Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Transfer of care hub (TOCH)
High level overview
January 2024

Key Messages

What is the Transfer of Care Hub?

System-level place whereby (physically and virtually) all relevant services (e.g. acute, community, reablement teams, primary care, Hospice teams, AACC teams, social care, housing and voluntary) are linked to coordinate care and support for people who need it – during and following discharge and to prevent acute hospital admissions.

They are Responsible for developing timely and person-centred 'step-down' or 'step-up' plans for people based on the principle of 'no place like home'

They will streamline referral and discharge processes, simplifying access for referrers, and reducing the potential of missed or duplicated referrals

What is the benefit of the TOCH:

An multiagency team supports the coordination of transfers of care between services to prevent the resident telling their story multiple times and ensures the right services are able to support the resident and their family on leaving a health or care service.

They ensure consistent discharge decisions by professionals with expert knowledge about community services means patients are discharged into the most appropriate service for their needs.

They reduce pressure on the system through improved flow and better person outcomes following admission or discharge to the most appropriate care and support.

What is the benefit to the person:

Conversations about support needed on discharges from all services including AA and acute will start at the time of admission to the service.

Discharge will be arranged as soon as clinically appropriate.

95% of People will have the final assessment of their care needs undertaken in their own home if they have ongoing care needs.

How do I contact the TOCH:

Central requests and those from external providers for signposting

mse.idthub@nhs.net

SW -
nelft.spa@nhs.net

SE -
toch.bbw@nelft.nhs.uk

Mid
provide.toch@nhs.net

Thurrock – TBC

Note to Staff - It's important to note that the development of the transfer of care hub involves collaboration between multiple healthcare organisations. Organisational guidelines and regulations should be followed to ensure compliance and resident safety.

Which teams make up the TOCH?

- The TOCH brings together existing health and social care discharge functions into one place to facilitate rapid decision making, providing safe and appropriate discharge from hospital and community settings as well as supporting step up and Admission avoidance team having closer links with colleagues.
- System partners are present in the ToCH to triage discharge to assess (D2A) referrals, identifying the most appropriate discharge pathway for the presenting needs and collaborating to meet those needs in the most time efficient way, aiming for discharge within 24 hours of the person becoming medically safe and to ensure people on Admission avoidance pathways needing an multi agency approach are reviewed. There will be contact between the Unscheduled Care Co-ordination Hub and the TOCH to facilitate this communication without duplicating functions.
- It consists of MSEFT Integrated Discharge Team (IDT), MSE Community Collaborative representation, and representation and staffing from Adult social care teams (including reablement) from Essex County Council, Southend City Council and Thurrock Council discharge teams and is co-managed by these organisations.
- It also supports discussions and closer working with voluntary sector partners, housing and other relevant bodies within each locality including integrated neighbourhood teams as these mature in our system.
- It operates Monday-Friday, 8:00-18:00 and Saturday-Sunday, 8:00-17:00.
- Although the TOCH will work with and engage other authorities, it does not arrange services for people resident outside of Essex. If a person lives outside Essex but has a MSE based GP (or the opposite), a decision on service provision will be made in partnership.

MSE TOCH Go Live Summary 21 November 23

Locality – Thurrock

Coordinator lead name and organisation
- Carmel Michaels NELFT (interim to 31st March 2024)

Go live partners involved
- Thurrock Council, NELFT, MSEFT, ICB Alliance, Primary Care/PCNs, VCSE, Healthwatch, UCRT/VWs

Areas of focus for go live
- Hospital discharge/pathways, VWs,

Locality – South East Essex

Coordinator lead name and organisation
- Tina Broderick (interim)

Go live partners involved
- SCC, ECC, EPUT, MSEFT IDT, SS9 & Benfleet PACT teams, VCSE

Areas of focus for go live
- Complex discharge & delays plus complex 'at risk' individuals in the community

Locality – Basildon and Brentwood

Coordinator lead name and organisation
- Elesha Jones - NELFT

Go live partners involved
- Social Care/ Hospice / PCN / Community Physical Health/Community Mental Health / Acute /VCSE

Areas of focus for go live
- Patients with a decision to admit from ED
- Patients escalated by community providers
- IDT escalations for an MDT (currently agreeing frequency of MDT)

Locality – Mid

Coordinator lead name and organisation
- Heather Joslin (interim), Provide

Go live partners involved
- IDT, Provide Community Services (incl. District nursing, Virtual Wards, Respiratory, Cardiac), Adult Social Care
- Phase 1b: EWS, Community Hubs/VCSE, CHC, Hospice, Primary Care

Areas of focus for go live
- Broomfield Hospital Discharges - Patients referred to the IDT only

Voluntary Sector teams linked to the TOCH support:

- Receive Referrals from the team at provide following the welfare calls (or directly from the TOCH daily call)
- From referrals to the RADs team for end of life care

Link residents with local community activities to support in areas such as

- Reduction in isolation and loneliness
- Hording support
- Community MH projects
- Walking and other activity groups
- Connections to dementia cafes and other support structures
- Shopping support
- Signposting to financial support and advice including Debt support and benefits advice
- Community transport links
- Any referrals received by the VCSFE team outside of its geographical remit will be signposted appropriately.

CVS leads linked to the TOCH development

B & B - Linked via the specialist social prescribing team – Hamelin Trust, Craig Tyler Trust and Sociability.

Southend – SAVS

Thurrock – Thurrock CVS

CPR – Castlepoint CVS, Rochford CVS

Mid – Chelmsford CVS, Maldon CV, Community 360 (who cover the Braintree District).

For Residents this means

There is a piece of work currently taking place across the system called “Transfer of Care Hubs”, which in summary intends to improve communication between providers when any transfer of care takes place. As part of this programme, the hospital ward teams and community services you may be using wish to improve their communication when you are discharged from hospital. We will always work with the focus of getting you back to your home as a first priority.

- On Admission to the hospital or a community service you will be asked about your current home arrangements including if you have informal or formal care.
- We will discuss with you as your treatment progresses what your post discharge support needs might be.
- We will coordinate you post discharge support need if you have any within the TOCH.
- If you have existing community service’s we will ensure this information is used to support your planning to return home at the earliest stage.

Support offered to you may include:

- Follow up calls or support from our local voluntary sector partners
- Community nurses and specialist community teams supporting your care
- Health and care reablement services supporting you to become more independent
- Community hospital or short-term residential care to support you getting ready for home where a step towards home will support your recovery
- Returning to your own home where this is a nursing or residential setting with your exiting care package restarted