North Cumbria 2021-22 AW Plan Review Sept 2021

Enhanced Health In Care Homes

1. Establish dashboard/baseline of PCN delivery against DES
2. Refresh Frailty Pathway/Model to take account of EHCH; specifically approach to severely frail patients, how case management transfers from home based to residential care based e.g. transfer of care around mental health, potential move of GP practice etc & how to support patients & families with this
3. Link this work with the development of the Digital CGA tool to improve the continuity of care

Current position: refresh undertaken as part of re-establishing cross agency care homes group as part of COVID recovery. Work currently focusing on:

a) Improving access to MDT – via engagement sessions with care homes by CLIC (learning collaborative)

b) Digital support – Healthcall E Referral app

Aligning with ICS programmes e.g. CGA but potential use in care homes is likely to be much further down the line

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Anticipatory Care:

1. Data set/profile refresh using range of resources e.g. EFi, RAIDR and public health data
2. Review of MDT – to understand population being served and outcomes against Standard Operating Procedure & best practice guidance;
3. Refresh approach to risk stratification, look at how other ICP areas are approaching this. Use this to develop piloted cohort of patients to target for anticipatory care using MDT approach e.g. coordinated care to specific 'frail' group that would most benefit from anticipatory care model e.g. poly pharmacy, hospital admission, respiratory issues.

Current position: aligning this work with personalised care and health inequalities programmes e.g. risk stratification, telehealth & @home telemonitoring. In planning stage for pilot scheme using @home respiratory for cohort of patients in Eden (rural locality)

ICC/PCN have training from CI teams on population health management tools

ICC MDT meetings are working well for complex/frail patients but focus has been on urgent cases – plan to change to mix meetings to have urgent and AC cases

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Urgent Community Response

1. Review/audit current ICC Rapid Response service against Standard Operating Procedure to establish baseline of current service delivery.
2. Incorporate the Frailty Group work on frailty acuity in hospital admission and re-admission to understand demands for UCR.
3. Develop programme for training/workforce to enable staff to understand frailty and use Clinical Frailty Score in all settings. Enhanced training to key individuals to carry out CGA to increase use of this in the community.

Current position: Refresh of objectives has been necessary due to acceleration of implementation of UCR crisis response to 2021/22. Stakeholder workshops and full mapping carried out of current urgent/rapid service provision.

Aligning frailty scores as part of UCR data template to use in service planning

Including frailty awareness in embedding of UCR

Linked with EnCOP team & hope to initiate training scheme with frailty care coordinators in latter part of the year