Caring Together Update
Care Models

Health and Scrutiny Committee

7th May 2014

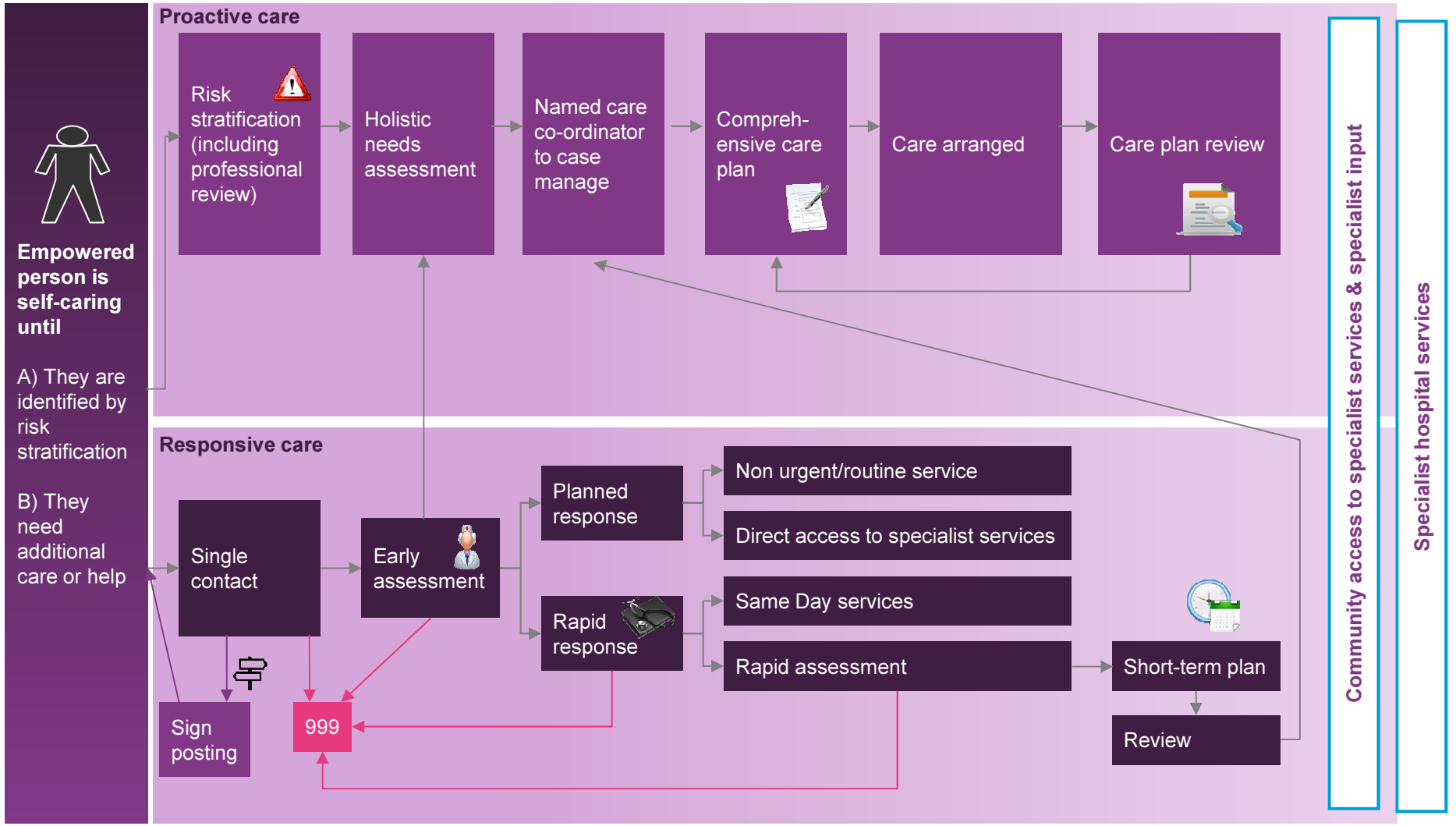
Integrating Care in Eastern Cheshire

Objectives for our discussion

- Discuss draft Caring Together care models
- Review the detail of the care model components

The Caring Together care model

DRAFT MODEL



Enablers

- Single patient record
- Directory of services
- Online prescription service
- Joint assessment tool
- Risk stratification tool
- Joint/personal commissioning
- Contractual levers
- Electronic ordering technology
- Access to specialist opinion/diagnostics
- Online patient resources

The design groups agreed on care model components for Caring Together (1/3)

ACUTE COMPONENTS TO BE ADDED

Whole system approach	**Single contact point (including early assessment)**	• People have a single point of contact with the system that makes things easy and convenient. This contact directs them to the correct service to best meet their needs. • Early assessment by a senior clinician to make sure that people receive an appropriate response as soon as possible. 24/7 response.
	Self care, self management support, and signposting	• Where possible, support to people to provide self care including the use of web-based resources. people are enabled to self care with person education and public health programmes. • Appropriate signposting to support people to self care, for example, to community pharmacists or the voluntary sector. Potential integration with other Cheshire East Council services. Directory of services available to professionals and people.
	Direct access to specialist services	• Direct booking to specialist services such as physiotherapy, hospital-based diagnostics, etc where a referral or A&E attendance is required. This will reduce appointments/A&E attendances and speed up diagnosis and treatment.
	Non-urgent/routine services	• Direct booking for non-urgent and routine community services at a time and location to suit the person (8-8 access to GP routine appointments).
	Same day service	• Access to urgent care for minor injuries at a place and time to suit the person – the aim to see and treat all people. Includes a GP-led urgent care centre that may be standalone or part of an A&E.
	Named GP	• People with specific conditions (long term conditions, cancer, end of life, mental health) to have a 'named GP' who will be their regular GP with additional appointment time allowed for discussion and disease management.
	Risk stratification	• Risk stratifying the population through the use of a predictive tool supported by clinical/social care review by the GP and/or multi-disciplinary team. To identify the top 20% most 'at risk' people for pro-active management.

The design groups agreed on care model components for Caring Together (2/3)

ACUTE COMPONENTS TO BE ADDED

Whole system approach	**Needs assessment**	• Conduct single assessment focused on people's lifestyle, goals and care needs using a joint assessment tool. Home assessment for those at the highest risk/needs, assessment outside the home (e.g. in GP practice) where appropriate. Identify care co-ordinator from within multi-disciplinary team, if required. To include advanced EOL discussion and plan.
	Care planning	• Jointly create a care plan with person for care needed to include goals, required interventions, provider details, and information on who to contact in case of change or crisis. This should also trigger a request for specific services e.g. falls assessment. Complexity of the plan matched to person needs – may be simply a crisis plan.
	Care coordination	• Match resources to assessed need. Support to ensure person is following the care plan, that care required for a person takes place and that a person is able to secure any appointments required and is actually attending them when needed
	Rapid assessment with short term plans and short term care	• Provide an alternative to unnecessary acute and care home admissions by responding to person's need in situations of crisis and ensuring that the relevant providers are able to put in care packages quickly to support the person at home. Requires joint commissioning/personal budgets and access to specialist opinion and diagnostics.
	Specialist input in the community	• Ensure specialists are able to provide support in the community for GPs or to provide input for people. Where people are appropriately seen in specialist services, contact to be maintained with the community team and person to be discharged back into the same team.
	Discharge support	• Ensure discharge planning starts from day 1, that people are assessed regularly during their stay, and that all required care packages are in place for when the person returns home. This will also aim to ensure that post-acute care can happen at home as much as possible, e.g. rehabilitation, or within alternative housing options and that it can be put in place in time for a person's discharge

The design groups agreed on care model components for Caring Together (3/3)

ACUTE COMPONENTS TO BE ADDED

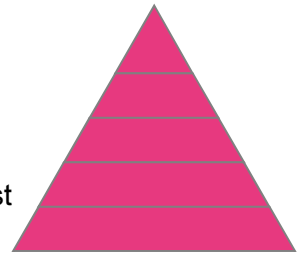
Whole system approach	Cultural transformation	• Communication campaign to inform and interact with the public about how to become an empowered person, including information, tips, suggestions and dialogue through social media tools. This requires the development of online resources such as a website that will signpost people to the right information and guide them through the system
	Workforce preparation	• Preparation of the workforce to interact with or promote becoming an empowered person. This will be done by adjusting the work description of the care professionals to incorporate best practices to interact with/promote empowered people and by organizing “Empowered development teams” that will gather care professionals with people to train them and discuss how to achieve the “Empowered people” quality standards
	Community centres participation	• Leveraging the existing community centres, support and investment in existing programmes such as healthy eating services, stop smoking services, stop drinking services and other relevant initiatives to empower people.

Single point of contact: Component Overview

PRELIMINARY

Relevant population

- Everyone in the population will use the same single point of contact for services and be directed to the most appropriate place



Total people **~201,000**

Description

- The single point of contact number would be a call centre that would help direct people to the most appropriate place of care for calls that do not require 999
- Triage would happen immediately by a care professional on the phone, who would be able to schedule appointments, make referrals, and re-direct calls to the most appropriate setting
- Single point of contact would be in operation 24/7 to help direct people to the most appropriate place for their care, and to help avoid hospital admissions

Key design features

Provider view

Staff training and education about services available and appropriate triage locations and services to ensure that single point of access is staffed effectively

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Single point of contact telephone number is monitored by a nurse or clinician and triage is done immediately for people who call in

person view

Person has a crisis or urgent need that does not require 999

Person has a care need and would like to talk to a professional

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Person telephones single point of contact where their call is picked up by a nurse or similar care professional. Nurse has access to integrated patient record and history quickly through IT platform.

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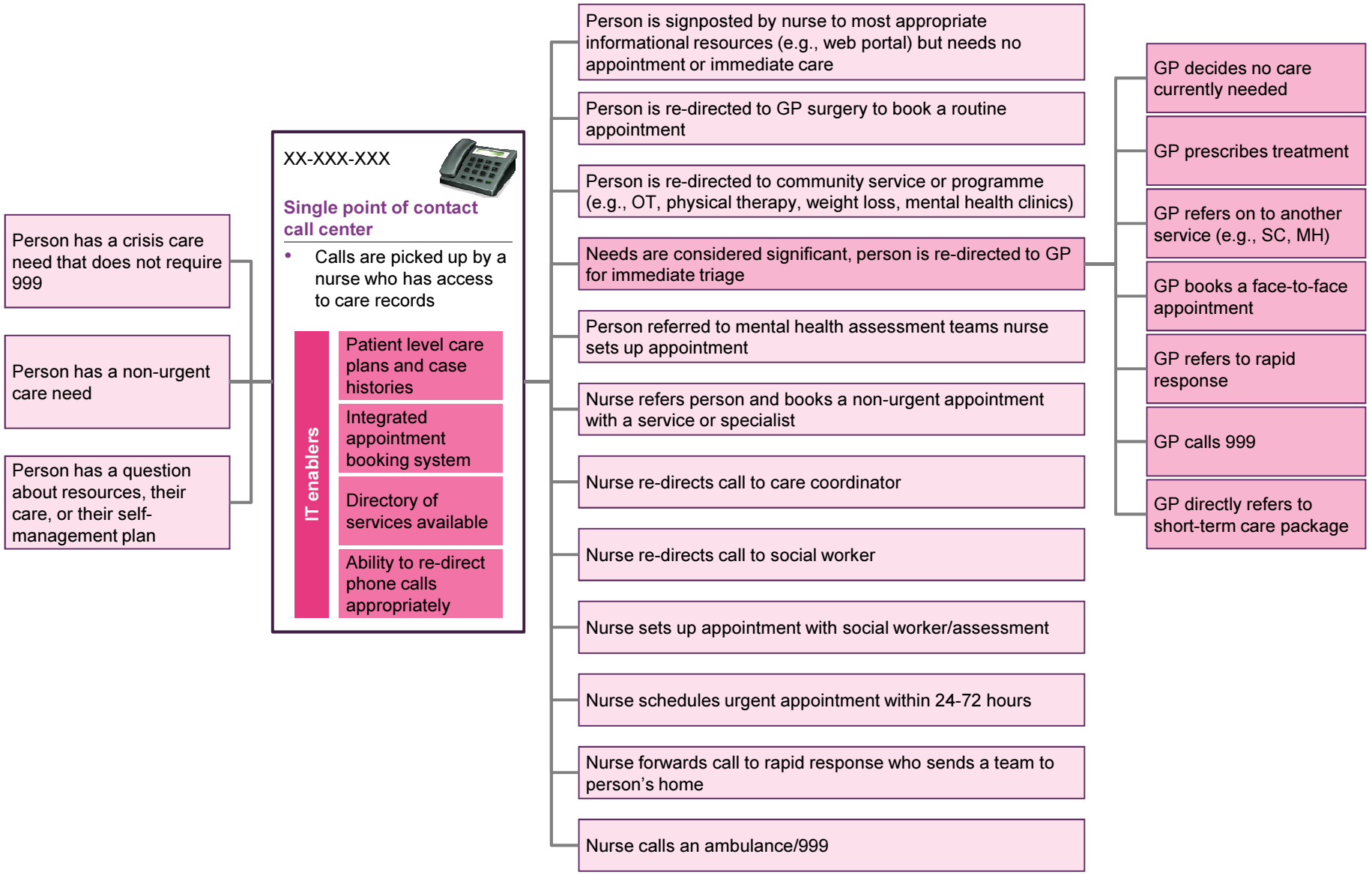
Person is triaged by either a nurse or a clinician on the phone and directed to the most appropriate setting of care for their needs

Single point of contact: Detailed component flow

DRAFT – PRELIMINARY

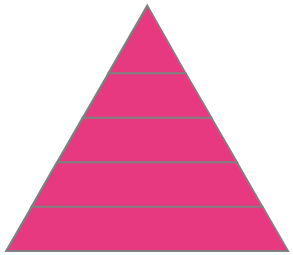


Risk Stratification: Component Overview

PRELIMINARY

Relevant population

- All people will be risk stratified to identify those at high risk of admission or predicted cost of care



Total people ~201,000

Description

- Providers will run the risk stratification software at least once a month to come up with the list of people who are at high risk of admission
- Stratification will either need to have social care input or be a joint risk stratification tool across health and social care (ultimate goal)
- GPs will usually be the ones to review the lists of high risk people and ensure that services are targeted to the correct people
- A flagging system will be in place for further review by social care or by mental health services if needed

Key design features

Provider view

Single analyst who is dedicated to risk stratification runs the software across the patch

→ **Flagging system** in place to identify people who will need review by other professionals (e.g., person lives alone, is a carer, or has specific conditions)

→ **Social care** or **mental health** workers review list **along with GPs** to ensure that appropriate people are identified

→ **GPs or MDTs review the list** each quarter to ensure that it is up to date and is capturing any new high risk people

person view

Person-level health and social care data is collected and fed into the risk stratification tool

→ 

All people are risk stratified

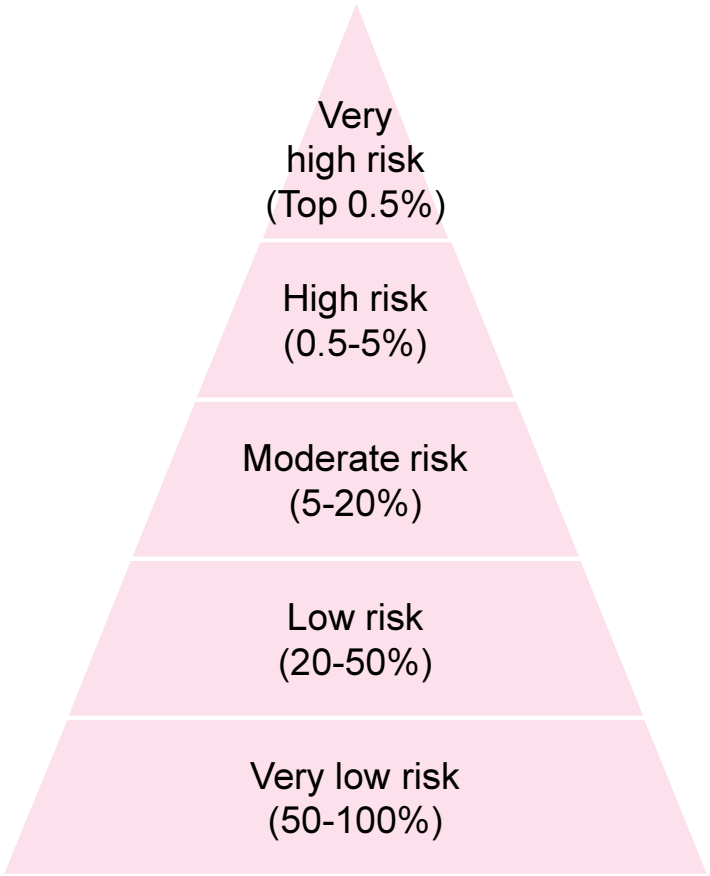
→
- People who are high risk (top 20%) will receive intensified assessment, care coordination/MDTs
- Lower risk groups will be empowered to self care

→ People will be informed when their risk status is being reviewed by a clinician or by their care coordinator, and will be kept up to date on changes in their care as a result

Risk Stratification: Understanding the risk of emergency admission in the population

- Risk stratification uses either the CPM model or a newly developed tool to predict the risk of emergency admission in the next 12 months or to predict overall care costs or vulnerability
- These models are predictive, which means they can be used to understand likely events in the future
- CPM is already being used in Eastern Cheshire to understand which people are high risk
- Risk factors include current conditions, age, other demographic factors and past history of admission
- **Review will be necessary by care professionals to add the richness needed to truly understand people on an individual basis**

CPM predicts risk of an emergency admission in next 12 months

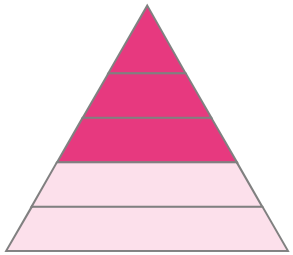


Needs assessment: Component Overview

PRELIMINARY

Relevant population

- Holistic needs assessments will be offered to anyone in the top 20% of risk



Total people **~40,000**

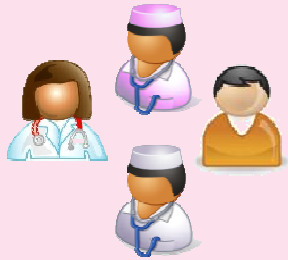
Description

- Holistic needs assessments will be joint assessments of physical, biological, and social care needs by the appropriate professional in the right setting. This setting may be a GP practice, a community center, or, for high risk people, may be the person's home
- These assessments will be enable the identification of who the most appropriate care coordinator will be, and should be carried out by anyone who is trained to do them (e.g., nurses, GPs, physios, social care workers, mental health professionals)
- Trainings will give care professionals a core ability to assess needs in a person-centred way across the different types of care, and will provide protocols on when to flag for further assessment by an appropriate professional

Key design features

Provider view

Professionals receive 5 days of training on how to conduct holistic assessments across disciplines



Most appropriate care professional carries out needs assessment either in the home or the most appropriate setting

person view

Person is risk stratified and assessed

Person is assessed in the **most appropriate setting by the most appropriate professional**. This may be the next person to visit them, the GP, or a district nurse, and should be decided based on the risk strata and other knowledge of the person.

Assessor decides if **additional professionals should be pulled in** for further assessment (e.g, social care, mental health) based on a list of criteria.

Person is assigned the **most appropriate care coordinator**. This could be a GP, social worker, community nurse, mental health etc.

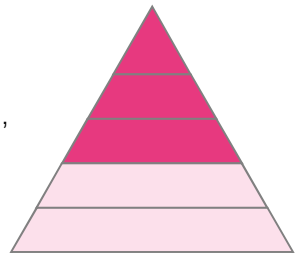
Care Planning: Component Overview

PRELIMINARY

Further detailed on following pages

Relevant population

- Care planning will happen at different levels for the top three risk strata (e.g., top 20% of the population)



Total people **~40,000**

Description

- "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve outcomes important to me." –National Voices
- A care plan is a document owned by the person that will help them plan their care. It should be created with the individual's GP, their carer, and any other relevant care professionals.
- Care planning is the process of holistically assessing care needs, creating a care plan, and then reviewing the plan regularly with the person and the correct professionals.
- Care plans should be put in place for anyone who has a long term condition or complex needs

Key design features

Provider view

Care coordinator identified/assigned after risk stratification.

Very high risk	***Comprehensive care plan*** created and discussed by MDT and with carer/person	Care plan is reviewed after a change in status or quarterly by MDT
High risk	***Comprehensive care plan*** created with care coordinator and GP	Care plan is reviewed annually or after a change in status by GP
Moderate risk	***Light touch crisis plan*** is created with care coordinator if needed	Crisis plan is reviewed if there is a change in status by the care coordinator

person view

Person is risk stratified and assessed

Person is assigned the **most appropriate care coordinator**. This could be a GP, social care worker, community nurse, mental health worker, etc.

Very high risk	Care plan includes information about home situation, clinical history, family situation, etc.
High risk	Care plan includes clinical history and relevant personal details
Moderate risk	Crisis plan includes a light touch plan of who to contact in a crisis event and where to go

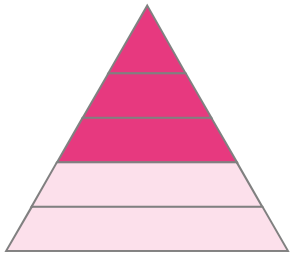
Care Coordination: Component Overview

PRELIMINARY

Further detailed on following pages

Relevant population

- Care coordination of different levels of intensity will be provided to all moderate to very high risk people (e.g., 20% of population)



Total people **~40,000**

Description

- Care coordination is personally tailored support from a named care worker to empower a person to self manage their health and wellbeing and to join up their care
- Care coordination will provide navigation for people between the different care professionals and organisations. Care coordinators will help people schedule appointments, ensuring home visits are happening appropriately, liaising with different care professionals, and providing proactive check-ups on people who need intensive managing.
- Care coordination will look different for different types of people. For example, the most high risk people may have a GP to coordinate their care, while a moderate risk person may have a very light touch coordination service from a well-being coordinator.

Key design features

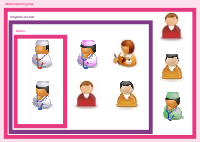
Provider view

Care coordinator identified/assigned after risk stratification/assessment. Coordinator is most appropriate for person.

Care coordinators go through 5 day training on how to be a coordinator

Coordinators have access to integrated IT system with single record

Care coordinators assess holistic person needs and create joint care plan



Care coordinators liaise with MDTs, discharge coordinators and rapid response teams to provide the best care. They also proactively check-in with person and carers at regular intervals.

person view

Person is risk stratified and assessed

Person is assigned the **most appropriate care coordinator**. This could be a GP, social care worker, community nurse, mental health worker, etc.

People get regular calls from their care coordinator

Care coordinator helps people after they've been discharged

Coordinators help set up appointments and referrals

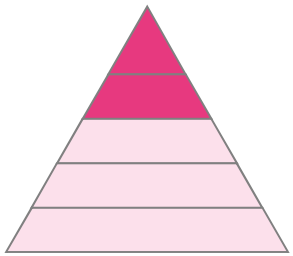
People are able to **form a lasting relationship with their care coordinators**. As a result, they don't need to repeat their history to different professionals or go through the confusion of navigating the system on their own. They are also proactively cared for.

MDTs: Component Overview

PRELIMINARY

Relevant population

- MDTs would cover and review all very high risk and high risk people (e.g., top 5% of people)



Total people **~10,000**

Description

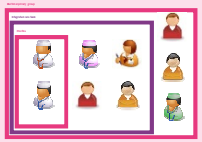
- Multi-disciplinary teams will form the core of new models of care. These teams should bring together all of the relevant care professionals, volunteers, and other partners who provide care for a given individual.
- The professionals included will effectively look after the physical, mental and social care and support needs of the individuals it covers. The vital part of an MDT is to facilitate conversations and referrals amongst care professionals. Effective discussion should result in a balanced care plan and care process that is supportive of an individual's whole needs.

Key design features

Provider view

Integrated informatics system across the MDT

Risk stratification identifies high risk and very high risk people for discussion at MDT



MDTs meet **twice a month for 2 hours**. In these meetings, they:
1. Review complex cases and acute admissions
2. Refer individuals to relevant services directly
3. Provide advice and opinions across disciplines

Care coordinators feedback outcomes of meetings to people, carers, other care professionals

person view

Person is risk stratified and assessed

Assigned care coordinator explains to person that they will have their case discussed at the MDT

Any ***change in status*** is reviewed by the MDT, including admissions, development of new conditions, and change in household status. Care plan is also regularly reviewed for very high risk individuals by the MDT.

Care coordinator lets person and carer know of ***any changes in care plan as a result of review***. In addition, ***direct referrals*** that come out of the MDT meetings are communicated with the person, and MDT discusses how the person can be empowered to self care.

MDTs: Multi-disciplinary teams will include input from a wide range of care professionals

Multidisciplinary group

Integrated care team

Practice

GP

Practice Nurse

District Nurse

Social Care Representative

Community Matron

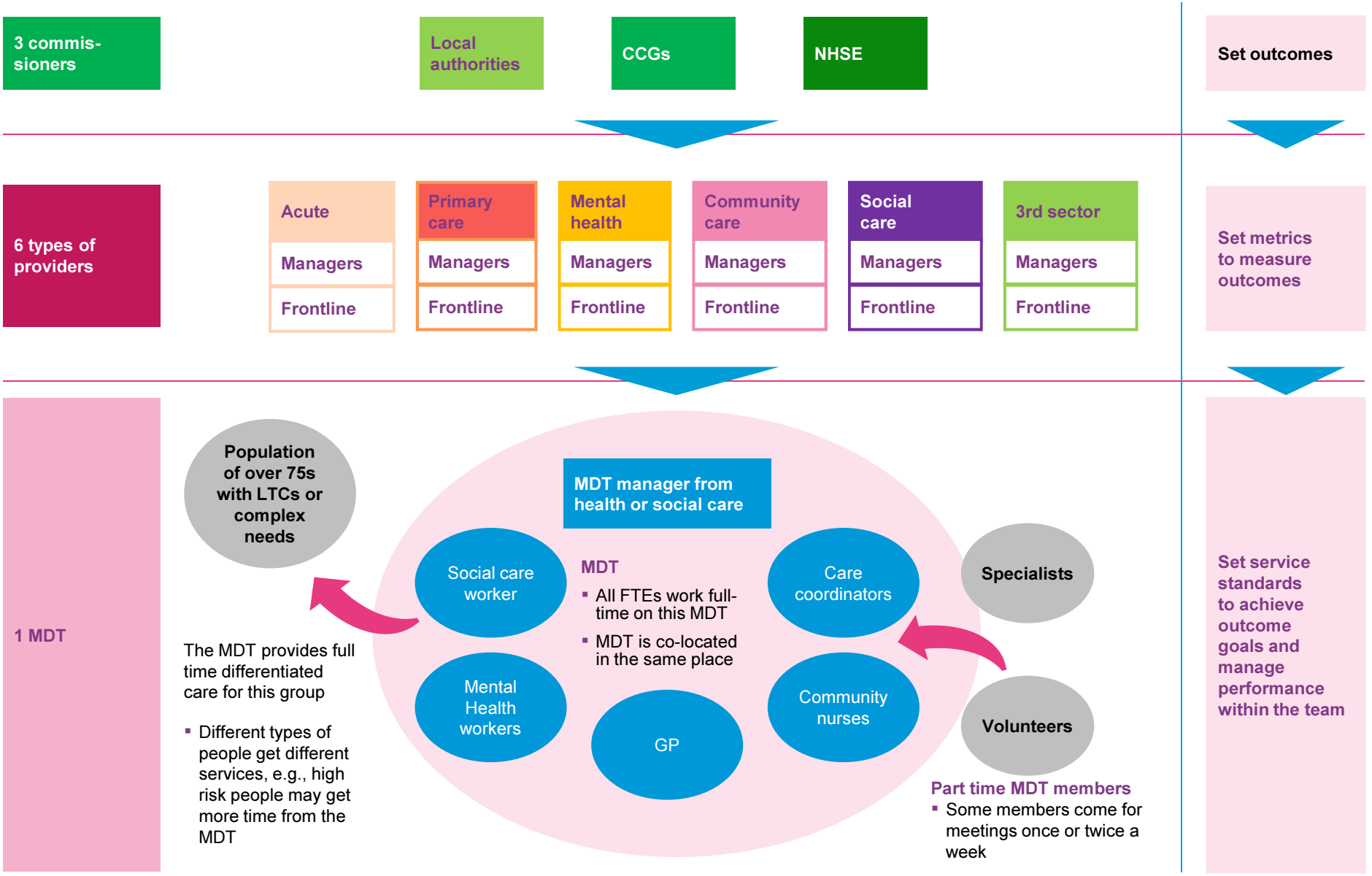
Community Mental Health Representative

Social Care Specialist

Mental Health Specialist

Community geriatricians and other specialists

MDTs: The operating model for MDTs will provide differentiated care

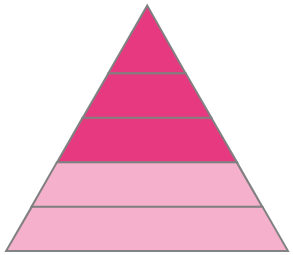


Specialist input in the community: Component Overview

PRELIMINARY

Relevant population

- Access to specialists in the community will target the top 20% of risky people, but some clinics may be open to everyone



Total people **~40,000 – 201,000**

Description

- Specialist input into the community will help join up clinical care across primary and secondary and aim to cut down on unnecessary appointments and hospital attendances
- Three part approach to specialist input in the community:
  - Email and phone liaison that GPs and MDTs can use to gain specialist opinions on complex cases
  - Specialist presence on select MDTs (e.g., diabetes specialist comes to MDT once a quarter to review diabetes cases)
  - Open clinics for specialists to see people deemed to be high risk by MDTs

Key design features

Provider view

Phone and email liaison – GPs email or phone for rapid response about complex people

Different types of specialists put time to input into the community in three major ways (includes diabetes, cardio, etc.)

Presence on MDTs- Once a month each MDT will have a rotating specialist who joins for 1-2 hours

Occasional clinics- Specialists give clinics for those who need time according to MDT

person view

Person is risk stratified and assessed

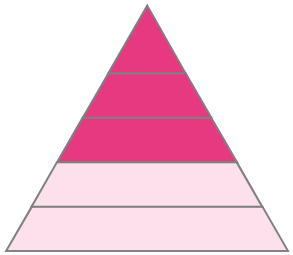
People are able to access specialist opinions and services in the community, rather than having to go for an outperson appointment

Rapid response and short term care: Component Overview

PRELIMINARY

Relevant population

- Rapid response will be available to people in the top three risk strata (top 20%)



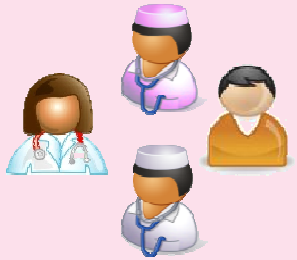
Total people **~40,000**

Description

- Rapid response will be a service within the single point of contact service to respond to crises in a way that will support more people to stay in their homes/communities
- Provide a 24/7 single point of access and a rapid response
- Provide a rapid response within a short timeframe (maximum of 3 hours)
- Ensure coordinated response across health and social care to provide the most adequate intervention and ensure person is able to remain safely at home
- Put in place short term care packages in peoples' homes

Key design features

Provider view



Rapid response team **sits at the hub or is on-call 24/7** to respond to urgent calls that do not require an ambulance

→ Team is dispatched to person homes when they are needed

→

Liaises with care coordinator after a rapid response to discuss the care plan and any short term care

person view

Person calls **single point of contact** with urgent sickness that they thought did not require 999

→

- No care needed; signposting and self-care
- Phone liaison needed for appointment scheduling or triage
- Rapid response needed
- Ambulance needed

→ **Rapid response team** comprising a GP, community nurse or community matron, and social care worker **arrive at the person's home within 3 hours**

→ **Response team assesses person in their home**

→

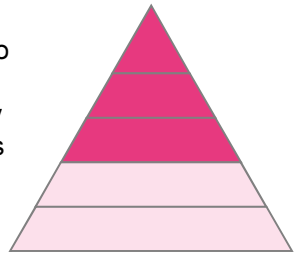
- Person transported to hospital by team
- Ambulance needed
- Person stays at home- no extra care
- Person at home – extra care arranged

Discharge Support: Component Overview

PRELIMINARY

Relevant population

- Target population is all people admitted to an acute centre, which would typically be in the top 3 bands of the pyramid



Total people **~40,000**

Description

- Provide discharge coordination for people 7 days a week, to start at the front end with A&E/AMU attendances flagged for discharge coordinators
- Ensure coordination across health and social care to provide the most adequate intervention and ensure person is able to return safely to home
- Provide target discharge date from day 1 of admission
- Monitor quality of work of various discharge coordinators through establishment of team leadership

Key design features

Provider view

Supportive IT systems will notify discharge coordinators of high risk person admissions

Electronic care plans will allow discharge coordinators to understand case histories

Discharge coordinators will be embedded in the ***hospitals*** and have ***lists of high risk people*** and their designated care coordinators

person view

person admitted to hospital

Discharge coordinator will contact care coordinator, understand case history, and liaise with family within 1 day of admittance

Discharge coordinator will discuss options for return home with clinicians, set a goal date, and arrange any short term care

Discharge coordinator will liaise with care coordinator to set up follow-up appointments and ensure a smooth transition home