healthwatch
Barking and Dagenham

Care closer to home

New intermediate care services in Barking and Dagenham.

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Contents

Introduction

This report has been compiled following a public event on Thursday 16th January 2013.

Healthwatch Barking and Dagenham was commissioned by Barking and Dagenham Clinical Commissioning Group to run workshops on the two new pilot services; The Community Treatment Team and The Intensive Rehabilitation Service. The workshops gave local people and organisations a chance to understand the new services that are being piloted, share their views and any concerns.

The event was attended by over 70 local residents and organisations.

A presentation was delivered by NELFT Integrated Care Director, Caroline O'Donnell'. This was followed by a question and answer session allowing participants to ask specific questions.

Healthwatch then facilitated workshops to discuss the four main questions.

- What do you think of the changes?
- Do people want to get home quicker with the right support in place?
- Do the new services sound like the right ones?
- Anything else?

This report represents a collective response from the participants who attended the event on the 16tH January 2013.Healthwatch Barking and Dagenham have no organisational view.

Copies of this report are available by contacting Barking and Dagenham Healthwatch on 020 8526 8200 or by emailing Info@healthwatchbarkinganddagenham.co.uk

Copies may also be downloaded from our website www.healthwatchbarkinganddaegnahm.co.uk

Background to the new services

Local people have told the Clinical Commissioning Group that they want better services and more treatment closer to home.

Too many people in Barking & Dagenham end up in A&E when they do not need to and are admitted into hospital too quickly without consideration for their needs, choice and when and how they will be able to return home.

Barking Havering and Redbridge have more rehabilitation beds then other similar parts of the country and patients are in them for far too long.

What sort of patients and conditions are the CCG & NELFT talking about here?

- All adults but generally older people
- People injured as a result of a fall
- Dementia/delirium/confusion
- UTIs - e.g. cystitis or bladder infections
- People requiring short term, intensive nursing intervention after surgery to support their return home
- Worsening of respiratory conditions e.g. chronic obstructive airways disease, emphysema and chronic bronchitis.

Improvements made so far

The CCG have said they have already made improvements to the current services in 2013/14.

These changes include:

- The same admission criteria and medical cover on all sites
- Care tailored to the needs of the patient with a clear rehabilitation focus
- Moving to 7 day working for therapy teams to improve recovery times and help people to return home sooner
- Making it easier for community services and GPs to 'step patients up' if they need a period of more intense support, thereby potentially reducing the need for going into hospital
- Improved average length of stay and transfer rates from hospital so people are accessing services quicker.

To improve things further new service are being piloted in Barking and Dagenham; The Community Treatment Team and The Intensive Rehabilitation Service (IRS).

What is the Community Treatment Team(CTT)?

The Community Treatment team consists of doctors, nurses, occupational therapists, physiotherapists, social workers, and support workers. Who provide short term intensive care and support to people experiencing health and/or social care crisis to help them be cared for in their own home, rather than be referred to hospital.

The CTT has an assessment team and screening team at Queens Hospital which aims to support people who present at A&E to access appropriate alternative community support where this is required/appropriate. There is also a team based in the community , which provides follow ups for people seen at hospital. This team also provides crisis response in people's homes to avoid A&E attendance.

There is no specified time limit for support from the team, however most patients are supported for between 1-7 days. It is open from 8am-10pm seven days a week and responds within two hours.

Anyone can refer, self, family/friend/carer, GP, nursing home etc by a simple telephone call to 020 3644 2799.

Community Treatment Team

Jack is a 55 year old male living at home with COPD. Jack has been visiting his GP frequently about his COPD because he does not feel confident managing his condition alone.

November 2012

- Jack experiences an exacerbation of his COPD at 6pm; this triggers a panic attack and Jack calls '999'
- Jack is taken to A&E and spends two days under observation in Queen's Hospital before being discharged home
- Two weeks later, Jack experiences another exacerbation of his COPD and calls '999', spending another two days in hospital
- Jack understands what he should do if he experiences an exacerbation of his condition, and would rather be treated in his own home rather than having lots of disruptive A&E attendances.

November 2013

- Jack experiences an exacerbation of his COPD at 6pm; this triggers a panic attack. Jack calls the Community Treatment Team (CTT)
- The CTT respond to Jack's call within two hours and treat him at home without the need for an A&E attendance.
- Jack feels more confident about his condition with the knowledge that he has the choice to call the CTT if he needs them; he now better manages his condition at home as his confidence grows.
- CTT links Jack to Integrated Case Management for ongoing management and support

What is the Intensive Rehab Service (IRS)?

This team consists of nurses, occupational therapy staff, physiotherapy staff and rehabilitation assistants with access to a geriatrician as required via CTT. It aims to provide an alternative to admitting patients to an inpatient unit for rehabilitation by supporting people within their own homes where it is appropriate to do so.

The in-home support provided is intensive and will involve between one and three home visits each day, depending on the patient's needs. The service will operate from 8am - 8pm, seven days a week.

The CTT will be the first point of contact to access the IRS. The IRS will work closely with the CTT and with existing community inpatient units to manage a smooth patient journey to recovery.

The IRS team will accept referrals for people aged 18 and above who live or are registered with a GP in the area and have an intensive rehabilitation need. Offering IRS means that admitting someone to a community inpatient unit will not be the default option and individual needs and choice can be considered.

The IRS will work closely with The CTT and community beds to 'step people up' and down if required, this means that if patient needs to go into a community bed then this will be easily possible and if an individual is in a community bed and recovers quicker the expected, they can then go home with support.

Intensive Rehab Service

Amy is an 86 year old widow living at home with hypertension, rheumatoid arthritis and the early stages of dementia.

November 2012

- Amy falls down the stairs at home; her neighbour calls '999' as Amy is unable to get up
- Amy spends three weeks in Queen's Hospital before being discharged to an inpatient rehab bed
- Amy spends four weeks receiving rehab at the inpatient unit
- Amy contracts a UTI whilst in the inpatient rehab bed
- Staff note that during Amy's stay, her memory has significantly degenerated; Amy is deemed unsafe to return home and is discharged to a residential home

November 2013

- Amy falls down the stairs at home; her neighbour calls '999' as Amy is unable to get up
- Amy spends three weeks in Queen's Hospital; Amy is referred to the IRS service, who put in place a package of rehab delivered to Amy in her home
- Amy receives 21 days of intensive rehab at her home, including re-learning to walk up and down her own stairs
- Receiving rehab at home allows Amy to maintain her routines, Amy recovers more quickly and is able to continue to live independently. IRS work with social care to put in place a low level of support. IRS access home aid equipment to support daily tasks such as getting in the bath safely.
- The IRS service refers Amy on the Integrated Case Management service for ongoing management of Amy's conditions.

The overall aim is to have:

- easier access and choice about how care is received by patients and improved patient experience. More people receiving care in their own homes.
- better packages of care tailored to a patient's specific needs rather than providing the same care to all.
- fewer potential risks from bed based provision e.g. risk of infection, loss of independence etc.
- decrease in inappropriate admissions to hospital, but anyone who needs a bed will have one.

Key themes from the workshops

A number of key themes emerged from the workshops , which have been summarised below. These themes have been collated from both the "question and answer session" and from the notes and comments taken from the tables. These were addressed directly by NELFT as part of the Q&A session.

What do you think of the changes?

- Overall participants felt that the changes were needed, however there was some concern that as the services were still fairly new it is difficult to see the real outcome. Participants were interested in hearing from patients who had used the services.
- Although the pilot has been running since before Christmas, not enough organisations or individuals were aware of the two services. It was felt there needs to be more publicity and awareness to ensure the uptake of services. Participants felt that services can then be monitored to see if they can cope with the demand.
- The presentation did not mention how voluntary organisations would be involved. Participants felt that there are some organisations who already offer support which could be useful in conjunction with the CTT, for example Carers of Barking and Dagenham offering support to informal carers and Independent Living Agency offering equipment.
- It was expressed that service managers need to be clear about the criteria for accessing the services for example would this service be offered to those in need of end of life care ? Also how long would patients wait to access the service?
- Participants felt that the changes could have a positive impact as long as the services are adequately resourced with staff and skills. It was also noted that there should be one dedicated person that the patient can be familiar with, similar to the key worker scheme.

Do people want to get home quicker with the right support in place?

- Overall the majority of participants agreed that people do want to get home quicker with the right support. However it was highlighted that there would be a proportion of people who would not want to go home, especially those who live alone.
- Participants raised concerns that the social and emotional needs of individuals have not been taken into account. For some individuals the only person who they will see will the professional visiting them at home. There needs to be something else in place so that the individual is not left alone 7 days a week with only short professional visits.
- Some patients may choose not to have care at home due to overcrowding and strangers coming into their home. What will happen to those patients will have a choice?

- Frequently mentioned was the involvement of informal carers and paid carers . How will carers be involved? What right does the carer have? Are their concerns taken into account?.Carers needs to be taken into account, some informal carers see it as having an opportunity to have a break when the person they care for are in hospital. All carers also need to be made aware whether to call 999 or the CTT. If this is not done then there is a potential risk of calls being made to 999.

- Often older people who are sick and alone are prone to panic and feel anxious during the night. This situation could be addressed by a visit or phone call by a befriending service and this could prevent the inevitable call to a health professional which might result in the person being taking to A&E.
- Are all homes suitable for home care?. Will a prior home assessment be undertaken? Some homes may be too small for certain equipment that may be needed for patients recovery. Will the standard of hygiene/cleanliness be taken into account when assessing suitability for home or nursing care?

Do the new services sound like the right ones?

Participants felt that the services sounded like ones that are needed to help keep people out of hospital, however the following concerns and questions were raised :

- There was a concern about personal hygiene. For example who will be responsible for domestic and personal care for those patients at home?. Whilst in hospital this is taken care of, but if neglected at home, it can also lead to risk of infection.
- Concerns were raised over people missing medication, who will give this if its needed four times a day? Or during the night? Patients need to be able to cope over night.
- Participants wanted to know if there would be support for palliative care or end of life care.
- There needs to clear guidance on who is responsible for what area between London Borough Barking and Dagenham, Clinical Commissioning Group and North East London Foundation Trust to ensure that the patient receives the best quality of care and there is no disputes in regards to responsibility.
- How are patients nutritional needs going to be meet?

Anything else?

- Participants felt that it would be beneficial to have an update session with the CCG and NELFT where participants would be able see the progress of the services.

- Although people may access the services through the GPs and hospitals, publicity needs to be wider. Participants felt that leaflets need to be distributed to public places for example libraries, care homes and cafes.
- Patients need to be involved in planning, designing, monitoring and evaluating to really make this service work.
- Who do patients talk to if they have a concerns or issues with the service?
- Participants were glad to see services working together although wanted assurance that services will continue to communicate effectively to ensure the smooth transition of the patients from hospital discharge to home and the pathway that follows.
- Medication was another area that was mentioned frequently. Clear information needs to be given to the patient in relation to the medication prescribed.
- How will patients with mental health be identified when they call the CTT. Will staff be confident treating patients with mental health issues if they are working alone? .
- Are mental health patients who currently access services through NELFT able to use the CTT service?

  NELFT Integrated Care Director, Caroline O'Donnell led a question and answer session that addressed a wide range of queries from participants in the available time and all questions/concerns were answered. This workshop was designed differently to those in other BHR CCGs as the CCG wished to cover a range of topics including intermediate care services. The report – including responses to key themes and 'conclusions' will be distributed via Healthwatch to all attendees.

  NELFT has made it clear that it is happy to respond to any outstanding concerns and has also committed to feed back further evaluation at the end of the services trial.

Conclusions

In conclusion the main themes to highlight are (please note under each theme there is a response directly from NELFT:

- More publicity is needed of the new services in community areas. Leaflets need to be distributed to libraries, care homes, pharmacies and voluntary and community groups.

Subsequent NELFT Response: NELFT has now produced an updated patient information leaflet with ten alternative community language versions. The services are currently seeing good numbers of referrals by GPs, by patients themselves and through the CTT teams in the acute hub (i.e. 76% not subsequently admitted).These workshops, being held across BHR, are part of the patient engagement work by the CCGs.

- Patients need to be involved in the evaluation process and be able to influence service delivery.

Subsequent NELFT Response: This is already happening. Patients are asked to complete an 'exit survey' on discharge from the service and NELFT carries out additional phone surveys with service users. Public/patient workshops and presentations at CCG patient engagement forums also provide opportunities to influence service delivery.

- Domestic, personal care and nutritional needs have to be taken into account. Will these be made available as part of the package?

Subsequent NELFT Response: Barking and Dagenham social care have been involved in the development of the new model to ensure these needs would be routinely assessed. There are clear pathways in place for this.

- How will overnight care be incorporated into the package, will a befriending service be available?

Subsequent NELFT Response: CTT has been designed to operate during the hours where there is greatest demand from service users in A&E- 8am-10pm. The CTT team is a multi disciplinary team and has a social worker within the team. In the full assessment process patients social care needs are assessed, if this reflects the need for overnight care this will be arranged with social care providers.

Is there sufficient money to fund demand of the service?

Subsequent NELFT Response: Yes. The current trial is fully funded. Commissioners will make decisions as to the future funding of the services following completion of the trial and further evaluation of outcomes.

- Carers may need support to identify whether to call the CTT or 999.

  Subsequent NELFT Response: *There are clear pathways in place between LAS and CTT. In an emergency situation carers should always call 999.*

- Will all homes be considered suitable for the delivery of the service.

  Subsequent NELFT Response: *The services are delivered in homes as appropriate based on the care needs of the patient.*

Comments from the workshops made by participants

"It's great to hear some new developments in services and I'm very positive about things going in the right direction'
B&D Patient Engagement Forum member

"As long as the service is adequately resourced, with staff and funds the changes could work"

"Voluntary organisations can support social care needs"

"Intensive rehabilitation is a good idea but what happens after 3 weeks?"

"Some patients would rather be in hospital then at home"