# Evelina Complex Care Coordination Team


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# General Paediatrics at Evelina

- Treat children from south London and south east England with a wide range of common childhood problems
- Support other specialist teams treating children with more complex medical conditions
- Mountain Ward
  - 8 bed High dependency unit and 36 bedded ward
  - Surgical, ENT, Respiratory, Gastroenterology, Haematology
- Snow Leopard long term ventilation unit
- Two Community centres; Mary Sheridan Clinic & Sunshine House

# Definition

- Current definitions relate to the problem we are aiming to influence; healthcare burden and family psychosocial burden
- Applied four current definitions; subjective with 3 professionals 80% match on ward
- Surveyed staff & patients
- Definition dependent on aim;
  - Assessing the size of the problems retrospectively (reliant on information databases)
  - Identifying the child on proactively for intervention

# Assessing the problem

- *'At least one chronic or significant medical condition and 2 or more specialities involved in their care'-> 1000*
- Removing atopic and sickle cell disease-*>600*
- 150 local

# ECCCT Multidisciplinary inpatient structure

- Evelina Complex Care Co-ordination Team Consultant
- Administration Co-ordinator
- Complex General Paediatric Clinical Nurse Specialist
- Well Child Discharge Co-ordinator

# Criteria

**Inclusion:**

- At least two long-term medical, functional or developmental conditions complicating their acute admission
- Under the care of two or more specialities or professionals;
- Currently admitted in the Evelina hospital under the care of the general paediatric team Medically stable with no significant acute medical concerns which would require frequent senior medical review

**Exclusion:**

- Admitted from external organisations / hospitals solely into the care of the ECCT
- Admission for acute medical problem

**Number cap:** 6

# Communication central

- Children, young people and families inform care
- Information gathering from patient's local paediatric and community paediatric teams->inform care and reduce DNA
- Early multi-professional ->establish relevant diagnostic and management pathways, enabling clear co-ordination of care.
- Communication of discharge information to all relevant professionals enabling continuity of care.
- Learning together monthly meetings with Community Colleagues
- Co-designed patient information booklet (ongoing)

# Challenges

- Ownership of patient
- Role boundaries
- Further layer of communication
- Competing demands
- Wellbeing of team
- Unpredictable work load
- Trainee needs

# Evaluation

**Qualitative**

- Patients and Families; survey + interview
- Consultants; ECCCT and Attending perspective; focus group
- ECCC CNS, Administrator, Well Child discharge coordinator; interviews
- Trainees; survey and focus group (trainee led)
- Ward MDT (survey)
- Ward Nurses (survey)

**Quantitative**

- Number of Presentations to A&E in last six months
- Number of hospital admissions in last six months (readmissions)
- Number of wasted appointments prevented
- Inter-professional communication metrics: MDT/ info sharing
- Length of Stay

# Questions?