NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

# Lowestoft out of hospital team evidence

Better Health, Better Care, Better Value

## Background

In April 2014, following a 12 week public consultation NHS Great Yarmouth and Waveney set up an out of hospital team in Lowestoft to support people better during a crisis so that they could get the care they need in their own home, or as close to it as possible.

Provided by East Coast Community Healthcare and Suffolk Adult Social Care, the Lowestoft out of hospital team was a pilot which was developed as the service grew to adapt to the specific needs of people in Lowestoft.

The aim of the new out of hospital service was to replace old ways of working and delivery of care which did not satisfy patient needs fully, were out of date and did not comply with best practice. NHS Great Yarmouth and Waveney CCG believe that the best place for people to be cared for is in their own community. Older people who are kept in a hospital bed during treatment can lose their mobility and their independence. This can affect their overall health and increase their likelihood of having no option but to go into long term care in a residential or nursing home. When cared for appropriately, we know that patients will recover faster and more fully in their own home environment.
The percentage of the population aged over 65 years in Great Yarmouth and Waveney is currently 24% and this is set to double over the next 20 years. Alongside rising demand, as a health service we are capable of doing much more in the community than we have ever done before, and we owe it to our patients to provide the best care that we can. The public sector is also facing financial constraints and we need to spend what we have carefully.

The out of hospital service in Lowestoft was piloted to see if we could support people better in their own community.

## Principles underpinning high quality out of hospital care

We developed some principles by which the out of hospital service would be guided. They are:

- Care must be patient centred - staff will involve patients and their family and, or carers in the planning the right care
- Care should also be sensitive to the needs of carers
- Care should only be delivered out of acute hospital when it is safe, in line with optimal outcomes and affordable
- Care should be available through all 24 hours of a day, every day
- Care should be available to all Great Yarmouth and Waveney residents
- Care should be delivered through a process of early identification of at-risk patients, proactive delivery of care which prevents deterioration, is able to be delivered quickly in a crisis and is appropriate to patients' needs and desires

Joined up working between different organisations is also a key feature of the pilot and is delivered through:

1. Service Integration – teams of professionals from health and social care working together to deliver joined-up care for patients who will see no obvious distinction to the patient between the organisations, be it health or non-health.
2. Clinical Integration – through using shared guidelines and protocols and a single

coherent assessment process, making sure that information is shared with the aim to discharge patients back to their general practice in a smooth and effective manner.

The out of hospital team works closely with the patients GP so the GP always knows what is happening.

**What are the benefits to patients and family carers?**

**For the patient**

- supporting patients to remain living independently in their own home, especially if they are at risk of moving into hospital based or longer term carea single assessment so patients do not have to keep repeating the same information to different professionals
- reduced waiting times and a more efficient referral system between services
- some key services provided 24 hours a day, seven days a week
- health and social care coordinators to guide patients through the system
- improved dignity and patient experience as patients are being cared for in their own home

**For carers**

- signposting to support groups
- help in maximising financial benefits
- equipment at home
- respite care such as day or night time support

**The first twelve months**

The activity and achievements of the Lowestoft out of hospital team have been closely monitored since it was started. The table below shows:

1. the reduction in emergency admissions for patients within Lowestoft when compared to the previous year

| | Lowestoft GP practices emergency hospital admissions month by month | | | | |
|---|---|---|---|---|---|
| | 2013/14 | 2014/15 | Change | Expected | Reduction |
| Apr | 476 | 402 | -74 | -6 | -68 |
| May | 497 | 405 | -92 | -31 | -61 |
| Jun | 424 | 439 | 15 | -11 | 26 |
| Jul | 471 | 420 | -51 | 3 | -54 |
| Aug | 405 | 380 | -25 | 5 | -30 |
| Sep | 343 | 383 | 40 | 19 | 21 |
| Oct | 480 | 456 | -24 | 61 | -85 |
| Nov | 398 | 417 | 19 | 26 | -7 |
| Dec | 450 | 446 | -4 | 20 | -24 |
| Jan | 486 | 406 | -80 | 24 | -104 |
| Feb | 375 | 436 | 61 | 17 | 44 |
| Total | 4805 | 4590 | -215 | 123 | -338 |

This table shows that emergency admissions are decreasing and this is in comparison with the national picture which we know shows numbers of emergency admissions into hospital are going up.

**What do patients tell us about the out of hospital service?**

As part of the evaluation of the out of hospital service we wanted to know what patients think about this new service. The feedback shows us that patient, family and carer satisfaction with the team is high – almost 90%.

Some of the comments received include:

"My mother was really well looked after. Your nursing staff are wonderful, helpful, caring and efficient"

"Your service is absolutely brilliant in all respects. To all your staff that I have met, thank you."

"The out of hospital team meant less form filling, more understanding of personal circumstances. More realistic consideration of patients actual needs."

**Developing out of hospital services across Great Yarmouth and Waveney**

We have used the learning from the Lowestoft out of hospital team to help us develop plans for the roll out of out of hospital services across Great Yarmouth and Waveney.

We have used the evidence to calculate the numbers of staff needed in the out of hospital teams and also the beds (acute, intermediate and beds with care) required across Great Yarmouth and Waveney.

**Supporting Patients where they live**

The highest numbers of referrals received by the Lowestoft out of hospital team in a month, throughout 2014/15, was 121. This was in December and reflects the demands on this type of service during the winter.

Based on the staffing model for the Lowestoft team, the maximum number of referrals it received and the population of Lowestoft, we can predict that the maximum number of patients an out of hospital team for Bradwell, Gorleston, Great Yarmouth and the Northern Villages could support in a month will be about 150.

Using this same method we can predict that an out of hospital team for South Waveney will be able to support a maximum of 70 patients a month. We would build each team to have the staff in place to meet these demands.

**Supporting Patients in a Bed with Care**

Before the consultation in Lowestoft there were 17 GP community beds in Lowestoft Hospital. After the consultation the Lowestoft out of hospital team was launched and five Beds with Care were provided in a local care home and we stopped using the beds in Lowestoft Hospital.

Throughout 2014/15 the five Beds with Care have been used to great effect for patients in Lowestoft. We know that these beds are not always all in use at one time but there is a peak period during winter when the beds are at their busiest and on occasion are all being used. However, all five beds are required to support the Lowestoft system during periods of peak demand and to provide flexibility for unexpected high levels of activity.

We know that five beds support the population of Lowestoft. Using this information we can calculate how many beds will be required to support patients from Bradwell, Gorleston, Great Yarmouth and the Northern Villages. Our calculations show that we would need seven beds with care in a local care home.

We also know the number of beds required to support patients from South Waveney would be four, again in a local care home.

**Supporting Patients in an Intermediate Care Bed**

As part of its work to develop the out of hospital service the CCG carried out some clinical service reviews of patients receiving care in community hospitals across Great Yarmouth and Waveney.

During these audits we learnt that there were a small number of patients in each community hospital that had care needs too complex to be provided at home or in a Bed with Care. However, these patients did not need to go into the local District General Hospital for their care either. These patients require care in an intermediate care setting.

To provide the best care for patients and make the best use of resources intermediate care services should be provided from one location. The CCG is therefore proposing that the current services at Beccles Hospital be redeveloped to deliver intermediate care for all those patients across Great Yarmouth and Waveney requiring this level of care.

**Conclusion**

The evidence above shows us that the Lowestoft out of hospital team pilot has shown some excellent results. Using these results we have developed plans to roll out the service across Great Yarmouth and Waveney and this forms the basis of our Shape of the System consultation.