Florence Nightingale Foundation

QI Project: The Implementation of a Complex Health Pathway

Introduction

The purpose of this project is to create a Complex Health Pathway for young people in transition who we identify as having Complex Health Care Needs.

The QI team defined 'Complex Health Care Need' as '*having one or more physical and mental health condition (in addition to a diagnosis of learning disabilities), the management of which significantly impacts upon a person's life and the lives of their family and carers.*'

This is a multidisciplinary project that aims to identify health outcomes through collaboratively working between teams and identifying a health coordinator to lead on each service user's care.

Care needs of people with complex health can often have a significant impact on their carers, often leading to carer stress/ burden and even placement breakdown. By creating a Complex Health Pathway we would be identifying the clients that are more vulnerable to deterioration in their overall care needs.

The Approach

What we were trying to accomplish?

A streamlined pathway which allows us to identify and better manage the health needs of complex health clients who are transitioning from the children's to the adults service, as well as existing clients.

This will be a multidisciplinary project in which an Appreciative Enquiry approach will be used to develop the complex health pathway. An Appreciative Enquiry is an approach for creating and sustaining change, rather than starting with 'what is the problem?', we will build on what is already working in the service and implement a pathway that is streamlined and can be shared amongst the service.

What we will measure to understand if our change will be an improvement?

- All complex health cases will have a recurring review that will be documented on the clinical system. The QI team will periodically review these cases on the system to ensure an appropriate care professionals, including a care coordinator are allocated to cases.
- Depending on the complexity of cases, review meetings will take place every 3, 6 or 12 months. Clients can be discharged if health needs are stable and are agreed by the multidisciplinary team working on the case.
- The QI team will gather information from the care coordinators to discuss the impact of changes in clients' care, capturing the positive health outcomes and areas to improve.
- The QI team will seek staff feedback, client/ family and carer feedback six months after a client has been added to the pathway to address any barriers and offer support where needed.

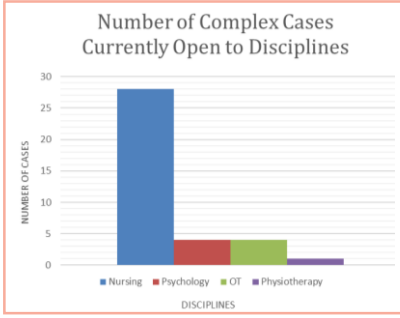

Figure 1: Number of Complex Cases funded by NHS Continuing Health Care. Historically care coordinators of these complex cases were held only by nurses. Currently, a few cases have been handed over to other disciplines, as demonstrated through this chart.

Next Steps

- To discuss progress of pathway work with the Transition Team and wider CLDS Management
- Regular QI team meetings to implement agreed PDSA actions

The Impact

By adhering to this pathway the following changes will happen across the service:

- A change in ways of working in which all staff are aware of the need to flag complex needs clients so that all cases have an identified care coordinator, appropriate to their primary needs.
- A rag rate system will be made in which existing cases with complex needs are identified on the clinical system.
- Staff will capture new referrals and flag new referrals early, in order to allocate the case to an appropriate care coordinator who can then seek joint working with other professionals
- The QI team will check which clients have health professionals already involved in their care. They will notify the allocated workers of the new complex needs procedure so they can discuss and agree who will be the lead care coordinator.
- Reduction in hospital admissions and improved health outcomes.
- Training will be offered to those not familiar with the role of a care coordinator.
- Staff will be more confident as they will know where to seek support if the intervention is not appropriate to their skillset and there will be stronger team working.

PDSA

	Cycle 1	Cycle 2	Cycle 3
Prediction	There is a large number of complex clients without a care coordinator	Cases without a care coordinator at an increased risk of unmet health needs	Having a multidisciplinary approach will improve confidence in staff for the role of care coordination
Do	Put together a QI team who will be a part of the complex health pathway	The QI team will assess each case in identifying the needs and care planning that is required	The QI team will offer training on the role of care coordination to identified staff
Study	Two meetings were held to establish and define the term 'complex health needs' and establish a criteria for clients with this presentation	It was agreed at the QI team that a case study open to one of the QI team members will be brought forward to the next meeting to track their timeline since the point of referral to the service	The care coordination role has historically only been held by the nursing team, despite the responsibilities a times being appropriate for their skillset. By opening it up to the wider service, clients' cases will be better managed
Act	Go through the clinical records to identify clients under the age of 25 who have complex health needs and establish what professionals are already allocated to the case, adding the appropriate staff to the case as needed including care coordinator.	To identify barriers in the case study and how this can be avoided. To identify gaps and missed opportunities in the case study and what improvements can be made to streamline the pathway	Some complex cases have been transferred already to other health disciples. For example, clients with challenging behaviour have been moved from the nursing team to the psychology team. This initially created a lot of anxiety among the other health staff. Assessing further cases to ensure the correct support is provided is needed.

Leadership Learning

The team identified the following strengths about our work in the Community Learning Disability Service and Transition Team:

- Being an integrated service with weekly team meetings and case discussions
- Referrals being thoroughly screened prior to Single Assessment, ensuring the best placed professionals are allocated to complete it
- Having two professionals completing a Single Assessment, particularly when a service user has complex needs
- When clinicians can complete an initial health assessment (e.g. physio, SALT, OT) as part of the Single Assessment, so the service user can be fast-tracked to relevant disciplines and duplication avoided.

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