healthwatch Walsall

Welcome to our

First Friday Focus Meeting

Friday 7th July 2023

your voice counts

Our next First Friday Focus Meeting... is

Care Navigation

Guest speaker

Fiona Micheli

Lead Nurse

Care Navigation Centre / Virtual Wards

Friday 7th July 2023

from 10am till 11.00am

Please book to join.

Or if you have spare time drop in to the meeting.

Link to Zoom meeting

https://tinyurl.com/4wfpuwak

Meeting ID: 853 9650 7189& Passcode: 242686

To dial in by telephone: 01314601196

healthwatch Walsall

Or scan QR code

Info@healthwatchwalsall.co.uk

or call 0800 470 1660

Meeting Outline

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- Introduction and welcome
- Meeting Etiquette
- Presentation
- How to get involved
- Share your services experiences
- Information and signposting
- How to contact us

Meeting Etiquette

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Please put your microphones on mute to avoid any feedback or background noise

Please save your questions till we come to the Q&A part of the meeting

Comments and questions can be made in the chat facility

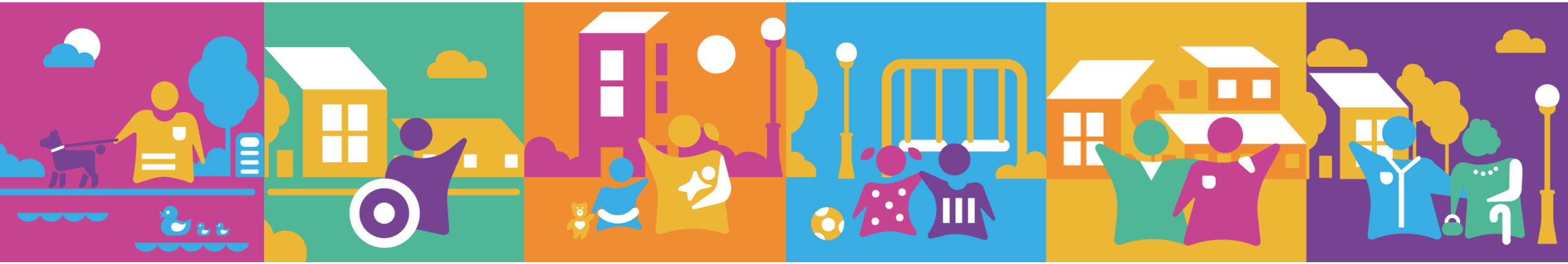
Please respect each others views and allow people to ask a question or make a comment

Walsall Together

Walsall Community Services

Fiona Micheli

Clinical Lead Urgent Community Response



Collaborating for happier communities

Community Services Overview

- Population of approx. 287,000
- 64 teams across community and some based on the acute hospital site
- 8 Integrated Health and Social care ‘Place Based’ Teams
  - a number of the specific service areas are either directly aligned to or have close working links (4 adult & 4 Children)
- Palliative & end of life care including a 12 bedded hospice
- Community stroke services including a 12 bedded rehab unit
- Specialist services integrated within locality teams
- Rapid Response
- Clinical Intervention Team
- Therapy services for the whole Trust

Care Navigation Centre

Single point of access for all Urgent Community Response and Same Day Emergency Care referrals

Service Overview:

- 7 days a week from 8:00am to 12:00am (midnight)
- Staffing – there is always a registered practitioner on duty with team of experienced clinical support workers
- Staff manage take calls from all external and some internal services to ensure a community first response or direct referral into a Same Day Emergency Care service

Community First response

What?

Community response to every port of entry:

- WMAS
- NHS111
- Care Homes
- Care agencies
- GP referrals
- Self referral
- Nursing teams
- Palliative care
- ED/ Ward teams

How

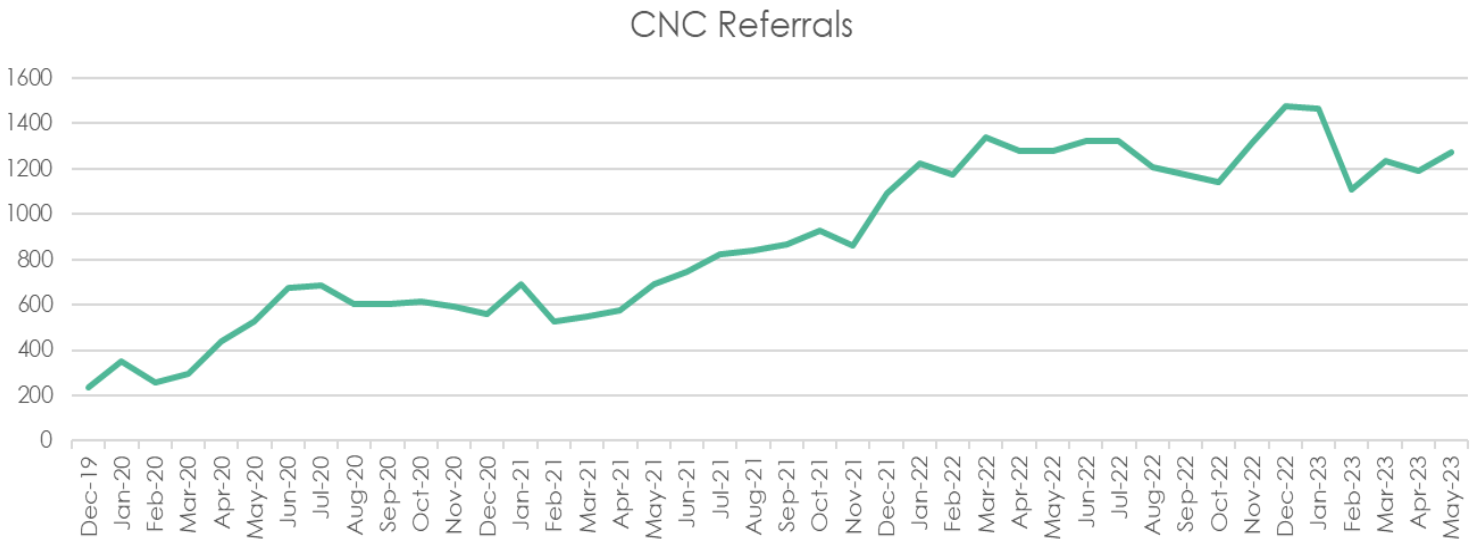
- Care Navigation Centre
- Integrated Front Door

Disposition Routes

- Virtual Wards: ARI, Heart failure; Palliative, Frailty, Hospital @ Home
- Clinical Intervention Team – DVT diagnostics/ IV antibiotic pathways
- Covid 19 Safe at Home pathway
- Enhanced Care Management in Care Homes
- Frailty Case Managers – Locality ACPs
- Heart Failure Service/ Respiratory Nurses
- Long Covid pathway
- Pre-optimisation Pathway
- Rapid Response Team
- SDECs

Avoiding Hospital Admission:

Care Navigation Centre: Received over 1,200 referrals in May 2023



The CNC receive a high level of referrals

CNC disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

CNC works closely with lots of different teams or professionals to stop long waits for ambulances, stop unnecessary hospital admissions ensuring a patients receive the right care at the right time, first time.

CNC - Breakdown

Care Navigation Centre					
	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Total Referrals	1455	1129	1231	1191	1272
Discharge on the phone	529	295	342	234	271
Referred to Rapid Response	304	245	341	278	297
Referred to Locality (District Nurses)	39	35	34	43	50
Referred to Case Managers	153	143	137	166	166
Referred to SDEC-SACU	60	47	57	52	60
Referred to SDEC-FES	6	5	4	2	1
Referred to SDEC-AEC	25	19	26	25	39
Referred to SDEC-GYNAE	4	12	8	6	8
Referred to Other Services	335	328	282	385	380
Referrals received from:					
Care Home	263	235	213	280	280
GP	287	181	276	186	209
WMAS	168	143	221	133	117
Family Member/Self Referral	225	158	200	175	183
Therapy	11	8	10	2	3
Nurse	171	110	134	152	172
Mental Health	2	0	0	0	1
Social Worker	19	7	15	7	8
Unknown	7	0	0	0	0
111	17	8	10	11	12
Clinical Validation/CAD	31	48	29	115	132
Carer	85	58	68	60	51
CMDU	10	0	0	0	2
UTC	69	56	55	40	73
Other Services	90	117	0	30	29

- The service continues to see growth from referral sources such as GP's, and Care Homes supporting Primary Care and preventing hospital admission. This has been particularly pronounced following the introduction of GP referrals via CNC to SDEC pathways.
- As referral pathways with NHS 111 and WMAS have become established there has been an increase in referrals, this has helped to reduce the number of inappropriate referrals
- CNC also dispositions to the well-established falls service directly from WMAS.

Avoiding Hospital Admission:

Safe@Home and Long CoVid-19 Pathways

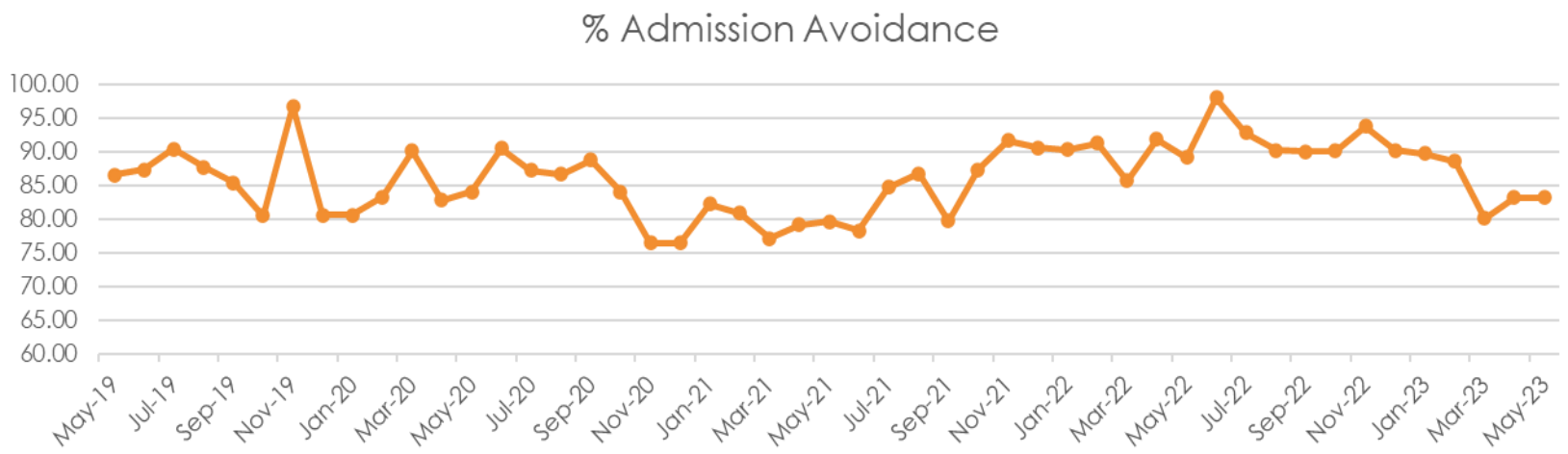
	Mar 23	Apr 23	May 23	Cumulative
Patients referred for Safe@Home	5	3	4	562
Calls made Safe@Home	160	96	144	18,320

	Mar 23	Apr 23	May 23	Cumulative
Patients referred for Long Covid	36	40	13	2,822
Contacts (F2F and Telephone) Long Covid	125	34	50	4,335

Long Covid

Patients referred onto this pathway are screened for Long Covid via a 6 week and 12 weeks triage through an MDT. The service has received 2,822 referrals to date. As both a discharge and community pathway this enables patients to manage their condition without the need for intervention from General Practice, Emergency or Acute Hospital services.

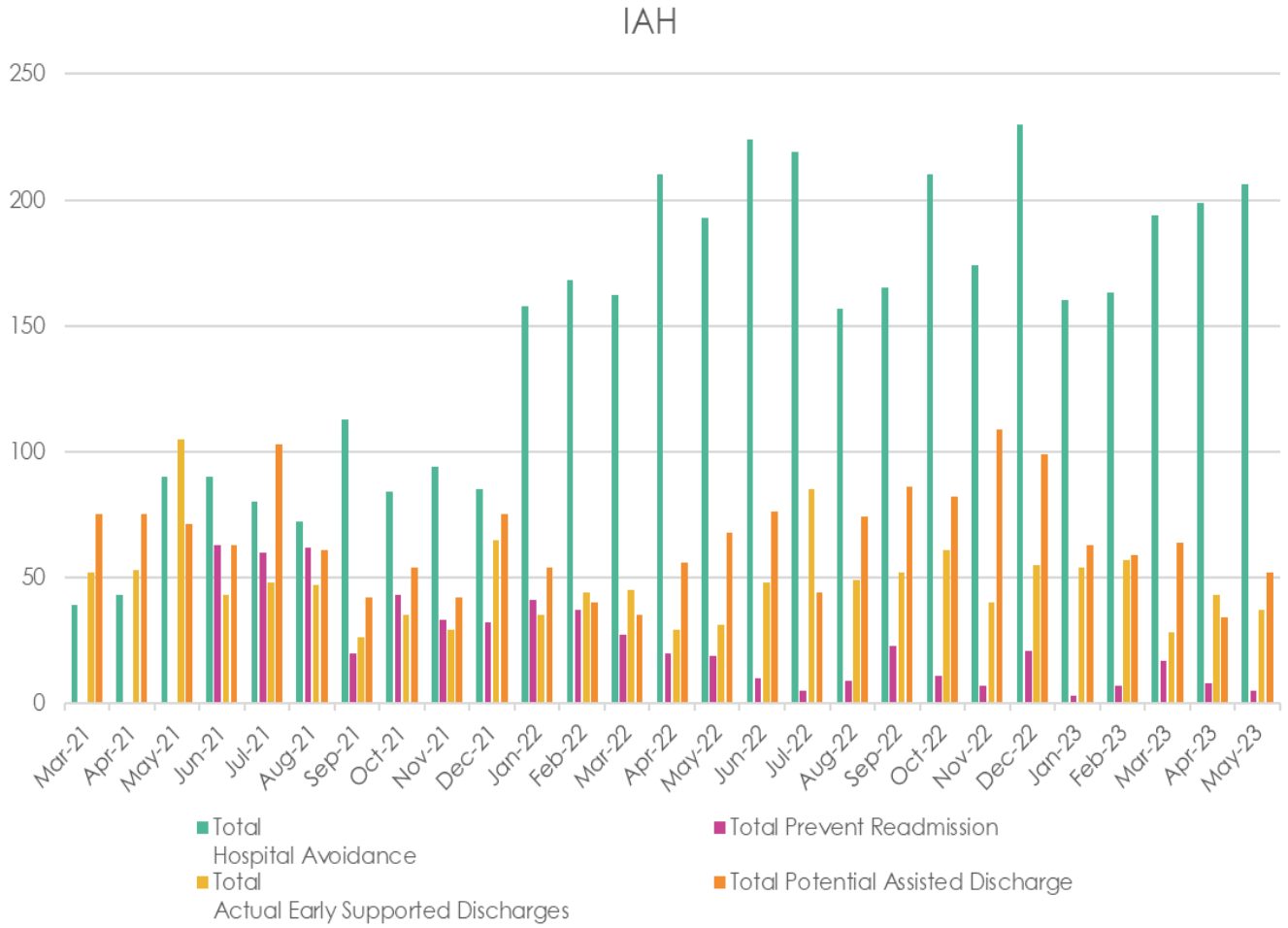
Rapid Response
The high levels of admission avoidance



CNC dispositions patients into the Rapid Response pathways from WMAS, GP practices, Care and Nursing home, patients or their relatives.

Highly skilled nurses provide, assessment, diagnosis including blood test and ECG, create a treatment plan and then ensure proper follow up by other community service.

Integrated Front Door :

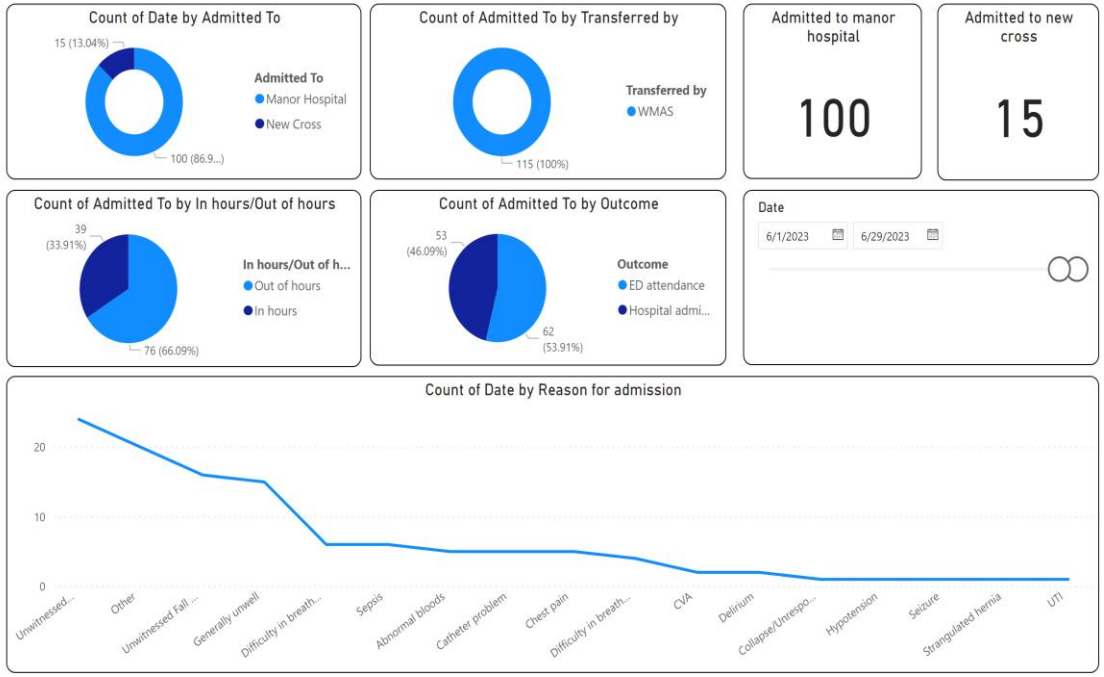


Integrated Front Door

- A nurse lead enhanced service that bridges the gap between community and acute service. Highly skilled experienced nurses' support acute staff mainly in ED to ‘ turn’ patient around by ensuring effective referrals to community services. The success of this can be seen in the hospital avoidance activity data.

Case Managers for Care Homes

- The **Case Management Team** will see all the residents in the care home and nursing homes across Walsall.
- The team plans weekly ward rounds with the aim of spotting changes before your resident develops a problem.
- The team can provide a frailty assessment for all residents, to ensure effective care and case management.



Any questions ?

- Thank you for your time

Get involved

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There are a number of ways:

- Tell people about Healthwatch Walsall in your local community. Spread the word
- Share your experiences and views of health and social care services in Walsall. Go to our ‘Have Your Say’ on our website.
- Volunteer with us in one or more of our volunteer roles available. Recruiting volunteers and to our growing Youth Healthwatch volunteer team.

Share your Services experiences

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Share your health and social care services experiences by going on our online

‘Have Your Say’

platform on our website.

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Information and Signposting

We provide an information and signposting service so that people can get the support or access to services and information when they need it.

How to contact us

By Telephone: 0800 470 1600
By Email: info@healthwatchwalsall.co.uk

Via our Have Your Say experience section
https://www.healthwatchwalsall.co.uk/share-your-views

Social Media
- Facebook : @HealthwatchWSL
- Twitter: @HWWalsall
- Instagram: hwwls
- YouTube: Healthwatch Walsall 2020