NHS
Northumberland
Clinical Commissioning Group

Complex Care at Home Project

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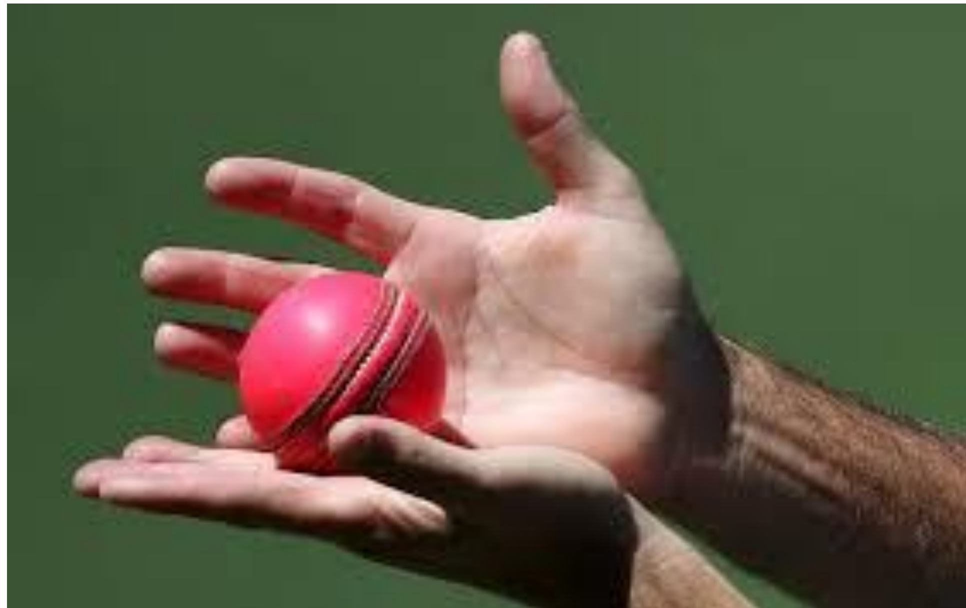
CATCH teams

Care at Home Team for Complex Health Needs



Why…?

- Improve patient experiences
- Support patients to remain at home living as well and independently as possible.
- Enable patients to have a timely return home safely from hospital
- Reduce unnecessary admissions
- Prevent further deterioration

Aims of CATCH teams

- Proactive care of our high risk patients
- A truly multidisciplinary team (MDT) approach to patient care
- Promote the lowest level of care to meet the patient's health needs
- Sharing of care on managing these high risk patients in the community

Right level to meet need.

Prevention and wellbeing local approach

Self-care and empowerment

Primary care clusters

Integrated Health and wellbeing Hub

In patient Nurse led care

In patient Medical care

Specialist Emergency care

Lowest level of pathway that can meet the patients' needs and focus on improving / maintaining independence.

Who will the catch service work with?

- Adults over 18 years old
- Majority of case load is expected to be older people with complex comorbidities, but not restricted to older people.
- Referrals would be through practice MDT's assessed by them as being at particular risk.
- Referrals too directly from Secondary care.

The Model - Two key roles.

Proactive MDT care

- For patients at highest risk of health crisis and hospital admission.
- MDT decision
- Coordination of current care
- Emergency Health Care Plans in place.
- Would not include day to day management

The model – Two key roles

Urgent Care

- The provision of urgent support for patients in a health crisis whether or not already known to CATCH

- CATCH team would have direct access to all community services, mental health and social care services required to deliver lowest level of care to meet patient’s needs.

North Locality Service Director

NHS

Northumberland Clinical Commissioning Group
Northumbria Healthcare NHS Foundation Trust

CATCH

Coordination of care through MDT working

North Locality Service Directory

CARE OF THE ELDERLY

Urgent advice or assessment

On-call geriatrician: **0344 811 8111**

Frailty Assessment Service at Northumbria Hospital: **0191 607 2822**

Proactive support

- To discuss patient at weekly MDT held at Alnwick and Berwick Infirmaries, or
- To discuss suitability for a geriatrician home visit
- Dr Morton or Dr Adamson: **0344 811 8111** James.Morton@nhct.nhs.uk / John.Adamson2@nhct.nhs.uk

Direct admissions to community hospital

- Alnwick Infirmary - Dr Morton: **0344 811 8111** Ward nurse practitioner: **01665 626709**
- Berwick Infirmary - Dr Adamson: **0344 811 8111**

Outpatient Review

Appointments made via individual GP through Choose and Book

onecall

- Short term support
- Equipment for the home
- Carer packages
- Emergency respite
- Support planners
- Physiotherapy
- Occupational therapy
- Macmillan support

01670 536400

CATCH

Opportunities

- Identifying gaps
  - Service provision ?
  - In skills and training ?
  - In resources ?
- To shape clinical strategy for community services
- To enhance care closer to home
- To enable investment into the right places.

Outcomes…

Our 3 big outcomes

01

To recover & stay well

02

To make their own choices

03

And to participate on an equal footing in daily life

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Thank you