Better Care in Hull

Conference 2016

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#BetterCareHull2016

Hull City Council

NHS
Hull Clinical Commissioning Group

Intervention:
Care Coordination

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City Health Care Partnership CIC

Objectives

- Introduce CHCP
- Define Care Coordination
- Identify the benefits of care coordination
- Discuss the rollout of Care Coordination across City Health Care Partnership CIC and Hull
- Provide a vision for the future
- Discuss a Case Study – illustrating Care Coordination
- Provide time for questions and discussion

City Health Care Partnership CIC

A growing, **for better profit business**, **owned by staff**, providing a **wide range of health and care services** across Hull, East Riding, North and North East Lincolnshire and the North West. A **socially motivated** company, our diversifying **portfolio of businesses** and **registered charity** allow us to **invest into services, staff and the communities in which we work.**

City Health Care Partnership CIC

Social Benefits

Contributing to the wider wellbeing of the communities in which we provide services.

- Corporate Social Responsibility
- City Health Care Partnership Foundation has distributed over £190,000 in Hull and the East Riding.

Definition – Care Coordination

- the process of co-ordinating care around the **service-user and not their condition** – making it simpler for people with complex needs to understand who is providing care and support
- focused on those service users with the most complex needs
- care and support **designed in partnership** with the **patient or carer.** Service users will be supported with a **comprehensive care plan that will support them to manage their condition**
- a named **care co-ordinator** (lead person) for service users, who will have responsibility for their care. This will be the person who is most appropriate to meet their needs and can change as the service user's needs change

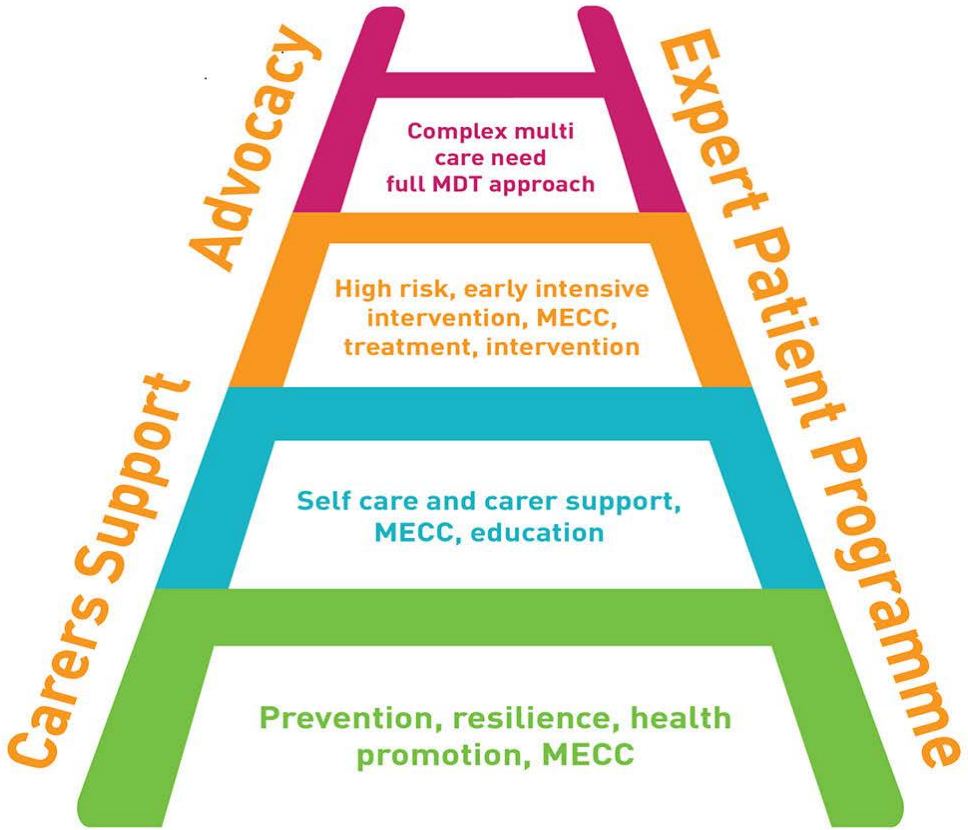
Who will benefit from Care Coordination ?

- All service users with complex needs, including:
- **those requiring palliative and end of life care**
- **those with chronic and multiple disease** including older people, those with frailty, dementia
- **those who need intensive support but for a short period of time,** for example, intermediate care support
- **Families and Carers**
- **Wider health, social and third sector communities**

Benefits of Care Coordination include:

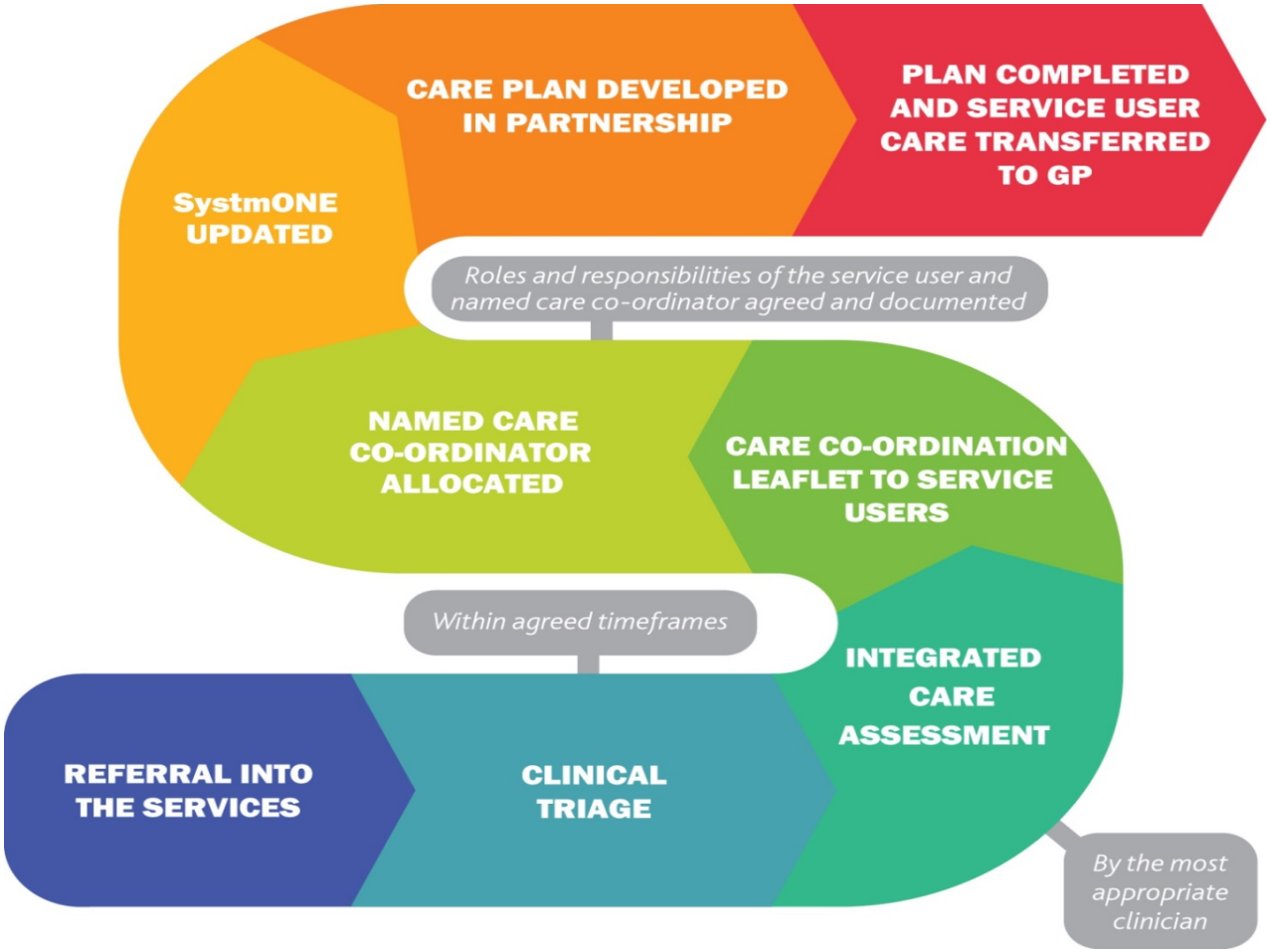
- Holistic and Person/Family Centred Approach
- Addressing the Wider Determinants of Health
- Only telling your story once
- One Record, one person, real time information
- MDT approach – health, social, third sector – person and family as partners
- Faster Access – 24/7 access to a clinician
- Appointments Coordinated

Care Coordination and Navigation



Ladder of Care

Process


CARE PLAN DEVELOPED IN PARTNERSHIP
PLAN COMPLETED AND SERVICE USER CARE TRANSFERRED TO GP
SystmONE UPDATED
Roles and responsibilities of the service user and named care co-ordinator agreed and documented
NAMED CARE CO-ORDINATOR ALLOCATED
CARE CO-ORDINATION LEAFLET TO SERVICE USERS
Within agreed timeframes
INTEGRATED CARE ASSESSMENT
REFERRAL INTO THE SERVICES
CLINICAL TRIAGE
By the most appropriate clinician

Care Coordination Centre

- A single point of contact, 24 hours a day, 7 days a week through one dedicated phone number, 247111 – direct access to a clinician
- IT enabled integrated Electronic Care Records (ECR)
- Co-location with Telehealth services – proactive contacts
- Working with a full range of partners – offering onward referral to health social and third sector services and support
- Online booking and triage also available for some services
- Clinicians in community settings working via fully mobile IT enabled systems

Phase 1: April 2016

Phase 2: April 2016 – April 2017

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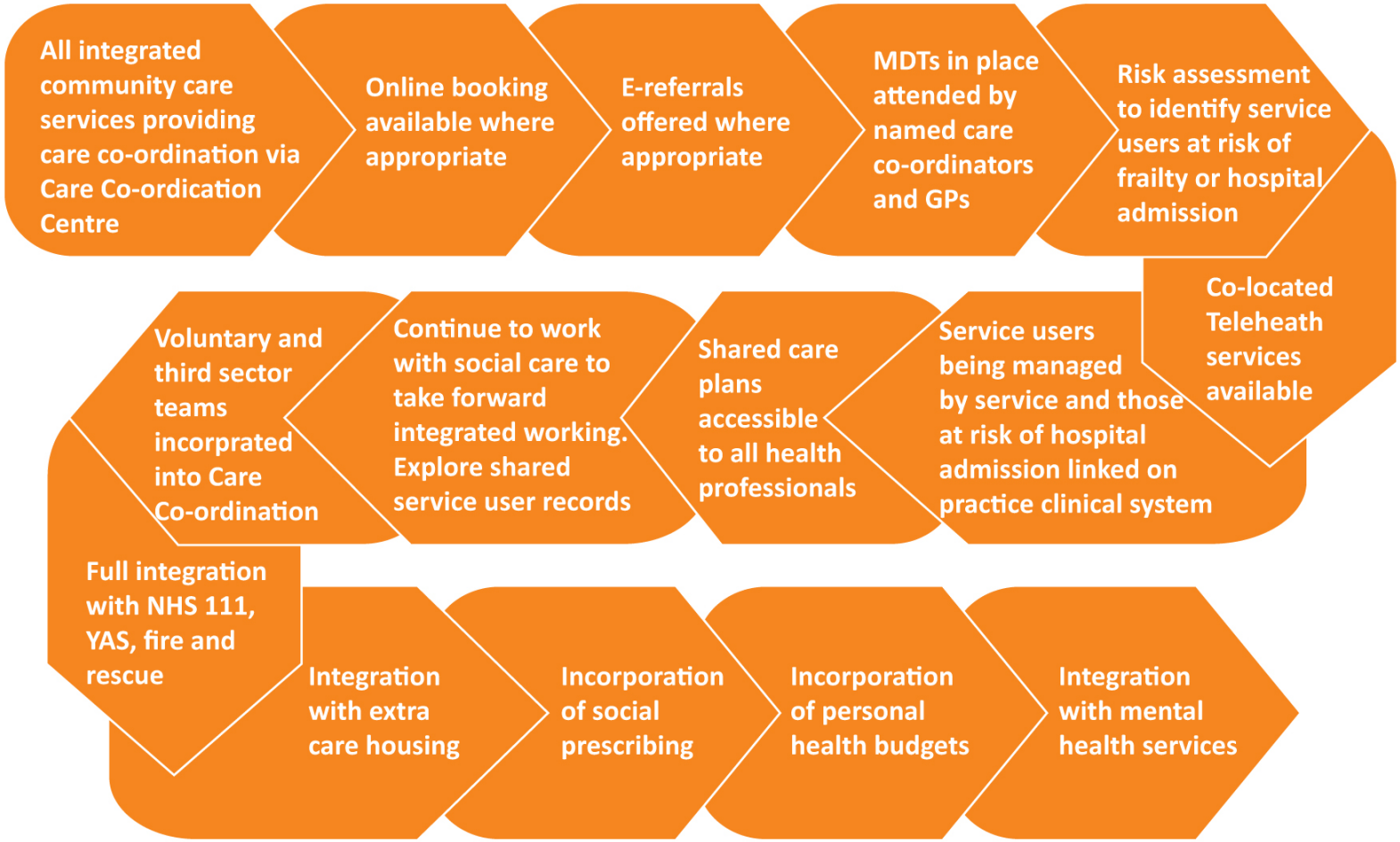

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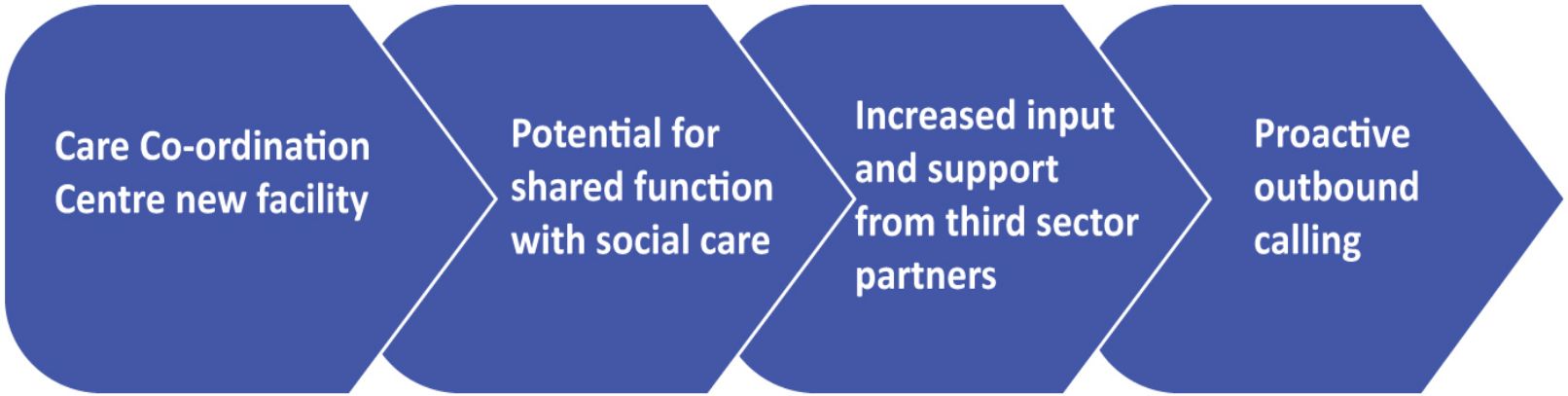
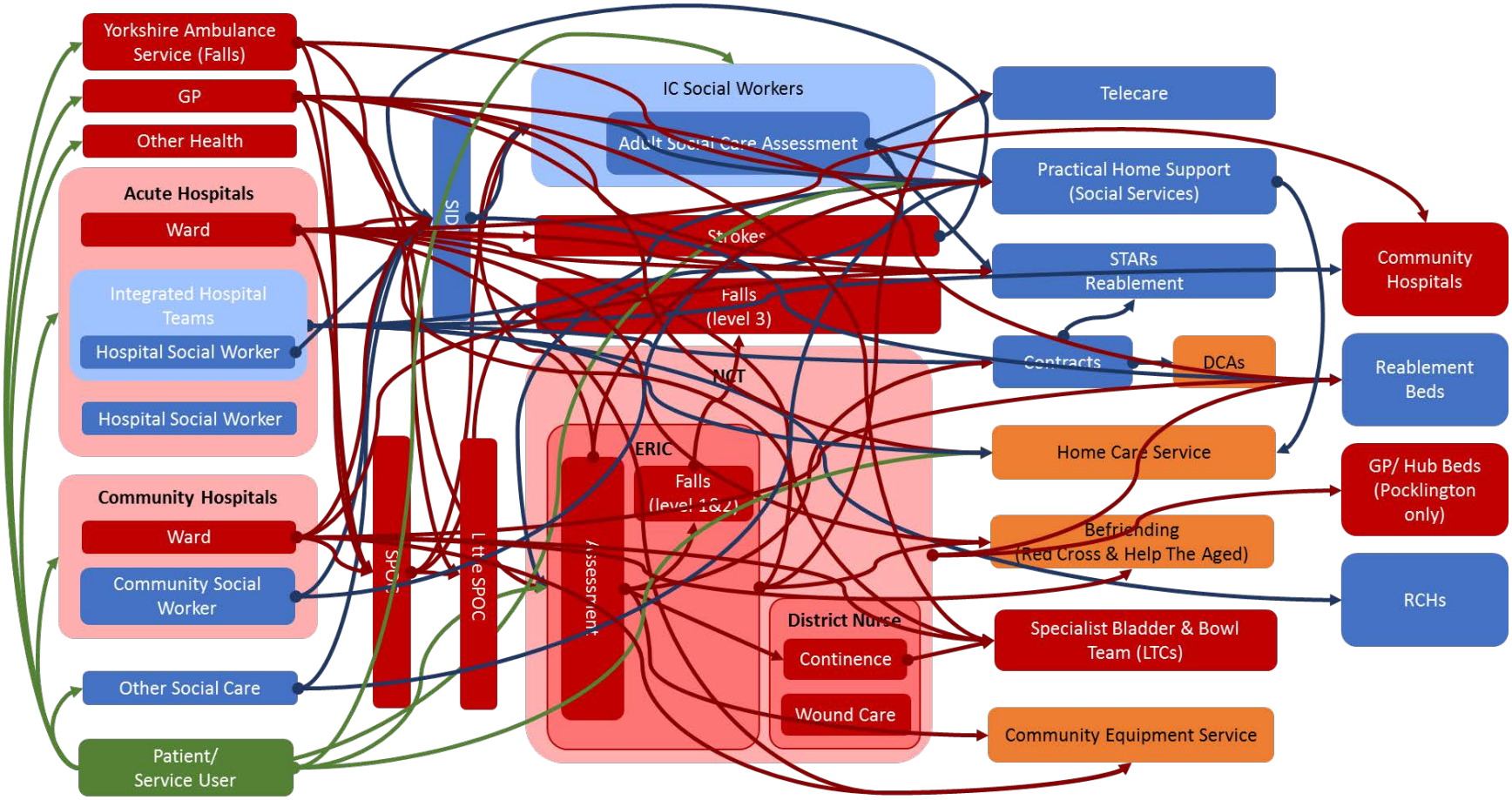
Phase 3: Our Vision



Case Study

Mrs Andrews' story: Her failed care pathway

Current State Model



adopted from East Riding Intermediate Tier Review 2015

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What is changing?

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We want to make it easier for patients to access care and get better health outcomes.

Currently

a complex system that currently has over 70 different services in the community; patients and key partners often don't know who to contact

April 2016

- Transforming community services and new models of care
- Numerous services already moved to 247111
- Care co-ordination for complex needs
- Better patient outcomes
- Quick and easy contact
- Reducing health inequalities

What does it mean for Mrs Andrews

One call, one number
One conversation

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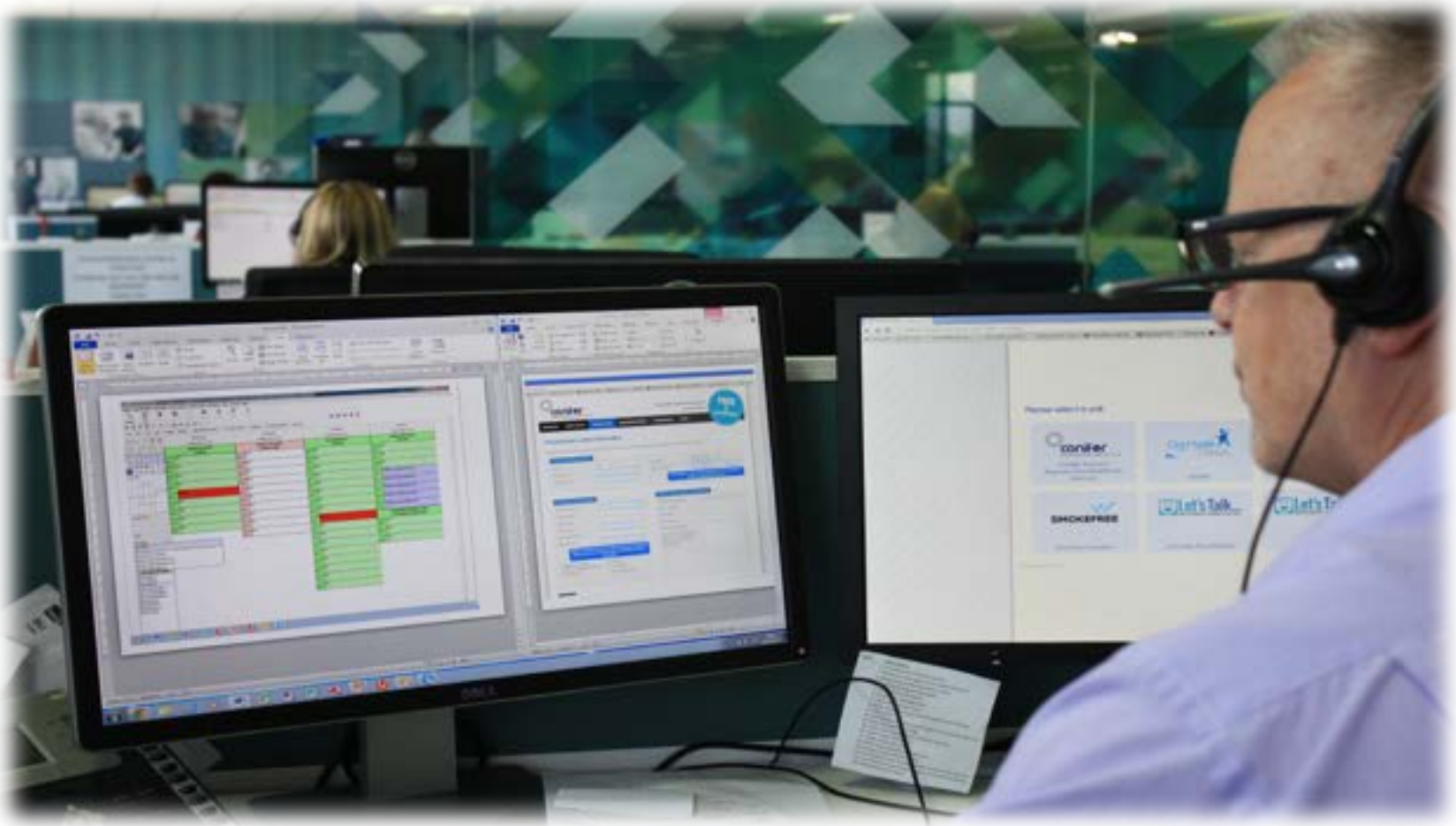

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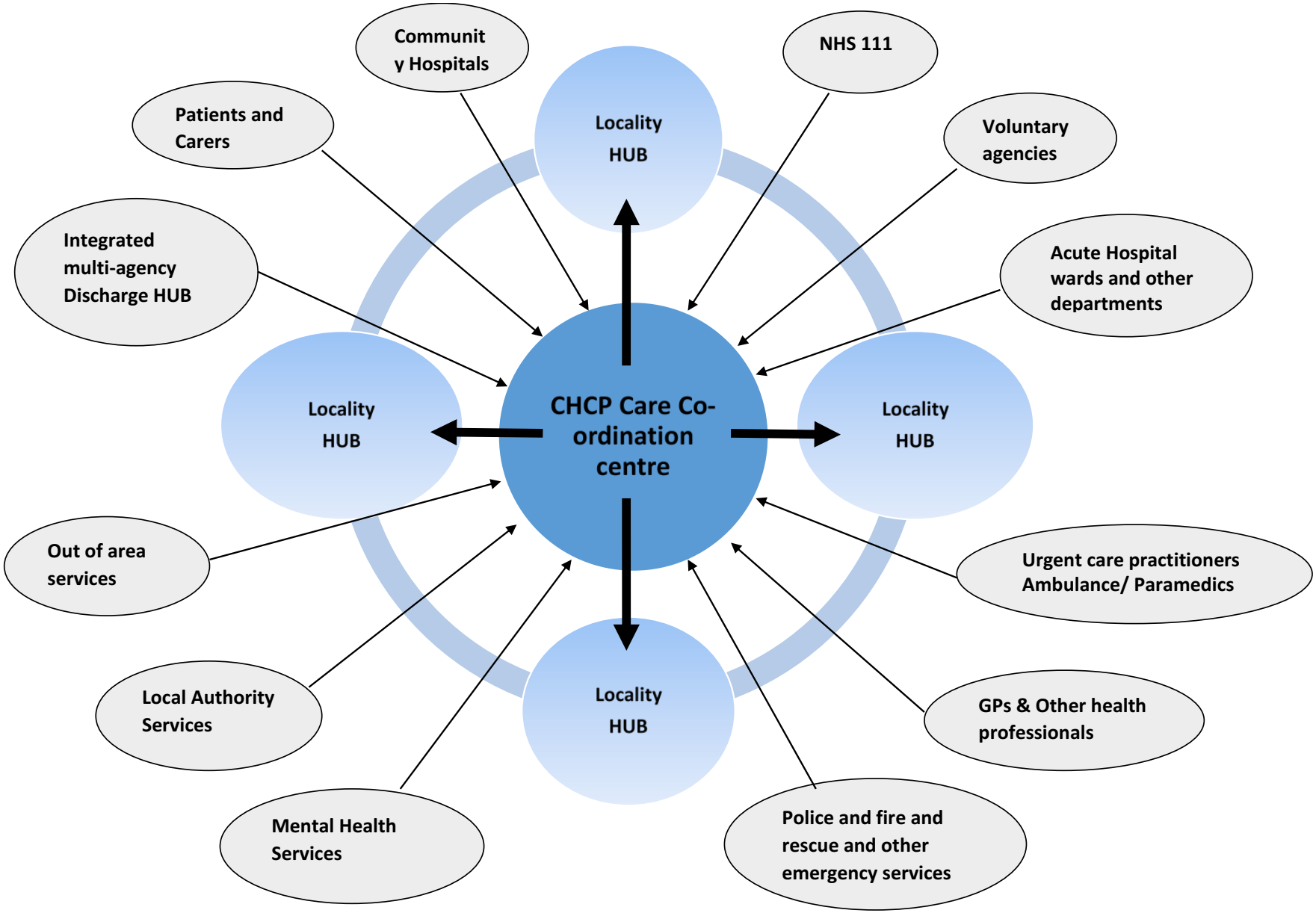
Communit y Hospitals
NHS 111
Patients and Carers
Locality HUB
Voluntary agencies
Integrated multi-agency Discharge HUB
Acute Hospital wards and other departments
Locality HUB
CHCP Care Co-ordination centre
Locality HUB
Out of area services
Urgent care practitioners Ambulance/ Paramedics
Local Authority Services
Locality HUB
GPs & Other health professionals
Mental Health Services
Police and fire and rescue and other emergency services

Person Centred Care

What do patients say

- Thank you so much for this, I have been passed from pillar to post until I rang here and you've given me all the information I needed
- Your all so helpful here, whenever I've called you've always helped
- I love the fact its one number
- Thanks I really needed this help
- So easy calling this number
- I love that I can call one number and get to see if I want the other services
- I don't get to speak to the nurse directly like I used to

What do staff say

- Easy to manage diaries for appointments
- Clinical time used much more effectively
- Less time on the phone, more time with patients
- Have lost the local admin input
- Some referrals not managed correctly
- Local expertise and service knowledge lacking

Next Steps

- Community nursing moving to mobile working
- SOPs for named co-ordinator being developed in intermediate tier
- Re-designing/integration of community nursing with primary care
- Proposals for integrated health and social care SPOC incorporating voluntary sector
- Involved in development and pathway design for Integrated Care Centre (ICC)