**One Hackney Quadrant Care Coordinators**

The One Hackney Quadrant Care Coordinators are now in place.

They are:

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| --- | --- | --- | --- |
| Quadrant | Name | Contact | Manager |
| North East | Elina Marques | elina.marques@nhs.net074 6835 1782 0207 729 7236 Ext: 318 | Joan Battley0207 729 7236 Ext: 311 |
| North West | Gareth Walsh | garethwalsh@nhs.net074 6935 17830207 729 7236 Ext: 308 | Kostana Banjac077237214110207 729 7236 Ext: 305 |
| South East | Sybil Omolabi  | sybil.omolabi@nhs.net074 6935 17810207 729 7236 Ext: 319 | Amaia Portelli0207 729 7236 Ext: 314 |
| South West | Alexandra Williams | alexandra.williams7@nhs.net074 6935 17780207 729 7236 Ext: 317 | Sonia Hall078763436910207 729 7236 Ext: 304 |

**What can the Quadrant Care Coordinators do?**

They can help to co-ordinate the care of patients by:

* Talking to different teams involved in a patient’s care to find solutions where “things have got stuck” and helping solve the problem and feeding back to the GP
	+ Where issues occur repeatedly across different patients and areas, we will look at whether there are gaps in service or whether we can improve/simplify processes
* Work with the different teams who are involved in a patient’s care to help share information more effectively to assist the development of a multi-disciplinary care plan
* Liaise directly with a patient about their wishes to improve the management of their health and wellbeing including undertaking a home visit if appropriate
	+ Help patients access appropriate voluntary sector services or arrange for support from a voluntary sector navigator
	+ Link patients into other parts of the Quadrant clinical teams if appropriate such as social care, mental health, community nursing
* Organise case conference/MDTs where it becomes apparent this is needed and hasn’t already taken place
	+ Suggest that a patient is discussed at a practice MDT
	+ Contribute to the development/review of a care plan
* Work with the patient and team to identify appropriate services available to Hackney patients suited to their needs and help patients access/use these services

We will not say “No” to any referral. If we do not think it is appropriate we will pass the referral across to the right service and feedback directly to the referrer about actions taken.

**Who can refer?**

Anyone can refer a patient to the Quadrant Care Co-ordinators including GPs, practice nurses, Adult Community Nursing Teams, Social Services, Community Pharmacists amongst others.

Page 3 provides some additional information which might be helpful when considering a referral.



**How do we refer?**

* By telephone (please have the information available we ask for on the referral form)
* Fax referral form to Care Coordinator (0207 729 8303)
* Email referral form to the appropriate Quadrant Care Coordinator
* Emis GP referral form

Once the referral is received, it will be acknowledged by the Quadrant Care Coordinator and you can expect feedback on the planned actions within two working days. You will then be kept informed regularly as to progress. The Quadrant Care Coordinator will also update you on the outcome of their involvement with the patient when help is no longer required.

Any questions, please ask your Quadrant Care Coordinator or your quadrant manager

**If you have any feedback on this process or comments on One Hackney, please contact Jennifer Walker (****Jennifer.walker9@nhs.net****), One Hackney Programme Director**



**Further guidance on referring to the Quadrant Care Coordinators**

* **Care plans/Emis patient summary**
	+ When referring to the Quadrant Care Coordinators it is really helpful for them to be able to see a care plan (if it exists) or an Emis patient summary
	+ These can be faxed securely to the office number (0207 729 8303)
* **Patient consent**
	+ The Quadrant Care Coordinator can begin working with the patient more effectively and rapidly if the patient has been consented/informed that the Quadrant Care Coordinator will be contacting them. For complex patients, it is easier to make an assessment of their needs and take appropriate action after a home visit (which would need patient consent).
* **MDT**
	+ For complex patients with multiple agency involvement, it would be useful to know if they have been discussed at an MDT meeting
	+ If they haven’t, it might be appropriate to schedule them for discussion at an MDT in the future so that the Quadrant Care Coordinator can update the practice and multi-disciplinary team on their involvement and progress with the case
* **Asking for help**
	+ The Quadrant Care Coordinators can work more rapidly if the reason for referral is as specific as possible (we appreciate this may not be possible in all cases). Some examples might be:
		- We feel that the patient may benefit from befriending services, can you help find this service and put the patient in touch with them?
		- The patient is waiting for a mattress/bed/key safe etc. Could you check whether this will be done soon?
		- The patient and family report that they are not coping well? Could you liaise with other services involved and visit the patient to see whether there is anything further that can be done or what other services they may benefit from?
	+ The Quadrant Care Coordinators can also help access the other quadrant staff if you are not clear who is available yet and how to help them?
* **Other key workers/teams involved**
	+ It is really helpful to know who else may be involved in the patients care and who would be a good person to talk to. Some of the most successful visits are where the community matron/district nurse can undertake the visit together or discuss the case before the care coordinator gets involved.
* **Managing risk**
	+ The Quadrant Care Coordinators will undertake home visits. If you know of anything that might pose a danger or that it may be important for them to know about the home environment, it would be really useful to know that as early as possible.