What is HCT doing to support our frail population

Our aim is to improve health and independence of this population by

- undertaking of holistic assessments to ensure the whole person is being looked at in the whole
- early identification of those at risk
- promoting proactive care
- working closely with both acute and primary care
- keeping patients in their usual place of care for a long as possible
- reducing lengths of stay wherever clinically appropriate

Key areas of clinical focus are

- polypharmacy
- falls
- advance care planning
- catheter care – Trial without catheter within both community and inpatient setting
- IV antibiotics within a community setting
- Osteoporosis screening

HCT Inpatient units

- Acute Step-Down Pathways and Community Step-Up pathways were introduced last year to increase flow into our in-patient units resulting in an increase of approx. 20 more referrals each month
- Bed occupancy remains high with approximate average rates of occupancy over the last 12 months of
  - Danesbury 91%
  - Herts and Essex 83%
  - QVM averaged 80%
- Introduction of the COMPLEX NEURO pathway to support the Acute flow to prevent patients waiting long length of stay whilst awaiting Level 2 NEURO rehab – this pathway is up to 12 weeks. This pathway is offered Danesbury (capacity allowing).
- Reduced our 19-day REHAB pathway to 17 which has maintained flow through our units
- Average Length of Stay remains within target - for H&E & QVM is within the 17-day REHAB pathway or 28-day COMPLEX pathway targets

HCT Inpatient units continued…..

The percentage of patients being discharged back to their normal residence post in-patient rehabilitation remains high with the mean percentages for the past 4 months:

- REHAB: 93%
- COMPLEX: 90%
- NWB: 85%
- NEURO: 85%
- Community Step-Up: 86%
- Acute Step-Down: 96%

Medicines optimisation within our inpatient units

Background

- HCT implemented a medicines optimisation programme to improve medicines safety, reduce avoidable medicines-related harm, support appropriate deprescribing, and strengthen medicines management at key transition points, including admission, transfer, and discharge.

Quality Priority Focus

- As part of the programme, an inpatient Quality Priority was delivered to reduce anticholinergic burden, supporting the **Excellent Clinical Effectiveness and Outcomes** domain.
- **What Was Implemented?**
- Patients at highest risk from anticholinergic medicines were identified and reviewed.
- Medicines were optimised to reduce the risk of avoidable harm.
- Targeted education was provided to prescribers and multidisciplinary clinical teams.
- Anticholinergic burden assessments were embedded into the admission process.
- Patients with a score of **3 or above** are now routinely reviewed for intervention and medicines optimisation.

Outcomes and Impact

- ✅ **86%** of inpatients received an anticholinergic burden assessment.
- ✅ Patients at risk were identified earlier and received targeted medicines reviews.
- ✅ For patients with an initial anticholinergic burden score of **3 or above**, scores reduced by an average of **37%** following medicines optimisation interventions.
- ✅ Reduced exposure to high anticholinergic burden supports safer prescribing and may help reduce medicines-related harm.

Frailty interventions enhancing carer in our inpatient units

- Patients can receive both IV antibiotics and IV fluids in our inpatient units
- A Comprehensive Geriatric Assessment is completed on all patients admitted to our inpatient units
- Falls prevention work with a focus on
  - medicines optimisation
  - postural hypotension management
  - physiotherapy
  - equipment provision
- Dietician input for patients with a low albumin
- Psychology input for low mood and anxiety
- Osteoporosis assessment on all patients
- Advance Care Planning conversations taking place

Falls

Pathways

- Long lie
- Management of a fall with head injury where the patient is anticoagulants/anti-platelets and unlikely to be suitable for a CT scan
- Non-injurious falls
- *In development Falls with transient loss of consciousness*

Use of FRAT (Falls Risk Assessment tool) is a five-question screening tool for individuals aged 65 and over. A score of three or more indicates the need for further assessment.

Falls leads and champions for both inpatients and community

Pilot studies

- Stroke – Virtual reality trial within Inpatient unit – upper arm
- Ambient voice technology trial – support improved efficiency
- Changes to community frailty clinics – piloting a face-to-face assessment option

East & North Herts Hospital at Home model

Hospital at Home service

Step up/Step down care

- Herts Urgent Care - Acute in hours visiting Service and Early Intervention Vehicle
- 111 — NHS 111
- Acute hospital
- Primary care
- Ambulance service – call before convey and Ambulance STACK
- Home Care agencies
- Careline
- Care Homes
- HCT Community Services
- Social Care
- HPFT – Mental Health services

Integrated Care Coordination centre

Clinical Triage

Service response (based on a capability approach)

- Remote monitoring
- Face to face
- Hybrid model
- Early Intervention Vehicle

Daily ward rounds/MDTs

Discharge

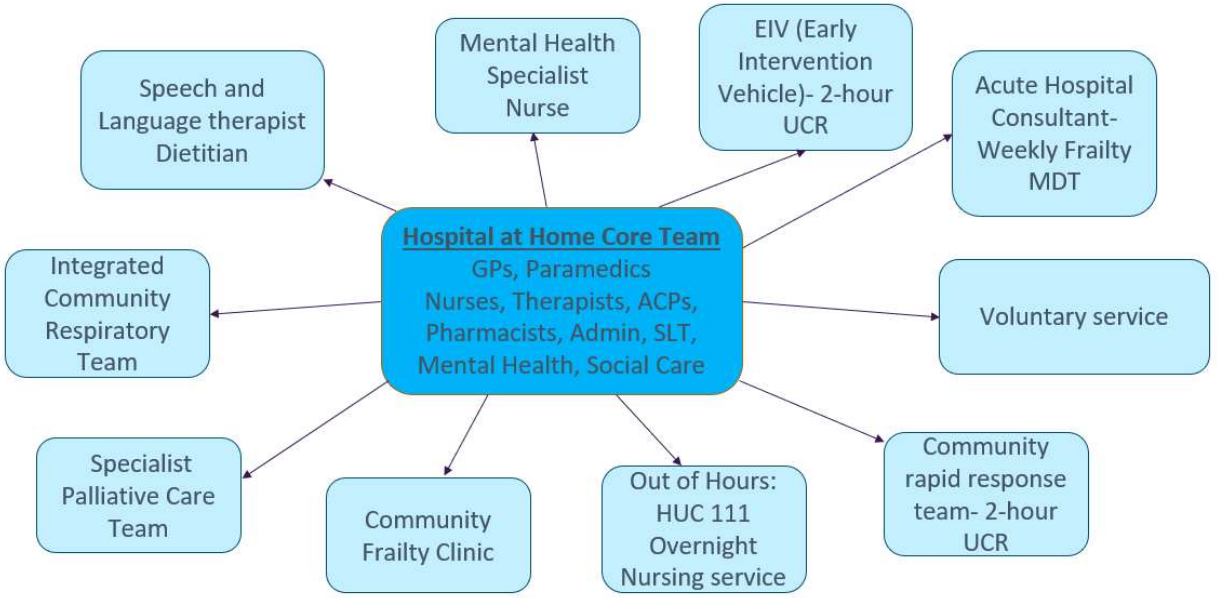
- Back to usual place of residence under care of own GP
- Onward referral to other community services
- Onward referral to acute services
- Onward referral to Palliative care services
- Onward referral to social care service

Up to 14 days Length of stay

Support of Voluntary Sector/Bridging Carers

East and North Herts Health and Care Partnership

Access to Specialist Services/Wrap around support



Hospital at Home initiatives

POINT OF CARE TESTING (POCT)

- Community staff have access to POCT devices that can be used to support the diagnosis and treatment options for patients where we urgently need to know if we need to convey a patient to the acute hospital or if could manage the patient within HaH.

ATRIAL FIBRILLATION AND ATRIAL FLUTTER PATHWAY

- Community staff will have portable ECG machine to visit patient sand undertake an ECG in their own home if required
- AliveCor device to be include in the Remote monitoring equipment for patients to use
- Will include a medication review and onward referrals for diagnostics and further treatment

FALLS PATHWAY

Long lie – for a management of a person on the floor with a possibility of a long lie as fall time unknown or on the floor for greater than 4 hours or significant signs of skin damage on patient.

Non injurious falls – for management of patients who have been reviewed by the falls desk clinician, who have no injury or condition that will require transport to A&E via an ambulance and where the patient has been on the floor for less than 6 hours

Patients on anti-coagulation treatment – for management of a fall where the person is on anticoagulants and unlikely to be suitable for a CT as not a candidate for neurosurgery – Pathway is now live and the evaluation is to be based on Sept- Dec data

ELASTOMERIC PUMP PATHWAY

- The elastomeric device pathway is a new part of the HaH toolkit. It allows patients to receive IV antibiotics at home – a daily dose can be administered over 24 hours and can be carried by the patient in a bag worn on their body.
- It can be used to deliver two types of IV antibiotics – tazoin and flucloxacillin. Once a patient has been correctly identified for this pathway, a nurse will visit the patient's home and set them up with their pump to ensure it's functioning correctly – and return every 24 hours while they are receiving the antibiotics.

East and North He
Health and Care
Partnership

Our service is supported by a wide range of robust data, which we use to ensure we are efficient, effective and meeting the needs of the population

8,341 total accepted referrals in 2025/26

1,666 referrals - 22% of total - direct from **999/A&E** 2025/26 YTD

77% of patients are **over 75**, with **27% over 90 years old**

Cost per bed day is £85 (compared with £450 for equivalent in hospital)

78% of referrals are **prevention of admission** (step up)

Consistent high levels (90%+) of **positive patient feedback**

84% of patients received **face to face** care

Average **length of stay is 8 days**

c. 50% of patients on H@H are being treated for heart failure, frailty or respiratory conditions

We accept referrals from a wide range of sources including:

- 999
- 111
- Patient self-referral
- A&E
- Careline
- Primary Care
- Care Homes
- Hospice
- Social care
- Nursing Home
- Community Services
- Acute in-hours visiting

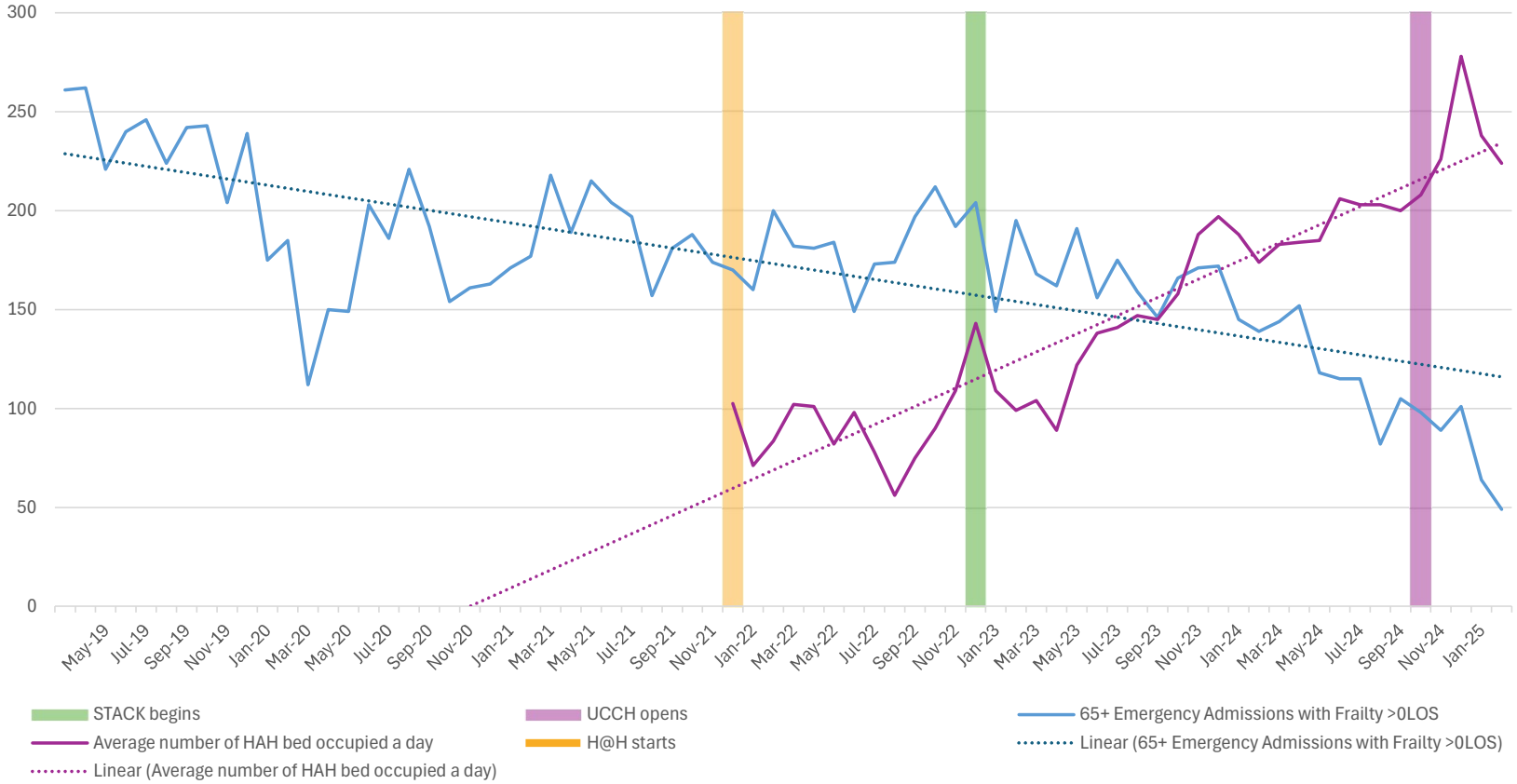
We have cared for patients with:

- Heart Failure
- Frailty
- Respiratory
- Cellulitis
- Bowel conditions
- UTIs
- Renal problems
- Diabetes
- Post operative care
- Neurological problems
- Wound care
- Dehydration
- Delerium
- Cancer
- End of life care
- Catheter Care
- Musculoskeletal problems
- Endocrine disorder

East and North Herts Health and Care Partnership

Successfully shifting from hospital to community

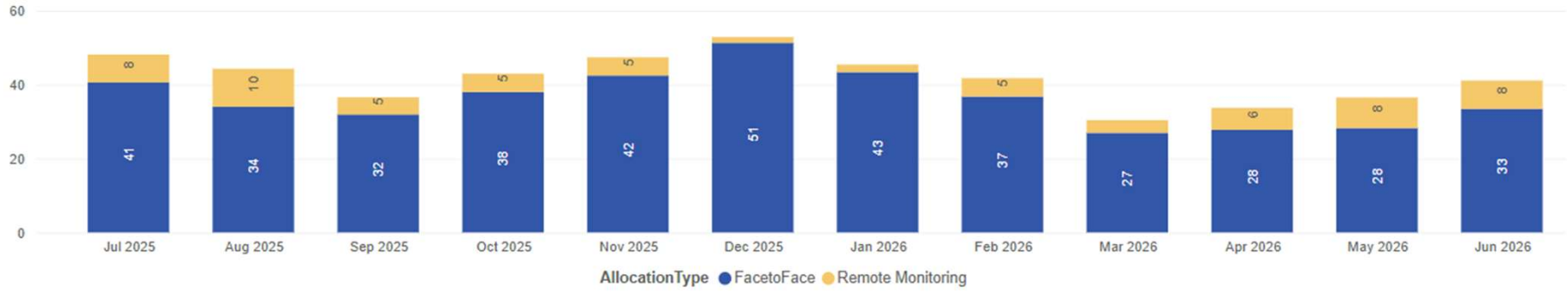
We have seen a direct impact on our Hospital at Home success, and new targeted initiatives, on the number of frailty admissions into Lister Hospital



Maintaining the rates of admissions since both Stack and UCCH have opened, compared with the same time in 2022 – this equates to **1,500 fewer frailty patients being admitted to hospital per year** – having their needs fully met in their own home

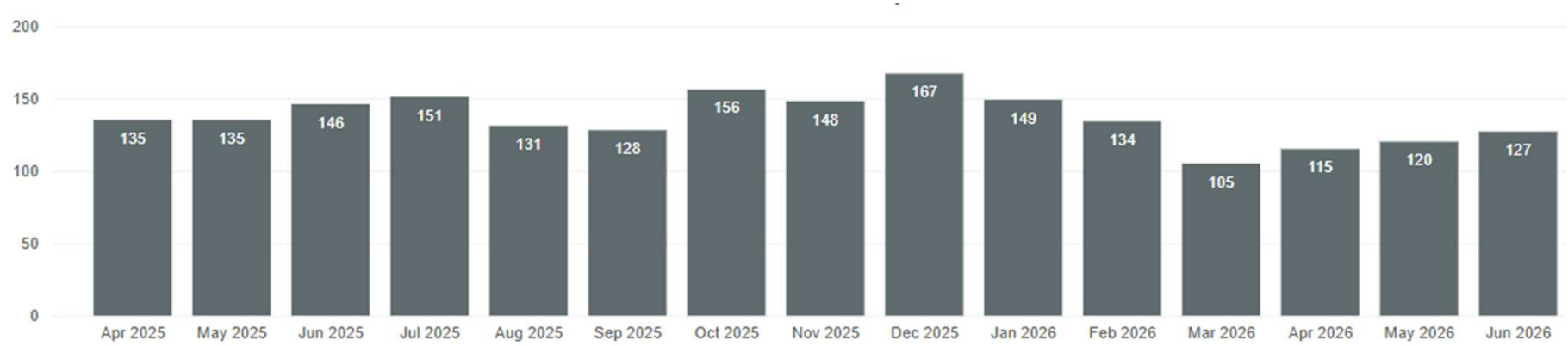
HaH Frailty

Daily Occupancy



Average daily occupancy of 42 frailty patients on HaH (36 face to face and 6 remote monitoring).

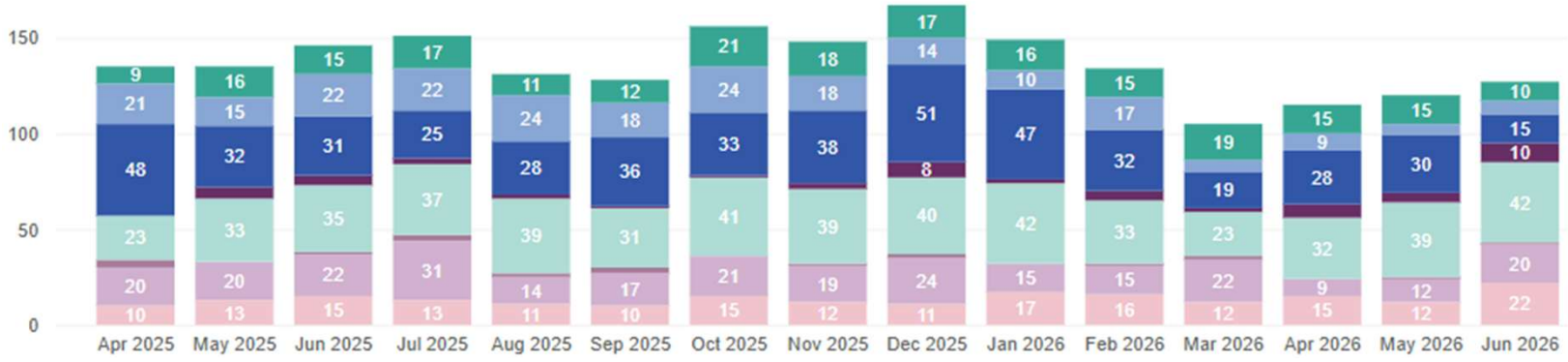
Referrals



136 frailty referrals accepted a month on average

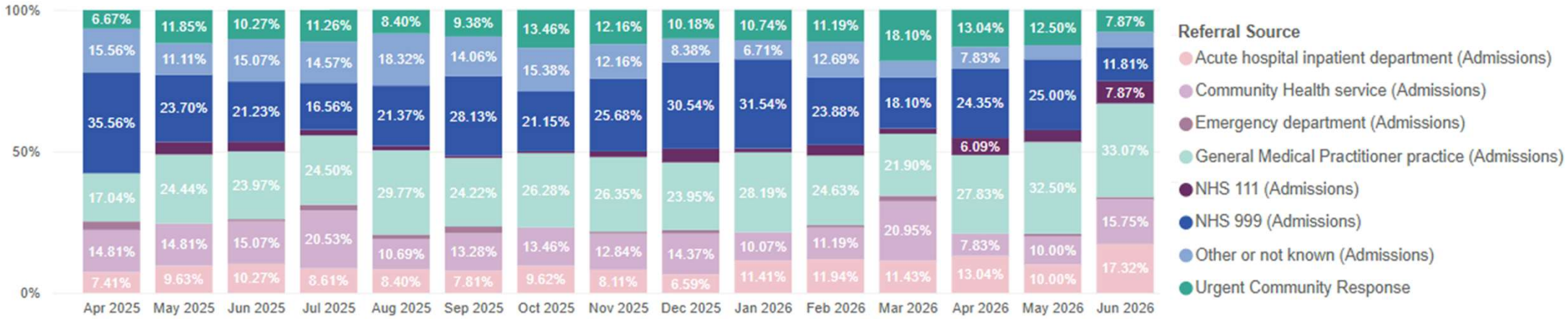
HaH Frailty – Referral Source

Referrals by source (Number)

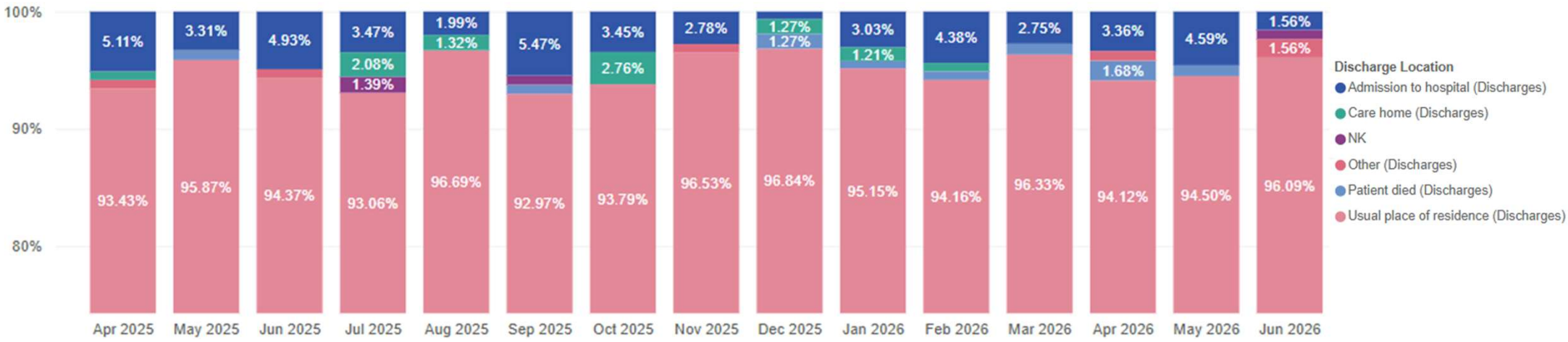


The majority of patients are referred directly from their GP (26%) followed by and Ambulance Trust / Paramedic (24%). 25% are from Community Health services and Acute inpatient departments. The remaining 25% are from UCR (EIV), Emergency Departments,111, Care Homes, Social Services, and Hospices

Referrals by source (Percentage)



HaH Frailty – Discharge Location



On average, 95% of frailty patients are discharged to their usual place of residence and 3% are admitted to hospital. The remaining 2% are discharge to a care home, hospice bed, intermediate care bed or passed away.

Summary

HCT is delivering proactive, integrated and evidence-based care that helps people remain independent at home, reduces hospital admissions, and improves outcomes for older people living with frailty. This is being delivered by the Hospital at Home and HCT inpatient rehabilitation pathways, multidisciplinary working and ongoing innovation

Frailty principles are now embedded into our service with a focus on prevention, proactive care and improved patient outcomes

HCT is supporting the shift from hospital to community with effective step-up and step-down care within both Hospital at Home and inpatient units demonstrating strong discharge outcomes for patients and significant system-wide benefits

Any questions?