Name of project: Virtual acute liaison team

Project leads: Pene Stevens, Tracey Rose and Anette Clarke

Kent Community Health NHS Foundation Trust

What was our aim?

To support East Kent Hospitals NHS University Foundation Trust (EKHUFT) to identify and flag patients with a learning disability, reflected by an increase in the specialist EKHUFT register, to ensure appropriate care planning and reasonable adjustments are made, between March 2020-April 2022.

Why is it important to service users and carers?

At the beginning of the COVID-19 pandemic, EKHUFT requested closer links with the Adult Learning Disability Service at Kent Community Health NHS Foundation Trust (KCHFT).
It is known that people with a learning (PWLD) have better health outcomes if their experience within an acute hospital is positive. Research and statistics show that PWLD:

- Often experience health inequalities (NHSI report 2019)
- Die on average much younger than the general population (CIPOLD, 2013 and LeDeR, 2021)
- Are three to four times more likely to die of something which could have been prevented than the general population (NICE Impact – People with a learning disability, November 2021)
- Often have associated complex health needs (NICE Impact report, November 2021).

By law, Accessible Information Standard (section 250 of the Health and Social Care Act 2012) must be followed in full from August 2016. This suggest that it is now a legal requirement to make sure services are accessible to all people with protected characteristics under the Equality Act (2010 Section 20 and 21). Sharing of information across the NHS is a key part of being able to make sure patients are identified and the appropriate adjustments made, therefore we were happy to support.
We provided a learning disability nurse to support the hospital and their patients using their expertise. This included, but was not limited to, identifying PWLD, making reasonable adjustments, making sure patients returned home with the correct medication and starting/engaging the use of the treatment escalation plan (TEP) and My Health Navigator (MHN) to promote a safe and timely discharge with reduced risk of early readmission.

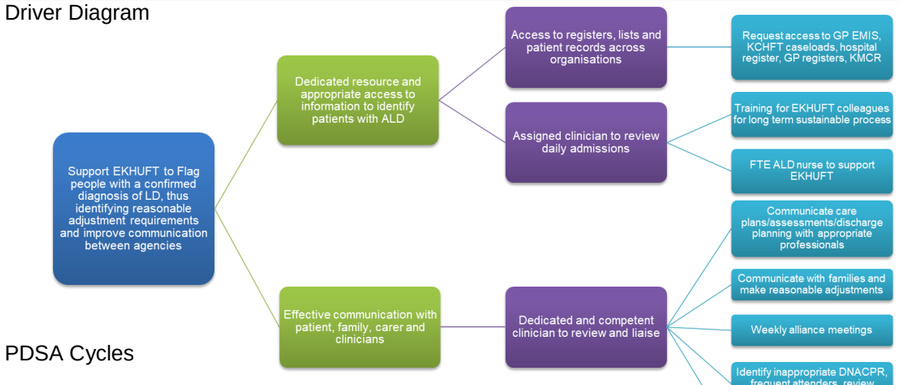
Ideas and tests of change

The main change was to establish a Virtual Acute Liaison Team in March 2020 (during COVID-19).
The purpose of the introduction of a Virtual Acute Liaison Team was to:

- Improve communication between EKHUFT, KCHFT, Kent County Council, families and care providers.
- Act as a single point of contact for carers/ family, ensuring the right support at the right time via a single point of access
- Reduce length of stay in hospital
- PWLD identified early at first point of contact, can ensure reasonable adjustments are put in place promptly.
- Community Learning Disability Team offering support with baseline knowledge, existing care plans, attendance at discharge planning
- Promote that PWLD have an equal access to all service to aid effective, safe and timely diagnosis and treatment.

The tools we used

Driver Diagram

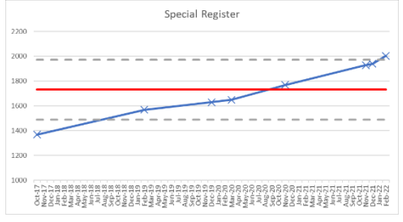


PDSA Cycles

Project Idea Brief

Results/How did we do

As a supporting organisation, we were limited as to what we could get involved with; however, offering support with baseline knowledge, existing care plans, attendance at discharge planning/multi-disciplinary meetings proved extremely helpful to ward staff.
The learning disability (LD) nurse could confirm learning disability status on admission to EKHUFT, identify where reasonable adjustments are required, ensure the right support at the right time via a single point of access, follow up on discharge any ongoing therapeutic identified needs or recommendations on EKHUFT electronic discharge notes. The nurse also supported end of life ReSPECT guidelines, My Health Navigation, aspiration pneumonia, frequent attender plans, safeguarding concerns and avoiding/reducing diagnostic overshadowing. These people could them be referred to the community learning disability team where appropriate
EKHUFT Special register data: Since the introduction of the LD liaison nurse in March 2020, the special register has grown by around 435 people.



Date	No. Patients	No. added
Oct-17	1367	
Feb-19	1568	201
Dec-19	1629	61
Mar-20	1649	20
Nov-20	1768	119
Nov-21	1929	161
Dec-21	1940	11
Feb-22	2003	63

Patient experience:
"I would like to thank the nurse for all the support she has given me throughout the time my client was in hospital. There were times I wasn't getting much support regarding information from the hospital ward and she made her call, which made things a lot clearer.
"So thank you all for your input as it definitely speeded up the assessment, treatment and discharge process."

What we learned and what's next

What we learned:
Support is in-reach of the wards, from physiotherapy to support ward occupational therapy/physiotherapy staff struggling to engage with LD patients. We can help make sure all reasonable adjustments are made and patients are ready for discharge.
Sustainability - during the pandemic, there was a great ability to invest time in the project but now that services are returning back to normal, it is more difficult to sustain the commitment.

What's next:
We would like to look at employing/funding this as a full-time role; therefore, a business case will be written.
We would like to look into re-admission rates and why they are higher for PWLD.
Emergency department attendance:

- Can we identify any avoidable reason for attending (for example, bowel management)?
- Currently frequent attendees' plans are carried out ad hoc, can we produce a pathway?

Planned outpatients/ investigations often miss appointments or have poor attendance. We would like to understand 'was not brought' versus 'did not attend' rates.
We would like to maintain improved communication to make sure reasonable adjustments are implemented.
Potential further benefits:

- Increased incoming and outgoing referrals
- Signposting for individuals that do not have LD
- Linking up and collaborating with acute teams
- Develop LD champions throughout partner organisations
- Liaison with 16+ neurodevelopment team

we care

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