Improving utilisation of Community Services for Frailer Patients in the Emergency Department

NHS
Oxford University Hospitals
NHS Foundation Trust

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Background

Oxfordshire has a number of services aiming to provide timely patient care in the community, provided by two separate NHS trusts. The **Hospital at Home (H@H)** and **Crisis Assessment Response (CARe)** teams operate as virtual wards, which can manage **hospital-level acute medical needs** and **acute mobility/ care needs** respectively. These services have highest impact when involved **early** in **frailer** patient's acute care, however only few referrals were received from the **Emergency Department (ED)**; instead potentially eligible patients were admitted to hospital under Acute Medicine.

Why?

Patients who continue their acute care in the community (vs in hospital) divert from exit blocks– this improves patient flow. Community care is less costly than inpatient care.

Frailer patients can be harmed by hospital stay. >75yo are at increased risk of deconditioning. The mean length of stay (LOS) for 65-84yo is >10 days, and >12 days for >85yo.

AIMS: To increase the referral rate from ED to H@H and CARe community services (by an estimated one additional patient per day) over a 6 months period, and to assess the impact on patient care and on staff.

Methods

studying the problems

- baseline referral rate
- ED staff survey
- process mapping
- stakeholder matrix
- driver diagram

Complex referral process
inability to refer out of hours
multiple H@H teams covering different geographic areas

??? Uncertainty of scope/skills

Poor confidence in follow up and continuity of care

measures

Process
- Referral rates
- Missed referrals
- Median age
- Staff surveys

Outcome
- LOS
- Sample quality review
- Patient survey

Balancing
- 7d unscheduled return

continued monitoring

PDSA 1 Nov 24

the change
streamline referral to H@H
- new EPR **referral template**
- referrals **centralised** to single H@H coordinating team
- new **out of hours** (OOH) pathway

Community pathway for ED patients with hospital-level acute medical needs

supporting interventions

teaching & awareness
- ED handover "success stories"
- ED middle grade teaching

communication & engagement
- dissemination via TEAMS, posters
- EOLAS clinical app updated
- regular stakeholder meetings
- presentations at leadership meetings for ED, H@H, CARe

PDSA 2 Jan 25

the problem
patients with isolated care/mobility needs continue to be admitted to hospital for inpatient mobility/care assessment

the change
new OOH referral to CARe
- add to existing ED to H@H referral template
- referrals centralised to same single coordinating hub

Community pathway for ED patients with isolated acute mobility/care needs

PDSA 3 Mar 25

the change
new referral pathway to DN
- new EPR referral template
- 24/7 referrals centralised to ED admin team

the problem
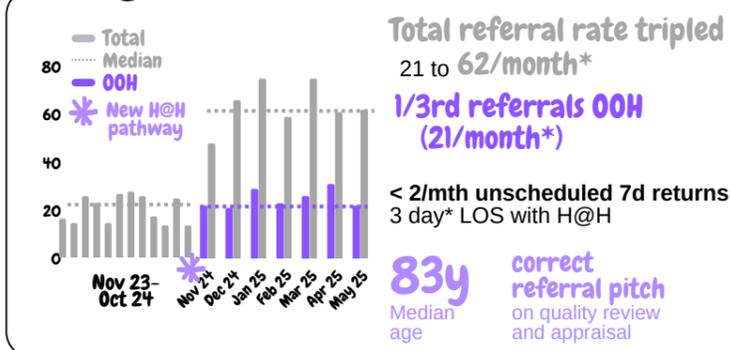some referrals for community-level care... why are ED not referring to District Nurses (DN) directly?

Community pathway for ED patients with community-level acute needs

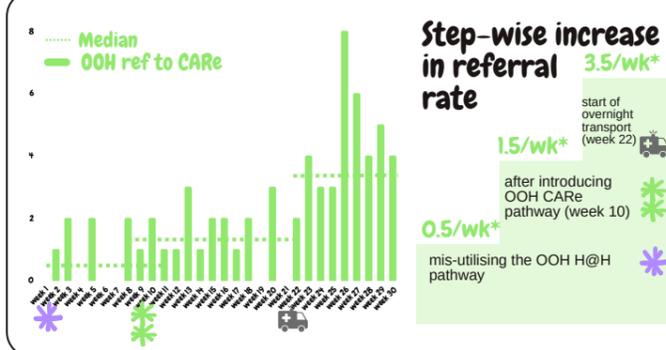## Results

ED-H@H referrals/ month

- Total
- Median
- OOH
- New H@H pathway

80 / 60 / 40 / 20 / 0

Nov 23-Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | May 25

Total referral rate tripled
21 to 62/month*

1/3rd referrals OOH (21/month*)

< 2/mth unscheduled 7d returns
3 day* LOS with H@H

83y Median age

correct referral pitch on quality review and appraisal

ED-CARe OOH referrals/ week

- Median
- OOH ref to CARe

Step-wise increase in referral rate

3.5/wk* start of overnight transport (week 22)

1.5/wk* after introducing OOH CARe pathway (week 10)

0.5/wk* mis-utilising the OOH H@H pathway

ED-DN referrals/ week

- Median
- Total

3 ref/wk*

78y Median age

30% wound
70% catheter

*medians
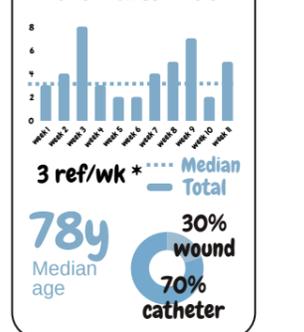
Sustainability

Staff
- ED doctor induction programme (delivered Dec24/ Mar25/ Apr25)
- Poster created to support ED clinical decision making and embed pathways in routine practice
- Decision tool created to support virtual ward triage of referrals

Organisation
- Cost saving data generated to show benefits to wider organisation
- **>£30,000/month saved**
  63 patients/ month with 3d LOS hospital bed £350 vs H@H bed £180
- current H@H team consultation process: to formalise the new coordinating &re-triaging role

Process
- Existing H@H and CARe data recording system amended to collect source and IH/OOH referral data

Next steps...

INTERVENTION
Spread pathways to other (non-ED) hospital front-door services, such as SDECs.
Adjust pathways for OUH trust second ED site, located in north of Oxfordshire county, including developing additional cross-border DN pathways for Northamps/ Bucks/ Wars.

DATA full handover to existing IT monitoring team to include in routine data collection and standard reporting systems.

PEOPLE identify local champions in both ED sites.

ORGANISATION include in existing governance systems, tracking performance and reviewing slips