NHS Rotherham

Clinical Commissioning Group Committee:  3 October 2012

Care Co-ordination Centre

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<th>Contact Details</th>
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<tr>
<td><strong>Lead GP</strong></td>
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<td><strong>Lead Officer</strong></td>
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<td><strong>Title</strong></td>
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**Purpose:**
The purpose of this report is to update the Clinical Commissioning Group on the development of a Care Co-ordination Centre in Rotherham.

**Recommendations:**
It is recommended that the Clinical Commissioning Group note:
- The development of a Care Co-ordination Centre for patients with urgent health care needs
- The routing of all GP requests for additional medical support (including urgent medical admissions) to the Care Co-ordination Centre
- The four key functions of the Care Co-ordination Centre as set out in this report
- Plans to introduce a soft launch of the service on 15th October followed by a hard launch on 29th October

**Background:**
Rotherham has identified the development of a Care Co-ordination Centre (CCC) as a priority under its Efficient Access to Unscheduled Care workstream.
The Centre will have 4 key functions.
1. Support discharge planning, ensuring appropriate and timely community services are in place
2. Single point of contact for GPs and health professionals to support the identification of the appropriate level of care for their patients.
3. Support the case management of patients with long term conditions
4. Urgent response service for patients with a long term condition or those who contact NHS 111

The CCC will be delivered by Rotherham FT. It will be staffed by a combination of call handlers and nurse advisers. Call handlers and nurse advisers will have the appropriate skills to support clinicians and patients. Opening times for the care Co-ordination Centre will be;
11.00 am – 10.00pm weekdays and 9.00am – 6.00pm weekends.

**Approvals**

Proposals for the development of a Care Co-ordination Centre have been considered by the following groups:

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<th>Group</th>
<th>Date</th>
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<tr>
<td>Strategic Clinical Executive</td>
<td>22\textsuperscript{nd} August</td>
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<tr>
<td>GP Reference Group</td>
<td>29\textsuperscript{th} August</td>
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<tr>
<td>LMC</td>
<td>10\textsuperscript{th} September</td>
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All groups supported the development of a Care Co-ordination Centre.

**Implementation Plan**

Once the proposals for a Care Co-ordination Centre have gone through the approvals process Rotherham FT is intending to initiate a 2 staged launch.

**Soft launch 15\textsuperscript{th} – 28\textsuperscript{th} October**

Rotherham CCG will identify GP Practices represented on either the CCG or GPRG to start utilising the CCC. The soft launch will last for 2 weeks. These GP Practices will not be able to make direct referrals to B1 during this period. All urgent medical admissions will be routed through the Care Co-ordination Centre. There will be review meetings held with the GP Practices at the end of each week. The first review group (19\textsuperscript{th} October) will act as an advisory committee to RFT highlighting problems and fine tuning the service. The 2\textsuperscript{nd} review group (25\textsuperscript{th} October) will authorise continuation into the hard launch period. At this stage the review group can:

- Make recommendations on remedial actions to fix any problems
- Make recommendations to the GPRG and CCG
- Recommend suspension of the hard launch

**Hard launch 29\textsuperscript{th} October**

By this stage the concept of the CCC will have been widely discussed across the local health community. The implementation plan will have been endorsed by all relevant committees and the CCC will have been rigorously tested as part of the soft launch process. It should therefore be on a robust enough footing for full roll out.

**Analysis of Key Issues:**

Commissioners have worked closely with Rotherham FT to establish a service model which is supported by health professionals, particularly GPs. We need to ensure that patients receive the support they need, in the appropriate setting and in a timely manner. We also need to ensure efficient use of the services currently commissioned by Rotherham CCG. The Care Co-ordination Centre will carry out the following functions.
1: **Supporting Hospital Discharge**

The CCC will support discharge planning, preventing readmissions by streamlining the referral process to community health and social care services. Ward staff will be able to notify the CCC of patients scheduled for discharge, specifying their post-discharge support requirements. The CCC will agree the support package and set this up within specified timescales. The CCC will also take responsibility for coordinating transport home.

Implementation date: 29th October 2012

2: **Alternative Level of Care**

The Urgent Care Management Committee has been focusing on reducing the number of avoidable hospital admissions and redirecting patients to alternative levels of care. There are two key components to this strategy.

1. Developing an appropriate range of community services to meet the needs of patients who would otherwise be admitted to hospital
2. Ensuring that GPs and other health professionals have quick and easy access to these services

The Care Co-ordination Centre will ensure that, where a community based clinician is supporting a patient with an urgent health need, they are able to access the most appropriate service quickly and efficiently. GPs and A&E will be able to contact the CCC when considering making a medical admission. The CCC will advise on the available range of services, which include:

- Short term support from the Fast Response Service
- Intermediate care (Residential and Community)
- Breathing Space (Respiratory and Neuro-rehab)
- The Care Home Support Service
- Enhanced Community Care Service
- Medical Assessment Unit

After discussion with the CCC the GP will make an informed decision on the appropriate level of care for their patient. The CCC will co-ordinate care provision, ensuring appropriate transfer arrangements are in place. The CCC will inform the referring health professional when the patient has been handed over the appropriate level of care.

Implementation date: 29th October 2012

3: **Supporting Case Management**

The CCC will support the case management of patients who are at high risk of hospital
admission. High risk patients will be identified using Rotherham’s risk stratification tool.
Under the case management pilot GPs are completing care plans for these patients and co-
ordinating holistic packages of support. The CCC will be able to carry out the following tasks
as part of any care plan.

- Provide an access point for patients who require advice and support on self care
- Monitor conditions remotely using telemedicine and responding to these where
  appropriate
- Delivery of health coaching, improving outcomes through lifestyle changes

The CCC will be able to carry out this support function 24/7. The responsible clinician will be
able to set up monitoring and support arrangements through the CCC once a full care plan is
in place for a patient. The case manager will still have overall responsibility but will use the
CCC to enhance the quality of care delivered, proactively supporting implementation of the
care plan.

Implementation date: 1st January 2013

4: Urgent Response

The CCC will also provide a reactive service to the same cohort of patients when they have
an urgent care need. As well as agreeing a planned programme of activity aimed at
supporting patients in the community the CCC will be able to provide a responsive urgent
care service. This will be different to that available through NHS 111. The care plans for
these patients will be held at the CCC and these care plans will include guidance on actions
that should be taken if a patient phones in with an exacerbation.

The CCC will provide self management advice where appropriate. If the patient requires
additional support the CCC will co-ordinate this, ensuring that they stay with the patient until
it is safe to hand over. If it is not safe for the patient to remain at home or if treatment is
requires within an alternative care setting the CCC will identify the most appropriate level of
care, set this up and ensure that arrangements are in place to transfer the patient.

The CCC will also act as a portal to community services for all patients who contact NHS
111. If after clinical assessment a patient requires referral to a community service such as
district nursing, intermediate care or Fast Response, NHS 11 will be able to arrange a call
back from the Care Co-ordination Centre. Alternatively the patient can be routed to the CCC
as a warm transfer if the patient needs to speak to someone immediately.

Implementation date: 1st April 2013

Interface with NHS 111

The interface between NHS 111 and the Care Co-ordination Centre is critical to ensuring
that patients who have an urgent health need are routed to the correct service. Rotherham
currently has a Single Point of Contact for patients with an urgent health care need. This will
be replaced by NHS 111 in April 2013. The Care Co-ordination Centre will act as a portal
into community health services for patients referred by NHS 111. Where a community health
service disposition is identified by an NHS 111 call handler the patient will be routed through
the CCC to ensure that the appropriate response is made within required timescales.

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<th>Financial Implications</th>
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<td>Rotherham CCG has reinvested £321,000 of savings from non-elective admissions paid at 30% of tariff. This non-recurrent funding has been used to cover set up costs. Future funding for this initiative is dependent on outcomes achieved. Key measures of success for the Care Co-ordination Centre are;</td>
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<tr>
<td>- Impact on unscheduled hospital admissions</td>
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<td>- Increased utilisation of alternative levels of care</td>
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<td>- GP satisfaction with service</td>
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<td>Approved by: Keely Firth</td>
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<th>Patient, Public and Stakeholder Involvement:</th>
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<td>Commissioners have undergone a comprehensive communications campaign amongst health professionals to explain the purpose of the Care Co-ordination Centre, the likely benefits to clinicians and the links with community services.</td>
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<td>There has been no public engagement on the introduction of a Care Co-ordination Centre.</td>
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<th>Equality Impact:</th>
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<td>No equality impact assessment has been carried out to date. However the Care Co-ordination Centre should support some of the most vulnerable people in Rotherham.</td>
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<th>Human Resource Implications</th>
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<td>There are no HR implications for NHS Rotherham staff.</td>
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<td>Approved by: Peter Smith</td>
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<th>Procurement</th>
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<td>There are no procurement issues relating to this service. However Rotherham CCG does have the option in the future of commissioning a Care Co-ordination Centre separately. There are some advantages with this approach as we would then be able to incorporate community services which are not currently managed by Rotherham FT.</td>
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<td>Approved by: Doug Hershaw</td>
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