

Clinical Navigation Hub and Directory of Services (DoS)

- Brenda Re, Hub Team Leader

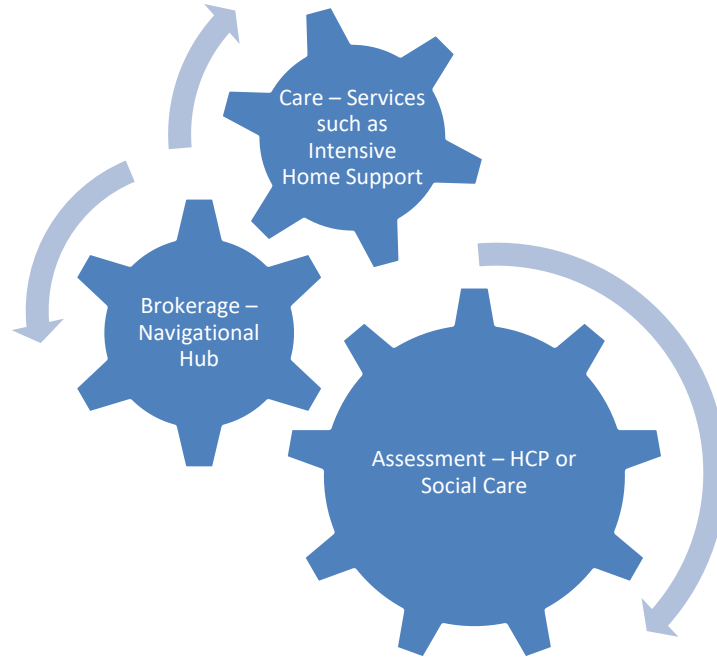


**INVESTORS
IN PEOPLE**

The Clinical Navigational Hub



Interface and co-ordination



Clinical Navigation Hub
Intensive Home Support
Discharge to Assess

Collaboration and Partnership

- Social care
- Acute hospital services
- Primary care
- Community health providers
- Mental health
- NWAS
- Voluntary sector services



Clinical Navigation Hub
Intensive Home Support
Discharge to Assess

What's the Navigation Hub?

Single point of contact for HCP's for referral brokerage on their behalf.

Ongoing care provision, monitoring and treatment for patients through the Intensive Home Support Service.

Signposting service providing advice, solutions and service contact numbers.

Meet The Team



Avoiding Hospital Admissions

(Kings Fund, Purdy, S. 2010)

Interventions where there is evidence of positive effect in reducing admissions:

- Continuity of care with a GP
- Hospital at home as an alternative to admission
- Assertive case management in mental health
- Self-management
- Early senior review in A&E
- Multidisciplinary interventions and telemonitoring in heart failure
- Integration of primary and secondary care

PATHWAY FOR OUT OF HOSPITAL SERVICE REFERRALS

Dial 0300 247 1040 & a call handler takes patient demographics and passes the details to a nurse navigator.

Working together

Nurse can Access
patient's PMH,
medications,
previous
investigations etc.

Nurse has
knowledge of the
most appropriate
services to suit the
needs of the
patient

with HCP and
other services
provides a holistic
package of care
and frees HCP
time

Real Examples To Date

1. Male patient at home; already diagnosed with cancer, visit diagnosed chest infection and prescribed antibiotics. GP concerned patient in crisis - lived alone – social isolation; house in poor condition; struggled with activities of daily living; needed advice on finance and personal care
2. 88 year old lady had fallen at home and was admitted to ELHT overnight on surgical triage unit as no beds available on MAU. OT was contacted by surgical triage as being fit enough to go home but needed care input as patient and family struggling. Patient had been having problems remembering to take medication and needed an assessment at home due to falls and mobility.
3. AVS referred patient on behalf of Paramedic Pathfinder. Female patient had had a fall at home the previous night but had refused to go into hospital. Patient was medically stable but needing referral to services to enable her to stay at home and so avoid admission. Patient lives alone, currently struggling with activities of daily living and personal care. Consent obtained to refer.

Feedback from service users



"I was impressed that one phone call generated all the referrals that I hoped for, and more, since I had not considered the dietician, which was a good idea."

Phil Huxley Chair – GP and ELCCG

"Just to let you know doctor who you spoke to on Friday think's you're the best thing since sliced bread and is telling all the other GP's the same. Keep up the good work!!! Can you send me details of your contact details and I'll pass them onto the other GPs"

Julia Miller-Over 75's nurse Hyndburn

"Here to Help Project at Age UK BwD work with the Navigation Hub to ensure a quality, coordinated service to patients. We receive referrals from the Hub and consult with them and benefit from their extensive directory of services and the knowledge of the staff. We find the service to be fast, efficient and effective."

Rachel Nolan - Help Coordinator, Age UK

Performance Summary – Year 1

April 2015 to March 2016

- 651 Total Referrals in start up year
- 814 service referrals brokered
- 95% of all referrals where deemed “Step Up”
- 70% of all cases referred deemed - Urgent - 2 Hour Response
- 58% of referring HCPs said they would have admitted if service not available
- 54% of all referrals avoided hospital attendance

Performance Summary – Year 2

April 2016 to December 2016

- 724 Total Referrals in year – 11% increase on Year 1 to date
- 1279 service referrals brokered – 57% increase on Year 1 to date
- 97% of all referrals where deemed “Step Up”
- 72% of all cases referred deemed - Urgent - 2 Hour Response
- 64% of referring HCPs said they would have admitted if service not available
- 62% of all referrals avoided hospital attendance

Service Types Referred – Year 2

Name	Total	%
Community Based Services	410	32.06%
Social Care	331	25.88%
IHS	155	12.12%
Adult Community Services	97	7.58%
District Nursing Service	86	6.72%
Age UK	52	4.07%
Voluntary Service	27	2.11%
Mental Health	24	1.88%
Medicines	22	1.72%
Falls Service	20	1.56%
ICAT	17	1.33%
Specialist Service	6	0.47%
Podiatry	5	0.39%
Treatment Room	4	0.31%
Clinics	3	0.23%
Diabetes	3	0.23%
Information Service	3	0.23%
Cancer Support Group	2	0.16%
Children & Family	2	0.16%
Health & Social Care	2	0.16%
Pharmacist	2	0.16%
Support Group	2	0.16%
Care Network	1	0.08%
Citizens Advice	1	0.08%
Hospice	1	0.08%
Therapist	1	0.08%
Total	1279	

Performance - January 2017

Count of Case Calls	120
Count of Directory Calls Only	13
Step-up or Step-Down Referral	Step Up 116 Step Down 4
Urgent or Routine Referral	Urgent 113 Routine 7
Conveyance/Potential Admission Avoided	Yes 108 No 12
Call Disposition/Outcome	177 Referrals

Performance - January 2017

Deflection of 79.4% of reported case calls result in deflection due to non-conveyance.

Phase 1 target for deflections was at 3 per week; average of reported case calls =15. 5 per week.

Cumulatively, across the service is above target.

Directory of Services

Directory of Services

- Over 600 out of hospital services
- Services across BwD and East Lancs area
- Directory is proactively maintained
 - Liaise with services
 - Information update through regular meetings
- Transfer to the service or just get the number
- Fast, efficient and friendly service
- Advice on the most suitable service available

Intensive Home Support





What is Intensive Home Support

Inclusion Criteria

Resides & registered with BwD GP
GP Diagnosis requires enhanced care
preventing admission

Lives in own home, relative,
residential, nursing home

Accepted & documented by IHS
Medic

Age > 65 yrs

Patient or Relative Consent

Exclusion Criteria

Unpredictable acute medical illness

Deemed unsafe in the home
environment

Unpredictable mental state

Alcohol/drug rehabilitation
safeguarding concern identified
that prevents a patient from
returning home

End of Life Care Pathway

CLINICAL NAV HUB : 0300 247 1040

Proposed Conditions

Dehydration UTI

Soft Tissue & Skin Infections

Orthopaedic Infections

IV VAD infections (venous access devices)

Bronchiectasis & related Infections

Heart Failure (daily weights, medication
monitoring, dosage changes & bloods)

Chronic kidney Disease (bloods monitored
regularly & acted on accordingly)

Abscesses & Ulcers

Care Provision

IV Therapy	NG Feeding
Blood Monitoring	Bridging care packages
OT/Physio	Personal Care
Anticoagulant Therapy	VAC Therapy
Wound care	Tracheostomy Care
Catheter Care	Routine Observations
B/P monitoring	

Benefits of IHS

- Prevents Hospital Admission
- Monitoring of vital signs and bloods
- Escalation to medics and other services
- Liaise with PTS, radiology, pathology etc.
- Refer to other services if required
- Provide assistance with personal care, meals etc.
- Arrange ECG, CXR, access.
- Review daily basis if required



Audits and improvement



User Survey: June 2015

96% of service users said they are extremely likely to use the service again.

What areas of the service would you like to see more of/keep doing?

- multi-agency involvement,
- links with the community,
- Keep the service the same. Friendly, helpful, knowledgeable and professional staff.

Encouraging comments:

- Effective service, keep going.
- Quick process for referral freeing my time for patients. Will definitely use again.
- Excellent service so far, helpful staff.
- Extremely quick, efficient service.
- Excellent, helpful service, continue.
- Good signposting, saves GP time. 1 telephone call rather than 3.

Listening - to improve our service

Service users have expressed their vision for improvement and performance

- Quicker response and feedback to GP personally.
- Feedback more of what has been organised.
- Written feedback would be better.
- Could do with out of hours.

How have we improved service user satisfaction from the feedback received

- Informing GPs to access the *post event message* on EMIS via Adastra
- Providing alternative communication channels which benefits the HCP
- Return telephone call, email, Adastra, Fax
- The opening hours extended to 8-8 Monday to Friday – Extended Access
- Plans are in place to extend hours further to a 7 day service/SPA

Thank You

- Any Questions?

