North East Essex Community Services

East Suffolk and North Essex NHS Foundation Trust

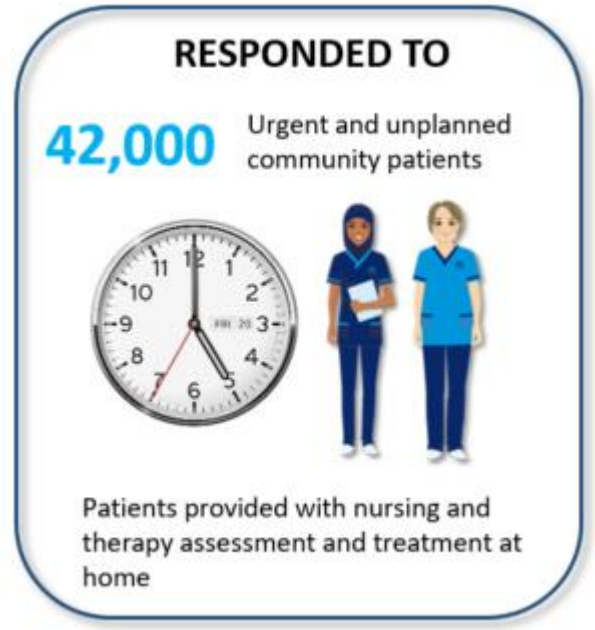
UCRS & Transfer of Care Hub

Service Update – March 2025

Urgent Community Response (UCRS)

East Suffolk and North Essex NHS Foundation Trust

- Urgent, community-based care to prevent unnecessary hospital admissions and support patients at home.
- Aims to respond within **2 hours**, delivering rapid assessment, treatment, and stabilisation for those in crisis.
- Multidisciplinary team includes **nurses**, **therapists**, **paramedics**, **voluntary sector/social prescribers** and **social care professionals**.
- Working closely with primary care, ambulance services, and secondary care to offer alternative pathways for patients needing urgent care.
- Supports patients with **frailty**, **falls**, **infections**, **deteriorating long-term conditions**, **and urgent care needs** that can be managed outside of hospital settings.
- Over **3,000 contacts** a month with **1,600 first contacts** (within 2hrs) significantly reducing pressure on emergency services.



UCRS – System Benefits

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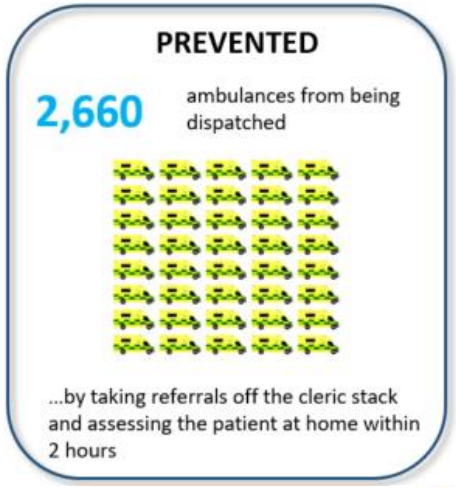
- **Reduces hospital admissions** by providing urgent care at home, lowering A&E attendances and inpatient stays.
- **Improves patient outcomes** by enabling timely intervention in familiar settings, reducing risks of hospital-associated deconditioning.
- **Enhances system efficiency** by diverting crisis calls away from ambulance services and ensuring capacity for the most critical cases.
- **Strengthens integrated care** by linking health, social care, and voluntary services, improving long-term patient support.
- **Proven impact**:
  - **92.61%** of cases met the 2-hour response target in 2024/25 (up 9.5% from 2023/24 and 40% from 2022/23).
  - Acceptance rate for referrals increased by **22%** in the same period.
  - Potential to **increase direct referrals from GPs and care homes** to reduce 999 calls and A&E reliance.
- **Aligns with NHS strategic goals** by promoting community-led urgent care, reducing health inequalities, and minimising emergency demand.



UCRS – Referral Details

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Contact us via Community Gateway (Monday to Sunday 08.00-20.00):

0300 003 2144 **communitygateway@esneft.nhs.uk**

- ✔ Over 18 Years Old
- ✔ Urgent Diabetes Care
- ✔ Palliative/End of Life Crisis Support
- ✔ Urgent Catheter Care/Bowel Care
- ✔ Falls
- ✔ Decompensation of Frailty/Condition
- ✔ Reduced Function/Mobility
- ✔ Break Down in Care Crisis
- ✔ Urgent Equipment Provision

- ✖ Under 18 Years Old
- ✖ Mental Health Crisis

Transfer of Care Hub (TOCH)

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- System-level hub within ESNEFT Acute Hospital, coordinating services across acute, community, primary care, social care, housing, and voluntary sectors.
- Primary role is to enable timely discharge, recovery, reablement, and rehabilitation while reducing unnecessary delays and duplication.
- Working closely with wards to triage patients, assign Case Managers, and ensure a "one touch approach" to personalised care and discharge planning.
- Discharge to Assess pathways (1, 2, 3) guide patient care post-discharge, ensuring appropriate support and assessment outside of acute settings.
- Key partners include social care, voluntary organisations (C360 & CVST), and housing services to provide holistic support.

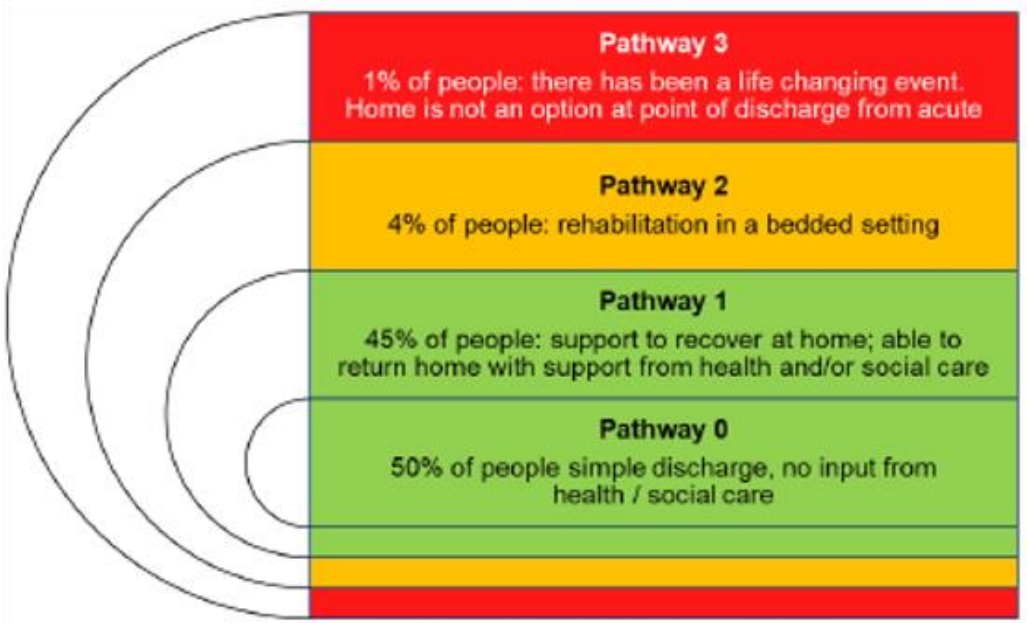

Figure 1: Discharge to Assess model

Improving Patient Flow

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KPI 1

Discharge Pathway Split - 95% of adults 65+ are discharged home from hospital

KPI 2

Medically Optimised Length of Stay – Everyone in hospital on Pathway zero should be discharged within two hours of no longer meeting the criteria to reside, or on the same day for other pathways

KPI 3

65+ Readmission Rate – Reduce readmission rate and ensure that discharge decisions and intermediate care provision are appropriate to keep people supported in the community

KPI 4

Intermediate Care Effectiveness – Levels of independence will have improved during the persons intermediate care spell

KPI 5

Intermediate Care Outcome – Ongoing outcomes will be identified within 6 weeks and people will understand who to contact if their situation changes

KPI 6

Intermediate Care Length of Stay – People should receive their long-term care assessment within 4 weeks of discharge

2025/26 Priorities

- Streamlining TOCH processes, in partnership with ASC and IP, including ensuring a maximum of 48hrs between receipt of referral and ASC sourcing commenced
- Improving P1 flow ensuring the discharge of P1 patients within 24 hours from MOFD
- 30% of patients discharged home in time for lunch, and 90% discharged by 5pm, including reducing variation between weekdays and weekends
- Strengthening *Pull Model* including closer integration with community and virtual ward services
- Realising the benefits of being one Division which has 10 wards under one management umbrella, including finding efficiencies, improving patient care, and reducing the number of outliers by ensuring the right patient is in the right bed, including by clarifying portfolio/criteria for each ward
- Increasing inpatient capacity:
  - Great Tey Ward (MoFD)
  - Durban Ward (Community Step Up & Step Down)
- Reducing hospital readmissions – informed by deep dive findings (*Q4 24/25)*
- Maximise virtual ward utilisation stepping down from inpatient areas, increasing impact on LOS and bed base modelling

TOCH – Direction of Travel

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- **Ward Reviews/Pilot Scheme:** Trialling TOCH staff on specific wards to oversee end-to-end patient journeys, enhancing discharge coordination and reducing delays.
- **D2A Model Review:** Aligning the Discharge to Assess process across system partners for a standardised approach, avoiding duplication.
- **Social Prescribing Changes:** Transitioning services as CVST support ends in March 2025, with efforts to retain key social prescribers on fixed-term contracts while ESNEFT develops an internal offer.
- **Homelessness Lead Role:** Strengthening TOCH's role in homelessness referrals and holistic ward support, integrating with case management for all patients, not just TOCH-specific cases.