Whittington Hospital @ Home

Started: 2014
Region: Islington CCG, North Central London
Geography: Urban
Estimated local pop. 0-18 years: 40,500

Background

- 8 months of planning prior to opening service
- Commissioners of local CCG involved from start of planning phase

Aims

To reduce LoS of admissions to Whittington Hospital

Target patient groups

Acutely unwell CYP (respiratory is the main referral)

The service model

Hospital at Home

- Add-on to the existing Children's community nursing service
- The nurses attend most morning ward rounds at Whittington and 2 WR/week at UCLH, to help to identify suitable patients for their service.
- Average of 3-5 visits per shift
- Communicate between shifts via a generic handover sheet that is emailed

Children's nurses in primary care: this is a separate service and an add on to CCNT provision

- CCNT run primary care clinics to support the education of practice nurses – Mon-Fri 9-5 and evenings to 7.30pm
- Cover 4 conditions (asthma, eczema, wheeze, reflux)
- GPs refer CYP to the service
- Work in 4 GP hubs across Islington
- Weekend clinics too
- Patients can have a 1 hour education session in the surgery

Opening times

- 8am-10pm
- 2 shifts each day – 8am-4pm or 2pm-10pm
- Originally commissioned until midnight, but staff assessed that wasn't necessary beyond 10pm
- Last visit starts at 9pm

Staffing

Provides ongoing hospital type care at home until GP based community provision can take over. Recruitment took up most of planning time

H@H team

- 1 nurse per shift (Nurses are flexible and work across services during quieter times)
- 2 nurses
- 1 x band 4
- Part-time matron
- 0.5 WTE Consultant (0.2 WTE is sufficient)
- Initially part-time pharmacist to assist electronic prescribing (now no longer required)
- Staff have a different skills-mix (some community and some acute based) and they learn from each other

In total the CCNT have:

- 17.5 WTE nurses
- 1.5 WTE administrative support
- 0.5 WTE consultant paediatrician

Nursing team consist of band 6 and above nurses from ED and community background; majority have worked in acute paediatric setting. 2 nurses are advanced practitioners with aim that all members over time will achieve this status. All have received training in assessing acutely unwell child and each nurse is paired with acute paediatric consultant for ongoing reciprocal learning and mentoring programme.

Who can refer

Referrals are from UCLH and Whittington paediatric wards. A referral criterion is that the child must have a working diagnosis and physical signs and symptoms within set parameters. Any diagnoses not on the list will be considered after discussion with hospital or nurse on shift and attending consultant.

Most common referrals:

- IV antibiotics (up to 3 times/day)
- Breast-feeding support (+/- use of nasogastric feeding)
- Asthma exacerbations (once req. inhalers max of 3-hourly)
- Cellulitis – particularly peri-orbital
- Neonatal jaundice (req. phototherapy & twice daily bloods)
- Infected eczema (IV antibiotics and eczema education)
- Bronchiolitis (for nasogastric feeding support at home and illness monitoring)
- Gastroenteritis (monitoring for up to 48hrs of rehydration)

Who is accountable for patients?

The CYP continues to be under the overall care of a named Paediatric consultant at the hospital

Discharge is nurse-led.

Resources

Equipment necessary for operation:

- Apple iPad configured to the same image as that used for the Adult hospital at home service which includes access to programs and systems at the hospital with wireless/3G access
- Mobile phone
- Cool bags to carry medication which needs to be kept cold
- Sphygmomanometer
- Stethoscope
- Backpack of similar size and design used by Adult hospital at home service
- Bilirubin blanket

Members of staff carry the Lone Working Device which monitors where the member of staff is to a central security system and allows member of staff to send an alert if in danger which results in police attendance.

Funding organisation

Islington CCG

Level of patient/family involvement

Since the service is at home, the parents are supported at home to look after their children.

Level of integration in the system

Currently integrated into the community care nursing program and the ED paediatric services at Whittington Hospitals.

Evaluation

From August –December 2014:

- 107 referrals
- 376 face-to-face contacts
- Positive feedback from patient/parent surveys

Challenges, successes, lessons learned and advice

- Improved liaison with the SN – can share same treatment plan.
- Good staff motivation and retention – the staff are developed, highly skilled and keep their acute skills up to date.
- Continuity of care – from ward to house and holistic approach – can review other risk/health factors in the home and safeguarding strengthened.

- May reduce the need for future presentations if educate well re: disease e.g. asthma and eczema.
- Initially there was resistance from doctors during the set-up phase and during the design of protocols. In order to build trust, the H@H service paired nurses with registrars/consultants, to demonstrate their physical assessment skills – this helped to build trust and increase. confidence.
- Safety of workers is a concern, as lone-workers. Management have an on-call system to check the last person has left work and they use Skyguards.
- Limited uptake from GPs – planned to have GP referrals as part of the model, but GPs don't refer. Perhaps should have had more GPs involved in the planning process stakeholder group. Most of the design work came from secondary care.
- There is a disincentive for the hospital to refer too many patients into the service.
- In order to be effective, the parent needs to be engaged, be prepared to be educated and trained about the illness and how to look after them. About 10 families have chosen to not take part because of lack of confidence.
- Should have started the model with a staff consultation and ensured everyone had the same job description. Would be good to have more staff on the rota, to ensure cover for leave/sickness and to share the late shifts out. A diverse workforce enables mutual learning and regular refreshing of skills.
- Connectivity was so poor that electronic prescribing wasn't possible.
- Be reasonable in your expectations.
- Research how other services have developed their service and adapt local pathways.
- Find a paediatrician to champion the service.
- Consider involving other services e.g. physiotherapy and dietetics.
- Coding could be improved – based on ICD-10 codes and for ease many doctors use term 'other' – this has made analysis very difficult and a process of re-coding was necessary. Would have been beneficial to have an economist to guide the start/coding process.

Contact for more information

Annette Langseth, Consultant Lead (Locum)

Dolores D'Souza, Lead Nurse (The Whittington Hospital NHS Trust) (pending new Matron appt) or Bernadette O'Gorman (The Whittington Hospital NHS Trust)

Sabina Ilya, Islington CCG GP lead

Catherine Lad, Children's Commissioning Manager (Islington Clinical Commissioning Group)

whh-tr.PaedsHospitalathome@nhs.net

alangseth@nhs.net

catherine.lad@islington.gov.uk

020 3316 1950

http://www.whittington.nhs.uk/default.asp?c=20049