Features and benefits of the ‘Care Closer to Home’ Model of Care

We hope you think we already provide great standards of healthcare and support in your homes and communities, last year 85% of the people said they’d recommend Locala care to their family and friends. But we’ve been challenged by the local Clinical Commissioning Groups to ‘up our game’ even more. So, many of our clinicians and over 250 members of the public helped us develop a new model of care - a new style of providing our services.

Our patient is still at the centre of all we do. Our new model of care will mean you’ll be able to say:

- “I’m seen at the right time by the right person”
- “More of my care happens nearer to home”
- “I and my carers know how to manage my health and wellbeing”
- “Everyone involved in my care knows my story”

We’ll do this by:

1. Introducing a Single Point of Contact which will be a telephone centre where clinicians and administrative colleagues will take your calls and make sure you receive the right response quickly. This will be the one telephone number for: new appointments, changing appointments and asking questions about your care.

2. Spending much longer with you on your first appointment to really get to know you, what you need and put clear plans in place. This will mean you get the right sort of ongoing support, which in most cases will mean fewer follow up appointments. When we say ‘get to know you’ we mean we’ll be focusing on the whole person – holistic care - not just looking at a wound for instance but at your general health and wellbeing and your lifestyle which may contribute to your condition.

3. Helping you to play a more active role in decisions about your care. We will support you by providing information about your condition and the actions you can take to improve your health. We are calling this maximising independence.

4. Going for a different mix of skills in our considerably in coming years. This means you can talk to and see your clinician via their laptop from the comfort of your home or at work, saving time and effort and travel costs.

5. Working much more closely with the Council’s Social Care teams, South West Yorkshire Partnership NHS Foundation Trust - particularly in providing elderly mental health services - GP Practice teams, our local hospitals and organisations such as Milen Care, Age UK, the Denby Dale Centre and Kirkwood Hospice. We’ll work in a joined up way so we all know what each other is doing and when.
This will help reduce duplication - you won’t have to go over your details time after time – ensuring not only is there a smooth change but that you benefit!

6. workforce, meaning we’ll have more highly skilled specialists and more non-registered but trained, multi-skilled colleagues. This will mean we have the right skills to meet the needs of each patient.

7. Using our technology so that colleagues out and about across Kirklees can, via their laptops, contact one another and check or update patients’ notes. They can even meet via the technology saving travel time and costs.

8. Offering video appointments to you where appropriate and we plan to increase this

Here are some examples of what the people of Kirklees can expect in the future:

(Please scroll down)
Kulvinder is 82 years old and has **Chronic Obstructive Respiratory Disease (COPD)**. She has been diagnosed by her GP as having a suspected Urinary Tract infection and has been given a course of antibiotics. Kulvinder has become slightly confused, not eating or drinking with reduced mobility due to COPD.

Kulvinder obviously needs help – her carer, her GP, her Homecare assistant or the ambulance service realise she needs help but also know she could stay at home, rather than be admitted to hospital, if the right support can be provided.

They make a call to our Single Point of Contact using the one, well publicised, telephone number. Our member of staff triages Kulvinder’s condition, getting advice from a highly qualified clinician if necessary, and prioritises a home visit by an appropriate clinician within two hours. The clinician might be a nurse, a therapist, a …[need to build confidence through the range of options]

Our clinician makes an assessment of Kulvinder and her needs.

If she can be stabilised at home the clinician will make sure Kulvinder is comfortable and has the right equipment and support to be there. They will make sure our night team are fully briefed about her and those that care for her know what to do should there be a problem. We will also let her GP know what’s happening. If help is needed there won’t be a long list of confusing options – in most cases our Single Point of Contact will cover most needs other than a 999 call. We will make sure we continue to visit Kulvinder until we agree with her/her carer this is no longer necessary.

If Kulvinder can’t be stabilised at home but really doesn’t need to be in hospital then the clinician will call our Single Point of Contact and they will arrange a bed in a community healthcare setting – letting her GP know what’s happening. They’ll also arrange transport and make sure the right people at her destination know Kulvinder’s situation before she arrives, so that she gets the best possible care and support straight away.
Marley is 8 years old. He has recently started to have severe eczema on his arms and legs and a significant worsening of his asthma.

Marley’s parents, his GP, a Locala colleague from our Children’s services team or his school realise he needs help.

They make a call to our Single Point of Contact using the one, well publicised, telephone number. Our member of staff triages Marley’s condition, getting advice from a highly qualified clinician if necessary, and prioritises a home visit by an appropriate clinician within two hours. This will be a member of our Children’s services Expert team – it might be a specialist nurse or therapist. They will be available to make this home visit between 8am and 10pm.

Our clinician makes an assessment of Marley and his needs and makes sure the person who referred Marley to our services knows what action has been taken. The actions are put into a Care Plan that is with Marley and his parents and shared with his GP and any other relevant services – it may, for example, involve providing equipment and prescribing or amending the prescription of medicines. It will, where appropriate, enable Marley to stay at home rather than go into hospital. It’s therefore important that Marley’s parents know who to contact if they have a query or need help. The clinician makes sure: they know the contact details for our Single Point of Contact, mentioned earlier and: that there’s a handover to the night team of children’s community staff so that those involved in Marley’s care know everything there is to know – just in case they’re called upon. We’ll let Marley’s GP know what’s happening too.
Stan is being transferred home from hospital. He was admitted to hospital following a fall due to low blood pressure. He’d fractured his hip and had cuts to his lower leg.

Stan has been in hospital for a fortnight and he’s now fit enough to be discharged. The hospital sends an electronic referral to our Single Point of Contact. Our member of staff triages Stan’s condition, getting advice from a highly qualified clinician if necessary.

If Stan is fit enough to go straight home the hospital will inform his GP and arrangements will be made by our Single Point of Contact for a clinician to visit Stan when appropriate. The clinician will assess Stan’s needs and develop a Care Plan that will involve measures that Stan can take to help improve his health and regain his independence, as well as any support needed from Locala. Goals for Stan’s rehabilitation will be discussed and agreed with Stan. Stan’s Care Plan will be shared with his GP so that they know what’s being done to support his recovery.

If Stan’s not yet fit enough to be back at home then the Single Point of Contact will arrange a bed in a community care residence and inform his GP. They will also arrange transport to take Stan there and ensure that the clinical and social care team who’ll be looking after Stan have all the necessary care record information to pick up Stan’s care where the hospital left off. Arrangements will be made for a clinician from Stan’s locality team to visit Stan when appropriate. The clinician will assess Stan’s needs and develop a Care Plan that will involve measures that Stan can take to help improve his health and regain his independence. Goals for Stan’s rehabilitation will be discussed and agreed with Stan.