CONFERENCE ABSTRACT

Hospital at Home as an Enhancement to an Existing Rapid Response Team in a Semirural setting in Scotland

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Midlothian is the area to the south of Edinburgh with a population of 86,000 spread across an area of 354km². Midlothian Council and NHS Lothian work together as a Health and Social Care Partnership governed by the Midlothian Integration Joint Board. The work described here is an example of fully integrated working at ground level.

For many years, Midlothian has had a successful Rapid Response Team, with a team of Allied Health Professionals and carers who deal with a variety of crises in the community, including attending to people with falls, those that require intensive rehabilitation in their homes and anyone who has an immediate crisis affecting their care. In 2014, in conjunction with NHS Lothian, the team was enhanced by the appointment of a community based consultant geriatrician and four advanced nurse practitioners. This has enabled the provision of a “Hospital at Home” service for the population of Midlothian as a meaningful alternative to an acute hospital admission. Following the initial success of this venture, the team is expanding with further investment in additional nursing and medical time.

The Hospital at Home team work with the pre existing Rapid Response Service and are fully integrated with them, working in the same office in a community setting. The doctor, nurses, physiotherapist and pharmacist are aligned with the NHS, while the administration staff, occupational therapists and carers are employed by the council. In practical terms the team functions as a single entity. This service is different from the other “Hospital at Home” teams around Scotland, as it has grown from its roots in Social Care, whereas other services have tended to be outreach ventures from hospital secondary care.

The goal of the team is to offer an alternative to admission for frail older patients, though younger people can also be referred if appropriate. Patients are admitted to a “virtual ward” on the NHS Lothian computer based TRAK system and have identical access to the same medical investigations as acute hospital inpatients, including all laboratory tests, Radiology and physiological testing where appropriate. The patient however remains in their own home (or care home) throughout their admission. Usual length of stay in the “ward” is around 7 - 10 days.
Additional care support can be provided if needed and there is immediate access to allied health professionals as required. Daily observations are carried out by the nursing staff.

For many patients the key intervention is adjustment of medication and support for the patient and their family through the acute illness. However a variety of more invasive treatments can be provided, including administration of intravenous or subcutaneous fluids. Intravenous antibiotics and also diuretics are also given.

In the first 15 months of the service, up to September 2015, 294 patients were referred, of whom 260 (88%) were suitable. Of these 255 (87%) were referred by their GP, with 51 (17%) being referred by acute hospitals to support early discharge. The local Acute Medical Admissions Unit at Edinburgh Royal Infirmary has now started a daily geriatrician ward round and a rise in referrals is anticipated.

Although somewhat subjective, the team’s perception was that hospital admission had been “definitely avoided” in 184 patients (63%), with another 49 (17%) “unable to comment”. Joining an ongoing National Multicentre Randomised Controlled Trial will help answer this question in future. As expected, the majority of the patients were elderly, with 221 (75%) over the age of 75 years. Females outnumbered males 59% to 41%.

Patients are taken on with a wide variety of problems. The commonest scenario is of acute infection with 59 patients having this (20%). Cardiac problems accounted for 48 patients (16%) and those with respiratory issues including COPD numbered 34 (12%). Many have multiple problems, with falls, delirium and musculoskeletal problems being common in this population.

In each case the benefits and risks of staying at home versus being admitted to acute care are carefully evaluated with the patient, their family and the GP. If the clinical situation changes, then patients can be admitted to the “real” hospital and the team is able to ensure this is to the most appropriate setting for them. This happens for around 10% patients. Until October 2015, the service was provided 5 days a week but it is now available 7 days, allowing a greater number of patients to be referred.

The Midlothian Enhanced Rapid Response Service is popular with patients and staff. Ring fenced funding from an integrated Health and Social Care Board has been key to its success.

Keywords: hospital at home; integration; community; frail; elderly