Admission Avoidance Pathway in Tower Hamlets

September 2017- May 2018

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 Tower Hamlets
Voluntary sector

Services and Teams

Physician Response Unit (PRU)

- Partnership between London's Air Ambulance, LAS, Barts Health Trust and ELFT
- Emergency doctors + senior clinician
- 12 hours per day (8am-8pm), 7 days per week
- Treats 8 to 10 patients a day/ mostly complex adults/ frequent hospital attenders/ frail
- Keeps care in the community

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
- Clinical triage
- Response within 2 hours
- Usually 4 Nurses and a therapist on each weekday shift (including triage nurse)
- If required, patients will be referred on to other services after 3-5 days

- ❑ **Rapid Response Team (RR)**
- ❑ **Admission Avoidance Team (AAT)**
- ❑ Discharge to Assess (D2A)
- ❑ In-Reach nurses
- ❑ Seconded social workers

Admission Avoidance Team

- Based in Emergency Department RLH
- Multidisciplinary team (nurses and therapies)
- Operates 9am-7pm
- EPCTS staff can call AAT if patient on way to ED to hand over information
- Community follow up within 24 hours if required
- Out of borough patients assessed in ED

Hospital Team

- 17 social workers, two first response officers, two senior practitioners, a reimbursement officer and a team manager
- Liaise closely with health and other social care services to assess need/ organise care packages

Admission Avoidance and Discharge Services

Multidisciplinary team (nurses – including prescribers - OTs and physios rotate across RR, AAT and Discharge to Assess service; approx. 39 staff, mostly locums)

Geriatrician from BHT
Worked 1 day a week in the community – currently working on frailty clinic only

Patient's home

Community geriatrician

GP

36 practices working in 8 networks. Each localities includes **two GP networks** (four/ five GP practices in each network) and an assigned social worker

Community Health teams/ Extended Primary Care Teams (EPCTs)

- Four multidisciplinary locality teams (district nurses, mental health nurses, therapies, care navigators, and staff with clinical management and administration responsibility)
- Work directly with and support local GP networks
- Initial assessment and day- to-day workings of community health/ supported by borough-wide specialisms
- Treat and support adults with complex needs and those with specific time-limited interventions – patients mostly housebound
- Provide care coordination*

*used to provide case management but no longer capacity, according to staff

Locality Community Health Teams (reconfigured as EPCTS in 2018)

Social workers/ CHT

Hospital to Home programme

Hub in RL's ED to support admission avoidance of patients with social needs

Age UK

Community Health Team

- 14 SW; 2 senior practitioners; 1 hospital services; 1 team manager
- Act as a front door for complex cases on the ICP list
- Take direct referrals from health
- Should work closely with EPCTs

Admission avoidance referral pathways

- Relationship of trust between A&E staff social workers in A&E/ AAU and AAT team
- Awareness of each other's role

Growing awareness of service = more referrals
LAS is 24h but PRU is not – this might create confusion

- Improving relationship
- Aligned hours
- PRU can offer medical support to RR for very urgent cases

Difficult to get GPs to call back RR for prescriptions etc.

Confusion among DNs about what appropriate for EPCT's caseload v. RR's

Overlap with DNs because of broad criteria and RR pick up unscheduled DN visits

- Being part for the same team (AADS) means AAT feels safe to discharge from A&E to either RR or EPCTS (direct referrals)
- More risk averse for out-of-borough discharges
- Access to both EMIS and CRS helps

- GPs can be difficult to reach delaying response times when DNs need prescriptions/ other medical support
- Lack of capacity in social care = SWs are not always visible in the EPCTs; attend MDTs but can't always prepare adequately
- Care navigator now widely recognised and appreciated role
- Multiprofessional approach welcome
- But DNs and therapies still work in silos – **learning process**

The relationship between **GPs, EPCTS**, and **social services' CHT** is crucial to strengthen the admission avoidance pathway. However, this part of the system is particularly stretched. Teams are understaffed and under-resourced which leads roles to be task orientated, leaving limited opportunities for the required holistic approach.

Undergoing new reconfiguration to align CHTs to EPCTs

SW Hospital Team · **LAS** · **A&E** · **Age UK** · **AAT** · **PRU** · **RR** · **GP** · **SW CHT** · **CHT/ EPCTS**

All referrals to community services (including AADS) go through the **Single Point of Access** (SPA). Individual teams do their own triage of referrals from SPA. Referrals are not always appropriate because of knowledge gap of available community provision. **What happens to referrals rejected by teams?**

Major barriers between Social Care and health:

- Data sharing and access to each others' caseload
- Differences in commissioning
- Separate health and social care triage
- Different ways of assessing needs

Example of when broad inclusion criteria can compromise RR's effectiveness

So we had two [RR] nurses visiting and they already had a case-load of patients. We'd come to about four o'clock… three or four o'clock and then one nurse finishes at five, and then the last nurse is left to work until eight. So they've got their list and we had about fourteen calls that day. So a lot of them were catheter-related calls, blocked catheters, leaking catheters that traditionally would have gone to district nurses. So they're all going out doing their visits plus the calls and then we had one call from a GP […] maybe about four o'clock saying that they've got this patient who has got dementia, behaviour's getting worse, probably has a UTI but she has a catheter and she's always pulling the catheter out. […] So it's a call that we could have gone with our bladder scanner, scanned the retention, you know, done a full assessment rather than just dealing with a catheter problem. But we couldn't deal with it because the last nurse that was working was already going to do a simple blocked catheter.

A good case of Admission Avoidance

- 96 year old lady, lives with 2 sisters - one aged 95 and one 91 (who is blind and has QDS POC)
- Patient referred has no POC
- Referred by GP for acute onset confusion, not eating and drinking and reduced mobility – also had a fall
- Refused to go hospital. Her wishes before confusion were not to go hospital. GP expected death letter (and referral then went to NW DNs)
- Care navigator also involved and visited with social worker to set up POC, which started the next day
- RR nurse visited and liaised with PRU, ruled out infection blood showed ↑ K, ↑Cre, ↑Urea
- PRU gave IV fluids for dehydration
- RR nurse and therapist visited for three days to ensure hydration and safety
- Nursing: Holistic clinical review, encouraged fluid intake, follow up bloods, continence ax completed, pressure area care, wound care, – was then referred to DN for ongoing monitoring
- Therapy: Referred to ICT for on-going home exercise programme

Discharge pathways in Tower Hamlets September 2017- May 2018

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 Tower Hamlets
Voluntary sector

Services and Teams

Complex Discharge Team (CDT)

- 2 social workers, discharge coordinators attached to specific wards (i.e. "needy" wards such as 11th and 14th), one OT (recently left)
- Facilitates complex discharge (**delayed transfers of care**) from all wards
- Focus on out of borough discharges which tend to raise more challenges
- Weekly Get Me Home meetings to discuss Dtocs

What is a complex discharge?
"A range of things: from a restart to a family dispute, to people refusing to leave hospital, to safeguarding […] disputes between local authorities, like in the care pathway, ordinary residents' issue [e.g. patient has not paid rent and can't go back home]. […] Anything that comes to a dead-end comes to us."

CDT

Royal London 11 and 14 floor

SW Hospital Team

- **11 floor**: acute admissions
- **14 floor**: care of the elderly

Hospital Team

- 17 social workers, two first response officers, two senior practitioners, a reimbursement officer and a team manager

Take Home & Settle service

Support for up to 4 weeks post-discharge with tasks such as:

- Light housework
- Shopping
- Collection of prescriptions

Age UK

Discharge to Assess (D2A)

- OT, nurses, social workers, physios, Reablement social workers
- Facilitate discharges of patients with rehab potential as soon as medically optimised
- **Screeners** (one nurse and two therapies/ team now expanding to include more therapies) take and triage direct referrals from wards and in-reach nurses.
- **Dedicated social workers arrange same day care package** (no need for section 2 and 5)
- For nursing can be expected to become stable in 1-2 days
- **Reablement** provides majority of care packages.
- Patients on caseload for up to 6 weeks
- Work closely with EPCTs and neuro team
- Funded until March 2019

What does a Screener do?
Screeners are based at RLH where they meet patients on ward following referral and let the referrer know if accepted. Screeners check EMIS records to establish if patient is active on EPCTs' caseload. If so, referrer advised to refer back to them.

- ❑ **Discharge to Assess (D2A)**
- ❑ **In-Reach nurses**
- ❑ **Seconded social workers**
- ❑ Rapid Response Team (RR)
- ❑ Admission Avoidance Team (AAT)

In-reach nurses

- Attend hospital MDTs and board rounds to identify patients for discharge to D2A and EPCTs
- OPAT (Outpatient Parenteral Antimicrobial Therapy)
- Order nursing equipment for discharge
- End of life care/Fast Tracks, close working with Continuing Health Care (CHC)
- Mainly cover 10th,11th, 13th and 14th floor

Admission Avoidance and Discharge Services

Reablement Team

Patient's home

GP

Each localities includes **two GP networks** (four/ five GP practices in each network) and an assigned social worker.

Community Health Teams (CHT)/ Extended Primary Care Teams (EPCTs)

CHT/ EPCTS

- Four multidisciplinary locality teams (district nurses, mental health nurses, therapies, care navigators, and staff with clinical management and administration responsibility)

Long-term needs team

Longer term support

- OT Teams – 13 staff trained to do adaptations in homes and work across health and social care on a rotation framework
- East and West social work teams (CHC patients mainly)
- **CHT (ICP patients only)**

Reablement Team

- 66 staff
- Short-term interventions (up to 6 weeks)
- Provides reablement care packages for D2A/ joint intermediate care service
- **Ambition** to use trusted assessors and remove clinical gatekeeping to services

Discharge referral pathways

All referrals to community services go through the **Single Point of Access** (SPA). Individual teams do their own triage of referrals from SPA. Direct referrals from wards to In-reach nurses and screeners for D2A. Plans for integrated SPA and triage process for health and social care.

CDT
Out of borough
Age UK
RL Ward 11 and 14
In-reach
SW Hospital Team
SW Seconded to AADS
Reablement
D2A
Long-term needs
Adaptation team
SW CHT
CHT/ EPCTS
GP

D2A-CDT:
- ✘ Lack of clarity around roles and responsibilities
- ✘ Lack of understanding of each other's role along pathway
- ✘ Lack of trust (including on data recording)
- Ongoing dialogue between teams to address issues

SW- AADS: Some divergence on needs assessment but overall positive relationship.

Ward staff – D2A: Confusion around appropriate referrals due to flexible D2A criteria

In-reach- screeners: Perception that D2A's screeners overlap/ duplicate some in-reach functions – some lack of clarity over roles.

Discharge to EPCTS: Late discharges (often due to transport)

Referral to DNs not always issued

Patients discharged without required medicines/ equipment (i.e. pads). Hospital staff can raise unrealistic expectations from patients about community provision.

D2A – CHT/EPCTs
Lack of consistency in referring patients to one or other team. Perception of some overlap among therapies

D2A and Continuing Healthcare pathways

Case Finding at ward MDTs/ Huddles OR Direct referral from ward
→ Complex needs that can be met at home by D2A/ rehab potential
→ D2A Screeners to identify correct pathway
→ D2A home rehab pathway (max 6 weeks) – reablement package set up in a few hours
→ LA arrange package of care and DST at home (within 2 weeks)
Positive CHC checklist → D2A Screeners to identify correct pathway

Because there is no clear criteria in terms of what type of patients do we accept, what type of patients do we reject, how long we should keep those patients. I know that we have to keep the patients for six weeks but there are people who are keeping the patients longer than six weeks sometimes, more than eight months on their caseloads. So... (AADS worker).

There can be very unrealistic referrals [from the hospital]. *So three times a day dressing changes. Things like that, that could be facilitated on a ward, but not facilitated here.* (CHT/EPCT DN).

Community services roles in the hospital

- ☑ **In-reach nurses** highly valued by ward staff, as vital bridge between hospital and community
- ☑ A lack of capacity means in-reach nurses can only cover a limited number of wards and their role is not widely understood.
- ☑ In-reach nurses struggle with working conditions – really small office outside hospital. This affects their sense of worth – they carry their own bag and coats as they work on the wards and often have to explain who they are/ what they do. This also applies to **screeners**.

AADS integrated working with Reablement

Perception from reablement team that AADS therapies are not always able to visit patients on the day after discharge. This was not confirmed by AADS and this perception might be due to poor dialogue between the two teams.

Reablement staff not always clear about value added of D2A pathway v. traditional reablement pathway: *Hospital SW ⟶ Reablement OTs and ROs*

The Reablement team appears to struggle to work effectively with AADS – no direct and ongoing communication with ADDS therapies affects ROs' work.

Weekly meetings including AADS and Reablement help improve relationships. Because of the high number of patients discussed, limited information can be shared and some felt the format of these meetings should change to make better use of the available time.

Patient discharged from hospital with reablement package → Allocated to Key AADS worker (PT/OT/nurse) on morning after discharge → SW to inform reablement officer via email → First visit – Therapist agrees goals and leaves doc for RO → Discussion of patients at Tuesday meeting

Issue of trust between the two teams on how data is recorded.

End of Life Care pathway in Tower Hamlets September 2017- May 2018

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 Tower Hamlets
Voluntary/ Charity sector

Services and Teams

Hospital

Barts Health Trust Specialist Palliative Care team

Palliative social worker

BHT Specialist Palliative Care team
- Multi-professional team: consultants, specialist nurses, palliative social worker
- 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

In-reach nurses

In-reach nurses
- District nurses in the hospital (part of AADS)
- Support Fast Tracks, close working with Continuing Health Care (CHC) and EPCTs
- Mainly cover 10th,11th, 13th and 14th floor

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

Marie Curie nurses

St Joseph's Community Palliative Care Team

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

Age UK

Last years of life
- Provide practical and emotional support to adults 18+ with palliative care needs
- Personal Care Support Escorting to GP and hospital appointments
- Domestic Help
- Shopping
- Planning for the future
- Works closely with St Joseph

Community

Patient's home

GP

CHT/ EPCTS

- GPs and district nurses in charge of care at home and take responsibility for prescriptions
- EPCTs' DN palliative champions raise awareness across team

Longer term support/ CHT

- ICP patients
- Palliative champions scheme just started

STP Vision
Our vision is to work and learn from each other with our communities to achieve person centred care. We will have shared outcomes and priorities and aim to do things differently

End of Life Care Pathways

Continuing Healthcare eligibility criteria based purely on care needs and NOT on a person's income. **Fast track funding** is available for elderly people with significant health needs, not just those at the end of their life. A special process for **immediate provision** is used in emergency situations when a person is in a period of rapid deterioration and may be entering a terminal phase.

Patient with rapidly deteriorating needs identified by registered medical practitioner

Issues:
- ✘ Task orientated approach to care can affect early identification of end of life stage
- ✘ Eternalism-nihilism dichotomy - medical culture is to keep treating
- ✘ 'Specialist palliative care', 'palliative care', 'end of life care' often used interchangeably, and people have different definitions
- ✘ Integrated care and end of life kept as separate programmes but clearly closely interlinked
- ✘ For elderly frail people idea of **uncertain recovery** more useful than EOL

Fast-track forms to be completed by medical practitioner

Issues:
- ✘ GP/ ward consultant/ nurse can experience difficulties in filling out form for lack of knowledge of patient's care needs or required phrasing
- ✘ Ward nurses often very busy and form may get delayed
- ✘ Specialist teams in hospital and community struggle to offer support with form filling for lack of resources

Patient moved to his/her preferred place of care - CHC DST should not delay process

Issues:
- ✘ Nursing home of choice might not have beds available
- ✘ Instances where patient was directed to less costly nursing/ care home against patient's relatives choice
- ✘ Rhetoric around patient's choice: at times patient's choice is not viable because of relatives/ carers' situation or complexity of symptoms.
- ✘ No 24 hour service package in the community. In order for people to die well in the community, relatives have to be involved.
- ✘ Need for honest conversations with patients about effective provision and support to help them make informed decision**. Who should be in charge of having these conversations with patients?**

CASE STUDY - 95 year old patient with end stage dementia and registered blind. Fast track completed and care plan due to start on discharge. Discharged late on a Friday evening and readmitted at 23:05 on Saturday night. No district nurse referral made on discharge from the ward. Agency care workers concerned he was not eating or drinking. LAS said he should not have been discharged as he was in last stage of dementia and was unable to eat and drink. Family raised concern with site practitioner.
Site practitioner emailed complex discharge team that he was readmitted.
The patient was discharged again after 9 days with referral to St Joseph and call to GP but no DN referral. The care agency contacted EPCT to say they were unable to give medication. DN said no referral had been received and the patient was not open to them. CHC advised to refer via SPA.
GP prescribed EOL injections to be given subcutaneously. Expected death letter was completed, but there was still no DN referral. DN finally visited 20 days post discharge.

Where are the gaps and what are staff doing about it?

Well-integrated care, with continuity of provision is key for patients and their family (Parker JPSM 2007, Belanger Pall Med 2011).

- Barrier between acute and community/ primary care –DNs in EPCTs do not always receives referrals from ward when patients are discharged
- Ward discharge checklists do not take account of what available in the community (e.g. prescriptions for injectable medications)
- When BHT Specialist Team is involved referrals are made to St Joseph's community team but GPs and DNs are not always informed
- Community palliative care in TH heavily relies on St Joseph's team's input, also on advanced care planning discussion, but many feel GPs should have a more central role – need to raise awareness
- *"Specialist palliative care teams spend too much time doing tasks that you don't need specialist knowledge for"* (Specialist Nurse)
- Knowledge and practice gap around role of therapies for palliative and EOL patients
- Some services under used – e.g. Marie Curie's night sitting
- DNs' task-orientated approach

Improving coordinated work
- **EOLC steering group monthly meetings** have been instrumental in connecting different actors in TH and co-creating joint narratives/ visions/ goals. Currently attempting to bridge gap between hospital and community.
- EPCTs DNs have **weekly palliative meetings** with CNS from St Joseph to discuss their palliative patients.
- **Palliative champions meetings** are organised by lead nurses and social workers in different localities to raise awareness about palliative care and end of life pathways and strengthen joined-up working – designated palliative champions in each team take responsibility over training colleagues

Good model - renal palliative care MDM led by a group of specialists keen to work with St Joseph's team to address EOL needs for people with advanced kidney disease.
- Started in 2016
- Use a screening tool on whole cohort of dialysis patients to identify those at risk of dying in the next 12 months
- Patients on register get discussed at renal palliative care MDT meeting

My experience would tell me, clinically, that a lot of people want to be at home until it gets really difficult, until maybe they're being doubly incontinent or until they're frightened of being on their own, and then they want to be anywhere but home […] So we encourage ladies for a birth plan, but we say to ladies when we're writing the birth plan, 'Look, this might not happen. Lots of things might change that. You might need intervention, you might need medicines, you might need this you might need that […] I don't know why we approach death and birth in a different way. […] I think we have to educate patients about if you want to die at home this is what it might mean for you; is that really what you want? And therefore make it a… It's the only time I think in healthcare we don't give information.
[Nurse]