



Healthy London Partnership
Improving children and young people's out-of-hospital care

The Bridge – An integrated community virtual ward for children with complex needs in Tower Hamlets

Started: 2014

Region: Tower Hamlets, North East London

Geography: Urban

Estimated local pop. 0-18 years: 90,000

Background / Motivation

The Bridge began as a pilot project at Barts Health NHS Trust under the Darzi Fellowship scheme and ran from March 2014 until July 2014. It was developed with engagement of the specialist community children's teams and in consultation with parents of some of the children with complex needs in the Borough of Tower Hamlets. 20 CYP with the most complex needs in the borough were offered to be on the virtual ward.

This consisted of weekly MDT meetings attended by representatives from secondary care, community nursing, physiotherapy, school nurses, school teachers, occupational therapists and community paediatrics doctors and coordinated by an integrated care professional. Parents were contacted before each meeting to identify specific concerns which could be brought to meeting.

The pilot was then extended by a project grant from the CCG which runs until March 2017. This enabled employment of a dedicated Integrated Care Childrens health professional to take on the care coordination role and a Band 5 administrator to support the service.

Aims

- Early intervention for unwell children which has avoided admission to hospital.
- Co-ordination of care between the GP, acute services, education and social care.
- Improved palliative care facilitation.
- A more informed process for review of care packages for families.
- Better information sharing across organisations in health, education and social care.
- Reduce care contacts spread out across the community and providing a point of contact.
- Accessible support for parents with children with complex cared needs – Improving care experience

Target patient groups

CYP 0-16 years of age with complex health, mental health, learning disability and or social issues. The children were identified by clinical teams in the hospital and community setting and through special schools. Many were known to the borough continuing care teams. They were stratified using admission and length of stay data. Currently the cohort consists of 50 children.

The service model

1. Virtual ward model of MDT meetings where the key professionals involved with CYP and families meet to discuss the progress of the children on The Bridge. Representatives include secondary care, community nursing, physiotherapy, school nurses, school teachers, occupational therapists and community paediatrics doctors. The intervention is a personalised care plan which can be responsive to the CYP needs. This improves quality and experience of care and aims to address day to day problems in real time. The Bridge also aims to encourage advance planning for families and facilitate discussions with palliative and social services so that care is considered holistically and not just medically.
2. Care coordination lead by a senior nurse/health professional. The Integrated care professional provides a single point of contact for the team involved with the CYP ensuring the most appropriate services are being accessed. The CCL helps to manage early discharges by organising increased community support as needed.
3. Education and empowerment of the CYP, their families and the professionals around them is supported by the CCL. This enables the virtual ward to remain dynamic and continually address the needs of the most vulnerable complex children in the borough.

Opening times

Monday-Friday 09.00-17.00

The service is part of the Children's Community Nursing Team and as such benefits from their extended opening hours which are 08.00-20.00 weekdays and 10.00-14.00 weekends.

All the CYP on the ward are known to the Royal London Hospital with 24/7 access to emergency care

Staffing

- Band 7 Integrated Care Children's Nurse/AHP
- Band 5 Ward administrator

Who can refer

Any healthcare professional within the Borough, Children's Social work teams, mental health professionals.

All referrals are assessed against referral criteria and a decision regarding acceptance onto the ward is made within 5 working days.

Who is accountable for patients?

The referrer retains clinical accountability

Resources

The Virtual ward meetings take place in the setting most appropriate for the CYP. This includes special schools, specialist children's community centre and acute hospital setting. The team are based at Mile End Hospital collocated with the CCNT and children's therapy teams.

Funding organisation

- THCCG
- Barts Health NHS Trust
- Tower Hamlets Together (Multi Speciality Community Provider Vanguard)

Level of patient/family involvement

Healthwatch evaluation to provide an understanding of key themes and issues underlying the opinions and perceptions of patients and their families of service provision across health and social care; and provide feedback from patients and their families about their expectations, experiences, and outcomes of the new programme (final report currently in draft)

Internal validation data collected on a weekly basis by the Bridge team assessing the impact of the MDT intervention on each family

Level of integration in the system

- Horizontal: linking the members of the team around the child from many designations
- Vertical: ability to obtain rapid access to primary or secondary care teams in times of crisis
- Longitudinal: focus on the achievable outcomes for an individual child and an ability to support their progress over time and through the education system

Evaluation

- Evaluation data from 2014-2016 reported to THCCG
- 21% reduction in A&E attendance
- 31% decrease in emergency admissions
- 7% decrease in hospital Outpatient attendances
- 50% reduction in OP DNA rates
- 29% reduction in hospital LOS
- We are currently mapping individual progress data for the CYP on the ward (much as they do in education) to give a more meaningful assessment of impact.
- Healthwatch final evaluation due to report Oct 2016
- Internal validation data from parent and professional feedback attached including:
 - % MDT attendance from all invited health Care Professionals .
 - Positive feedback from parents on care experience (Qualitative measures)
 - % Completion of the actions from MDTM

Challenges, successes, lessons learned and advice

Successes: tangible impact experienced by all agencies involved in the project achieved through supportive relationships from the CCG through the Children's Integrated Care Steering Group

Lessons learned

- The key to success is through strong supportive relationships and leadership at all levels.
- Engagement with stakeholders and CYP and their families to shape the service at the onset.
- Interventions which focus on the progress of the individual break down the barriers between the health systems around them

Challenges: identifying the agents of change within a complex system

- Making connections with people in other agencies as there are many political, commissioning and cultural barriers to overcome (but it is worth the effort!)

Downloads:

[The Bridge Service Specification 2016.docx](#)

[The Bridge Project Referral Form.docx](#)

[Terms of Reference for meetings.docx](#)

[Parents & professionals feedback.pptx](#)

Contact for more information

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N/A