Creating a healthier Hull

Better Care in Hull

Care Coordination

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#bettercarehull

Hull City Council

NHS Hull Clinical Commissioning Group

What is it?

- **Care coordination** is the concept of health and social care professionals working with service users to ensure that their health and social care needs are being met and that the **right person** is delivering the **right care** at the **right time**.

- Co-ordination of care for patients with complex needs and long-term illness is currently poor (King's Fund 2011) and those with long-term conditions have a lower quality of life (Department of Health 2011)

Who is it for?

- Our focus is on care for those people who are at most risk of being admitted to hospital e.g. older and frail elderly people, people with more than one long-term condition, people who have complex conditions which means that there is often more than one professional involved with their care

Services coordinated around your needs

A single care plan is in place equipment has been provided with support that allows care and health conditions to be managed on a daily basis. Information and advice is clearer and professional support is available as and when needed. People and carers feel in control.

An agreed plan of care is in place to manage disease progression. People have a choice of local services accessible form a community hub, their coordinator supports and accesses additional support e.g. respite whilst the Lead Care Professional monitors health and changing needs

7 day working , care is more consistent and if a crisis or unplanned care is required it is easy to access, people receive help in their community and avoid admission to hospital and care homes with the help of staff who are well informed, clear about their roles and work together

When circumstances change people are reassessed. They each have a care coordinator whose role is ensuring that support is available to people in their communities. People have access to the Lead Care Professional particularly in difficult times.

Communities provide more practical help in Community Hubs e.g. volunteer drivers to get people to community out patient's appointments. Social prescriptions are issued for a good range of activities, reducing isolation, improving health and well being Dementia friendly communities are developing, so people with dementia and carers can participate and contribute, Bert and Marianne feel well served in local shops and services.

GP and surgery staff work well with community services; one worker is nominated to coordinate our care which is set out in a single care plan. Single patient and care records, as they become available can be accessed by the individual and used by their clinicians and care staff to ensure we only have to tell their story once. We know we will have continuity of care and support, seven days a week, even if hospital admission is needed

Homes are adapted with various simple aids around the home much more quickly with less risk of falls. Waits for major adaptations to homes are reduced; with extra care housing offering choice and more options for disabled. Care hubs contribute to improving specialist care

The Therapy services team (with social work, nursing, geriatricians and pharmacy support) provide both early, focused and intensive care and support. Advanced care planning is enacted by coordinators when needs dictate more support is needed. GPs remain involved when a patient is in hospital to add support and assist discharge

What will it mean for the city?

- From April 2016 we will see a change in how our community services (health and social care) work with each other and with all general practices in the city to support and coordinate care for patients

- There will be better coordination between all services including the hospital and services provided by the council and the voluntary sector

- By doing this we will make better use of the voluntary sector to support people to improve their health and well-being

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Pilot schemes in general practice

- Several schemes in place funded by the CCG to trial different approaches to coordinating care for the over-75s
- Anticipated outcomes – reduction in emergency admissions helping people to better manage conditions at home
- Identifying gaps in services, areas where communication between agencies could be better

What the pilot schemes have achieved so far…

- Increased referrals to community groups/befriending services/health services
- Supported people to apply and obtain social care benefits
- Supported care homes to better manage their residents
- We regularly get asked why our service is for over 75's only? There are many people, particularly in the 65-75 age range with very similar problems!