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Bridging the Gap between Community and Acute Care
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• Main provider of community and mental health services to the population of Berkshire
• Split approximately 50:50 between mental and community health
• Annual income of around £220m, employing approximately 4,000 staff and providing services from just over 100 sites
Rapid Assessment Community Clinic (RACC)

• Based in a local community clinic – covering East of Berkshire

• For people with complex health & social care needs who require urgent medical attention

• Referrals from GPs, ambulance crew and front door of the acute hospital
RACC and Admission Avoidance

• Within the last 36 months the service has dealt with 1256 people of which:
  ~ 977 (79%) were managed in the community
  ~ 136 (10%) warranted admission to secondary care
  ~ 143 (11%) were admitted to one of our community hospitals

• Referrals responded to within 15 minutes and most patients seen same day

• Average age 84 – with 100% FFT rating and nominated for NT Award
What makes the Clinic a success?

- Tight, fully integrated MDT – consultants, advanced nurse practitioners, therapists, support staff - all specialists in looking after older people

- Focus on reablement, underpinned by strong care planning & care co-ordination

- On site diagnostics

- Part of a strong community network with a direct route into our other community services, such as district nursing, intermediate care, dementia teams etc
Hospital at Home (H@H)

- In proof of concept phase across the West of Berkshire – currently reviewing learning from first 2 weeks

- Acute hospital level care within patients homes – greater acuity than the RACC can deal with

- Developed in US by the John Hopkins University School of Medicine and Public Health

- Team members drawn from different organisations – acute, community & social care
RACC and H@H – Workforce Challenges

• Technical knowledge and competency

• Risk aversion

• Difficulty attracting the best geriatricians to this work

• Status – many nurses view working in community based teams as a ‘step down’

• Lack of capacity and capability within Home Care

• Lack of community competency
Community Competency

The skills, knowledge and ability to help people remain at home in addition to the clinical intervention:

• Understanding the range of services in the community and how to make the most of them
• Housing, equipment, welfare and benefit issues
• Managing a different dynamic with the patient & carer
• Case management
• Comfortable working away from a hospital setting and understanding all of the above is as important as the treatment intervention
• In terms of NHS “DNA”, Mental Health (MH) is far more evolved with regard to out of hospital care
• 60% reduction in MH beds between 1987 – 2010 (70% in Berkshire)
• This shift in the location of care was underpinned by a social movement and a voice for change involving elements of both the workforce and service users – this currently does not exist with regard to physical healthcare
• Case management since 1990 (CPA)
Learning from Mental Health (2)

- New ways of working (2005) – liberated psychiatrists and gave them new roles in supporting MDTs and reduced caseloads dramatically
- ‘Creating capable teams’ (2007): right staff doing the right jobs – saw increase in psychological therapists and support workers
- New teams rolled out at scale – evidence based and an exciting time for the workforce
- Risk assessment and management capabilities of the workforce greatly enhanced and positive risk taking in the community encouraged
On my To Do List

• Community competency – how can it be accelerated?

• Students/Learners – getting the right experience and exposure

• Social care workforce – mismatch between supply and demand of circa 1m workers in 10 years’ time: a 35% shortfall on predicted demand

• Achieving scale in community based alternatives