of patients to be supported at home by nursing, therapy and social care assessments, rehabilitation support and treatment.

These services include:

- Expanded Community Response Team (CRT) - allied health professionals, nurses and generic support workers who work as part of a multidisciplinary team providing nursing, therapy and social care interventions;
- Community Discharge Liaison Service – ensuring that people receive the most appropriate community service appropriate to their level of need;
- Advanced Clinical Practitioners – providing enhanced assessment, diagnosis and treatment of people in their own homes;
- An Outreach Pharmacy Service – providing support in managing multiple medicines following discharge from hospital.

2. Actions to Date

The closure of Archways inpatient unit was successfully completed, as planned, on the 19 December 2016.

The York Community Response Team (CRT) was expanded by 50% to ensure that an additional 350 patients each year can be safely managed at home and that an equivalent number of step-up patients (patients admitted to Archways directly from home which averaged 3 per month) can be

accommodated and managed at home by the CRT. The expanded CRT has also extended their hours of service from 8pm to 10pm (365 days a year).

Importantly, all Archways staff have been redeployed within other YFT services. As expected, recruitment to the expanded CRT was challenging for some posts, however, all posts in the expanded team have now been appointed to.

From 19 December 2016, 70% of the planned additional capacity was in place, allowing the team to support 15 additional patients at home (at any one time). From the end of January 2017 the team were able to support an additional 22 patients at home (as planned).

The Discharge Liaison Team are in place to:

1. Facilitate acute hospital transfer/discharge into community inpatient beds;
2. Proactively 'pull' patients into community services;
3. Work with partner organisations and families to facilitate discharge from community wards.

As part of the reconfiguration, the criteria for admission to White Cross Court and St Helens Rehabilitation Units has also been expanded to take a wider range of patients. Additionally, White Cross Court is now able to admit patients directly from the community and the Emergency Department. The Community Discharge Liaison Team has in fact been shortlisted for the National Health Service Journal 'Value in Healthcare' awards.

The Advanced Clinical Practitioners (ACP) provides clinical support and advice to the CRT and liaises directly with GPs as needed.

The ACPs attend multi-disciplinary team meetings to identify any concerns the team may have regarding the on-going health/progress of CRT patients, and initiate early clinical review/intervention of individuals as required. The ACPs are able to prevent admission to hospital where appropriate and provide early assessment at home.

The Outreach Pharmacist carries out clinical medication reviews that aim to improve safety and compliance with taking medicines as well as increasing people's ability to manage their own conditions and minimise waste. They do this through the assessment of people's own medicines and the review of repeat prescriptions.

The main aim of both the ACP and outreach pharmacy role is to allow patients to be cared for at home and to avoid admissions or prevent re-admissions to hospital (where appropriate).

3. Impact

Charts 1 and 2 show the total number of referrals to the Community Response Team and the split between patients who have 'stepped up' from the community and those who 'stepped down' from hospital. Chart 1 shows progress against the planned increase in referrals to CRT. As a result of the expected shortfall in capacity whilst recruitment was completed, additional therapist support was allocated to the CRT throughout January 2017 to mitigate the impact.

Chart 1: Number of referrals into York CRT

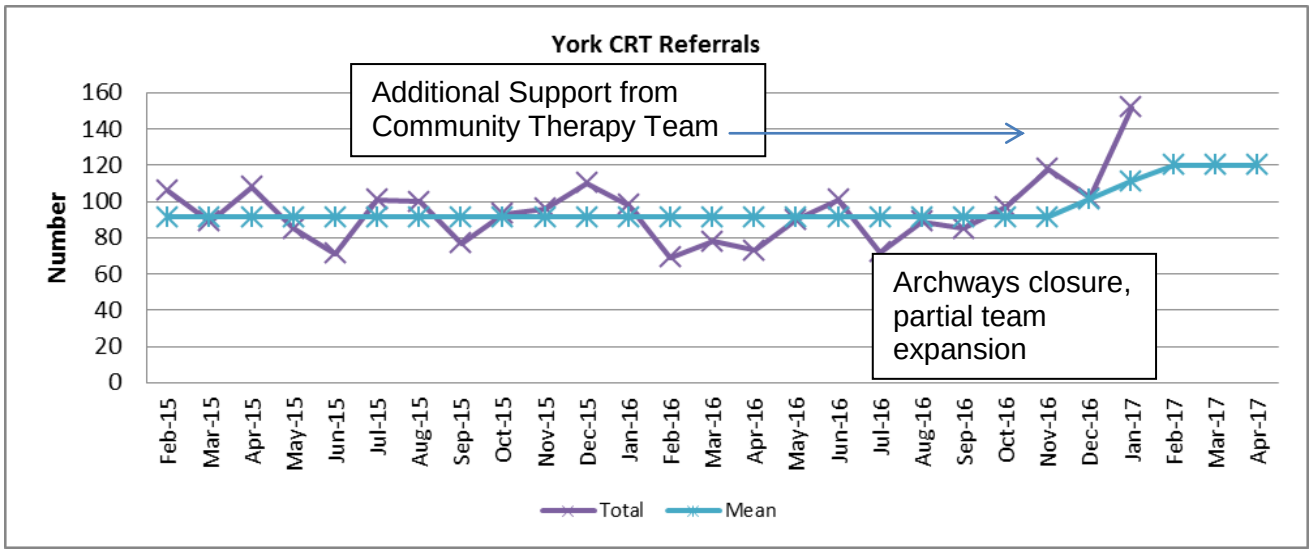

Chart 1 demonstrates that the team have exceeded the increased number of referrals that were planned from November 2016 onwards.

Chart 2 : % Split between step up /step down referrals

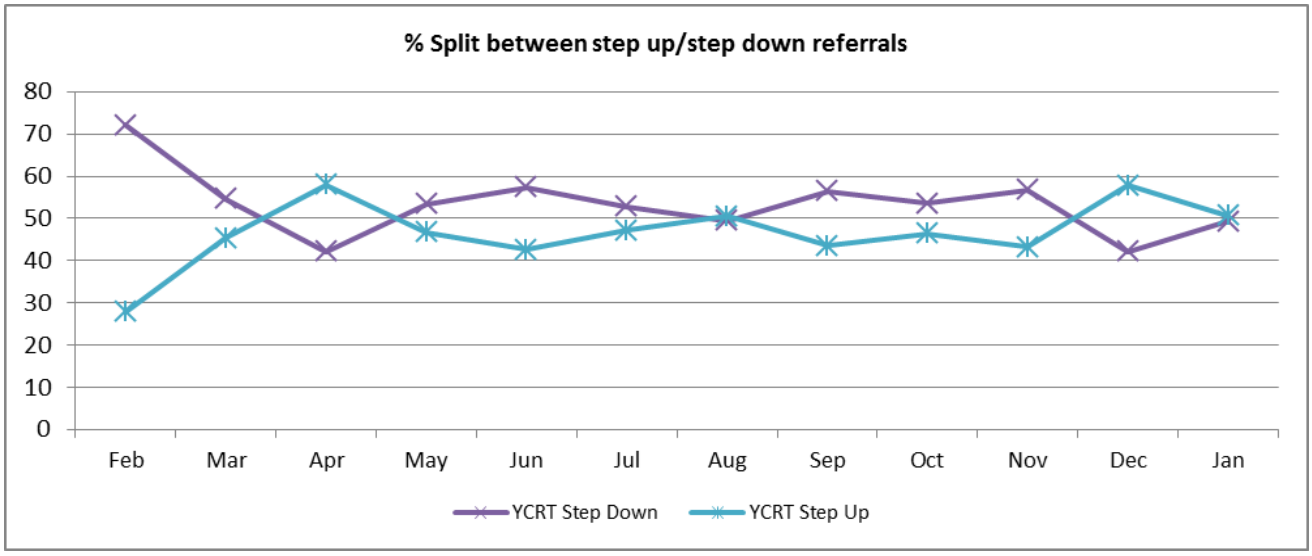

Chart 2 demonstrates that there has been an increase in the proportion of referrals for people 'stepping up' from the community (potentially avoiding the need for an acute hospital admission).

Chart 3 shows the actual number of 'step up' referrals to the CRT against the planned increase of 4 additional step up referrals per month. Chart 4 shows the admissions to Whitecross Court and St Helen's Rehabilitation Units, split by step up and step down referrals.

Chart 3: Step up patients referred to York CRT

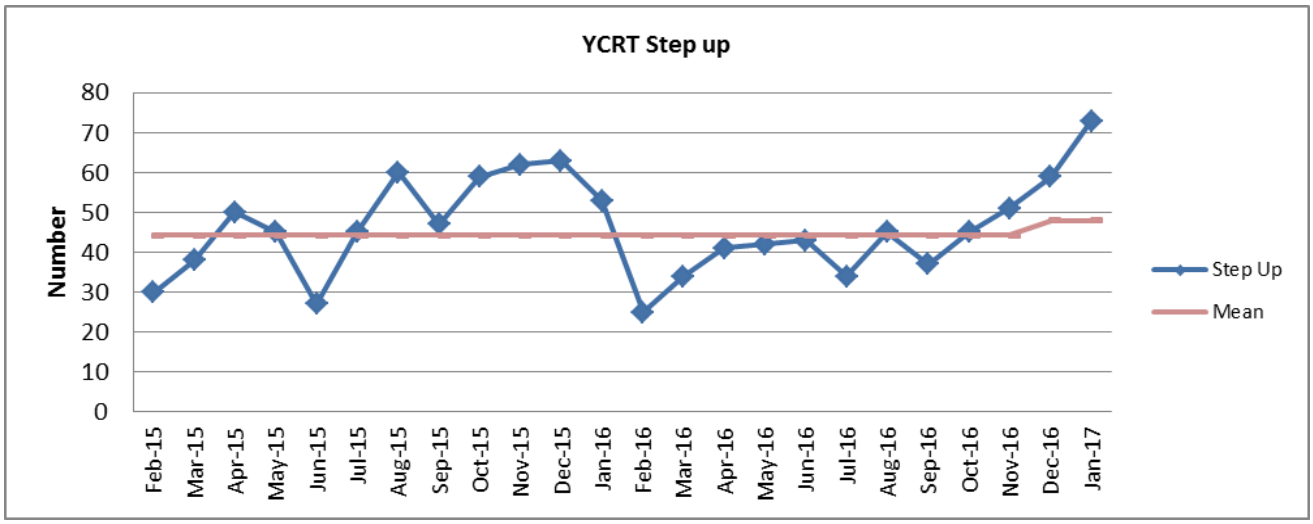

Chart 3 demonstrates that the number of step up admissions has exceeded the planned increase from December 2016 onwards.

Chart 4: Step up admissions to Whitecross Court

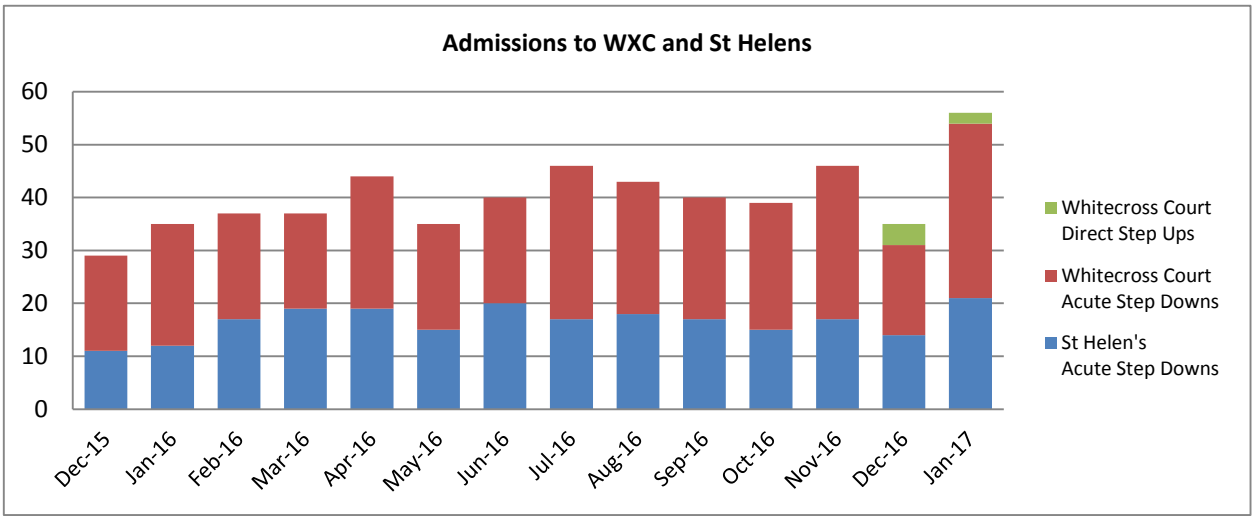

Chart 4 demonstrates that Whitecross Court has also provided capacity for patients who required a direct admission into a community inpatient bed.

Chart 5 shows the monthly referrals to the CRT from the Emergency Department (including the Rapid Assessment Team Service (RATS) that works within the department).

Chart 5: Monthly referrals to York and Selby CRTs from ED/RATS

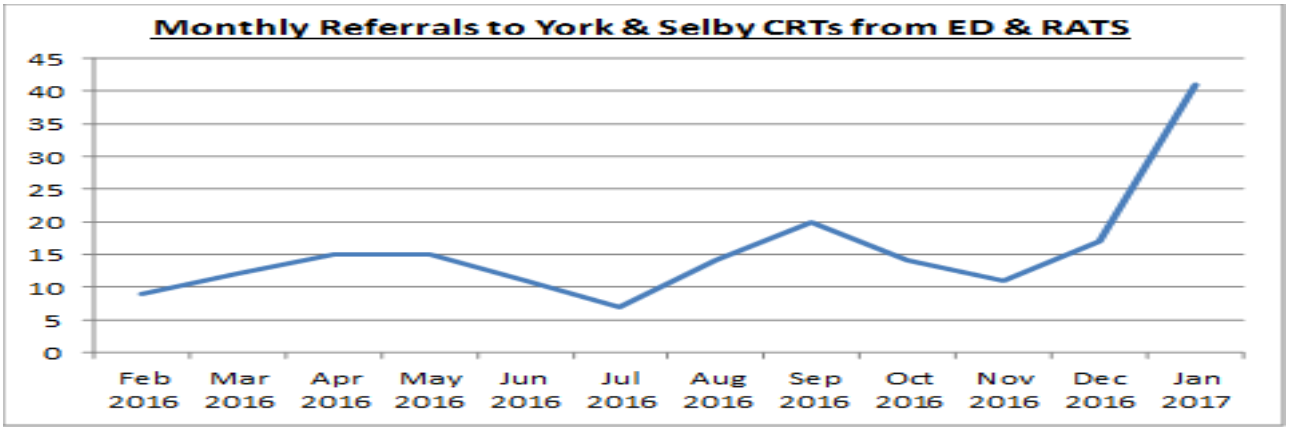

Chart 5 demonstrates the increase in referrals from the Emergency Department directly into the CRT, (potentially avoiding the need for an inpatient admission to an acute or community bed).

The Discharge Liaison Team provides a single point of triage into community inpatient beds. This enables better overall utilisation of the community resources and enables flow across the system. The following charts (6-8) show the utilisation of the community resources.

Chart 6: Total number of admissions to community inpatient beds

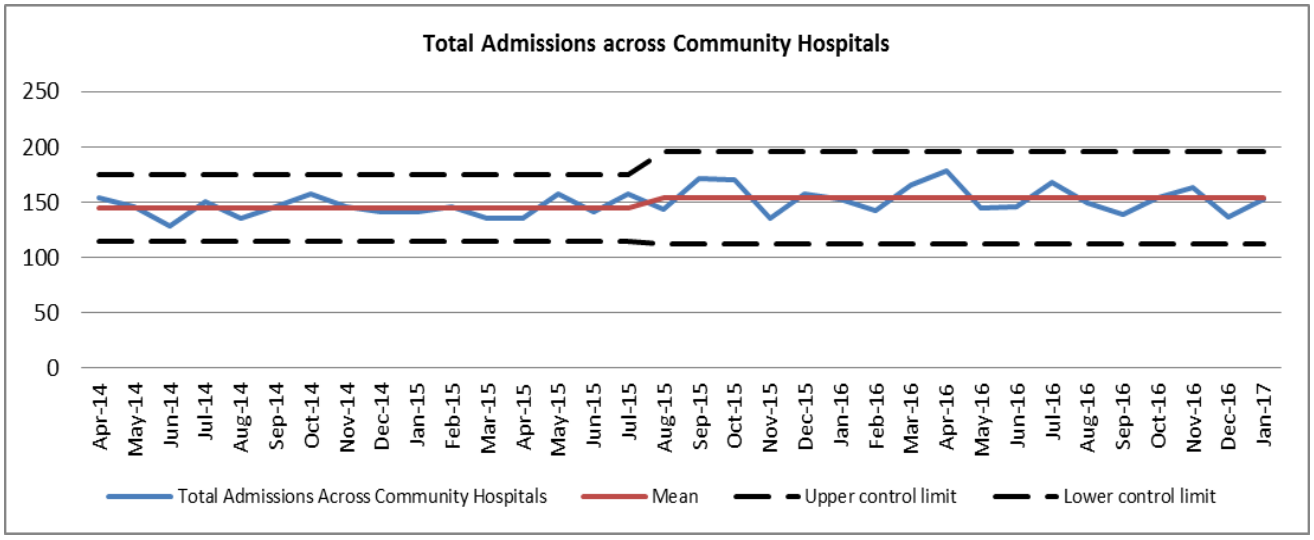

Chart 6 demonstrates that, despite the reduction of 22 beds as a result of the Archways closure, there was no reduction in the number of admissions (a reduction was anticipated) during January 2017.

Chart 7: Percentage of beds occupied within the community units

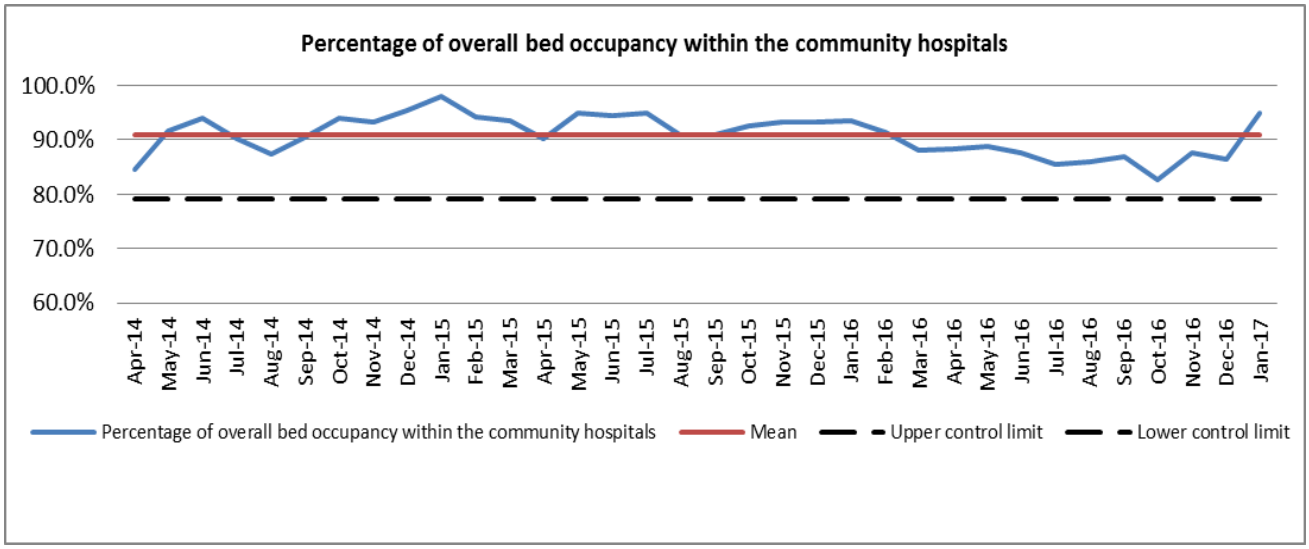

Chart 7 demonstrates an increase in bed occupancy levels in community hospitals in January 2017.

Chart 8: Average length of stay across community hospitals/units

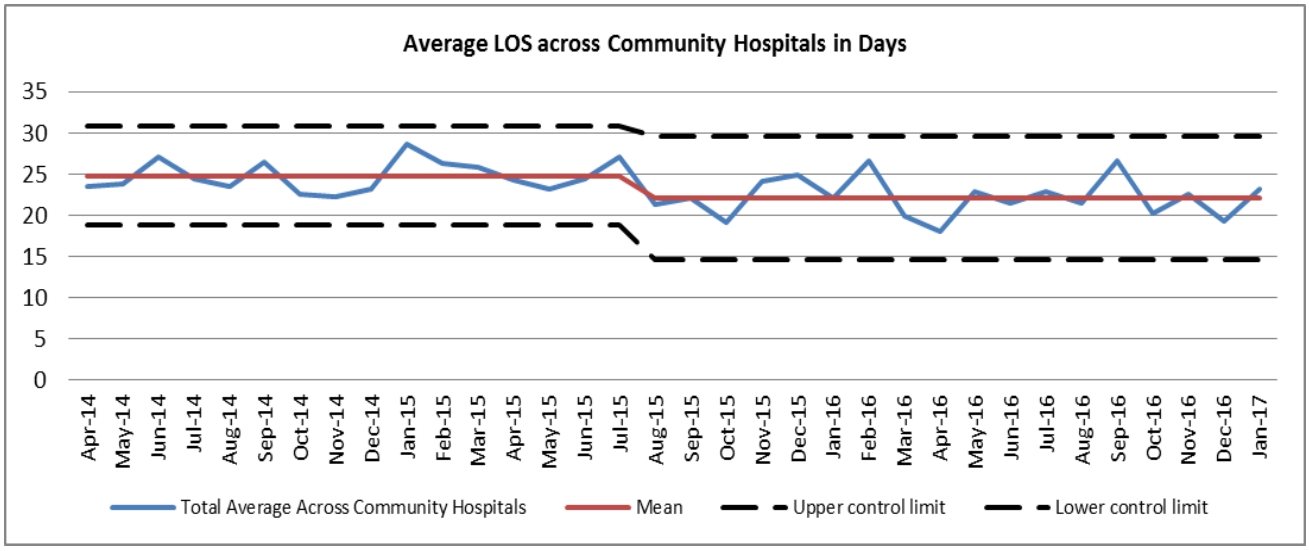

Chart 8 demonstrates that the average length of stay has continued to remain static following the trial of the Discharge Liaison Team which commenced in August 2015.

Chart 9 shows the monthly number of referrals to the Advanced Clinical Practitioners.

Chart 9 Referrals to the Advanced Clinical Practitioners

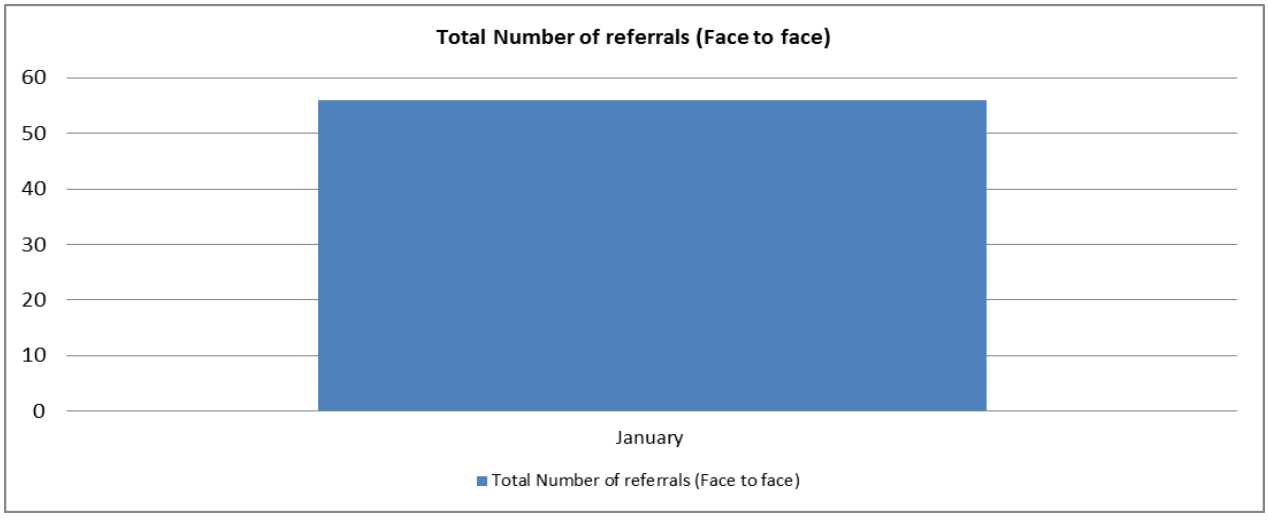

Chart 9 demonstrates that 56 referrals were received by the ACPs in January 2017.

Table 1 provides a comparison of intermediate care activity across YFT between January 2016 and January 2017.

Table 1: January 2016/17 activity comparison

Service	Jan 16 activity	Jan 17 activity	Comments
York CRT	98 referrals	152 referrals	York CRT managed an additional 54 patients at home compared to the equivalent month last year
All CRTs	205 referrals	334 referrals	Overall CRTs managed an additional 129 patients at home compared to the equivalent month last year
Community Inpatient Units	153 admissions	153 admissions	Managed the same of number of admissions with 22 fewer beds
Total community intermediate care (CRT + IPU)	358	487	Overall an additional 129 patients were managed by community intermediate care services in January compared to the equivalent month last year

Table 1 demonstrates that overall in January 2017, an additional 129 patients were supported by community intermediate care services when compared to the same month in 2016.

The project group continues to monitor activity on a weekly basis to ensure that referral growth meets the planned rates, and to take corrective action if there is divergence from this.

4. Case Studies

Case studies 1 and 2 provide real examples of how the ACPs have been able to react promptly to manage and assess patients in their own homes. Case study 1 identifies a patient who was able to be assessed and managed appropriately at home and as a result of this an admission to hospital was avoided. Case study 2 demonstrates a patient who was promptly assessed and triaged to the most appropriate service to manage their care needs.

Case Study 1: (ACPs)

Situation: CRT asked an ACP to urgently assess an 86year old lady (Mrs A) who lived alone and who was complaining of chest pain.

Background: The warden was present and was staying with Mrs A until the ACP arrived.

Assessment: On arrival she looked well but was complaining of chest pain radiating to her jaw. The warden was concerned and wanted to dial 999. Mrs A looked well in herself, was mobilising and her observations were all within normal ranges.

Recommendation: Following a full examination, Mrs A was diagnosed with heartburn (which was treated). She had a painful jaw as a result of her arthritis (which was treated) She was very anxious but felt reassured and was able to remain at home.

Without the input of the ACP, Mrs A would have been taken to hospital by an emergency ambulance.

Case Study 2: (ACPs)

Situation: A 91 year old lady (Mrs B) was discharged home from hospital with CRT support. An ACP was asked to review Mrs B as CRT had concerns that she had not been well since discharge; her shortness of breath was worsening and she had abdominal pain.

Background: Mrs B was originally admitted to York Hospital with loin pain and a urinary tract infection.

Assessment: The ACP visited Mrs B and assessed the problem as an acute abdominal problem with a potential bowel obstruction.

Recommendation: The ACP was able to re-admit the lady directly to the Surgical Assessment Unit at York Hospital for further investigation and on-going management.

This ACP intervention avoided a GP visit or Emergency Department attendance and allowed Mrs B prompt access to the care she needed.

Case Study 3: Outreach Pharmacist

Situation: The Outreach Pharmacist was asked to review Mrs C's medication as she required four visits daily by the CRT to administer eye drops.

Background: Mrs C had been prescribed lubricating eye drops following an ophthalmic procedure at YFT. She has dexterity problems and lacks the strength to use the drop dispenser.

Assessment: The Pharmacist switched to an alternative product that fitted a different type of dispenser that Mrs C was able to use.

Recommendation: The Pharmacist prescribed alternative eye drops, collected the prescription and delivered it to Mrs C's home (and assessed her ability to use them with the dispensing device). He was also able to provide further advice and support and followed up with a telephone call the following day.

The patient was able to use the device and is confident to self-administer her medication.

This pharmacist intervention enabled Mrs C to self-care and prevented the need for four visits per day from the CRT.

5. Conclusion

The Archways Intermediate Care Unit was successfully closed as planned on the 19 December 2016. Alternative services were implemented and the latest performance data has demonstrated that activity has exceeded planned activity assumptions.

6. Recommendation

The Health and Adult Social Care Policy and Scrutiny Committee are asked to note and discuss this report.