Introduction

- Acute hospitals are challenged by changing population, increasing clinical demand, and fractured care
- Hospital at Home projects alleviate pressures by providing care in the community
- Endorsed by NICE and British Thoracic Society (for COPD care)
- Numerous Systematic Reviews and Randomised Controlled Trials since 1999
- Early Discharge vs. Admission avoidance

Aims

- Reduce acute hospital admissions by providing care in the community, saving 4 hospital beds
- Reduce Emergency Department presentations by patients with long term conditions by 1%
- Reduce placement of patients to residential care from hospital by 50%

Methods

- Built on three pillars:
  • Acute Hospital at Home
  • Roaming Night service
  • Alternative Offer

Hospital at Home

- 10 beds in community
- Covers Dorchester and Weymouth
- Principally an Early Discharge model
- Majority of patients admitted from EMU following PTWR
- Patients are treated and counted as inpatients
- Daily virtual ward round with Consultants
- At least twice daily nursing visit, with observations recorded and monitored electronically
- Physician review as required either in hospital or in community
- Range of services provided include: IV medications, cannulation, venepuncture, Physiotherapy, Occupational therapy, Dietitian and SALT input
- Most patients under Acute Medicine, but increasing uptake from other medical and surgical specialties

Patient Pathway Through DCH F.T. Acute Hospital at Home

- 1 X Band 6 Staff Nurse
- 2 X Band 5 Staff Nurses
- 2.5 X Health Care Assistants
- 1 X Band 5 OT
- 1 X Band 6 Physiotherapist
- 1 X Band 6 SALT
- 1 X Band 6 Dietitian
- 0.4 X Band 7 Pharmacy

Roaming night

- 1 nurse and 1 HCA covering West Dorset overnight offering telephone advice or personal assistance
- All patients are given access to Roaming night

Alternative offer

- For patients with long-term care needs
- Aim is to allow patients to retain their independence for as long as possible and prevent avoidable Residential care admissions
- Comprehensive assessment of patient needs over a 2 week period and arranging necessary support

Outcomes

- 6 in-hospital beds saved during winter months
- 75% reduction in residential placements from hospital
- 1% reduction in unplanned re-attendances in ED
- Excellent patient and staff satisfaction
- Project executed within budget (£560,000/yr)

The Future

- Increase capacity to 15 beds
- Raising awareness of AHaH - broadening specialty access
- Establishing regular consultant visits

References:


Acute Hospital at Home

<table>
<thead>
<tr>
<th>Project aim/objective</th>
<th>Type of measure</th>
<th>Expected</th>
<th>Actual</th>
<th>Actual</th>
<th>Actual</th>
<th>Quarter 4 overall</th>
<th>Actual</th>
<th>Actual</th>
<th>Actual</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid opening of 4 DGH beds.</td>
<td>Agreed KPI</td>
<td>4 beds</td>
<td>3.5 beds</td>
<td>5.8 beds</td>
<td>7.6 beds</td>
<td>5.8 beds</td>
<td>7.6 beds</td>
<td>7.4 beds</td>
<td>7.5 beds</td>
<td>6.3 beds</td>
</tr>
<tr>
<td>Friends and family test: usefully likely or extremely likely to recommend the service</td>
<td>Agreed KPI- Patient Experience</td>
<td>75%</td>
<td>100% (patients with survey results)</td>
<td>100% (patients with survey results)</td>
<td>100% (all patients with survey results)</td>
<td>100% (2 patients with survey results)</td>
<td>100% (2 patients with survey results)</td>
<td>95% (10 patients with survey results)</td>
<td>100% (6 patients with survey results)</td>
<td>100% (6 patients with survey results)</td>
</tr>
<tr>
<td>Number of patients admitted to AhAt</td>
<td>N/A</td>
<td>21</td>
<td>24*</td>
<td>28*</td>
<td>73</td>
<td>22*</td>
<td>27</td>
<td>21*</td>
<td>70</td>
<td>25*</td>
</tr>
<tr>
<td>Maximum length of stay on AhAt of patients admitted</td>
<td>N/A</td>
<td>21 days</td>
<td>39 days</td>
<td>60 days</td>
<td>60 days</td>
<td>32 days</td>
<td>28 days</td>
<td>24 days</td>
<td>32 days</td>
<td>15 days</td>
</tr>
<tr>
<td>Number of patients admitted as an acute inpatient from AhAt.</td>
<td>N/A</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>14</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1 (same patient)</td>
</tr>
<tr>
<td>Percentage of referred patients seen within 24 hours</td>
<td>Therapy Measure</td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>67%</td>
<td>89%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

* A patient was discharged from AhAt and transferred to a DGH ward and readmitted to AhAt during the same month. Counted as 2 patients admitted. 

Acute Hospital at Home commenced on 6th January 2014

<table>
<thead>
<tr>
<th>Quarter 4</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-14</td>
<td>2013/14</td>
<td>Jan-15</td>
</tr>
<tr>
<td>Feb-14</td>
<td>Feb-14</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Mar-14</td>
<td>Mar-14</td>
<td>Mar-14</td>
</tr>
<tr>
<td>Apr-14</td>
<td>Apr-14</td>
<td>Apr-14</td>
</tr>
<tr>
<td>May-14</td>
<td>May-14</td>
<td>May-14</td>
</tr>
<tr>
<td>Jun-15</td>
<td>Jun-15</td>
<td>Jun-15</td>
</tr>
<tr>
<td>Jul-15</td>
<td>Jul-15</td>
<td>Jul-15</td>
</tr>
<tr>
<td>Aug-15</td>
<td>Aug-15</td>
<td>Aug-15</td>
</tr>
</tbody>
</table>

Acute Hospital at Home

- The Acute Hospital at Home project at Dorset County Hospital
- by Dr Peter Szedlak and Dr Paul Andrews

References: