Kent Community Health NHS
NHS Trust

Health Overview and Scrutiny Committee Meeting -14th October
Reducing Accident and Emergency Admissions

Kent Community Health NHS Trust is a newly formed organisation on 1st April 2011 formed from the merger of community services from West Kent and East Kent and Coastal PCTs.

The Trust's annual turnover is approximately £200 million. The Trust employs 5,458 members of staff of which approximately 85% are in clinical services. The services operate from a range of sites across the county.

The Trust provides a range of community based services which cover:

- Health and wellbeing to ensure people remain in good health e.g. smoking cessation
- Children and young peoples universal services e.g. health visiting, school nursing and services for children with specialist needs e.g. speech and language therapists, community medical paediatric service
- Patients with long term conditions with the aim of sustaining their quality of life e.g. district nurses, community matrons, therapy services
- Rehabilitation and rapid access services e.g. therapists, rapid response, community hospitals
- Specialist services such as dental, diabetic services, minor injury and illness services

These services all contribute to reducing the need for patients to attend Accident and emergency department and to avoid emergency admissions to acute hospitals. The Trust as a whole made **3,279,389** contacts with people in 2010 /2011.

1. ***Do the current levels of attendance at Accident and emergency departments pose any particular challenge for the delivery of community health services ?***

The levels of people attending A&E do not directly pose a particular issue for community health provision. However, we are commissioned to provide admission avoidance services that are not always understood nor utilised effectively and we would like to hone the ability in our contract to do more.

The advent of the national 111 number will involve the use of algorithms to determine the pathway for a patient and this should drive the use of alternative care pathways which will then begin to impact on the use of community health services. This requires a good directory of services to describe the options to redirect patients to services in a community setting.

We actively promote our services, encouraging referrals and are an essential part of the care closer to home agenda. We support all initiatives that are designed to deliver admissions avoidance and earlier discharge facilitation and rehabilitation activity where it is safe and appropriate.

2. ***What is the role of community health services in reducing attendances at accident and emergency departments***

A significant number of patients who attend A&E and are admitted are suffering from a long term condition. Kent Community Health Trust is actively working with partners to join up care for this group of patients with the aim of maintaining their health and managing their symptoms to prevent the need for them to attend hospital. The introduction of integrated personal health budget pilot in Kent will explore what impact this has on an individual in managing their own condition.

The use of assistive technology (telehealth) is now key in our management of appropriate patients with long term conditions. This initiative, together with KCC has proved to be invaluable, firstly for patients and their carers, not only promoting confidence, independence and understanding of the management of their condition but also an early indicator of an impending exacerbation or crisis. An individual management plan is in place for patients and is activated to ensure that their emerging symptoms are managed together with the GP and sometimes their hospital consultant, therefore averting a possible admission. This has shown a reduction in admissions, GP visits and also the need to attend for out patient appointments in some instances.

In addition, we have recently been implementing a risk predictor tool that when patient level data is run through the computer software it can provide a prediction of risk of attendance at accident and emergency. This allows a targeted approach to managing the patient's condition through early intervention. It can also provide evidence that interventions made by

community health services have an impact reducing the need for patients to attend accident and emergency departments

Rapid response services provide a 2 hour or less response to any patient that requires nursing, social care and therapeutic interventions to prevent a hospital admission where it is safe to manage the patient in their own home. This can be for conditions such as chest infections, urinary infections and falls.

Kent Community Health Trust has been working with the ambulance service paramedic practitioners (PP) to identify those patients who could safely remain in their own home. The PP will assess patients and call upon community and other services to support the patient rather than transfer them to hospital.

If the team deem it is not appropriate or safe for the patient to be managed at home they can 'step up' the patent into a bed either in a community hospital, integrated care centre or care home (where there are commissioned short term beds). It is always the team's aim to restore the patient to their former ability or to a level of independence and return them back to their home as soon as possible.

Community hospitals, integrated care centres and short term commissioned beds in care homes play a key role in admissions avoidance through the option to 'step up' patients from the community (their home) directly to a bed in a community setting (if it is safe to do so), providing nursing and medical care in a therapy, with the aim to again to get the patient home as soon as is possible to their own home.

At present the split between transfers to the community hospitals from acute trusts and the stepping up of patients from the community is approximately 75% / 25%. We would be keen to work with the wider health and social care economy to increase the ratio of patients stepped up to community hospitals and other community beds from home to prevent admission to acute hospitals where possible.

Minor injury /illness services are provided by Kent Community Health Trust and see and treat a large number of people per year across the minor injury units (MIU). In 2010/11 there were 94,460 attendances at the MIU centres. At present units in the West of Kent do not provide minor illness treatments but this is planned for a start towards the end of the year following discussions with commissioners. The conversion rate (the numbers of patients sent onto acute hospitals from the units) is relatively low.

Discharge multi professional facilitation teams actively case find patients for early supported discharge, working on acute hospital sites across Kent together with social care. Community based services then continue

rehabilitation, recuperation or longer term support either in the patients own home, community bed or care homes.

A programme which delivers redesign of patient pathways where, traditionally, patients would have to stay in hospital was a collaboration between Community health services in Kent, GP's, social care, and East Kent Hospitals University NHS foundation Trust. These include treatment of conditions such as, deep vein thrombosis, pulmonary embolus and cellulites management, delivering intravenous therapy and anti-coagulation (blood thinning) treatments in the patients own home. A survey of those patients, who received their treatment at home, as part of this programme, was found to be positive.

Patient Examples:

New Care Home Pathways:
Patient A resides in a residential care home and had a fall in their room. The patient had not bumped their head and did not appear to have any bony injury. They had a small abrasion on the small of their back which appeared to suggest they had slipped to the floor while trying to sit in an armchair. This was not the first fall and previously the care home would have dialled 999 and the patient would have been taken to A and E for review.
With the new care pathway developed with the care homes, KCC, SECAMB and KCHT the patient was reviewed in the care home by a paramedic and the Rapid Response senior nurse on duty.
Following a full assessment and agreement that the patient did not require transfer to A and E, the patient was put into bed by the team.
Rapid Response agreed to provide additional monitoring of the patient for the next few days to support the care home in keeping the patient there. In addition, Rapid Response then sent out a therapist to undertake a full falls prevention assessment and provided the patient and the care home staff with strategies to try and prevent future falls and a new walking aid that met their needs.

Long Term Condition management:
Patient B is housebound with a diagnosis of Chronic Obstructive Airways Disease. He has an oxygen condenser and requires regular review. They receive 2 care package visits per day. He had a history of dialling 999 when they were anxious, short of breathe and of being taken to A and E for assessment and usually ending up being admitted for between 3 days and 2 weeks.
To improve this patient's management programme and reduce potential admissions to hospital the GP practice set up a multi disciplinary team (MDT) meeting which included the community matron, care manager and practice nurse. The outcome was an agreement to assess the patient's suitability for telehealth monitoring, then once installed to ask the community matron to review the patient's readings daily and so provide assurance to the patient as well as allow proactive review of medication and early warning of infection or exacerbation.
The GP is given regular readings of the patient and meets the Community Matron as required to ensure the patients readings remain within acceptable levels. It has also enabled the care manager to flex social care support to ensure the patient remains at home.
Before this MDT approach to this patient was initiated he was dialling 999 an average of 3 times a month. This has now dramatically decreased and this summer they have attended A and E just once which was appropriate and following a chest X-ray and a short course of intensive treatment the patient returned home to the care of the community matron.

3.What is the place of urgent and emergency care in your organisations QIPP programme ?

The QIPP programme sits with Clinical Commissioners and therefore we would expect to be contributing to the programme through collaboration in the development and delivery of redesigned care pathways to assist in meeting the urgent and emergency care QIPP programme.

This would relate to the proactive management of patients with long term conditions, through the use of the predictive tool as described earlier (this is a software tool that can be used to identify people via GP practice registers who are at risk of admission to hospital) so that people and be assessed by health and social care services in order to promote health and well being and ensure appropriate case management.

End of life care and dementia will also be areas that Kent Community Health Trust together with social care and mental health services can make an impact on reducing avoidable admissions to hospital and allowing more people to die at home.

We believe that the delivery of the QIPP programme and urgent care management can be achieved through the proposed Integrated Health and Social Care Service model. This brings together primary care (GP practices), community nursing, social care, rehabilitation, rapid response, enablement and mental health services into what can be described as neighbourhood (locality) teams. The team will be accessed via a local single point of referral for health and social care, aiming to deliver the following outcomes:

- Reduction in occupied bed days (average)
- Reduction in emergency bed days for over 65's and over 75's
- Reduction in delayed transfers of care
- Reduction in readmissions

In addition the following is hoped to be achieved:

- Reduction in emergency admissions for end of life care
- Reduction in admissions to care homes –nursing and residential

4. From the perspective of the community health service, what are the main challenges to reducing attendance at accident and emergency departments ?

Patients will attend A&E if they do not know what alternative services are available and the challenge for Kent Community Health Trust is to raise awareness of these alternatives and provide an easy access point.

There is still, despite efforts, a lack of a whole system approach to the management of urgent care demand, some of which relates to the lack of use of alternative care pathways. Our services are largely reactive as a result and are dependant on others who are likely to see the patient first for example; paramedics, GP's and A&E staff. Despite the provision of minor injury / illness units (which are well utilised) people still choose to attend major A&E departments. This is the patient's personal choice.

Challenges also include the lack of commissioning decisions relating to development of new / revised pathways that require the disinvestment in acute services and reinvestment in alternative community service provision. However, we are working with East Kent Hospitals University NHS Foundation Trust to explore opportunities relating to possible sub contract arrangements in some areas of provision. An example is increased intravenous therapy treatments.

There is also a lack of a single co-ordination point via a single telephone access number service for managing redirection of patients who can be safely cared for in a community setting locally. This is contributing to the way patients are still being transported to Accident and Emergency departments rather than utilising alternatives through a robust process. Kent Community Health Trust has been looking into possible options to propose a potential solution. It may be possible to collaborate with others to provide such a service and support a reduction in readmissions.