Appendix 2

COMPLEX CARE COORDINATION UPDATE

LOCALITY	GP/PRACTICE	NUMBER OF REFERRALS	CURRENT CASELOAD	MDT SHEDULED/ ATTENDED
EAST CENTRAL	DR VASHISHT	56	33	
	DR. SHAH	70	27	
	DR. HADLEY	66	52	
	DR. KHAN	49	25	
	DR.JACK &PARTNERS	416		
	CARNARVON	75	ONGOING REGISTRATION/ASSESSMENTS	
	DR. KENT & PARTNERS	183	ONGOING REGISTRATION/ASSESSMENTS	17/01/2017
	DR SIDDIQUE			15/02/2017
EAST	DR. MARASCO	9	5	
	DR MOSS	70	ONGOING REGISTRATION/ASSESSMENTS	03/02/2017
	DR. MARIO			18/01/2017
WEST	DR. KRISHAN	100	ONGOING REGISTRATION/ASSESSMENTS	
	DR. SATHANANDAN	192	ONGOING REGISTRATION/ASSESSMENTS	02/02/2017
	DR. NAGLE	1	1	19/01/2017
	DR. ZAIDI	235	ONGOING REGISTRATION/ASSESSMENTS	
	DR. GUL	2	DECLINED	
WEST CENTRAL	DR SOORIAKUMARAN	1		
	DR. CHUTURVEDI	4	3	13/02/2017
	DR.BEKAS	1	1	
	DR. NG	4	3	23/12/2017

GP Engagement

GP engagement has been positive and encouraging. Sourcing and case finding the complex care cohort through the NELIE system as was initially intended had proved challenging. The suggested use of the frailty index on SystmOne has proved more successful and more patients have been populated using this method. The complex care team continue to screen the acquired list to ensure the right patients are targeted for assessment and ongoing support.

Appendix 2

CASE STUDIES

To protect the privacy and interests of patients, all written and verbal information are disclosed under confidentiality. Care has been taken to anonymise all names of patients.

Mr. S

A Case Study in Complex Care Coordination

Background - Mr S is a 66 year old man with a history of progressive type 2 diabetes complicated by elevated blood pressure, COPD, asthma and a problematic heavy smoker with occasional feeling of depression. He has also had a stroke in the past and highly susceptible to falls. He has limited mobility and walks with the aid of a stick. He is currently on 13 different medications. Mr S is able to drive when absolutely necessary. He was referred by a local GP within the East Central locality having been identified by the NELIE system as an at risk patient of unplanned hospital admission.

Mr S can be described as an elderly man with a lean frame weighing about 7 stone, lives alone on first floor supported local housing association with a tamed parrot. He spends most of his time confined in his flat with no support from any other relations or friends.

Presenting issues - Mr S's poor mobility means he is unable to do much for himself. He has difficulty managing the stairs due to his breathlessness and therefore has been unable to do regular food shopping and had nothing in his fridge. The presentation of his flat was very poor with dirty dishes, left over food and rubbish. He had bags of outdated medication littered across the flat. Mr S indicated he has a contract with an external pharmacy that delivers his medication monthly. He appeared nonchalant in his attitude towards his health care. He has been non-compliant with his medication regime and had not attended several of his diabetic checks and other GP routine appointments. He also appeared socially isolated with almost non-existent communication with the outside world.

Complex care Coordination involvement – Mr S initially put up a resistance to any support from the service and declined any onward support or referral but gradually took to accepting support after a few visits. The initial assessment prompted a safe disposal of his outdated medication and signed an agreement to allow his GP to send his prescription to a local pharmacy to deliver in blister pack for a more effective administration. He agreed to attend his next appointment with support from the complex care coordination team. Referral was made to the falls team for an assessment, referral also made to ascertain a social care package and to the pharmacist for a medication review. The team agreed to visit again the following week. Mr S however phoned the office to inform he has had 9 falls over the weekend, and a Complex Navigator went to visit straight away but Mr. M had called 111 for an ambulance and was taken to A&E and later admitted to Shopland ward. Mr S asked if the team could feed his parrot as that is all he has. Another visit to his house revealed the flat in a squalid state posing a hazard. He would also require a lot of support on discharge with personal care and around the home. Concerns were raised with the hospital social care team and together a care page was put in place for Mr S.

Coordination outcome – Working with Mr. S in a co-productive way has enhanced collaborative work among professionals providing care for Mr S. He has now consented to being discharged to an in house rehabilitation centre where he will receive support with his poor mobility. He also has a care package with domestic support two times a day to enable him stay safely in his own home.

Mr. R

A Case Study in Complex Care Coordination

Background - Mr. R is a 64 year old gentleman who lives with his wife Mrs. D as his main carer in South Essex Homes house. His daughter and grandson have recently moved in to provide emotional support to both Mr R and his wife. Mr R has been downstairs living for 10 years. He has an ensuite with fully adapted level access shower facility.

Presenting issues - Mr. R has a medical history of - MI x4, Ischaemic Cardiomyopathy, Chronic Cardiac Failure, Atrial Fibrillation, Angina, Defective heart valve, Enlarged heart, Enlarged Spleen, Enlarged liver, Cirrhosis, Chronic Kidney Disease, Insulin dependent type 2 diabetes myelitis, Peripheral Neuropathy, Insulin needle stuck in leg – unable to have CT/MRI scans, Pneumonia, Aneurism, Blind in left eye, Hearing impaired, Reduced mobility, Shortness of breath on exertion and weak right arm.

Mr R feels he no longer has any quality of life and only has access to his bedroom and bathroom. He has difficulty accessing the community and has found transport service very unreliable. He has an electric wheelchair currently at repairs. Mrs. D doesn't drive so they rely on transport services. He would like to be able to access community for better social inclusion. Mr R has a phobia around hospital procedures and wants services at home with his wife. He would like to access support with his hearing so he can watch TV without disturbing others. Mr R currently in receipt of DLA (low mobility, high care) and ESA benefits and would like advice on any additional benefits. Mrs. D receives Carer's Allowance last reviewed in June 2016.

Complex Care Coordination input – have established a good relationship with patient and carer and the following referrals were made on his behalf:

- Referral to social services sensory team for loop system/hearing assessment.
- Information to be sourced on disabled transport services.
- Offered and additional benefits advice.
- Made enquiries about Carer's Assessments and support groups.

Complex Care Coordination Outcome – Explanation of outcome of Mrs. D's Carer's Assessment and Carer's Personal Budget which was last reviewed in June 2016 to be reviewed annually unless there are any new concerns communicated. Mr R waiting for his assessment with the sensory team for hearing equipment. Information obtained on the Southend SHIP Directory for wheelchair transport services including Access Anyone, information on Carer's Forum, Blind Welfare Association and Sitting Services all forwarded to patients with a follow up to discuss further if required. Again Information obtained on Pension and Savings Credit communicated to patient offering support to complete if required.