Admission Avoidance Pathway in Waltham Forest

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

Barts Health Trust
North East London Foundation Trust
GP
London Borough of Waltham Forest
Voluntary sector

Services and Teams

- Manage the referrals and enquiries for all planned and unplanned care services
- Patients and carers can self-refer
- Review the NHS.mail for referrals received and update onto RIO as per SOP
- Categorise referrals received to clusters and specialities and forward onto teams
- Liaise with clinical triage on referrals that have been screened & accepted
- Upload referrals onto RIO allocating to relevant services
- Complex calls requiring clinical input diverted to clinical triage nurse (9am-5pm) or RRT (after 5pm)

Rapid Response Team (RRT)

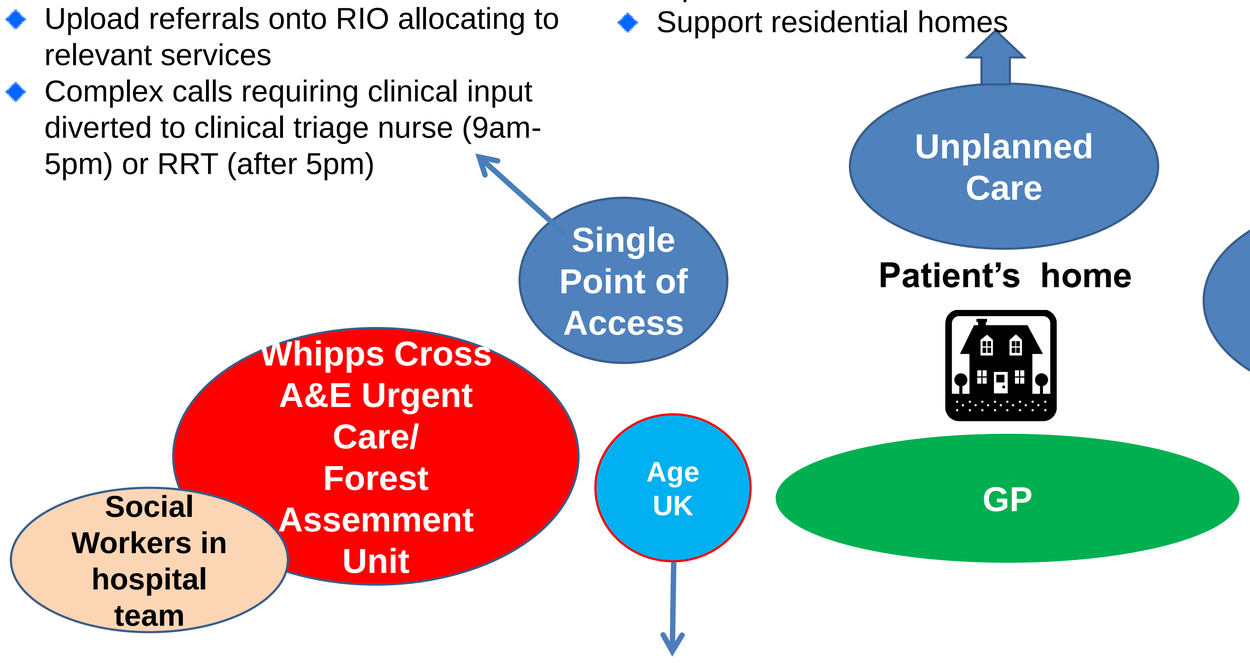
- Nurse-led 24 hours service, based at Woodbury Unit near Whipps Cross's Urgent Care
- Prescribers from different background (e.g. hospital; community)
- Provide a rapid assessment and immediate treatment for patients within their own homes (e.g. catheter management; chest infections, UTI, managing shortness of breath, heart failure, wound management)
- Clinical triage 20 minutes from receipt of referral
- Response within less than 2 hours for very urgent referrals/ 2-12 hours for less urgent ones
- Out of hours palliative care
- Support patient up to 3 days and then discharge to ongoing management pathway
- If patient known to service, undertake visit if care plan requires review
- Support residential homes

Integrated Care Teams (ICTs)

- All referrals for District Nursing, Community Matron/Case Management & Therapy, Palliative/End of Life care and Continence are sent to one of the three ICTs:
- North Integrated Community Team (Chingford)
- Central Integrated Community Team (Walthamstow)
- South Integrated Community Team (Leyton/Leytonstone)
- ICTs are multidisciplinary teams including:
- ✓ District Nurses
- ✓ Community Matrons (ICP patients)
- ✓ Therapies (OTs and physios)

Adult Community Health Services have different functions that operate under planned care:

- District Nursing
- Therapy Rehabilitation Service
- Diabetes Education
- Community Respiratory Team
- Community Matrons/Case Management & Therapy
- Palliative/End Of Life care
- Tissue Viability Service
- Podiatry
- Continence Service
- Nutrition & Dietetics
- Specialist services – Parkinson's; Multiple Sclerosis & Haemoglobinopathy.

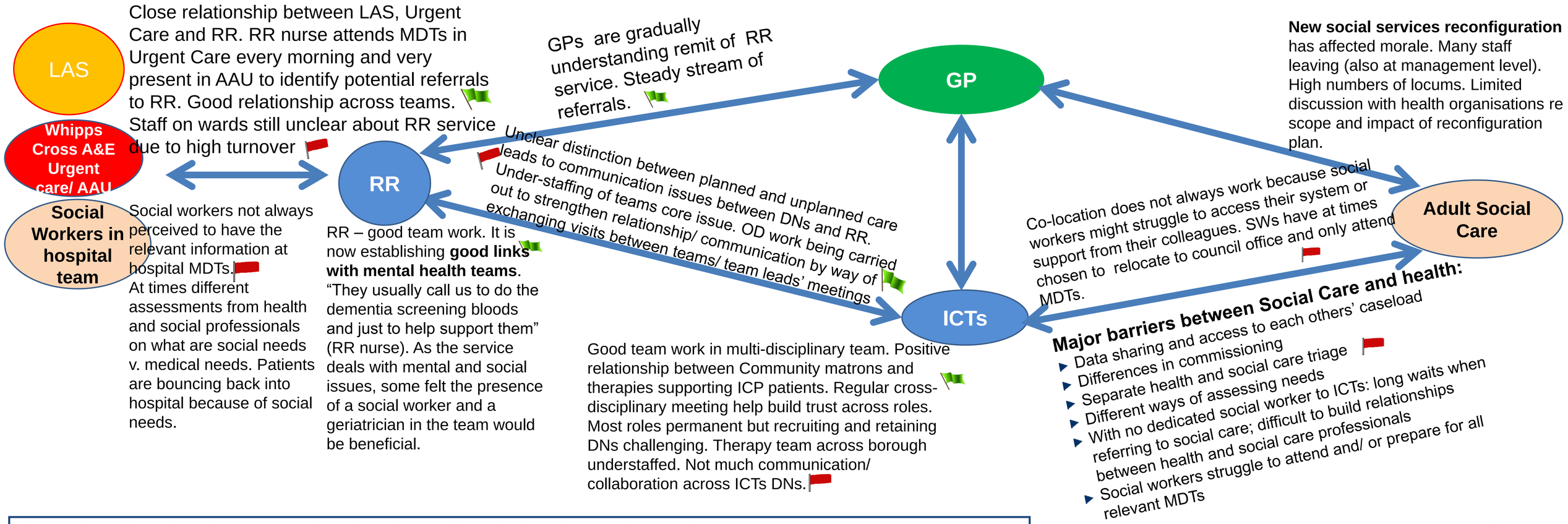


Provide support and a wide range of services for older people and their carers in WF

Complex care team

- Should be integrated with ICM/ICT
- Three social workers, each attached to one ICT (but also deal with other complex care cases because of a staff shortage)
- Referrals mainly from community matrons
- Weekly meetings with community matrons and GP
- Patients over 18 and on ICP list
- Communication with ICT via ICT email box

Admission avoidance referral pathways



Close relationship between LAS, Urgent Care and RR. RR nurse attends MDTs in Urgent Care every morning and very present in AAU to identify potential referrals to RR. Good relationship across teams. Staff on wards still unclear about RR service due to high turnover

Social workers not always perceived to have the relevant information at hospital MDTs. At times different assessments from health and social professionals on what are social needs v. medical needs. Patients are bouncing back into hospital because of social needs.

RR – good team work. It is now establishing **good links with mental health teams**. "They usually call us to do the dementia screening bloods and just to help support them" (RR nurse). As the service deals with mental and social issues, some felt the presence of a social worker and a geriatrician in the team would be beneficial.

GPs are gradually understanding remit of RR service. Steady stream of referrals.

Unclear distinction between planned and unplanned care leads to communication issues between DNs and RR. Under-staffing of teams core issue. OD work being carried out to strengthen relationship/ communication by way of exchanging visits between teams/ team leads' meetings

Good team work in multi-disciplinary team. Positive relationship between Community matrons and therapies supporting ICP patients. Regular cross-disciplinary meeting help build trust across roles. Most roles permanent but recruiting and retaining DNs challenging. Therapy team across borough understaffed. Not much communication/ collaboration across ICTs DNs.

New social services reconfiguration has affected morale. Many staff leaving (also at management level). High numbers of locums. Limited discussion with health organisations re scope and impact of reconfiguration plan.

Co-location does not always work because social workers might struggle to access their system or support from their colleagues. SWs have at times chosen to relocate to council office and only attend MDTs.

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
- With no dedicated social worker to ICTs: long waits when referring to social care; difficult to build relationships between health and social care professionals
- Social workers struggle to attend and/ or prepare for all relevant MDTs

There is a fine line between what is *planned* and what is *unplanned* care

So a blocked catheter would be unplanned [care] *because it's blocked, it needs changing. But bypassing catheters that are leaking, that actually can wait for a few hours and becomes planned* [care] […] *But planned services will say it's not planned because 'I* [DN] *didn't have the visit in my diary for today', so it's not planned. But also Rapid Response will say actually, 'If you'd planned better and done better care for your patient, it should be a planned event to go in and change it'. So that's where we're struggling: it's about what is planned and what isn't… What's really easy is if the GP rings in and says, 'This patient has had a fall, they've got a new cut on their leg, can someone go and see it?' then it's obviously unplanned and Rapid Response will go. So those ones are easy. It's the fine line ones that we really struggle with. And the model was sold that actually the District Nurses would go out with their list of patients on a daily basis, those were the patients they were seeing, they wouldn't see anyone else, and the additional resources went into Rapid Response. But the demand far out-stripped the resources that were put in Rapid Response; so then we had to review that and look at how we could manage it better. And I think that's where the issues come from because the nurses felt it was a really good idea, 'I'm going out with my ten patients, this is all I'm going to see. I can plan my day around it,' but actually that's not a reality at all. […] And again, I think the other big issue for me is that Rapid Response take the [SPA] calls after 7 o'clock, so they are triaging them and they know what their workload is, and they know what's out there; but the nurses out there* [DNs] *don't want to hear it. It's like, 'You took the call, it's yours, sort it! […]* ***I think this model would work if you had enough resource to actually do your planned care better.*** (NELFT nurse)

*So when it was historically **ICM,** it used to be the District Nurses and Integrated Case Management, which was the therapy and matrons. Now we're the ICT. When it was the ICM… […] each base used to have an allocated social worker and that's how Social Services were commissioned, so that each cluster got an allocated social worker. […] The ICM function is still there but we're known as **the Integrated Care Team**. So over, I'd say, the past four or five months the social care input has dwindled and dwindled and dwindled; **they no longer attend our MDT meetings**. We find that the Matron is dealing with multiple social workers; whereas before it would be one social worker that you dealt with* (ICT team member staff)

Discharge pathways in Waltham Forest

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

Barts Health Trust
North East London Foundation Trust
GP
London Borough of Waltham Forest

Services and Teams

Hospital Team
- 15.5 staff: 12.5 social workers; 2 senior practitioners; 1 manager
- Social workers allocated to different wards, based on skills and numbers of section 2s and 5s
- 2 designated workers in ED
- Six weeks reviews
- Out-of-hours discharges

Discharge Team
- 3 patient flow coordinators; 3 discharge coordinators; 1 clinical lead; 1 manager; 1.2 admin
- Complex discharges
- Input on continuing care assessment/ fast-track patients
- Single Point of contact for rehab services
- Attend board rounds
- When the hospital is in crisis involved in basic discharges (i.e. contacting nursing/ residential homes).

Ainslie Unit
- Community hospital
- Referrals mainly from acute (i.e. Whipps Cross hospital)
- Case finding function through therapist on hospital wards
- Provide rehab following falls, joint/ hip replacements, but also respiratory rehabilitation to patients over 18 and resident in WF
- 32 beds
- Over 50 nursing staff; therapists (including speech therapist); on site pharmacist; 1 social worker per ward (but **no longer co-located**); dietician (external)

SW Hospital Team

Integrated Discharge Team/ Whipps Cross

Health and social care staff colocated at Whipps Cross Hospital

Discharge Team

Ainslie Unit

Hospital to Home Pilot

Rapid Response

Reablment Team

Patient's home

GP

ICTs

Complex care team/ ICM

Discharge to Assess (D2A)
- Pilot started in October 2016/ co-funded by LBWF and Health
- 5 days a week 9am-5pm service/ moved to 7 days with Winter money (but few referrals at the weekend)
- Led by NELFT working closely with Reablement – nurse support from Rapid Response
- Facilitate early discharge of medically optimised patients/ reablement package starts on day of discharge up to six weeks
- Maximise independence
- Provide timely therapy and social care assessment in the patient's home environment
- **Plan to expand to cover complex discharge pathway**
- Multidisciplinary team:
  - ✓ NELFT: 2 Band 6 OTs; and 2 Band 7 Physio (including 1 team lead); 3 Band 3 rehab assistants/ 7 days cover: 1 Band 6 OT and 1 Band 6 Physio
  - ✓ LBWF: 1 social worker; 1 senior reablement officer; 1 OT; 1 rehab assistant

Reablement
- Improve people's function in the community
- Facilitate discharges from hospital
- Patient on caseload for up to six weeks
- Referrals from acute, community, and social workers
- Three members of staff work on D2A service with NELFT therapies

Integrated Care Teams (ICTs)
- Three teams (Chingford; Walthamstow; Leyton/ Leytonstone)
- ICTs are multidisciplinary teams including:
  - ✓ District Nurses
  - ✓ Community Matrons (ICP patients)
  - ✓ Therapies (OTs and physios)

Complex care team/ ICM
- Part of Complex Care which deals with legal cases/ safeguarding
- Should be integrated with ICM/ICT
- Three social workers and two assistants, each attached to one ICT (but also deal with other complex care cases because of a lack of staff)/ partly funded by CCG
- Referrals mainly from community matron
- Weekly meetings with community matron and GP
- Patients over 18 and on ICP list
- Communication with ICT via ICT email box
- Also includes dedicated social workers overseeing discharges from Ainslie Rehab Unit

Discharge referral pathways

D2A
- Positive patient experience data and ongoing dialogue between NELFT and reablement team to address issues
- **Trusted assessment across team**
- Capacity issues and reconfiguration of Reablement team has affected relationship and integration efforts and led to poor retention of staff (including management)
- High turnover of reablement staff working with D2A → poor handover and attendance at daily meeting
- Difficult to find SRO willing to relocate at Whipps Cross with D2A team
- Good relationship between D2A NELFT therapies and RR – referrals by direct calls for nursing support

Despite co-location of health and social care staff in the Integrated Discharge team, each time works in silo and having different management lines complicates relationships of mutual trust. No regular communication between Adult social care senior management and IDT management (Barts health Trust).

SW Hospital Team

Discharge Team

Hospital wards

Ward staff more aware of D2A service
Discharges from WXH - often late in the day, and d/c dates changes at short notice

- *Often no nurse handover when patient is discharged to ARU*
- *Patients often discharged without required medication*
- *ARU set up system of "discharge alert" to CCG to report inadequate discharge process*

Staff in community services feel that patients are often discharged too early from hospital – leading to cases of failed discharges.

RRT

Reablement

Hospital to Home Pilot

Most patients don't need further therapy input following D2A 6 weeks. When urgent input from GP or DNs is required it has been difficult to access (i.e. 3 days wait). GPs tend to refer to RRT.

Ainslie Rehab Unit (ARU)

Social workers from Complex care team working with ARU

- 2 SWs working with ARU (1 per ward) to set POCs for patients
- Attend MDTs but not based there
- ARU staff feel relationship would be stronger if SWs were based there
- SW said that when co-located at ARU they did not have access to their own data system and colleagues' support

- Good relationship between ARU and ICTs – close working with community matrons and DNs
- Easy to refer through SPA and follow up with ICTs

GP

ICTS

Complex care team/ ICM

- Perception that social workers have been less present since summer 2017 – **things now improving**
- **Difficult for only three social workers** (some newly trained) to attend all relevant MDTs/ ICM in the postcode they're allocate to.
- High turnover of staff in Adult Social Care is an issue.

I started in September and I already had two managers appointed to do this. I don't think it is a unique situation in Waltham Forest, I think it is everywhere. […] In the last five years Social Care has shrunk at least in half in terms of staffing, there is no money to employ more staff, I'm fully aware of it. But we are turning into a bit of the delivery service [Social Worker]

Issue with inappropriate/ incomplete referrals from WXH to ICTs/ referrals not always sent to DNS – i.e. referral for wound dressing without mentioning patient had cancer

It just seems that they are so desperate to get their estimated discharge date. Obviously the minute you are admitted they are already doing that, but I think because they've got that in mind they are almost forgetting that there's other stuff still going on with people [Community Nurse]

Why can't I set up a package of care? Because I've got enough experience and that… If someone needs someone to go in and look after them three times a day, why can't I as a nurse set that up? Why do we have to wait for social worker? So I find that that kind of boundary is still there, and I think that limits the success of having an integrated team, we are not working across [Ward Nurse].

All referrals to community services go through the Single Point of Access (SPA)

Out of hospital pathways

D2A/Reablement
Patient can benefit from OT/Physio assessment

Reablement
- Reablement POC required on discharge with OT/PT follow up within a few days
- For other social services needs referrals to Integrated Discharge Team

D2A
- OT/PT input required on day of discharge

Community rehabilitation
Existing package of care/ family OT/PT input to progress function

- **WFRS** intensive rehab for up to 6 weeks
- ICT therapy Long-term condition management

In-patient rehab
- Rehab needs cannot be met at home
- Assessment carried out on ward
- Plan transfer to Ainslie Unit for up to six weeks

The **Waltham Forest Rehab Service** (WFRS)– based at WXH – triage all therapy referrals. ICT therapists also get direct referrals from CMs and DNs in their teams.

End of Life Care pathway in Waltham Forest

Barts Health Trust
East London Foundation Trust
GP
London Borough of Waltham Forest
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

Community Palliative Care team

- Based in the Margaret Centre
- 6 CNSs and 1 part-time consultant
- Mon-Fri 9am-5pm service
- Visit patients in the community
- Cover all WF; each CNS has caseload
- Complete Fast track of identified EOLC patients
- Work with DNs and ICTs' therapies/ attend ICM meetings
- Funded by BHT but working under NELFT's umbrella – **policy and guidelines grey area**

Rapid Response

- Based at Whipps Cross hospital
- Provides HCA (Healthcare assistant) for night sitting
- 24h nurse-led urgent care service

Marie-Curie nurses

- Provide one-to-one nursing care and support (i.e. overnight) in the home, usually for eight or nine hours.
- Currently in WF, Marie Curie budget is sitting with Rapid Response

The Margaret Centre

- 12 beds hospice based at Whipps Cross hospital
- Medical cover 9am-5pm (admitted to A&E)
- Provides specialist palliative care for people affected by life-limiting illnesses
- Provides advice and support in the hospital and the community

St Joseph's Hospice Community Palliative Care Team :

- Provide clinical guidance and supportive care on social, emotional and spiritual matters
- Limited involvement in Waltham Forest – perceived as out of borough by residents who prefer Margaret Centre

Rapid Response

Barts Health Trust Specialist Palliative Care team

Marie Curie nursing service

Margaret Centre

Community palliative care team

St Joseph's Community Palliative Care Team

Patient's home

GP

ICTs

Adult social care

Provides packages of care for fast track

- GPs and district nurses in charge of non-complex palliative care in the home and take responsibility for prescriptions

EOLC in the community

- The community palliative care team is very stretched with only 6 CNS covering the whole borough
- Limited out of hour service - Rapid Response have an HCA overnight that can sit with patient but there is limited capacity
- There is no longer a community Palliative OT (locum has recently left, no plans for recruitment)
- There is no palliative social worker in the community
- The 6 CNS rely on ICTs' therapy and DNs but there is **limited collaboration**

> *Although we do work with the ICTs in the community, which obviously have access to occupational therapy, I think you'll find that when patients refer to palliative care they're almost passed on as if to say, 'Well you know your responsibility now'.* […] *So in terms of kind of integrated working there there's gaps really and it is disjointed.*
> [Specialist Nurse]

- Several great teams doing great work, but they work very much in isolation
- CNS organise monthly Gold Framework meetings at Margaret Centre but community staff (including GPs) do no attend **– barrier between BHT and community/ NELFT. CNS team caught in between as paid by Barts but working closely with community**
- Limited resources: CNS faxing to communicate with ICTs and GPs
- Confusion around referral form for DNs which include palliative care – incidents where GPs wanted to refer to specialist team but referred to DNs by mistake. DNs not always aware of when to escalate to CNS
- Difficult relationship between DNs and CNS – lack of clarity around roles
- A number of services were lost

> *We used to be able to ask 'Can this family have a little bit of respite?' […[and they would take them in for a week or two. But now that has gone as well.* (DN)

> *Years ago we had a man with a van, so if we had anyone coming in for respite and the odd symptom control admission would just be picked up and dropped off home. And we had a cat, we had a washing machine, we had a day centre.*
> (Palliative community nurse)

Fast Track: whose responsibility?

- Specialist teams often picking up the pieces and completing/ submitting forms

> *It distracts us from doing core business which is symptom control for patients. And then we have to go and meet the patient when teams already know them. District nurses obviously know the family really well, know what their care needs are…*
> (Consultant)

EOLC in the hospital

- BHT hospital palliative care team, the Margaret Centre and the community palliative care team should work as an integrated service but the hospital team works in isolation (i.e. psychological support for patients)
- The Margaret Centre is registered as a hospice for palliative care but when there are empty beds, the in-patient unit is expected to take acute admissions with other care needs from other areas of the hospital. Not all nurses are trained to treat acute patients placed at the Margaret Centre
- Gaps in transition from acute to community – staff mentioned need for one transferrable document (i.e. Respect)
- Lack of financial governance – i.e. monthly activity reports against contract

What is happening to address these gaps?

- Programme of palliative champions has been agreed
- Investment in EOLC (although not as much as initially planned)
- Transformation board Task and Finish Group on developing EOLC as accountable care system (**but BHT community team not invited**?)
- Coordinate my Care pilot in Chingford (some staff pessimistic about it taking on because GPs might not have capacity)
- Work led by Social Finance

> *I hope we get the model right. And then it doesn't become political battle ground around who is going to run what. Because I think that, in a way that's a shame... […] Because if everyone wants to lead... unless one partner is willing to follow how are you ever going to be working to the same thing? And I guess that's where they sort of see the provider, the Accountable Care system comes into play because it puts all the money in one organisation's pocket and then you can sub-contract out to other organisations. But I think there will be some power struggles with that..*
> [Specialist Palliative Care]

What other solutions do staff envisage?

- Targeted training for DNs (i.e. Band 5) for them to take ownership. Not all palliative patients need referring to specialist team
- Joined up services: Margaret Centre-CNS-Hospital specialist team-DNs-GP-Rapid Response to have a **Hospice at Home** or 24 hour access to palliative advice. Currently too many services with little clarity on who takes responsibility over what.

> So we'd say give us the Fast Track money, we will set up a Hospice at Home service; or we will commission a **Hospice at Home service**, for which we will have absolute responsibility. And we will be responsible for the training of those carers, the outcomes, for the documentation, for the governance, and if it starts to go belly up you can come to us, we can use the Margaret Centre as that hub.
> (Consultant)