NHS
Essex Partnership University
NHS Foundation Trust

Care Cordination Centre and unplanned care pathways

West Essex

WEST ESSEX CARE COORDINATION CENTRE

1

Person Centred Care

The CCC will ensure a single timely and coordinated response to each individual

2

Visibility

The CCC will create a single real time view across the system that keeps all partners informed from referral to outcome.

3

Performance

The CCC will enable collaborative, flexible working with a simple referral process that prevents duplication and is a trusted service.

4

Workforce

The CCC will have experienced workforce at the front door, harnessing technology and promoting multi-disciplinary problem solving.

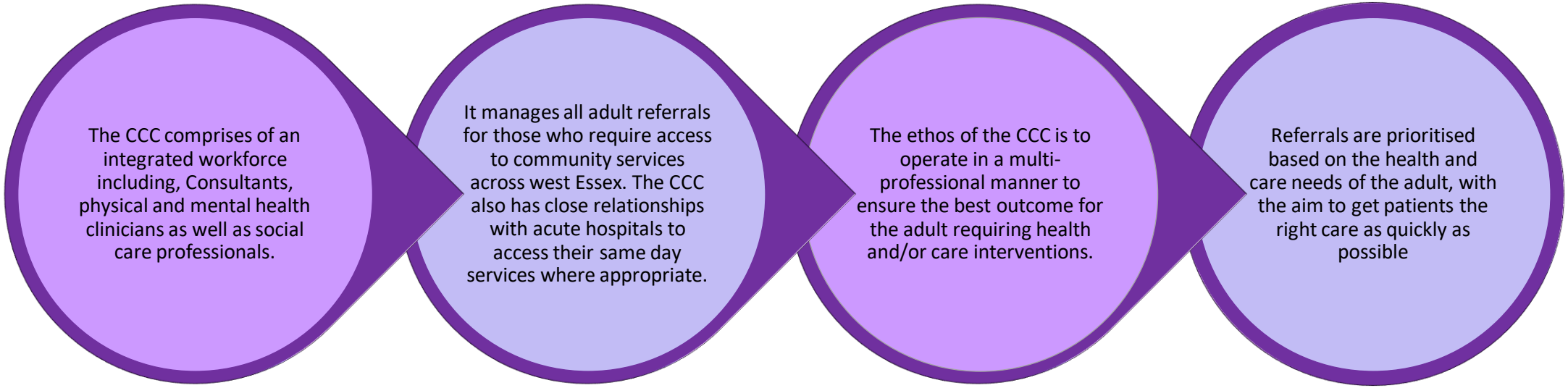
Tel: 0300 123 5433

7 days per week 08:00-21:00

CCC Vision Statement:

"Working together as the West Essex Health and Care Partnership to improve people's outcomes and experience by navigating to the right services at the right time, in the right place."

CCC Referrals



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Care Coordination Centre (CCC): Urgent Care Services

1. Transfer of Care Hub (TOCH – Option 2)

- West Essex health and social care system linking all relevant services across sectors to aid discharge and recovery and admission avoidance. Operates 7 days a week
- The TOCH is responsible for developing timely and person-centred transfer of care plans based on the principle of 'no place like home'
- It decides which 'Discharge to Assess' pathway each person should be placed on (1, 2 or 3) based on the detailed referral description of the adult received from the acute or community hospital.

2. Access to Stack & H@H (Option 2)

- Category 3, 4 and 5 calls are transferred to the CCC for Urgent Community Response where deemed appropriate
- The calls are assessed and triaged by the CCC clinician to determine if the patient can be safely supported at home or alternatively admitted to a Community inpatient setting) rather than being conveyed to ED for assessment.
- Supports to reduce ambulance handover delays and increase availability of ambulances.
- Operates 7 days a week

3. Urgent Community Response (UCR) Team (Option 2)

- Standardised service across Epping, Harlow and Uttlesford Districts – 8am-8pm 7 days a week
- Aim to respond in timely manner to people with an urgent physical or mental health and/or social care need, typically assessing needs and providing an appropriate short term intervention within 2 hours.
- **Dedicated 2 hour falls response vehicle** for adults 65+ who have had a fall with or without serious injury or require lifting from the floor, either at home or in a care/ residential home

4. Virtual Hospital (Option 4)

- Personalised, hospital equivalent care at home for adults aged 18+
- Team consists medical consultants, advanced clinical practitioners, senior clinical practitioners, general and mental health nurses, healthcare support workers and administrators.
- Patients are monitored and reviewed daily via MDT board rounds,
- Care is provided either face-to-face care or remotely utilising digital remote monitoring equipment.
- Capability to provide intravenous therapies in the home

5. Bridging Service (Option 2)

- Provides urgent short-term, intensive social care support to adults for admission avoidance and facilitation of discharge 7 days a week
- The service aims to
- Enhance recovery by preventing delayed hospital discharges
- Maximise independence by offering early recovery support within the home.
- Reduce the risk of readmission to hospital
- Prevent unnecessary hospital admission and enable patients to remain in their own home, supporting improved outcomes for patients.

6. Community Hospital (Option 2)

- 4 Wards including Stroke/Neuro
- Direct admissions
- Adults requiring additional care and monitoring which is unable to be delivered in their usual place of residence.
- Discharges from Acute
- Adults with clear medical, nursing or therapy need/goals to participate with rehabilitation programmes
- Supports 7 days a week discharge, EDD identification for all adults to facilitate discharge planning

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Care Coordination Centre (CCC): Integrated Services

1. Integrated Community Care Teams (ICCTs -Option 1)

- Single point of access for referrals into the Integrated Community Care Teams across all localities Harlow, Epping and Uttlesford
- Referrals triaged by trained clinicians
- Convening of MDT discussions as required
- Access to care coordinating advice and guidance
- Ensuring all referrals for EOL are prioritised and accurate medication authorisation completed
- Access 7 days per week Mon-Sun 08:00-21:00

2. Adult Mental Health (Option 3)

- Single point of access for referrals for Adult Mental Health
- Referrals triaged by trained MH clinicians
- Convening of MDT discussions as required
- Access to care coordinating advice and guidance
- Access 5 days a week Mon-Fri 09:00-17:00

3. Specialist Dementia Frailty Service Triage (Older Adults Mental Health - Option 3)

- Single point of access for referrals for Specialist Dementia frailty service, (Older Adults Mental health)
- Referrals triaged & screened by trained Older adult MH clinicians
- Convening of MDT discussions as required
- Access to advice and guidance
- Access 7 days a week 09:00 - 17:00- (Sat & Sun covered by Intensive Support Team)

4. Adult Social Care (Option 2)

- Support crisis intervention for referrals from EEAST, Rapid Intervention Service, Acute ED, Intensive Support Team, Falls Car, UCR & Virtual Hospital
- Commissioner for EPUT bridging service
- Access to care coordinating advice and guidance
- Supporting transfer of care function and complex discharge
- Access 7 days per week 08:00 to 18:30 Mon-Sat and 08:00 to 17:00 Sun & BH

5. Community Therapy Triage(Option 2)

- Single point of access for referrals for adults requiring urgent and routine therapy/rehabilitation services
- Referrals triaged by trained therapist
- Convening of MDT discussions as required
- Access to care coordinating advice and guidance
- Access 5 days a week Mon-Fri 09:00-17:00

4. Specialist Services (Option 2)

- Single point of access for referrals into Specialist Services
- Referrals screened for appropriate information and forwarded to the appropriate specialist service for triage.
- Liaison with appropriate team for any urgent/same day access referrals received
- Access 5 days per week Mon-Fri 09:00-17:00

Tel: 0300 123 5433

7 days per week 08:00-21:00

CCC Functions Catalogue – Interim Operating Model

An overview of the functions provided by the CCC, along with the expected customer outcomes

Function	Description	Customer Outcome
1. Pro-active Case Management Information	• Manual sharing of information with system partners based on provider registers • Identification of individuals who are high impact to the system • Manual provision of data to enable holistic view of individuals	• Improved co-ordination of people with complex needs • Reduction in escalation of care by early identification of needs • Better use of data to support risk stratification
2. Enable Monitoring / Virtual Support	• Real-time data monitoring to enable virtual care and support, supported by equipment • Clinical oversight for individuals based on agreed triggers and clinical parameters • Escalates where necessary into CCC (incl for step up / step down support)	• Reduction in escalation of care and support • Promotes flexible, place based / at home care and support • Optimised use of technology • Supports safe early discharge limiting decompensation
3. Information Sharing	• Manually provides intelligence where available to the system to inform decision making • Supports provision of data to improve pathways / services	• Visibility of all individuals across the system through the CCC • Access to information that enables improvement
4. Provision of operational data and management of system capacity and flow (incl triage)	• Facilitates the manual flow and tracking of individuals and triggers follow up activities as required for known high impact users • Provision of manual demand and capacity data • Single point of referral into services for cases that require CCC support • Setting parameters for referrals in, including prioritisation • Access to system wide community-based pathways • Active management of system wide capacity when required • Supports ICP / ICS assurance and provider reporting on system demand and capacity	• Reduced duplication and hand-offs, improving flow • Further integration across all health and social care providers to deliver shared outcomes with system capacity • Oversight of all referrals through to completion • Visibility of system pressure and informs responses (i.e. alternatives where capacity is limited) • Informs future commissioning and development of future services
5. Facilitate MDT problem solving	• Engages with the referrer and other system partners to facilitate MDT delivery of support, bringing together the right people to agree a system response • Make the final decision on prioritisation where capacity is limited, serves as escalation point • Accepts handover of clinical risk / governance	• Promotes a holistic, person-centred approach • Care pathways strengthened by personalised care and systematic follow-up • Enables most effective utilisation of available services
6. Liaise with providers to source care / support	• Sources most appropriate support and care to meet individual's needs • Liaises with providers to create seamless pathways • Confirming back to referrer full details of support provided	• Improved utilisation of system capacity • Reduced failed discharges • Gives assurance that each individual receives appropriate care and support

Virtual Hospital

West Essex

Virtual Ward Definition - NHSE

West Essex Virtual Hospital

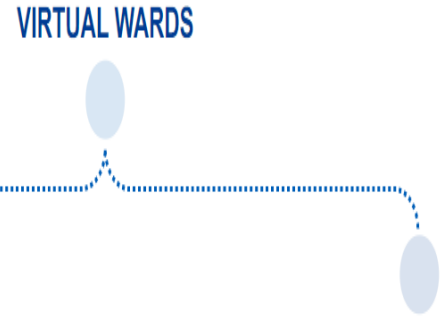
A virtual ward is a safe and efficient **alternative** to NHS bedded care. They provide acute care, support and treatment to people who would **otherwise be in a acute hospital bed**, and are often enabled by digital technologies.

Virtual wards can support people as an **alternative to admission** into hospital settings, and can also help **support early discharge**.

The level of support someone gets in a virtual ward will vary depending on what their condition requires.

Through this work we are describing two models of virtual ward

1) Technology enabled virtual wards
2) Hospital at Home which includes frailty virtual wards



	Mostly remote	Mostly face-to-face
	Based on technology-enabled remote monitoring and self-management, with minimal face-to-face provision	*Based on a blended model of technology enablement with face-to-face provision (Hospital at Home)*
What	• Personalised and digitally-enabled remote monitoring, with supported self-management and escalation pathways	• Hybrid service model that blends digital monitoring and face-to-face care to support patients with acute needs
How	• Digital remote monitoring service, or suitable digital alternatives • Early deterioration detection and recognition to trigger clinical input and responses from MDTs • Patient and carer enablement to self-monitor with escalation routes	• Digital remote monitoring and relevant service enablement • Care assessments, intervention planning and face-to-face support with senior clinical oversight and MDT support • Delivering acute-level interventions (i.e. screening, diagnostics, prescription and medicines reconciliation, IV therapies)

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Virtual Hospital Service in West Essex

8am – 9pm 7 days a week Referral and Query Hotline Tel: 07581 013636

Service offer

- Remote monitoring and in-person care for up to 2 weeks
- Frailty related syndromes
- Acute Respiratory Infection
- Heart failure symptoms & diuresis management
- COPD exacerbation
- Response to infectious conditions requiring antibiotic therapies

Referral criteria

- Registered with a west Essex GP
- Consent obtained for care in their usual place of residence
- Needs hospital level care that can be safely managed at home

The Team

The Virtual Hospital team includes medical consultants, advanced clinical practitioners (ACPs), pharmacists and nurses, with easy access to advice and care from dietitians, the palliative care team, social care the community respiratory and heart failure team, and other specialist services

WEX Virtual Hospital Patient Story

Background

57 year old lady with a history of paraplegia, long term catheter and T2 diabetes. Called the GP with a 3 days history of abdominal pain, fever and sediments in the urine.

Admission to VH

Referral was made to the VH from the GP. Catheter associated UTI, with E.coli requiring IV antibiotics.

Assessment

The patient was assessed at home by an ACP. Blood samples were taken and Doccla installed. IV antibiotics were ordered by the VH pharmacist who completed medicine reconciliation.

Treatment and Interventions

The patients catheter was changed and IV antibiotics commenced the same day at home. The patient was visited once a day by an RN for treatment, and supplied further observations through Doccla. She was discussed at the Consultant led MDTs. Treatment completed and the patient felt better. A repeat CSU was taken after completion of treatment and the GP was tasked to follow up the results.

Discharge

The patient was discharged back to her GP and the DN team for ongoing catheter care.

Sharon's Feedback:

“Under virtual hospital, my care is absolutely fantastic. It has saved me going to the hospital, waiting for 999 ambulances..(with Virtual hospital) you get the same treatment that you would get in hospital. In fact, better because you are in your own home.”

Falls Response/UCRT

EPUT Urgent Community Response

Currently delivering:

- ✓ A standardised 2hr response across the 3 localities in West Essex
- ✓ Delivering service 08.00-20.00 7 days a week
- ✓ Accepting referrals from all appropriate sources including self-referral via Care Coordination Centre
- ✓ Supporting Cleric Portal (EEAST)
- ✓ Consistently achieving National requirement of 70% of referrals seen within 2 hours (NHSEI requirement)
- ✓ Access to EPUT Bridging service to support individuals to stay at home
- ✓ Access to Community Hospital Beds for direct admission to avoid reduce demand on acute capacity
- ✓ Partnership working with EEAST Rapid Assessment Car- RIS
- ✓ Working in close partnership with EPUT Virtual Hospital team delivering urgent face to face assessment when need identified and liaising with VH team for ongoing monitoring and support
- ✓ Falls Response Car

EPUT Falls Response Car

West Essex EPUT Falls Response Service went live 1st June 2023
The vehicle is staffed by an EEAST Clinician responding alongside an EPUT OT or Physiotherapist or Nurse.

- Full clinical assessment of physical function and mobility including the identification of falls risks.
- Provide any immediate intervention including basic equipment provision to reduce the risks identified.
- Review any current input the patient may be receiving, and request follow up by those services as appropriate.
- Consider any further referrals or input required to manage risks identified.

The service will respond to calls diverted from 111 or via EEAST CLERIC portal, Handover @ home and EEAST crew referrals for patient's aged over 65, who have fallen without a red flag presentation or obvious hip fracture or where a predefined pathway is appropriate.

What are the benefits?

- Prevents long waits for an ambulance, if the falls car is available it has a 2-hour response time.
- Prevents long lies for patients and further deterioration of health.
- Specialist care for people at home, avoiding the need to be admitted to hospital and reducing bed days in hospital.
- Prevents unnecessary conveyance to emergency department
- Better health outcomes likely.

Feedback from Care Home Manager

I would like to express our gratitude for having the ability to use the Falls Car Service for our residents.
Using the service has offered us so much confidence as we know that our residents will be attended in a timely manner by competent and qualified professionals.
In current times, the waiting time for an ambulance to attend is at times extended to 12hrs which everyone can appreciate that for an elderly resident that had a fall laying on the floor for that long is clearly an increasing in the pains and discomfort and adding to this a possible diagnosis of dementia, when the resident can't retain the information of why we can't support and why we do not help to come off the floor has created some much anxiety and issues at time.
The Falls Car service will attend quicker, will assess the resident and advise us and the resident/family on any action needed to be taken.
The staff attending will make the needed calls, involving the 999 service, 111 or GP and they will always maintain an open communication with our staff, telling them what is going to happen next and teaching them but also allowing us to keep the family aware during the process.
What is also so different at the Service is that an actual physiotherapist is attending to assess the resident and the staff attending are so good as they don't just get the resident from the floor and leave the staff to deal with what that brings but they will assess the resident once they are off the floor, advice the senior staff on what to observe for the following 24-72hrs, discuss with family members if needed and follow up with a phone call to find out how resident was in the 24hrs after the fall.

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THANK YOU

EPUT