The Graham Care Group

Relationship Centred Care™

The Hawkinge House Integrated Community Healthcare Centre (ICHC)

A prototype for new community care as an alternative to hospital

This prototype will enable people to have their acute clinical care met in the community – reducing the need for acute hospital beds whilst making local primary care more sustainable.

Working in association with the Design and Learning Centre for Clinical and Social Innovation to develop new ways of integrated working to meet the needs of the complex frail patient.

Design and Learning Centre

CLINICAL & SOCIAL INNOVATION

'Making out of hospital care safer for both citizens and the professionals'

What does the ICHC do?

- Provides an environment that patients would choose to have their acute clinical needs met that feels like an extension of their home rather than a hospital – "Home from Home"
- Enhanced clinical care in a safe, family-friendly environment
- Care as an extension of the patient's General Practice without making extra work for the GP and their community team
- Use of the patient's own electronic GP record for the stay to ensure seamless care not admission and discharge
- Provides a safer environment for complex patients to stay in the community rather than staying at home without diagnostics and monitoring, reducing the need to dial 999, attend A&E or acute admission
- Provides enhanced medical and therapy input to support primary care in the community

How will the ICHC do this?

- Each patient will have their own ESTHER Care Coordinator to ensure that their needs and priorities are met
- Additional GP input to ensure clinical needs are met, linked to the patient's own practice
- Additional consultant input (medical and psychiatric)
- Additional therapy input including IV antibiotics, fluids and transfusions
- Innovative diagnostics including a community lab
- Identification of respiratory and urinary causes reducing inappropriate antibiotic prescribing and reducing microbial resistance





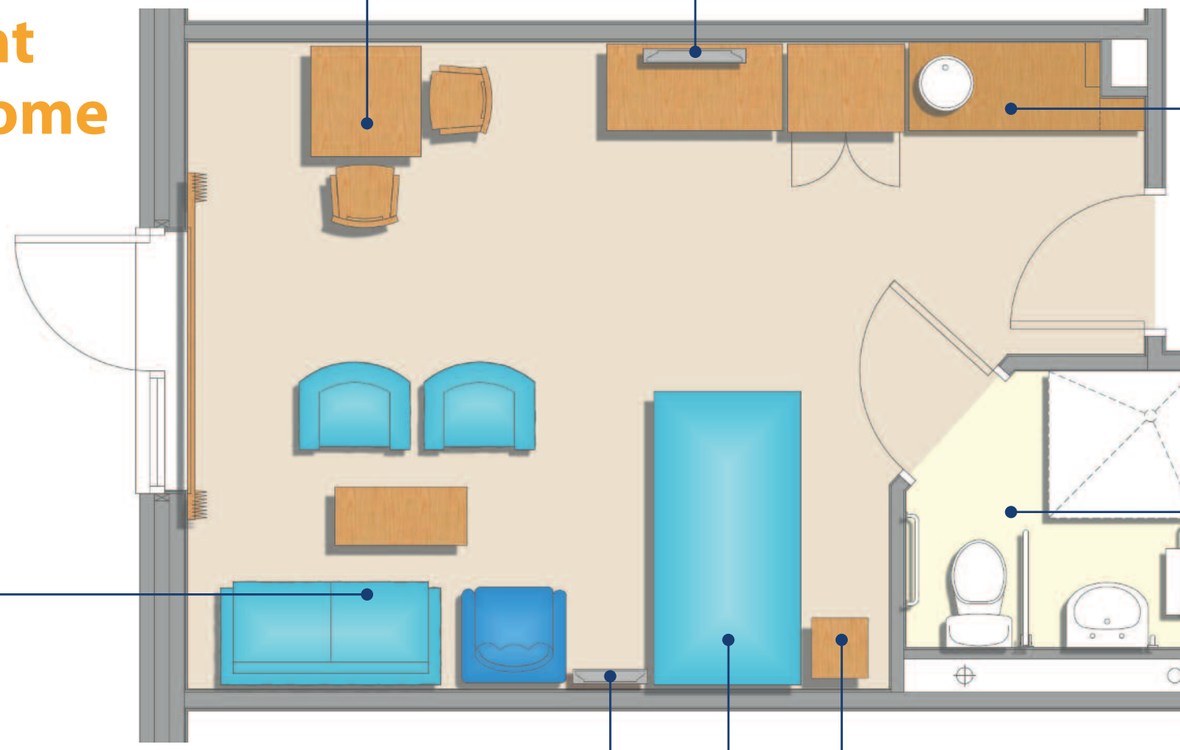
What will the Integrated Community Healthcare Centre (ICHC) look like?

Feels to the patient like Home from Home

Dining table
Able to eat on own or with family and friends
Communal eating and social facilities as chosen

Interactive TV screen & Web cam
Skype type with family, friends and own primary care team
Virtual consultations with specialists
Ability to see care plan real time

Ultramodern diagnostics
Onsite Community lab providing traditional and innovative diagnostics
Access to William Harvey Hospital facilities available urgently as Virtual Inpatient (VIP) when needed

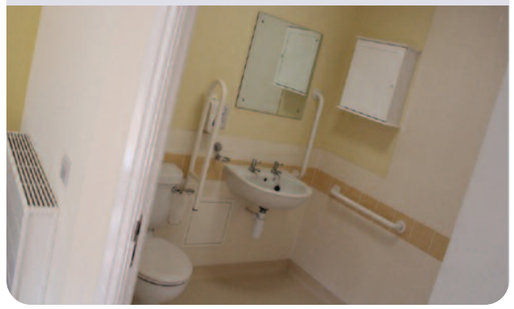


Own cooking facilities not institutionalised hospital care
Able to make own hot drinks
Microwave
Fridge
Available for family and friends

Registered with CQC as a Community Healthcare Service supplying enhanced integrated care services 7 days per week
Medical including additional GPs and consultants
Nursing
Therapies including physio, OT, tissue viability
Pharmacy
Social
MDT personal approach to meet individual needs

Relationship Centred Care ™
Patient's priorities met through personal ESTHER care coordinator
Creative interactive environment
Carer support
Linkage with community and voluntary sector

Fully equipped bathroom
Disabled friendly
Respects dignity
Facilitates independent personal care



Family-friendly environment
Personal social seating space
Sofa bed for relatives and friends to stay
Enabling carers to continue to care where appropriate

Modern therapies available 7 days per week
Piped oxygen to all suites
IV therapy including antibiotics, fluids and blood
Pain relief management
Interactive social activity with links to patient's own community

Ultramodern monitoring
Ability to detect the acutely deteriorating patient

Utilisation of own GP electronic record
Record available to patient and relative
Patient / Carer agreement with personalised care plan

'Making out of hospital care safer for both citizens and the professionals'

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How will the ICHC support frail patients to have their acute clinical needs met in their community?

• Reduces emergency admissions to hospital

GP practices are increasingly expected to look after complex frail patients when they have increased clinical needs rather than referring these patients to A&E and acute admissions. This is causing significant pressure on an increasingly unsustainable primary care, particularly with the lack of acute diagnostics and community resources to visit and manage these patients safely.

The ICHC will provide enhanced and additional resources to manage this clinical risk, linking directly with GP practices and the community team including social care so that the patient is managed as an extension of their GP practice, accepting patients who do not have specific conditions including:

- Heart attack
- Stroke
- Fractures
- Potential surgical conditions

Patients will be identified in primary care as having acute clinical needs that cannot be managed in their own home safely

- Patient screened by Emergency Visiting Paramedic Practitioner
- Patient accepted by Hawkinge House clinical team 7 days per week
- Examined, investigated and managed as an extension of their own GP practice
- Will stay until well enough to return home

• Reduces need to dial 999 and attend A&E

Increasingly primary care is held to account for patients dialling 999.

The enhanced clinical service in the Hawkinge House ICHC will provide an innovative option for primary care to make "out of hospital care safer for both citizens and the professionals".

This will give the citizens confidence that their clinical needs will be met in a social care, family-friendly environment that will return them back to their own home when they are clinically fit enough to return, rather than dialling 999.

The other local care homes will feel that this facility is an extension of their care home.

The practices will feel that this is an extension of their service in a similar way to the Folkestone Prime Ministers Challenge Fund hub, giving additional support and enhanced diagnostics that they may have difficulty providing themselves. They will also be able to feel more in control and able to inform how the ICHC should function.

The Emergency Visiting Paramedics will recognise that this is an additional primary care option to enable patients to meet their enhanced clinical need. Emergency Visiting Paramedic Practitioners will assess patients in their own home to ensure that their acute clinical needs will be appropriately managed in the ICHC.

'Making out of hospital care safer for both citizens and the professionals'

Patients, carers, practices and communities will choose the ICHC rather than acute hospital care

- ## Supports GP practices to look after complex patients in their community

  The ICHC will operate as an extension of the GP practice but without the need for the practice to provide any additional clinical input. It will use the existing GP clinical records and care plans to ensure that the additional clinical care is a seamless transfer of care – a stay rather than an admission or a discharge. It will have a strong Multi Disciplinary Team approach looking at the needs of the patient rather than organisational needs, supporting and linking directly with the integrated community teams.

  Patients' individual needs and priorities will be met by the ICHC operating a Swedish model of care (ESTHER). Each patient will have an ESTHER care coordinator thus ensuring that they can return home quicker and safer when they are well enough, having been looked after in a family-friendly environment.

  All members of the ICHC team, including the carer, the community and the voluntary sector, will be focussed on the individual's total needs, thus reducing length of stay and recurrent admissions whilst setting up in-reach care into their own home.

  The proposed lengths of stay will be 4 days with a potential to be increased to 14 days depending on circumstances, enhanced by the ICHC's experience in managing dementia and confusion.

- ## Improving quality, safety and saving costs

  The ICHC will give much needed additional clinical support for primary care to care for patients with enhanced clinical need in a family friendly environment - "Home from Home".

  New acute options of modern diagnostics, including radiology and ultrasound, will improve quality of care and decision-making including options of referral to the hospital as a VIP (Virtual InPatient) so that the patient only stays as long as the test or procedure takes, as well as access to virtual televideo consultations.

  An innovative community lab will provide real-time on-site tests:

  - DNA identification of infections
  - Innovative identification of pre-diabetes and myocardial ischaemia
  - Routine DDimer, CRP, renal function, blood counts, blood gases.

  Plans are in place to be a centre of excellence and training integrated with the hospital who are very supportive of this prototype, which could reduce need for up to 100 acute beds at a cheaper price with reduced length of stay.

  This is based on work by the Clinical Senate commissioned by East Kent Strategy Board, internal hospital analysis, external review of admissions and designed in association with the Design and Learning Centre for Clinical and Social Innovation.