# Admission Avoidance and Supported Discharge Whole Systems Review

November 2020

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# Executive summary

## Background and Introduction

Between 2014 and 2016, Sonia Bussu and Martin Marshall from University College London Hospital (UCLH) undertook a two-year qualitative evaluation of The Waltham Forest, East London (WEL) Integrated Care programme. A major component of this work was an in-depth study of patient pathways across multidisciplinary teams from acute, community and social care to understand collaboration, and identify sustainable organisational development strategies.

One such pathway focused on Admission Avoidance and discharge from hospital, and the findings of this research were shared in June 2018. This research focused on service provision and integrated ways of working and did not include feedback from patients or THT partner organisations. The Patient Experience Team (PET) aimed to build upon this work and review the extent to which the overarching themes identified have been addressed.

It was agreed that in addition to talking to staff directly involved in delivery of AADS type services, the review would also include service users and carers , and a wider group of stakeholders across THT and the TH Community to find out what works well, reasons for effectiveness, what doesn't work so well, and identification of potential opportunities for improving anticipatory interventions, prevention of ill health and promoting wellbeing across the whole system.

In January 2020, the first draft of this review was due to be sent to participants for comment, but while preparing the draft, the Coronavirus Covid-19 resulted in suspension of the work to focus on supporting partners in THT to contact Shielding Patients. This final version has been completed in autumn 2020 with additional comments added reflecting on some of the challenges and opportunities faced in Tower Hamlets since the pandemic.

# Executive summary

- Improve opportunities for prevention and awareness of the importance of maintaining health and wellbeing from the earliest possible age.
- Facilitate ways of linking more people into the various health and wellbeing Life Course work streams, particularly at operational level, and create productive partnerships with people with lived experience
- Encourage take up of opportunities to promote wellbeing across the system at all points of contact
- Promote a consistent message across the whole system about self-care, reinforcing the importance of accessing support in a timely way to prevent problems that may lead to otherwise unavoidable hospital admission
- Work in partnership across the system to develop a relationship based on honesty and trust in order to manage service user / carer expectations and promote understanding of the challenges and opportunities faced
- Promote a relationship that enables timely access to appropriate advice, referral or signposting to preventative interventions while encouraging a sense of responsibility for managing our own health
- Improve Health Literacy and shared decision making to increase knowledge, tools and skills needed to manage our own health in an effective way; acknowledging that low income, stable and suitable housing, environment and access to employment can all have an impact on health and wellbeing
- Improve information sharing systems as appropriate across the pathway to ensure IT recording systems used by partner organisations are mutually accessible
- Raise awareness across the system of the Rapid Response team role and how it works with the PRU function to ensure the teams are being used appropriately

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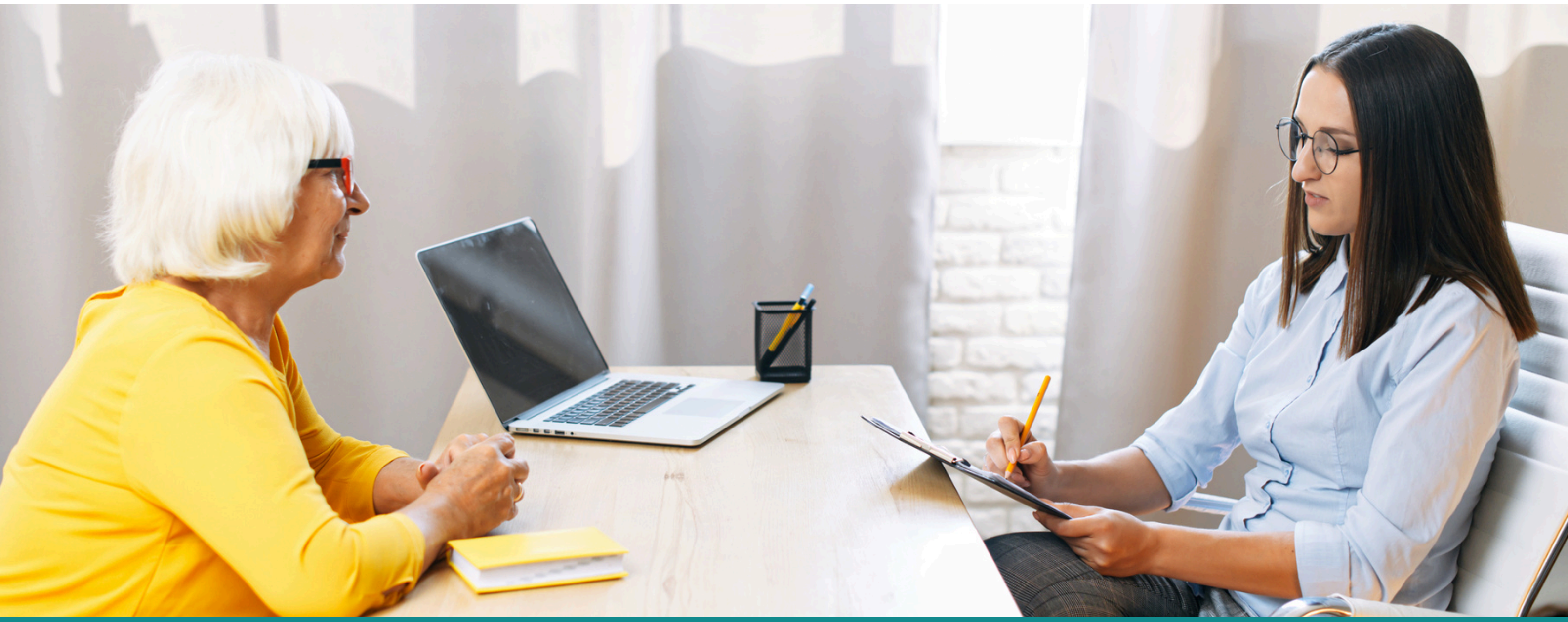
- ·Invest in Voluntary Sector support services to help to ensure that people assessed as being low risk are signposted to and/or supported appropriately and in a timely way should their physical or mental health change
- Explore joint funding between community and acute trust for the OPAT Pathway, in-reach nursing team and a Discharge Coordinator role to work across organisational boundaries to ensure seamless provision of support and promote cooperative cross organisational working to inhibit competitive and unproductive relationships

# Executive summary

## Methodology

The main methodology used was qualitative using discovery Interviews. These are one to one semi-structured interviews using a 'spine' of questions as developed by the Coronary Heart Disease Collaborative of the NHS Improvement Agency. This methodology allows people to direct the interview according to their own priorities rather than steering the interview in a directive way. There were also facilitated group discussions and a Process Mapping session, and thematic analysis was used to understand the key messages from in-depth interviews. Analysis of data relating to LOS and cycles of repeated admissions pre and post AADS interventions was also undertaken.



# Key recommendations

**Recommendation 1:**

Prevention Working across partners to promote good self-care and provide timely screening, advice and information to enable people to manage their health.

**Recommendation 2:**

Health promotion messages and access to support should be focused on realistic and honest communication about what is available across the system

**Recommendation 3:**

Promote consistent messages about what support is available across the system to aid management of expectations

**Recommendation 4:**

Integrated approach to training to ensure staff have the skills to assist the community in maintaining health, and to understand early signs of ill health, and ways to signpost people to access help should health decline

**Recommendation 5:**

Adopt an asset based approach to investment in preventative strategies such as ensuring procurement of TH services in partnership with local providers with relevant skills, insights and knowledge of the local community, e.g. consider funding Ability Bow in a more sustainable way in recognition of the preventative role it plays in supporting patients

**Recommendation 6:**

Invest in developing cooperative and constructive partnerships across agencies providing anticipatory interventions to counter relationships perceived as competitive and promote seamless care

**Recommendation 7:**

Learning from those who have developed and maintained healthy lifestyles: harness the knowledge and experience of local people to influence and support others

**Recommendation 8:**

Enable more effective appropriate access to IT recording and information systems used by the different partner organisations

# Key recommendations

**Recommendation 9:**

Increase equipment available on wards (e.g. number of riser recliner chairs and commodes) to promote rehabilitation and support a return to optimal levels of independence and review current practice around recycling and reusing equipment

**Recommendation 10:**

Build on the QI underway on 14th Floor at RLH to develop, explore and resolve barriers across the discharge process, increase engagement and joint attendance at.

Forums and continue to improve cross-organisational integrated working as was being addressed by the Urgent Care Working Group sub-groups before the pandemic.

**Recommendation 11:**

Involve psychologists in designing services in a way that acknowledges some of the behaviours that can challenge uptake of lifestyles promoting health and wellbeing

**Recommendation 12:**

Explore options around upskilling and educating ward staff in caring for people with learning disabilities to promote smooth discharge from hospital

# Introduction

## Context

It is widely acknowledged that there is a need for a joined up or ‘whole systems’ approach to prevention of avoidable health problems, admission avoidance and the benefits of timely liaison with colleagues in other parts of wider health and social care providers to help ensure that health and wellbeing is seen as a concern and responsibility of everyone. There has also been a consensus that joined up approaches are key to ensuring that any changes implemented in one part of the system do not adversely impact on capacity and demand elsewhere in the pathway or system. Key to these discussions are the inclusion of those with lived experience. This need for a whole systems approach was brought firmly into focus when faced with the additional challenges resulting from the pandemic.

## Objectives

To examine awareness of role and function of services and their contribution to prevention of admission, perceptions of effectiveness and how the services work in an integrated way across TH. To look at referral systems, access to and types of services and support available to promote wellbeing and prevent avoidable admission across the health and social care sector. To seek the views of service users, carers, citizens and those working in TH regarding how they maintain their health; identification of gaps in or access issues relating to existing provision, what is working well and what requires improvement.

Participants
In the course of the review, 48 staff (Commissioners, providers and clinicians) took part in 1:1 interviews.

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These were:

Joint Director of Clinical Commissioning, Barts Health Chief Nurse, Barts Health Ward Manager, Barts Health Community Neuro Team Manager, Barts Health ARCaRe Manager, Barts Health ARCARE Admission Avoidance Lead, Barts Health Director of Operations and Transformation, Barts Health Senior Physiotherapist, Barts Health Children’s Specialist Asthma Nurse, PRU Manager and London Ambulance Service Lead, Barts Health Head of Complex Discharge Team, Barts Health Consultant Community Geriatrician, ELFT Foot Health Manager, ELFT Care Navigation Manager and Senior Care Navigator, ELFT Learning Disabilities Lead Nurse, Senior Occupational Therapist: Dementia Specialist Care Home Liaison Team, ELFT Mental Health Crisis Line Service Manager, ELFT Senior Manager, PAS Nurse Consultant, ELFT Clinical Lead Admission Avoidance & Discharge Service (AADS), ELFT AADS Rapid Response Nurse, AADS physiotherapist, AADS Senior OT, AADS Deputy Clinical Lead, ELFT Clinical Lead Triage and Assessment Team, LA OOH Senior Practitioner Social Worker for AADS , LA Service Manager – Initial Assessment & Hospitals Adult Social Care, LA Service Manager Hospital Social Work & Reablement, LA Commissioning Manager Integrated Commissioning: Ageing Well Health, Adults and Community Services, GPCG Social Prescribing Manager, GPCG OOH/SPA Lead, Interim Manager Alzheimer’s Society Tower Hamlets, Healthwatch TH Director, Age UK Take Home and Settle Lead and Hub Coordinator, REAL service manager, and Zacchaeus Project Lead.

# Introduction

## Methodical Apporach

A qualitative methodology was used to gain patient experience data in this evaluation because of the opportunity it provides to engage in direct dialogue with respondents and to unpack their views. In qualitative research, the main interest lies in identifying and describing the range of issues, themes, views or experiences and the relationships between them, rather than counting or estimating their prevalence. The work is in-depth and detailed as opposed to standardised and large-scale. Sample units are thus small since there is a point of 'diminishing return' where increasing the sample size no longer contributes to the evidence. Thus, the sample does not need to be large enough to support statements of prevalence or incidence since these are not the concern of qualitative research. It is also impossible to do justice to the richness of the data yielded if the sample is large-scale.

In the case of this study, a qualitative methodology was able to:

- Provide an opportunity for patients/carers to tell their stories and experiences
- Enable an understanding of the themes from both a provider and user perspective
- Allow an exploration and ‘unpicking’ of the different factors that have created either previous positive or negative experiences/opinions and how they might be interlinked
- Provide a mechanism through which aspects of service provision can be explored through the perspectives of health and social care professionals, citizens and service users and carers participating in the review
- Enable an understanding of the nature of the role of the THT partners /third sector in the process; and
- Enable an understanding of the interplay between health, social care and voluntary sector professionals and patients/carers in relation to self-care strategies.

It was considered that the most suitable qualitative methodological tools for this project would be individual in-depth interviews.

# Introduction

## Data Collection

The Patient Experience and Discovery Interview team undertook the discovery interviews which were digitally recorded and transcribed by an external provider

In addition to these interviews, a Process Mapping session was held at an early stage of the review in summer 2019 which enabled an overview of current state and processes, the extent to which the recommendations from the previous review had been implemented, and also focused on the learning and potential future state, which helped consolidate the current set of recommendations.

177 service users, carers, citizens and those with lived experience shared their views. Of these,14 took part in face to face 1:1 interviews, and 83 participated in telephone interviews. A further 80 participants shared their views in the following local focus groups: Arthritis Support Group, ELFT Working Together Group, MS Support group, 2 Singing for Breathing Groups, Create Coproduction Group, Sonali Gardens Older People’s group and the Older Peoples Reference Group.

## Data Analysis

Existing research and evidence was read and analysed. Process mapping enabled identification of key issues and individuals were then contacted, and transcripts of interviews were thematised and informed the recommendations in the report.

## Limitations

The demographic in Tower Hamlets and the limited resources of the team meant that there were some communities who were excluded from the direct interview process e.g. Chinese, and Vietnamese, although the views of organisations working with these communities were sought.

# Discussion: Preventative approaches

## Staying well and self- management strategies

One of the facilitated discussion groups took place with the Tower Hamlets Older Peoples Reference Group (OPRG), who are a well organised and confident group of local residents, some of whom are living with long term conditions, and others who are very active and healthy. The membership of the OPRG tends to be predominantly people who have spent their working lives in public services or have been active campaigners, so the levels of confidence in expressing views and awareness of issues was more evident than in some other groups.

There was consensus amongst the OPRG around core strategies for maintaining health and wellbeing and during the discussion and workshop the group compiled a list of the factors they felt were key to good self-management. This included the crucial role of diet and food poverty and access to appropriate housing were issues that the group highlighted as potentially impacting on health and wellbeing. Engaging in physical activity, whether through joining in organised activities or classes, or through unstructured activity such as walking was also seen as key. There was agreement that keeping the brain active was also vital to wellbeing and some reported participating in solo pursuits such as crosswords or group activities such as quizzes, with the importance of avoiding boredom and isolation being emphasised. Although some of the issues identified by the group were unsurprising and reflected general perceived wisdom around key components of health and wellbeing, the identification of the importance of feeling connected to other people emerged as a key element in discussions with those who contributed to the review.

# Discussion: Preventative approaches

## Staying well and self- management strategies

There was widely held recognition of the positive contribution made by social prescribing in enabling people to link up with others and access group activities which in turn provided a social focus and enabled people to combat loneliness. This sense of being part of a vibrant and active community was identified as playing a crucial role in overall wellbeing and contributed to reported ability to overcome some of the challenges of living with long term conditions. As an OPRG member shared:

> “There’s lots to consider about ways of maintaining health such as mobility, dexterity, vision, physical capabilities and all of that is linked to being ‘well’, but if cuts are made to preventative services, it can makes ones health deteriorate, and if you aren’t getting basic care and support, this can eventually become a major issue and lead to other complications and support needs. There needs to be more cross-organisational communication around costs and benefits when making changes to services.”

The OPRG membership also demonstrated a high level of awareness of the benefits of joint decision-making and health literacy, and being part of the group had clearly impacted on levels of awareness of such issues through presenting opportunities for dialogue and discussion, in turn helping less confident members to gain skills around asking questions and making informed choices. As a group member asserted:

> “People should challenge their medicines with their GP and query whether all are necessary, as some people are on lots of repeat medicines which they probably don’t need to be on, so there need to be regular medicine reviews.”

# Discussion: Preventative approaches

The OPRG illustrate well the concept of what the King's Fund refer to as 'patient activation'; linking to all the principles of person-centred care and enabling delivery of a form of personalised care that supports people to recognise and develop their own strengths and abilities. This model links directly to the work ongoing across Tower Hamlets integrated care pathway, and led by the Local Authority, where a series of Life Course workstreams (Being Born and Growing Well, Living Well and Promoting Independence) meet regularly to discuss issues with a particular focus on how these are impacted on at different life stages in a holistic way, enabling stakeholders to take account of challenges around environmental factors, housing, poverty, transport and accessing health and social care support, while capitalising on the existing strengths and 'assets' that exist within communities. The Kings Fund identified that this enables an asset-based approach that supports people to develop their capability to manage their own health and care by giving them information they can understand and act on and providing them with support that is tailored to their needs.

While many of the workstreams have continued to meet since the pandemic, the meetings have moved to being virtual, an so only digitally connected members are able to participate, which is a theme that has emerged as one of the key challenges to inclusion.

During discussions with a variety of groups, lack of opportunities and what one group identified as 'support to venture outside the home' were regarded as both isolating and potentially leading to health issues such as obesity. Added to this, challenges faced around using public transport resulting in limited access to local community centres offering a way in to a social network were identified as potentially contributing to a 'downward spiral of ill health', so provision of preventative opportunities was felt to be crucial and seen by citizens as an important focus of investment in order to help people to maintain wellbeing.

# Discussion: Preventative approaches

Another clear message was that challenges around accessing GP services when needed had led to some participants feeling they had no alternative but to go to ED, and it was felt that investment in primary care is key to prevention of unnecessary attendances at ED and UTC and potentially leading to avoidable admissions. This has been further exacerbated during the pandemic when many appointments were offered as virtual consultations, and some patients reported feeling that they lacked the reassurance that a face to face consultation might offer.

A facilitated discussion with members of the Arthritis Support Group, a patient led group that meets monthly in a local community centre, identified similar concerns about access to suitable housing and timely provision of aids and adaptations to enable people to remain independent and safe while living with decreased mobility. One of the participants spoke about the importance of establishing good rapport with a professional in order to get some support in finding solutions, and the challenges of high staff turnover.

> "It took us two years to get the shower…. a wet room. First, we had the physio and the OT, and it often feels like it can depend on the person involved. There are some good people who will push things through. But once they've moved on it's very difficult then to establish another relationship with somebody else".

Another Arthritis support group member talked about their determination to stay active and the clear sense of responsibility they felt for ensuring they maintained as much independence as possible.

> "I do exercises, and we haven't got a car, so I just walk everywhere. Up and down 16 stairs all day. We do exercises here in the group too, and I do Pilates which has helped my neck, my shoulder, and my knee. I went swimming last week as a couple of local baths have got a good deal for older people. Poplar baths is good. Lovely hot showers there. Two days a week they offer it free, and if you've got disabilities, they have equipment".

# Discussion: Preventative approaches

The inability of this group to continue to meet during the pandemic, and limitations to access to leisure services will no doubt have impacted on this patient group's ability to remain active and fit.

The Coordinator of the Zacchaeus project, a local church based organisation which hosts the Arthritis support group, spoke of how the overall vision for the centre is focused on providing opportunities for people to engage in enjoyable activities that have health benefits as well as providing a social element:

> "Pre-Covid 19 we provided a wide range of activities. We did line dancing and ballroom dancing, Keep Fit twice a week, and a City Sights walking group. We often went to the Sky garden at the top of 1 Fenchurch Street, and for walks through Victoria Park, down the canal, down to Broadway market, through London Fields, into Hackney Weatherspoon's, then got the bus back. We would keep off the main roads, to avoid pollution and a man from the Walk East group came to support it. There is also a cycling group, as well as a BreatheEasy group Monday and Friday run by the ARCaRe team".

As part of the review, the team also met with the inspirational members of the Singing for Breathing Group, many of whom have COPD, although a few of the original members have asthma. This group aims to attract people completing the 12-week pulmonary rehabilitation course to provide an ongoing opportunity for them to receive exercise and support in a social setting. Participants described it as a real 'life saver'. The following comments demonstrate the value placed on the sessions.

> "I've never had a hospital admission since I came to this group. I've got COPD and asthma as well. If I hadn't have done this, I'd have been in A&E. because I couldn't breathe. But I had the confidence to know I could breathe so I sat quietly on the bed and concentrated on my breathing".

# Discussion: Preventative approaches

"I use my lungs much more efficiently. 2 or 3 weeks ago I was wheezing away like a harmonica and was that short of breath that I didn't know what to do and didn't know if I needed steroids- but I learned how to get air in my lungs through this group".

The group met weekly with a core group of around 12 participants. Some people described how they had initially been resistant to attending an exercise focused class as their breathing difficulties made them doubt their capacity to take part, but they delighted in sharing how the Singing for Breathing Group helped them on so many different levels.

Some people in the group talked about the tension between wanting to attract more members (as they felt so passionate about the benefits) and the advantages of having a smaller group which enabled real friendship and support to evolve. It was felt that they preferred to resist being called a 'singing group', as they felt this fails to accurately reflect the amount of commitment and work that participants invest to build their lung strength. As one member explained:

"We don't like the idea we are a singing group as a big chunk of the session is the breathing. In a choir you might spend up to 10 minutes doing breathing exercises but here it's at least 30-40 minutes of exercise. The singing bit is the fun add on…. although the exercises are quite fun too!"

The Singing for Breathing Group is an open access group so referrals are not required, and while initially people may be very conscious of the challenges of the exercises, as the sessions evolve and the focus becomes the singing, people acquire a sense of where the power or 'supported breath' is coming from, and the enjoyment of singing in a group setting becomes the source of much enjoyment, as the facilitator explained:

# Discussion: Preventative approaches

> “The actual business of singing addresses so many issues and has multiple outcomes; it connects people; it stimulates memory and makes people form connections with other songs. The supported breath and the outbreath are the important factors, and we have data to evidence that those who join the group visit the GP and ED less often.”

“Singing for Your Life” is a similar group which provides weekly classes from Newby Place Health Centre and is funded through a group of people with a variety of lung conditions pooling their personal health budgets to employ a facilitator. This innovative group is accessed via referral only, but has a strong sense of ownership and, again, people described it as a lifeline.

> “I’ve been coming here for a year or so. It gives me a different way of life. Everybody knows each other; it’s more like a club. I’ve been like this for 12 years. I got a certificate for the Pulmonary Rehab course 12 years ago, then tried Tai Chi and physical exercise and walking, but for me there’s no comparison. This is much better. You’re not alone; there are other people to talk to with similar conditions. We made a video and I called this ‘my happy hour’. It’s the fact its ongoing and you don’t have to leave after a certain number of weeks that makes it better”.

This group continued to meet virtually throughout lockdown with all participants taking up the offer to attend. One group member was digitally excluded so continued to take part using their landline. This provided a quite different experience but was still highly valued by the individual.

# Discussion: Preventative approaches

Another innovative project emerged from a shared concern that a group of women were declining the offer of physiotherapy opportunities that could greatly promote their independence and lead to fewer hospital admissions. In a reflective practice group facilitated by an ELFT psychologist, a physiotherapist identified a cohort of housebound Bengali women in their 30s to 50s who had all disengaged with therapies despite often receiving multiple referrals back to the service after discharge. Most of these patients lived with a pattern of chronic ongoing pain; often with a diagnosis of fibromyalgia, and feeling unable to do much, with the result that they rarely left home, apart from to attend health related appointments.

After identification of a common theme of low motivation and possible low mood, the psychologist and physiotherapist decided to offer a pilot project as a way of exploring how to increase motivation and engagement. After mapping the support system around the women, it was clear that they were known by but described as 'not attending' many existing services. Often for these women English was a second language or English wasn't a language, but the project team identified that it was about more than accessing support. The team "flipped the problem", so rather than seeing the non-engagement as the issue, they instead acknowledged that they were not offering a service that was meaningful to these patients, so embarked on a journey of discovery around what could be offered that had physiotherapy elements and incorporated some psychology as well.

The project that evolved was a gardening activity that enabled the women to move and strengthen their legs, while not being solely focused on exercise. The overall benefits of gardening are well documented in terms of enhancing and creating wellbeing, so the project leads negotiated a community space for the pilot and brought in occupational therapy as well. The team discovered as they started talking about being in the outdoors, the women started to engage and develop trust.

# Discussion: Preventative approaches

Working in partnership with Spitalfields City Farm where there were already raised beds, the women began to attend the sessions, and, as many had been born in Bangladesh in a rural setting, they shared deep connections with the earth and growing things. The project leads also had a passion for gardening, so they too experienced a great sense of satisfaction from their involvement.

> “The women came many times because it was meaningful, and they knew their bodies. We made sure, that we called them every week, and involved a care navigator too, as we were interested in what would happen after the pilot ended, so we were quite well-resourced …and we found that our staff wellbeing greatly improved through being involved too”.

Outcome measures included flexibility, strength and achievement of self-identified goals  with an emphasis on understanding why the women were coming to the group, when previously they hadn’t engaged. The narratives that emerged were more around abilities, so while pain was acknowledged, the women felt that being somewhere where they could express and devise coping strategies was what was important to them.

The project leads ensured that they were aligned to what was described as ‘an Ethos of Ability’ where it was acceptable for someone to say they were unable to participate and where there was awareness and responsiveness to someone feeling tired. At the final session there was a celebration where the group cooked food outside using the produce they had grown. There were strong elements of coproduction in evidence, and when the group ended the women expressed sadness, but the project leads had prepared them for the time limited nature of the project, and many of the participants went on to join an established cooking club based at the same farm.

# Discussion: Preventative approaches

"I think our pilot was important in benchmarking something for these women around building a platform of trust and safety, and the fact that we did take them seriously, and wanted to help".

Another positive outcome of this pilot (which had planned a second group to start in April 2020) was the establishment of the partnership forged with the facilitator of the Cooking Group and with the farm. A key component to the success of the project was identified as the high-level buy- in from ELFT senior management to support an initiative that would take staff away from the day to day work and allow some creativity and autonomy that was not wholly target driven. There was recognition that this opportunity was not open to all staff, and learning from this experience, given the degree of satisfaction reported by those involved, it could provide a useful template for others to experiment with similar initiatives involving a wider group of staff.

# Discussion: Preventative approaches

## Pro-active organisational approaches to prevent avoidable admission and promote safe discharge

The AADS team has gradually evolved over time, and a partnership approach has been embedded whereby the Community team works closely with the Local Authority and the RLH, including development of a joint policy around a community IV service.

One of the issues with the AADS team remains its relative invisibility, which was acknowledged in Sonia Bussu's report and remains a challenge. As a team member shared:

> "It can be hard to evidence our impact, as giving some advice or changing a conversation, how do you evidence that? Lots of people may have contributed to the discharge, so we can show that we influenced it, but it is not a scientific thing, you can't say that a discharge happened solely because of one team in many cases".

A suggestion that came out of Sonia Bussu's report and which remains as yet unaccomplished was to undertake a return on investment or ROI' to evaluate the monetary value of the service when compared to increased length of stay (LOS) resulting from delayed discharge. There is a belief that the amount of money being saved by interventions made by In-Reach nurses within AADS, whichenable people to be safely discharged could potentially demonstrate their value when comparedwith replacing Band 7's with Band 4s who may be less effective in facilitating discharge. However, to gather the data to evidence this requires a significant investment in time and, both pre and during the pandemic, it is hard to free up individuals to spend time looking at this calculation, as well as overcoming the challenge in accessing data that may or may not prove compelling enough to enable informed decisions to be made about staffing.

# Discussion: Preventative approaches

What was described by one interviewee as the 'the competitive culture' at the Royal London Hospital may also contribute to there being more interest outside of the borough in what the TH AADS team are achieving, with the team being consistently held up as an example of good practice and asked to present at mainly local authority led conferences nationally. As the local authority can more easily identify the benefits of the AADS role in relation to their spend on long term care, there has been much LA interest in the work, with the AADS Lead nurse co-presenting with the LA Hospital Social Work Lead at a number of national and London-wide events, although less often approached to speak locally.

A cross organisational evaluation of the specifics of the value of the teams as part of this review would have offered an opportunity to look at the financial benefits of the roles but would depend on having access to data and systems across the partnership and would have resulted in the scope and focus of the review taking a different direction to that agreed by the THT Board. It was suggested by a number of managers across organisations that if the service was funded through joint commissioning, it might enable the focus to be more on achieving the right outcome for the patient, and enable a joint budget to be agreed to fund identified needs.

The allocation of the (now defunct) Improved Better Care Fund (IBCF) was made jointly to health and social care, and there is evidence to support that this did help promote joint working by necessity. However, if money for a specific post was ringfenced, there was felt to be little scope for discussion about how effective the role might prove, and by the same token, no evaluation undertaken of the value of a post when the money stopped. This was seen by some as a missed opportunity as was an IBCF bid to expand the AADS service which was submitted by the LA. A relatively successful piece of partnership work has been the AADS led Discharge Forum, held at the RLH to encourage participation by ward staff. However, participation by partners was not equal or consistent so led to disengagement in the process.

# Discussion: Preventative approaches

The capacity of the AADS team to spend time raising the profile of the service is limited, and frontline service provision is understandably regarded as the priority, but there is a sense amongst some team members that if all partners were to acknowledge the true value of the service, and invest in it jointly, this could have a real impact on the capacity of the team.

The AADS Team were however supported by the NHS England Emergency Care Improvement Programme (now ECIST) to enable and support staff across the acute and community pathway to rethink, challenge and behave differently in the management of risk and devise effective ways to support safe and timely discharge.

ECIST have participated in a number effective events, bringing together groups of staff across the system including community staff, ED staff, doctors, consultants, and nurses, and key questions were raised while looking at a snapshot of patients who were in ED at the time, asking participants which patients they would consider admitting, and this enabled the community teams to explain how these patients might instead be supported at home, thus effectively raising awareness of the various roles and functions within the community.

The pandemic has led to an increase in adoption of a joint approach to discharge, which will be discussed at the end of the review, and similarly, the winter pressures budget awarded to Barts Health offers an opportunity to invest in services at the interface between acute and community services.

# QI work to prevent delayed discharge

"We wondered how we could reduce the length of stay across both of the older person's wards, so looked at why patients often stayed for much longer and identified four main reasons. One was a squeeze on social services funding; another was people waiting for nursing home placements; issues around funding when people were waiting for assessment and then finding a placement or 24 hour care. And the fourth issue was about family conflict".

It was identified that often patient's families would often only be informed about discharge plans the day before they were due to go home; potentially creating anxiety and conflict. Families and patients may be risk averse and concerned about the level of support being planned on discharge, having spent some time in hospital, and issues around communication may mean ward staff only identify practical issues such as security (e.g. a door being broken to gain emergency access, or utilities having been cut off) shortly before the planned discharge. These complex situations may take time to sort out and lead to an avoidable delayed discharge, so the QI project team revisited the existing discharge planning tools to ensure that such issues were identified and addressed early on.

"We saw a number of tasks that need to be done to prevent delayed discharge, so we revised the discharge checklist. Markers on the board act as a visual prompt, with amber indicating the patient is going to go home the next day, and all tasks required to enable the discharge to take place being highlighted. The next day the board is changed to green to indicate the patient will be able to go home, with another green checklist to highlight all the tasks needed to be done on the day, such asfind the door keys, and all the detail that can get overlooked".

# QI work to prevent delayed discharge

The QI team also measured how many patients who had been Amber progressed to Green the next day, and how many of these went home. It was identified that initially the checklists were used quite sporadically, often only shortly before confirmation that a discharge was going ahead, and staff would not routinely be thinking about what needed to be done in advance. Reasons for this were primarily due to the challenge of having no one individual person identified as responsible for actioning the tasks associated with preparing for discharge, and the check list of tasks often fell to the nurse looking after the patient that day, which meant it was easy for the preparatory tasks to be overlooked. Issues such as transport were also identified as a challenge, with the transport officer reporting that over 90% of transport was being booked on the day of discharge which was proving unmanageable in terms of forward planning. Transport is now included in the list of tasks for the Amber day, as the transport team confirmed their preference for a cancellation over a later eferral.

The QI team have also been careful to monitor that decreasing length of stay has not impacted on readmission rates, and pre-pandemic data supported that this remained static. Another issue identified as problematic is residential homes reluctance to accept residents back after a long stay in hospital. Reasons for this may now be if they require two people to assist them, or if there had been previous concerns about their level of care and support needs prior to the admission.

The Discharge to Assess CHC Pathway was introduced in Autumn 2019 (which differs from the Discharge to Assess rehabilitation model and discussed later). This pathway was introduced to ensure that the CHC specific assessment is carried out in the community rather than on the wards once patients are deemed medically fit for discharge, and if there could be a delay in undertaking itwhile an in-patient. The CHC team now provide staff to undertake the necessary checklist and paperwork to speed up the process of discharging patients to enable theassessment to take place out of hospital. This is a DOH target and is regarded as best practice as itcan both take considerable time to carry out a robust assessment, and if undertaken at home or in the place the person is discharged to, enables the assessor to gain more insight into how people are able to manage once in a community environment.

# QI work to prevent delayed discharge

The D2A DoH model supports patients to return home as soon as they are medically optimised and uses statistical and case study evidence to support that patients thrive better when they are assessed and treated in their home environment rather than in hospital. A recent webinar hosted by the Bromley by Bow Centre included a contribution by Dr Sam Everington where he referenced the data that demonstrates that for an 80 year old, 10 days spent in a hospital environment can lead to 10% loss of muscle strength, which is equivalent to losing 10 years of physical activity, which in turn can impact on life expectancy. However, citizen knowledge about the model appears patchy and through discussions with groups, it is evident that there remains limited understanding of the context behind the model, with D2A sometimes being perceived as a cost saving exercise rather than being in the best interests of patients. This suggests that further efforts to raise awareness of the benefits of the model might help people better understand and therefore support the positive outcomes of timely intervention.

The need for a whole systems approach to supported discharge has been one of the issues identified by the QI discharge project, with an awareness of the pressures resulting from reduced resources being available. This is also being addressed by the Urgent Care Working Group (UCWG) which is chaired by the chief executive at the Royal London and made up of senior partners from Social care, ELFT, and with input from the CCG. The group meets monthly to support improvement initiatives.

As evidenced in the QI study, the diminishing LA resources have led to some of the longest stay patients waiting to go home with 24 care, and these people with extremely high support needs are in danger of being readmitted if discharged without 24 hour care packages. Patients may not feel ready to accept residential or nursing care, so intensive packages of support at home can enablepeople to reach a point of acceptance that they need additional care. The ward teams feel generally able to predict who is at risk of bouncing back into hospital, and it has often been those who priorto their admission only received a once a day package of care.

# QI work to prevent delayed discharge

This can make it difficult to place such patients in residential or nursing homes straight from hospital as it is not known whether, had they received the maximum available community support, they may have managed to remain in the community, so efforts to access optimal levels of support before placing them would first be made.

The RLH or OPS QI project is still in progress and the team continue to collect the data. One focus pre-pandemic was the ‘ticket home’ whereby a folder to be kept by the patient’s bedside for the patient and relatives to read and populate was being piloted; thus, working in partnership while avoiding yet more responsibilities falling to the nurses.

> “The folder is individualised so if someone has come in with a fall, we can provide them with all the Falls Prevention Leaflets we have, or if someone has got dementia or delirium, we can put in the relevant information and key contacts and say to families and relatives ‘please look in the folder and if there are any other questions you have, then contact the relevant people’. We also include details of the physio and OT involved, their consultant and other key people to open up a bit more communication with families, including an estimated discharge date to introduce the idea of planning and enable timely discussion with the family”.

Another aspiration of the QI Team was to create and make available a ward email address, with an emphasis on information-giving rather than to encourage patients and relatives to use it as a forum to ask questions. This pilot was introduced during the height of the pandemic when there were very strict limitations on family visits, and under the ‘FamilyContact Centre’ gave email access via PALS and Patient Experience to link family members directly to the clinical team caring for their relative. The questions raised would be answered within one day and this has proved popular with both relatives and clinicians, the latter being relieved to only have to answer questions relating to a patient once while under extreme pressure, so this initiative is to be rolled out across the Trust more permanently.

# QI work to prevent delayed discharge

In addition, the wards involved in the QI were in the process, pre-pandemic, of introducing a ‘courtesy call’, whereby any member of the team contacts the next of kin on a rota basis to inform them about basic information such as the ward name, bed number and visiting times to proactively introduce themselves.

> “This could be done by a nurse but equally could be the junior doctors, physios, OTs, social workers, dieticians, speech and language therapists… really if shared across the MDT nobody should have to do more than one or two phone calls a week”

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The wards involved in the QI also acknowledge the need to refer to the AADS team as early as possible to ensure more timely opportunities to prepare the appropriate support required for safe discharge.

> “Ultimately, our aim would be to get a ward discharge co-ordinator role reinstated, so we would have a designated person to tie up all the loose ends, because it’s a full- time job”.

This sentiment was shared by the Complex Discharge Team manager who went a step further and suggested the creation of a Discharge Coordinator post at the interface of acute and community tooversee all discharges at the RLH

# AADS Discharge to Assess

When Discharge to Assess or D2A services were initially piloted via the Home Support Pathway, they were able to support patients to return home with an interim package of care for a limited amount of time, even if there was a temporary need for overnight or 24-hour support, and occasionally until a suitable placement was identified. Funding for this social care element was through the Better Care Fund which ceased some time ago. The AADS role changed in response to this pre-pandemic had a Senior Nurse, and a physiotherapist who work in an integrated way with an OT from the Local Authority Reablement team. The team recognise that interpretations of rehabilitative potential can vary, and this can sometimes result in a difference of opinion across the team.

> "Admission avoidance, under D2A, provides support in a flexible person centred way, even where there's no clear rehab goal, where the focus may be more on safety, bearing in mind we are facilitating discharge and we are preventing them from getting readmitted, so it can be challenging, because Reablement have a far stricter set of criteria…"

The AADS team acknowledged the challenges faced by Reablement in relation to their commissioned function which means that occasionally, even though individual team members may see the benefits of working with somebody to help them reach an optimum level of independence with additional input, they cannot always be that flexible while adhering to their eligibility criteria. However, as the teams have become more integrated, there is a sense of mutual support and respect and one team member described the relationship as being 'increasingly harmonious'.

Another element of the D2A pilot that is no longer available to the teams were three dedicated step-down flats in Sue Starkey House, an extra care sheltered facility, and although there are still some step-down beds available, these are not dedicated AADS placements.

# Initiatives in Housing

In non-Covid times, in recognition of the need for a longer term more sustainable approach to maintaining independence, there have been some developments in supported housing to prevent readmission to hospital, through investment in extra-care sheltered, nursing and residential care homes. The LA have furnished several flats in a couple of extra-care schemes should people require additional support with an element of hands on care funded within the contract. Placements are set up by the hospital Social Work team to support people who may be clinically optimised, but who, for a variety of reasons, are unable to go home. This could be due to lack of confidence as discussed previously, or because of the unsuitability of their existing accommodation. As the LA Commissioner for Supported Housing explained:

> “One person was a hoarder who needed the flat to be cleared before they could safely return, and that can take some weeks to arrange. The first person to be placed wasn’t an older person but someone who had been in a road traffic accident (RTA) and couldn’t go back to their existing tenancy so went into the flats so their ability to live independently could be assessed. AADS Physiotherapists and Reablement team assessed the level of support needed in the longer term”.

The challenge of preparing people in interim housing for the move to permanent accommodation, whether a return to their previous home or to more suitable housing, can be a challenge, and these patients are often referred to AADS. Step- down accommodation can enable medically optimised patients to move out of hospital or prevent them from being admitted in the first place. It can also act as an introduction to extra-care housing and enable people to consider this option and the potential benefits. Staff in the scheme work with the LA and the hospital to meet the needs of those placed, with each case being looked at on an individual basis. In addition to the Tower Hamlets step-down beds, the LA have block-purchased care home beds out of borough to provide enough facilities to meet need.

# Initiatives in Housing

Extra-care is a specific and innovative model and differs from the old extra-care sheltered housing, with the LA having introduced some exciting changes to traditional models of sheltered housing. One reason for rethinking the old model was to leave behind notions of housing need being based on age and towards developing a model focused on individual need. Extra-care supported housing schemes no longer have an age-based criterion but rather an identified care need, a minimum of three hours care per week; and an eligibility to hold a tenancy. A person's care and support needs must also be compatible with the support offered within such a scheme.

Most sheltered blocks have traditionally provided opportunities for social interaction in a communal area, but this model became increasingly underutilised and unsustainable as costs increased. The LA surveyed all tenants and visited schemes and it was evident that while people appreciated living in sheltered housing because it is safe and secure, tenants were clear that they did not want to pay additional rent for the warden service, and many regarded the daily screening service performed as intrusive and disempowering. From feedback it was also evident that tenants wanted to maintain their independence as far as was possible.

The numbers of people living in the units who still worked had greatly increased, in line with the rising retirement age, and although people may have acknowledged the need for some support when they took on a tenancy, once settled many no longer required significant support. This changing profile resulted in the creation of a 'floating support' model which was recommended and then resulting in a housing management service which ensures the safety and security of the buildings, with risk assessments undertaken and provision of signposting to housing benefit support. This service is funded through housing benefit and the model developed in consultation with residents; enabling locally agreed arrangements tailored to suit the tenants.

"Because the LA is not paying grants anymore, as this is covered by housing benefits, we recommended that an individual's allocation be reinvested in each unit in the scheme, so if you've got pooled units, that's potentially a

# Initiatives in Housing

This innovative model showed positive outcomes from its inception, with initial quarterly data showing a high number of activities taking place attended by over 800 people, 600 of whom were tenants, and around 200 carers, relatives, and people from the local community. This initiative has helped to act as a vehicle to integrate people back into the community and promote social connectedness, which reflects the feedback from people who talked to the PE Team about what they feel they need to stay well.

Pre Covid activities have ranged from Christmas lights trips, outings to pantomimes and Wilton's Music Hall, to local history talks and 'Furry Tales', where petting animals visit sheltered schemes. In some cases schemes have merged. For example, the organisers of a Valentine's karaoke night invited people from another scheme to provide opportunities to meet other people. Some activities are organised by the tenants themselves and as they are not delivered one to one, housing staff have capacity to help support arrangements, providing yet another opportunity for enabling integration and coproduction while challenging notions of 'us and them'.

Developments included a partnership with Newham College students offering 'pampering sessions'at low cost, so the students gained opportunities to interact and learn while practising their skills. Other benefits in evidence are where schemes without Wi-Fi accessed it throughout the building through pooling resources. While it is likely that the impact of such initiatives on admission rates and prevention will not necessarily be in evidence immediately, there are anecdotal reports ofpeople being more active and positively engaging in activities as part of a community which promotes wellbeing, and according to groups and individuals this helps them stay well and out of hospital. Voluntary sector groups such as Magic Me and In Common are benefiting from some ofthis funding being used to facilitate work with local schools, where older people support the younger generation, helping them with their classwork and homework and befriending them. The LA have also worked in partnership with landlords to support a gardening project whereby the landlord purchases the materials to make raised flowerbeds while the LA funds the gardening skills for the tenants; promoting health through both physical activity and supporting 'food on a budget'.

# Initiatives in Housing

Relaxation type therapies have also been useful in helping tackle isolation, but tailoring programmes is key to achieving engagement. An example was a small scheme for Bengali people where it was evident to facilitators that men were not attending the relaxation techniques provided. Through offering a wider variety of relaxation activities such as Tai Chi and yoga this changed the dynamics of the group and men started attending the scheme. As with many initiatives addressing health and wellbeing, the theme of being able to attribute the provision of interventions to a reduction in avoidable admission is challenging to evidence. The LA Commissioner explained how this is being addressed:

> "I'm working work with the Housing Association Charitable Trust (HACT), to work out the social return on investment, because as money gets tighter, we want to be able to demonstrate that by spending money in this way, we're saving in the longer term. I've shared the outcomes with HACT, and we have based our work on what members want around the 'campaign to end loneliness and isolation' questions".

The impact of this work will be interesting, as the structures for people to form connections were put in place pre-pandemic which may well have made a significant difference to what might otherwise have been a very lonely and challenging time for tenants during lock down.

# Housing to support people with Dementia and Learning Disabilities

In residential homes, one of the challenges identified for preventing admission is around identifying timely interventions where people may not be able to describe feeling unwell. Recognising symptoms to enable preventative treatment relies on people being able to identify and express that they are feeling unwell or in pain, and those with, for example, dementia, may be unable to express early warning signals and so can end up in ED or hospital at a later point than those able to alert family or carers to symptoms.

Similarly, someone confused and in a care home environment may have suffered an unwitnessed fall, so the severity and potential impact of the fall may be hard to assess. The decision around whether to send someone to ED for further assessment is complex, given that such a trip and potential wait in an unfamiliar environment can be disorientating for a confused person. Another concern the LA are mindful of when providing different types of supported housing are different vulnerabilities, and overnight concierges can help to address and prevent safeguarding issues. One of the issues the LA are exploring is whether there are people in the schemes who are not obtaining the benefits to which they are entitled, and if not, they are able to refer to the outreach team who can potentially support vulnerable people with the process of applying. This can also contribute to admission avoidance in a broad way as it addresses poverty and associated health issues.

The concept that people can access a range of support proactively while living in supported housing aims to prevent ill health and promote wellbeing, and one of the questions being explored is how best to enable services to proactively come to the residents, with extra-care viewed as model providing a home for life rather than a stepping- stone before residential or nursing home care.

"Much of the work being done in the borough is around ensuring that people make decisions at the right time about where they want to live, what support they need, where they want to die, and if it's in their own home, they should be able to do so.

# Housing to support people with Dementia and Learning Disabilities

A disproportionately high number die in hospital……. for the older population, where you can make an informed decision you should be able to have a choice about where you die".

One extra-care scheme run by Peabody had a focus around dementia. The scheme did not have age range as the determining criteria, but rather identified needs compatible with the support offered. Evidence gathered by the PET Team during previous reviews shows that in TH, people with early onset dementia tend to want to stay in their own homes rather than move to institutional care.The idea with the Peabody flats was to enable people to move into an apartment within the scheme in a timely way so they can age there, getting used to that environment with the added advantage of the Sundial centre providing activities and support on site. However, one challenge identified is that people with early onset dementia often want to remain in their current homes, and do not want to move to an unfamiliar flat, so that scheme has been adapted to meet changing need.

ELFT also provide two specialist OTs with a focus on dementia who establish links with the wider EPCT's and work in partnership with the LA, with the residential, nursing and extra-care homes in the borough, to build up a rapport with the residents and upskill the staff. A piece of research undertaken with these schemes, funded by the CCG as a pilot, looked at the incidence of falls after the introduction of the OT's, and ran a series of training programmes, such as a 10-week course on dementia for care home staff, offering practical and theoretical skills, and invited comments and suggestions from staff regarding development of the training programme. Pre-Covid, the two Dementia specialist OT's were supporting the five care homes in the borough, two of which have nursing.

"We see people who have a diagnosis of dementia and who are not being care coordinatedby the CMHT, and present with some form of behaviour that would indicate they were distressed or exhibiting some challenging behaviour. That can be those who are loud, angry, or aggressive, but can include people who are withdrawn and disconnecting from the world as well".

# Housing to support people with Dementia and Learning Disabilities

The OT’s are not limited to direct patient contact, and their work also focuses on interactive training for care home staff and the extra care staff. One of the challenges faced is the staffing levels in care homes, which tend not to be generally conducive to being able to deliver care that is preventative.

The staff often report having limited time for activities outside of core roles of washing, dressing, assisting with toileting and feeding as well as ensuring people are safe, clean and comfortable. The care homes do however provide activities and most employ an activity or wellbeing co-ordinator, while some have a role of Activities Champion, which is often a staff member whose main job is a care assistant, but who is also tasked with overseeing and managing activities. This can mean that due to prioritising care needs, only group work is feasible, which can result in one person trying to meet every resident’s needs, rather than being able to work to tailor activities to individual need, interests and abilities.

> “One care home has no activity co-ordinator but does have a couple of really good Care Staff who take a group to ‘singing for the brain’ sessions delivered by the Alzheimer’s Society every month, so they do value activities and find other ways of meeting need.”

This level of dedication and commitment by care staff to ensuring the residents are stimulated and supported is not always recognised and felt to be linked to the high staff turnover. Lack of respect for the skills as well as opportunities for development are also issues that the OT’s tried to address as part of the project.

# Housing to support people with Dementia and Learning Disabilities

The OT pilot project, with support provided by UCLP, although time limited, trialled a specialist tool to detect earlier deterioration of residents, such as loss of appetite or frequency in passing urine, or lower mood than usual. The tool enabled carers to monitor subtle changes at the earliest possible opportunity, and an accompanying monitoring tool helps establish a baseline. The data is visible prior to a weekly clinic held by the GP and advanced nurse practitioner and can also help enable the timely raising of a concern about a patient. Other outcome measures included a reduction in unnecessary and avoidable ambulance call outs, and by consequence, avoidable admissions. One of the pilot sites chosen appeared in the national top 100 care homes for ambulance call outs, and rarely used the Rapid Response team, who can link with the PRU, and so reduce admission rates.

The pattern of call outs identified that when a patient would become unwell, the most common course of action if the GP was not available, was to contact 111 or 999. Even though Rapid Response made their direct mobile number accessible to the process, they were very rarely contacted. The Project, which was due to come to an end shortly before lockdown in March, aimed to demonstrate an increase in referrals from the pilot care homes to RR, and the OT's set up a project group to promote management of deteriorating patients by reducing the options available on a simple flow chart for care home use.

One of the examples shared related to a resident with COPD and dementia, with the main problem being frequent exacerbations of their COPD. The patient was very vocal about not wanting to go to hospital, having had frequent admissions. Despite the team leader reminding the staff to call direct to Rapid Response, the care home nevertheless phoned an ambulance.

# Housing to support people with Dementia and Learning Disabilities

"There can be a fear around doing something outside of what they feel comfortable with, and risk aversion, so they feel they are covering themselves by phoning an ambulance. We need to raise awareness of community services and how they manage to keep people well. It is the case that if they had phoned Rapid Response, they would be told "We will be there in X amount of time, but if the patient deteriorates further phone 999." Because Rapid Response are trained clinicians, they would take responsibility for that decision".

There was also a view expressed by the project lead that many people near the end of life who are living in care homes, if given a choice, would prefer to die in a familiar environment with people whoknow them, rather than go through the upheaval of admission to die in an acute ward. As part of theproject the team explored opportunities for improving communication, and focused on how to better support families of residents. This was aided through bringing in a relative of a resident to co-deliver the sessions, and through sharing personal experience and their emotional journey itenhanced staff engagement and helped them appreciate the stress experienced by each other.

"The relative talked about their caring role and it really helped staff to see their perspective. You can almost see the change on their faces as they relate to the relative as a person rather thansomebody who comes in and moans about them!"

Another initiative breaking new ground and supported although not funded by the LA was Creative Encounters (formerly known as 'Endless Imagination'); a music and dance programme for people with dementia, whereby musicians and dancers work with residents in care homes as part of a three-year research project linked with Spitalfields Trust. Valuing and acknowledging the importance of the care worker role has been a positive aspect of the Covid-19 crisis, and has led to a heightened public awareness of their key contribution, but fears around the ability of Care Homes to remain safe places during such challenging times are regarded as potentially having an impact on the viability of the current system in the long term.

# Supporting People with Learning Disabilities (LD)

There is a move towards offering less institutional style housing options for people with a Learning Disability to enable people to maintain their optimal level of independence and offer a different dynamic.

One of the imaginative extra-care schemes that provides housing to people with an LD enables people with a range of abilities to live together with others up to the age of ninety, reflecting wider society. Another scheme is located next door to accommodation for dental students, with the students befriending people from the supported scheme. In Tower Hamlets there is an integrated LD team with either LBTH or Health meeting the support costs or a jointly funded care package. NHS continuing care is only provided to around 30 people with LD's in the borough who have high nursing care needs, with most people being supported through non-specialist community provision.

"If a person with LD develops an ulcer, they will be cared for by a district nurse as the NHS provides universal services: the GP, the Admission Avoidance Team and community EPCT's are already funded, and we may also have specialist input from Adult Respiratory and Rehabilitation Care Service (ARCaRe) for example".

Uncontrolled or undiagnosed diabetes was given as an example of a condition common among those with LD's and often linked to obesity. This can result in potentially serious consequences such as amputations.

"In Tower Hamlets 48% of children live in poverty, and there is a proven correlation between poverty and obesity which impacts on people with LD just as much as is reflected in the general population. The particular issue with obesity and LD is often around income, but food is also sometimes used as a pacifier or distraction. Children with LD are twice as prone to become obese because they rely on their carer to feed them".

# Supporting People with Learning Disabilities (LD)

A recent survey looking at diet undertaken in a TH LD day centre showed that 75% of attendees were obese or overweight. The LD Lead Nurse manages a weight management programme and is involved in a highly acclaimed second research trial to support clinically obese patients with LD's tomanage their weight. The focus of the group is exercise, and the team are pioneers of the model, and have been nominated for two awards for their work in improving health outcomes. A focus group at a Day centre provides diabetes testing, exercise and peer support, several attendees have reversed their diabetes.

Links between the children's and adults LD Services are regarded by the ELFT lead Nurse for LD as less coordinated than desired, and while partnership working is well established, the relationship is viewed as having the potential to be more seamless. The different services accessed by people with LD are managed by different organisations, with Children's LD Services being managed through Barts Health and Adults through ELFT and there was a call for better co-operative working across the system, including between Adult LD and EPCT Community nursing. When particularly problematic issues are identified and escalated, there was felt to be a need for more shared learning to prevent recurrences of similar issues.

Where the primary need is identified as being health related rather than LD related, this was viewed as an opportunity to educate colleagues in the EPCT's about the appropriate focus. Being able to demonstrate how a condition is impacting on day to day living; the intensity and complexity of the disease and how complex, unpredictable or challenging the behaviour might be are regarded as crucial to ensuring access to appropriate support. There was agreement that all parts of the system need to function effectively to enable excellence in delivery of joined up preventative services, and this is one of the aims of the various Life Course Workstreams that bring organisations together. An example shared concerned where the LD team requested Community nursing to teach a patient to appropriately manage their own insulin, and it was explained that this plan should be actioned through a joint approach rather than managed by one team.

# Supporting People with Learning Disabilities (LD)

Discussions were underway pre-pandemic to clarify financial responsibility and access to pooled budgets, so that, should a patient with a LD be admitted to the acute hospital, they will be treated as any other patient, with the onus on Barts Health to undertake a risk assessment on the ward. If the patient is assessed as having challenging behaviour, the expectation is that the ward pay from their own budget for one to one support, as community services are not be liable for funding this in the acute setting. Exploration of opportunities for upskilling and educating ward staff were identified as being key to avoiding inappropriate referral to the Specialist LD team. Work is also progressing to redesign day centres for people with LD in Tower Hamlets. The vision is to transform day care into hubs where people with LDs are not attending passively over five days a week but are, rather, participants in a facility offering a range of activities purchased from individual resources allocated in the form of personal budgets.

> “Our team contribute to fostering some reliance on services to manage day to day life. TH LD team supports people with mild to profound learning disabilities, whereas in other boroughs, LD services will only look after people who have moderate to severe learning disabilities”.

There is a national shift towards supporting people with a mild to moderate LD to transition from dependency to independence and integration into mainstream society. In Tower Hamlets there are estimated to be 4,000 people with a LD, although the Specialist LD Team only see and support 800, and this is a good indicator that many people with a LD can live independently. In line with the NHS plan, there a change in focus away from trying to ‘fix a problem’ for the individual, to working to support the person to identify a solution to fix their own problem.

# Understanding of the AADS in-reach and intermediate care teams

There is a clear consensus that integration is the shared vision, but a challenge remains around how to achieve this. Integrated triage of referrals was happening pre-pandemic at the RLH but there was a shared perception expressed that rather than achieving real integration, in reality the teams were closer to what was described as working ‘in parallel’. Most referrals to AADS and reablement were received from the ward therapists, who previously had to identify the most appropriate team to refer to.

By providing a central referral point this clarifies the pathway, with screeners looking at all the referrals and allocating to reablement, EPCT or AADS intermediate care. There was acknowledgement that there was still work to be done to fully integrate the process to achieve an integrated Rehab and Reablement team, and the Integrated Discharge Hub created during the pandemic has helped to support progress towards this goal. The AADS team have a track record of managing and delivering effective services and embracing a whole systems approach.

With integration as a goal, it is a clear challenge to get the balance right in recognising and developing some effective services and systems while being open to bringing in different organisations, managers and perspectives on ‘what good looks like’.

Adequate resources to support an integrated model, with responsible and effective use of available funds is an agreed and ongoing priority across the whole system, as is investment in community services to prevent avoidable admission and support timely discharge. Each admission comes with a set tariff that transfers to the hospital for up to seven days, and there was interest expressed in seeking clarification around whether the AADSteam could access some of this funding where they can demonstrate that effective support and intervention facilitated early safe discharge.

Similarly, a conversation about allocation of resources is sought such as where provision of “VAC pumps” and consumables is resourced by the acute trust while the person remains in hospital, when a patient is discharged, there is an argument that the resource could be handed over when the person transfers to the community.

# Intermediate Care and the role of the family

When discharging patients from AADS intermediate care, the exit strategy may include a referral to the social prescribers and voluntary sector, particularly if the patient is lonely and demotivated. Where loneliness is not so much of a problem, particularly if people are living with family, there can be other types of issues that arise as a result of family dynamics and often tense relationships resulting from caring situations. Problems identified as presenting challenges to therapy input include overcrowded housing, lack of privacy and challenges to rehabilitation being undertaken due to physical lack of space. There are also other issues that can occur where a patient lives with family members.

> “Sometimes we try to provide a toilet frame and toilet raiser, and the rest of the family object to it as they are sharing the facilities. Initially the family may accept it, but next day, they decline the delivery, because they are feeling embarrassed or uncomfortable, particularly if there are visitors coming to the house.”

Creating a space that is safe and appropriate for the patient, can thus lead to potential conflict within the family, so the team invest time in communicating with the household to enable an understanding of the patient’s need. While there may be many positive things to be gained by living within an extended family unit, such as access to food and drink leading to fewer incidences of malnutrition and dehydration, and regular supervision reducing the incidence of falls, there can also be occasions where mental health can suffer as a result of loss of independence and few social opportunities eroding confidence, and people with low mood may be de-motivated to regain mobility.

Another issue identified by the team was that Asian carer workers providing support to an individual at home may be more risk averse and culturally less comfortable with challenging a person to be more independent and thus support agreed rehabilitation goals. The predominance of non-white indigenous care staff can, it was suggested, also present a challenge when white indigenous individuals refuse support from available black or Asian care staff.

# Intermediate Care and the role of the family

If there are no mental capacity issues but rather the person chooses not to have a care worker unless they are white indigenous, this can result in the care package being withdrawn and potentially raises the risk level. EPCT Care Navigator (CN) involvement is seen as key to exploring alternative options and solutions where risks are identified, and sometimes act as a bridge to explore individual reasons for people's reluctance to accept non-white indigenous support which are often complex, and Social Prescribers and CN's can help enable acceptance of a care package. One of the IC therapists shared that working with considerably older people was the most rewarding aspect to the AADS work (the oldest person on the caseload at the point of undertaking the review was 103) as they were identified as often more enthusiastic, motivated and realistic in terms of setting and achieving their goals.

"We aim for a lower intensity programme, because we're not expecting them to run a Marathon, and they carry on doing the exercises themselves and achieving a lot. They will say "I'm 98 years old and looking forward to celebrating my 99th birthday in two months" which is often enough of a motivation for them to engage. With people in their mid to late 40's, they can become upset, particularly if they have a neurological or longer-term mobility issue, and tend to give up more readily, as they can feel angry so are less motivated to cooperate."

# Exit strategies

Where patients feel demoralised and upset, they can feel abandoned when therapy input is finishing, particularly if they feel they have not achieved their goals, and this issue of managing expectations once again come to the fore. In these circumstances it may be appropriate to extend the input by one or two more sessions to enable the patients to recognise their achievements, limitations and accept their situation. The therapists shared their sometimes-challenging experience of enabling patients to manage their frustration with slow progress towards achieving their optimal independence:

> "One patient who had been bed-bound, and was in ITU for three months, was able, after therapy input, to start going out shopping and to the pub to socialise.  It is a success story but at the end of the day, they complained about our late arrival (due to traffic problems) on a few occasions. Maybe we should regard this as an achievement too as it shows they really can't remember how limited their life was before, and they can focus on the little things now".

The physiotherapists also raised the issue of inappropriate referrals:

> "It may be a Ward based Band 5 who is inexperienced in community and so they're referring everyone. It reassures people when we go around and see them, but we get up to nine patients a day so it isn't feasible to offer a 'reassurance' service because we're not then giving the priority to other people who really need it. So, if the people making referrals are filtering properly, it would help us greatly to manage the service".

The therapists also felt that pre-pandemic they were receiving too many referrals that would be better dealt with by EPCT's but because people want an immediate response rather than wait for an assessment and service from EPCT. AADS had also identified a spike in the number of referrals at weekends and after 4 o'clock, and recommended that an increase in the number of screeners and extended working hours would greatly decrease the inappropriate referral rate. The need to educate therapy staff at RLH about the role and remit of EPCT and AADS therapists raised last year may well have been addressed because of the pandemic and creation of the IDH.

# Physician Response Unit (PRU)

One of the established initiatives in Tower Hamlets is the PRU, which describes itself as ‘taking the Emergency Department to the patient’. PRU provide a car with siren, blue lights and extensive equipment to enable tests to be undertaken in the patient’s own home. PRU can undertake anything that is done in the ED apart from X-Ray and CT imaging, including advanced clinical assessment, diagnostics and therapeutics. The team also have a comprehensive supply of drugs, sutures and catheters, and the clinical team consist of an emergency medicine doctor, a London Ambulance Service (LAS) clinician, plus quite often, a consultant in a supervisory role.

One of the key stated functions of the team, apart from their role in admission avoidance, is to challenge the attitude of acute clinicians to risk management, and to promote the idea that a patient may often benefit from staying in their own home environment. They do this in part through encouraging the RLH ED team to shadow the PRU as observers on their shifts, but also welcome GP’s and other community and acute teams to raise awareness of what can be offered and achieved through their service. The team have also recruited specific PRU staff who are local emergency medicine doctors, and this is seen as further promoting insight into how the local population live, how the ambulance service works, and further benefits their teams when they return to ED as they can interact with ambulance crews having developed a relationship with them in the community.

The ability to perform tests that otherwise people would be potentially waiting hours to have done in ED means PRU can deliver community-based emergency medicine.

> “Most of the PRU work is the equivalent of what you would see in 70% of an Emergency Department caseload, where patients require advanced assessment and some diagnostics, some can be discharged home, and some may get admitted to hospital. Through seeing patients in their own homes it is possible for PRU to get a much richer understanding of the patient’s needs, their social support, their community network, their friends, family, carers and next of kin, as well as therelationship they have with their GP, and other community providers”.

# Physician Response Unit (PRU)

PRU have close links with the Rapid Response Team to enable onward referral as appropriate, for example for those needing catheter care or IV antibiotics, and so enabling their needs to bemanaged in a community setting. PRU also refer to the Frailty Clinic, OPAT and EPCT for example for palliative care in the community. PRU have a high profile in the borough and beyond, and have been successfully creating what they describe as:

> 'A cadre of clinicians who have some belief and understanding in the community systems, and who challenge previously held notions of or reluctance to engage with community providers, or who may not necessarily trust community systems to work. PRU doctors are leading the way within the ED in advocating for community-based care, saying, "No, don't refer that patient to the medics for an admission, refer to the AA or Rapid Response Team!" I do believe that community pathways can be better for patients."

The challenges in changing the culture and approach of staff within the acute setting cannot, however, be underestimated. At the point of writing, great changes to ED are underway. Some of the changes have been necessitated by the pandemic but there has been a longer-term drive to ensure that ED and UTC are used appropriately. As part of a number of initiatives under 'Help us to help you', the PRU are piloting the Barts Emergency Access Coordination Hub or BEACH which enables the PRU Team to work closely with Emergency call centres and colleagues in LAS to triage patients within a tight timescale and, where appropriate, will undertake assessments via a virtual appointment before deciding whether the patient requires treatment by community providers such as PRU, Rapid Response or Alternative Care Providers (ACP'S), or whether immediate transportation to ED is necessary. Another Pathway has been developed whereby 111 and LAS ambulance crew facilitate virtual consultations from the patient's home.

# ED and admission avoidance

While all services are concerned with risk management, the degree of risk aversion or otherwise can impact on ED and admission rates. There is recognition amongst staff in ED that it is often the wishes of the patient and family members to avoid an admission at all costs. In this environment there are high levels of pressure and responsibility to try and avoid an admission where assessed as not in the patient's best interest. This decision will not only be based on clinical grounds, but account is also taken of the patient views and situation.

The informal carer of a patient with MS described their preference for being treated at home wherever possible, as they identified community-based interventions as minimising the risk of infection and disruption to routine. They also recognised community team's ability to manage risks associated with increased chance of complications arising from straightforward infections acquired in the community, such as a cold. The last time the patient had caught a cold, the PRU were called as their oxygen saturation level had been low, however the PRU were concerned enough to feel an admission might be the best option.

> "They kept saying to him, "You've got to go into hospital." He really didn't want to do that. So, the PRU contacted the RR Team to clear out his chest, and they came that same day, meaning they were able to leave him at home. I think it was really good, and also quite unexpected that he was going to be allowed to stay at home Another time AADS gave IV antibiotics for two days, and the physiotherapy came as well and did all sorts of things that just seemed to work quite well for him".

ED staff also frequently encounter a reluctance for a patient to be admitted from ED:

> "Sometimes, even if we think it would be better and in their best interests to stay in hospital, if they want to go home, we try to commit that as soon as possible, but it is important to acknowledge that admission avoidance isn't always being pushed by ED, so we have to focus on how we can make that as safe as possible".

# ED and admission avoidance

A couple of live projects are concerned with supporting High Intensity Users (HIU's) similar to previous work undertaken to support 'frequent attenders', where a relatively small number of patients account for a relatively high number of attendances and admissions. While much of the time this is completely appropriate and necessary, evidence suggests that at other times admission may have been potentially avoidable had timely support and appropriate intervention been provided in the community. The Frequent Attenders Meeting involved people who are high intensity users who use the emergency care pathway at a high level. These people would be accessing this pathway ten or more times in a year and ED becomes a trigger point, whether access is via ambulance, police, RR, or CMHT's, and the mental health liaison team undertake some case management work with these patients.

> "Our ethos is that everyone who attends ED frequently has an unmet need. The reason they attend might not be the driver behind them attending, so we try to understand what the drivers are. Forinstance, someone with COPD who also has necrotic bowels following opiate use has poor posturing and respiratory problems. The reason for frequent attendance is an aneurism and chronic pain, so the driver for attending is poor quality of life and depression. They might need to be admitted due toCOPD, and require tests for the aneurism but the team would work on the drivers and unmet needs that exacerbate the attendances".

Some of the issues for attendance at ED can relate to underlying mental health and psychological issues and people may be living with high levels of anxieties about their health. There may be no mental health issues specifically identified, but they may be experiencing multiple health concerns, or present at ED for completely different reasons: such as seeing it as a place of safety, or feeling reassured by the interaction, or some people may forget that they presented there three times within a one week period.

# ED and admission avoidance

Some of the ED staff said that they believed that the Admission Avoidance Team based in ED were a Barts Health team, despite working closely with the AAT Community Team. After it was established that the team under discussion were indeed the ELFT Community AAT and part of the AADS Team, it still wasn't fully acknowledged that it was a non-Barts Health initiative. The interview clearly demonstrated the degree to which the AAT team are highly regarded and recognised for their excellent and close links with community and with social work as well as their relationships across the pathway. Examples of interventions such as timely stair and home safety assessments were shared to illustrate the important role the team play in ensuring patients are safe to be discharged.

> "The Admission Avoidance Team that we've got are fantastic and as a resource for advice for patients they're great. They see patients straight off the bat, even if we're still waiting for bloods, as long as they're safe to get up and move around, they'll go and they're really proactive; they can also set up packages of care; if a patient comes in at 9am, sometimes they go home at 5pm, with the package of care starting that night. They are really great, and they can put lots of things into place. We've also got a team who can go out to do IV antibiotics in the community".

The IV team referred to are also part of the ELFT AADS service, and on one level the identification of the team as being part of Barts Health is an excellent indication of how well integrated they are and that they provide a seamless and effective service. From a patient perspective there would be little concern regarding who is funding or managing AADS, as long as they enable safe and timely admission avoidance and supported discharge. However, AAT felt it would be respectful to recognise the Team as well-integrated but a separate community resource in order to promote better understanding of what is being provided across the system and help to forge relationships based on recognition of the work being undertaken in partnership. There was also an assumption the team were setting up care packages, whereas this is a role undertaken by the Hospital Social Workers (HSW).

# ED and admission avoidance

Referring to AAT and the IV team as being a Barts Health resource could be an indication that there is some way to go before whole systems approaches and mutual respect and cooperation is fully embedded. Commissioners acknowledged this issue and felt that there is an underlying problem in the acute service establishing and demonstrating trust towards community services.

> "Whether that's therapists or anyone else, it's just about that kind of viewpoint that what happens in hospital is better than what happens in the community, and that needs to be addressed".

The UTC work closely with ED to triage those patients who have urgent but non-life threatening conditions. Most patients attend UTC via 111 but some (pre-pandemic) were those patients self-presenting at ED. There were some concerns that after triage, ED were sending some patients to UTC who would be more appropriate for ED, and this meant sending a proportion of patients back to ED, which was frustrating for the patients and providers. Since the pandemic, the frequency with which this happens has decreased rapidly as the access routes have changed to prevent people self-presenting. There are still issues evident such as patients presenting at UTC for dressings to be changed, which is a GP practice nurse function, so there is work to be done to ensure best use of the ED and UTC. This is being addressed as part of the national 'Help us to help you' initiative previously referenced and launched in April 2020.

# Mental Health, Admission Avoidance and safe discharge

People presenting at ED primarily with mental health issues who may not be known to community MH systems are able to access the team (formerly known as RAID but subsequently renamed) the Mental Health Liaison Service (MHLS). There is also a crisis line available for patients to make contact, although the patient would have to recognise that they are sliding towards a crisis and be able to proactively contact them.

As many patients pre Covid-19 would present at the front door or via ambulance and be triaged from this point, the ED have had to explore potential organic causes to ascertain whether there might be a physical problem, such as an electrolyte imbalance or a head injury accounting for what may be identified as unusual behaviour. It can be more straightforward if a person comes in stating that they feel suicidal or depressed and if they have a history of depression it makes it fairly easy to attribute behaviour to mental health issues, but where someone presents at ED acting strangely, and has not been seen in ED before, staff are obliged to ensure it is not due to another cause such as encephalitis, is drug induced or due to a head injury resulting in a bleed.

Some people with a mental health crisis come in for their own safety and safety around others, so may require administration of sedation, which is not something that can be managed on most mental health units.

"We may need to calm them down and that needs to be done in a proper way and in an environment which, were there to be any adverse effects, we would be able to manage".

There are slower sorts of decline in wellbeing that may have happened as a result of self-neglect and been contributed to by social isolation which can lead to people presenting at ED with a variety of preventable conditions such as dehydration and poor nutrition. Similarly, a person who may be frail and so requiring daily support or input from health and social care agencies may come to ED if their support network breaks down for any reason.

# Mental Health, Admission Avoidance and safe discharge

> "We see situations such as where a patient was discharged with a package of care but that package of care broke down for whatever reason, such as the carers didn't arrive … you definitely do see when community services don't work cohesively then of course people do end up in A&E. It's not necessarily the fault of the community, the hospitals don't always get it right either".

While there is general agreement that there needs to be a significant change in culture whereby people need to take more responsibility for their own health, there is also recognition that for some people that is just not possible; whether they are too vulnerable or they've got cognitive impairment, or their needs are just so complex that realistically they are not going to be able to do that.

Triaging for emergency calls having transferred to 111 where previously this was a service provided through a rota of local doctors had also led to a spike in attendance at ED before the pandemic. The reasons for this was identified as complex, but it was felt to be likely that a local GP who may previously have spoken with a patient who frequently used ED would have some knowledge of the patient leading to a tendency to be less risk averse than an algorithm.

An interview undertaken with the Community Neuro specialist nurse identified that prior to the awarding of the Community Health Contract across a variety of THT providers, there was felt to have been a much closer working relationship across community providers, thus facilitating better opportunities for sharing intelligence about individual shared patients.

> "I would be able to say to a colleague "This person has got a brain injury; they get very over-anxious and they will dial 999 if they can't cope. If you encounter them in this state, and there are no physical issues evident, phone me, because I know them, so I can talk it through with them and help reassure them."

# Mental Health, Admission Avoidance and safe discharge

At a time when integration is high on the agenda, and challenges around capacity and demand proving difficult for the whole system, establishing effective forums for information sharing and closer working was seen to make sense. The MH team stressed the need for good communication and trust:

> "There are some patients who attend ED time and time again, and within the department they've got patient specific protocols but it's always with the caveat of you always assess them first of all, rather than just saying, "Oh, it's so and so again!" because you never know. So, they always get an assessment by a senior doctor to make sure we're not missing anything, and we're not being blindsided by the fact that they're here all the time".

# Accessing preventative interventions

There was some concern expressed across the voluntary sector around the squeeze on resources available for procurement of advice and information services that had sometimes resulted in national or regional organisations being awarded contracts as they could better compete on price and offer economy of scale that local providers could not. This led to loss of local knowledge and it was felt could result in a lesser quality of provision. Another issue flagged up was the Commissioners perception of there being 'duplication' of services, where it was felt there were too many organisations offering the same service, whereas providers felt the real issue is one of demand and capacity.

One of the issues under discussion was that an element of the budget available for commissioning of advice and Information was being used to fund the procurement of a digital portal which could be used for signposting people with lower level need to community resources and provision. Where such online resources like the e-marketplace or TH Community Catalogue had previously stalled due to a failure to keep the site updated, it is hoped that this new portal which may be managed by CVS will be maintained to be both current and relevant. However, some voluntary sector groups have drawn attention to the problem of busy staff being sometimes lax in updating information or where projects lose funding at short notice, leaving no available personnel to update the resource directory, and highlighted the ongoing and unresolved nature of this challenge. As a key organisation supporting people with disabilities in TH explained:

> "That's certainly one of the problems we have when we're trying to signpost people. They are calling up saying, "I'm interested in X, Y, Z. Do you know of anything?" and trying to find up to date information or keep on top of it is hard. For example, there was this good gardening project for people with mental health issues, and while their website is still there, it is tricky to know if it still exists."

# Accessing preventative interventions

Another issue raised by advice agencies was that in their experience the people who are able to navigate the digital portal and access the relevant support needed are unlikely to require services from advice and information, and the people who require support would be unlikely to use the digital portal.
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There was also recognition by many voluntary sector groups of the need to repackage and present their work in a way that appears 'new', so that fresh approaches to problem-solving are in evidence, rather than continuing to deliver services in the same way with diminishing resources over time.

> "The trouble is with the whole third sector and commissioning processes, it's not very exciting to just go and say, "Can we have some more money to continue doing the same thing but a bit better." They have to try and sell it, I guess, politically to people like 'now we're introducing a digital portal' so it sounds new and exciting."

The increase in resources made available to Social Prescribers was also initially approached with some caution, as the voluntary sector reported significant increases in referral and demand for their services without an equal investment in capacity building to enable the organisations to meet that demand. This led to longer waiting lists and a concern that Social Prescribing can raise expectations that are then frustrated when the person referred has to wait on a list before any contact or assessment can be undertaken. Where the service provided is very specific and niche there were fewer problems reported, but services that have a less rigid remit, such as those who aim to help bring people together to tackle loneliness and isolation, shared that they were struggling to manage increased demand.

One of the ideas behind funding Social Prescribing and the signposting function was to adopt a more holistic view of wellness and make support solutions more individually tailored and less prescriptive to support people to make choices around how best to utilise allocated resources to fit their needs and lifestyle. This approach to provision of support is likely to be more effective and thus makes best use of available funds.

# Accessing preventative interventions

A concern was expressed prior to the pandemic about lack of ongoing investment in some of the innovative pilots such a gardening projects, as well as opportunities for social interaction close to where people live and the impact this has on isolated people living with long term conditions.

While understanding the scarcity of resources available, there was a consensus across the system that if people are unable to access these 'softer' preventative services, it can result in a downward spiral of loss of independence and wellbeing, and a diminished ability to deal with some of the other challenges they may be facing.

> "The hardest enquiries are when on the face of it they're "less serious" so when somebody tells us they live at home, are not working and have a disability and hope to get out a bit more and find a social group, it is hard to identify something suitable. Where someone's PIP benefits have been cut and some help with that is needed, that's actually much easier".

Pre-pandemic, access to somewhere to meet other people was identified as being something lacking but really beneficial.

> "If people could attend a morning or afternoon once a month where we could offer a get together with a cup of tea and have a chat, and maybe refer on or just get people talking, then they're in a better frame of mind to be able to deal with the big things like benefits and housing."

The local Alzheimer's Organisation voiced frustration about the way in which support for those caring for loved ones with dementia was procured by the LA, as the two dementia specialist carers support roles were 'lost' to the Carers Centre to become generic roles.

# Accessing preventative interventions

"A much longer consultation with our carers would have helped, because many of those carers involved in the procurement process were former carers, and that made sense, because a current carer would lack the ability to spend whole days being involved if looking after somebody. However, without capturing the views of somebody who is going through that pressure and in that emotional state, the procurement process will be flawed. Somebody who has been a carer a year ago is not in the same emotional state now as they were then".

There was also acknowledgement of the need for more support to be offered for group interaction and mutual support given by carers to each other, and this was felt to be key in maintaining their own and the cared for person's health and wellbeing.

"At the dementia café's the volunteers and I provide support to the carer and the person withDementia together, so I would like to support the carer to have the opportunity to separate from the cared for, and be offered an activity for themselves such as group therapy or relaxation, a massage, or maybe go to the gym or have a swim while we engage with the cared-for person".

One of the barriers to being able to pilot such initiatives was identified as a lack of funding but also a perceived lack of joined up or whole systems thinking. It was hoped that the Life Course workstreams can build on the knowledge and skills of those on the front line of service delivery in partnership with those with lived experience to inform future commissioning

# Children and Young People (CYP)

A recent example of some innovative and effective work to support children with asthma is gaining recognition in Tower Hamlets and beyond, having been shortlisted for an LGC Award.

“Taking a Breather: Stopping the Monster days” utilises QI methodologies to improve outcomes for children and young people with asthma. The project has delivered rapid system change that is evidence based and co-designed, and is showing an impact on population health, and being adopted nationally. The project has involved the employment of a Children’s Specialist Asthma Nurse to follow up on children who have had two or more hospital attendances, and over 814 CYP have received a review to date.

Originally intended as a pilot, the CCG went on to agree a permanent post to support CYP up to the age of 17. The work has increased knowledge and confidence of health, education and wider professionals across the partnership, with 557 staff gained an improved level of understanding and knowledge of asthma management during the pilot period. There is also evidence of increased confidence and understanding of asthma amongst children and families and a reduction in Unplanned Admissions of 22% following interventions and awareness raising. This has led  to a reduction of a minimum of £142K in the cost of acute care, and 92% of high-risk children demonstrated improved asthma control. There is evidence of widespread systems improvement with a 25% increase in those being treated for asthma receiving a formal diagnosis: between 40-75%increase in asthma care plans being completed and 503 new CYP identified as being at risk of an asthma attack.

There have been some challenges to the work, including a DNA rate that was being addressed pre-Covid. Although efforts are made to re-book appointments, many people do not remember to respond to appointment letters, do not answer their phones or respond to text reminders while others may not listen to voicemail, and this leads to some CYP and families failing to attend the Specialist Asthma Nurse follow up appointment.

# Children and Young People (CYP)

One of the actions taken was the relocation of the Specialist Nurse, who was originally based in the GP surgeries that host the OOH Hubs, but logistical and practical issues necessitated a move the Specialist Children’s unit at MEH. Since relocating the DNA rate has improved, and this could in part be due to parents taking a ‘hospital’appointment more seriously. It could also be that some parents felt reluctant to attend appointments ata GP surgery that was not the one they are registered with. The DNA rate saw someimprovement, but there may still be further unplanned admissions that can be prevented, as concerns were voiced about some parents who were missing the appointments and unable to access the advice that is key to managing the asthma. Another issue is where some children are admitted to non-respiratory wards at the RLH because of pressure on specialist beds, and so on discharge may not be given the information sheet explaining the role of the specialist nurse, and what to expect at the follow up appointment. This leaflet is also available at GP surgeries and in schools. The project has also produced a valuable information pack or ‘Asthma Toolkit’ for distribution.

# Community Neuro patients and avoidable admission

The Community Neuro Service (CNT) lead was another who raised the problem of evidencing the contribution teams make to preventing admissions, and the difficulty faced when trying to quantify the financial savings that are made through the interventions provided.

"I think it's important to log it, because to protect the service, we need to be putting pound signs on the input provided and you can do that more easily with facilitating discharge, but if we take, for example, someone with multiple sclerosis over the course of 12 years, our service still sees the same patients dipping in and out".

The Neuro team make interventions whenever someone's condition changes and thus prevent potential crises from occurring through, for example, recognising any deterioration that could lead to an admission. Strategies to achieve this include educating patients and their families to self-refer, to enable reassessment to take place in a pro-active way. Through early recognition of any changes in health and the need for specialist input it is possible for them to directly access the CNT team without waiting for a GP appointment, or having to go through SPA, enabling the team to undertake a timely review.

"For example, any urinary tract infections (UTI's) will cause an increase in spasticity and increase carer burden, and they will be less able to manage any pain, or extremes of temperature, so we educate them about how to manage this. If someone contacts us to report increased stiffness, for example, we'll go through that with them, and there is a spasticity pathway which enables them to access the GP, continence, tissue viability, etc. to manage it and prevent progression" .Interventions may include physiotherapists checking positioning and putting in equipment to ensure that joints are aligned, and may also involve specialist OTs looking at seating needs as disease progresses".

# Community Neuro patients and avoidable admission

Another important role played by the CNT is training for paid carers to undertake what is termed "passive movements", such as positioning, and the team have explored joint funding opportunities with Social Services to provide seamless support to meet need. The team also work with Reablement on a case by case basis, particularly when people are coming out of hospital, and enjoy a strong partnership with AADS. the CNT might refer to Reablement for people with a brain injury or or some functional neurological diagnosis, or if the physical cause is unclear, but they have a psychological cause that is causing the physical deficit, as is the case with Medically Undiagnosed Symptoms or MUS.

> "We're trying to empower people with MUS to see that they can do things for themselves. If we intervene early, there is more chance of having a positive effect than if someone has been experiencing chronic pain for years on top of their worsening symptoms".

In some cases, if a person has MUS, there can be an element of their feeling safer in hospital, and coming home from a secure environment can perpetuate the symptoms. Research into MUS suggests that withholding equipment and rehabilitation where avoidable can sometimes be beneficial, as interventions can prolong symptoms. This journey towards building trust requires a considerable investment of time, and failure to establish that trust may result in avoidable admissions and readmissions. GP's send patients with MUS for extensive tests to ensure patientswill accept diagnosis, having ruled out other conditions, and the CNT will only see patients once they have a diagnosis of MUS.

> "If you see someone without a neurological diagnosis, or diagnosis of MUS, you can create more fear and panic with someone, so we do lots of work and education with people, and can spend an hour just educating them about the processes around their symptoms".

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# Community Neuro patients and avoidable admission

It is recognised that different cultures may want to help, nourish and care for a sick person in different ways, so it is seen as crucial to educate carers to avoid inadvertently prolonging symptoms, and explaining and reinforcing the approach taken by the CNT. Integration between Social Services and Health is seen as vital to the maintenance of people with long term neuro conditions and their ability to remain well in the community and there were concerns about how the reduction in resources available to Social Services has impacted on some people with neurological conditions

> “There isn’t the right capacity in terms of demand. Specialist Social Workers are holding cases from non-neuro as well as neuro patients and we are making referrals which may go to a non-neuro Social Worker because of limited capacity, so you lose that joint working with clients. If a Social Worker isn’t allocated straight away that person may end up going back into hospital because there are care needs and high anxiety levels within the family which may have been avoided had it been seamless handover of care”.

Previously Ability Bow, a disability gym, was enabling many of those discharged from the CNT caseload to access more mainstream forms of rehabilitation, but the funding for Ability Bow wasreduced, meaning only six weeks of support can be offered, and this had previously provided the only source of ‘maintenance’ for people unable to access mainstream gyms.

> “It kept people out of hospital because it enabled them to exercise, use standing aids, if you think of spinal cord injuries, clients who cannot have the frame in their home due to space, or if they don’t have carers or friends to help them use it, could access this in Ability Bow so while they exercised,they could also stand. Wheelchair users could stand for 30 minutes three times per week, as per good practice guidelines, and it also gives people opportunities for social interaction, and standing prevents the organs being on top of each other, which could otherwise potentially lead to digestive problems, lung problems, and UTIs. There is nowhere else for them to access these preventative facilities, and Ability Bow don’t have secure long-term funding”.

# Community Neuro patients and avoidable admission

Standing aids cost £6,000, and when combined with the cost of providing carers to support a patient at home, would be an expensive way to provide support on an individual basis, whereas Ability Bow was providing a service to many people which was cost effective. Patients who meet the criteria for accessing personal care can use a personal budget, but otherwise may risk hospital ad mission.

> “When you talk about Admission Avoidance, you tend to think about somebody acutely unwell, but it’s not always the case, as these are patients who over the course of their disease could be in and out of hospital five or six times a year, had it not been for the rehab, positioning and standing aids”.

The CNT regard best practice following an admission to hospital to be for referrals to be made at least two weeks prior to the planned discharge date, especially for those with traumatic brain injuries, to enable the CN team to participate in the pre-discharge family dialogues.

> “Some of the team are working on a pathway with the acute for Traumatic Brain Injury (TBI’s) to manage family expectations because family are expecting rehab every day and consequently their first experience of community is to feel let down and disappointed as their expectations haven’t been managed. It might be that they were informed correctly by ward staff about what to expect, but were too stressed to process this information. By being part of that discussion, we can help facilitate effective discharge”.

# Community Neuro patients and avoidable admission

Barriers to smooth discharge for neuro patients are largely the same as across the wider acute pathway, with issues such as staff turnover and pressures on time and beds being flagged across the system. Good relationships and strong partnership working between AADS and CNT are helping to address potential delays to discharge with AADS having input often at short notice. This means that people with conditions such as Parkinson's Disease or mild head injury who are on the wards for a shorter period can access support with AADS enabling discharge to take place within 24 hours, and handing over to CNT when they have capacity, although often their timely input means the CNT are not required so can target their resources to those who require specialist input.

Knowledge of predicted discharge dates, and prior knowledge of dates of family meetings also help ensure that at least some of the family's anxieties can experience are managed and supported. The input provided by CN psychologists is key, particularly where rotation of therapists can prove unsettling from a patient and family perspective, and there is an appreciation of the benefits of continuity in relationships built up over time. The established relationship between AADs manager and the previous CNT manager predated the current Community Contract and employment arrangements and this ongoing relationship was identified as a key factor in the excellent working partnership which it is hoped will be maintained despite personnel changes. As the CNT manager who recently left shared:

> "With AADS, there's trust and a 'can do' attitude so if there is a rapid response need, there's no sense that AADS will try to bat referrals back, and therefore the pathways between CNT,AADS and Reablement are so important ".

Previously, the CNT had their own Care Navigator (CN) to support patients and carers through benefits and support queries and the loss of that post led to a reliance on the EPCT CN's as Social Services lack capacity to support the role. The CNT also talked about the roles that addressing loneliness and isolation play in keeping people with long term neuro conditions well and independent.

# Community Neuro patients and avoidable admission

The example shared was of a person who would not have met the eligibility criteria to qualify for day care who had accessed companionship through visiting his local pub where he was well known and had a support network of sorts. When the person was unable to mobilise after their access to Ability Bow ceased, their support network collapsed, resulting in complete isolation, and their admission to a long-term nursing home placement. This has resonance during the pandemic when most forms of informal social networks and support mechanisms have been affected.

The issue of the timeliness of discussions regarding wishes in terms of advance planning was raised as important in the context of people living with long term conditions. The benefits of having suchdiscussions at an earlier stage rather than when someone is very unwell following several readmissions is evident, however difficult that might be.

> "If a person is diagnosed with certain conditions we need to be able to ask 'If X, Y and Z were to happen, would you want full care? Would you want to keep being readmitted to hospital if you experienced the same issues? These are discussions we need to have when the person is compos mentis and able to make that decision …".

NG fed neuro patients who are unable to swallow when very unwell may only require a tube feed in the short term, but sometimes elderly frail people on NG feeds might not be able to regain their swallow function. The medical model encourages clinicians to offer some sort of hope to enable a positive conversation, so even if someone has been given a limited prognosis, it may be framed in terms of options around "What do you want to do or achieve?" which can make open and honest discussion about end of life difficult.

The CNT benefit from input from a health psychologist who is supporting such discussions as many patients feel anxious about considering the future. The mental health liaison team are more involved in diagnosis or an acute problem that is resulting in an inpatient stay, so psychological support to help people come to terms with their conditions is invaluable..

# Community Neuro patients and avoidable admission

Another growing movement to support such conversations is the death cafes which help aid forward planning, through attempting to normalise conversations about death. Social media and blogs by those living with stage 4 cancer have also enabled frank discussion and contemplation of death. Such personal accounts by those living their best lives and being as active as possible, while being good advocates for quality of life, are demonstrating that even with a terminal diagnosis a great deal can be achieved. These discussions tend to be different with older people and even though the term 'ageing population' is commonly referred to, the complex issues and concerns that may be experienced towards the end of life are rarely discussed. This ageism is reflected to a degree in NHS and Social Care career structures.

> "I remember when studying to be a physio, nobody wanted an elderly care Rotation, but in fact I really loved it because with orthopaedics or cardiology, you're just trying to fix that one thing, but with elderly care, it's more about optimising everything; all the different comorbidities make it really challenging and interesting. With stroke you get everyone working together so this is the model I favour. I think because I've worked in different settings you spend a bit more time with your patients because you have that luxury, and I've worked in about 20 different teams, so I know what works well and what doesn't work so well".

Another recommendation that came out of discussions with the CNT was around patient feedback concerning the level of discomfort experienced because of chairs provided on the wards while they are sitting out of bed. The team encourage neuro patients to 'sit out' forfour hours to encourage them to feel confident that they can go home and sit between care calls, but ward chairs are uncomfortable for patients. Other Trusts use riser recliner chairs that can be wheeled into different bays but current chair provision at RLH wards are not suitable to sit patients out due to the discomfort, and this means the team cannot demonstrate that patients are safe to go home as they are not sitting out in their chair for long enough, which then can lead to delayed discharge.

# Community Neuro patients and avoidable admission

“Something as simple as provision of a couple of riser recliners per ward that could be used for Assessment would have a significant impact on reduction of delayed discharges and LOS. Similarly, we are concerned about the limited numbers of commodes available. If can get out of bed, they are able to use the commode in a timely way as many neuro patients would be unable to use a bedpan”.

There is also a tension on the wards about designated roles that can ultimately dehumanise the experience for the patient. While the wards have a decent amount of space, it was suggested that provision of more comfortable chairs, and more commodes would encourage more people to have showers and improve wellbeing. It is recognised that such changes can take time as they concern people’s behaviour around what a nursing role is.

In some hospitals, Neuro QI projects have seen ward rooms converted to a gym equipped with weight machines, and trials have shown improved patient outcomes. However, when the QI project ended, sustainable improvements without a dedicated person leading the work proved challenging. One of the more successful initiativesinvolved marking a route with stickers to look like local landmarks and the physiotherapists engaged patients in balancing exercises on the 2-dimensional stickers. There is evidence that such initiatives encouraged engagement and led toearlier discharges.

“Patients could get their ‘passport’ signed off because they’d been to all the places on the route in the ward. I think it would be great to do a London marathon route at the RLH and have different landmarks around the ward for them to go and explore so it’s not just confined to their bed space”

# Homelessness and avoidable admissions

A specialist multi-disciplinary team: The Pathway Homeless Team work from the RLH, led by a GP and including a nurse, occupational therapist, social worker and care navigator. Referrals to the team come from inpatient wards, and people who are homeless are assessed with the aim of improving ongoing health. A major part of the team's work involves trying to ensure patients are not discharged onto the streets, but equally to connect them with preventative support such as help registering with a GP and accessing community health and social services input as appropriate.

The specific type of input provided post discharge varies depending on the reason for admission, as well as individual situations including whether they have recourse to public funds. Many homeless people have multiple other issues in addition to physical health problems, such as mental health and addiction problems which can lead to the involvement of the mental health liaison service and drug and alcohol nurses based in the hospital, and there can be a degree of overlap in the caseload seen by the teams. People living on the street and sleeping rough can be difficult to support especially if they have long term health conditions. If homeless people can stay with relatives or friends temporarily (known as sofa surfing) or stay in a hostel or temporary accommodation provided through LA housing, there is more potential for accessing support with ongoing health issues. Some people on the streets do manage to attend diagnostic, screening and treatment appointments, but those who have no base find it more challenging both in terms of getting to appointments and receiving appointment letters.

Some community services such as ARCARE have attempted to address such issues through delivery of programmes such as Pulmonary Rehabilitation (PR) in a hostel setting. Similarly, people accessing a hostel in TH are eligible for services like Reablement but one of the challenges is that being homeless often means moving around, sometimes across borough boundaries, so the Pathway Team spend time proving whether a person is entitled to services in a particular borough. Homeless people themselves may be unaware of the boundaries and may have a GP in another borough as they have a relative there but have been living in other areas.

# Homelessness and avoidable admissions

The GP who leads the Hospital Pathway Team also works at Health E1 GP surgery for homeless people in TH and regularly refers people with COPD to PR programmes with their consent. It was emphasised, however, that scope for a more preventative approach depends on many factors such as length of time a person has been homeless, their awareness of available services, and whether they are UK nationals and/or speak English. Practices like Health E1 enable people to get registered and potentially increase the ability to access timely interventions. There can be misunderstandings around the kind of support offered by hostel support workers, as their roles are not ‘hands on’ care, and this can lead to people not being provided with appropriate care packages.

> “They tend to help people with things like benefits but not necessarily with showering, bathing or preparing a meal. Sometimes hospital staff think they have a support worker in the hostel, so do not need to be referred for care, so we have to educate them about the role”.

Since undertaking this interview, an additional High Impact Change has been introduced by the DOH which has been actioned by the UCWG to ensure that links with the Homeless Team are strengthened and awareness raised, which is helping to address some of the above concerns. There are an increasing number of people who might not have eligibility for support including some EU residents who have not been in recent employment, which means they cannot access or be eligible for benefits or housing. People ‘without recourse to public funds’ may also be living with a long term condition and have limited access to nutritious food. There are night shelters, but people cannot always access them, and they are not available indefinitely, tending to be more available in the winter months.

# Homelessness and avoidable admissions

TH has the Grow TH night shelter open for five or six months of the year but people can only stay there for up to four weeks, so this is not a permanent solution. People also have to be well enough to be able to use a night shelter, as generally these are held in churches with a mattress on the floor and not are available during the day. If someone has mobility problems a shelter is unlikely to be a viable option. Some shelters require a financial contribution towards the cost of running them, and while Whitechapel Mission provides breakfasts, foods are limited. Often foods that people donate to individuals tend to be high in carbohydrates perceived as filling the stomach rather than nutritionally balanced or suitable for diabetics. Hospital management are very aware of the need to discharge people when they are medically stable, but being discharged to a safe and warm environment or to the streets is clearly a different proposition. While the Pathway Team try to advocate for homeless people, in a big busy hospital the focus is inevitably more on the immediate problem that led to the admission, even though homeless people may have many other problems.

> “Cognitive and memory problems are common, perhaps due to alcohol intake, so we try to highlight this while they’re in hospital, as well as any other things that may be barriers to safe discharge”.

The fact that a poor discharge is likely to result in a readmission can sometimes be overlooked where pressures to free up beds is paramount, so another important role played by the team is in helping wards to risk assess whether a homeless person is fit for discharge.

> “When most people come out of hospital, they probably have people to care for them, but regrettably, that’s not the reality for many homeless people. Some of them go onto the street or into night shelters, but even where housing is provided by the council, it might be a basic bed and breakfast up four flights of stairs. So, you really need to assess fitness for discharge against where you are being discharged to. You might be fit to go somewhere where you will get a lot of care and support, but you might not be fit for discharge if you’re going somewhere inappropriate.”

# Homelessness and avoidable admissions

Before the Pathway team raised awareness around homelessness, hospital staff often perceived they were offering helpful solutions to people living on the streets while not understanding the system. Previously the ward would signpost people to the LA homeless person's unit where it was assumed they would access accommodation. The reality is that it rarely offers accommodation and requires evidence of a local connection to an area in order to be eligible for help. Proof of a need for and eligibility for housing is often something that homeless people often don't have. When patients are first admitted to hospital, they undergo an assessment, so this is potentially an opportune point at which their housing status and ongoing support needs might be usefully explored, but resource issues mean this does not routinely happen.

> "We keep emphasising the importance of these questions early on in admission: do you have somewhere safe to go on discharge? And often we'll get a referral, sometimes when they've been in hospital for a while and it might be that they're just told, "Right, we're discharging you!" and at that point they have the conversation and discover that the patient hasn't anywhere to go. That's frustrating and often it's a lengthy process to help people apply for benefits or do housing applications and all those sorts of things which could have been done in parallel."

A positive development since the pandemic and the creation of the Integrated Discharge Hub (IDH) which is discussed in detail later, is that the question "Does this person have somewhere safe to go"? has been added to the IDH referral form.

# Homelessness and avoidable admissions

This issue will also be highlighted as part of a wider review of progress against the High Impact Change model being undertaken as part of the UCWG referenced previously. The Pathway Team facilitate benefit and housing applications and sometimes do manage to help get people housed bythe LA while they assess their case, and these interventions mean they gain access to 'the system', and opportunities to achieve some stability. The Team have achieved some positive outcomes with asylum seekers, working in close partnership with a local specialist Voluntary Sector organisation and a dedicated immigration solicitor.

Last year the team benefited from an LA employed social worker and saw evidence of improvement of outcomes for people with cognitive problems, memory problems or older homeless people whowould not have easily been placed within nursing or residential homes. The other advantage of having input from a Social Worker is that it helps to raise awareness of issues affecting homeless people across the social work team, and again demonstrates the positive impact of integrated working. The value of a dedicated homelessness occupational therapist is useful in the context of theRLH role as a major trauma centre. Many homeless patients who might previously have been independent may suffer major trauma such as being involved in a car accident, or being attacked, and the OT has specialist understanding of how needs might change. The OT can make a better case for housing around their vulnerabilities or the sort of support they might need. The Team also have aCare Navigator who has lived experience of homelessness and addiction in line with the model Developed by the Pathways Charity with the aim of improving the healthcare of homeless people.

# Rapid Response (RR) and Community Nursing

Delivery of the RR service was agreed widely as being effective but concerns about inappropriate use was voiced by team members, who felt that particularly those with long term conditions and complex issues were being referred inappropriately to RR for assessment to ease pressures and manage risk in different parts of the system.

> “The patient is safe at home, but they want RR to go in quickly to check them for long term care . We are asked to go in even though the referral was made five or six days before”.

Where there is a need for crisis management, for example if a GP refers a patient following a fall with the aim of admission avoidance, should RR assess a need for a care package to be set up to support avoidable admission, a referral can be made to Reablement directly. Where there are strong links with social workers support is easier to access, but if these established relationships are not in evidence, there can be inconsistency and a gap in service for those in the community who struggle to access more preventative input at short notice. AADS are flexible in their interpretation of rehab potential in order to provide timely support.

> “For example, a person who has cancer, and is nutritionally compromised with low energy, poor attention span, and in considerable pain, may not benefit from a conventional rehabilitation programme, so we would look at patient’s mobility, lying to sitting, and if they’re in bed and unable to roll, may be at risk of getting pressure sores with no potential to walk. The initial priority for us would then be optimising bed mobility”.

A suggestion made regarding Admission Avoidance was that co-location of a social worker with the Rapid Response Team would unlock many of the problems being experienced, but this has in many ways been eclipsed by the remote working systems implemented during the pandemic and found to be effective in resolving many existing communication issues.

# Rapid Response (RR) and Community Nursing

The creation of the RR Team was reported as very enabling by patients and carers, with clear evidence of the contribution it makes to preventing hospital admission. What is less clear is whether the RR team are being used to manage a capacity issue within the Community Nursing Team as was previously raised by therapists working in AADS.

Having a dedicated team to undertake assessment has advantages but also presents challenges, as each one takes a minimum of one hour. Early identification of any issues that may otherwise have been missed does, however, enable timely measures to be put in place and /or enables signposting to appropriate services. One of the systemic challenges identified is that TAA only undertake a maximum of three assessments per day due to issues such as unreliable Wi-Fi access and the unpredictable nature of where assessments may be required geographically, and the resultant travel time.

> “The team have the iPads, but sometimes when back to base, what was uploaded in the patient’s home is not on EMIS due to connection issues, so inputting is then completed in the office. Also, anassessment on the Isle of Dogs could be followed by one in Spitalfields, and because the level of demand for new assessments was initially not clear, the reduction in numbers of pool cars means TAA can only use the pool car during nights”.

It may take more than two hours to assess to complete a robust assessment, and both TAA and AADS felt an allocation of a dedicated pool car each would prove a good investment and lead to benefits for those responsible for urgent or unscheduled care.

# Rapid Response (RR) and Community Nursing

Another issue identified pre pandemic was the lack of multi-service team meetings, where opportunities to develop relationships across teams and to resolve issues across organisational boundaries and more cooperative approaches could be embedded. The care delivery teams felt under intense pressure and identified a limited amount of understanding across the community about the exact role and remit of the various services being provided by TTA and RR. Much as the NHS England team had set up in ED to challenge perceptions of the community, it was suggested that a similar exercise could prove useful amongst the community services.

> “We could enable people to step back, analyse and identify examples of different types of referral and different teams could engage in discussion about where this referral should or could best sit, thus enabling greater understanding of AADS and TAA. Part of the challenge is that people don’t understand what the various service remits are”.

> “It could be that a person has just been discharged from hospital and they need to have their insulin and the District Nurses (DN) don’t have capacity, so RR end up picking it up as there is the capacity to respond within two hours.We keep our capacity open, but before there was an RR team, the District Nurses would do it, although this often meant the DN would go home late. A lot of the time, the DN’s will call and say, “Please, will you help us?” and then you can’t not help your colleagues.”

# Rapid Response (RR) and Community Nursing

The Triage and Assessment Team (TAA) function is to undertake full nursing needs assessments, and the size of the team leaves them with limited scope for processing new referrals within a tight time scale as they book their visits in advance, and this means many referrals which are within 24 hours tend to land with the RR team.

> "Sometimes what happens is SPA will speak to a DN who will say, "I can't take it, tell RR to take it." And then poor SPA is in the middle...I think it's just easier for them to tell admin staff and then the admin staff are communicating with us, saying, "Well, they said they can't see this patient, can you see them?" A lot of the time I will say, "Can you tell me who the staff member was?" or "If you can ask them to give me a call?"

This can lead to tensions, and a degree of understanding is sought across EPCT and AADS to avoid the RR team feeling exploited. The Triage and Assessment Team enjoy a close relationship with AADS, with both teams being aware that between them they share responsibility for all unscheduled and urgent referrals. With only scheduled care falling under the responsibility of the EPCT's, the levels of pressure experienced across the teams differs. It wasn't entirely clear how the planning of the TAA staffing with regards to capacity and demand was undertaken, as attempts to access data that would help inform, for example, the numbers of new assessments in any week was not available. Although post creation of the TAA the EPCT staff may well have capacity for robust data collection and analysis, they shared that prior to the handing over of unscheduled care, the EPCT teams were under too much pressure to spend time gathering and analysing data. Lack of such data has created reported challenges in ensuring that staffing levels within the TAAT are adequate to meet demand.

# Rapid Response (RR) and Community Nursing

“We look at prioritising every referral that comes in: if it’s deemed to need to be dealt with within 24 hours, then TAA will discuss with the AADs RR team and agree whether they should lead on it. However, if it is clear that the referral was deemed urgent because the GP or social services have decided it requires urgent input we will have a discussion regarding the appropriateness or otherwise, and if it is agreed that it is in fact less urgent and more appropriate for the EPCT, then we’ll contact the locality therapist to have a discussion with regards to their contacting the patient to explain that they have a waiting list, but they will still be able to prioritise”.

Prior to the pandemic, daily meetings or telephone conference calls between TAA and LA staff ensured prevention of duplication and regular communication to some extent compensated for the lack of mutual access to Frame worki and EMIS systems and promoted positive integrated working .In terms of the contribution of the TAA to admission avoidance the aim is to provide robust and high-quality initial assessment that results in individualised care plans agreed with patients and families and handed over to EPCT’s to impact positively on avoidable admission. The teams ensure patients receive a regular supply of products as appropriate so, for example, catheters, as previously stock control issues presented problems.

> “Patients would go to ED because the night staff find no catheters in the house so now they are on the system every month they have supplies and a minimum of four extra catheters in the house”.

Having a dedicated team to undertake assessment has advantages but also presents challenges, as each one takes a minimum of one hour. Early identification of any issues that may otherwise have been missed does, however, enable timely measures to be put in place and /or enables signposting to appropriate services. One of the systemic challenges identified is that TAA only undertake a maximum of three assessments per day due to issues such as unreliable Wi-Fi access and the unpredictable nature of where assessments may be required geographically, and the resultant travel time.

# Rapid Response (RR) and Community Nursing

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It may take more than two hours to assess to complete a robust assessment, and both TAA and AADS felt an allocation of a dedicated pool car each would prove a good investment and lead to benefits for those responsible for urgent or unscheduled care.

Another issue identified pre pandemic was the lack of multi-service team meetings, where opportunities to develop relationships across teams and to resolve issues across organisational boundaries and more cooperative approaches could be embedded. The care delivery teams felt under intense pressure and identified a limited amount of understanding across the community about the exact role and remit of the various services being provided by TTA and RR. Much as the NHS England team had set up in ED to challenge perceptions of the community, it was suggested that a similar exercise could prove useful amongst the community services.

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There is evidence that there is widespread lack of knowledge and understanding of different services across the whole system, as well as how they can best work together at the interface, and as a consequence a lack of detailed awareness of how and where the TAA, Intermediate Care, Rapid Response, In-reach and Admission Avoidance Teams work, as was evident when talking to ED personnel as well as Community.

# Rapid Response (RR) and Community Nursing

One successful suggestion to emerge from the Discharge Forum and to be implemented, was the sharing of examples of poor discharges to provide an opportunity for providers across the system to problem solve together. The Discharge Forum did this on a bi-monthly basis pre Covid and engaged participants from across the system so represented a positive example of building bridges, identifying what good can look like as well as sharing learning across individuals and teams. As the Clinical Lead for AADs explained:

> " It also helps focus people's understanding of the patient context, for example, identifying when a patient actually needs imminent therapy, as sometimes they are presented as requiring RR, when once triaged, it becomes evident that the need could wait another week or so clinically. For example, we had a referral stating 'Very high risk of falls' for a patient in a residential home. Originally it was a referral to community EPCT therapists, but as there was a waiting list, they appeared to decide to refer instead to Rapid Response".

The high expectations of and pressures on the AADS, RR and In-reach were recognised by LA partners and in particular the need to have an integrated approach across the system. The UCWG meets regularly to ensure a whole system approach to admission avoidance, and this helps manage patient flow and timely discharge. The UCWG includes representation from CCG, London Ambulance Service, Barts Health clinicians, Hospital Social Work, LA social care, and Community representation and there are two sub-groups looking in detail at particular areas. Barts Health developed a 'Choice' policy, which aimed to enable discharge to take place once an offer for a suitable support package or interim placement was made. Barts Health were able to implement a legal process to get people out of hospital, but this Choice policy was viewed as a last resort and its implementation seen as 'too little too late', with a commitment to more timely discussions to avoid confrontations and help to better manage expectations being preferable. This policy was suspended during the pandemic, as there was a shared view that hospitals were not safe places to be if alternatives could be set up.

# Reablement

The perception that Reablement can be used as a means of cutting services rather than something positive to empower a return to optimum independence was raised by some voluntary groups working with people with LTC’s and disabilities in the community. The reassessments undertaken by Reablement were viewed with caution by some; regarded as evidence of attempts by the team to challenge a culture of dependence, with those relying on services perceiving Reablement as a way of rationing or stopping their ongoing care and support. While the work that Reablement undertake in partnership with the AADS team has received positive feedback from service users and carers, there is more scepticism amongst those who have experienced a reduction in support following a review by the team.

> “People come to our Advice team and say “We’ve got a reablement assessment coming up!” and although I’m sure it can be very successful and is used well for people coming out of hospital to get back into the swing of things when they’ve just done their hip in or whatever, it’s sometimes used as a way to put in arbitrary cuts for people with disabilities care packages.”

Many examples were shared of annual reviews of care packages resulting in a decrease of support which was viewed as punitive rather than liberating by the patients and carers. While an annual review is not intended to be used as an opportunity to completely reassess a person’s needs unless there has been a substantive change to their situation, and evidence of a change to their need, people can be offered 4-6 weeks of reablement that while sounding like a great opportunity to benefit from help to become more independent is not always made clear that at the end of the input this may result in reduced services. There was a recognition of the challenge faced in the context of decreased resources, but the potential impact of reducing support can be a squeeze on a different part of the system, and an avoidable admission to hospital.

# Reablement

This perception about Reablement can sometimes then act as a disincentive to people who benefit from care packages and who struggle over the longer term with tasks that they manage to achieve with the extra input. It is unsurprising that if the Reablement are assessing with a view to a reduction in the level of care provided, those being assessed may feel reluctant to demonstrate their optimal ability or to try to be more independent, as it can feel like a punishment for their efforts.

"In some cases maybe a reduction is appropriate, but in many cases it's been short-sighted as, not unlike benefits assessments: you'll get a question, "Can you lift your arm above your head?" and if you say, "Yes" they'll just assume you can do that many times a day, unless you stress, "Yes, I can but it's really painful!" or "Yes, I can but then I have to rest for half an hour afterwards." Or "I can lift my hand, but I can't actually do anything with it, so I wouldn't be able to get something out of a cupboard".

Healthwatch have raised the issue of the extent to which the life Course Workstreams are able to have a direct influence on procurement of services. Despite the focus on strong collaboration across agencies to achieve outcomes outlined in the 'I statements' such as environmental factors that impact on health and a commitment to reducing mortality from respiratory diseases, there are identifiable missed opportunities such as around sustainable transport. The experience of GP's in TH during the early days of lockdown was that the improvement to air quality resulting from lower emissions led to fewer prescriptions being issued for asthma reliever medications and fewer asthma attacks leading to ED attendances and admissions. This suggests that the pandemic may offer a timely opportunity to look at and address environmental factors which lead to admissions in TH

.

"With patient transport for example, pollution reduction is not seen as a priority and given that there are over a million journeys a year being made to transport patients across Barts Health sites, it presents an opportunity to explore electric vehicles and the bigger environmental picture."

# Reablement

In 2015 one of the largest NHS trusts in the North East moved to an almost all-electric fleet of vehicles with savings in transport costs being reinvested in patient care, although there seem to be few initiatives since then, despite the shared agreement around the need for urgent action to address the climate emergency. Low Traffic Neighbourhoods or LTN's have been introduced with some controversy, but the pandemic provides an incentive to reconsider such issues, as many outpatient consultations become virtual and fewer journeys may result.

# Mental health and wellbeing

The Recovery and Wellbeing Service split into several different contracts early last year. Connecting Communities formed one strand, the Working Well Trust delivers employment opportunities through Mind in Tower Hamlets, while the Recovery College is led by ELFT and links into Recovery and Wellbeing. There is also a form of ‘floating support’ called the ‘One to One Service’, which specialises in supporting with emotional issues resulting from modern slavery and human trafficking. Connecting Communities deliver what they describe as ‘the right support at the right time’.

> “People were pointing out that they may be well at a particular moment in time, but might be unwell in six months’ time, so the challenge is how to stay well. By offering different elements within the service, such as a navigation team, including supported signposting and ‘warm transfers’, we aim to identify the support an individual needs and the way they can access it”.

The MIND navigators have extensive knowledge of different organisations in TH, and the different activities and groups that are running, and this enables provision of supported signposting to people. MIND also link in with the community navigators based in each of the Ideas Stores who focus on wellbeing and have a welfare benefits specialist advisor in relation to mental health and homelessness, so can signpost to a variety of specialist organisations such as those concerned with substance use. MIND also have a wide range of group activities which are free to access and provide onward signposting. The group activities focus on the ‘Five Ways to Wellbeing’ model and include activities such as cycling, Thai boxing, gardening, creative writing, and confidence building, which evolved from suggestions made by participants and are 20-30% co-produced; aiming to increase peer leadership and co-production over time.

As access is always through navigation this enables expectation and capacity to be successfully managed and navigators have training that equips them to deal with challenging situations, as well as access a range of more preventative interventions and available activities to signpost to.

# Mental health and wellbeing

A lot of the groups are run and led by people with lived experience of MH problems, and many who have been through programmes feel their involvement is key to spreading both understanding of recovery and acts as a means of inspiring others to cascade knowledge and understanding. As well as structured training programmes, mapping case studies has been powerful in promoting learning and understanding, and stories, visual, audio, and filmic tools can engage people to a greater degree than data alone.

A challenge already identified by many organisations involved in supporting admission avoidance and maintenance of wellbeing is around mapping an individual's journey, and the difficulty in evidencing the value and consequences of preventative interventions, as, by their very nature, it is hard to identify with any certainty that a particular intervention led to successful avoidance of a probable crisis.

> "How to evidence that you've prevented x number of hospital visits because of the elements of support provided is a challenge. We are doing a peer research project with people who have been through the programme, but it is hard to evidence which parts of the process may have prevented a crisis".

In a time where there is a scarcity of resources there is recognition across the system that a form of 'competition' exists around the various services and interventions who feel they need to lay claim to having made the all- important intervention to prevent avoidable admission, and this can conflict potentially with any commitment to developing a more integrated and cooperative approach across the system.

An issue raised frequently in relation to potential improvements to whole systems working is information technology, which is identified as creating barriers between organisations as EMIS, Adastra, RIO, CRS and Frame worki (now Mosaic) are all in use but inaccessible to different users. A universal desire to resolve this was shared.

# Post pandemic update and the creation of an integrated discharge hub

Since the pandemic, a cross organisational Integrated Discharge Hub (or IDH) has been created and led by the Clinical Lead for AADS. The team members work closely to ensure that discharges are safe, timely and appropriate. The AADS Team work together with Hospital Social Work, and the Complex Discharge team with twice daily virtual meetings held to discuss all patients identified as clinically ready for discharge. A multi-agency friendly risk assessment tool and scoresheet has been recently developed by Social Work. The aim is for Social Workers to set up care only for those who really need their input, and this is soon to be piloted. The Hospital Social Work Manager explained that they are aiming to maximise the best use of available resources.

> "Currently, we have everything going via a social worker, whether it's a high or low risk, but that really doesn't make sense with limited social workers, and the voluntary sector can do a lot with a little bit of support. So, I designed a tool for scoring to help people think through whether somebody who hasn't got a lot of need could manage to go home with support from the voluntary sector. The middle band of people are those who maybe need an OT assessment and then reablement, and the most complex will go via social work. I think the principle is basically sound as it is risk based, so it aims to help people think through: maybe this looks like an easy restart, but actually it helps to evaluate risk factors that might make it more complex, so is a safety measure really".

The voluntary sector often have established links with patients that mean they can be helped to reconnect and gain support. It was pointed out that it shouldn't be assumed that all older people are digitally excluded, and if they are, as part of Direct Payments laptops or mobile phones can be purchased.

> "Our use of direct payments is growing and has been for quite some time, and I think it will continue to, because it offers more choice for people and it's cheaper for social services to run as well, so the money goes around further".

# Post pandemic update and the creation of an integrated discharge hub

The Hub co-designed the discharge tool and developed an IDH referral form which has been reviewed with staff at RLH. Previously there were policies in place that gave the LA guidance around supporting people on discharge from hospital, and Section 5's meant that discharge must take place within 72 hours of their being medically fit, or risk incurring charges being enforced by health partners for unnecessary occupation of beds. This aimed to facilitate and support timely discharge without incurring charges and was intended to be in the interest of both patients and service providers.

However, since the pandemic, new guidance was issued that decreases the timeframe and puts increased pressure on the discharge process. Patients who no longer meet the 'criteria to reside' in hospital are meant to now be discharged on the same day, and for the cohort of patients with more complex needs, this is viewed as potentially unrealistic.

Broad agreement across IDH and other partners was expressed that safety must be a priority, so a more flexible and integrated approach has been implemented. A pilot on 14th with IDH has been measuring the impact of aiming for discharge to take place within 48 hours of the person being referred, with the date changed to the 'predicted date of discharge', proving more achievable at the point of writing.

# Post pandemic update and the creation of an integrated discharge hub

Where there is a need for a step-down bed while awaiting placement in a nursing home, or if a person is homeless, for example, a number of beds have been purchased to enable safe transfer out of hospital. Jubilee Lodge in Chigwell is one option, but in the absence of the Choice policy being implemented, patients and their relatives may be reluctant to accept an interim placement and this can present a challenge. At this stage there has been some resistance from family members about accepting step down arrangements outside of TH, and this can sometimes conflict with the wishes of the patient who may recognise their own need for support in such an environment. One strategy to help manage such potential resistance is the production of an information leaflet that clearly sets out the plans and necessary measures to ensure safety, particularly during the pandemic where hospital may present infection control issues, so that from the point of admission it is clearly understood by patients and their relatives that once the criteria to reside is no longer met they will be moved out of hospital.

A positive outcome in evidence and prompted by the pandemic was a significant change in attitude of patients and relatives towards timely discharge. The risks of acquired infection and exposure to Covid-19 meant that there was shared agreement and understanding that stays in the hospital environment should be kept to the absolute minimum, and this led to greater levels of cooperation around discharge plans. Although there was a slight reduction in cooperation during the summer when the levels of Covid were diminishing, the resurgence of infection in autumn means expectations are that discharge planning will see a return to greater cooperation once more as concerns about risk are raised..

he creation of a ‘corridor’ in East Ham Care Centre to protect residents from patients who may have Covid means that placements can be challenging to set up and any delays in agreeing to a proposed move can mean the bed ceases to be available. No-one who is Covid positive should be discharged to a Care Home, and must go to an interim placementEarly on the poor experience of people being unable to access tests and PPE meant that there was a degree of caution amongst families about accepting a Care Home placements for their loved ones, as they feared they might become infected.

# Post pandemic update and the creation of an integrated discharge hub

Another issue raised by care homes was that swabs should always be undertaken while the patient remains in hospital to ascertain whether they test positive. This has been implemented due to an injection of additional funds. There has also been resourcing for increased packages of care to be provided in people’s own homes through health funding. This can be provided for up to 6 weeks to enable safe and timely discharge from hospital, however, the additional funding must only be used to support the care needed over and above that which was being provided prior to their admission, so requires careful tracking and evidencing per patient. Another related potential challenge is where informal carers may feel that they are unable to provide additional levels of support after the 6 weeks ends, and where there are ongoing additional support needs. The LA may assess eligibility to provide additional ongoing resources is not met, so this may lead to a potential risk of the patient bouncing back into hospital after the 6 weeks expires.

Another positive development identified during the pandemic has been that the AADS therapists joined with therapists from EPCT’s and Reablement, to form one large team, and this increased their ability to be responsive in a timely way. The acute therapists were also redeployed to form a larger hospital discharge team and to support the respiratory and other specialist teams within the hospital (with the benefit of additional training). The challenge associated with this was that the therapists in the discharge team only tended to see the patient once and their ongoing needs may not be so apparent. The discharge to assess model advised avoidance of generalised assessment of baselines, as this is deemed to be subjective. It recognises that the ward staff do not know the person or their level of independence prior to admission and the importance of working in partnership to enable the individual to achieve personal goals is regarded as paramount.

D2A Home First innovators such as Liz Sergeant acknowledge that this can be a factor in exclusion of some people from accessing rehab and raises concerns about patients who may not be able to return to baseline, but who may still benefit from rehab being denied it.

# Post pandemic update and the creation of an integrated discharge hub

D2A challenges therapists who might feel there is an absence of “rehab potential” and regard this notion as essentially negative, advocating instead that therapists should ask each person what they need to get home. This way of working can however be hard to establish on one meeting as it requires a level of trust and rapport that typically takes longer to establish.

D2A advocates that it is preferable and more appropriate for a patient to be assessed in their own environment, but this is potentially more time consuming and complicated where the person may have some challenging behaviour, as is often the case.

The step-down beds in Jubilee Lodge in Chigwell may be an appropriate way to meet need but patients and relatives have raised concerns about the distance and potential impact of being unable to have any visitors and this in turn has led to a degree of concern by patients and families. Another concern is that people who do agree to go to the step down beds out of borough may not be able to access a level of input from therapies while in the facility to ensure they maintain their optimal level of independence, so even where it is agreed that it will be an interim measure, the Tower Hamlets team may struggle to address any deterioration in ability to enable them to return safely to independent living.

There is general agreement that there is a need for a unified approach to empowering patients to make decisions about their future, and this patient-centred approach should be evident across organisations. Several examples were shared where the expressed wishes of the individual patients were somehow ‘lost’ in the pressure on staff to facilitate discharge. This is perhaps inevitable during these challenging times, particularly where patients may have been expressing unwise wishes that would require a longer journey to support them to explore and maybe accept that their aspirations may not be realistic. A potential inequality also exists where those without relatives and friends to advocate on their behalf may feel pushed into making decisions they are less comfortable with

# Conclusions

The planning for more integrated systems was well underway before the pandemic, withconsideration being given to the extent and level of integration required being explored by commissioners. Questions being debated included systems requirements for structures to work to enable unified planning, with recognition of the need for this to happen at operational as well as at a very senior level. While those in senior management and leadership positions understand the bigger picture around what is required for integrated systems to work, several managers shared that because of crisis management related to the pandemic as well as regulatory and other pressures, attention gets necessarily diverted and creates organisation specific problems and an inward looking focus. In order to enable systems change to happen at different levels; from individual practitioner to head of service, it was agreed that the dynamic of understanding of what can and should be done needs to be openly shared. Tower Hamlets Together offers an ideal conduit to bring people together around this shared vision; enabling issues to be explored and addressed across the partnership and leading to quality improvement being actioned across the whole system.

Some of the comments made by the CCG and senior managers during the updated Pandemic context follow up calls indicate that the level of communication and joint approach adopted across the system and necessitated by the need to manage the crisis have led to some improvements. The Hospital Social Work and Reablement Manager shared her view that rather than the pandemic presenting a challenge to integrated working, it has acted as the springboard for organisations to look creatively at ways to work more effectively together:

> "It's been one of those things where people respond to a crisis, and it's because we know we've all got to pull together, and we've managed to let our usual cultural differences go. The willingness to see things the same way and pull together; that is really important, I think, probably more importantthan being physically co-located".

# Conclusions

There was, however, an acknowledgement by other managers that the initial goodwill shown across the system has begun to be replaced by an organisational perspective once more.

Looking to the future, a truly person-centred approach that looks at health and social care as well as emotional care is perhaps one way of managing to address avoidable admissions and promote health and wellbeing. Instead of the medical model, service users, carers and citizens would be involved in defining what 'good health' and 'good care' look like to them, and so feel empowered to work in partnership in designing the sorts of support that will end cycles of avoidable admissions to hospital. Some of the exciting work being done in the Life Course Work steams has done just that, but to date there is little evidence that those with a more operational level overview or lived experience are engaged in this work. The intention to continue some of the Vanguard led work created in partnership with the User and Stakeholder group, to be succeeded by the Stakeholder Council, has been interrupted by the focus on the pandemic but presents an opportunity for partnership work going forward.

In terms of leadership, it was suggested that leaders may benefit from being allowed to problem-solve first, without having to consider organisational boundaries, but this may require a maverick way of doing things that the system is does not currently support.

Similarly, people using services and informal carers could be empowered to come together as partners to ask, "If we could do this differently, how would we do it?", and service providers, could be enabled to test out and transform these new visions into a reality, given the wealth of experience, expertise, insight and operational management know-how that exists across the system. As a senior leader shared:

# Conclusions

“We need to put systems in place that still meet needs, but do so in a different way, while controlling the finances to ensure we are making good use of available resources. It is about ‘what does good look like’ and ‘how can we get there’, as one of the problems is everything is so short term. People think it’s not a great time for piloting new ways of working when budgets are so squeezed, but it’s actually the best time because you need to be more creative”.

A way forward might therefore be for THT to provide opportunities for partner organisations, stakeholders, those with lived experience and carers to all come together and consider not only what ‘good’ would look like, but to be able to weigh up the potential impact on different parts of the system of any proposed changes; to have the opportunity to explore what might be done in a different and a better way, and engender a sense of shared ownership of the whole system and outcomes.

While there has been real investment in preventative services delivered in particular through the voluntary sector, there is an argument that the system is not set up to ensure best use is made of resources available. Services such as Linkage Plus centres that provide opportunities for social networking, may not be reaching those who might benefit most from them. The Local Community Fund has replaced the LA mainstream grants programme, and is vastly oversubscribed we with hundreds of applicants for a relatively small pot of money. In order for the voluntary sector to make contact with those who may be very isolated, there needs to be adequate resources to enable development and identification of those in need, but many single person projects struggle to expand the work they do. Given that the reduction in resources is a reality, Commissioners are equally realistic about the need to ensure that the right services are available to those who need them at the right time.

# Conclusions

> "I think one of the things we need to get a common consensus on is what is the activity that needs to happen, so regardless of who does it or where the system is, to agree what it is that people need, whether that is somebody to go with a vulnerable person to an appointment, or to not only make a referral, but to follow up".

A carer turning up at A&E with the person they are caring for in crisis through lack of support may be more indicative of problems accessing support than the support not being available, which is an example of the need to ensure services are widely publicised and that people in the system know about the services. An up to date and widely accessible Directory of Local Services would help ensure appropriate uptake.

> "There is a respite policy for example, but it depends on whether that person hits the social care threshold. Attempts are underway to develop a broader respite policy for crisis situations which is potentially to support those who don't hit social care thresholds, but that's more challenging. It is not clear whether everyone knows how to access it and feels comfortable with accessing it. Whether anybody in ED for example, is aware of the crisis respite arrangements if somebody was to take the person they care for there …are they going to put them in touch ….probably not, but you'd hope that that's what should be happening".

A carer described her attempts to join one of the relevant Life Course workstreams and her request for meetings to be held at a specific time on a particular day of the week to enable her to set up respite care, and was told that this wasn't possible given the scope of the meeting and existing commitments of key members of the group. This is understandable but also, equally easy to understand the frustration of the carer. The workstreams are operating with varying degrees of effectiveness and a review of membership and structure is underway

# Conclusions

Another real issue in terms of the forward plan and changing the health of the residents of Tower Hamlets is that people are complex, and behaviours are often contradictory. Many of us know what is good for us but behave in a way that can have a negative impact on health. The inclusion of health psychologists in designing new models might therefore help to inject another level of understanding.

# Appendix 1: links and further information

References
https://www.england.nhs.uk/publication/why-not-home-why-not-today-reducing-length-of-stay-action-cards/

https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-term-stays/?mkt_tok=eyJpIjoiWWpKaE16UmtZalF6WkRBeSIsInQiOiJueVdnYXBCS0Q1a3EybzByZlYxaDRtRmNaYkRMVytITFV6em1TblwvQXJjc0R3S1dOZjlndjY2Q1lWbCtkMGFqTWxQR1FOQlpYSnBcL2xjZ3F3K3BMMTc4a3RpTHh1VHNIVU41bnhRSnNSTWp0eEdjVzZlaGpnUW83K1B3K0RDS2RqIn0%3D

https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

P.32 https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/shared-lives-schemes/
P.29 https://spitalfieldsmusic.org.uk/creative-encounters-with-spitalfields-music/

Links:
https://www.youtube.com/watch?v=Cc97hvLrUFk&feature=youtu.be
Singing for your Life

https://spitalfieldsmusic.org.uk/creative-encounters-with-spitalfields-music/
Spitalfields dementia and music project

Principles of Reablement
https://www.scie.org.uk/reablement/what-is/principles-of-reablement?utm_campaign=11344530_SCIELine%2026%20February&utm_medium=email&utm_source=SOCIAL%20CARE%20INSTITUTE%20FOR%20EXCELLENCE%20&utm_sfid=0030f000031hXhIAAU&utm_role=Researcher&dm_i=4O5,6R5HU,V7YK2A,QZTF4,1

# GLOSSARY of Abbreviated Terms

AADS: Admission Avoidance and Discharge Services
AAT: Admission Avoidance Team
ACP: Alternative Care Pathway
A&E: Accident & Emergency (now known as ED or Emergency Department)
ARCaRe: Barts Health Community Respiratory Care and Rehabilitation Service
BEACH: Barts Emergency Access Coordination Hub
CCGs: Clinical commissioning groups
CN's: Care Navigators
CNT: Community Neuro Team
COPD: Chronic Obstructive Pulmonary Disease
CPD: Certification for Professional Development
CYP: Children and Young People
D2A: Discharge to Assess
DI: Discovery Interviews
DNA: Did not attend
DoH: Department of Health
ED: Emergency Department (formerly known as A&E)
ELFT: East London Foundation Trust
EMI: Elderly Mentally Infirm
EPCT: ELFT Tower Hamlets Enhanced Primary Care Teams
ECIP: Emergency Care Improvement Programme
GPCG: GP Care Group
HACT: Housing Association Charitable Trust
HIU's: High Intensity Users
LA: Local Authority
LD: Learning Disabilities
LGC:
LOS: Length of Stay as in inpatient
MEH: Mile End Hospital
MHLS: Mental Health Liaison Service (Formerly known as RAID)
MiDoS: My Health London Directory of Services
MS: Multiple Sclerosis
MUS: Medically Unexplained Symptoms
OOH: Out of Hours Service

# GLOSSARY of Abbreviated Terms

OPAT: Outpatient parenteral antibiotic therapy
OPRG: Older Peoples Reference Group
PAS: Psychological Assessment Service (formerly known as RAID)
PET: Patient Experience Team
PRU: Physician Response Unit
REAL: a group for disabled and non-disabled people in Tower Hamlets to make change happen www.real.org.uk
RESET: Drug and alcohol service
RR: Rapid Response
SLT: Speech and Language Therapist
TAA: The Triage and Assessment Team
TBI: Traumatic Brain Injury
THT: Tower Hamlets Together
UCWG: Urgent Care Working Group
UTC: Urgent Treatment Centre
UTI: Urinary Tract Infection

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