Lewisham NHS@Home Service

Provided by: One Health Lewisham
Email: ohl.virtualcare@nhs.net

What is NHS@Home?

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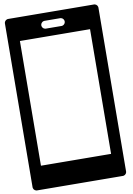
The Integrated Community Provider



The Lewisham NHS@Home service is a fully managed service that enables patients to receive the care they need within their own home, or place of residence, avoiding hospital attendance. The service can provide home visits, prescriptions and diagnostics, where required.

Sometimes referred to as a virtual ward, the service has an objective to support secondary care capacity pressures. Supported by technology, the NHS@Home service provides a safe and convenient alternative to in-hospital care.

- Consultant led, 50 bed capacity service
- Multi disciplinary team of clinicians supporting daily monitoring
- 7 day a week monitoring from 08.00 – 18.00
- Phlebotomy, in home Xray and mobile ECG services available
- Face to Face visits available, where required.
- Exclusive or shared clinical responsibility (pathway dependent)

Primary Care and Community

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Emphasis on admission avoidance, how can we prevent hospital attendance/admissions through the use of the NHS@Home service to identify and monitor patients in the community. The NHS@Home service works closely with primary care & the community to identify acutely unwell patients, but also uses available data to proactively identify patients at high risk that could avoid attendance/admission through at home monitoring.

Inclusion Guide

•Over 18 years of age.
• Registered with a Lewisham GP (and address.)
•Safe and appropriate social situation/package of care.

•Has dexterity to use the devices **or** has a carer/next of kin who can support with using the devices.

•Has capacity to give consent **or** a "best interests" decision has been made on their behalf.

Pathways Live

General Obs
Frailty
Heart Failure
Respiratory
Diabetes
Care Home

Exclusion Guide

•Patient requires immediate or urgent lifesaving treatment/investigations via A+E/secondary care.

• Severe/acute mental health issues or substance abuse issues that are significant enough to greatly impact ability to maintain compliance and contact with clinicians.

• Patient is on an end-of-life care pathway

Primary Care Clinicians are urged to complete the NHS@Home referral template within EMIS Web and then book and appointment in the OHL appointment book

Community based clinicians can refer by calling **0203 929 4999.**

Secondary Care

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The role of the NHS@Home service in secondary care is to support a facilitated discharge of patients from hospital to potentially release bed capacity where clinically safe and viable to do so. Ideally these will be patients that are nearing the end of their stay in hospital and could benefit from being discharged to continue their recovery at home.

EXCLUSION

Under 18 years of age
Not registered with a Lewisham GP and non Lewisham postcode
Lack of safe social care plan
Lacking capacity to give consent or no 'best interests' decision made
Patient or carer/NOK is unable to adequately use the devices or is unlikely to be compliant.

- Requiring administering of IV medication.
- Requiring immediate/urgent life saving treatment/investigation via A&E/Secondary Care.
- NEWS2 of 4 or above (or 3 in any one parameter)
- Acute mental health crisis
- End of life care pathway
- No working diagnosis or follow up plan.

Pathways Live
General Obs
Frailty
Heart Failure
Respiratory
Diabetes
Short Term
Oxygen Therapy

We invite all LGT clinicians to refer patients in directly through our single point of access hub by calling **07900 594 383** between **08.00 and 18.00 Monday – Sunday**
Out of hours please email: **lg.ucr@nhs.net**

Example Presentations

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Asthma/COPD exacerbation - patient is assessed and brought onto our service where we will monitor their observations and symptoms whilst on antibiotics/steroids and optimise their long term disease management.

Infection/sepsis - when a patient requires oral treatments only, they can be monitored on the virtual ward where we can provide daily monitoring of patients and follow up blood tests to check that infection markers/kidney function return to baseline. We also have radiology is patients require repeat chest x rays during their stay.

Heart failure fluid overload - where a patient requires diuretic titration, we can monitor patients symptoms, observations, ECG monitoring and renal function as well as titrate their long term medications.

Dehydration - any patients who are at risk of dehydration e.g. AKI patients or gastroenteritis patients not requiring IV fluids can have their vital signs monitored and repeat blood tests done.

Diabetes - patients post an event e.g. DKA or hypoglycaemia can have their blood sugars and hypoglycaemics titrated on the ward.

What do our patients think?

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'I'm writing this email to all the staff that's been involved with my care, what a wonderful service that I haven't had to leave home. You act so efficiently when it comes to calling back, and your so reassuring and friendly on the phone. Any issues are always addressed. Keep up the good work.'

'My sincere thanks to the whole team for being excellent. The service made me feel safe and took away any vulnerability. I would recommend to any other patients who would need support when coming out of hospital'

'The team of professionals and my nurse Edith made me feel safe and taken care of. I was lead through all the processes by Edith in a nice warm atmosphere and received help with any I had and support with paperwork too. I'm very grateful for all support received and positivity. The equipment was also easy to use and the system. Once more time Edith, thank you for taking care of me, you are the best.'

'Three weeks ago, my husband was ill and was put on the virtual ward and must say without it and the amazing staff that run it my husband would have ended up in hospital. They saw that my husband oxygen level had dropped and changed his medication without hesitation. I am very grateful for all that they have done for him and hope that this system continues for everybody in need.'

The first 12 months…

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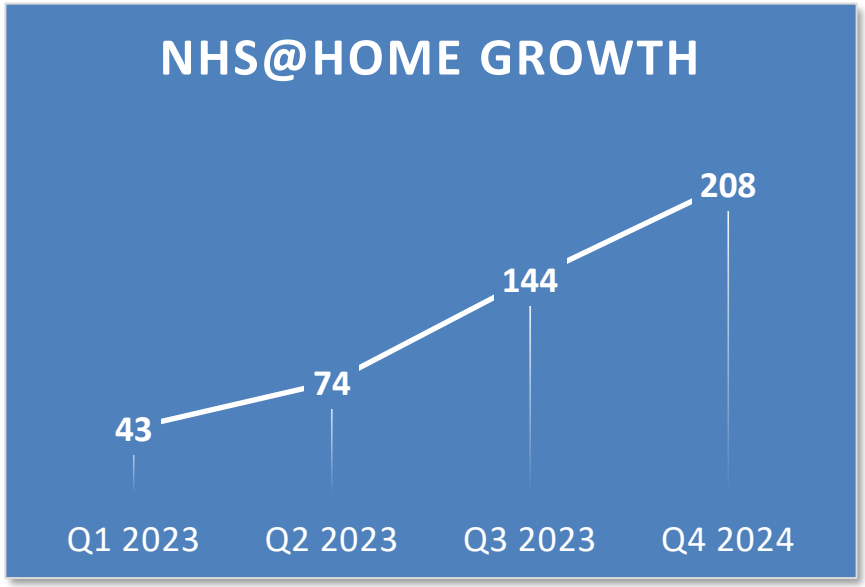
482 successful referrals



Average patient age of **77** years old

12.3 – average length of stay on the ward

9.5% required a discharge (step-up) to hospital

31% of referrals came from Lewisham Hospital