Admission Avoidance Pathway in Newham

What roles are involved and what do they do?
What works?
What can be improved?

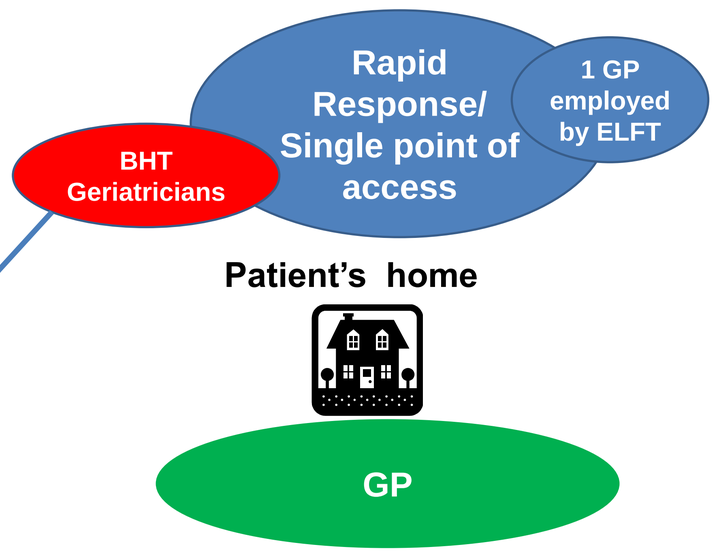
Barts Health Trust
East London Foundation Trust
GP
London Borough of Newham
Voluntary sector

Services and Teams

Rapid Response Team

- 8am-8pm 7 days per week service that provides rapid assessment and treatment of acute episodes within a patient's home – typical referrals UTI; blocked catheter; falls
- Patients should be medically stable and resident in Newham/ registered with GP
- Referrals from health and social care professionals, such as GP's, hospitals, care homes and social services; patients can self-refer
- Response within 2 hours for urgent referrals
- Onward referrals as appropriate
- Patients on caseload for two weeks or more from referral
- Clinical triage – 1 RR nurse in charge of triaging all referrals to Single Point of Access through to appropriate community services
- Multidisciplinary team (1 Band 8 and 4 Band 7 nurses – all prescribers; 5 Band 6 nurses; 1 Band 6 physio; 1 Band 6 agency OT; 2 in-reach nurses initially based in hospital – since July 2017 redeployed to train care homes as part of pilot project) supported by 1 part-time GP; 4 geriatricians from Newham Hospital
- Based in East Ham Centre and working closely with EPCTs located there

The Barts Health Trust **geriatrician role** within the RR team was initially envisaged to be full time but that has not translated into practice. **Two geriatricians** regularly work with the team: one for two full days a week; one on Mondays but cannot always guarantee presence because of high levels of hospital workload following weekends; two more consultants offer support on *ad hoc* basis.

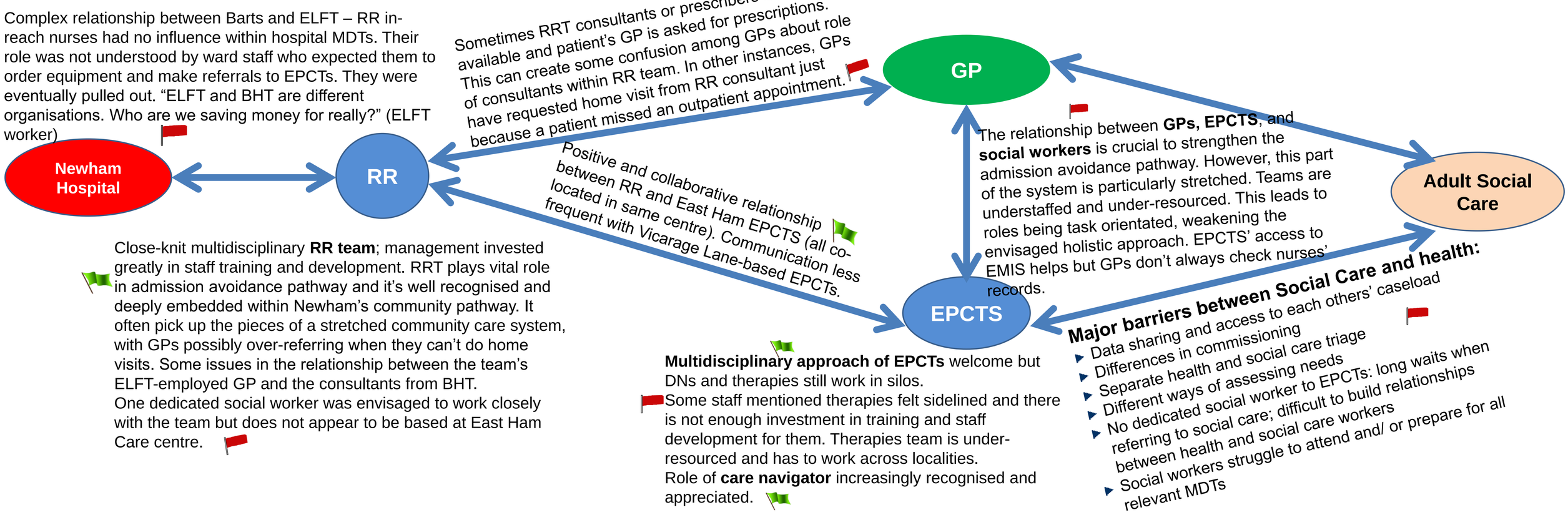


Extended Primary Care Teams (EPCTs)

- Cover four localities incorporating eight General Practitioner clusters in Newham
- Each team led by a Clinical Team Leader (Band 8) and consists of lead nurse, lead OT and Physio (Band 7) and District Nurses, Community Health Care Assistants, Occupational Therapists, Physiotherapists, Rehabilitation Support Workers, Health and Care Navigators
- Work directly with and support local GP networks
- Initial assessment and day-to-day workings of community health/ supported by borough-wide specialisms
- Work in conjunction with St Joseph's Hospice Palliative Care Team to provide end of life care
- Treat and support adults with complex needs and those with specific time-limited interventions – housebound patients only
- Provide care coordination and case management
- Referrals from health and social care professionals, such as GP's, hospitals, care homes and social services
- Referrals from Access to Adult Social Care team
- Provide help with regaining independence or reducing /delaying care and support needs
- Split into statutory function/ care management that sits within hospital service (1 social worker, 1 OT, and social care officers) and a provider service
- Free service for up to six weeks (under Health fund)
- Restructured to remove the care management team and externalise provider service
- Plans to add one OT and one physio to current team

Admission avoidance referral pathways

All referrals to community services go through the **Single Point of Access** (SPA). One Rapid Response team nurse sits on triage Monday to Friday. Referrals are not always appropriate because of knowledge gap of available community provision, but having a dedicated clinician with in-depth knowledge of community services to assess and triage all referrals guarantees greater efficiency with no referral lost in the system.



A case of admission avoidance

Patient, 91 years was referred to RRT by GP to avoid possible hospital admission. Patient had had cold/cough SOB for 5 days and was on antibiotics, Holistic assessment was undertaken by RRT. The patient did not want to go into hospital and wanted to remain at home where possible. Urine analysis was positive for infection and the RR nurse suspected a UTI infection.. A sample was collected and sent to the lab along with the bloods for the GP to review. The COE consultant who supports RR recommended commencing a cephalosporin as patient was allergic to penicillin. Current antibiotic was not covering the UTI. The GP who referred the patient was also contacted and was told about the outcome of the visit and the need to change the current antibiotic to the new one. She prescribed the antibiotic and the patient was asked to commence the course on receiving the medication from the pharmacy.
The RR nurse reviewed the patient 72 hours post commencing the antibiotic, monitoring any further deterioration during the weekend. The patient was discussed in the MDT with the COE consultant who also reviewed her antihypertensives which was making the patient have a postural drop with her blood pressure readings. RRT was able to do a medication review and the consultant recommended the GP should prescribe some different medication. Good communication between the RR nurse, the consultant and the GP ensured the patient was treated appropriately in her own home.

Discharge pathways in Newham

What roles are involved and what do they do?
What works?
What can be improved?

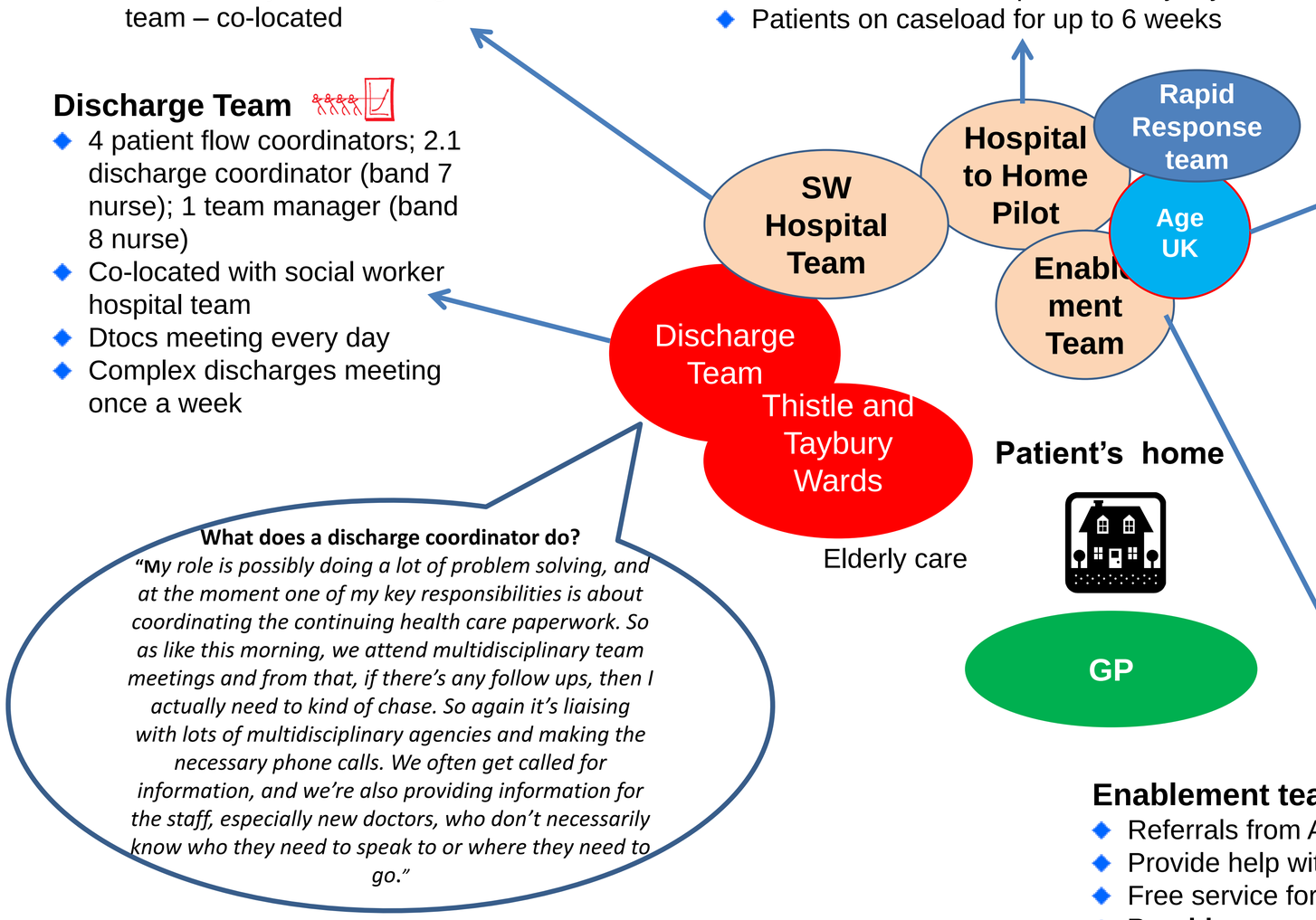
Barts Health Trust
East London Foundation Trust
GP
London Borough of Newham
Voluntary sector

Services and Teams

Hospital Team
- 14 social workers; 1 team manager
- Work closely with discharge team – co-located

Discharge Team
- 4 patient flow coordinators; 2.1 discharge coordinator (band 7 nurse); 1 team manager (band 8 nurse)
- Co-located with social worker hospital team
- Dtocs meeting every day
- Complex discharges meeting once a week

Hospital to Home pilot (H2H)
- Facilitate discharges of patients with rehab potential as soon as medically optimised
- Led by social services/ focus on social care needs
- Team includes 1 social services OT, 2 social workers
- Recently recruited roles: Band 7 agency nurse; Band 3 Rehab Support Worker
- **Rapid response** team provides nurses and physio. RR nurse to visit patient at home 2/3 hours from discharge
- Dedicated social workers arrange new care package within 48 hours or double up care package for significant change of functions
- **Enablement service** provides majority of care packages
- Patients on caseload for up to 6 weeks



Take Home & Settle
Work closely with Hospital to Home service. Support for up to 4 weeks post-discharge with tasks such as:
- Light housework
- Shopping
- Collection of prescriptions
- Welfare check

Based in Vicarage Lane, order home equipment and matches it to patient needs, on discharge from hospital or to keep patient at home.

Equipment coordinator

EPCTS

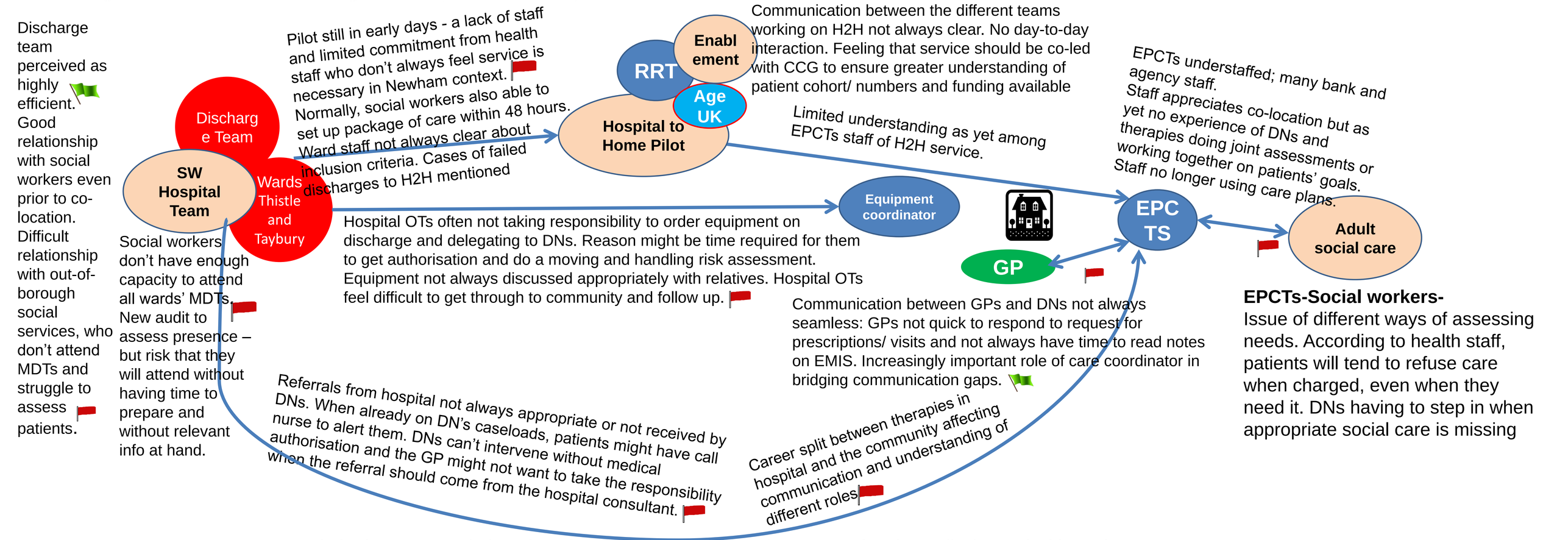
Extended Primary Care Teams (EPCTs)
- Cover four localities incorporating eight General Practitioner clusters in Newham
- Treat and support adults with complex needs and those with specific time-limited interventions – housebound patients only
- Referrals from health and social care professionals, such as GP's, hospitals, care homes and social services

What does a discharge coordinator do?
"My role is possibly doing a lot of problem solving, and at the moment one of my key responsibilities is about coordinating the continuing health care paperwork. So as like this morning, we attend multidisciplinary team meetings and from that, if there's any follow ups, then I actually need to kind of chase. So again it's liaising with lots of multidisciplinary agencies and making the necessary phone calls. We often get called for information, and we're also providing information for the staff, especially new doctors, who don't necessarily know who they need to speak to or where they need to go."

Enablement team
- Referrals from Access to Adult social care team
- Provide help with regaining independence or reducing /delaying care and support needs
- Free service for up to six weeks (under Health fund)
- **Provides care packages for Hospital to Home Service**

Discharge referral pathways

All referrals to community services go through the **Single Point of Access** (SPA). Rapid Response nurse triage all referrals and send through to appropriate community service.



Generally, limited awareness in hospital of community provision – instances of patients discharged without the necessary medication, i.e. pads. Ward staff felt in-reach nurses could help them bridge gap with community.

CASE STUDY – helping patients regain independence. The patient had a fall and had lost confidence and was the first case to be referred through the H2H. She was deemed medically fit to go home, went home, all the services were put into place and Rapid Response went in. She left the ward with four calls initially double handed, and within the first three days she was reviewed to see how she was doing. It was felt that she could benefit from the enablement pathway. So she was referred to the Enablement team who [acting as a broker] provided the carers to carry out hands on care. The social work team wanted a review and felt she could benefit from enablement to help her regain independence. Following an assessment, it was agreed she only needed one carer. The four calls a day were reduced down to three. At first she was a bit anxious about going down to three calls. By week 2 of being with the enablement service she was already growing in confidence, so the service was reduced down to two calls and, following a new assessment, to 1 call. At the end of her six weeks intervention with the enablement team she has actually gone on with no support. [Enablement team]

Clash of professional cultures in the hospital

R1: Everyone needs to be mindful that the Care Act… you know, it's an Act, it's statutory, it states three days [for discharge]. As we know with statutory changes, it takes quite a while for any service to adjust themselves to that. I mean we do appreciate… A hospital environment is a very different environment to the community services for example, and having that three day period is challenging depending on what's going on in the hospital and the pressures they have to experience. I totally understand that, you know? And this is where it kind of goes out of our hands.
R2: See, with the section 2s before it used to be any person that comes onto the ward they'll do an automatic section 2. Now we're having problems trying to get a referral, because it's like chasing and chasing…
R3: I think they've got into the culture of, 'This person is going to probably need a care package, let's do a section 2,' because the section 5 they'll just do whenever. So they've got into their own culture and we're trying to feed into this culture that's already developed. [*Group interview with social workers*]

End of Life Care pathway in Newham

Barts Health Trust
East London Foundation Trust
GP
London Borough of Newham
Voluntary/ Charity sector

Services and Teams

BHT Specialist Palliative Care team

- Multi-professional team: 2 part-time consultants, 2 specialist nurses (Band 7), 1 team leader (Band 8) 1 palliative social worker; 1 psychologist; chaplaincy; **1 EOLC facilitator** to support and train staff (recently appointed)
- Work across the whole of Bart's Health, four acute hospitals and the community team in Waltham Forest
- Gives specialist advice about symptom control and psychological and social support to patients, families, carers and staff
- Expert support in bereavement for families and carers

Marie-Curie nurses

Provide one-to-one nursing care and support (i.e. overnight) in the home, usually for eight or nine hours.

Barts Health Trust Specialist Palliative Care team

Palliative social worker

Marie Curie nursing service

St Joseph's Hospice Community Palliative Care Team :

Provide clinical guidance and supportive care on social, emotional and spiritual matters:

- clinical nurse specialists (CNS)
- occupational therapists
- physiotherapists
- social workers
- specialist doctors
- counsellors/chaplains

The hospice also offers:

- In-patient wards (34 beds for short stay – i.e. two weeks)
- Respite
- Day hospice
- 24/7 support line

Works closely with Fothergill providing medical advice and regular visits from CNs

St Joseph's Community Palliative Care Team

There's always an illusion that conversations have been had

The patient is always in assumption you are seeing me because you know what my GP has already done for me. So that illusion of conversation and communication has been received, but yet... (Specialist nurse)

Fothergill Ward

- Based at East Ham Care Centre
- Provide continuing and respite care to Newham residents age 65
- Fast-track discharges from Newham hospital
- Referrals from EPCTs
- Merged with Cazaubon Unit offering intermediate care/ rehab/ loss of beds

Patient's home

GP

EPCTS

Adult social care

- GPs and district nurses in charge of care at home and take responsibility for prescriptions
- Working closely with St Joseph community palliative care team
- Some practices run Gold Standard Framework monthly meetings but DNs not able to attend regularly

End of life action plan to be delivered with CCG:

- Set up EOLC steering group
- Identify and train palliative champions
- Establish champion network
- Provide training to social care workers and domiciliary care managers

End of Life Care Pathways

Fast-Track process in Newham hospital

- **Discharge to Fothergill Ward -** After confirmation of eligibility, the EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham passes the forms to the Continuing Care Team / East Ham Care Centre who liaise directly with the family and the ward

1. Fast Track forms completed by the medical team with support from Palliative Social Worker (SW)
2. SW completes section with specifics of proposed care package following discussions with patient (i.e. if they have capacity), significant others (family / friends) and at MDT
3. SW submits forms to EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham to confirm eligibility
4. SW contacts care agencies to identify a provider who has capacity for proposed care package
5. SW completes form to request care package providing details of the input required, costings and provider. This is submitted to the Continuing Health Care Manager for approval
6. Once the care package is approved, the SW liaises with the ward, patient, care agency, family members, friends and other professionals to facilitate the discharge and commence the package of care
7. A risk assessment is required by EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham within 2 weeks of discharge
8. Changes to the care package (increases etc.) are the responsibility of the SW for 6 weeks post discharge as long as the patient remains at home
9. The case is handed over to EOLC Co-ordinator Continuing Healthcare Team - Community Health Newham 6 weeks post discharge

- The process for **Out of Borough** discharges is as above except the forms are submitted to the appropriate team in the relevant borough.

Communication issues between the hospital palliative specialists and the community

I would say I... we do get more response from St Joseph's instantly, we don't get a response or confirmation from the District Nurses. Sometimes we do, sometimes we don't. GPs we hardly ever hear anything back from them saying 'Oh I went to visit a patient as per your request." (Specialist nurse 1)

There is no handover from the community back into the acute Trust.[…] The whole emphasis is to make sure that we hand that over going that way, but actually if somebody is coming back in then there is problems; you have no communication [… *I mean in an ideal world you would all have the same access to the same database and the same records. But I guess the frustration is there is so much emphasis on our documentation out, but nobody ever mentions that handover back in. So almost you need a patient held passport, that the patient keeps.* (Specialist nurse 2)

So you send someone home, they've just come from hospital, […] you know they're end of life but you send them home with no end of life care drugs. Now there in the community it will now take me up to two days to get the drugs. The drugs need to be ordered […] we only recently in the last four years or so have a chemist that has end of life care drugs, and they open up until midnight. In Newham we didn't have any place that had end of life care drugs. And as a professional if you go in and this patient has no drugs, you have to find the drugs, you've got to get the drugs for them. That then takes more of your time because you can't leave them now. (Community palliative care team)

Night sitting

This last week I did a fast track… up to four times a day you can get visits to see someone, but you need night sitters. […] I requested night sitters and the continuing care nurse then said to me, 'Well you know, it's difficult. Maybe you should offer them a nursing home?' She doesn't want to go to a nursing home. They said, 'Yeah, but the commissioners probably won't agree with the night sitters.' I said, 'Well she can't stay at home if she doesn't have night sitters. […] She has capacity; she doesn't want to go to a nursing home.' What do you do? So in fact you don't have a choice because the services are not set up for that, and then you've got your Marie Curie sitters. You would only get two weeks of Marie Curie sitters, and you request a Marie Curie nurse… with all the good will in the world they try, but you request a Marie Curie nurse and they'll say to you, 'No, I don't have anybody for the next three nights. The next person I have is Tuesday night,' but that doesn't help me. If I request for you tonight and you tell me you only have somebody for Monday night, how does that help me between now and Monday? (Community palliative care team nurse)

End of life care in the community: who takes responsibility?

So my reason that I cc in the District Nurse and the GP is to inform them that this patient will be followed up and it will be reviewed by the Palliative Care team in the community for specific reasons, symptom control, psychological and psycho-social issues, so we are only letting them know. But it is not for them to assume that the palliative care nurse is fully responsible, and solely responsible for that patient and that... (Specialist nurse1)

At the minute you've got GPs who believe that we do all the care. So when you call a GP and say, 'Can you go and please visit Mrs Smith?' 'No, I'm not going.' End of conversation. 'Because she's under palliative care.' 'Yes she is, we complement the care, but we don't take over the care you're still responsible for Mrs Smith.' (Community palliative care team nurse)

I think in a way it should be the GP [to take responsibility] because they are the constant aren't they, everybody... 99.9% people have got a named GP. […] Yet a lot of complaints that we get will be from GPs that say they have not been kept up to date. They get very upset when they don't know what is going on with their patients. But with that information comes a level of responsibility, and I think we get that wrong. We don't sort of force the issue that actually the GP is the accountable person. Well actually the patient is the accountable person if they have got capacity; and they [should] work in partnership with their GP (Specialist nurse 2)

End of life care in the community: a lack of consistency

I do feel that the understanding of who cares for people at End of Life is so variable across different nursing practices because you will have a District Nurse in one area who knows a palliative patient is coming out and will put in care and support. Yet in another area you get them saying 'No - it is Social Care'. So Social Care go in, and until that patient needs a syringe driver or something needs that intervention...only at that point will they put a District Nurse in. So that compounds that [EOLC] being task orientated. And I have... When I worked in the community I used to hear people all the time from the acute trust saying 'Put a syringe driver up, because at least if we put a syringe driver up that will make the District Nurse go in". (Specialist nurse 2)