East London NHS Foundation Trust

'Improving flow in ED - an approach to improving care throughout the emergency care journey'

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The Royal London Approach

- Triage role
- Frequent Attenders planning
- Hopewall

Triage

Ethos – to ensure right care sooner in the ED journey…… not to turn people away

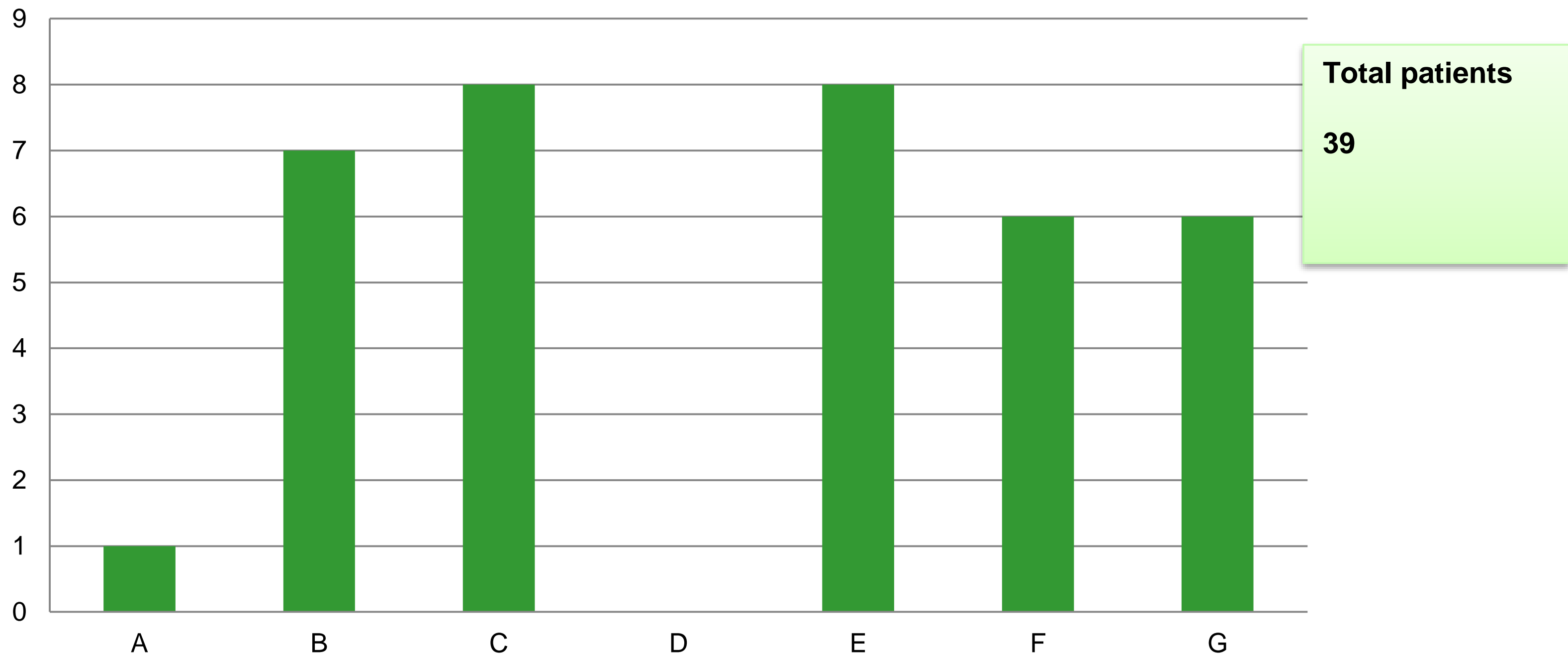
- Band 7 nurse – 2pm-10pm
- Bristol Triage tool adapted – based on the Australian Triage Tool
- Assessment is right after initial 2 minute streaming
- Aim to see person within 20 min of referral

Who is it not for

- Under 18 years old
- Attending A&E with condition which requires medical check such as overdose or self-harm requiring medical intervention
- People being brought in on a section 136
- People being streamed into UCC
- Intoxication

People are now seen in LAS bay as well as people walking through from the street

What is the picture so far



Barriers?

- Reinforcing the ethos – it's not about turning people away
- Initially getting a room
- Fluctuations in numbers of people coming through ED
- Staffing

Frequent attending and care plans

- Numbers – 87 discharged
  - 44 CQUIN
  - 24 on current list
- Care plans for LAS and ED – approaches to repeat attendances (all personalised)

Common presentation

- Mental Health Reasons
- Learning Disabilities (or low IQ)
- Alcohol dependence
- Personality disorder
- Homeless
- Long Term Health Conditions
- Medically unexplained symptoms

→ Overlap (lots of comorbidities: e.g. MUS, Personality Disorder traits, homeless and long-term health conditions)- not uncommon to see all of the above in one patient

→ Personality Disorder traits in many

→ Vulnerability and isolation

Background:

- Mr G is a 60 year old white British man who has been attending A&E Frequently over the last few months. He used to work as a builder abroad for many years. He used to drink heavily but has not done so for many years.
- Was initially thought to have a psychosis – the reports of harassment was interpreted as paranoid.
- Over a few years his vulnerability has been a concern in the community with noxious substances being thrown through his windows, money and cash cards being taken off him. His neighbours have reported an increasingly amount of social vulnerability. His house has recently been used for drug dealing and prostitution.
- Mr G had home carers but there were concerns about their safety due to the environment. He would be incontinent of urine and faeces (recent onset) and needed hands-on care but staff were concerned about their safety
- Would refuse to mobilise or go home from A&E when he did attend

Typical Presentation in A&E:

- Falls
- Neighbours or Mr G will call ambulance. Often due to pain or behaviour unusually (i.e. wearing soiled incontinence pad and refusing help with it)

Main diagnoses and summary of healthcare:

- Vulnerability
- Falls
- He is currently being screened for cognitive impairment.

A&E pre-referral – 18
A&E after discharge 2

Outcome:

- MARAC referral and sheltered accommodation
- Assessment for needs including behaviour management – likely cognitive impairment.
- Improved quality of life

What is unique about the FA team?

- Making sense of 'chaos'
    - Responsive and Flexible
    - Using mental health perspective to understand complexity
    - Working in an integrated way – engaging speciality teams in acute and primary care to make the right care plans

Hopewall

Aim – to improve the environment where people are seen when in a crisis.

- Co-produced art for the Health Based Place of Safety room
- 300+ questionnaires and many sessions with local 'Working Together Group'

We care

inclusive

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inclusive

THANK YOU