The Strategy Unit.

Urgent Community Response

Evidence Scan

February 2022

Prepared by:
Shiona Aldridge and Trish Lacey

NHS
Midlands and Lancashire
Commissioning Support Unit

Contents

1. Introduction

This evidence scan has been commissioned as part of the evaluation of the NHS England and NHS Improvement (NHSEI) two-hour urgent community response (UCR) programme.

The evaluation aims to provide:

- **Operational learning:** to establish what are the essential elements of a successful service at scale and maturity
- **Patient and carer/family outcome insights:** to understand the health and wellbeing outcomes and experiences of patients and carers/families receiving support from two-hour UCR services
- **Healthcare system impact data analysis:** to assess the impacts of the programme on flow, health economics (including return on investment (ROI)) and presentations and admissions to acute care.

An earlier scoping study for the programme included a rapid review of the evidence in the form of an evidence signpost (see appendix 1). This provided a summary of evidence for a selection of interventions which have a primary or secondary aim to provide a rapid health and/or care response in the home/place of residence to avoid hospital admission. The signpost was intended to provide a high-level overview of secondary evidence (reviews) to inform the scoping of the proposed evaluation.

The evidence signpost identified a limited number of reviews or summative evaluations. This evidence scan explores a wider range of evidence types to see if further, relevant learning can be drawn from services that may resemble those that will deliver the new two-hour UCR services. It is important to note that the examples cited may not be consistent with all the criteria specified in the current national guidance (see Table 1 for full inclusion and exclusion criteria used).

Searches for this evidence scan confirmed the limited peer-reviewed or evaluative, robust evidence available. The sources identified are limited to primarily research and case studies conducted during the development of services.

This evidence scan first presents key features of the UCR models identified, followed by key learning for delivery (section 3). This is followed by an overview summary table for each service, including reported key challenges and lessons learned (section 4).

1.1 Methodology

1.1.1 Search strategy

Search terms were developed based on the following criteria:

- Urgent/rapid response approaches and models, aimed at avoiding admissions

- Urgent community-based models
- Delivered by community-based services
- Short-term intensive support (received within 2-hours) via crisis response services provided by multi-skilled teams
- People in crisis/experiencing worsening health problems who can be managed safely in their home/residence.

Final search terms are presented in Figure 1.

Figure 1. Search terms

Urgent community respon*, Crisis care, community, Crisis response care, urgent care need*, community two-hour crisis respon*, urgent care service*, crisis response team*, crisis response service*, Resident* OR home* OR house OR residen*, rapid response, Urgent community respon, urgent care need, community two-hour crisis respon*

Literature searches were conducted over nine days from, 15th December 2021-11th January 2022. Medline, Embase, Cinahl, BNI, Psycinfo, Amed, were searched via the platform Healthcare Databases Advanced Search (HDAS) using free text search terms only. Turning Research into Practice (TRIP) was also searched using free text terms.

More in-depth searches using a combination of free text and subject headings were conducted in Ovid on Medline and HMIC, and in Ebsco on Cinahl and BNI. Words producing a high number of hits were combined with adjacency terms to help focus the results.

1.1.2 Screening

The operational guidance for community health services two-hour crisis response (NHS England, 2021b) was used to help develop inclusion and exclusion criteria for screening results (see Table 1). A response time of two hours was too restrictive for the limited evidence base, returning few relevant sources, so this was extended to four hours. It should also be noted that although other admission avoidance services such as Hospital at Home (H@H) in Scotland, Acute care at home services in Northern Ireland and @Home services in Wales provide similar care to UCR teams in England (British Geriatrics Society, 2021) we excluded examples where it was unclear from the evidence what the response time was (e.g. Cantley et al., 2016).

We focused our searches on English language sources, from international literature of the last ten years, including both peer reviewed and grey literature. We found one international example (Sydney South) with all other sources reporting services in England.

Table 1. Inclusion and exclusion criteria

Include	Exclude
Adults over 18 People within their homes or usual place of residence, (residential care, care home residents) Patients with: dementia, falls (non-service injury), frailty, reduced function/mobility, palliative/ end of life (not hospice), confusion, diabetes, lack of carer Telemedicine or video consultation (mixed approach only)	Response time over four hours / not specified Children (under 18) Patients needing hospital treatment / emergency care Hospitals only services Hospice/end of life only services Mental health crisis (inc. suicide risk) Falls with serious injury (breaks, fractures, loss of consciousness), Non-crisis care / Planned care only service

2. Background

The NHS Long-Term Plan published by NHS England in 2019 committed to a new NHS offer of urgent community response (UCR). The ambition was that within five years all parts of the country would improve the responsiveness of community health crisis response services to deliver services within two hours of referral. This ambition would help achieve the National Institute for Health and Care Excellence's (NICE, 2017) recommendation that there should be crisis response within two hours. This recommendation applied to patients experiencing an urgent increase in health or social care needs where the cause of the deterioration has been identified, and their support can be safely managed in their own home or care home. It was also hoped this would help prevent unnecessary admissions to hospitals and residential care, and free up over one million hospital bed days (NHS England, 2019).

The ambition of full coverage of UCR services across England has been accelerated by two years to support the COVID-19 pandemic recovery effort (Robb et al., 2022). Systems are now expected to provide two-hour crisis community health response at home and provide consistent national cover (8am-8pm, seven days a week) by April 2022 (NHS England, 2021a; NHS England, 2021b). National guidance was published in July 2021 and set out operational and clinical requirements for NHS-funded crisis response services (NHS England, 2021b).

Seven accelerator sites were selected to help develop the UCR standards (NHS England, 2021b). These services formed in different ways: some created new teams; others built on existing teams; or redesigned the care team with community nursing in the centre (Robb et al., 2022). Whilst different models are used to deliver crisis response care the operational guidance states all services should be coordinated through one local single point of access (NHS England, 2021b). Teams will typically consist of a flexible workforce who are deployed according to each person's needs. Teams are likely to use a multidisciplinary approach consisting of registered nurses, advanced clinical practitioners, physiotherapists, occupational therapists, health and care support staff, social workers and paramedics and have support from other relevant professionals including GPs and geriatricians (NHS England, 2021b). The guidance also suggests conditions that might be suitable for a two-hour response, including (but not limited to): falls, decompensation of frailty, reduced function/reduced mobility, palliative/end-of life crisis support, urgent equipment provision, confusion/delirium, urgent catheter care, urgent support for diabetes, and unpaid carer breakdown (NHS England, 2021b).

Although the national UCR standard is new (NHS England, 2021b), the practice of urgent community response is not. The 2013 National Audit of Intermediate care (NHS Benchmarking Network, 2013) recognised 'crisis response' as one of the four intermediate care service models. A response time was not specified in the 2013 and 2014 audit, instead crisis response services were defined as services providing assessment and short-term care (up to 48 hours only). The majority of respondents (88%) in the 2013 audit specified a standard for response time, with the average standard response time recorded as two hours (NHS Benchmarking Network, 2013). In 2015 the

audit introduced an expected standard response time of four hours or less (NHS Benchmarking Network, 2015). In the 2018 audit (NHS Benchmarking Network, 2018) this was reduced to a response within two hours to reflect the introduction of NICE intermediate care guidance (NICE, 2017).

The most recent data available from the National Audit of Intermediate Care is from the 2020 audit (NHS Benchmarking Network, 2021). A total of 40 organisations took part, registering 176 submissions. This included data for 37 crisis response services, 39 home-based services, 88 bed-based services and 12 reablement services. Data from the 37 crisis response services report that 91% had a standard response time of two hours. The average percentage of service users seen within two hours (referral to assessment) in all locations was 70%. The average time from referral to assessment in all locations was 4.2 hours.

Although the national audit of intermediate care recognises crisis response as a key type of intermediate care, service evaluations specifically looking at the crisis response function are lacking. Rapid response teams are often integrated within a wider intermediate care team. Many evaluations fail to distinguish the crisis response service from other admission avoidance hospital at home services (e.g. Admission avoidance hospital at home Cochrane review, Sheppard et al., 2016). Rapid response teams/functions have also often been set up quickly, in response to new short-term funding received at short notice, for example, to address winter pressures (Stevenson and Spencer, 2009). As a result, evaluations are lacking with little time given to planning which outcomes should be monitored and evaluated.

NICE (2017) recommend that intermediate services should be delivered in an integrated way. The Local Government Association and Social Care Institute for Excellence (2019) describe the provision of rapid response for urgent health and social care needs through a single-point as one of 15 best practice actions achieving integrated care. Rapid response has therefore unsurprisingly been a key feature in many national integrated care programmes, such as the New Care Models programme (Cordis Bright, 2018), or the Integrated Care and Support Pioneers programme (Erens et al., 2015). However, as with evaluations of intermediate care, integrated care programme evaluations often do not evaluate the rapid response element separately and evaluate the whole programme or model of care. For example, the Health Foundation evaluated the Integrated Care Transformation Programme in Mid-Nottinghamshire to explore the long-term impacts of new care models on hospital use (Clarke et al., 2020). The model introduced several interventions including a proactive and urgent care intervention called Call for Care. Call for Care offered clinical triage and could arrange a response from community clinicians within two hours. Call for Care also included a crisis response team (called the Rapid Intervention Team) which operated 24/7 to support patients at home until other services could be initiated. The evaluation found that lower rates of hospital utilisation started emerging between two and six years after implementation of the integrated care model. By year six (2018-19) there were 4.3% fewer A&E visits and 6.7% fewer emergency

admissions per 10,000 people per month compared with a carefully selected comparison area. The authors could not however be sure which interventions caused the change as the integrated care model introduced many interventions at the same time.

3. Summary: UCR type models and key learning

This section provides a summary of key features from the models we found that resemble UCR services (3.1) and key learning from the evidence reviewed (3.2). We were unable to provide a summary of outcomes reported. Outcomes reported across models were inconsistent and often low quality (e.g. lacking methodology). It was therefore not possible to draw together key summary learning relating to this, but where available or appropriate, outcome-related information for individual services has been included in the detailed case study records in Section 4. Section 4 provides a summary table for each of the models referred to here.

3.1 Key features of UCR service models

The following section provides an overview of key features of models akin to urgent community response services reported in the literature reviewed. It represents the authors' understanding of the models reported however some details may not have been reported fully, and some services are likely to have adapted since the publication date of some sources. The literature review may not reflect the full breadth of UCR service models currently available across the country, particularly since the roll-out of UCR as part of the implementation of the NHS Long Term Plan. Most of these models are yet to be evaluated and some will be covered by the national evaluation.

3.1.1 People: patients and service users supported

Most services were described as providing care for the local adult population who were at urgent risk of hospital admission. Service users tend to be older adults, or where they haven't reported this explicitly, the staff mix included in the team is indicative of older adults (e.g. geriatrician, dementia specialist). In Gloucestershire, younger service users have been reported to use the service where ambulatory services were not available (e.g. IV therapy for cellulitis), or where patients living with comorbidity would be impacted by a hospital environment, including the risk of hospital acquired infections (Dowell et al., 2018).

The rapid response service in Middlesbrough, Redcar and Cleveland is led by community matrons (Penfold, 2015). They combine their role in the rapid response service with supporting their existing patient caseloads. It was unclear from the information available whether the service is restricted to patients only on their caseload.

Three models specify that they include care home residents in their provision; the Acute clinical team (ACT) in Neath Port Talbot (Griffiths & Davies, 2017), the Ipswich and East Suffolk: Reactive Emergency Assessment Community Team (REACT) (Local Government Association, 2021), and the Enhanced Rapid Response Service (ERRS) in Kent (Monitor, 2015c). Two services are described as being established to provide support to care home residents. The Rapid Response and Treatment (RRaT) service in Berkshire West provides services for residents from a registered care home

(nursing or residential) registered with a Berkshire West GP (Waldon, 2021). It is also one of the seven UCR programme 'accelerator' sites. The Geriatric Flying Squad (GFS) in South Sydney provides care for residents living in residential aged care facilities (RACF) who are experiencing an acute deterioration in condition (Jain et al., 2018).

3.1.2 Staff: roles and skills mix

3.1.2.1 Clinician led

The majority of models are led by a senior nurse. Senior nurse roles include:

- Specialist community practitioners (nurse or therapist) in Southampton (Clift, 2015)
- Advanced nurse practitioner (ANP) in Neath Port Talbot (Griffiths & Davies, 2017) and Bristol (Penfold, 2014)
- Senior nurse (unspecified role name) in Central and North West London (Monitor, 2015b)
- Community matron led in Enfield (North London Partners in health and care, 2020) and Middlesbrough, Redcar and Cleveland (Penfold, 2015).

Two models state they are geriatrician led: Sydney South (Jain et al., 2018) and Kent (Monitor, 2015c).

3.1.2.2 Geriatrician input

Geriatrician input features in many of the models, although the amount of input and level of support provided by them is not always clear. In Neath Port Talbot (Griffiths & Davies, 2017) the evidence reviewed simply stated that geriatricians provide support. In South Sydney (Jain et al., 2018) the service is described as geriatrician led. In contrast, Enfield (North London Partners in health and care, 2020) describe how the team are supported by a geriatrician for 16 hours a week. In Greater London (Monitor, 2015a) the level of support provided by geriatricians has developed over time. Initially support was provided on an adhoc basis. Later reports of the model state that geriatricians undertake daily virtual ward rounds, and provide out of hours medical support (Chua. et al.,2020).

Some models describe the number of sessions or multi-disciplinary team (MDT) meetings, including:

- Southampton (Penfold, 2014) has a caseload review with the geriatrician three times a week
- Ipswich and East Suffolk (Local Government Association, 2021) has two sessions of geriatrician support per week
- Kent (Monitor, 2015c) has two consultant geriatrician led multidisciplinary team review meetings per week.

Access to geriatricians for advice is also described in the Berkshire West model (Waldon, 2021), and in Southampton (Penfold, 2014) where it is in addition to caseload review.

3.1.2.3 Other specialist medical input

Other specialist input includes a consultant physician in the Neath Port Talbot model (Griffiths & Davies, 2017), a consultant psychiatrist in the Enfield model (North London Partners in health and care, 2020) and nurse consultant in Ipswich and East Suffolk (Local Government Association, 2021) and Sydney South ((Jain et al., 2018).

The model in Kent (Monitor, 2015c) also states they receive input from specialty doctors. In Berkshire West (Waldon, 2021) the multidisciplinary team includes a rapid response and treatment (RRaT) GP, however it is unclear what this role entails. We did not find any other models that suggests GPs were included in their multidisciplinary team. We did however find examples of models that suggested GPs are accountable for patients using the service. In Greater London (Monitor, 2015a) clinical governance of patients is shared between GPs and geriatricians. In Central and North West London (Monitor, 2015b) GPs maintain medical accountability for the patient on the rapid pathway.

3.1.2.4 Health care staff

All models include nursing staff. There are a variety of nursing roles across the models including advanced nursing roles (e.g. advanced nurse practitioners, community matrons, nurse practitioners), specialist nurses roles (e.g. rapid response nurses, mental health nurses), registered nurses, district nurses, and nursing assistants/support (e.g. healthcare assistants). Therapists (e.g. occupational therapists, physiotherapists, a speech and language therapist) also regularly feature in the majority of models.

Mental health input was highlighted in a number of models; Berkshire West (Waldon, 2021) include registered mental health nurses, Neath Port Talbot (Griffiths & Davies, 2017) a community mental health nurse, Enfield a consultant psychiatrist and mental health nurses (North London Partners in health and care, 2020), Bristol mental health specialists (Penfold, 2014) and Ipswich and East Suffolk a mental health specialist nurse (Local Government Association, 2021).

Other roles include specialist paramedics (Gloucestershire, Dowell et al., 2018; Greater London, Monitor, 2015a; Kent, Monitor, 2015c), pharmacists (Berkshire West, Dowell et al., 2018; Central and North West London, Monitor, 2015b; Enfield, North London Partners in health and care, 2020; Bristol, Penfold, 2014), dietitian (Greater London, Monitor, 2015a) and a phlebotomist (Enfield, North London Partners in health and care, 2020).

3.1.2.5 Care sector input

Several models include a social worker in the team or facilitate access to social worker support. Models with social workers include: Greater London (Monitor, 2015a), Southampton (Clift, 2015),

Bristol (Penfold, 2014), Middlesbrough, Redcar and Cleveland (Penfold, 2015), and Ipswich and East Suffolk (Local Government Association, 2021).

3.1.2.6 Voluntary sector input

Evidence of voluntary sector involvement was found in one model. In Ipswich and East Suffolk (Local Government Association, 2021) the team is supported by British Red Cross and Suffolk Family Carer support workers.

3.1.2.7 Non-clinical support staff

A large number of the teams indicated that administrative and clerical workers are part of the team: Berkshire West (Waldon, 2021), Greater London (Monitor, 2015a), Southampton (Clift, 2015), Neath Port Talbot (Griffiths & Davies, 2017), Enfield (North London Partners in health and care, 2020), Bristol (Penfold, 2014), and Kent (Monitor, 2015c).

The Greater London service also includes a staff member to help with transport (Monitor, 2015a).

3.1.2.8 Prescribing

Many of the models reviewed reported that non-medical prescribing is encouraged in the team. In Gloucestershire (Dowell et al., 2018) approximately a third of the rapid response practitioners (nurses, specialist paramedics and physiotherapists) are registered non-medical prescribers. Advanced nurses prescribe in Greater London (Monitor, 2015a), Neath Port Talbot (Griffiths & Davies, 2017), Bristol (Penfold, 2014) and Middlesbrough, Redcar and Cleveland (Penfold, 2015). In Enfield the team includes a prescribing pharmacist (North London Partners in health and care, 2020).

3.1.2.9 Generic role

In Gloucestershire (Dowell et al., 2018) all team members from across different clinical backgrounds have the generic title of 'rapid response practitioner' (RRP) rather than professional titles. This encourages all staff work holistically, performing tasks that cross the traditional specialty boundaries. Whilst Gloucestershire was the only example we found reporting generic team titles we also found examples where all staff were trained to perform tasks regardless of clinical background. In Greater London (Chua. et al.,2020) all staff are trained to be competent in general clinical assessments. In Neath Port Talbot (Griffiths & Davies, 2017) they have developed their own multidisciplinary assessment tool which covers nursing, medical, social and functional aspects. All staff receive specific induction training to learn how to use it.

3.1.3 Place of care

Care is provided in patients own homes or care homes according to patient type (see section 3.1.1).

Two services indicated that step up care is used to manage some patients. The Bristol rapid response team has access to a safe haven which provides four respite beds in a nursing home

(Penfold, 2014). The Enhanced Rapid Response Service (ERRS) in Kent provide some care in step-up care in community hospitals (Monitor, 2015c).

3.1.4 Process: features of delivery

3.1.4.1 Response time

At the time of publication the majority of services reported that they provide a response time within two hours. Others provide a response time within four hours (Neath Port Talbot, Griffiths & Davies, 2017; Central and North West London, Monitor, 2015b; Bristol, Penfold, 2014) or varied response time according to patient clinical condition (Gloucestershire, Dowell et al., 2018; Sydney South, Jain et al., 2018). For services in England the response times may have altered in response to the two-hour national standard, however it was outside the scope of the review to follow up individual models.

3.1.4.2 Hours of operation

A number of models operate 24 hours a day (Gloucestershire, Dowell et al., 2018; Southampton, Clift, 2015; Central and North West London, Monitor, 2015b; Ipswich and East Suffolk, Local Government Association, 2021). Some rapid services use other teams to help with out of hours (OOH) services. This is integrated directly into the team in the case of the Central and North West London rapid response service who uses the Trust's overnight staffing service to help staff the service (Monitor, 2015b). Or indirectly, such as the Berkshire West model where OOH support is provided through the GP OOH service, which the rapid response team liaises with if there are concerns that may arise overnight or over weekends (Waldon, 2021). Table 2 below provides details of their hours of operation.

3.1.4.3 Days of operation

Most services provide a seven day service, with the exception of the Enfield Care Home Assessment Team (North London Partners in health and care, 2020) which operates Monday to Friday, exclusive of bank holidays.

3.1.4.4 Maximum length of contact

Some services specify a maximum target length of contact. The highest maximum target found is ten days for Central and North West London (Monitor, 2015b). Other time limits are seven days (Southampton, Clift, 2015; Bristol, Penfold, 2014; Kent, Monitor, 2015c), five days (Berkshire West, Waldon, 2021; Ipswich and East Suffolk, Local Government Association, 2021), 72 hours (Middlesbrough, Redcar and Cleveland, Penfold, 2015), and 48 hours (Gloucestershire, Dowell et al., 2018).

Some services highlighted that capacity levels are driven by factors such as number of patients, location of patients and the acuity/ complexity of their clinical needs (Dowell et al., 2018; Monitor, 2015b).

3.1.4.5 Single point of access and referrals

Most services specify that referrals are received through a single point of access. No alternative model was described. Some models described clinicians managing the referrals (Gloucestershire, Dowell et al., 2018; Central and North West London, Monitor, 2015b; Enfield, North London Partners in health and care, 2020) whereas others described management by an administrative team (Greater London, Monitor, 2015a; Kent, Monitor, 2015c).

Some models also described the single point of access acting as an advice line (Berkshire West, Waldon, 2021; Enfield, North London Partners in health and care, 2020). In the Bristol model advanced nurse practitioners (ANPs) are available to provide clinical advice to clinicians via an on-call system (Penfold, 2014).

Referrals are received from a wide range of sources. GPs are the most common referrers reported, followed by ambulance services. The Greater London (Monitor, 2015a) model reports that referrals from London Ambulance Service (LAS) are only made after a face-to-face assessment. Acute and community teams are also sources of referral. A limited number of models specify accepting social care referrals (Central and North West London; Monitor, 2015b) or family or self-referrals (Central and North West London, Monitor, 2015b; Enfield, North London Partners in health and care, 2020).

Table 2. Response time and hours/days of operation

	Within 2 hours	24 hours a day	7 days a week	Max. length of contact
Gloucestershire: RR team	No *(different response times according to patient clinical condition: 1 hour, 2 hours, 4 hours, 8 hours and 24 hours)*	Yes	Yes	Up to 48 hours *(although exceeds this)*
Berkshire West: RRaT service	Yes	No *(9am to 7pm, out of hours support by GP OOH)*	Yes	Up to 5 days *(can be longer depending on needs)*
Greater London: STARRS Rapid Response team	Yes	No *(8am to 10pm)*	Yes	Until the medical condition has stabilized or if they need hospital admission.
Southampton: RRT	Yes	Yes	Yes	Up to 7 days
Neath Port Talbot: ACT	No *(with 4 hours)*	*Not specified*	*Not specified*	*Not specified*
Central and North West London: RRS	No *(with 4 hours)*	Yes *(OOH managed by Trust's overnight staffing service)*	Yes	Up to 10 days
Enfield: CHAT	Yes	No *(9pm to 5pm, and in 2018-19 CHAT have now been sub-contracted to support GP OOH provision)*	No *(Monday to Friday)*	*Not specified*
Bristol: RR	No *(with 4 hours)*	No *(7.30am to 7.30pm)*	Yes	Up to 7 days
Middlesbrough, Redcar and Cleveland: RSS	Yes	No *(8am to 11pm)*	Yes	Up to 72 hours
Ipswich and East Suffolk: REACT	Yes	Yes *(8am-8pm therapy support and 24/7 nursing and generic worker support)*	Yes	Up to 5 days
Kent: ERRS	Yes	No *(9am to 10pm)*	Yes	Up to 7 days
Sydney South: GFS	No *(with 2-4 hours)*	No *(Mon to Fri: 8am to 7.30, and Sat to Sun 10am to 6.30)*	Yes	*Not specified*

3.2 Lessons learned

This section presents the learning identified in the evidence reviewed for effective UCR, organised by theme.

3.2.1 Workforce

3.2.1.1 Skill mix

The role of staff is likely to develop over time. For example in Enfield (North London Partners in health and care, 2020) geriatricians and consultant psychiatrists initially had a large role in training nursing staff. Community matrons shadowed the geriatricians and the consultant psychiatrists trained the mental health nurses and care home staff directly. As the team has evolved specialists are no longer required for less complex patients. Nurses now also take on a training role. In Enfield they have found that this has led to a decrease in need for the specialists.

The mix of staff included within the team may also adapt as the model develops. For example, models reported the addition of (or ambition to add) older person's mental health team / dementia support (Ipswich and East Suffolk (Local Government Association, 2021); Southampton (Clift, 2015)) and social workers (Kent (Monitor, 2015c)).

3.2.1.2 Training and development

Training and development is highlighted as a key feature of supporting an effective team in several of the models. Finding protected time to do this can however present challenges (Neath Port Talbot, Griffiths & Davies, 2017).

Case review was mentioned as a method for development in both the Gloucestershire (Dowell et al., 2018) and Enfield (North London Partners in health and care, 2020) models. In the Gloucestershire (Dowell et al., 2018) model the purpose of case review was thought to enable the transfer of skills across traditional professional boundaries. In the Enfield (North London Partners in health and care, 2020) model case review was specifically focussed on hospital attendances and understanding whether the attendance was warranted and what (if anything) could have done to prevent the attendance.

In Greater London (Monitor, 2015a) the rapid response team is part of a suite of initiatives to keep patients out of hospital where possible. This includes rapid response and admission avoidance, early supported discharge for hospital inpatient, and rehabilitation. Staff rotate between each of its three main functions: rapid response and A&E admission avoidance, early supported discharge and community rehabilitation. Rotations ensure community teams maintain their acute skills and relationships.

3.2.1.3 Recruitment and retention

The skills required and the roles and responsibilities needed mean that recruiting to rapid response services can be difficult (Neath Port Talbot, Griffiths & Davies, 2017; Kent, Monitor, 2015c; Greater

London, Monitor, 2015a). For example, Greater London (Monitor, 2015a) report difficulties finding nurses who have the confidence to make autonomous decisions on patients' care and are willing to learn new skills beyond their own specialty. They also report that where consultants running services have no direct responsibility for patients, and often no direct contact with them, they can be reluctant to take on the responsibilities.

Out of hours working and long shifts (Ipswich and East Suffolk (Local Government Association, 2021; Greater London (Monitor, 2015a), and a requirement to drive (Greater London (Monitor, 2015a) have also been reported to present challenges in recruiting staff.

In Southampton (Clift, 2015), a focus on clinical crisis support in the community was reported to be at the expense of developing the discharge service from the local hospital. This has been unpopular with the local hospital but popular with patients. Similarly, in Central and North West London (Monitor, 2015b) medical input into the MDT enhanced the scheme's impact, enabling more acutely ill patients to stay at home. However, moving consultants into the community significantly affected the cost of the service and capacity in the rest of the organisation.

To manage recruitment difficulties the rapid response service in Kent (Monitor, 2015c) had to recruit temporary staff from outside its own workforce to set-up the service. Staff were then gradually replaced by permanent employees.

3.2.2 Delivery

3.2.2.1 Capacity and impact on response time

As services grow in popularity demand begins to increase. As demand increases this can create capacity challenges for rapid response services, as reported in Neath Port Talbot (Griffiths & Davies, 2017) and Berkshire West (Waldon, 2021). This can subsequently impact on the ability of services to meet response time targets (Greater London, Chua et al., 2020). The service in Southampton (Clift, 2015) reported resorting to closing the service on limited occasions because it was unable to respond to patients within the two hour response time.

Demand is not the only factor impacting capacity and ability to respond to the patient within specified timeframes. Other challenges reported included a surge of late afternoon referrals that impact the ability to respond during service hours, and relatives asking to be present during assessments (Chua et al., 2020).

Mitigating actions reported to help with challenges to capacity and achieving target response times included restricting referrals criteria so that patients from the emergency department are only accepted in exceptional circumstances (Southampton, Clift, 2015), and introducing a tiered response times (e.g. within two or within four hours) according to need (Greater London, Chua et al., 2020).

3.2.2.2 Length of contact

In Gloucestershire (Dowell et al., 2018) the service was initially commissioned to provide 48 hours of acute clinical input, with ongoing referral to integrated care teams. In reality the average length of contact is slightly longer (2.6 days) with variation across the seven pathways within the rapid response service. For some pathways such as falls and palliative care the average length of contact is less day 2 days. However for other pathways, such as cellulitis and IV therapy, the length of contact was high at 3.9 days, due to complexity of patients' conditions and difficulties in successfully referring patients into step-down services. Kent (Monitor, 2015c) also report that the ability to transfer patients to other services (specifically social care packages) has presented challenges to discharge.

3.2.2.3 Importance of trusting relationships

Developing trusting relationships within the multidisciplinary team as well as between referrers, patients/families and partner teams is a key enabler. This is reported to take time, effort and energy (Neath Port Talbot , Griffiths & Davies, 2017).

Working together helps foster relationships for effective provision. For example, relationships between the medical staff and the care homes were reported to have developed over time in the Enfield model (North London Partners in health and care, 2020). Similarly, in Middlesbrough, Redcar and Cleveland (Penfold, 2015) where the community matrons picked up district nursing duties this has helped build good relationships with the district nursing teams.

In the Central and North West London model (Monitor, 2015b) the rapid response service works closely with the CareLink service which provides home-based reablement. CareLink and the Rapid Response Service are located together, which helps them communicate. They benefit from each other's experiences, and joint working brings economies of scale. Co-location of integrated health and social care alongside the voluntary and community sector in Ipswich and East Suffolk (Local Government Association, 2021) is reported to have led to fewer handoffs and a greater focus on the patient pathway.

3.2.2.4 Equipment

Portable equipment was listed as an enabler in the model in Sydney South (Jain et al., 2018). This means the team can perform point-of-care testing, including blood pathology lab, bladder scanner and electrocardiograph machine. Subcutaneous drug delivery pumps/syringe drivers are used for palliative care. The team also utilise private pathology home collection services as well as mobile X-ray service for additional investigations.

In Ipswich and East Suffolk (Local Government Association, 2021) the team introduced specific community lifting equipment for emergency falls response to help optimise admission avoidance opportunities pre-ambulance, with referral directly from the East of England Ambulance Service NHS Trust control room. Training was given to community responders to increase awareness of the (REACT) service and the type of patients that should be referred.

3.2.3 Service uptake and utilisation

3.2.3.1 Safety netting

The service in Gloucestershire (Dowell et al., 2018) reports getting busier towards the weekend with the greatest number of referrals received on Thursdays and Fridays. It is thought that this could be a sign that GPs identify patients for 'safety netting' – those who have been unwell during the week or had previous acute admissions and may deteriorate over the weekend.

3.2.3.2 Telephone triage

Before the pandemic the referrals from London Ambulance Service (LAS) to the Greater London short-term assessment, rehabilitation, reablement service (STARRS) were reported to be declining compared to previous years, and discussions to develop a telephone triage service by an LAS clinician to replace the face-to-face assessment required had started (Chua et al., 2020). The service wanted to ensure there was a robust mechanism for telephone triage with medical accountability so as not to compromise the older person experiencing frailty.

The impact of COVID-19 resulted in a change to mode of triage before referral (Chua et al., 2021). From October 2020, STARRS, in line with all rapid response services in the North-West London Sector, agreed to accept referrals directly from the central LAS central Hub after a telephone consultation. Chua et al. reflect that as this mode of triage is likely to become more common the service must adapt to ensure governance on service deliverance is maintained. They also flag a concern that a shift towards telephone consultations by GPs before rapid response service triage will present challenges assessing patient's symptoms due to the demographic serviced by STARRS. This is because consultations with older patients can be more time consuming due to multiple co-morbidities, and there is a greater likelihood of cognitive and hearing impairment.

3.2.3.3 Importance of trust and confidence in services

In section 3.1.2.3 ('Other specialist medical input') we highlighted models that specified GPs maintain overall clinical governance of patients referred to the rapid response service. The Greater London model (Monitor, 2015a) share that this requires significant trust between GPs and the rapid response service. The team found that GPs became more confident about referring directly to service as the service grew and evolved. However, in areas where GPs lacked this confidence they provided few direct referrals. Whilst the model in Middlesbrough, Redcar and Cleveland (Penfold, 2015) didn't explicitly state GPs were accountable for patients, a trusted relationship between community matrons and GPs described as built by working together over many years was reported to be an important factor for uptake of the service. Similarly, GPs using the Southampton model (Clift, 2015) are clear that their confidence in the service directly relates to the capacity of the team to respond quickly. Other models also report that GPs appreciate open communication channels they can use to contact senior clinicians (Central and North West London, Monitor, 2015b; Kent, Monitor, 2015c).

3.2.3.4 Increasing awareness / promotion of service

The importance of raising awareness and promoting services to help boost uptake of the services was mentioned in several models. Various approaches to doing this were reported, including:

- Multiple visits to all residential aged care facilities (RACF) and presentations to GP meetings to raise awareness and clarify the service referral process in Sydney South (Jain et al., 2018)
- Inviting staff from local acute trusts to shadow community teams, including the rapid response teams, to enhance colleagues' understanding of whole pathways and encourage appropriate referrals (Central and North West London (Monitor, 2015b)
- Leads (community matrons) working with services to increase awareness so that more professionals refer patients to the service (Middlesbrough, Redcar and Cleveland (Penfold, 2015)
- Targeting primary care practices not regularly using service (Kent, Monitor, 2015c)
- Engagement programmes across multiple referrers (primary care, the mental health trust, social care and the ambulance trust (Kent, Monitor, 2015c).

3.2.4 Service design

3.2.4.1 Incremental changes and continual improvement

It is clear from the sources reviewed that services have adapted over time. The model in Kent (Monitor, 2015c) highlights ongoing case review, internally at the trust and jointly with commissioners, as a driver for developments to the service. The REACT team in Ipswich and East Suffolk (Local Government Association, 2021) report that they have developed the model successfully through small, incremental gains rather than rapid transformation of these services. Each time a new change or addition to the model is introduced, they work to promote confidence in the model and prove its value, so that they can continue to address existing challenges and meet the future needs of the population.

3.2.5 Technology

3.2.5.1 Remote working

As the service expands in Ipswich and East Suffolk (Local Government Association, 2021) issues of sustainability are starting to be considered. It is reported that options for digitisation and remote working were already being explored before the pandemic to reduce time staff spent travelling back to base in Ipswich, due to the rural geography of East Suffolk. It is unclear how remote monitoring (if at all) has been used during the pandemic.

3.2.5.2 Shared clinical systems

Communication across teams was reported to be challenging in Neath Port Talbot (Griffiths & Davies, 2017) due to IT issues (e.g. lack of mobile technology, staff using both paper and electronic records), incompatibility of systems, and fragmentation of patient records across different departments. In Middlesbrough, Redcar and Cleveland (Penfold, 2015) where community matrons

can access recent clinical information via SystmOne and ICE (integrated clinical environment) system this was reported as an enabler to the service. Matrons can start patients on new medication or adjust the dosage of their current medication without delay. Similarly, in Greater London (Chua et al., 2020) all geriatricians have access to remote electronic prescribing to enable prompt initiation of treatment (e.g. antibiotics).

4. UCR type examples identified in this review

The following section provides an overview summary table for each UCR type model we identified. The information in each summary table represents the evidence reviewed and might not represent the service that is currently provided. This is particularly important to note for services in England. For models in England the service may have altered in response to the two-hour national standard, however it was outside the scope of the review to follow up individual models.

4.1 Gloucestershire: Rapid Response (RR) team

Background and aims
• Hospital admission avoidance service that aims to prevent hospital-acquired infections (HAIs), patient institutionalisation, and loss of functional independence by providing coordinated health care in the patient's own environment that is patient centred and promotes independence.
Model description
Patients • Adult population within the county. • There are seven pathways within the RR service: cellulitis, chronic obstructive pulmonary diseases (COPD); falls; intravenous (IV) therapy; palliative; unwell adult; and urinary tract infection (UTI). • Older patients (75+) represent 67% of the caseload, and many of these patients have a diagnosis of dementia. • The number of younger adults (18-64) admitted into the RR service is far fewer, and these patients predominantly received treatment to avoid hospital admission where ambulatory services were not available (e.g. patients receiving IV therapy for cellulitis, or where patients living with comorbidity would be impacted by a hospital environment, including the risk of HAIs). **Staff** • The existing team is made up of 69% nurses, 26% specialist paramedics and 5% physiotherapists. • Usual Agenda for Change hierarchy inverted: 44% are at band 7, 50% at band 6 and 6% at band 5. • Team members have the generic title of 'rapid response practitioner' (RRP) as all members work holistically, performing tasks that cross the traditional specialty boundaries. • Non-medical prescribing encouraged for all staff. **Place** • Patients recruited from their own homes, from the ED or the short-stay ward. **Process** • Referrals received through single clinical referral telephone managed by clinicians. Line used by GPs, the South West Ambulance Service, district nurses and allied health professionals (AHPs). • Operates 24 hours a day, seven days a week. • There are three locality teams to assist with prompt response. • Different response times according to patient clinical condition: one hour, two hours, four hours, eight hours and 24 hours. • Capacity levels are driven by the number of patients, location of patients and the acuity/ complexity of their clinical needs. Locality teams have the ability to flex capacity with other locality teams or other community teams.
Outcomes and Impacts

Service utilisation - April 2016 to August 2016

- Over the five-month study period, the mean number of patients admitted to the RR service per month was 251.
- Patient age ranged from 19 to 85+ but the majority of the patients were aged 75 years or more (67%).
- Referrals come from a variety of sources. The majority came through the single point of clinical Access (SPCA) team. This is a team of clinicians who triage patients to appropriate pathways of care within Gloucestershire.
- Other referrals come from Acute Trust (emergency department and acute assessment unit, general wards, community hospitals, specialist teams), Ambulance Service, community team including integrated health and social care teams, high admission care homes, and selected patients.
- The average contact time on an initial visit is 53 minutes (the data do not include the time taken to travel to the patient).
- Follow-up visits vary from 13 to 50 minutes.
- The majority of the patients seen by the RR team are on the unwell adult pathway.
- The average length of contact between the RR service and patients across all pathways is 2.6 days.

Hospital admission avoidance

- The majority of patients remain in their usual residence on discharge from the RR service. Out of the 1276 patients seen by the RR team over five months (April 2016 to August 2016), 70% remained at home at discharge who otherwise might have been admitted to the acute hospital.

Patient outcomes

- Feedback from 105 patient/relatives obtained via telephone interview over the five month period (April 2016 to August 2016) found overall patient satisfaction was high.

Cost savings

- A significant saving was demonstrated when using the RR service. An average estimated saving for one avoided admission is £1782. This is based on not transferring the patient to hospital (ambulance costs of £270), plus the reduction in length of contact from 2.7 days in the RR service compared to 6.9 days as an inpatient (£2760) minus the average cost of the RR service. This is based on one rapid response visit plus six follow up visits (1 + 6 * £208 = £1248).
- The cost saving ratio is further enhanced when analysing the over-75 age group whose average length of hospital stay is 11.72 days at a cost of £4688; this represents a saving of £3340 (the authors use the same cost of RR service based on an average of seven visits).

Lessons learned

Service uptake and utilisation

- The service gets busier towards the weekend with the greatest number of referrals received on Thursdays and Fridays. Staff suspect that this is because GPs identify patients for 'safety netting'—those who have been unwell during the week or had previous acute admissions and may deteriorate over the weekend.

Training

- Regular in-service training and case study review sessions ensure that evidence for best clinical practice is continually reviewed. This enables the transfer of skills across traditional professional boundaries.

Variation in pathways

- The service was initially commissioned to provide 48 hours of acute clinical input, with ongoing referral to integrated care teams. The average length of contact within the RR service across all pathways is 2.6 days, although there is variation in the length of stay across the seven pathways. The increasing complexity of patients' conditions and difficulties in successfully referring patients into step-down services has meant that for pathways such as cellulitis and IV therapy the length of contact was high at 3.9 days. The average length of stay is less than two days for Falls and Palliative pathways.

References
Dowell S. et al. (2018) Rapid response: a multiprofessional approach to hospital at home. British Journal of Nursing. 27(1), 24-30.

4.2 Berkshire West: Rapid Response and Treatment (RRaT) service

Background and aims
• One of the seven 'accelerator' sites to receive additional funding to increase capacity and responsiveness to older people with complex health needs who require urgent care. • Service was launched in October 2015, using funding from the Better Care Fund originally targeted for a hospital at home (H@H) service for older people living in their own homes. • In 2018, became integrated with the already established multidisciplinary Care Home Support Team (CHST) to form the Integrated Care Home Service (ICHS) with two distinctive elements: a reactive one (RRaT) and proactive one (CHST). • Additional funding has also been made available to the service through the Ageing Well programme to support and develop rapid response services, including enhanced primary care support for care home residents to access an urgent community response within 2 hours of a health crisis, where a hospital admission is a possibility.
Model description
Patients • Older people living in care homes. **Staff** • Multidisciplinary team including: a consultant geriatrician, an RRaT GP, advanced nurse practitioners, specialist rapid response nurses, registered mental health nurses (RMN), specialist senior nurse practitioners, healthcare assistants (HCAs), assistant practitioners (APs), occupational therapists (OTs), physiotherapists (PTs), a speech and language therapist (SALT) and pharmacists. • MDT staff are supported by a service manager and an administrative team. • Service also works closely with district nursing (DN) service (including OOH DNs), and specialist services e.g. respiratory and heart function team. **Place** • Covers three localities in Berkshire West, 51 care homes with a total of 2400 beds. **Process** • Within two hours of the telephone triage on receipt of the referral via the health hub. • Operate 365 days of the year between the hours of 9 am–7 pm. • Referrals are made through a central point, the Health Hub. • Referrals can be made directly from the care home as well as GPs and the ambulance service. • Service also supports early discharge. • Monday to Friday the team have access to an interface geriatrician at the acute hospital to discuss any resident whom they feel would benefit from a hospital admission. • Care home staff, GPs, and ambulance team can contact the team directly for clinician support and advice. • Out-of-hours (OOH) medical support is provided through the GP OOH service, and the RRaT team liaises with the OOH service if there are concerns that may arise overnight or over weekends. • Residents remain on the caseload for up to five days, but this can be longer (or shorter) depending on their health needs and treatment plans. • Discharge letters sent to GP within 24 hours of discharge from the service. A copy is also sent to the care home, so staff are able to clearly see ongoing plans to maintain the health needs of the resident.

Outcomes and Impacts
Impact of the pandemic: • The referral rate to the RRaT service tripled in April 2020. • Many residents were referred with COVID-19 symptoms, but a similar number had atypical presentations.
Lessons learned
Capacity / Response time • The ongoing increasing demand for the RRaT support among the care homes continues to challenge the capacity within the service.
References
Waldon M. (2021) A rapid response and treatment service for care homes: a case study. British Journal of Community Nursing. 26(1), 6-12.

4.3 Greater London: Short-term Assessment, Rehabilitation, Reablement Service (STARRS) Rapid Response team

Background and aims
• The service was designed to help support GPs to manage clinical and social crisis at home. • STARRS was set up in late 2010 (Brent). It was initially nurse led and had geriatrician support on an ad hoc basis. • The scheme expanded to Harrow in March 2012, taking over from four separate services previously provided by the acute discharge team, healthcare and rehabilitation team, falls team and the physical disability support team. • From mid-2013, there was regular input from a geriatrician three sessions a week. • In 2014, there were daily virtual ward rounds and also geriatricians support until 10pm, seven days a week. • STARRs care packages include rapid response, early supported discharge and reablement.
Model description
Patients • Frail older people / patients in crisis or at urgent risk of hospital admission. • Eligibility criteria are wide. These range from provision of equipment, responding to falls, personal care (washing and dressing), dietitian support, managing exacerbations of chronic obstructive airways disease, anticoagulation, non-mobile patients with suspected deep venous thrombosis and patients requiring intravenous therapy e.g. antibiotics for cellulitis or heart failure. **Staff** • Multi-disciplinary team including nurses, therapists (physiotherapists and occupational therapists), paramedics, dietitian and geriatricians. • The RRT is comprised of a manager (Band 8c nurse manager), a senior physiotherapist (Band 8b), 16 general nurses, 12 physiotherapists, three occupational therapist, two paramedics. All trained to be competent in general clinical assessments. • The team also includes a part-time dietitian, access to a social worker, a person for transport and five administrators. • Clinical governance of patients is shared between GPs and geriatricians. **Place** • Patients' home. **Process** • Service runs from 8am to 10pm, seven days a week.

- SPA (single point of access) team manages administration with support from a clinician.
- Referrals – GP, London Ambulance Service (LAS) after a face-to-face assessment and A&E up to 48 hours post presentation.
- Patients are given a comprehensive clinical assessment at home within two hours of referral (usually a senior nurse and a therapist).
- Patients remain in their home but are visited daily by nurses and/or therapists.
- Patients are discussed in daily virtual ward rounds with geriatrician to formulate a management plan. Daily ward rounds were undertaken by two geriatricians, with two trainees, with the MDT. Out of hours medical support including weekends was provided by four other consultant geriatricians.
- Patients were supported in their homes until the medical condition has stabilized or if they need hospital admission.

Outcomes and Impacts

Service utilisation

- Over four years (February 2016 to February 2020), 17,626 people were seen by STARRS.
- Patients were aged between 21 and 107, however over 99% of patients were aged 65 years and above.
- The two-hour response time for patients' clinical encounter have significantly reduced from 82% in 2016 to 71% in 2020 at the expense of corresponding increases in patients seen between two and three hours (from 13% to 16 %) and in patients seen after three hours (from 5% to 13%) over the same period.
- The mean length of stay in the virtual ward is less than five days.

Hospital admission avoidance (HAA)

- HAA from GP and LAS referrals has remained largely unchanged at just over 80% and under 80% respectively over the past four years. However, HAA from A&E has consistently declined from 92% to 87% over the same period.

Hospital admissions after discharge from RRT at 30 days

- Over the past four consecutive years, despite a significant increase in the number of referrals, hospital readmission at 30 days have remained relatively constant at about 10%.

Lessons learned

Capacity / Response time

- One of the unintended consequences of the increased referrals (30% over the past four years) is that they have impacted significantly on the response time.
- Several other factors may also have affected the response time. For example, a large cluster of referrals at specific times of the day will significantly stretch the ability of the RRT to see referrals within the time constraints.
- In some instances, relatives have made specific requests to be present during the assessment. As such, a mutually agreed time would need to be arranged.
- Due to increased demand referrals are triaged (in discussion with GP) to be seen within two or within four hours.

Service uptake and utilisation

- In earlier reports of the mode it was highlighted that GPs are in charge of the clinical governance of patients referred to the rapid response service. This requires significant trust between GPs and the STARRS team. The team found that GPs became more confident about referring directly to STARRS as the service grew and evolved. In some areas GPs lack this confidence and provide few direct referrals.
- Between March 2019 and Feb 2020 referrals from London Ambulance Service were reported to be declining compared to previous years. A telephone triage service by an LAS "clinician" to replace the face-to-face assessment was under discussion, to divert referrals directly to STARRS.

- The impact of COVID-19 resulted in a change to mode of triage before referral. From October 2020, STARRS, in line with all Rapid Service Services in the North-West London Sector, agreed to accept referrals directly from the central LAS central Hub after a telephone consultation.
- Telephone triage is likely to become more common therefore the service highlights it must adapt to ensure governance on service deliverance is maintained.
- There is also a concern that shifting towards telephone consultations by GPs before Rapid Response Service triage will present challenges due to the demographic serviced by STARRS. Consultations with older patients are often more time consuming as they tend to have several co-morbidities, a greater likelihood of cognitive and hearing impairment. As such, the history may often come from a second party caller (e.g. spouse) or worse a third-party caller (e.g. a relative some distance away from the patient). It is therefore significantly more difficult to fully appreciate the extent of the patient's symptoms via the telephone.

Skill mix

- There are increasing numbers of non-medical prescribers and all geriatricians have access to remote electronic prescribing to enable prompt initiation of treatment (e.g. antibiotics).
- Team members are mainly recruited from an acute care background as staff need to be able to deliver acute levels of care. The service functions through competency-based nursing; STARRS nurses must be confident and able to make autonomous decisions on patients' care.
- STARRS employs its own driver which enables patients to be brought to and from hospital with relative ease.

Training and development

- Staff in the STARRS teams rotate between each of its three main functions: rapid response and A&E admission avoidance, early supported discharge and community rehabilitation. The team highlights the importance of including community rehabilitation in this rotation. Rotations ensure community teams maintain their acute skills and relationships.

Recruitment

- The service takes healthcare professionals out of traditional working practices, which has led to recruitment difficulties.
- Nurses must have the confidence to make autonomous decisions on patients' care and be willing to learn new skills beyond their own specialty.
- They must also be prepared to work long shifts across seven days and be able to drive.
- Consultants running the service are subject to unique risks. With no direct responsibility for patients, and often no direct contact with them, some consultants can be reluctant to take on the responsibilities of overseeing STARRS.

References

- Monitor (2015a) Moving healthcare closer to home. Short-Term Assessment, Rehabilitation and Reablement Service: London North West Healthcare NHS Trust. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/458979/London_North_West_.pdf
- Chua E. et al. (2020) The short-term assessment, rehabilitation, reablement service "starrs": a rapid response team to support the frail older person to remain at home. MOJ Gerontol Ger. 5(3), 96–101.
- Chua P. et al. (2021) The impact of COVID-19 on the rapid response team: short term assessment rehabilitation and reablement service (STARRS) in England. MOJ Gero & Geri Med. 6(4),107–112.

4.4 Southampton: Rapid Response Team (RRT)

Background and aims

- The RRT was set up in early 2007 as part of a Section 75 joint funded programme with health and social care. Section 75 was part of the NHS Act 2006, which facilitated some pooling of health and social care funds.
- 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.

Model description

Patients

- Adult population (unclear if restricted to older adults but lowest patient age service data is 50-59).

Staff

- The team includes five band 7 specialist community practitioners (four registered nurses and one physiotherapist), supported by 11 band 6 senior community practitioners (ten registered nurses and one occupational therapist), two associate practitioners at band 4 and 15 rehabilitation and nursing assistants at band 3.
- The RRT social worker is a care manager based in the team who works jointly with local social care services.
- There is access to a community pharmacist for support with medication reviews.
- The RRT is further supported by a dedicated administration team, trained to deal with the multitude of tasks and enquiries received.

Place

- Patients' own home.

Process

- The team is part of adult services provision for the community provider trust and operates as a 24 hours a day, seven days a week service, with close links to the locality and emergency department (ED) teams.
- Two-hour face-to-face visit target.
- Seven-day length of stay target.
- The RRT has a caseload review with the geriatrician three times a week and they are available daily for telephone advice.

Outcomes and Impacts

Service utilisation

- The RRT collected data for patients referred to it between October and December 2013. Data were collected on 101 patients.
- Most referrals came from GPs (36%), with the majority of the remaining referrals 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 need an inpatient stay.

Outcomes on discharge

- 29% of patients were discharged home from the service with no increase in dependency from admission. The reablement service (rehabilitation teams) 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. 28 patients were admitted to a bedded unit (one older people's mental health, three step-up beds, 24 acute trust).

Lessons learned

Onward referral/care

- The team has found onward care is facilitated by liaison with the GP to lead on care delivery, comprehensive geriatric assessment (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.

Service uptake and utilisation

- GPs are clear that their confidence in the service directly relates to the capacity of the team to respond quickly.

Capacity / response time

- On limited occasions the service has had to close because it is unable to respond to patients within the two hour response time. To mitigate closing the service due to capacity issues the service does not accept patients being discharged from acute care except from the ED or in exceptional circumstances.

Skill mix

- Access to geriatrician 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 team was working towards achieving full integration with the older person's mental health by the end of 2015.

Impact of wider services

- The service has felt that focusing on clinical crisis support in the community has been at the expense of developing the discharge service from the local hospital. This has been unpopular with the local hospital but popular with patients.

References

Clift, E. (2015) How a rapid response team is supporting people to remain at home. Nursing Older People. 27(10) 16-21.

4.5 Neath Port Talbot: Acute clinical team (ACT)

Background and aims

- Community resource teams (CRTs) were created as part of the strategic delivery programme, to deliver an early-response service to people in the community, with the aim of preventing unnecessary hospital admissions. They bring together all the teams already working in the community into a coherent system under the multi-agency leadership of local authorities.
- There are 22 CRTs in Wales which provide nursing, multidisciplinary and medical care in the community.
- The CRTs' main goal is to assess and support people in their place of residence, avoiding unnecessary hospital admissions.
- The CRT is an example of a change in approach, moving from fitting patients into care processes to building care processes around patients.
- Acute clinical team (ACT) is the nursing branch of Neath Port Talbot CRT.

Model description

Patients

- Anyone aged over 18 years, who requires urgent treatment in their own home (or care home) that would have traditionally been given in hospital (mean age of patients is 80 years old).

Staff

- The ACT is led by an advanced nurse practitioner and supported by a consultant physician and geriatrician. The team comprises of ANPs, a community mental health nurse, staff nurses; healthcare assistants and clerical staff.
- The CRT includes three ANPs (and independent prescribers), who are skilled and experienced in assessment, diagnosis and older people's nursing. Another three team members are training to become advanced practitioners.

Place

- Patients' home or care home.

Process

- In urgent cases, the team can assess patients within four hours of referral so care can be delivered promptly.
- Through a single point of access referrals go directly to the most appropriate team within the CRT. Referrals are taken from GPs, the Welsh Ambulance Service Trust, other types of community teams (for example, mental health or district nursing) and secondary care services. Once a referral is accepted, the team either shares or takes over clinical responsibility for the patient.
- A referral must not duplicate care delivery from another service, although it can be complementary. As an example, the district nursing service may be caring for a patient who develops cellulitis that is not responsive to oral antibiotics; traditionally they would have been admitted to hospital, but the ACT will work with the district nurses while the patient is acutely unwell.
- The ACT provides rapid assessments – including comprehensive geriatric assessments if needed – and clinical interventions.
- All staff receive training, both formal and informal.
- The acute clinical team has developed its own assessment tool, which covers nursing, medical, social and functional aspects. All staff receive specific induction training to learn how to use it. The tool fulfils multiple functions: is a professional and legal requirement; supports communication between health professionals; collates patient information in all aspects listed above; screens patients to see whether they need further assessments; and records patients' wishes and needs

Outcomes and Impacts

Service utilisation

- Referral numbers have been increasing year on year. From January until 30 June 2014, 416 referrals were made – rising to 610 for the same period the following year.

Hospital admission avoidance

- Between January 2015 and January 2016, the team looked after 1,254 patients and were able to alleviate or resolve the health issues experienced in 85% of cases. The most common health issues encountered were acute infections, dehydration, falls and frailty.
- Around 88% of all patients were treated in their place of residence but, if needed, the team can request admission to hospital. Around 12% of all patients were admitted to hospital. Of these, 9% were admitted within the first 48 hours of care, most commonly at the time of assessment. Only 3% were admitted to hospital after 48 hours.
- Over the four-year period from 2011 until 2014, the number of acute medical admissions for Neath Port Talbot residents aged 80 years and over to local hospitals fell by 14%.

Lessons learned

Capacity / Response time

- Capacity is challenged by annual increases in demand.

Recruitment

- Due to the skill base required, one of the biggest challenges is recruiting suitably qualified staff.

Training and development

- Challenging to find time for training and development.

Shared records

- Communication across teams can be challenging e.g. IT (e.g. lack of mobile technology, staff using both paper and electronic records), incompatibility of systems, fragmentation of patient records across different departments.

Relationships/Trust

- Building good, trusting relationships with referrers, patients, families/carers, colleagues, and other services takes time, effort, and energy.

- Trust and respect need to be earned; they are not a given.

Leadership

- Running a nurse-led service requires vision, leadership skills, investment in team members and support from senior management.

References

Griffiths B. & Davies A. (2017) Reducing hospital admissions with person-centred intermediate care. Nursing Times. 113(2), 55-57.

4.6 Central and North West London: Rapid Response Service (RRS)

Background and aims

- Service provides both admission avoidance and supported discharge.
- Camden's Rapid Response Service aims to provide alternative care pathways in the community so that fewer vulnerable patients presenting at accident and emergency departments are admitted to hospital.
- The trust had a therapy-led rapid response service for some years. Two staff ran it from Monday to Friday, and it could carry four or five patients on the caseload at a time.
- From October 2013, the trust used winter resilience money from Camden Clinical Commissioning Group to expand and integrate its existing rapid response, rapid early discharge and hospital-at-home services to create a single Rapid Response Service.
- Integrating schemes brought benefits of sharing resources and better management of peaks in demand. This increased the trust's capacity and ability to avoid hospital admissions while supporting timely discharge, particularly at weekends.
- The Rapid Response Service began in November 2013.

Model description

Patients

- The service is primarily for patients with physical health needs. The main referral criterion is that patients have been assessed as medically stable but would not be safe to stay at home without further support. Most patients are frail older adults.
- Referral criteria broad -the team tries to serve as many patients as it can care for safely.

Staff

- Nursing and therapy led multidisciplinary team (MDT).
- A senior nurse manages the team, which consists of band 7 clinicians able to work autonomously. The team includes nurses, occupational therapists, physiotherapists, a pharmacist, a rehabilitation assistant and healthcare assistants.
- Doctors are not currently part of the team. However, links with acute trust consultants and GPs have been stronger since expansion.
- GPs maintain medical accountability for the patient on the rapid pathway - Accountability for community referrals, especially admission avoidance, remains with the GP and the Rapid Response Service clinicians. All changes in treatment pathways are discussed with the referring GP.

Place

- Care is provided mainly at home.

Process

- Single point of access - referrals are received 24 hours a day, seven days a week. Nursing or therapy staff prioritise them.

- Referral received from: GPs, London Ambulance Service, acute services, other health and social care staff including community teams and sheltered housing, carers, friends, family, or self-referral (if they have used the service previously).
- Within four-hour the rapid response service completes a nurse-led telephone triage and an MDT member will conduct a face-to-face assessment in the patient's home.
- MDT members design a care plan with the patient, with the aim of restoring the patient's independence as quickly as possible.
- Works with the Rapid Enhanced Discharge Support (REDS) team to support discharge referrals within 24 hours.
- The rapid response service is staffed from 9am-9pm but the Trust's overnight staffing service has been co-opted into the rapid response team so it effectively operates 24 hours a day, seven days a week. For overnight referrals the overnight nurses assess the patient at home, stabilise them and arrange for a therapist to visit at 9am to complete a full assessment and care plan.
- Supported by CareLink, providing therapy-focused reablement.
- Patients stay in the care of the rapid response MDT for up to 10 days.
- Caseload is adjusted according to patients' acuity. The service has a capacity of over 40 patients per day depending on casemix.

Outcomes and Impacts

Hospital admission avoidance

- The trust reports that it is avoiding around 80 hospital admissions a month with over 80% of referrals avoiding admission.

Lessons learned

Skill mix

- Medical input into the MDT would enhance the scheme's impact, enabling more acutely ill patients to stay at home. But moving consultants into the community would significantly affect the cost of the service and capacity in the rest of the organisation.

Increasing awareness / promotion of service

- Staff from local acute trusts have opportunities to shadow CNWL community teams, including the rapid response teams, to enhance colleagues' understanding of whole pathways and encourage appropriate referrals.

Service uptake and utilisation

- GPs say they appreciate the open communication channels: for example, being able to speak to a senior clinician immediately and decide together what is best for the patient.

Relationships and support of other teams

- Relationship building with primary care, adult social care and mental health services is an important aspect of providing a seamless service to patients.
- The Rapid Response Service works closely with CareLink. CareLink provides six weeks of home-based care for reablement. The trust can introduce a CareLink package to give more intense care and reablement to patients on a rapid pathway. CareLink and the Rapid Response Service are located together, which helps them communicate. They benefit from each other's experiences, and joint working brings economies of scale.

References

Monitor (2015b) Moving healthcare closer to home. Rapid Response Service: Central and North West London NHS Foundation Trust. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459191/CNWL.pdf

4.7 Enfield: Care Home Assessment Team (CHAT)

Background and aims

- Integrated multi-disciplinary physical and mental health team support to care homes enhancing end of life care, dementia care and primary care support.
- Service aims to 1) reduce the need for acute emergency and reactive care, and 2) improve end of life care, increasing the number of residents who die in their preferred place.
- CHAT provide emergency rapid response to deteriorating patients, medically supporting residents to not be admitted to hospital, where possible.
- In 2011 a pilot service of a geriatrician and community matron led service model, with support from GPs, was set up to establish a relationship with four care homes. CHAT has now expanded to support in 39 care homes (2020).
- In October 2016, CHAT became a fully integrated physical and mental health multi-disciplinary team.

Model description

Patients

- Care home residents.

Staff

- An integrated mental and physical health team including community matrons, geriatricians, a consultant psychiatrist and mental health nurses, occupational therapy, a phlebotomist, pharmacists and work closely with primary care, frailty networks and a tissue viability service.
- Original staff model was limited to geriatricians (16 hours/wk), psychologist (0.6 wte), band 7 matron (1 wte), band 3 admin (0.6 wte) in 2012/13. In 2018/19 the staff model included: geriatricians (16 hours/wk), Consultant Psychiatry time (16 hours/wk), Band 8a manager /matron (1 wte), band 7 matrons (4 wte), band 7 specialist mental health nurse (2 wte, including one with OT specialism), band 4 assistant practitioner / phlebotomist (1 wte), band 3 admin (0.8 wte). There are also pilot projects included the following staff: band 7 matron in Haringey (0.6 wte), band 7 matrons / trusted assessors (3 wte), band 8a prescribing pharmacist (1 wte), band 6 pharmacy technician (0.6 wte).
- Community matrons are responsible for rapid response. Additional functions of community matrons include holding a caseload and providing support and training to staff.

Place

- 39 care homes across Enfield.

Process

- CHAT urgently responds to a deteriorating resident at risk of hospital admission within two hours (previously four hours).
- There is a single point of contact (SPOC), the community matrons triage the call and can provide telephone advice to GPs, other healthcare professionals, care home managers and staff.
- The SPOC will organise a CHAT team unplanned visit, a consultant geriatrician review, co-ordinate with any members of the integrated care network e.g. GP, physiotherapist depending on what is required.
- Referrals are made by phone, anyone can refer residents. Residents and carers can also access the SPOC.
- Operates Monday – Friday 09.00 – 17.00 exclusive of bank holidays.
- CHAT ensures care / crisis plan information is provided to out-of-hours Rapid Response providers e.g. LAS and GP OOH with clear instruction of agreed care plans in the event of an emergency and follow up actions in hours where appropriate. In 2018-19 CHAT have now been sub-contracted to support GP OOH provision.
- CHAT keep residents on their caseloads, residents are only discharged from the service if; moved out of borough; moved back to a private residence; admission to hospice care; or deceased.

Outcomes and Impacts

Hospital admission avoidance

- There was 35% reduction (-2,118) in the total number of A&E attendances and non-elective admissions, compared with a 23% increase in Enfield's 65+ year old non care home population.
- This equated to a 9% reduction in costs (-£598,671). Against a 34% increase in costs for the general population aged 65+ (+£7,113,284).
- Falls leading to hospital attendance or admission were reduced by 7%.

EOL/ preferred place of death

- 99% of residents died in their preferred place.

Lessons learned

Skill mix

- Each care home has a named CHAT matron to build a therapeutic relationship and respond to urgent requests. This reduces the times a care home / resident has to repeat their story.
- The role of staff develop over time. As staff train others to work to the top of their skill set and skill mix their role adapts too. For example, community matrons initially shadowed the geriatricians so that the specialists are no longer required for less complex patients. Subsequently, the matrons train the care home staff to be able to deliver the best possible care. The consultant psychiatrists train the mental health nurses and care home staff directly. Overtime the need for the specialists has decreased.

MDT relationships

- As the relationships between the medical staff and the care homes develop and strengthen over time, so do the outcomes.

Training and development

- CHAT identify and record all hospital attendances, they review the case and assess whether the attendance was warranted and what (if anything) could have done to prevent the attendance.

References

North London Partners in health and care (2020) Supporting Older People's Mental Health: Enfield's Care Home Assessment Team. Available at: https://www.northlondonpartners.org.uk/downloads/plans/Mental%20Health/Dementia%20care%20in%20NCL/report-dementia-supporting-older-peoples-mental-health-CHAT.pdf

4.8 Bristol: Rapid Response (RR)

Background and aims

- Short-term interventions that enable people to stay in their own homes via three elements: rapid response, reablement and rehabilitation.
- The service is provided in partnership between Bristol City Council and Bristol Community Health.

Model description

Patients

- Any adult living in Bristol who has a Bristol GP, although the service is primarily accessed by older people.
- Primary focus on ambulatory care sensitive conditions.

Staff

- Each rapid response nursing team has an advanced nurse practitioner (ANP).
- As well as overseeing the patient caseload for the rapid response team, the role of an ANP involves managing the clinical development of the team.
- ANPs are prescribers and can diagnose, prescribe and administer medication, including offering antibiotics intravenously, to patients in their own homes.
- Integrated management and multidisciplinary membership including: registered nurses, physios, OTs, social workers, mental health specialists, pharmacists and reablement workers.
- A co-ordinator in the team organises follow-up visits (1-4 visits daily).

Place

- Treated at home or in a safe haven bed (four respite beds based in a nursing home).

Process

- The wider Bristol area is covered by three rapid response nursing teams.
- Referrals made through single point of entry and response times guaranteed within four hours.
- Rapid response referrals are made largely by GPs.
- The rapid response, reablement and rehabilitation teams operate seven days a week from 7.30am to 7.30pm. An out-of-hours service is also provided through rapid response.
- Rapid response teams carry out in-reach work at A&E.
- Once a patient has been diagnosed, the ANP will put together a plan of care for the rapid response team to follow.
- Patients are normally managed for up to seven days.
- ANPs provide clinical advice over the telephone to rapid response nurses, clinicians, team members, district nurses, physiotherapists and occupational therapists. The ANPs are available via an on-call system Monday to Sunday, 7.30am-8pm.
- Handovers take place on Mondays, Wednesdays and Fridays, where the ANPs and the whole team go through the patient caseload. The ANPs review all patient case notes to ensure they are up to date and completed correctly. The purpose of the handovers is to ensure the plan of care is being followed and assess whether patients are ready for discharge.
- Referrals may be made to Care Direct to ensure patients have carer support to enable them to return home.

Outcomes and Impacts

Hospital admission avoidance

- An estimated 4,000 hospital admissions a year have been avoided through the work of the rapid response nursing team, which represents an annual saving of £3.5 million.

Lessons learned

Skill mix

- The ANPs' enhanced clinical nursing skills are regularly called on to assist team e.g. to take over when a cannulation proves difficult for a district or rapid response nurse.
- A three-day senior case review has also been introduced by the ANPs. This has been implemented to ensure each patient receives high standards of care and that the right plan is in place to improve their state of health.

References

- Penfold J. (2014) Rapid response team enables patients to remain at home. Primary Health Care. 24(5), 8-9.
- Yorkshire and Humber Commissioning Support (2014) Reablement - A review of evidence and example models of delivery NHS Doncaster Clinical Commissioning Group. Available from: https://www.doncasterccg.nhs.uk/wp-content/uploads/2016/01/Reablement-review-FINAL.pdf

4.9 Middlesbrough, Redcar and Cleveland: Rapid response service (RRS)

Background and aims

- Service initially set up in 2012 to enable nurses and therapists to assess patients in their own homes.
- Subsequently extended to include community matrons with advanced skills.

Model description

Patients

- Not clear on patient referral criteria for service. It may be restricted to community matron caseload.

Staff

- 18 community matrons with advanced clinical skills, including nurse prescribing, and particular expertise in managing patients with long-term conditions.

- Community matron have access to wider rapid response multidisciplinary team for patients who require long-term care. The integrated community care team includes: district nurses, physiotherapists and occupational therapists.
- The service also has access to rapid social care to provide patients with extra support when it is needed. This can include regular visits to assist with medication, mealtimes or with washing and dressing.

Place

- Patients own home.

Process

- Service operates from 8am to 11pm seven days a week.
- Patients are largely referred to the service by GPs or via NHS 111. Other referrals include specialist nurses, hospital teams.
- GPs can identify patients for referral using a predicted risk tool.
- All calls must be responded to within two hours.
- Each referral goes directly to the local community matron who will clinically assess the patient, make a diagnosis and devise a clinical management plan.
- The plan will include guidelines on medication, investigations required and parameters on blood pressure, heart rate and temperature. Patients are monitored by rapid response nurses over the next 72 hours.
- If there is a deterioration in the condition of a patient, their community matron is immediately informed. The matron will reassess the patient and create a revised clinical management plan.
- Following the 72 hours, patients can either be discharged from the service or placed under the care of their local community matron.
- Community matrons combine their role in the rapid response service with their own patient caseloads.

Outcomes and Impacts

Hospital admission avoidance

- Between April 2014 and May 2015, 89% of the patients referred to rapid response therapy were treated at home rather than being admitted to hospital.

Lessons learned

Skill mix

- Community matrons are the first point of contact when one of their patients is feeling unwell as their trusted relationship helps to provide reassurance and immediate support when it is needed.

MDT relationships

- Community matrons sometimes have to carry out district nursing duties. This has helped build good relationships with the district nursing teams. Previously community matrons and district nurses worked separately from one another.

Shared records

- Community matrons can access recent clinical information via SystmOne and ICE (integrated clinical environment) system. This means that matrons can start patients on new medication or adjust the dosage of their current medication without delay.

Increasing awareness / promotion of service

- The promotion of the service is important.

Service uptake and utilisation

- GPs have confidence in the community matrons as they can offer advanced clinical skills, as well as being able to put in place management plans for patients.
- Community matrons have worked with GPs and built relationships with their practices over many years. This trusted relationship is important for uptake of the service. The community matrons are also working to increase awareness so more professionals refer patients to the service.

References
Penfold J. (2015) Community matron service helps patients stay at home. Primary Health Care. 25(7), 8-9 .

4.10 Ipswich and East Suffolk: Reactive Emergency Assessment Community Team (REACT)

Background and aims
• In 2017 Reactive Emergency Assessment Community Team (REACT) was introduced and bought together five existing services (Crisis Action Team, Frailty Assessment Base, Emergency Therapy Team, Admission Prevention Service, and Outpatient Parenteral Antibiotic Therapy Service) into one fully integrated, centralised admission avoidance team. • The aim was to improve services issues such as: limited capacity in each team; declined referrals due to capacity limit; duplication of assessments and no trusted assessor; different IT systems; and restricted referral criteria. • One of the key service offers of the new integrated service is crisis response dispatched into the community within two hours of referral. • During the pandemic the REACT model was integrated with Ipswich and East Suffolk's eight Integrated Neighbourhood Teams (INTs). This move to localising care enables fewer handoffs, seamless service for the patients, reduced deconditioning of patients, care to be provided closer the home and a reduction in travel time allowing the optimisation of face-to-face time.
Model description
Patients • Criteria not specified. However geriatrician and dementia specialist involvement so suggestive of older adults. A care home initiative was also launched in 2020. **Staff** • Team currently includes nurses, a mental health specialist nurse, trainee advanced clinical practitioner, physiotherapists, occupational therapists, therapy assistant practitioners, health and social care practitioners reablement workers, health care assistants and social workers, and is also supported by the British Red Cross and Suffolk Family Carer support workers. • The service also receives two sessions of geriatrician support per week and five hours of nurse consultant attendance at multi-disciplinary teams per week. **Place** • Care in the community. A care home initiative was launched in 2020. **Process** • REACT provides a centralised clinical triage and localised responses are delivered within two hours by Integrated Neighbourhood Teams (INTs), or by REACT in the case of more complex crisis referrals. • 24-hour service, 8am-8pm therapy support and 24/7 nursing and generic worker support. • Up to four reablement carer visits daily and night sits. • Support for up to five days. • Out of hours nursing and IV antibiotic service. • Comprehensive Geriatric Assessment for patients in the Frailty Assessment Base, located on the acute site. • 15-minute response time for therapy admission avoidance assessment in emergency department.
Outcomes and Impacts
Hospital admission avoidance • Achievement of an average of 23 avoided admissions per day.

- Annual net cost avoidance of around £3.8million.

Lessons learned

Recruitment and retention

- As a 24-hour service, the model has experienced issues with recruitment and staff shortages.

Remote working

- Options for digitisation and remote working were already being explored before the pandemic to reduce time staff spent travelling back to base in Ipswich, due to the rural geography of East Suffolk.

Approach to service improvement

- The REACT team have developed the model successfully through small, incremental gains rather than rapid transformation of these services. Each time a new change or addition to the model is introduced, they work to promote confidence in the model and prove its value, so that they can continue to address existing challenges and meet the future needs of the population.

Equipment

- In 2019 Raizer chair community lifting equipment for emergency falls response was introduced to help optimise admission avoidance opportunities pre-ambulance, with referral directly from the East of England Ambulance Service NHS Trust control room. Training was given to community responders to increase awareness of the REACT service and which patients should be referred.

Skill mix

- REACT also worked with the mental health provider, Norfolk and Suffolk NHS Foundation Trust, on mental health integration and a Dementia Intensive Support Team was added to the REACT model to increase provision for mental health support.
- In 2020, a new care home initiative was also introduced to the REACT service offer.

Co-location

- Co-location of integrated health and social care alongside the voluntary and community sector, leading to fewer handoffs and a greater focus on the patient pathway

References

Local Government Association (2021) Reactive Emergency Assessment Community Team - Creating a fully integrated admission avoidance hub for Ipswich and East Suffolk. Available from: https://www.local.gov.uk/case-studies/reactive-emergency-assessment-community-team-creating-fully-integrated-admission

4.11 Kent: Enhanced Rapid Response Service (ERRS)

Background and aims

- Service brings together a medically led community team to treat patients at or closer to home. It aims to avoid unnecessary A&E attendance and emergency admission to an acute hospital.
- The service also facilitates timely hospital discharge for patients who need a short stay in an acute bed, and can admit patients to a community hospital bed.

Model description

Patients

- Not specified but a geriatrician led service suggestive of older adults. Service also provided in residential care homes indicating care home residents.

Staff

- Geriatrician led multidisciplinary team which includes specialty doctors, paramedic practitioners, senior nurses and therapists.
- Team is supported by an administrative team.

Place

- Most care is provided in patients' homes. Some care is provided in step-up care in community hospitals and residential care homes.

Process

- The ERRS team works from 9am until 10pm 7 days a week.
- Assessment in patient's home within two hours of referral where appropriate.
- ERRS receives referrals directly from primary care, the ambulance service, A&E and hospital discharge teams. An administrative team takes referrals via a central referral unit.
- Referrals are received from a range of professionals and enabling patients to be treated for sub-acute conditions in their own homes.
- Multidisciplinary team review meetings, led by the consultant geriatrician, take place twice a week at the community hospital in Tonbridge.
- The team use an assessment tool to calculate risk to determine whether the patient can be managed at home or needs a short stay in a community hospital. From home care patients are admitted to a 'virtual ward', receiving short-term care and support at home.
- Patients can remain on the rapid pathway for seven days.

Outcomes and Impacts

- From November 2014 to March 2015 the trust received 119 referrals a month on average. GPs made most referrals – 69% – followed by community health services at 14%. The ambulance trust made 6% and acute services (hospitals and A&E combined) 7%.
- Data show that between November 2014 and March 2015, 342 referrals were recorded as being made to avoid admission.
- Response time depends on clinical acuity established at triage. Most patients are seen within two hours.

Lessons learned

Skill mix

- Currently there is no joint commissioning of social workers for the service but the trust hopes to work with the local authority to recruit social workers to the multidisciplinary team and to act as case managers.

Increasing awareness / promotion of service

- The trust is currently working with about 70 primary care practices, promoting their continued use of ERRS and working with those not regularly using it. GPs particularly appreciated being able to contact ERRS quickly through the central referral unit's telephone number.
- Engagement programme with primary care, the mental health trust, social care and the ambulance trust to boost uptake of the service.

Leadership

- Senior clinical leadership (consultant geriatrician) is thought to be an enabler of the service.

Continual improvement

- Ongoing case review, internally at the trust and jointly with commissioners, has led to developments to ERRS.

Recruitment and retention

- Challenges with recruitment - The trust had to recruit staff from outside its own workforce to set up ERRS. The trust initially employed temporary staff, gradually replacing them with permanent employees.

Onward referral / care

- Discharge targets - The trust discharges most patients within seven days, either to their GP or to other services. The main challenge to this is the availability of social care packages.

References

Monitor (2015c) Moving healthcare closer to home. Enhanced Rapid Response Service: Kent Community Health NHS Foundation Trust. Available from:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459193/Kent_Community_Health.pdf

4.12 Sydney South: Geriatric Flying Squad (GFS)

Background and aims
• The Geriatric Flying Squad (GFS) model has been developed to prevent avoidable hospital admissions from residential aged care facilities (RACF) caused by factors such as: access to intravenous therapy and rapid laboratory results within RACF; education of RACF nursing staff to improve skills; better communication with general practitioners (GP); improved advance care planning and palliative care services in RACF. • Started in November 2011 and initially included a geriatrician as the only service provider. The team now includes nurse practitioners/nurse practitioner candidates and clinical nurse consultant. • There were 21 RACF in the catchment area at commencement of the service in 2011. The number had increased to 26 by the study period (1 April 2015 to 30 September 2016).
Model description
Patients • Residents living in RACF with an acute deterioration in condition, where emergency hospital transfer is being considered. **Staff** • Led by a geriatrician and supported by nurse practitioners/nurse practitioner candidates and clinical nurse consultant. **Place** • Residential aged care facilities (RACF) **Process** • Referrals can be made by GP, geriatricians or RACF registered nurse after obtaining GP consent. • A comprehensive assessment provided within 2–4 h of referral. • Diagnostic testing and management is provided in the RACF with close follow-up and monitoring until the acute episode is resolved.
Outcomes and Impacts
Service utilisation • Data were retrospectively analysed from 1 April 2015 to 30 September 2016 inclusive. • Over the 18-month period, GFS saw 640 patients, of which 578 (90.3%) were managed at the RACF and did not require emergency transfer for that acute episode. Without GFS involvement, all of these patients would have been sent to ED. • 35 (5.5%) of patients required transfer to ED, after being seen by GFS. For the other 27 (4.2%) GFS facilitated direct admission to a medical ward at either the public or private hospital depending upon bed availability, the patient's level of insurance cover and the patient or family's preferences. Terminal palliative care was provided to 116 (18%) patients. • The median number of days patients stayed on the service was four days (range 1–22 days). • The five most common reasons for referral were respiratory symptoms, delirium, sepsis, dehydration and acute symptom management in a palliative/terminal care setting.
Lessons learned
Increasing awareness / promotion of service • All RACF in the area utilised the service during the study period. The service was promoted through multiple visits to all RACF and presentations to GP meetings to raise awareness and clarify the service referral process. **Equipment**

- Portable equipment was purchased over time to enable the GFS team to perform point-of-care testing, including blood pathology lab, bladder scanner and electrocardiograph machine. Subcutaneous drug delivery pumps/ syringe drivers were used for palliative care. The GFS team utilised private pathology home collection services as well as mobile x-ray service for additional investigations

Transfer to hospital

- Multiple factors impact on decisions to transfer patients from RACF to hospital. Shortage of skilled registered nurses, poor advance care planning, GP availability and preferences for treatment and inability of nursing staff to recognise early signs of deterioration are among the factors that influence decisions. The GFS aims to address these factors by providing rapid assessment and management plan within and after hours, ongoing education to nursing staff and engaging families and RACF in advance care planning.

Service uptake and utilisation

- Key factors impacting on service uptake and utilisation included establishing relationships with all stakeholders (patient/family/RACF/GP/hospital), effective communication, flexible/individualised patient management plans and availability of point-of-care equipment and consumables.

References

Jain S et al. (2018) Southcare Geriatric Flying Squad: an innovative Australian model providing acute care in residential aged care facilities. Intern Med J. 2018 Jan;48(1):88-91.

5. References

British Geriatrics Society (2021) Right time, right place: urgent community-based care for older people. Available from: https://www.bgs.org.uk/righttimerightplace

Cantley P. et al. (2016) Hospital at Home as an Enhancement to an Existing Rapid Response Team in a Semirural setting in Scotland. International Journal of Integrated Care (IJIC). 16(6), 1-2.

Chua E. et al. (2020) The short-term assessment, rehabilitation, reablement service "starrs": a rapid response team to support the frail older person to remain at home. MOJ Gerontol Ger. 5(3), 96–101.

Chua P. et al. (2021) The impact of COVID-19 on the rapid response team: short term assessment rehabilitation and reablement service (STARRS) in England. MOJ Gero & Geri Med. 6(4),107–112.

Clarke G. et al. (2020) The long-term impacts of new care models on hospital use: An evaluation of the Integrated Care Transformation Programme in Mid-Nottinghamshire. The Health Foundation. Available at: https://www.health.org.uk/publications/reports/the-long-term-impacts-of-new-care-models-on-hospital-use-midnotts

Clift, E. (2015) How a rapid response team is supporting people to remain at home. Nursing Older People. 27(10) 16-21.

Cordis Bright (2018) What works in creating an effective Multispecialty Community Provider? Available at: https://www.cordisbright.co.uk/admin/resources/01-hsc-evidence-reviews-mcps.pdf

Dowell S. et al. (2018) Rapid response: a multiprofessional approach to hospital at home. British Journal of Nursing. 27(1), 24-30.

Erens B. et al. (2015) Early evaluation of the Integrated Care and Support Pioneers Programme: Final report. Policy Innovation Research Unit. Available from: https://piru.ac.uk/assets/files/Early_evaluation_of_IC_Pioneers_Final_Report.pdf

Griffiths B. & Davies A. (2017) Reducing hospital admissions with person-centred intermediate care. Nursing Times. 113(2), 55-57.

Jain S. et al. (2018) Southcare Geriatric Flying Squad: an innovative Australian model providing acute care in residential aged care facilities. Intern Med J. 2018 Jan;48(1):88-91.

Local Government Association (2021) Reactive Emergency Assessment Community Team - Creating a fully integrated admission avoidance hub for Ipswich and East Suffolk. Available from: https://www.local.gov.uk/case-studies/reactive-emergency-assessment-community-team-creating-fully-integrated-admission

Monitor (2015a) Moving healthcare closer to home. Short-Term Assessment, Rehabilitation and Reablement Service: London North West Healthcare NHS Trust. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/458979/London_North_West_.pdf

Monitor (2015b) Moving healthcare closer to home. Rapid Response Service: Central and North West London NHS Foundation Trust. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459191/CNWL.pdf

Monitor (2015c) Moving healthcare closer to home. Enhanced Rapid Response Service: Kent Community Health NHS Foundation Trust. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459193/Kent_Community_Health.pdf

National Institute for Health and Care Excellence (2017) Intermediate care including reablement. NICE guideline [NG74]. Available from: www.nice.org.uk/guidance/NG74

NHS Benchmarking Network (2013) National Audit of Intermediate Care Report 2013. Available from: https://www.nhsbenchmarking.nhs.uk/naic-key-resource-dates

NHS Benchmarking Network (2015) National Audit of Intermediate Care Summary Report 2015. Available from: https://www.nhsbenchmarking.nhs.uk/naic-key-resource-dates

NHS Benchmarking Network (2018) NAIC 2018 Key findings England. Available from: https://www.nhsbenchmarking.nhs.uk/naic-key-resource-dates

NHS Benchmarking Network (2021) Intermediate Care Benchmarking 2020 Summary Report. Available from: http://www.communityhospitals.org.uk/IC%20summary%20report%202020%20FINAL.pdf

NHS England (2019) NHS Long Term Plan. 2019. Available from: www.england.nhs.uk/long-term-plan/

NHS England (2021a) 2021/22 priorities and operational planning guidance. Available from: https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf

NHS England (2021b) Community health services two-hour crisis response standard guidance. 2021b. Available from: www.england.nhs.uk/publication/community-health-services-two-hour-crisis-response-standard-guidance/

North London Partners in health and care (2020) Supporting Older People's Mental Health: Enfield's Care Home Assessment Team. Available at: https://www.northlondonpartners.org.uk/downloads/plans/Mental%20Health/Dementia%20care%20in%20NCL/report-dementia-supporting-older-peoples-mental-health-CHAT.pdf

Penfold J. (2015) Community matron service helps patients stay at home. Primary Health Care. 25(7), 8-9.

Penfold J. (2014) Rapid response team enables patients to remain at home. Primary Health Care. 24(5), 8-9.

Robb K. et al. (2022) Making waves: nurse-led urgent community response. British Journal of Community Nursing. 27(1).

Sheppard S. et al. (2016) Admission avoidance hospital at home (Review). Cochrane Database of Systematic Reviews. 9.

Stevenson J and Spencer L (2009) Developing Intermediate Care. A GUIDE FOR HEALTH AND SOCIAL SERVICES PROFESSIONALS. The King's Fund. Available from: https://www.kingsfund.org.uk/sites/default/files/Developing-Intermediate-Care-guide-health-social-services-professionals-Jan-Stevenson-Linda-Spencer-The-Kings-Fund-July-2009.pdf

The Local Government Association and Social Care Institute for Excellence (2019) Achieving integrated care 15 best practice actions. Available from: https://www.local.gov.uk/sites/default/files/documents/25.141%20Achieving%20integrated%20care_05.pdf

Waldon M. (2021) A rapid response and treatment service for care homes: a case study. British Journal of Community Nursing. 26(1), 6-12.

Yorkshire and Humber Commissioning Support (2014) Reablement - A review of evidence and example models of delivery NHS Doncaster Clinical Commissioning Group. Available from: https://www.doncasterccg.nhs.uk/wp-content/uploads/2016/01/Reablement-review-FINAL.pdf

6. Appendix 1 – evidence signpost

Earlier work included a rapid review of the evidence in the form of an evidence signpost. This provided a summary of evidence for a selection of interventions which have a primary or secondary aim to provide a rapid response in the home/place of residence to avoid admission or ambulance conveyance. The evidence signpost explored rapid response teams, paramedic practitioners, the extensivist model and hospital at home. The full review is available below:

Urgent Community Response evidence

The Strategy Unit
Tel: 0121 612 1538
Email: strategy.unit@nhs.net
Web: www.strategyunitwm.nhs.uk
Twitter: @strategy_unit

Midlands and Lancashire
Commissioning Support Unit