What's happened since the closure of Archways? An update report

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Introduction

Archways was a 22-bed community unit in York, designed to help stop people going into hospital and to help them leave hospital earlier. People were admitted directly from home, from the Emergency Department, or following a hospital stay. The focus of the unit was to assess what a person needed to be independent, and then support them with treatment and rehabilitation. The average length of stay was three to four weeks.

Why did Archways close?

Although not explicitly stated when Archways was closed, the underpinning principle was that there should be a move to provide more care based in people's own home and less time in bed-based units. The Home First approach intended to replace more expensive inpatient care, whilst also respond to the risks of hospital based de-conditioning. It is suggested that ten days of bed rest can cause the equivalent of 10 years muscle ageing in older people.

What happened next?

Archway's closure was announced in August 2016 and the service officially closed in December 2016. Following publicity in The Press about the closure, Healthwatch York received 19 phone calls and emails from members of the public.

All the responses were against the closure. Many expressed their anxiety and concern and asked why there had been no consultation. Thirteen of the callers had direct experience of care at Archways as patients, through a close relative or friend, or had been involved professionally.

The key issues raised were:

- Importance of Archways as a ‘bridge’ between hospital and home
- Good quality of care at Archways
- Promotion of independence and sense of well-being at Archways
- Discharge straight home is not desirable or feasible
- Closure will affect older people most
- Single householders will be most affected if needing help
- Negative impact of closure on hospital leading to re-admissions

People mentioned the smooth, anxiety-free transition offered through Archways, from initial assessment to final discharge. It was felt that there was a high quality of physical and specialist care available. A further strength of Archways was its sensitive responsiveness to different physical, social and personal circumstances (such as to those living by themselves).

Recommendations made in 2016

Healthwatch York produced a report on the closure of Archways highlighting patient experiences and concerns in September 2016[1]. Healthwatch York made three recommendations to the Health and Wellbeing board and the Health, Housing and Adult Social Care Policy and Scrutiny Committee which were:

- For future service changes, plans for consultation and engagement with the public / other agencies to be developed at the earliest stage
- Commit to co-design and co-production (in line with the Social Care Institute of Excellence definition)
- Consider the feedback received to date

These recommendations were accepted by the boards in September 2016 and November 2016. The Care Quality Commission (CQC) has since reported on several projects using co-production in York since this time, as the Health and Wellbeing Board member organisations are making efforts to use this approach[2].

[1] Healthwatch York (2016) Closure of Archways: Changes to intermediate care services in York.
[2] Care Quality Commission (2017) City of York Local System Review Report. Health and Wellbeing Board.

What has happened since the closure?

Since the closure of Archways a number of reports have been submitted to Health, Housing and Adult Social Care Policy and Scrutiny Committee and other organisations tracking the progress of intermediate care services in York.

At a meeting of the **Health, Housing and Adult Social Care Policy and Scrutiny Committee in April 2017**[3], members were advised of the alternative services being provided following the closure of Archways. These included York Community Response Team (CRT), Community Discharge Liaison Team (CDLT), Advanced Clinical Practitioners and Outreach Pharmacists.

York CRT is made up of therapists, nurses and support workers who provide short term support (usually for up to six weeks) to people where they live to maximise independence. This is a seven days a week service running from 8am to 8pm daily.

Those supported include:

- people leaving hospital (step down)
- people identified in the community as needing support (step up)

Two case studies provided by the CRT, available in appendix 1, further describe the way the CRT works with patients in the community.

At the meeting it was also reported that it cost £1.5m to run Archways and that £1.2m had been spent on the community services contract. Interestingly, this meant this 20% of the money available for community services had been spent elsewhere by the Clinical Commissioning Group. It was unclear where this £0.3m had been spent.

[3] City of York Council (2017) Health, Housing and Adult Social Care Policy and Scrutiny Committee Wednesday, 19th April, 2017. Available at: https://democracy.york.gov.uk/ieListDocuments.aspx?CId=671&MId=9634&Ver=4

Case study provided by the York Community Response Team

Fred (name changed to protect identity) came into the care of York CRT as a step down patient after being in hospital with a fall. He had a pressure ulcer on his heel which was causing him great pain.

Fred was assessed by a nurse at his home. Concerned about the wound, the nurse took a swab and arranged for the tissue viability nurse to meet her at the house for further guidance. The GP reviewed the swab results and prescribed antibiotics. Physiotherapists and Occupational Therapists assessed Fred for equipment he needed and gave him some exercises. Fred was referred to podiatry for a heel guard and he started taking his antibiotics.

The following day, Fred became ill and following a 111 call, an ambulance was sent. The Rapid Assessment Team assessed him and he was well enough to send home. The nurse believed that without this timely intervention that Fred may have become septic and may have needed a longer hospital admission and IV antibiotics. Fred was sent home that day. The nurse continued to visit Fred to review and evaluate the wound whilst changing the dressings daily.

Yesterday, Fred walked into his living room with a stick instead of a wheeled walker and declared he had made cupcakes. Fred thanked the team and said they had had a real impact on his life. Because of the team he felt he'd stayed out of hospital and was studying how to use his new oven to make cakes and pies. Fred said that the team's support had had a positive impact on his morale which was felt to be very important in Fred's healing and rehabilitation. Fred's wound is nearly healed and he's planning his next adventure.

Performance of the CRT

In September 2017, the committee were updated with further performance information about how the new approach was working. York Teaching Hospital reported that following the closure of Archways, the average monthly referrals to CRT were expected to increase from 91 to 120. However, it actually increased to an average of 139 per month in the year January to December 2017.

The same number of step up patients who were previously stepped up to Archways, an average 3 people per month, were accommodated by the change of admission criteria to White Cross Court. There has also been a sustained increase in the number of referrals from the Emergency Department avoiding the need for an admission to an acute or community inpatient bed.

Prior to the reconfiguration, an average of 245 patients a month were supported by intermediate care services (either at home or in a bed-based unit). Since the change, an average of 279 patients per month have been supported. This is in line with the ambition to deliver care closer to home with 50% of intermediate care now being delivered at home, compared to 37% prior to the change.

According to an audit review in 2017[4], this increase in referral numbers has not appeared to have impacted negatively on waiting times or satisfaction with the CRT. It reports that the wait for intermediate care across England was 5.8 days on average. The CRT have reported that it was 2 days in York. Waiting times for assessment have also decreased. In October 2017, 9 patients were in hospital awaiting home care, and by March 2018 there were 6.

[4] NHS Benchmarking Network (2017) National Audit of Intermediate Care Summary Report – England. Assessing progress in services aimed at maximising independence and reducing use of hospitals.

Home First engagement project

The accountable officers for the health and social care partner organisations in North Yorkshire and York were confident in the new approach to services, both for patient outcomes and cost effectiveness in intermediate care. They were keen to take on board recommendations to work with the public and local communities to increase awareness and listen to people's stories and ideas.

The project's aims:

To increase awareness of Home First and the evidence that supports it (deconditioning and loss of independence associated with stays in hospital).

To gather feedback from patients and relatives about how a Home First approach could work.

To gain insight from people about how and when to communicate Home First during a patient's episode of care.

In October 2017, York Teaching Hospital NHS Foundation attended Healthwatch Assembly and presented on the Home First approach. Going forward, they were keen to develop opportunities to have conversations with local people about the changes taking place and improve ways of involving people in the development of these services.

From December 2017, patient engagement projects took place with community groups and networks across the York Teaching Hospital NHS Foundation Trust catchment population (York, North Yorkshire, North East Yorkshire and Ryedale). The engagement exercises used existing community groups and networks with already established relationships to reach as many people as possible. Some of these included: Healthwatch Assemblies, Carers' Advisory Group, York Carers Centre, Scarborough Older People's Forum, Ryedale Older People's Forum, York Older People's Assembly, York CVS forums (including Ageing Well, Voluntary Sector, Mental Health, Community Voices), GP

practice patient participation groups (Haxby Group practices, Scarborough Practices, and Selby), Foundation Trust Council of Governors and Ryedale U3A (University of the Third Age).

This project aimed to raise awareness of the Home First approach, to enquire how the approach could work in practice and to find out how to best to communicate with patients, relatives and carers. Feedback was gathered through a range of meetings, focus groups and questionnaires (about 100 of which were completed). More than 400 people participated in the conversations and around 172 comments were recorded.

Key areas of concern identified by the public

People highlighted the need for hospitals to plan for discharge as early as possible with the patient and relatives, even before admission in the case of planned procedures.

"Talk to the family/carers in plenty of time - what can/can't they do - what support will they need as well as the patient. Work together, for example involve them in meeting planning."

People wanted good communication and joint working between all agencies involved, as well as with carers and families.

"Closer liaison between hospitals and care providers should ensure care needs after leaving hospital are not overlooked."

"Ensure all agencies work together and do not bounce patients and their carer round the system."

People wanted to be treated as individuals, their care adapted to them as people, and the contributions of their carers and family to be invited and given recognition.

"Families need to be involved in their loved one's care and decision making."

People said they generally supported the idea of care at home in the belief that that is where most people wish to receive it.

"Most people would rather live in their own homes as long as possible so wouldn't need much convincing."

However, concerns were expressed about practicalities and communication around being discharged from hospital.

"People need to be confident that there will be sufficient support at home, not just 'left'. We often hear about people getting home and not knowing when follow up appointments are, who's coming in, who to contact if it's not working."

People felt hospitals should be better at planning discharge. Staff should make sure the patient knows about their discharge, understands the process and has time to plan. They also felt that there should be better joined up care to reduce the fragmentation of services.

People said they wanted to make sure their individual needs were recognised and felt more could be done to prevent social isolation.

"Not everybody is lucky enough to have relatives or good friends who could respond."

During the engagement, people suggested some practical approaches to getting the message about Home First across. Many people favoured literature and leaflets, preferably to be given whilst in hospital. Using the media, and potentially 'real life' case studies, was another recurring theme.

The Engagement report was taken to Health, Housing and Adult Social Care Policy and Scrutiny Committee in November 2018. The committee was told that the next steps for the Home First project would be to reach out to more forums and service users for a second round of engagement. Members said they were pleased to hear about the significant level of consultation and engagement with residents on this topic.

Going forward

The NHS Long Term Plan has a focus on keeping people out of hospital as far as possible. Home First is in line with this principle. It assumes that more people will need to access intermediate care. It recognises the importance of assessing people in their own home using hospital beds only for those that need them. There is a recognition that more work needs to be done with partners towards improving referral processes and joint working with the non-statutory sector. There is still a need to improve care co-ordination with social care services, and to reduce fragmentation of services.

Healthwatch York commentary

We recognise the need to develop services that will meet future needs in light of the predicted growth in number of older people and those with complex health needs. It is important to have services which support individuals to maintain their independence but also that hospital care is provided when needed. Healthwatch will continue to take feedback from residents about issues related to their healthcare. Since the changes made, we do not appear to have had an increase in reported issues of unsupported discharge from hospital.

System wide changes to health and social care which are taking place across York such as the Home First Approach can offer potential for new and positive ways of working. However, they can also cause confusion, feelings of not being in control and difficulties trying to navigate the system for the patients at the heart of these services.

One of the key issues reported to Healthwatch York with the closure of Archways was the lack of consultation and communication. Healthwatch York recommends improved communication is needed in future. This should be prior to changes being made to make sure that what is provided also meets people's needs.

Recommendations

Recommendation	Recommended to
Continue to work towards making sure that plans for consultation and engagement with the public and other agencies are made and put in place at the earliest stage possible for all future service changes. Make sure a range of methods are used to contact patients and other stakeholders. Commit to co-design and co-production (in line the Social Care Institute of Excellence definition) when creating new services.	All health and social care commissioners, providers and leaders in York
Continue to improve communication. To make sure patients/families/carers understand what is happening at discharge. That information about different teams and how they work together is clear to the public and staff. The hospital should plan for discharge early, involving the patient in all decisions and checking their understanding.	York Teaching Hospital NHS Foundation Trust NHS Vale of York Clinical Commissioning Group City of York Council
Continue to monitor concerns and feedback around provision of services. Be particularly mindful of concerns about support overnight, ensuring that night support is adequate, and tracking of admissions of those in receipt of intermediate care is noted.	York Teaching Hospital NHS Foundation Trust NHS Vale of York Clinical Commissioning Group
Report on how the additional funding freed up from Archways which was not spent on Home First was spent.	NHS Vale of York Clinical Commissioning Group
Work with other sectors to address non-healthcare issues such as social isolation mentioned in engagement feedback.	York Ageing Well Partnership

Appendices

Appendix 1 – CRT Case Studies

Situation: Mrs X was discharged home from hospital with CRT support. An Advanced Clinical Practitioner (ACP) was asked to review Mrs M as CRT has concerns that she had not been well since discharge. Her shortness of breath was worsening and she had abdominal pain.

Background: Mrs X was originally admitted to York Hospital with loin pain and a water infection.

Assessment: The ACP visited Mrs X and assessed the problem as an acute abdominal problem with a potential bowel obstruction.

Recommendation: The ACP was able to re-admit the lady directly to the Surgical Assessment Unit at York Hospital for further investigations and on-going management.

This ACP intervention avoided a GP visit or Emergency Department attendance and allowed Mrs X prompt access to the care she needed.

Situation: Community Response Team (CRT) asked an ACP to urgently assess an older lady (Mrs A) who lived alone and who was complaining of chest pain.

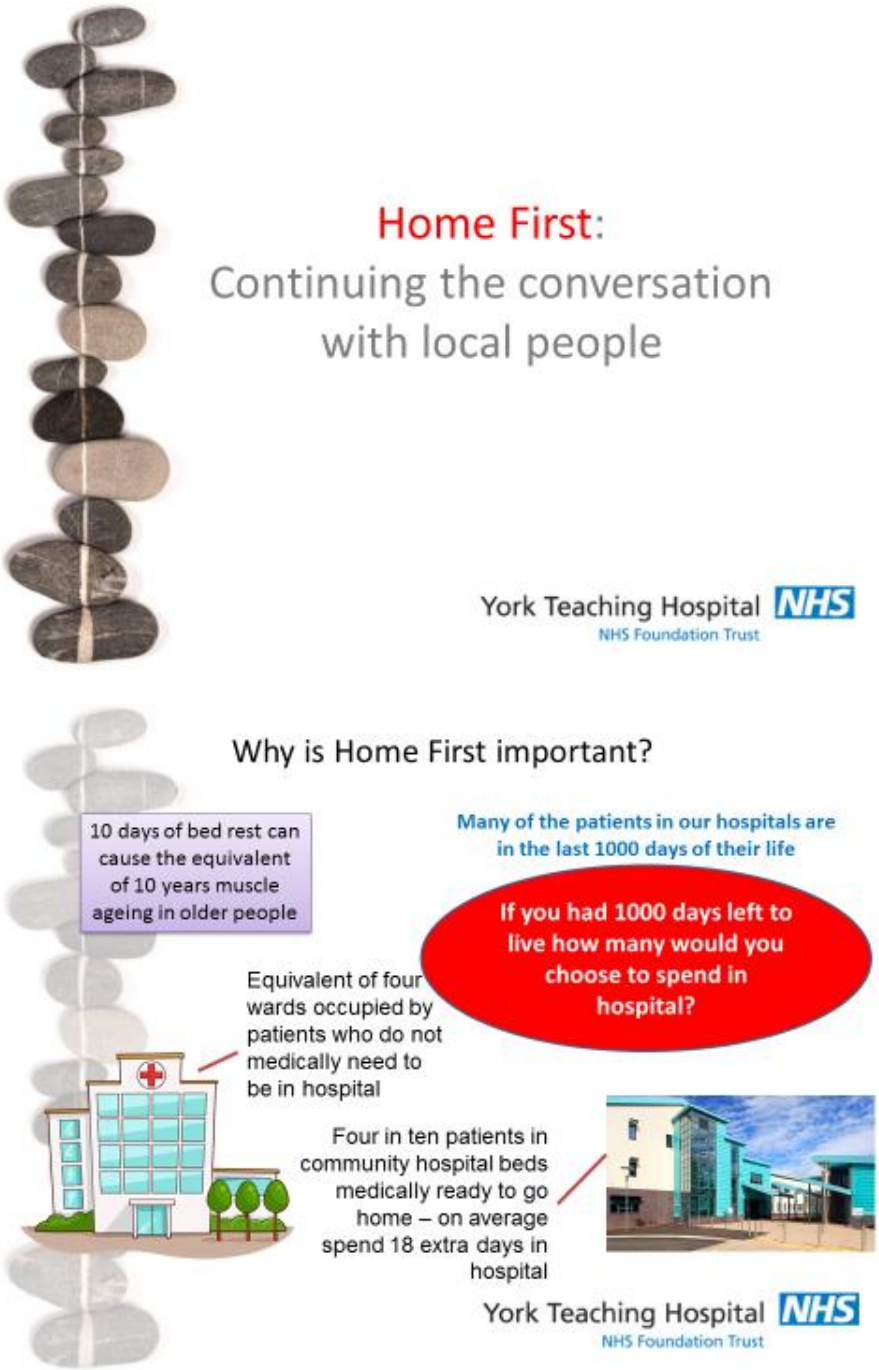
Background: The warden was present and was staying with Mrs A until the ACP arrived.

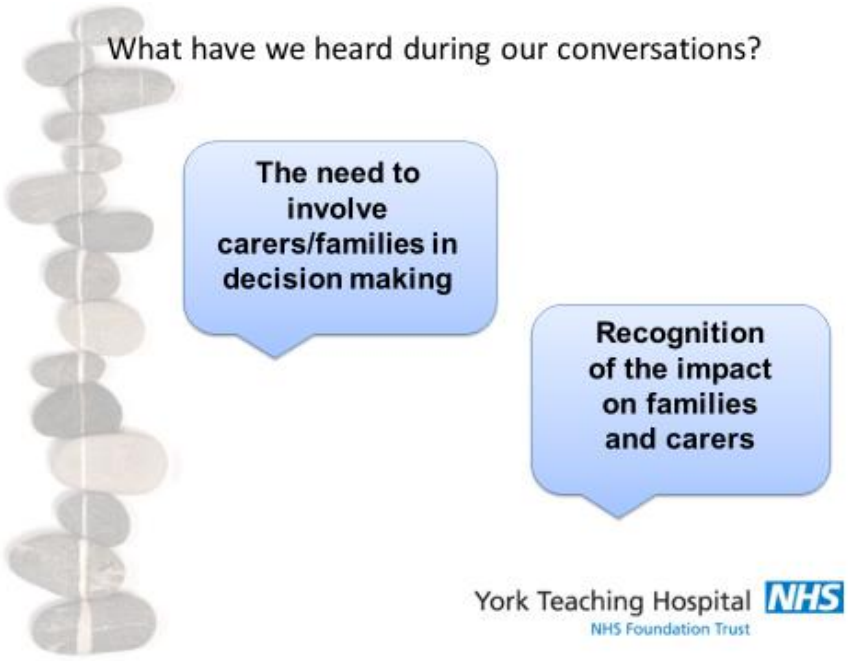
Assessment: On arrival she looked well but was complaining of chest pain radiating to her jaw. The warden was concerned and wanted to dial 999. Mrs A looked well in herself, was mobilising and her observations were all within normal ranges.

Recommendation: Following a thorough examination Mrs A was diagnosed with heartburn (which was treated with Gaviscon). She had a painful jaw as a result of her arthritis (which was treated with paracetamol). She was very anxious. She remained at home.

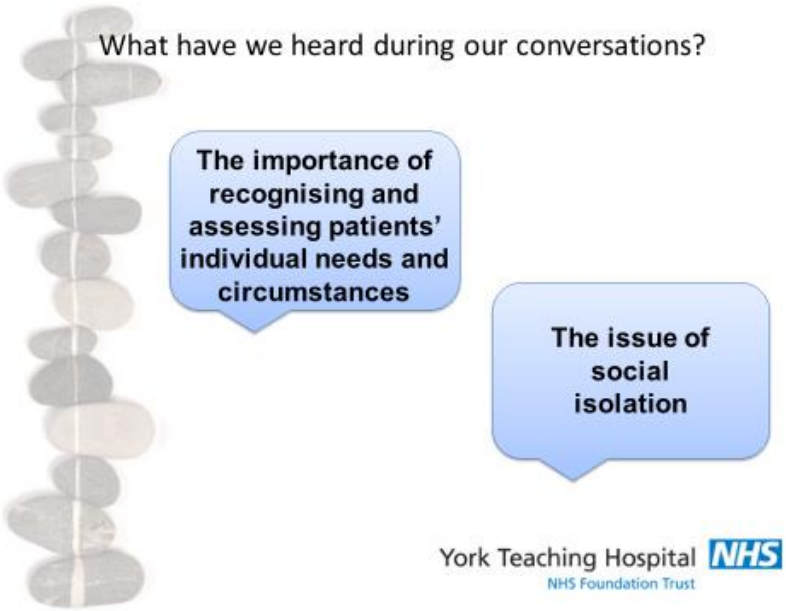
Without the input of the ACP, Mrs A would have been taken to hospital by emergency ambulance.

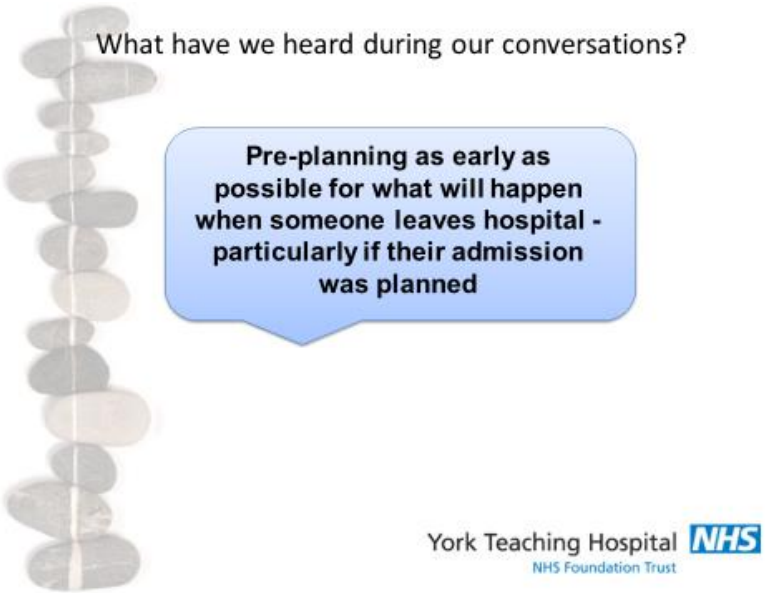
Appendix 2 – Home First Presentation Slides from the engagement project.




What have we heard during our conversations?
The need to involve carers/families in decision making
Recognition of the impact on families and carers
York Teaching Hospital NHS
NHS Foundation Trust


What have we heard during our conversations?
Communication - both with patients and carers and between professionals
The need for joined-up working
York Teaching Hospital NHS
NHS Foundation Trust


What have we heard during our conversations?
The importance of recognising and assessing patients' individual needs and circumstances
The issue of social isolation
York Teaching Hospital NHS
NHS Foundation Trust


What have we heard during our conversations?
Pre-planning as early as possible for what will happen when someone leaves hospital - particularly if their admission was planned
York Teaching Hospital NHS
NHS Foundation Trust

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York CVS

Healthwatch York is a project at York CVS. York CVS works with voluntary, community and social enterprise organisations in York. York CVS aims to help these groups do their best for their communities, and people who take part in their activities or use their services.

This report

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