Carlisle Healthcare

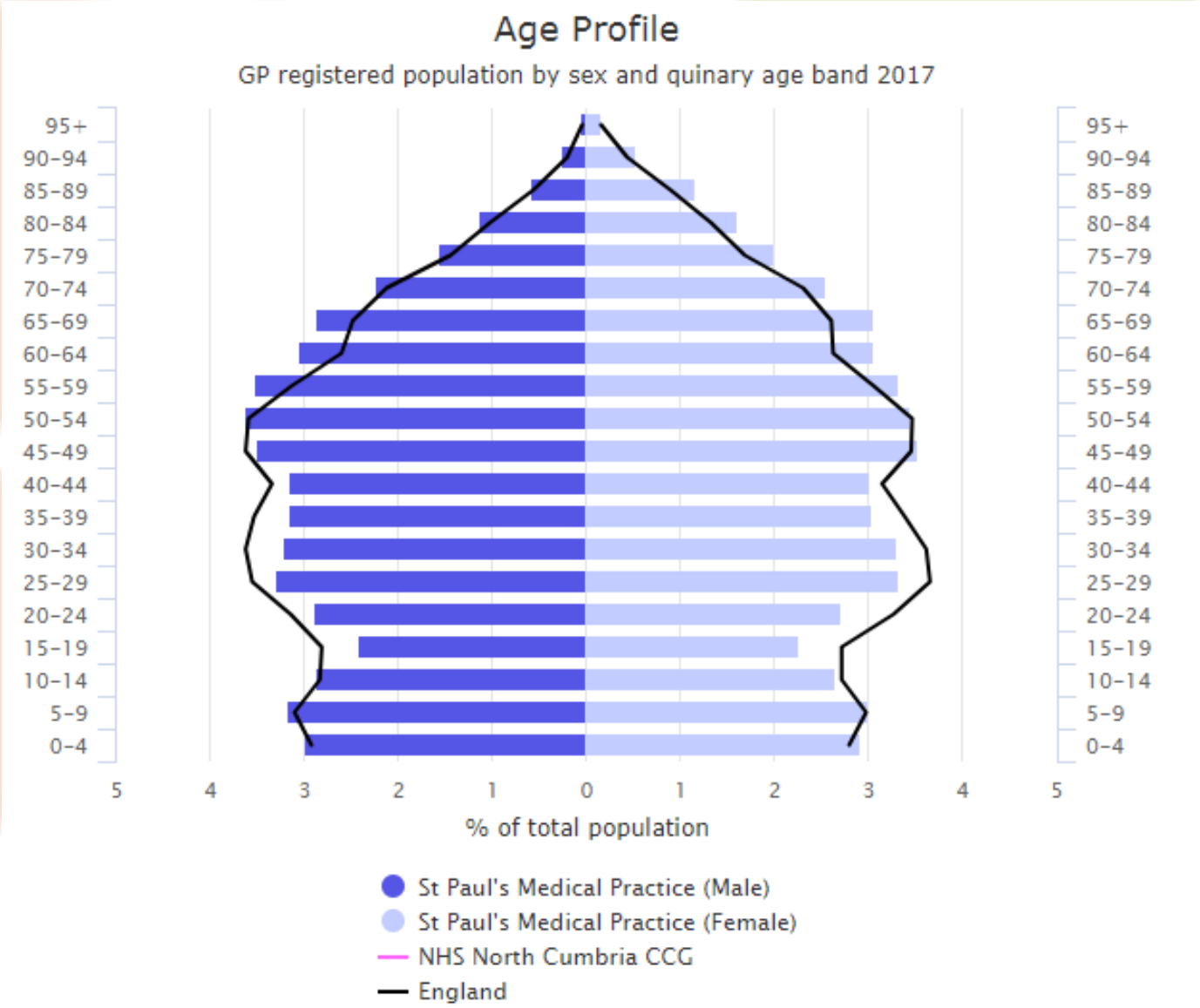
NHS
North Cumbria
Clinical Commissioning Group

Dr Robert Westgate MBBS FRCGP
St Paul's Square
Carlisle
CA1 1DG
01228 588121
www.carlislehealthcare.co.uk

Care & Support Planning for people living with frailty

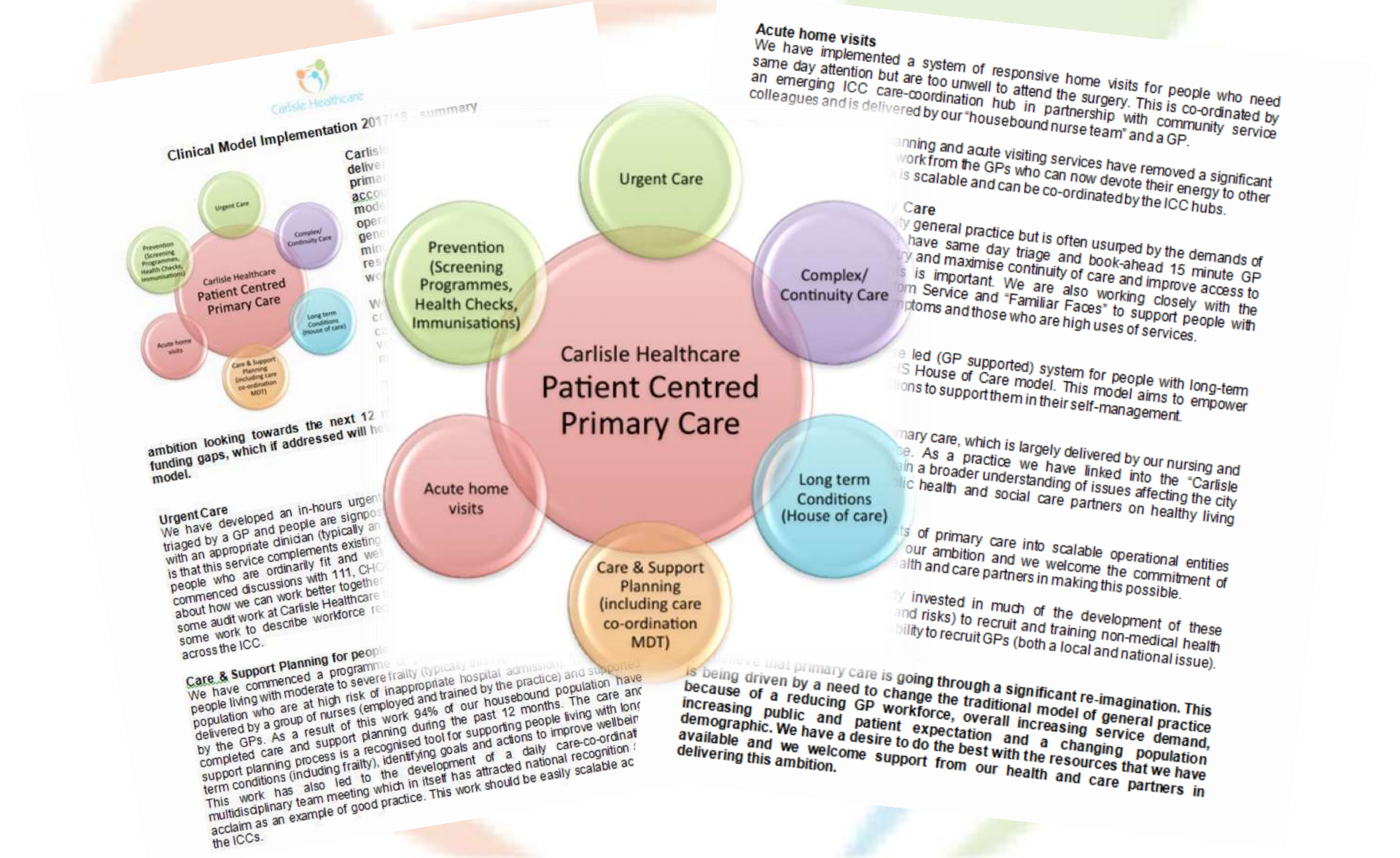

Annan
Gretna
Bowness-on-Solway
Solway Coast AONB
Haltwhistle
Brampton
Carlisle
Allendale
Silloth
Dalston
Wigton
Aspatria
Maryport
Broughton
Workington
Penrith
Keswick
Appleby-in-Westmorland
Whitehaven
Cleator Moor
Egremont
Kirkby Stephen
Lake District
Seascale
Windermere
Kendal
Sedbergh
Millom
Ulverston
Milnthorpe
Arnside
Dalton-in-Furness
Ingleton
Carnforth
Bentham
Barrow-in-Furness
Morecambe
Lancaster
Settle
Kilkenny
Tralee
Clonmel
Waterford
Cork
Stavanger
Sandnes
Inverness
Elgin
Aberdeen
Scotland
North Sea
Dundee
Perth
Kirkcaldy
Glasgow
Kilmarnock
Ayr
United Kingdom
Middlesbrough
Blackpool
Leeds
Hull
Liverpool
Sheffield
Nottingham
Stoke-on-Trent
Derby
Norwich
England
Great Yarmouth
Amsterdam
Den Helder
Ipswich
The Hague
Netherlands
Wales
Swansea
Headington
Bristol
London
Leigh-on-Sea
Cardiff
Reading
Woensel-Noord
Bruges
Antwerp
Barnstaple
Southampton
Brussels
Exeter
Portsmouth
Lille
Belgium
Plymouth
Bournemouth
Newquay
St. Ives
Truro
English Channel
Amiens

Carlisle Healthcare Population




Carlisle Healthcare

Evolving Clinical Model



Clinical Model Implementation 2017/18 - summary

ambition looking towards the next 12
funding gaps, which if addressed will he
model.

Urgent Care
We have developed an in-hours urgent
triaged by a GP and people are signpos
with an appropriate clinician (typically an
is that this service complements existing
people who are ordinarily fit and wel
commenced discussions with 111, CHC
about how we can work better together
some audit work at Carlisle Healthcare
some work to describe workforce re
across the ICC.

Care & Support Planning for people
We have commenced a programme
people living with moderate to severe frailty (typically this is admission) and supported
population who are at high risk of inappropriate hospital admission) and supported
delivered by a group of nurses (employed and trained by the practice) and supported
by the GPs. As a result of this work 94% of our housebound population have
completed care and support planning during the past 12 months. The care and
support planning process is a recognised tool for supporting people living with long
term conditions (including frailty), identifying goals and actions to improve wellbein
This work has also led to the development of a daily care-co-ordinati
multidisciplinary team meeting which in itself has attracted national recognition
acclaim as an example of good practice. This work should be easily scalable ac
the ICCs.

Acute home visits
We have implemented a system of responsive home visits for people who need same day attention but are too unwell to attend the surgery. This is co-ordinated by an emerging ICC care-coordination hub in partnership with community service colleagues and is delivered by our "housebound nurse team" and a GP.

nning and acute visiting services have removed a significant work from the GPs who can now devote their energy to other is scalable and can be co-ordinated by the ICC hubs.

Care
ty general practice but is often usurped by the demands of have same day triage and book-ahead 15 minute GP ty and maximise continuity of care and improve access to is is important. We are also working closely with the m Service and "Familiar Faces" to support people with ptoms and those who are high uses of services.

e led (GP supported) system for people with long-term S House of Care model. This model aims to empower ions to support them in their self-management.

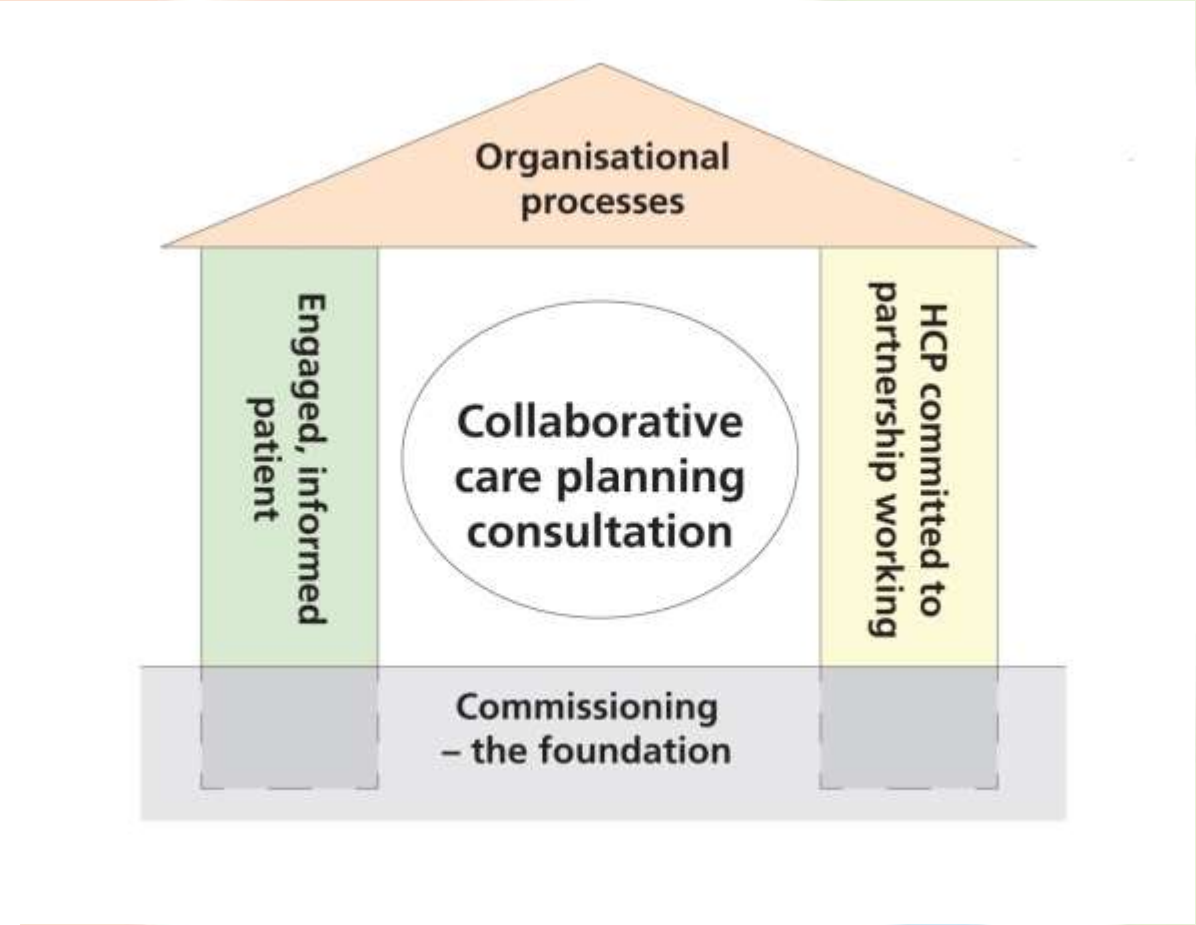
mary care, which is largely delivered by our nursing and e. As a practice we have linked into the "Carlisle in a broader understanding of issues affecting the city lic health and social care partners on healthy living

s of primary care into scalable operational entities our ambition and we welcome the commitment of alth and care partners in making this possible.

y invested in much of the development of these nd risks) to recruit and training non-medical health bility to recruit GPs (both a local and national issue).

is being driven by a need to change the traditional model of general practice because of a reducing GP workforce, overall increasing service demand, increasing public and patient expectation and a changing population demographic. We have a desire to do the best with the resources that we have available and we welcome support from our health and care partners in delivering this ambition.

Care & Support Planning



www.yearofcare.co.uk

Care and support planning (CSP) is a systematic process which replaces current planned reviews for people with long term conditions, and is focussed on creating the opportunity for a ‘better conversation’ between the person with LTC/s and a care professional, enabled by preparation.

The CSP process begins with an information gathering appointment in which tasks and tests are collected ahead of the CSP conversation. The results of any information gathered, together with reflective prompts, are sent to the person 1- 2 weeks before the CSP conversation (preparation).

Co-ordinated Care?

Home First

Discharge to assess

General Practitioner

Community Rehabilitation

Social Worker

Out of Hospital Care

Re-ablement

A&E/Acute hospital care

ROVI

COMPASS

Third Sector

Housing Support

Mental Health Service

HAWCs

Family and Friends

Private Care

Care Co-ordinators

What does the GMS contract require?

- The GP contract specification includes an obligation for annual review, medication review, falls assessment and a request to those with severe frailty to allow sharing of an enriched summary care record.
- Care & Support Planning provides an ideal way to deliver all this. At the same time, it provides a generic approach to routine care for everyone with long term conditions on practice registers including those who are elderly but fit or with mild or moderate frailty, to prevent deterioration.

The Housebound/Frailty Team

- Early 2016: joint employment of 3 senior nurses to work with our most vulnerable adults.
- The plan was to provide:
  - Care and support planning for the housebound adult population.
  - Proactive case finding, systematic care plans and regular contact.
  - Facilitating a care co-ordination multidisciplinary meeting with health and care colleagues
  - Reactive care in particular to acute visit requests from this patient group.

The Team:

- Well qualified nurses from different backgrounds: community nursing, practice nursing and care home manager.
- All with a willingness to work in a different way whilst pursuing advanced qualifications
- Acceptance from all that this would take time to deliver.
- GP time required to support them.

Carlisle Healthcare

A merger of St Paul's Medical Centre, Brunswick House Medical Group and North Carlisle Medical Practice.

Home Visiting Clinical Team

We are a group of Senior Nurses working with your usual GP and your GP practice. We aim to provide you with an annual health and social care planning appointment to try and maximise your health and wellbeing.

Typically, we will arrange to see your around the time of your birthday for a planned appointment at home. We will contact you in advance about this. It might be that one of our staff will visit you in advance of this appointment to arrange any blood tests or measurements (e.g. blood pressure) that are due. We will also send you some information in advance of the appointment so you can have a think through what is currently important for you & note down any issues you would like to discuss.

In addition we may contact you at the request of your GP during an episode of ill health or following a hospital stay, to help co-ordinate your care and to try and keep you well.

A summary of your consultation, including your future health preferences and plans will be posted to you to keep for future reference.

Please contact the surgery with any questions or comments you have about our service to you.

Office address:
Carlisle Healthcare
St Paul's Square
Carlisle CA1 1DG
01228 588121
www.carlislehealthcare.co.uk

Updated Dec 2016

Care & Support Planning Process

- Birth Month Recall
- HCA to attend re: biometrics/monitoring and brief explanation of process
- Results shared with patient along with awareness raising prompts and notification of CSP visit
- Visit takes place
- Documentation completed and shared with patient

Care Co-ordination Huddle

- Planning for a daily “huddle” to have a responsive and co-ordinated care response primarily linking together the effort of community services and general practice to try and be more efficient
- Aiming to impact positively on the normal GP working day (i.e a less chaotic and better co-ordinated)

EMIS Care Co-ordination Appointment Template

PATHWAY, Frailty (Dr)

Order	Description / Patient Name	Reason	Slot Notes	Date of Birth	Booking Notes
1	Out of Hours Follow Up				
2	MDT Meeting				
3	MDT Meeting				
4	MDT Meeting				
5	MDT Meeting				
6	Patients causing current concern (to discuss)				
7	MDT Meeting				
8	MDT Meeting				
9	MDT Meeting				
10	MDT Meeting				
11	Recent Hospital Discharges				
12	MDT Meeting				
13	MDT Meeting				
14	MDT Meeting				
15	MDT Meeting				
16	Hospital Admissions				
17	MDT Meeting				
18	MDT Meeting				
19	MDT Meeting				
20	MDT Meeting				
21	Palliative Care (to discuss)				
22	MDT Meeting				
23	MDT Meeting				

Daily Huddle

Frailty Data (List size 36291 (August 2017))

Number of people identified with frailty based on eFI (electronic Frailty Index)

Frailty Status (eFI)	Number of people	% of practice population
Mild (0.12 – 0.24)	3009	8.2%
Moderate (0.24 – 0.36)	1612	4.4%
Severe (>0.36)	815	2.2%

Number of people identified with frailty who have completed care & support planning (since January 2016)

Frailty Status	Number of people	Completed CSP	% completed CSP
Mild	3009	927	31%
Moderate	1612	845	52%
Severe	815	610	75%

Number of people identified with frailty who do NOT have co-existing vascular disease/diabetes/COPD AND have not been in receipt of a repeat medication during the past 6 months

Frailty Status	No of people outwith an existing recall system (as described above)
Mild	86
Moderate	6
Severe	0

Frailty Data (2)

Number of people identified with frailty who are coded as "housebound" & have completed care & support planning (since January 2016)

Total number of people coded as housebound = 470, but only 429 of these are also identified as having frailty

Frailty Status	Housebound	Completed CSP since January 2016	% completed CSP
Mild	59	52	88%
Moderate	136	125	92%
Severe	234	219	94%

Number of people identified with frailty who are coded as "housebound" or resident in a care home & have completed care & support planning (since January 2016)

Total number of people coded as housebound or living in residential/nursing care = 617 (= approx. 2% of practice population), but only 541 of these are also identified as having frailty

Frailty Status	Housebound & Care Home Residents	Completed CSP since January 2016	% completed CSP
Mild	87	78	90%
Moderate	181	167	92%
Severe	273	258	95%

Outcomes

- Positive patient experience
- Positive professional experience
- Beginning to address needs of an often forgotten population in a structured way
- Diversification of primary care workforce in a climate of falling GP numbers
- Shared learning & understanding across organisations
- Unplanned admissions ?metrics

Collaborative Working

Key Message

- **Person Centered Care and Support Planning** helps to inform care co-ordination and helps to prepare people for the challenging decisions they may face in their later years.
- Harnessing available resources across a health & care community (de-medicalising) and **working collaboratively** are key in an era of growing demand and relatively diminishing resources

Aspirations

- Developing a population based care co-ordination hub
- Better evaluation of impact of service change
- Seamless integration
- In-reach into acute units to support earlier discharge

A common care co-ordination platform

Summary

- Health and social care involves a complex arrangement of organisations and transactions
- The demands on statutory services are set to increase due to our changing demographic
- Care and Support planning, along with active care co-ordination can help to address these challenges

The Fridge of Dis-integration!

Carlisle Healthcare