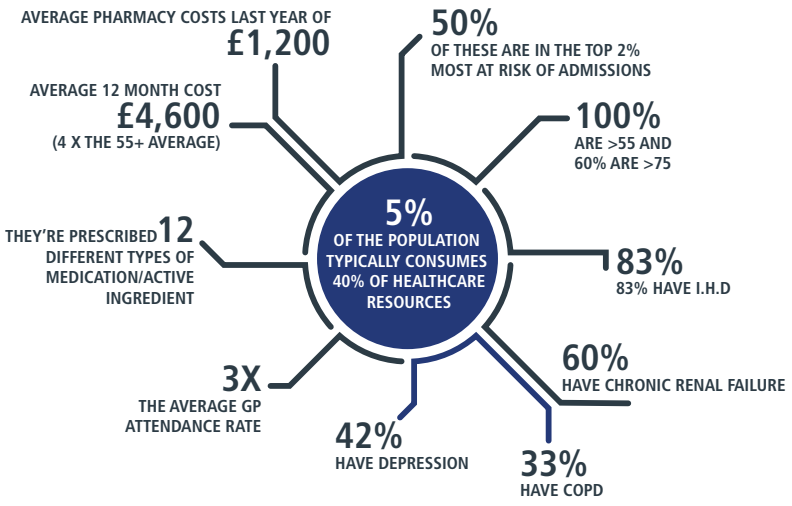
EFFECTIVE CARE COORDINATION FOR PATIENTS WITH MULTIPLE CONDITIONS AND OTHER COMPLEX NEEDS

NHS community matron services are currently focused on the most challenging top 0.5% of the needs profile. But there is significant opportunity to improve self-care and treatment adherence for the next most needy groups.



Conrane IHS, in partnership with Allus, has the solution. Holistic, pro-active and person-centred, our approach has been tested over 15 years and uses international best practice to improve patient experience and quality while delivering savings through reducing patient need for and use of high-cost services.

HOW DOES IT WORK?

Key components are:

- Evidence –based and peer-reviewed
- Backed by comprehensive, individualised practitioner training
- Fully integrated at patient, primary care and locality level
- Measurable, reportable, auditable
- Cost-effective

A PRIMARY-CARE LINKED MODEL

To be effective, care coordination must work with the primary care team. The GP retains the clinical team-lead role, approving patient selection and the care plan. GP, clinical pharmacy and care coordinators work together on medication reviews, reducing ad hoc contacts and home visits, transitioning patients to supported self -care in an average of 12 weeks, reducing GP workload and meaning that a full-time care coordinator can manage 200 patients per year.

ALLUS
primary healthcare partner

Conrane–IHS
International Health Solutions

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THEY SAID, WE DID

"I want to feel safe and trust my provider"

"My GP knows what services are out there to help me"

"I want my care to be seamless across social care and health"

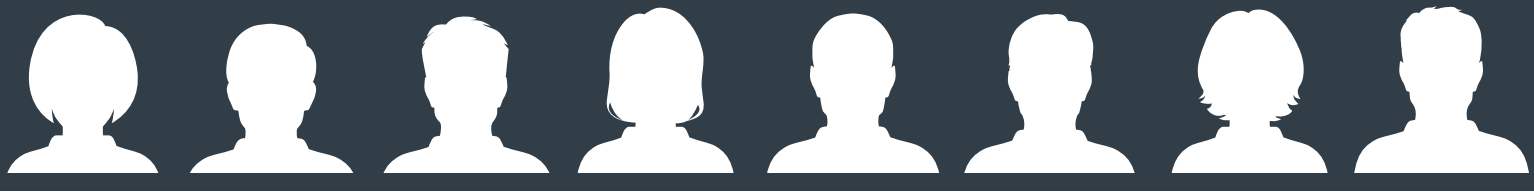
"My carers voice is heard and supported appropriately"

"I want to use technology to help manage my care and access helpful information"

"How I can do more about my lifestyle and my own care"

"I want my care/support to be responsive, in my community when I want it"

"I want good information and sign-posting to help me plan my care"



CASE STUDY

In North Kirklees we identified that there was a missed population of patients with high needs, multiple co-morbidities and greater than average attendances and admissions to acute services. Working with Conrane HIS, we introduced a new approach that brought together the GP federation, end-of-life care provider Curo Health and community healthcare provider Locala Community Partnerships to recruit and train five nurses in a new Clinical Care Coordinator role. The two-month training programme was followed by a year-long mentoring relationship.

Using international best practice, the methodology approaches patient care from a longer term perspective – what is likely to happen to these patients in the future, rather than what is happening to them now. This risk-focused methodology enables Clinical Care Coordinators to better manage patients living with long term illnesses such as diabetes or chronic obstructive pulmonary disease (COPD), so they are less likely to become unwell and need hospital treatment.

Clinical Care Coordinators also help to identify patients who need support to continue living at home and work with organisations such as the council and the voluntary sector to help them access this support.

First year outcomes can show a saving per patient of £1000 after the cost of the service is taken into account. A CCG with a population of 200,000 is likely to have at least 3,000 people who could benefit from this service.

What is a Clinical Care Coordinator?

- Band 6 nurse progressing to Band 7 on completion of training and mentoring programme.
- Possesses communication and liaison skills.
- Has inter-disciplinary skills around long-term condition management.
- Advanced clinical assessment skills including specialist case management and medicines management.
- Independent prescriber or training in independent prescribing.
- Skilled in: supporting discharge / transfer from hospital; diagnosing; predictive modelling; patient empowerment; motivational interviewing; holistic care planning; contingency planning; self-care management; goal-setting.

OUR PEOPLE AND WHAT WE DO

Allus works with GP provider organisations, identifying strategic issues and potential solutions, building trusted advisor relationships with GP practices.

Allus is the conduit into General Practice for specialist providers, and act as facilitators to ensure on-time, on-budget programme delivery and accountability.

Conrane brings academically sound, data -driven solutions, with the practical experience of clinical staff that have implemented the programme in many different international geographies.

Allus is Conrane's preferred project management team, with proven track record of delivery of this programme, through a collaborative and trusting relationship with clients.

TESTIMONIALS

"The care coordinator team has assisted in supporting patients with their diabetes management and has contributed to ensuring safety of patients with medication regimes that are complex but are necessary for good glycaemic control. They have attended additional training in diabetes care and management to enhance their role. They are able to highlight complex patients that require Diabetes Nurse input. Participation in joint review and monitoring of such patients has been valuable in maintaining safety and optimising glycaemic control." *North Kirklees GP.*

"I feel like a Health Visitor for Long Term Conditions. The proactive assessment is about picking up on cues and being a detective when reviewing the notes, looking for omissions, missed appointments and misunderstandings around communication." *Clinical Care Coordinator.*

"(the Clinical Care Coordinator) talks to me, answers any questions and we sort out problems together. She listens to me – a thing most people have forgotten how to do. She came into my life like a breath of fresh air." *Patient under CCC management.*

To find out more about how Allus and Conrane IHS can help you deliver new models of care contact:

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