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Care Coordination Centre and unplanned care pathways

West Essex

EPUT

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."

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)

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- 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

Tel: 0300 123 5433

7 days per week 08:00-21:00

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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

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UCRT & Falls Service

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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

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Anastasia, a care home manager in Chigwell:

"We all think it's an amazing service as it helps the residents in so many ways.

They do not need to wait for hours on the floor before they are seen. The Falls Car also has an occupational therapist who carries out an assessment and provides advice on the spot for us.

In current times, the waiting time for an ambulance to attend is at times extended to 12 hours which everyone can appreciate that for an elderly resident that had a fall, lying on the floor for that long clearly increases the pain and discomfort.

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.

They will assess the resident once they are off the floor, advise the senior staff on what to observe for the following 24 to 72 hours, discuss with family members if needed and follow up with a phone call to find out how resident is in the 24 hours after the fall."

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West Essex Hospital at Home Service

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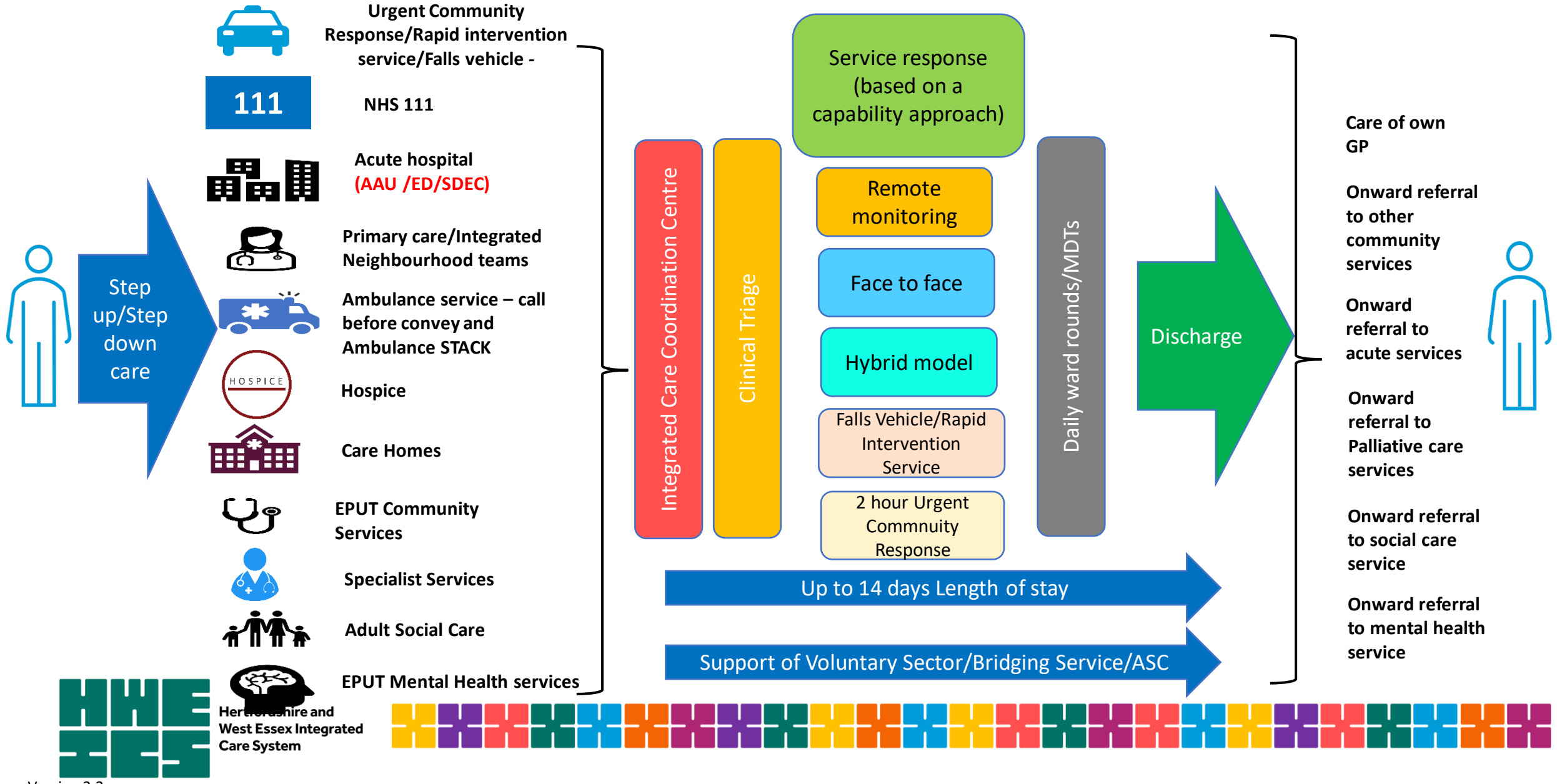
West Essex Hospital at Home Integrated Service Model



Hertfordshire and West Essex Integrated Care System

Version 3.2

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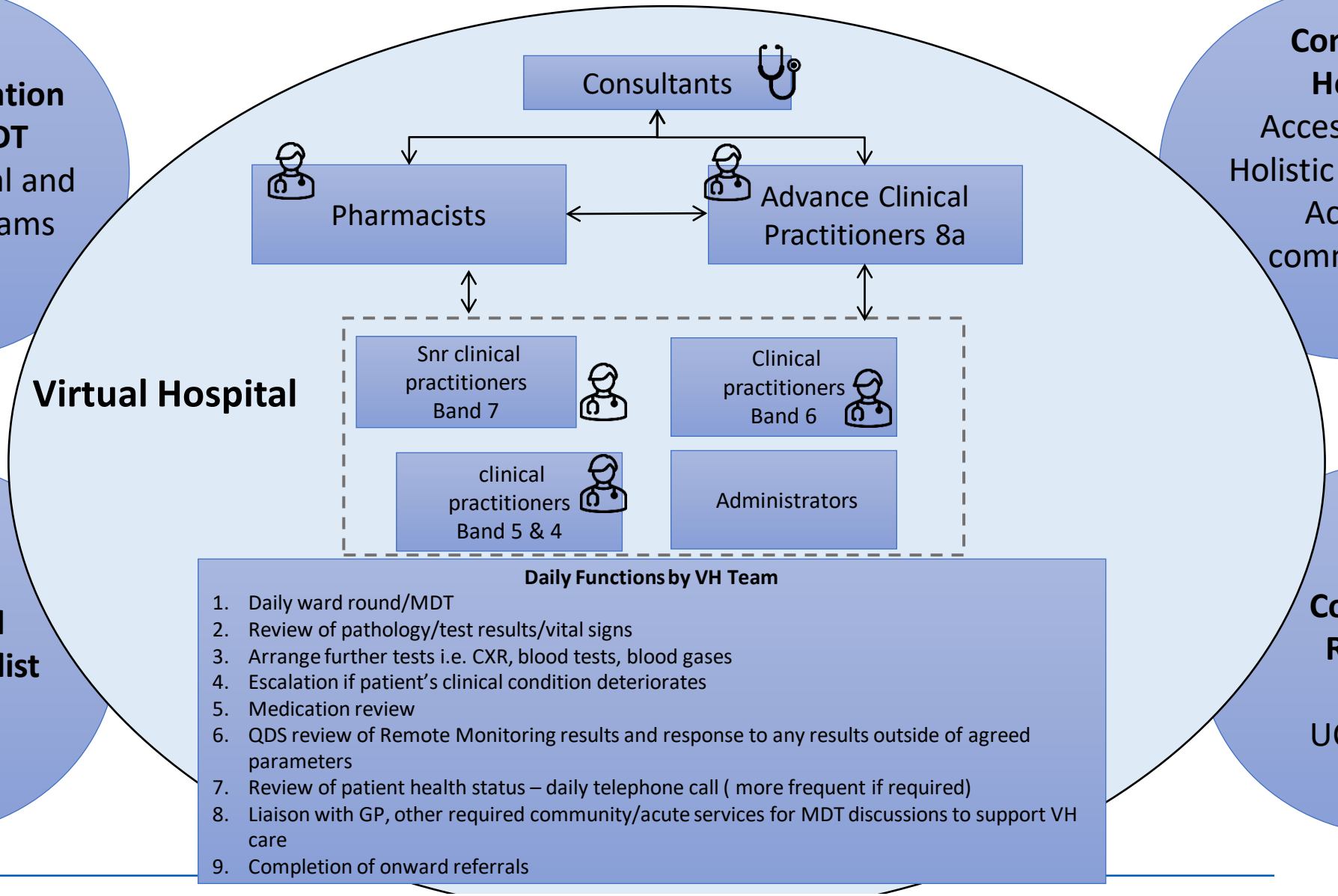
West Essex Hospital at Home Workforce

Care Coordination Centre – MDT
Physical, Mental and Social Care Teams

Community Hospital
Access to Rapid Holistic Assessment
Access to community beds



Daily Functions by VH Team

1. Daily ward round/MDT
2. Review of pathology/test results/vital signs
3. Arrange further tests i.e. CXR, blood tests, blood gases
4. Escalation if patient's clinical condition deteriorates
5. Medication review
6. QDS review of Remote Monitoring results and response to any results outside of agreed parameters
7. Review of patient health status – daily telephone call (more frequent if required)
8. Liaison with GP, other required community/acute services for MDT discussions to support VH care
9. Completion of onward referrals

Integrated Neighbourhood Teams and Specialist teams

Urgent Community Response
EEAST
UCR Service

Hospital at Home Service in West Essex – Alternative to Admission

8am – 8pm 7 days a week Referral and Query Hotline
Tel: 0300 123 5433 Option 4

Service offer

- Daily clinical assessment by Advanced Clinical Practitioner (ACP)/Consultant
- Comprehensive Geriatric Assessment
- IV antibiotics including 1st dose and ongoing management
- IV Diuretics
- Nebulisers
- Oxygen therapy/ weaning
- Phlebotomy and clinical review of blood profile
- Medicines optimisation
- Remote monitoring via enabling technology (BP, Temp, Respiratory rate, weight management, blood glucose, oxygen saturations
- S/c fluids
- Join working with specialist teams
- Palliative care

Referral criteria

- Registered with a west Essex GP
- 18 years or older
- NEWS2 score of <4 (NEWS2 score >4 will be considered by direct clinical discussion with HaH consultant)
- Consent obtained for care in their usual place of residence

Conditions Treated (*not exhaustive)

- Cellulitis
- Dehydration
- Delirium
- Diarrhea and vomiting
- Response to Frailty related syndromes - Rockwood score 5+
- Exacerbation of COPD and other long term respiratory conditions
- Heart Failure Decompensation
- Falls (including those with a long lie)
- Palliative Care Symptom Management
- Pneumonia/Acute Respiratory Infections
- Infected Pressure Ulcers
- Urinary Tract Infections
- Osteomyelitis
- Uncontrolled Diabetes management
- Reduced mobility
- Post-surgical care
- Acute Kidney Injury

The benefits seen in existing virtual wards including Hospital at Home services

Click to download a catalogue of evidence, covering different themes, pathways and countries

Research and studies are providing strong evidence for the benefits of virtual wards.
* The data below is based on observations from single site analyses relating to frailty.

Patient choice and preferences

>99% Over 99% of patients on existing virtual wards would recommend the service *

Treatment and care in a more comfortable home environment.
Keeping patients in a place where they would prefer to be cared for in future
23% of patients treated in a virtual ward achieved a more independent social care outcome than they would have in an acute setting.*

Reducing health inequality

Development of virtual wards offers opportunities to address healthcare inequalities in target areas including COPD and frailty.

Patient wellbeing and safety

5x Patients are five times less likely to acquire an infection * when treated on a virtual ward compared to an acute setting

8x Patients are eight times less likely to experience functional decline * whilst in a virtual ward compared to equivalent treatment in an acute setting

Avoiding potential harms in a hospital setting, such as falls and delirium

More holistic assessment in home circumstances

Capacity and productivity

2.5x Two and a half times fewer patients treated on a virtual ward are readmitted * to frailty beds than the national acute benchmark

Frees up physical beds for other patients who require an in-patient admission

Improves integration between hospital and community services

Improved staff experience and opportunities

Enabled by technology including remote monitoring

GIRFT GETTING IT RIGHT FIRST TIME

Produced in partnership by GIRFT and the NHS England Virtual Ward programme

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THANK YOU

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