HOW A RAPID RESPONSE TEAM IS SUPPORTING PEOPLE TO REMAIN AT HOME

Esther Clift discusses a popular scheme that is preventing unnecessary hospital admissions.
It has absorbed much of the ad hoc clinical work out of hours, such as the stroke early supported discharge work, some palliative care, twilight nursing service and housebound phlebotomy services.

The focus of the RRT is on supporting patients to remain at home in spite of a clinical crisis. The inherent value of such a service is that care can be delivered closer to home, which is recognised as being a safer place with better outcomes for older patients who are rapidly disorientated and deconditioned by even a short stay in hospital (Oliver et al 2014).

There are also a number of political imperatives for delivering care in this way. First, there is the failure of many EDs to see, treat and discharge 95% of patients within four hours (DH 2015). The four-hour target means there is often not enough time to complete a thorough history and full diagnostics for older patients with complex clinical presentations, and admission becomes a preferable option. Avoiding presentation to the ED therefore becomes paramount. Secondly, older people often have to wait in hospital while the complicated assessment of responsibility for payment of services on discharge occurs, rather than being in their chosen place of care.

A number of policy changes have been made to enhance care delivery closer to home. The £5.3 billion Better Care Fund, formerly the Integration Transformation Fund, was announced by NHS England in June 2013 (DH 2013a). It created a single pooled budget for health and social care, encouraging the NHS and local authorities to work more closely together and place the wellbeing of patients at the heart of care.

Patient groups, as well as clinical and independent experts, have provided a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the population’s health, quality of care and funding of services. The NHS Five Year Forward View (5YFV) (NHS England 2014) set out a vision for the future of the NHS. It was adopted by all political parties, and forms the backbone of the Conservative government’s health policy. One focus has been to deliver care in alternative ways. The first pilot areas, or ‘vanguards’, for delivering some of these new models of care were selected early in 2015. They include multispecialty care providers who will offer services usually provided in ‘acute’ settings, but integrated with GPs and community services.

All this adds to the weight of evidence that care is better delivered for patients in their own home, or as close to it as possible (Oliver et al 2014).

**Benchmarking against national data**

The complexity and variation in the caseload have made it difficult to evaluate the RRT, but the National Audit of Intermediate Care (NAIC) conducted in 2013 and 2014 (NHS Benchmarking Network 2013, 2014) provided some benchmarks against which to review the service. The RRT collected data for patients referred to it between October and December 2013. Approval for publishing these data was given by the trust research committee.

Data were collected on 101 patients aged between 53 and 102 years: 72 women and 29 men. Age distribution of referred patients was collated (Figure 1), as well as source of referral (Figure 2), and patients were classified as requiring social or clinical interventions. Outcomes of interventions were also recorded.

Data from the NAIC 2013 (NHS Benchmarking Network 2013) suggested a similar distribution across the age ranges as that seen by the RRT.

The NAIC 2013 (NHS Benchmarking Network 2013) showed the main source of referral to crisis response services was GPs (21%), followed by EDs (18%) and acute trust wards (16%). The main source of referral to home-based intermediate care was acute trust wards (28%) followed by GPs (26%).

Figure 2 shows referral sources to the RRT. As with the NAIC 2013 (NHS Benchmarking Network 2013), most referrals came from GPs (36%). A daily advice line with the community geriatrician is available for GPs, and an urgent domiciliary visit for comprehensive geriatric assessment (CGA) can be undertaken. Most of the remaining referrals were from community nurses (17%) or ED teams (EDTs) (19%). The EDTs use the RRT to monitor patients who have been unwell enough to require presentation at the ED, but do not

![Figure 1](image-url)
need an inpatient stay. They may then be referred to community matrons and therapists. The specialist team category included referrals from older people’s mental health, the community respiratory team, dermatology and palliative care. Those who self-referred or were referred by a friend or carer were included in the ‘other’ category. There was only one referral from the hospital discharge team, which has also been included in the ‘other’ category. It was an end of life referral and care was unavailable elsewhere. The RRT is not commissioned to support routine planned discharges from hospital, but focuses on crisis intervention in the community.

Initial triage for the RRT revealed a combination of actions to facilitate onward care, namely: liaison with the GP to lead on care delivery, CGA by the community geriatrician at home with an agreed level of urgency, or referral to the virtual ward and management by the locality-based community health team with community matron. A virtual ward works like a hospital ward using the same staffing and daily routines, but people are cared for in their own homes. Patients on the virtual ward are usually the most clinically unstable and most at risk of a hospital admission.

Due to the acuity of referrals, 10% of patients referred to the RRT in this two-month period deteriorated further and required admission to a bedded unit. The RRT has direct admission to the acute medical unit, bypassing the ED. The admission threshold is high, however, due to the team’s extended scope of practice enabling greater numbers of people to remain at home.

Patients who fall are managed along a similar pathway to those with frailty. A comprehensive domiciliary assessment is undertaken by therapy staff and there is discussion with the community geriatrician and further assessment and diagnostics either at home or in an appropriate clinic setting.

Audit of the RRT in the two-month period included a review of outcomes for patients supported by the team (Figure 3). The data demonstrated that 29% of patients were discharged home from the service with no increase in dependency from admission. This included those who had a care package and continued with the same level of care after their engagement with the RRT. The reablement service (rehabilitation teams, usually under the supervision of an occupational therapist) in the city supported 23% of patients while longer-term care packages were established. A further 12% were supported with additional care, which was started while still at home, and enabled the RRT to step down its care.

It is important to note that 28 patients who were in crisis were admitted to a bedded unit, as they required a level of care which was not sustainable at home. One admission was to older people’s mental health, three were to step-up beds and 24 were to the acute trust. Half of these were admitted within 48 hours of referral to the RRT. This demonstrates the value of having a specialist team of healthcare professionals integrated with wider community and social care teams. The team can support people at
home and only refer on for an inpatient stay when there is clear clinical need or complex diagnostics.

Patient-reported experience measures are key indicators to demonstrate support for any service. These were recorded in the NAIC 2014 (NHS Benchmarking Network 2014) and showed a high level of satisfaction with services. This was particularly true for patients who thought they had been treated with dignity and respect during their episode of care. More than 89% reported a high level of satisfaction in this area. Significantly, 75% reported that they were less anxious after their engagement with intermediate care teams. There was also a high level of praise in respondents’ comments for team individuals. In a separate snapshot audit in 2013, for the RRT, 85% of people strongly agreed with the statement that they had been treated with dignity and respect during their engagement with the team, and 96% had full confidence in the team. This compares favourably with the national data.

One further significant measure for evaluating services is the ability to respond in a timely manner. GPs are clear that their confidence in the service directly relates to the capacity of the team to respond quickly. The RRT has a key performance indicator that requires it to respond to a crisis call with a face-to-face visit within two hours. This target has been met consistently. There have been a handful of occasions when the service has had to ‘close’ because it has been unable to accept a referral within the time frames. To meet current targets, and continue to provide excellent outcomes for those in the community, the team does not accept discharged patients, except from the ED or in exceptional circumstances. There is ongoing discussion about additional commissioning to support hospital discharges, from other areas in the hospital. The NAIC 2013 (NHS Benchmarking Network 2013) reported crisis response waits of 7.3 hours, but these had increased to 8.9 hours in the NAIC 2014 (NHS Benchmarking Network 2014). Accessibility of services is also demonstrated by the number of days a year they are open for referrals. The NAIC 2014 demonstrated that only 68% of services were open 365 days a year. Many of the remaining services mirrored GP hours. The RRT is available for referrals 365 days a year and meets its two-hour face-to-face visit target 99% of the time.

Response time is linked with ‘length of stay’ for a patient on the caseload. This will vary for crisis intervention, or step-down care. The NAIC 2014 (NHS Benchmarking Network 2014) showed that since 2013 length of stay had increased by two days for home-based services to 30.4 days. The RRT has a target of a seven-day length of stay for crisis intervention work. The NAIC 2014 found little correlation between length of stay and patient outcomes, which may suggest that extended length of stay relates to the capacity of social care teams to continue to support people at home, rather than a requirement for the specialism of the intermediate care team’s rehabilitation.

Skill mix is another indicator of service quality. The NAIC 2013 (NHS Benchmarking Network 2013) suggested that fewer than 2% of intermediate care teams had the support and clinical oversight of a community geriatrician. This has an effect on the clinical complexity of patients who can safely remain on intermediate care team caseloads. The RRT has a caseload review with the geriatrician three times a week and she is available daily for telephone advice. This enables robust and appropriate clinical assessment, intervention and monitoring. It also ensures appropriate escalation, as well as a learning environment for the whole team. The NAIC 2014 (NHS Benchmarking Network 2014) showed an increase in the number of teams with community geriatrician oversight to 9%.

One of the few gaps in the RRT is lack of full integration with mental health services. There is close working with local teams, and full integration with the older person’s mental health team will be in place by the end of 2015. In the NAIC 2013 (NHS Benchmarking Network 2013) 2% of teams had full integration with mental health services. Another area for development might be daily reviews with community pharmacists to ensure that older people have the right levels of and appropriate medication for their long-term conditions (British Geriatrics Society 2014, 2015).

In 2012 the NAIC (NHS Benchmarking Network 2012) calculated that a 100% increase in intermediate care capacity was required to meet the demand for services. The NAIC 2014 demonstrated that there has been little material investment in intermediate care. In fact there has been a shift nationally towards supporting discharge, with 44% of referrals coming from hospitals in 2014, compared with 35% in 2013 (NHS Benchmarking Network 2013, 2014). This may suggest that supporting hospitals to manage their bed pressures has taken precedence over keeping more clinically unstable people at home in their familiar environments.

The case study (opposite) illustrates how the RRT can support patients.

**Conclusion**

Evidence demonstrates that the RRT has been able to maintain its specialism as a clinical crisis support team. It manages patients, where appropriate,
Case study of support offered by rapid response team

Florrie (a pseudonym), an 86-year-old woman, lived at home with a private care package. Her carers visited four times a day for support with personal care and hydration and nutrition needs. She was independent and mobilised with a Zimmer frame at home, but had significant postural instability. She had an underlying history of Parkinson’s disease, back pain and psychosis. A fall at home precipitated her crisis.

The GP was called when she fell and established that she had no broken bones, but confirmed that she had a lower respiratory tract infection. The RRT took her onto its caseload. She was prescribed appropriate antibiotics and the carers were able to continue with their usual routine. The GP reviewed her medication and reduced her lithium after checking the results of her blood tests, which the team had taken on their assessment visit. Florrie remained on the caseload for eight days for clinical monitoring. The team ensured she completed the course of antibiotics and that she had adequate analgesia, as the fall exacerbated her back pain and reduced her mobility.

It is possible for an integrated care team to support older people to stay in their own home during clinical crises. The RRT could be replicated elsewhere to support the wider targets of keeping people at home with appropriate diagnostics, where possible, and avoiding unnecessary and often detrimental lengthy stays in acute hospitals. Further investment would enable such teams to meet crisis intervention demand at home, and also support discharges from hospital.

The occupational therapist in the team reviewed her living arrangements and added a rail in the bedroom to reduce the risk of further falls. After eight days Florrie was stable and transferred to the community nurses’ caseload. The community nurses were able to maintain a lower level of clinical monitoring for a further two weeks and then step down her care to regular monitoring by the Parkinson’s disease nurse and the community mental health team.

Florrie was delighted to be able to stay at home with her usual carers and her pet.

The cost of this episode of care was significantly cheaper than an inpatient stay. An average elective inpatient stay, excluding excess bed days, cost £3,366, while the cost for a non-elective, inpatient short and long stay combined, also excluding excess bed days, was £1,489 (Department of Health 2013b). The National Audit of Intermediate Care 2014 (NHS Benchmarking Network 2014) estimated that the mean cost for an episode of home-based intermediate care was £1,045.

in the community (Moore et al 2014). This focus has been maintained at the expense of developing the discharge service from the local hospital. While this may have been unpopular with the local hospital, it is popular with patients. Close working with a community geriatrician has kept people safe while at home, and the skill mix of the team has enabled length of stay with the service to remain on target. Handover for ongoing rehabilitation goals is possible without lengthy and repetitive reassessments.

References

British Geriatrics Society (2014) Fit for Frailty – Consensus Best Practice Guidance for the Care of Older People Living with Frailty in Community and Outpatient Settings. tinyurl.com/p785sq (Last accessed: November 3 2015.)


Southampton City Council (2011) 2011 Census Briefing. tinyurl.com/qvppo49 (Last accessed: November 3 2015.)