Early Intervention Team

Working in the community to provide a “one stop shop” to help people retain their independence and avoid hospital admission in West Suffolk
Context

- Increasing ED attendances (DOH, 2014)
- Growing older population and number of patients with complex conditions (West Suffolk CCG)
- Poor outcomes:
  - long hospital admissions (Alzheimer’s Society 2009)
  - English and Paddon-Jones (2010) reduced muscle strength after hospital stay in older people
- Already established Early Intervention Team (EIT) (Occupational Therapy and Physiotherapy) based in ED and AMU Monday to Friday 8:30-16:30 who could refer on to Social Services and voluntary sectors
Drivers for change

• Needed changes to patient flow and admission avoidance (NHS Confederation 2016)

• Consultants requesting EIT at weekends and later on weekdays, as patients are not requiring acute medical treatment

• Better coordination for patients with frailty (BGS and RCN, 2015)

• Reduce hand-offs, improve rapid access to services

• Push model out into the community, challenge ED attendances
Opportunities identified

• Integrated working between health, social care and voluntary sector (NHS Five Year Forward Plan, 2014; Oliver et al 2014)
• Support from geriatricians, need to link up with community services
• Improved patient experience, promote reablement
• Reduce conveyance
• Cost avoidance for length of hospital stay, improve long-term health (Alzheimer’s Society, 2009; English and Paddon- Jones 2010)
• Increased role of AHPs
November 2015

- Community admission avoidance - outreach
- Reduce ED conveyance
- Integrate with Admission Prevention nursing service
- “The clinical audit at West Suffolk Foundation Trust in December 2014 identified that a significant proportion of the admissions were underpinned by frailty with respiratory, urinary tract infections and falls being a trigger” The West Suffolk 2014/15 Winter Review
Service prior to 2015

– Extended hours, 7 day service

– Integrated team, wraparounds service
  - Therapies (West Suffolk NHS Foundation Trust)
  - Age UK Suffolk
  - Suffolk Social Services
  - Dementia liaison nurse (Norfolk and Suffolk NHS Foundation Trust)
  - Carers (Crossroads East Anglia)
  - Access to Geriatricians
Moving forward

November 2015

- Extension of integrated team:
  - Colocation of Admission Prevention Nursing Team (Suffolk Community Healthcare)
  - Reablement support workers (carers) in-house
  - Suffolk Family Carers link worker
- Promotion of team to GPs, Ambulance Service, Social Services, community health teams, housing associations, hospice
Successes

• Improved communication, integrated team in same office
• Shared learning
• In ED became part of the core team, improved relationships and respect
• More control in patient discharge
• Increased referrals in ED and increased discharges
• Discharge to assess model
• Reablement focus
Barriers

- Different IT systems and governance agreements
- Delays in handing over for ongoing care
- Delays in Continuing Healthcare
- Office space
- Out of county patients in ED
Results and evaluation

• Exceeded KPIs in first year for ED and AMU
  – December 2012- April 2013: 360 avoided admissions and early support discharges
  – December 2013- April 2014: 777 avoided admissions and early supported discharges
  – December 2014- April 2015: 971 avoided admissions and early supported discharges
  – December 2015- April 2016: 1559 patients seen in the community, 804 avoided admissions and early supported discharge
  – August 2016-December 2016: 1530 patients seen in the community, 688 avoided admissions and early supported discharge
Results

• Qualitative- Positive feedback from patients, families, health and social care providers

• Improved wraparound service, holistic assessment/comprehensive geriatric assessment. Efficient “one-stop shop”, rapid access

• Cost avoidance for reduced conveyances, health promotion (£1078 average admission tariff)

• Need further promotion to GPs and Ambulance Service to increase community admission avoidance
Key learning points

- Team adapting to change
- Managing expectations
- Coordination
- Data collection from different organisations
- Promotion to public and primary care
- Value of AHPs in urgent care
Plans for spread

• Further integration with GPs/ Ambulance Service
• AHPs to triage in ED
• 24 hour reablement support worker service
• NHS England (2016) rehabilitation commissioning guidelines
• Promotion to patients to not attend ED
• Training opportunities- ? X- ray requests ?

Prescribing
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- Twitter: @WSH_EIT
- Youtube: https://www.youtube.com/watch?v=m76CkAn7JC4
Thank you!
References

• British Geriatrics Society and Royal College of Nursing (2015) Fit For Frailty [Internet] Available at: http://www.bgs.org.uk/index.php/fit-for-frailty
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• Oliver, D. (2015) ‘Integrated services for older people- the key to unlock our health and care services and improve the quality of care?’ Journal of Research in Nursing 20 (1) 5-11 Available at: http://jrn.sagepub.com/content/20/1/5.full.pdf+html
