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# London's Urgent and Emergency Care Collaborative

**Katy Millard**
London Community Services Director

**Claire Eves**
Operational Head of Hillingdon Health Care Partnership

**Thomas Dowle**
Clinical & Operational Lead, Camden Rapid Access Services

*Wellbeing for life*

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# Supporting people to come home sooner

- Current offer in Camden, Hillingdon and Tri-borough (CIS) to our acute partners – front door and back door
  - In-reach admission avoidance – “Rapid Response”
  - Discharge to Assess (D2A)
  - Post Acute Care Enablement (PACE)

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# In-reach into ED

- CNWL staff working in ED and acute wards
  - Royal Free Hospital
  - University College Hospital
  - Hillingdon Hospital
- Community Expertise
- Triaging patients to come straight home and managed in the community by highly skilled nurses and therapists
  - UTI, LRTI, Exac COPD, falls
  - Signposting

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# Case study: In-reach

92 year old female admitted unresponsive. Diagnosed with UTI and new AF

PMH: Vascular dementia

Social Hx: Lives alone in first floor flat. Good family support. Good neighbours. No POC

Pre Morbid Function: Independently mobile & for ADLs.

On Ax: Mildly confused, persistent cough, risk of falls. Requires a walking frame. Difficulty taking medication due to poor memory and confusion.

Action: Home from ED. Nursing and OT assessment. Liaised with GP re: blister pack. BD carers to assist with PC and med prompts. Equipment provided.

Progress: Spiked a temperature. Bloods taken, slight increase CRP- monitored- resolved. POC for ongoing BD care requested from social services.

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# Discharge to Assess - D2A

Patient no longer has care needs that can only be met in an acute hospital

| | |
|---|---|
| Pathway 0 | • The patient does not require any additional support – i.e. no needs or restarts of care |
| Pathway 1 | • The patient has some additional care or reablement needs that can safely be met at home – new or increased package of care, urgent therapy agenda or both. |
| Pathway 2 | • The patient is unable to return home for a short period of time as they require further rehabilitation/reablement or complex discharge planning |
| Pathway 3 | • The patient has continuing healthcare needs |

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# Discharge to Assess - D2A

- Patient no longer needs acute medical input and can be discharged from hospital's care
- Assessments are completed outside the acute hospital, post-discharge
- Same day discharge, 7 days a week, 8am-8pm
- "Home first" model, however other options available if home not appropriate:
  - In-patient rehabilitation
  - Residential/nursing home
  - Step down beds or reablement flats

# Standard Pathways

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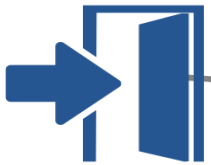

Admission

Deemed "medically fit for discharge"

Functional assessment in hospital

Assessment of patient's home

Social services determine size of care package

CHC assessments inside hospital

Step-down beds for patients awaiting long-term placement

Funding decisions about on-going care

Patient only discharged once care package confirmed, equipment in place etc.

Discharge

Patient deemed "medically fit for discharge" and is then sent home

Community team alerted to patient's discharge

Functional assessment within 2 hours of arrival at home

Any care, equipment etc. required: provided immediately

Reassessment as soon as appropriate to withdraw or reduce care as patient becomes more independent

Care package, once instituted, not reviewed

Long-term care needs will be determined within 6 weeks

## Discharge To Assess

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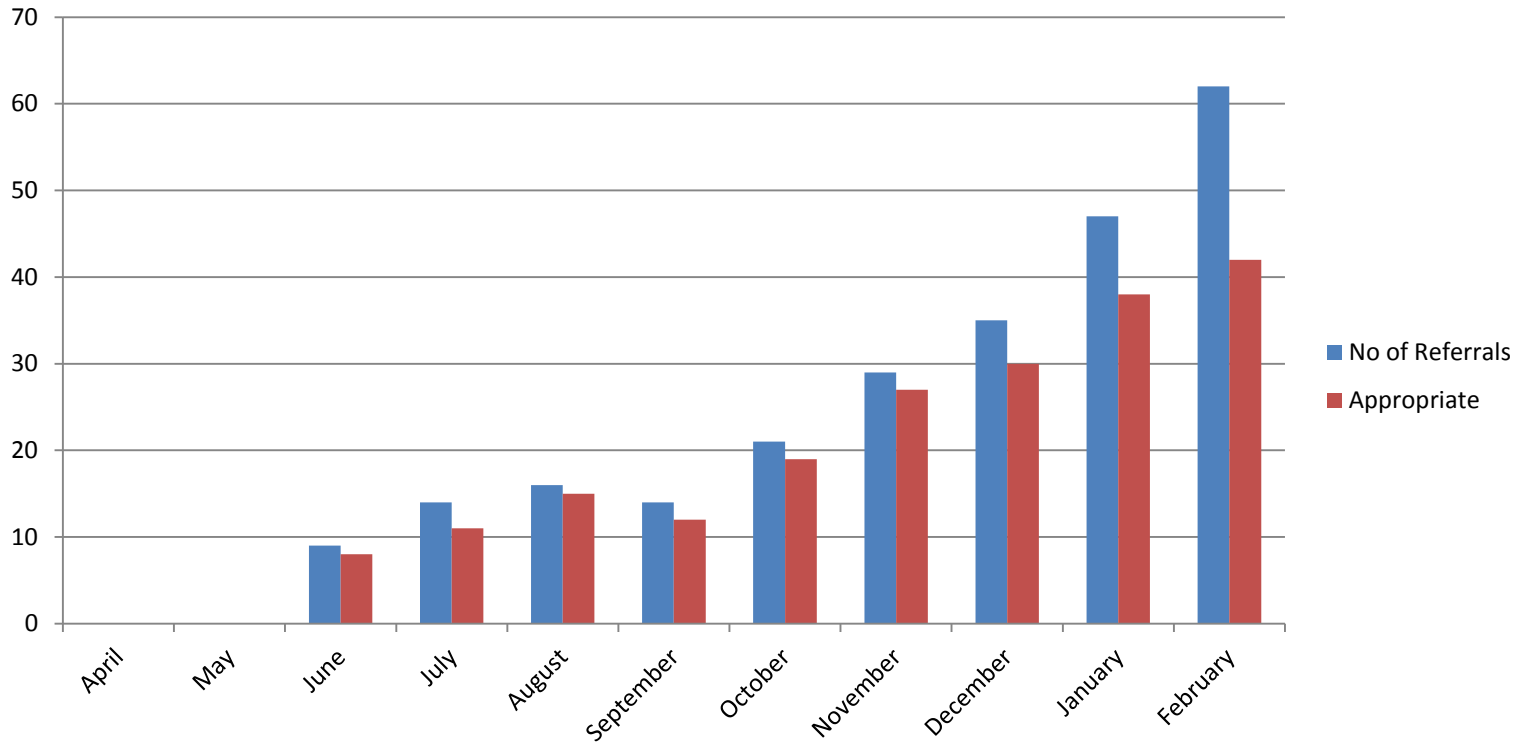
# Camden D2A Pathway 1 (Home)



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# CIS D2A Pathway 1: 'Home First'

- Building on well established supported discharge pathways in place with CIS Liaison
- In partnership with 3 borough integrated hospital teams, CIS has supported the achievement of one of the best DToC performance across London
- Home First pilot from June 2017 targeting a new patient cohort: those not functionally optimised requiring rehabilitation, reablement or bridging for social care
- System working across 3 inner London boroughs and 3 hospital sites: St Mary's, Charing Cross and Chelsea & Westminster

# D2A CIS: 'Home First'

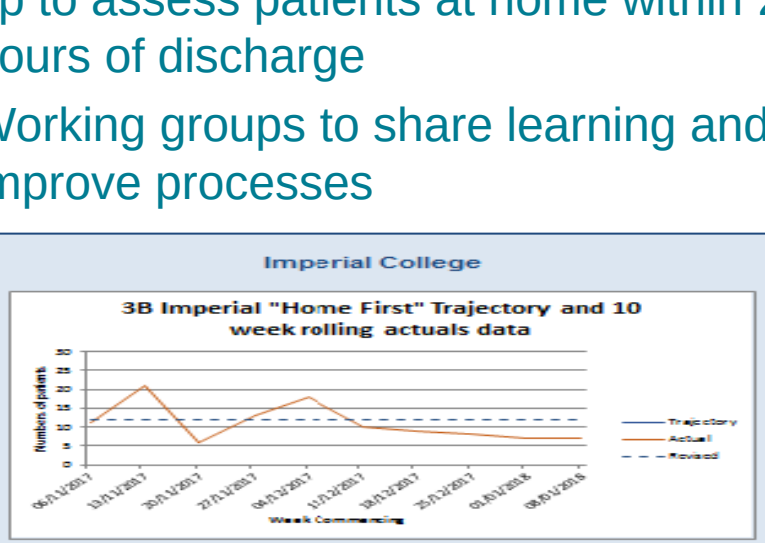
Significant progress made despite no additional investment

Community Physio and Social Work set up to assess patients at home within 2 hours of discharge

Working groups to share learning and improve processes

- Close working with hospitals to identify patients and define patient cohort
- Secondment of Home First operational lead to Imperial
- Developing business case to formally commission the pathway

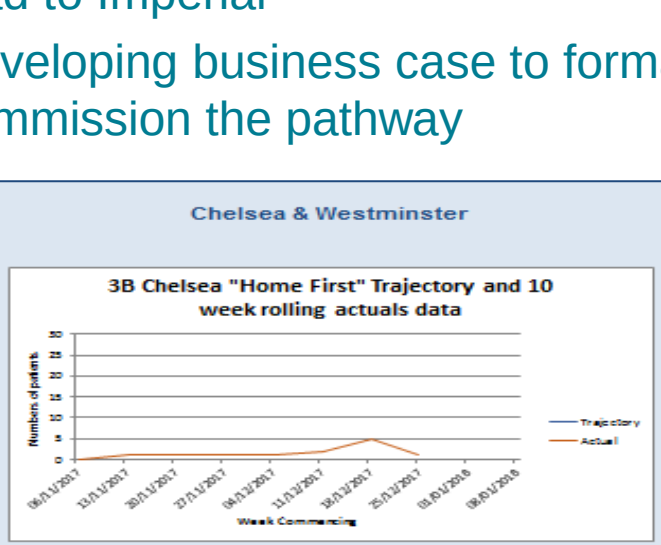
Imperial College




142

3B patients discharged from Imperial on "Home First" pathway

Chelsea & Westminster

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3B patients discharged from CWH on "Home First" pathway

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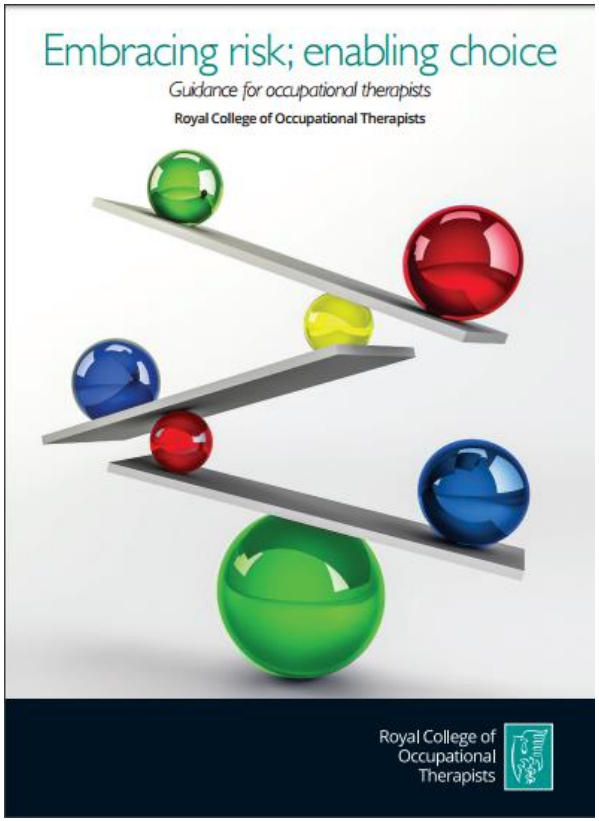
# Challenges/Difficulties

- Differences with other boroughs
- Differences across the sector
  - Some health led, some social care led, some integrated
- Patients referred before medically fit – delays
- Communication – sometimes no update that patient has left ward, no discharge summaries sent
- Medication errors
- Engagement from stretched social care colleagues
- Section 2 & 5 still being used occasionally

# Embracing Risk




- Patients coming home sooner than ever before – 268 bed days saved in Camden Nov-Feb (Pathway 1 alone)
- Acute therapists have some reluctance to discharge home
- CNWL used to dealing with risk with admission avoidance work
- Change culture

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# Case study: D2A

- 86 year old patient
- Previously no package of care at home, supportive son lives nearby, walking with stick.
- Admitted with urine infection – treated on ward.
- Receiving assistance on ward for personal care, using rollator frame for mobility
- Medically fit for discharge – ward round 10:30am
- Referral made to D2A Pathway 1 at 10:45am
- TTA sorted, transport booked, patient in D/C lounge by 1:30pm, home by 2pm
- OT visit from D2A at 2:30pm:
  - TDS package of care setup to start at 6pm
  - OT assessment of environment and transfers, rugs removed – trip hazard, needs toileting equipment
  - Heating malfunctioning – call to son, British Gas to attend next day
  - Missing medications from ward – call to ward, to be couriered over immediately
- Physio assessment day 2 – exercise program provided, toileting equipment provided
- Day 3 – heating now working, exercises being completed, managing toileting with new equipment, making own lunch
- Referral to social services for ongoing BD reablement package.
- Day 5 discharged

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# D2A - The future?

- Uniform referral and response across the sector
- All services operating 7 day, 8am – 8pm
- Single Point of Access (SPA)
  - All D2A referrals through one point – one phone number/one email
  - Easier for acute partners
  - Signposting
- Verbal referrals, no more paperwork
- Integration health and social care

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# Post Acute Care Enablement (PACE)

- "D2A for medically unfit patients"
- Casefinder in Royal Free Hospital
  - Acts as conduit between acute and community
- Seven day service, 9am – 9pm
- First visit before 9pm on day of discharge
- 7 day service
- Patient remains under care of hospital teams

# PACE

## What can we take?

- Exacerbation of a chronic condition
- Chronic anaemia requiring transfusion and outpatient investigation
- Chronic cardiac failure requiring titration of medication
- Dehydration needing subcutaneous  rehydration
- Intravenous drugs e.g. Antibiotics
- Minor infection - UTI, Chest Infection, Cellulitis
- Bio-chemical instability requiring titration - INR
- DVT
- Pain control

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# PACE

## What can we do?

- Blood tests e.g. INR, U&E's with liaison of results and treatment with hospital medical team
- Blood sugar monitoring for unstable diabetes patients.
- Medication management including intravenous drugs
- & nebulised drugs.
- ECG for monitoring of heart conditions with irregular rhythms and off load weight monitoring.
- Neurological observation monitoring post a stable head injury
- TWOC and catheter insertion for urinal retention
- Following a fall +/- syncope monitoring
- Pain control for acute or acute on chronic conditions
- Rapid assessment of the patient's home environment to meet functional needs

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# Case study: PACE

- 66 year old patient
- Admitted with CAP – needed IV antibiotics
- Responded well on ward to treatment
- After two days of inpatient treatment, sent home with ongoing input from PACE
  - Daily nursing visits
  - OT assessment as off baseline, equipment installed
  - Package of care set up on discharge – three times daily
- Two more days of IVs at home
- Switched to oral antibiotics
- Regular bloods monitoring, infection markers reducing
- Discharged day five, at baseline

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# Any questions?