Young

Densely populated

Diverse

Deprived
GSTT @ Home- Service

- Acute/ semi-acute health care in person’s own home
- 7 day service 0800-2300
- Referrals by phone 0800-2000 7 days a week
- Direct clinician to clinician verbal referral
- Matron in hospital 5 days/week to facilitate referrals
- Admissions 7 days a week
- Addition of Pal@ home service for end-of-life referrals which is 24/7

- Referral sources;
  - Community clinicians (GPs, specialist nurses)
  - London Ambulance service (as per agreed protocol)
  - Hospital outpatient
  - Hospital inpatient areas
New referrals seen by a nurse practitioner or @ home GP/Dr day of admission
  • Clerking
  • Care plan (medical and multidisciplinary)

Morning Board round

Every patient seen every day by at least one team member

Central co-ordinating matrons

Consultant led MDMs 3 times a week
Referral criteria

• Lambeth and Southwark resident with GP
• Over 16 years
• No over-riding need for admission
• Access to property possible
• Safe or with appropriate support overnight
• Maximum of three time day visits
Admission avoidance

- Semi-acute outpatients
- GP referrals
- LAS pathway
- Community teams
- Care homes
- End of life care

Outpatient reduction

- Domiciliary reviews for frail

Reduce length of stay

- Ongoing medical therapy
- Daily monitoring of clinical situation
- Dynamic functional support from MDT and ‘discharge to assess’
COPD 19%
LRTI 6%
UTI/pyelonephritis 15%
Cellulitis 9%
Other infections 9%
AKI 5%
Heart Failure 6%
Diabetic management 3%
Monitoring 3%
Falls 4%
Other e.g. urinary retention, hyperemesis gravidarum, Fast AF, delirium 21%
Mean length of stay around 5.5 days

Readmission to acute hospitals within 30 days 19%

60% patients over 75
Assumption - Based on the April 2014 SLIC paper "Integrated Care Organisation" without ERR and @home there was an expected activity increase of 27.27% from 2013/14 outturn to 17/18. With ERR and @home activity was expected to reduce by 13.64% from 2013/14 outturn to 17/18.
Assumptions;
• Acute medicine inpatient occupied bed day (OBD) costs £532
• A & E attendance costs £113
• One @ home admission saves 3.5 OBDs

Cost of @ home;
£5.58 million 2015-2016
• @ Home bed day costs £444

OBD savings (actual activity from month 7 projected for full year);
Acute hospital admissions 12,558 = £6.12M
A & E attendances 1,769 = £0.2M

Equates to 34 less hospital beds - just over one ward

Commissioning savings
£740,000
Benefits

• High satisfaction – no complaints!
• Reduced hospital length of stay
• Reduced number of admissions
• Reduced occupied bed days
• Increased links with community teams and GPs
• Development of new pathways e.g. care home and advance care plan
• New training environment
Unusual role – unusual skillset

Beyond traditional boundaries

Rules, myths and clinical governance

Education, training, supervision

Wrong borough
NHS Professionals

• Move from traditional care pathways
• Takes time to embed concept into practice
• Risk adverse – prefer to keep patients in hospital
• Specialist care only
• No evidence base
• Build up trust and support locally from hospital and community

Patient Choice

• Not all patients chose to have care at home- some prefer to stay in hospital
• After @ home intervention. Patients/ families declining out-patient follow up requesting further home visits
• Patient self referral
89

Seen in ‘frailty unit’
Increased confusion, fall

Managed at home for delirium, constipation, TWOC

Package of care, medication review, follow-up
94
Referred from OP clinic
 Decompensated heart failure
Medication in dosette box

@ home
• Monitored short term diuretic therapy
• Changed regular meds in dosette box
• Action plan
• Community HF team handover
Advanced dementia
Bedbound
Reduced oral intake
GP referred to @Home

K 7.9
Creatinine 795 (89)

Consultant review
End of life care achieved at home
90
Referred from OP
“Feeling great”
Pulse 44
ECG – complete heart block
Registered blind
@ home
• Monitored clinical condition
• Elective admission for pacemaker following week
• Therapies review at home
GP referral
Dementia
Residential home

Cough and confusion

IV antibiotics and fluids
Clinical monitoring
Care plan with residential staff
Advance care plan created
Personal reflections

Risk, comfort zone

Amazing to get out of hospital

Choice

Empowerment

Acute medicine
My ward. Everything between here and the hills!

#hospitalathome

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@trisha_the_doc

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Thanks to

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