URGENT COMMUNITY RESPONSE

LEICESTER, LEICESTERSHIRE AND RUTLAND

Leicestershire County Council

Leicester City Council

Rutland County Council

NHS Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

Our journey in Leicester, Leicestershire and Rutland (LLR)

System wide redesign of community services

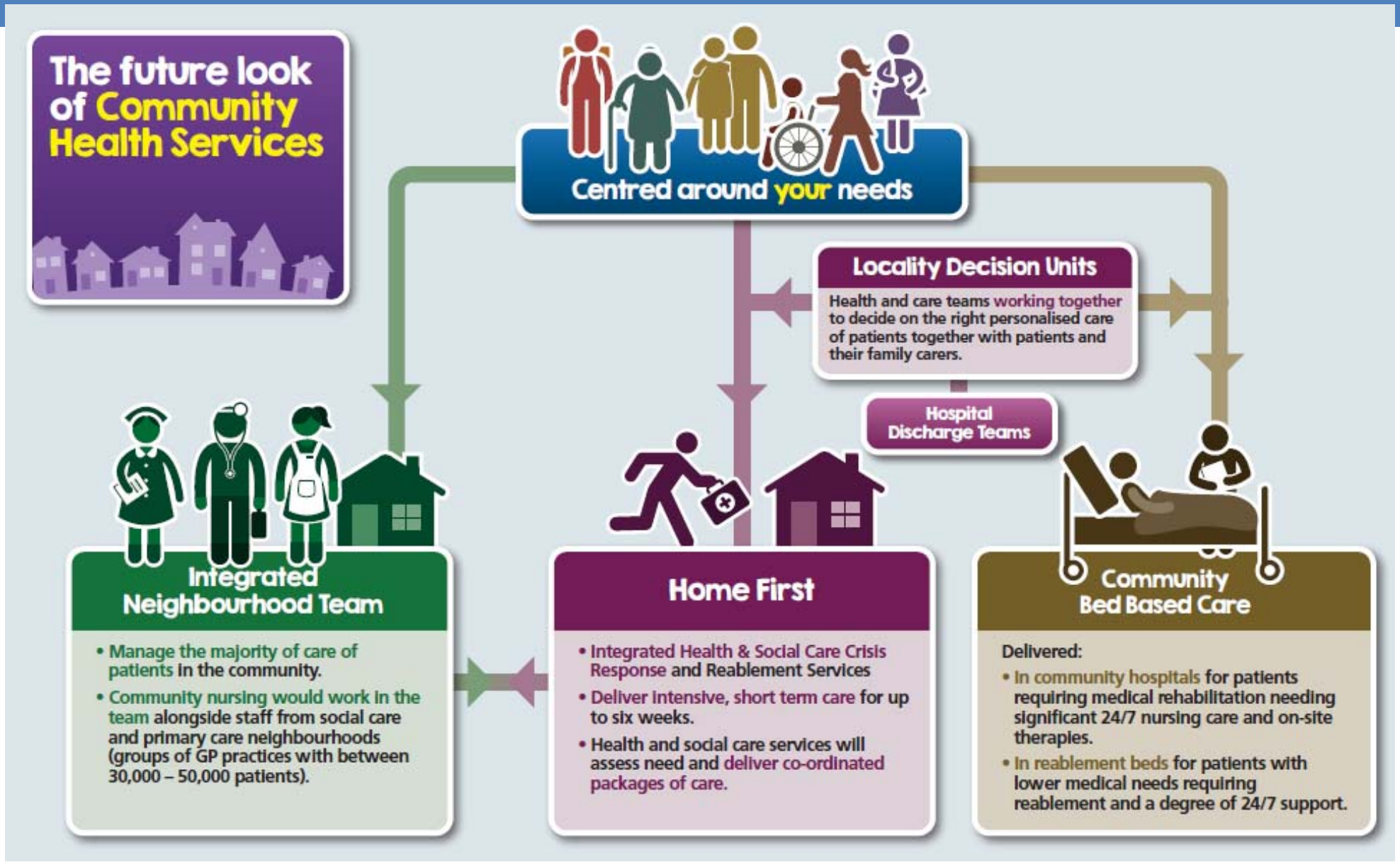
- One community trust
- Three Adult social care departments
- Three clinical commissioning groups (CCGs)
- LLR-wide vision and place based operational model

Urgent Crisis Response

- Integrated health and care model
- Deliver 2-hour response
- Two day reablement
- Step up and step down

Home First model

- Mobilised December 2019
- Community Health services reorganisation
- Different integration agendas in each place
- 2-3 year change programme


The future look of Community Health Services
Centred around your needs
Locality Decision Units
Health and care teams working together to decide on the right personalised care of patients together with patients and their family carers.
Hospital Discharge Teams
Integrated Neighbourhood Team
• Manage the majority of care of patients in the community.
• Community nursing would work in the team alongside staff from social care and primary care neighbourhoods (groups of GP practices with between 30,000 – 50,000 patients).
Home First
• Integrated Health & Social Care Crisis Response and Reablement Services
• Deliver intensive, short term care for up to six weeks.
• Health and social care services will assess need and deliver co-ordinated packages of care.
Community Bed Based Care
Delivered:
• In community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies.
• In reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

Crisis Response Services – National overview

- By end March 2022, everyone over the age of 18 in England will have access to a crisis response service within two hours, 8am-8pm, seven days a week. This was set out in the NHS Operational Planning and Contracting Guidance 2021/22, building on the commitments in the NHS Long Term Plan
- Leicester is one of 7 accelerator sites delivering the national standards for 2 hour crisis response services at scale. The Leicester team have shared their learning and experiences with other parts of the country to support the national roll out of these services.
- As at October 2021 25 ICS areas have rolled out the 7 day and 12-hour requirements, including the accelerator sites. This is expected to be 26 ICSs by the end of this month.
- The two-hour crisis response standard aims to improve patient outcomes by meeting their urgent care needs at home or usual place of residence, which could include a care home, in a timely way. Providing crisis care within the community aims to **prevent avoidable hospital admissions and support people to remain independent for longer.**

Delivering the 2hr standard: LLR's rapid response model

1. Access and referral	2. Response and Assessment	3. Care and support delivery	4. Service discharge
• A single point of access • A streamlined referral process and inclusion and exclusion criteria	• Personalised, holistic assessment of physical health, mental health and social care needs delivered in partnership with the person	• Integrated multi-skilled team supports timely delivery of care • Pathways support onward referral and other care and support needs	Onward referral or discharge

Creating an effective 2 hour UCR

Culture – focus on taking the patient home with crisis response for the first 72 hours, the rest follows

Shared system risk, responsibility and accountability with regard to capacity and management

Encourage creativity through the application of new ways of working

Shared principle of promoting independence at every level.

Multiskilled team approach reduces duplication, improves efficiency and supports better patient experience

Shared vision and objectives have developed transparency and trust across system

Impact of the Urgent Community Response in LLR

Successes

- Ageing Well accelerator site – developing the urgent care response (UCR) standard and sharing learning with other ICS's
- Working across three places with one vision
- Pre-covid: Reduction in admissions in frailty HRGs (5%)
- Project £1.6m pa savings
- 7 day Home First model including therapy
- Crisis response role development and multi-skilled team
- UCR on DOS and available from 111/999

Challenges

- Recruitment and building capacity in teams
- Data quality and CSDS reporting
- Integrated IT – visibility of capacity, documentation and reporting as a system on performance
- 'Describe don't prescribe' approach is hard to embed in practice
- Differing pace of integration
- Impact of reorganisation on teams and established relationships
- Pull of capacity to UCR reduces focus on anticipatory care.

Next steps

- Developing a single workforce approach (shared recruitment and hybrid roles)
- Increase capacity in community services further, particularly post-COVID
- Consistent patient-centred outcomes collection across health and social care
- Develop the use of technology in homes
- Strengthening the MDT approach between hospital based specialists and home first pathway
- Unscheduled Care Coordination Hub to direct patients from EMAS/ DHU stack (Cat 3/4 calls) in to more appropriate pathways delivered by UCR providers

Case Study 1: Two-hour Urgent Community Response (UCR)

Referral

14:14 GP telephone phone call referral via Local Decision Unit (LDU) direct to UCR clinician for Mrs A following fall, back pain and unable to mobilise.
History of recurrent falls, dementia and diabetic.

Outcome:
- Triaged in LDU as a 2 hour UCR
- Response from the health and social care team put in place

Response

14:45 Face to face assessment completed at home by Occupational Therapist and Crisis Response Service (CRS)

Outcome: need for crisis package of care (POC), ongoing therapy, urgent equipment (bed) and referral to nursing

- Referred to equipment provider for urgent bed (delivered within 2 hours)
- 18:47 Registered nurse face to face visit - education and liaison with GP re: diabetes management
- Crisis POC commenced same day to help remain at home safely
- Further daily therapy interventions over the next week plus temporary crisis POC

Outcome

- **Hospital admission avoided**

- No ongoing care needs
- Improvement in back pain and diabetes management
- Independently mobile with frame/transfers, no longer requiring hospital bed.

Case Study 2: Two-hour UCR

Referral

WC is a 69-year-old female involved in a road traffic accident at a young age resulting in long term physical injuries. After a period of short-term support from Adult Social Care in 2013, WC continued to live at home independently alone without the requirement of services.

2/2/21 at 06:56 WC pressed her assistive technology (lifeline) to activate an emergency response as she was struggling with her mobility. The integrated crisis response service (ICRS) was deployed to assess the level of support WC required.

Outcome:

- Triaged as a 2 hour UCR
- The team arrived at WC's home address at **07:40 on the day**

Response

Assessment of immediate needs

Outcome: deterioration in mobility and unable to transfer, red swollen leg, no equipment at home, fearful of admission to hospital

Case discussed at **daily MDT** 2/2/21

- GP same day intervention – Antibiotics for cellulitis, 1 week review and further course prescribed
- Nursing team – observations, dressings to leg applied
- Therapy team assessment - input from occupational therapist and physio
- Urgent equipment ordered and delivered within 24 hours
- Social care assessment – further support to aid recovery and reduce further deterioration in health and well-being – package of care (POC) for 3 calls, review in 3 months

Outcome

- **Hospital admission avoided**

- WC's wishes to remain at home whilst accessing the UCR supported
- Case then transferred to locality team to enable planned work to continue by adult social care
- Regular therapy input delivered for 3 weeks to improve mobility and independence
- **WC remains at home**.

Case Study 3 – Unscheduled Care Coordination DHU Home Visiting Service (HVS) to ICRS/LPT Therapy

Referral

10/01/22 HVS referral received from GP

Presenting complaint - left shoulder and arm pain, bruising following fall 3 days ago, wrist pain

13:30 Triage within Unscheduled Care Coordination Hub

Outcome: May benefit from increased POC
Video call by physiotherapist to assess wrist for ?fracture

Response

Dispatch of ICRS carer to patients home with video call arranged for therapist.

ICRS attended property - arrival 14:45 (1hr 15 response)

15:00 Video consultation by Physiotherapist facilitated by ICRS carer (1 hr 30 response)
Outcome:

- Fracture ruled out
- Mobility assessment completed
- Environmental assessment completed

Outcome

- ED avoidance
- Direction to most appropriate pathway (from HVS to Home First Urgent Community response services
- Ongoing input put in place from ICRS and Community Therapy in order to support to continue to remain at home