

Improving Care Home Access to Urgent Care

London Clinical Senate Forum, 26th January 2017



Summary

Data from the London Ambulance Service (LAS) shows that there are a significant number of care homes across London STP/ U&EC Networks that frequently ring 999 when another service may be more appropriate, for example in London there were **513 requests** for an ambulance for **catheter problems** between April to November 2016.

The ratio for conveyance of these calls to EDs is high. An **average 83%** of LAS call outs from care homes resulted in **conveyance to ED**, between April and November 2016.

The following slides provides further detail on these challenges as well as ways that Integrated Urgent Care can help support care homes when they are unable to get in contact with the care home resident's GP.

Total Calls by Time of Day

The main time of day for care homes to request an ambulance during November was predominantly **in hours**, particularly around **midday and in the afternoon**, mid-week. During this time it is more likely that patients who have been conveyed will be admitted to hospital.

Therefore, if care homes are experiencing difficulty in contacting the resident's own GP Practice, then they can now ring 111 and use a **special access code for urgent clinical advice from a GP (see slide 18 for more detail)**.

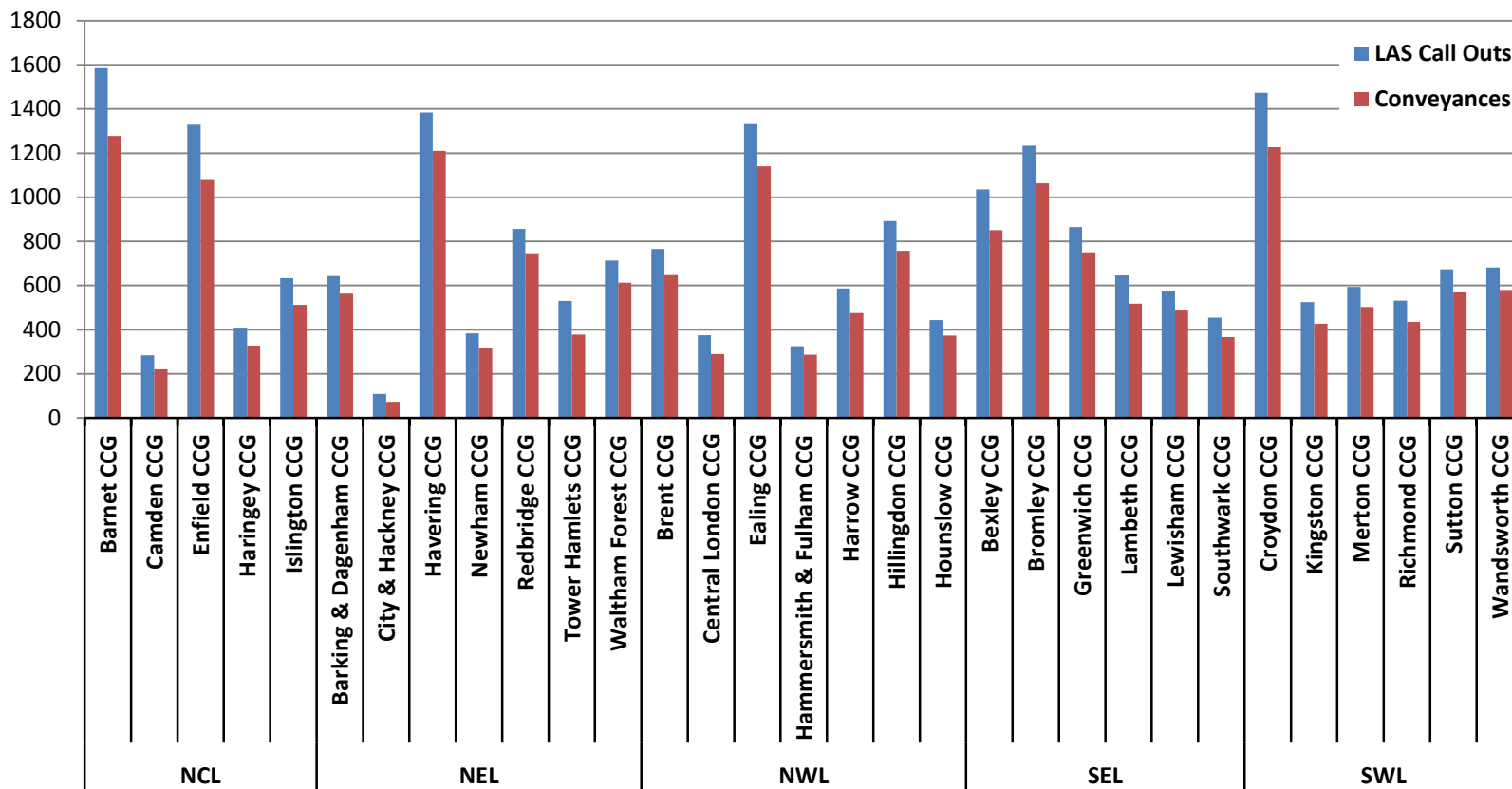
111 Providers are staffing GPs within the 111 Contact Centre during these peak times to help reduce call volumes to 999 and inappropriate conveyance to hospital.

Total	Hour																							Total	
Day	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
Mon	11	11	10	8	9	4	9	12	19	24	27	28	28	25	23	21	23	17	15	16	12	14	18	10	394
Tue	10	5	3	10	3	12	12	21	30	18	28	26	27	22	29	28	33	26	30	25	12	13	19	10	452
Wed	9	13	6	6	8	9	15	15	21	40	31	35	28	34	33	25	24	22	21	18	23	21	17	11	485
Thu	4	8	7	7	11	6	10	6	20	21	23	19	27	31	23	27	15	26	17	10	15	11	10	6	360
Fri	8	2	4	3	4	7	11	8	20	22	18	24	23	27	33	32	24	19	18	22	17	13	20	14	393
Sat	11	5	3	7	6	8	4	14	16	19	34	30	26	16	15	18	21	17	28	22	16	17	16	5	374
Sun	11	11	4	11	10	10	6	15	25	29	27	21	23	23	15	20	28	18	13	16	10	12	11	9	378
Grand Total	64	55	37	52	51	56	67	91	151	173	188	183	182	178	171	171	168	145	142	129	105	101	111	65	2836

LAS Call Outs & Conveyances

Over a 8 month period Barnet CCG had the highest number of requests for an ambulance with 1585, and 1278 conveyances to hospital, between April and November 2016. The following slides show a breakdown by each STP area.

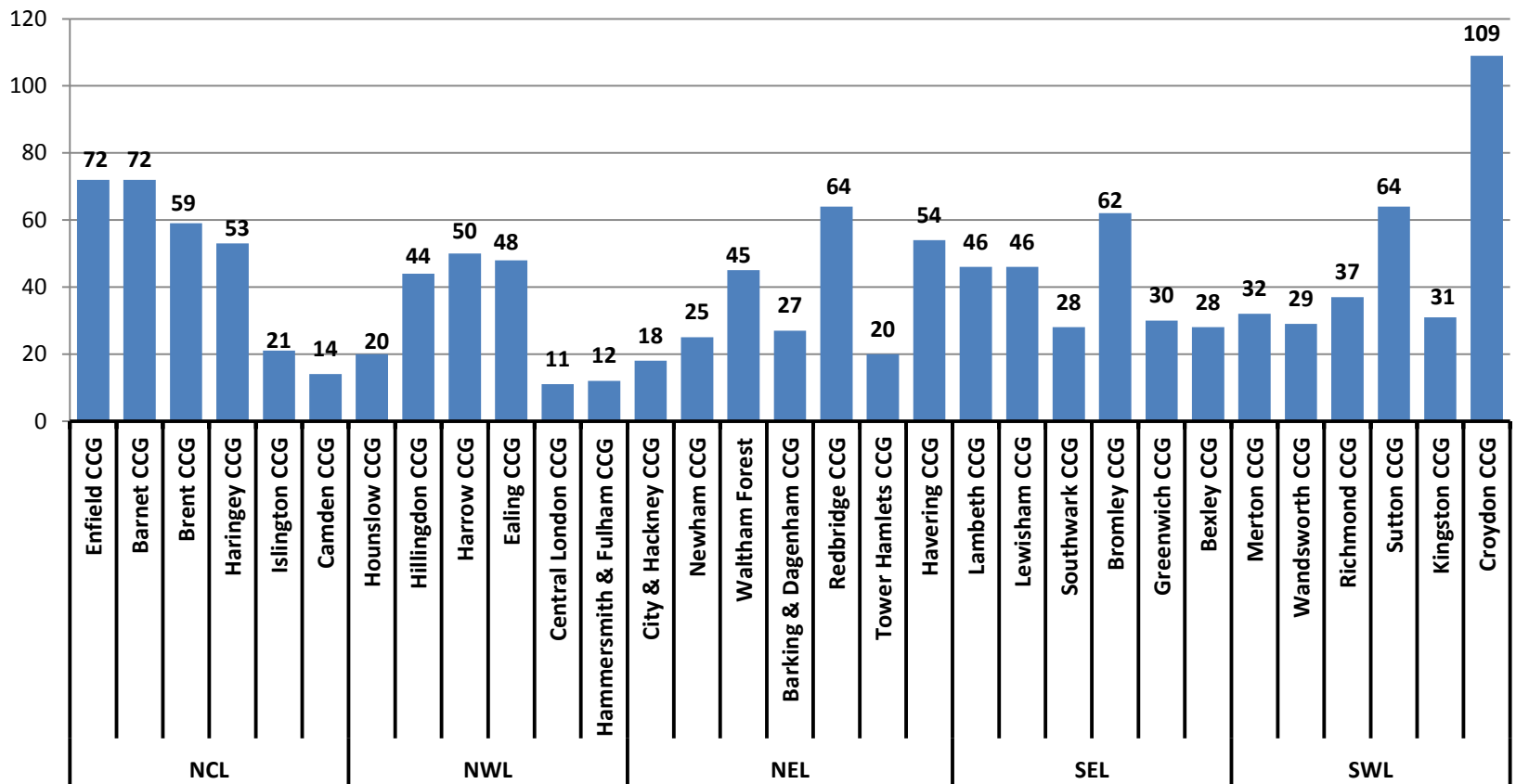
LAS Call Outs & Conveyances by CCG/STP



Number of Care Homes across London

The following shows the number of care homes within each CCG and STP area so that the numbers can be compared relative to the breakdown in each area.

Number of Care Homes by CCG/STP Area



Monthly Trends of LAS Call Outs by CCG

STP	Rank	CCG Name	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
NCL	1	NHS Barnet CCG	218	197	216	215	226	227	224	177
	5	NHS Enfield CCG	192	184	163	153	155	139	171	172
	17	NHS Islington CCG	90	75	57	99	70	68	77	97
	26	NHS Haringey CCG	52	55	62	51	43	45	49	52
	31	NHS Camden CCG	46	32	31	34	38	42	32	29
NCL Total			598	543	529	552	532	521	553	527
NEL	3	NHS Havering CCG	166	151	152	180	191	183	190	171
	10	NHS Redbridge CCG	124	127	105	105	113	100	94	88
	12	NHS Waltham Forest CCG	94	97	87	85	95	84	86	86
	16	NHS Barking and Dagenham CCG	77	86	90	98	77	64	86	65
	22	NHS Tower Hamlets CCG	70	78	72	64	63	70	54	60
	27	NHS Newham CCG	47	47	55	54	52	49	44	35
	32	NHS City and Hackney CCG	12	13	20	15	16	15	4	14
NEL Total			590	599	581	601	607	565	558	519
NWL	4	NHS Ealing CCG	160	136	164	141	199	179	184	169
	8	NHS Hillingdon CCG	102	104	119	113	120	106	109	120
	11	NHS Brent CCG	84	95	99	96	102	104	98	88
	19	NHS Harrow CCG	71	62	66	77	58	79	88	86
	25	NHS Hounslow CCG	61	60	50	55	70	58	50	39
	28	NHS Central London (Westminster) CCG	54	45	34	54	44	58	46	40
	29	NHS Hammersmith and Fulham CCG	43	30	45	43	54	32	45	33
	30	NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	36	50	34	36	47	30	43	47
NWL Total			611	582	611	615	694	646	663	622
SEL	6	NHS Bromley CCG	167	163	134	158	152	143	171	146
	7	NHS Bexley CCG	114	123	132	127	122	137	137	144
	9	NHS Greenwich CCG	106	113	98	126	119	89	96	118
	15	NHS Lambeth CCG	75	93	73	78	85	82	84	76
	20	NHS Lewisham CCG	69	72	57	77	71	73	84	71
24	NHS Southwark CCG	41	58	62	29	57	64	71	72	
SEL Total			572	622	556	595	606	588	643	627
SWL	2	NHS Croydon CCG	212	173	176	207	146	201	182	176
	13	NHS Wandsworth CCG	91	90	85	95	66	73	90	92
	14	NHS Sutton CCG	87	88	80	81	86	78	93	80
	18	NHS Merton CCG	78	85	67	98	77	74	64	51
	21	NHS Richmond CCG	66	81	75	74	57	53	52	74
23	NHS Kingston CCG	82	75	63	50	62	66	59	68	
SWL Total			616	592	546	605	494	545	540	541

NCL – Top 10 Care Homes

Within NCL between April-November 2016, the care home with the highest number of LAS call outs and conveyances was Carlton Court Care Home which had a **total of 115 LAS call outs**, of which on **87% resulted in conveyance** to hospital.

CCG	Location	Incidents	% Conveyed
Barnet CCG	Carlton Court Care Home	115	87%
Barnet CCG	The Arkley Nursing Home	107	83%
Islington CCG	Lennox House	107	90%
Islington CCG	Sheltered Housing Scheme	99	62%
Haringey CCG	Priscilla Wakefield House	94	90%
Brent CCG	Birchwood Grange Nursing Home	93	89%
Camden CCG	St Johns Wood Care Centre	93	92%
Barnet CCG	Lady Sarah Cohen House	86	84%
Barnet CCG	Lansdowne Care Home	83	90%
Barnet CCG	Apthorp Lodge	78	82%

NCL – Reasons for LAS Call Outs

The following table shows a few of the reasons for LAS call outs from care homes within NCL between April and November 2016, including **372 requests for an ambulance for patients who were 'generally unwell'** and **262 for patients with a chest infection** and **181 for vomiting**, which could be potentially treated within Primary Care.

Illness Type	Total
Generally unwell	372
Respiratory/Chest infection	262
Urological	226
No injury or illness	204
Vomiting	181
Abdominal pains	178
Pyrexia of unknown origin (fever)	146
Minor cuts & bruising	142
Catheter problems	135
Confusion/distressed/upset	106
Laceration/incision (superficial)	105
Minor injuries (other)	93
Hypoglycaemia (low blood glucose)	88
Dizzy/near faint/loss of coordination	85
Hypotension (low blood pressure)	84
Pain – Back	67
Hyperglycaemia (high blood glucose)	66
Hypertension (high blood pressure)	52
Diarrhoea	47
Psychiatric problems - diagnosed	47

NWL - Top 10 Care Homes

In NWL, between April-November 2016, the care home with the highest number of LAS call outs and conveyances was The Grange Care Centre which had a total of **159 LAS call outs, of which 82% resulted in conveyance** to hospital.

CCG	Location	Incidents	% Conveyed
Ealing CCG	The Grange Care Centre	159	82%
Ealing CCG	Norwood Green Care Home	116	89%
Central London CCG	Forrester Court	99	89%
Ealing CCG	Acton Care Centre	98	97%
Ealing CCG	Manor Court Nursing Home	96	93%
Hillingdon CCG	Kingsley Court Care Home	87	95%
Central London CCG	Penfold Street Project	81	58%
Hammersmith & Fulham CCG	The Chiswick Nursing Centre	81	91%
Ealing CCG	Martin House	80	78%
Ealing CCG	Sycamore Lodge	77	79%

NWL - Reasons for LAS Call Outs

The following table shows a few of the reasons for LAS call outs from care homes in NWL between April and November 2016, including **281 requests for an ambulance for patients who were 'generally unwell', 214 for patients with a chest infection and 134 for vomiting**, which could be potentially treated within Primary Care.

Illness Type	Total
Generally unwell	281
Respiratory/Chest infection	214
Urological	196
No injury or illness	158
Abdominal pains	138
Vomiting	134
Pyrexia of unknown origin (fever)	122
Confusion/distressed/upset	117
Minor cuts & bruising	108
Catheter problems	84
Laceration/incision (superficial)	70
Pain – Back	66
Dizzy/near faint/loss of coordination	63
Hypotension (low blood pressure)	63
Psychiatric problems – diagnosed	58
Minor injuries (other)	55
Hypoglycaemia (low blood glucose)	49
Hyperglycaemia (high blood glucose)	43
Hypertension (high blood pressure)	37
Diarrhoea	28

SWL – Top 10 Care Homes for LAS Incidents

Within SWL, between April-November 2016, the care home with the highest number of LAS call outs and conveyances was Laurel Dene which had **a total of 104 LAS call outs, 83% of these resulted in conveyance** to hospital.

CCG	Location	Total Incidents	% Conveyed
Richmond CCG	Laurel Dene	104	83%
Wandsworth CCG	Nightingale House	104	88%
Croydon CCG	Albany Lodge Nursing Home	96	88%
Wandsworth CCG	Ashmead	90	90%
Merton CCG	Woodlands House	85	79%
Merton CCG	Eltandia Hall Care Centre	84	90%
Wandsworth CCG	Brendoncare Ronald Gibson House	83	89%
Croydon CCG	Addington Heights	82	84%
Wandsworth CCG	Lyle House	77	71%
Croydon CCG	Parkview Nursing Home	75	88%

SWL - Reasons for LAS Call Outs

The following table shows a few of the reasons for LAS call outs from care homes in SWL between April and November 2016, including **380 requests for an ambulance for patients who were 'generally unwell', 217 for patients with a chest infection and 150 for vomiting**, which could be potentially treated within Primary Care.

Illness Type	Total
Generally unwell	380
Respiratory/Chest infection	217
Urological	202
Fracture/possible fracture	189
No injury or illness	167
Abdominal pains	162
Vomiting	150
Minor cuts & bruising	123
Confusion/distressed/upset	115
Pyrexia of unknown origin (fever)	100
Laceration/incision (superficial)	93
Catheter problems	92
Minor injuries (other)	85
Pain - Back	82
Dizzy/near faint/loss of coordination	81
Psychiatric problems - diagnosed	79
Hypotension (low blood pressure)	73
Hypoglycaemia (low blood glucose)	48
Gastrointestinal	35
Diarrhoea	31

SEL – Top 10 Care Homes

Within SEL, between April-November 2016, the care home with the highest number of LAS call outs and conveyances was Northbourne Court which had a **total of 180 LAS call outs, 81% of these resulted in conveyance to hospital.**

CCG	Location	Total Incidents	% Conveyed
Bexley CCG	Northbourne Court	180	81%
Bexley CCG	Old Wells House	161	80%
Bexley CCG	Parkview	157	81%
Greenwich CCG	Ashgreen House	100	87%
Bromley CCG	Lauriston House	97	95%
Lewisham CCG	Brymore House Care Home with Nursing	94	89%
Southwark CCG	Tower Bridge Care Centre	89	85%
Lambeth CCG	British Home & Hospital for Incurables	86	90%
Greenwich CCG	Brook House	84	83%
Bromley CCG	Regency Court	84	83%

SEL - Reasons for LAS Call Outs

The following table shows a few of the reasons for LAS call outs from care homes within SEL between April and November 2016, including **487 requests for an ambulance for patients who were 'generally unwell', 245 for patients with a chest infection and 134 for vomiting**, which could be potentially treated within Primary Care.

Illness Type	Total
Generally unwell	487
Respiratory/Chest infection	245
No injury or illness	213
Urological	209
Fracture/possible fracture	188
Minor cuts & bruising	185
Abdominal pains	167
Vomiting	134
Pyrexia of unknown origin (fever)	132
Laceration/incision (superficial)	109
Minor injuries (other)	105
Catheter problems	103
Confusion/distressed/upset	93
Hypotension (low blood pressure)	92
Pain – Back	87
Hypoglycaemia (low blood glucose)	73
Hyperglycaemia (high blood glucose)	70
Dizzy/near faint/loss of coordination	68
Psychiatric problems - diagnosed	53
Gastrointestinal	28
Diarrhoea	27

NEL – Top 10 Care Homes

Within NEL, between April-November 2016, the care home with the highest number of LAS call outs and conveyances was Chaseview Residential & Nursing Home which had **a total of 154 LAS call outs, 90% of these resulted in conveyance to hospital.**

CCG	Location	Total Incidents	% Conveyed
Barking & Dagenham CCG	Chaseview Residential and Nursing Home	154	90%
Havering CCG	Havering Court Nursing Home	136	84%
Havering CCG	Romford Care Centre	128	91%
Havering CCG	The Fountains	97	88%
Redbridge CCG	Springfield Care Centre	94	94%
Waltham Forest CCG	Heathlands Care Centre	80	96%
Waltham Forest CCG	Albany Nursing Home	79	87%
Newham CCG	Manor Farm Care Home	78	82%
Havering CCG	Barleycroft Care Home	77	92%
Havering CCG	Hillside Nursing Home	74	81%

NEL - Reasons for LAS Call Outs

The following table shows a few of the reasons for LAS call outs from care homes within NEL between April and November 2016, including **441 requests for an ambulance for patients who were 'generally unwell', 190 for patients with a chest infection and 162 for vomiting**, which could be potentially treated within Primary Care.

Illness Type	Total
Generally unwell	441
Urological	224
No injury or illness	205
Respiratory/Chest infection	190
Vomiting	162
Abdominal pains	151
Minor cuts & bruising	146
Pyrexia of unknown origin (fever)	108
Confusion/distressed/upset	103
Laceration/incision (superficial)	103
Catheter problems	99
Minor injuries (other)	81
Psychiatric problems – diagnosed	80
Dizzy/near faint/loss of coordination	69
Hypotension (low blood pressure)	68
Hypoglycaemia (high blood glucose)	61
Diarrhoea	54
Pain – Back	50
Hyperglycaemia (low blood glucose)	46
Gastrointestinal	30

Overview

The evidence shows that we need to work with care homes and make them aware of **alternative services** are available such as 111, when patients present with non-life threatening symptoms, amenable to primary care assessment and intervention.

Opportunity to **target care homes** with the highest number of LAS call outs / conveyance rates first, to **reduce system wide pressure**, i.e. the top 10.

A number of **IUC Winter Improvement Pilots** can help support care homes when accessing Urgent Care, the following slides provides a summary of each initiative, as well as ensuring learning from the **Sutton Care Home Vanguard** is shared and embedded.

IUC Winter Improvement 111 Code Pilot

New 111 Code for Care Home Staff

This is a **dedicated code for care home staff** when they call 111 to ensure no clinician/HCP/carer is alone.

If a care home resident is unwell, requiring an urgent assessment and attempts to contact the resident's GP have been unsuccessful, then care home staff can dial 111.

The Interactive Voice Recording (IVR) will then prompt the care home staff to input a code ***6** which will enable them to be **routed directly to a GP within 111**, or if a GP is not immediately available then they will be called back within 20 minutes.

Additional GP capacity within 111 has been funded during times of high demand from care homes.

This ensures that care home staff receive a more efficient service, by enabling them to:

- **Gain clinical advice & assessment from GP (when resident's GP is unavailable)**
- **Arrange for a home visit / home video link if required**
- **Be transferred to a relevant service e.g. mental health, dental, pharmacy or community nursing service**

Purpose & Benefits

Enables care home staff to speak directly to a GP via 111, when the resident's own GP is unavailable, ensuring right care is provided in a timely way and enabling **quicker access to senior clinical advice and treatment**, referral to primary care or transfer to other appropriate services.

A **more efficient and positive experience of using NHS 111** increases the likelihood that care home staff will use this service rather than relying on 999, which can lead to a **decrease 999 incidents, reducing conveyances to ED and hospital admissions.**

IUC Winter Improvement Tele Care / Video Linkage Pilot

Care Home Tele Care / Video Linkage Winter Pilot

When care homes cannot access support from the resident's GP, care home staff can be supported to make use of technology to make **joint decisions about the care of residents with a GP via 111**. For example, residents can be assessed remotely through a video link, thereby **avoiding unnecessary trips to hospitals or call-outs of NHS staff to care homes**.

Objective: reduce demand on LAS 999 from care homes by giving carers and nurses **rapid access to a GP assessment via 111** without the need to move the patient or for a visit by a doctor

- **Initial pilot with LCW in NCL/INWL to compliment the vision outlined in the Enhanced Health in Care Homes toolkit**
- **Call volumes from care homes to 111 across all of London are significantly less than calls to LAS999**
- **We know that care for patients at the end of their life could be much better in London and for most patients if asked state they want to remain in their home/care home. An estimated £4,223 is saved when patients die in a care home rather than hospital.**

Purpose & Benefits

Creation of a video link between care home services and extended virtual GP In Hour provision to support **reduction of demand on LAS999 in real-time and drive uptake of 111** across London's care home, supporting care home patients achieve preferred place of death and reducing impact on Emergency Departments.

IUC Winter Improvement Rapid Response Winter Pilot

Enhancing & mobilising Rapid Response Services Winter Pilot

Objective: **Prevent admissions, reduce length of stay and reduce DTOC** by managing patients in out-of-hospital settings by **increasing capacity in Rapid Response Nursing services** in the community to accept a greater proportion of referrals from NHS 111.

A rapid review of London, national and international Rapid Response nursing initiatives carried out by the HLP U&EC team in October 2016 produced **key findings on best practice** and the vital ingredients **for successful Rapid Response services**, including:

- **A single point of access with referrals possible out-of-hours and opening hours extended; often 7 days a week**
- **Most initiatives allowed for any health care provider and social care to refer**
- **Response times are short, usually assessment within two hours, giving patients and other healthcare professionals and services confidence**
- **Many initiatives had direct links to other health and social services for onward referral**
- **Social care provision was often included, especially for frail, vulnerable patients after an event and older falls patients**
- **The services were only offered to patients for a set time - usually from 48 hours to a week after which patients are referred.**
- **Acceptance criteria are clear to avoid delay**

Purpose & Benefits

Provide greater Rapid Response Nursing support through integration with Integrated Urgent Care services to reduce high acuity outcomes from NHS 111 calls, such as ambulance conveyance, A&E attendances and ED admissions.

This will build on the learning gleaned from detailed case study analysis which demonstrated the importance, whose common theme was supporting frail, vulnerable patients who have suffered an event and also for older falls patients and using the service to treat patients in their own home, where in all cases ED admissions and ambulance conveyance were significantly reduced.

Sutton Care Home Vanguard

The Care Home Vanguard in Sutton has been carrying out a number of initiatives to improve the care of patients as well as increase care home staff knowledge and skills.

A range of **e-learning modules** have been developed for staff covering areas such as continence care, dementia and person-centred thinking.

In addition, a number of resources have been developed to help the hospital transfer pathway for when a care home patient has been assessed by a GP as requiring hospital intervention.

For example, the **Red Bag Initiative** which is for patients when hospital admission is the appropriate care. The red bag contains standardised paperwork, medication and personal belongings, stays with the care home resident from the time they leave the care home to go to hospital until the time they return to their care home at the end of their stay in hospital.

The standardised paperwork ensures that everyone involved in the care of the care home resident will have **vital information to hand about their general health**, e.g. the current concern, and any medication they are already taking, ensuring their stay is minimised and the patients return to their care home is speedily arranged.

For more information on all the Sutton Care Home Vanguard Initiatives go to <http://www.suttonccg.nhs.uk/vanguard/Resources/Pages/default.aspx>

Sutton Care Home Vanguard Care Home Poster

As part of the Sutton Care Home Vanguard, a **poster** has been created by Sutton Community Health Services for care home staff, this has been adapted and is being **rolled out across London** with the support of the U&EC Network Leads, and **tailored to CCG areas**. The image below depicts the poster for Lewisham CCG.

Are you concerned about a resident?*

*Please check the resident's Care Plan before ringing

							
Self-Care or Community Pharmacy	111	Rapid Response Team	Community Nursing	Palliative Care	Mental Health	GP	999
<p>For common illnesses, please contact your community pharmacy</p> <p>Skin conditions, e.g. mild acne, mild eczema and itchy scalp Coughs and colds, including nasal congestion and sore throat Minor cuts and bruises Minor burns Constipation and haemorrhoids (piles) Hay fever and allergies Aches and pains, e.g. headaches, earache, back pain and toothache Indigestion and threadworms Warts and verrucae, mouth ulcers and cold sores Athlete's foot, head lice and scabies</p>	<p>Medical help that is not for an emergency, which could include:</p> <p>Unwell resident Chronic breathing problems Worsening confusion Worsening pain Need health information</p> <p>During Out of Hours contact 111 for:</p> <p>Palliative Care GP Mental Health Community Nursing Minor injuries Wound care Urinary catheter issues</p>	<p>Lewisham Winter Assessment Team 020 8315 8722</p> <p>Monday-Friday 8am-6pm (Tel triage from 8am, last referral 4pm)</p> <p>Prevention of A&E Admission for symptoms such as;</p> <p>Urinary Tract infections/retention; worsening long term conditions; functional deteriorations; breathing problems; chest infections; Falls, Wounds, slips/trips and vomiting etc</p>	<p>In hours: 8.30am-5pm 0208 3147777</p> <p>Out of hours: Weekday 5pm-10.30pm; Weekends and bank holiday 8.30am-10.30pm Call 111</p> <p>Urgent nursing problems that will not wait until the next planned visit, including minor injuries, wound care and urinary catheter issues</p>	<p>Lewisham Macmillan support Mon to Fri: 9am-5pm 020 8333 3017</p> <p>St Christopher's Hospice Opened 24 hours 7 days a week: 020 8768 4500</p> <p>Deterioration/disease progression</p> <p>Supportive care at home Pain and symptom management End of life care Emotional support</p>	<p>South London and Maudsley Mental Health Trust New referrals: via GP only</p> <p>For known patients call 0800 home intervention team</p> <p>Mon to Fri: 9am-5pm 0203 228 8672</p> <p>Urgent support line (new and known patients - 18+) 24hrs 7 days a week 0800 731 2864</p>	<p>Available on telephone advice during surgery hours, home visits and surgery appointments</p> <p>General medical concerns Medication concerns e.g. side effects On-going medical/psychiatric problems</p> <p>GP Out of Hours Call SELDOC (GP out of hours) 0208 693 9066 Or Call 111</p> <p>Mon to Fri: 6:30pm-8am Weekends and Bank Holidays: All hours</p>	<p>A life threatening emergency that needs immediate intervention or transport to an acute hospital</p> <p>Chest pain Choking Fitting (new or prolonged) Severe breathing problems Stroke Sudden change in responsiveness Severe loss of blood Diabetic emergency (Hypoglycaemia with other symptoms such as drowsiness, or Hyperglycaemia with increased thirst and urination) Head injury - on anticoagulant medication and/or has a bleeding tendency</p>

Working with
Lewisham Clinical Commissioning Group
London Ambulance Service NHS Trust, The Royal Marsden NHS Foundation Trust,
Sutton Community Health Services, Healthy London Partnership

Healthy London
Partnership

NHS

Sutton Community Health Services

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For any required changes please contact england.nhs111submissions@nhs.net

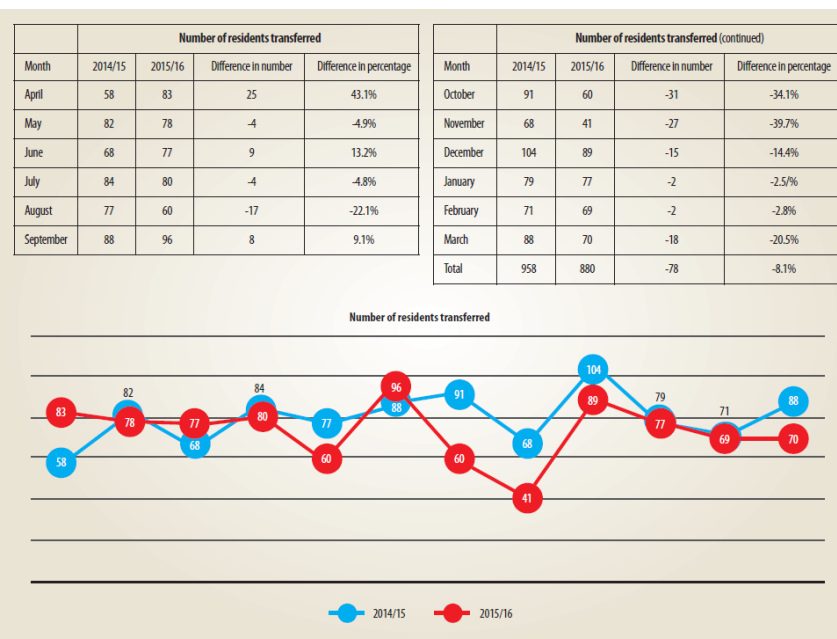
Care Planning in Care Homes

High quality end-of-life care ensures that people die in the place of their choosing with dignity and in comfort. Care home residents have the same entitlement to these types of high-quality care as everyone else.

Ensuring **care homes develop care plans** using an end of life system such as Coordinate My Care (CMC) can help ensure care home staff and other agencies involved in a patient's care e.g. LAS, Primary Care and Acute Hospitals etc., are aware of the patient's wishes in regards to their preferred place to die.

CMC are working with the Sutton Care Home Vanguard to increase the number of residential patients with care plans. An audit found **8.3% fewer calls from nursing homes to the ambulance service** in the year following CMC training and development of CMC care plans.

Also from the Sutton Vanguard there has been a **50% increase in Advance Care Planning** and **80% of care home residents dying in their preferred place of death**.



Ref: Improving end-of-life care in nursing homes: an innovative model of education and training, EUROPEAN JOURNAL OF PALLIATIVE CARE, 2016; 23(5)

Care Home Forums

An **active, well-attended care provider forum helps strengthen relationships** between CCG and local authority commissioners, providers, care home owners and managers.

Likewise, online communications or **regular engagement** between commissioners and a care home association can achieve the same goals. Online engagement is particularly helpful for providers who are not members of a forum and for regional managers who work across large areas and may therefore be unable to attend meetings in person.

Commissioners and providers of care home services **working together** either through a local care home forum or through online networks can help to **co-develop** and **co-produce solutions** to problems that they have in common.

For example, the Sutton Vanguard has used care home forums to **help understand the local issues faced** and to explore what specific support and training is needed.

Croydon Pilot Care Home Pack

The Care Home Pack was created, as part of an initial 111 learning & development programme, for a pilot with Croydon, to be adapted and shared across UEC networks, includes the **SBAR tool** to help nurses identify any red flags when assessing a patient.

The SBAR Tool – Situation, Background, Assessment & Recommendation

If your patient has any of the Red Flags consider dialling 999 When calling 111 stand by the patient.

RED FLAGS

CURRENTLY FITTING
UNCONSCIOUS
CRUSHING CHEST PAIN
OBSTRUCTED BREATHING
RESP RATE >25 OR <8
HEART RATE >130 OR <40
BP < 90

Name	DOB
Address	
Tel No:	
Staff to contact at residence:	
Next of kin	Contact no.

Significant Medical history	✓	Year / comment
Diabetes		
Stroke / Neurological		
Heart		
Lung		
Dementia / mental health		
Recent operations	Circle:	CmC SPN DNAR Allergies:

Situation:
I am a registered nurse/nurse/health care worker calling from xxx Home
I am calling about (patient X)
I am concerned that...
(e.g. he has a chesty cough or he is confused more than usual)

Background:
Patient X is years old with a history of (significant medical history)
He appears to have ... (e.g. fallen down the stairs/steps, deteriorated over the last 24 hours)
He was last seen by the doctor on
He has/has not a DNAR in place

Assessment:
I think he has a possible (Chest infection, broken hip) He is conscious, his BP P.....
respiratory rate
OR
I am not sure what the problem is but patient (X) is deteriorating, in a lot of pain, not responding
OR
I don't know what's wrong but I am really worried

Recommendation:
I need (you to assess him, arrange for a district nurse,)
AND
Is there anything I need to do while I am waiting?
(E.g. repeat the obs, give analgesia)

PTO

Medication	Dose regimen	Covertly given

If your patient has any of the Red Flags consider dialling 999

This sheet is designed to assist your conversation with the Urgent Care Services. The SBAR tool helps staff anticipate the information needed by colleagues and provides a structure for the conversation with the doctor. The information will help you answer the questions asked by the 111 Health Advisors or LAS quickly and efficiently. Write over the grey areas as necessary.

Important - You need to be standing with the patient when talking to 111 as you will be required to touch the patient to assess for 'shock' and report the patient's condition at the time of the call.

If your patient is transferred to hospital please send a copy of the sheet with them for the hospital staff.

S Situation:

Identify yourself the unit you are calling from
Identify the patient by name and the reason for your call
Describe your concern
Firstly, describe the specific situation about which you are calling, including the patient's name, GP, patient location.

B Background:

Give the patient's reason for admission
Explain significant medical history, DNAR status
You then inform the Doctor of the patient's background: admitting diagnosis, date of admission, prior procedures, current medications, allergies. For this, you need to have collected information from the patient's chart, flow sheets and progress notes.

A Assessment:

Vital signs
Clinical impressions, concerns

R Recommendation:

Explain what you need - be specific about request and time frame
Make suggestions
Clarify expectations
Finally, what is your recommendation? That is, what would you like to happen by the end of the conversation with the doctor/health advisor? Any order that is given on the phone needs to be repeated back to ensure accuracy.

The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

How will we know the impact?

- **Call quality**
 - 111 Call reviews, include end to end call reviews within local AE delivery groups and networks
- **Staff experience** (111, GP in hub & GPOOHs, 999, Care Homes)
- **Patient outcomes – tracking the patient’s journey**
 - PEMs
 - Final Patient Outcome
 - Case studies – qualitative interviews with patient & staff
- **Impact on NHS 111 / IUC Hub/ Primary Care /GP OOH/Ambulance Services**
 - Monitor number of ambulance call-outs & conveyance rates in targeted care homes against baseline data
 - Number of GP care home visits / call backs (in hours / out of hours)
 - Monitor call to 111 from Care Homes from baseline