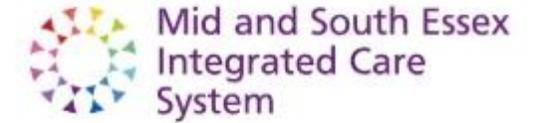


# Mid and South Essex ICS Integrated Care Transfer Hub (ICTH)



The ICTH team provide expert advice and support across the local health system in mid and south Essex to help to help prevent unnecessary admissions to hospital and to sort out issues that cause delays with patients being discharged from hospital at Southend, Basildon and Broomfield, and from community and mental health bed.

## This includes

- Working out and understanding why delays happen and how to prevent them in the future and sharing this knowledge with teams working across the health system to improve outcomes for patients.
- Working with partners in our health system to sort out problems that are preventing patients with care needs being discharged from hospital when they are medically well.
- Working with partners in our health system to help people stay well outside of hospital and reduce the number of people who are admitted to hospital when it would be better for them to be treated and return home or to their place of care.
- Responding to early signs of pressures in the system that might cause delays to patient care and coordinating with partners in the health system to resolve issues and stop the pressure getting worse.
- Checking and confirming that all organisations across the health system are doing everything they can to work as effectively and efficiently as possible to move patients through their health and care journeys without avoidable delays.
- It doesn't include routine arrangements for simple discharges, or transfers of patients who still need clinical care between hospitals.
- The ICTH team are not able to take questions or queries from members of the public or patients' families.

# What area does the team cover and who do they work with?

The team covers the whole of mid and south Essex including Southend, Basildon and Broomfield hospitals, which are run by Mid and South Essex NHS Foundation Trust.

- They work with North East London NHS Foundation Trust (NELFT) to use community beds at Thorndon, Mayfield and Mountnessing Court, as well as Essex Partnership University NHS Foundation Trust (EPUT) for Cumberlege Intermediate Care Centre (CICC) beds and Provide for beds at Halstead and Bayman
- The team also work with hospices and patient transport services, local authorities, primary care, NHS111, mental health providers, the ambulance service, care homes, community and social enterprise partners, and Third Sector providers.

They also work with hospitals and organisations outside of the Mid and Southend Essex Integrated Care System who have been treating patients that need to return to Essex to either:

- transfer them to one of the acute hospitals (known as repatriation),
- transfer them to intermediate care (temporary out-of-hospital care before a patient is able to go home),
- help make arrangements to discharge them straight home with the appropriate care.

# When should I contact the team?

**If you're a healthcare professional, you can contact the ICTH team when:**

- you have a patient with complex care needs who is medically well enough to be discharged from hospital but waiting for additional support to be put in place.
- you have a patient who needs treatment but would benefit by not being admitted to hospital.
- you have a patient who is well enough to be transferred out from a hospital outside of mid and south Essex, and could be discharged directly home – rather than hospital to hospital - with appropriate care arrangements.

**What should I do before contacting the team?**

- Before contacting the team for **help with a patient's discharge**, you should make sure you have completed all routine actions needed for a straightforward patient discharge.

**Who's in the team and when are they available?**

- The ICTH team members come from both clinical and non-clinical backgrounds with extensive experience in discharge planning and in-depth knowledge about our local health and care system.
- The Hub is open six days a week, Monday to Saturday, 8am to 6pm.

**Contact the team**

- If you're a healthcare professional involved in arranging complex patient discharges, hospital repatriation or you're working to avoid a hospital admission, you can contact the team by email at [mseicb-bb.dischargecell@nhs.net](mailto:mseicb-bb.dischargecell@nhs.net) and they will aim to contact you the same working day.
- Alternatively, you can contact the acute discharge team on [mse.idthub@nhs.net](mailto:mse.idthub@nhs.net)

# Hospital Integrated discharge team will

---

Arrange dedicated staff to support and facilitate hospital discharge.

This will include:

- Coordinate case management for patients on p 1-3
- Local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge
- Ensuring 'settle in' support is provided where needed
- in conjunction with local care home providers, use trusted assessment arrangements to facilitate the prompt return of their own residents after a hospital stay
- Prepare number of discharges today and tomorrow, escalations for the internal bed meeting and System 10am call
- Pull NMCTR Lists and track complex case management activity
- Attend ITCH handover and take any actions that supports the activity of ITCH
- Establish the link between ITCH and the wards and escalate any discharge delays and challenges.
- Upkeep IDT discharge list, ensuring it is up-to-date and circulated daily
- Ensure that all infection control status is known and evidenced for discharge
- Support IDT management with activity associated with quality management
- Where ITCH are notified that a person has been discharged without prior notification, to ensure appropriate post discharge follow-up and escalation where required.
- Liaising with the wider IDT team around complex discharge activity.
- Complete once a day reporting each morning shared via Shrewd
- Prepare for and lead on IDT Meetings and escalate to the wider ITCH hub as required
- Take a lead on complex case management and out of county referrals
- Point of escalation for clinical information where the information is not recorded or accessible on EPR and engagement with the wards and wider ITCH