NHS
Merton
Clinical Commissioning Group

A&E services: reducing pressure and supporting frequent attenders

The Healthier Communities and Older People Overview and Scrutiny Panel - 12th March 2019

right care
right place
right time
right outcome

Introduction

- Working alongside system partners, the CCG is delivering a range of interventions to reduce pressure on A&E services and to ensure patients are treated in settings appropriate to their level of need
- Key objectives include:
  - Primary and community services being enhanced to meet growing demand
  - Effective signposting/assessment to direct people to appropriate settings of care
  - Collaborative working with acute trusts to support the management of patients, including timely assessment and discharge

Primary care

There is a wide range of work underway in primary care to ensure that practices are able to support patients appropriately:

- Primary Care Extended Access hubs providing weekend and evening appointments
- Access at practice level being supported by a range of interventions including digital solutions
- Frequent attenders initiative, where frequent A&E attendees are identified and invited to attend an extended GP consultation to discuss the reasons for their attendances as well as being sign-posted to alternative appropriate services
- Social prescribing services enabling people to be directed into a range of non-clinical services, addressing wellbeing needs in a more holistic way

NHS 111

The SWL CCGs are working to enhance the Integrated Urgent Care Service (NHS 111 and GP Out of Hours) as follows:

- Development of a Clinical Assessment Service (CAS) within NHS 111 to allow more calls to be handled and managed by clinicians, negating the need for onward referral or signposting
- Extending the range of services that NHS 111 can directly book into, supporting patients to attend an appropriate service following their 111 call

Integrated Care and Community Services

- The Merton Health and Care Together Board has been a vital instrument for driving forward change in an integrated manner within the borough
- A number of initiatives have been developed which align with partners across the health and care system to help avoid unnecessary attendances at A&E and ensure greater access to community based interventions
- Schemes include:
  - Managing complex patients using the Integrated Locality Teams
  - Reactive and Rapid Response and Falls Prevention Services
  - Enhanced Support to Care Homes
  - Improving Discharges

Integrated Locality Teams (ILTs)

ILTs are multidisciplinary teams of specialists comprising staff from health and social care, aligned to GP practices. They aim to:

- Embed partnership working:
  - HARI (Holistic Assessment and Rapid Intervention) – providing clinical assessment for patients with complex needs and developing care plans, which may include rehabilitation or referral to other health or social care services and utilising therapists, geriatricians and advanced nurse practitioners
  - Care coordinators
- Avoid unnecessary hospital attendances through closer working and more coordinated care:
  - MERIT URGENT – clinical service providing urgent (within 2 hour) review in the community to avoid admission
- Promote well being and maximise independence:
  - Bed based and home based intermediate care

Enhanced Support to Care Homes

- A range of individuals, services and organisations play a role in supporting care homes and care home residents which helps to reduce avoidable A&E attendances and non-elective admissions
- Red bag pathway in place in nursing and residential homes for older people – red bags are provided to care home residents and are packed with important information/supplies of medicine if patients are admitted to hospital
- Merton Joint Intelligence Group (MJIG) established, bringing together a range of professionals to support quality improvement in care homes
- Merton Care Home Forums taking place which are positively received
- Care home training / other initiatives delivered in relation to identified priority areas
- Plans are being developed in order to deliver enhanced primary care and community services input

Improving Discharges

Effective discharge is crucial in supporting the flow of patients through A&E. A range of initiatives are in place:

- Single Point of Access – partnership initiative between London Borough of Merton, CLCH, Merton CCG, and St George's Hospital (with roll out to St Helier and Kingston Hospitals) to provide a single point of access for intermediate care
- Home First – discharge to assess model, with home as the usual pathway
- Intermediate Care beds – a new 14 bedded unit to open in Wimbledon in 19/20 staffed by CLCH nurses (and interim use of beds at Woodlands)
- Managing Delayed Transfers of Care to ensure patients are discharged from hospital in a timely manner

Mental Health

Frequent attenders scheme:

- Acute hospitals identify and support frequent attenders in A&E – individuals are supported to understand their condition better and to access alternative services
- Crisis Care Plans are developed in partnership with the patient and community mental health teams and shared with the GP

Alternatives to hospital attendance/admission:

- Crisis Café has been commissioned and has been in place for 2 years – providing safe, welcoming spaces for people who are struggling to cope with their mental health during evenings and weekends
- Social Prescribing piloted in 2017-18 and rolling out to all of Merton in 2018-19. Intended to support people to manage their wellbeing and some of the non-medical issues that can lead to crisis e.g. housing, access to employment or benefits etc

Acute Hospitals and London Ambulance

- St George's Hospital has implemented a streaming model which identifies patients who may be better supported in alternative settings (such as their own GP practice), and redirects them away from the front door of A&E. This is also being implemented at St Helier Hospital
- For those who need to be in a hospital setting, the Trusts are running Ambulatory Emergency Care (AEC) services. These services will ensure patients are seen, treated, and discharged from hospital on the same day, thus supporting flow through the hospital
- The CCG will be commissioning an Older People's Advice and Liaison (OPAL) Service based in St George's A&E. The service will facilitate and support the early identification of frail and complex patients and will initiate a geriatric assessment
- The CCG is also working with London Ambulance Service to review and update local Appropriate Care Pathways (ACPs), ensuring they are relevant, accurate and easy to use for paramedics. ACPs allow patients to be taken to settings that are not A&E if clinically appropriate
- The CCG will be working to implement the national High Intensity Users programme in 19/20, building on the work already in place to support frequent A&E attenders

Appendix

Merton Senior Health & Wellbeing Services 2018








Merton Rapid Enhanced Intervention Team (MERIT)

Mon to Fri: 8am – 7pm

020 8687 4840

Saturday, Sunday and Bank Holidays: 10am-6pm

0333 004 7555

Infections, including urinary tract

Urgent urinary catheter issues

Worsening long term condition

Functional deteriorations

Breathing problems

Diarrhoea and vomiting

Minor injuries (sprains, cuts, minor burns) resulting in further deterioration

Concerns regarding diabetes management

Uncontrollable pain

Community Nursing and Case Management

Mon to Fri: 8am – 5pm

0333 004 7555

At all other times including bank holidays:

020 8102 3333

Urgent nursing problems that will not wait until the next planned visit, including minor injuries, wound care and urinary catheter issues.

End of life care such as syringe driver support.

For Out of Hours Urgent Problems Call 111

Case Management – Clinical and non-clinical interventions incl. care navigators and domiciliary medications reviews

Palliative Care

CLCH Merton End of Life Care Team

Mon to Sun: 9am to 5pm

0333 004 7555

End of life care - advice and support
Advance Care Planning
Coordinate My Care
Care home support

St Raphael's Hospice
0208 099 7777
Referrals: 9am-3.30pm
Community Specialist Team: 9am-5pm Mon- Sun
Hospice @ Home: 9am-5pm Mon- Sun
Inpatient Unit: 24 hours
Deterioration/Disease progression
Supportive care at home
Advanced Care planning/Coordinate my care
Psychological/Emotional support
Pain/Symptom management
Bereavement support

Mental Health

Mental Health Services for Older People

Mon to Fri: 9am – 5pm

020 3513 6325/6301

For ages 75+, and those 65+ with memory problems

Adult Mental Health Assessment Team

Mon to Fri: 9am to 5pm

020 3458 5596

Adult Mental Health Services for all referrals

Out of hours Crisis Line

0800 028 8000

Specialist Support

CLCH Dementia Service

Mon to Fri: 9am – 5pm

0333 004 7555

- Pre-diagnostic advice and assessment
- Post-diagnostic support
- Cognitive Stimulation Therapy
- Carer support
- End of life support

Specialist Nursing:-

- Cardiorespiratory including cardiac and pulmonary rehab
- Diabetes
- TVN
- Parkinson's
- HIV

Falls Prevention

CLCH Falls Prevention Service

Mon to Friday 8-4:00

0333 004 7555

Non urgent Referrals

- Pts who have fallen
- Potential to fall
- Fear of falling.

Home Response

- Falls Risk Assessment Advice
- Home Exercise programme.

Onward referrals Staying Steady Exercise and advice Classes

Otago Home Exercise Programme for those who are less mobile or cannot attend the class.

Proactive Rehabilitation

CLCH Domiciliary Therapies

0333 004 7555

- Rehabilitation for patients at home to increase functional abilities
- OT, Physio, SALT & Dietetics

HARI

- Geriatrician, Nursing, Physio & OT MDT
- Holistic assessment for frailty with co-morbidities
- Multi LTC.
- Clinic based at The Nelson
- Patient groups
- Pharmacist

Home Based Rehab

- MDT rehabilitation for a maximum of 6 weeks
- Post-acute /intermediate care admission or intervention to prevent acute admission

Voluntary Sector

Local organisations include:

- Age UK
- Dementia Hub
- Wimbledon Guild
- Merton Vision

Age UK

A practical guide to healthy ageing in Merton

Click Here

This page is intentionally left blank