EnCOP
Enhanced Care for Older People

Enhancing Care for Older People Webinar Series. Session 28

Date: 19th June 2024

'Developing and delivering a person-centred approach to proactive care for people with multiple long-term conditions and frailty'

Presenters:

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Helen Kleiser, National Trainer and Facilitator, Year of Care Partnerships

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EnCOP Strategic Lead: Angela Fraser

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Session aims and linked EnCOP Competencies

- **Aim:** This webinar will detail the learning from the NENC regional proactive care pilot which was delivered in 2 Primary Care Networks in North Cumbria and looked at the feasibility of implementing the national Proactive Care Guidance (Dec 2023).

- **Linked EnCOP Domains:**

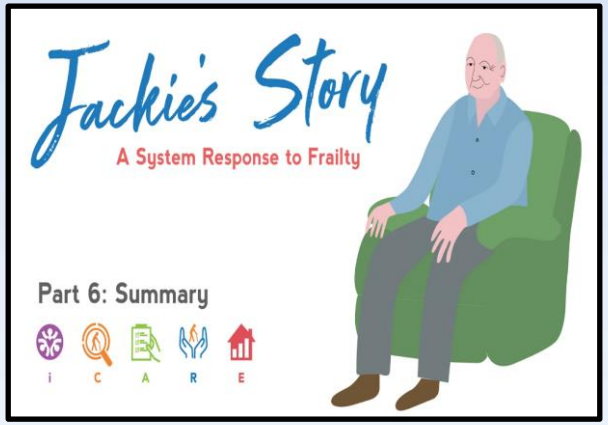
A. Values, attitudes and Ethics
B. Understanding and supporting evidence – based practice; leadership & improving care & support for older people
C1: Partnership working and communication with older people , families and friends
C2: Interprofessional and interorganisational working, communication and collaboration
D1: Ageing Well – Understanding Frailty - Prevention, Identification and Recognition
D2: Ageing Well : Assessing, planning, implementing and evaluating care and support
D3. Ageing Well - Promoting & Supporting Independence, Autonomy & Community Connectivity for Older People
D4: Ageing Well: Promoting & supporting holistic physical health and wellbeing with older people
D5: Ageing Well: Promoting and supporting holistic psychological health and wellbeing with older people
D6: Ageing Well – Promoting & Supporting Older People with Medicines Optimisation
D7:End of life care: Older people and frailty – recognition, assessment and care planning

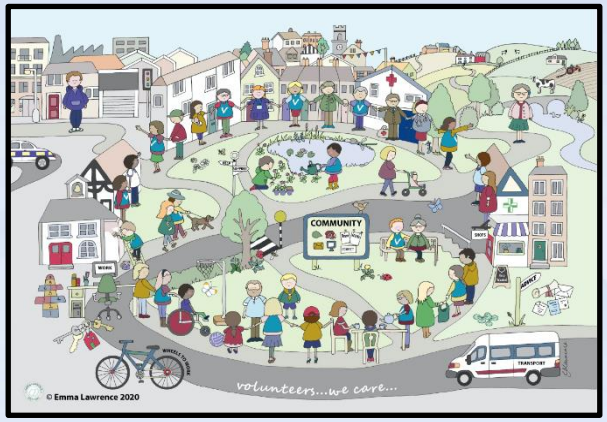
Designing and delivering a person-centred approach to Proactive Care for people with multiple long-term conditions and frailty

(Northeast and North Cumbria)

Dr.Dan Cowie, Lindsay Oliver, Helen Kleiser & Becky Blake

It's all about ***people and communities:***

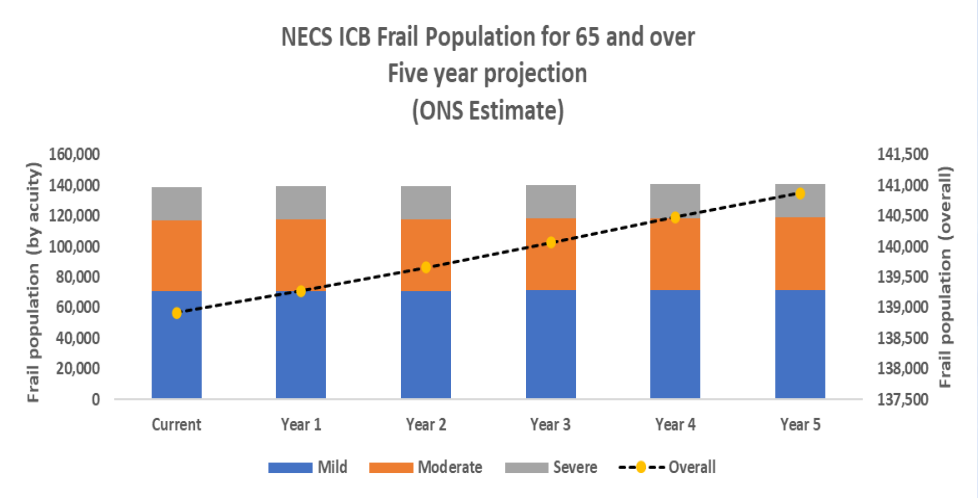




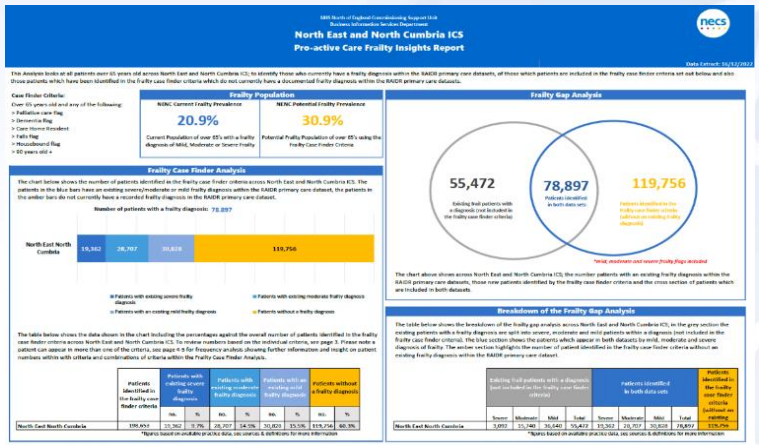
The offer should be **timely**, based on **need** and what **matters** to people

ICB Frailty population do nothing projections

ONS population estimates an increase in frail elderly population of 1.41% over the next 5 years. This would equate to an increase of 1,953 more frail elderly patients aged over 65 by 2029



We know frailty is around 20% in people aged 65 and over in NENC – roughly 5:3:1 ratio for mild, moderate and severe!



NENC Frailty Packs

Over the period from 2018 to 2023, the 65years and over population accounted for:

23%
of all A&E attendances

51.6%
of all A&E attendance via ambulance

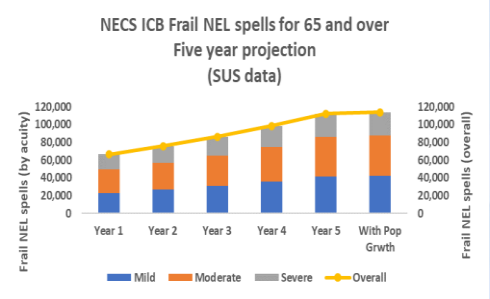
43.9%
of all Emergency hospital admissions

37.6%
of all admissions to hospital from A&E

52,000 people had 3 or more admission to hospital in their last year of life

8,800 people MLTCs in the last 12 months were recorded as having 5 plus A&E attendances

6,000 people MLTCs in the last 12 months had a hospital admission for a condition that could have been managed in the community



Projection for NEL (65 and over) is to increase from average of 58,298 to 113,801 per financial year over the next 5 year

Proactive Care: A Case for Change

People report less favourable experiences of care conditions and don't feel they are getting the support they need

People want a focus on more personalised care, they want to be a partner in decisions about their care and be seen as a whole person and to be asked about all their needs.

People value care that is coordinated, continuity of relationships with professionals, time to talk (and be listed to) and access to community support closer to home

We need to change our approach!

The latest Chief Medical Officer Report argues for healthy ageing and proactive care for frailty as part of the Government's overall public health strategy.

Proactive Care National Guidance

Proactive care – five core components

Personalised, coordinated multi – professional tailored support and interventions for people living with complex needs

Case identification

People who would benefit using **risk stratification local knowledge and clinical validation**

Holistic assessment

Using a biopsychosocial approach **to understand a person's** health, social and self-care needs

Personalised care and support planning (PCSP)

a PCSP plan is **co-produced** with the multi-disciplinary team, the person and those important to them

Coordinated and multi professional working

Address a person's range of needs, with effective care co-ordination

Continuity of care

including agreed **needs-based** follow ups

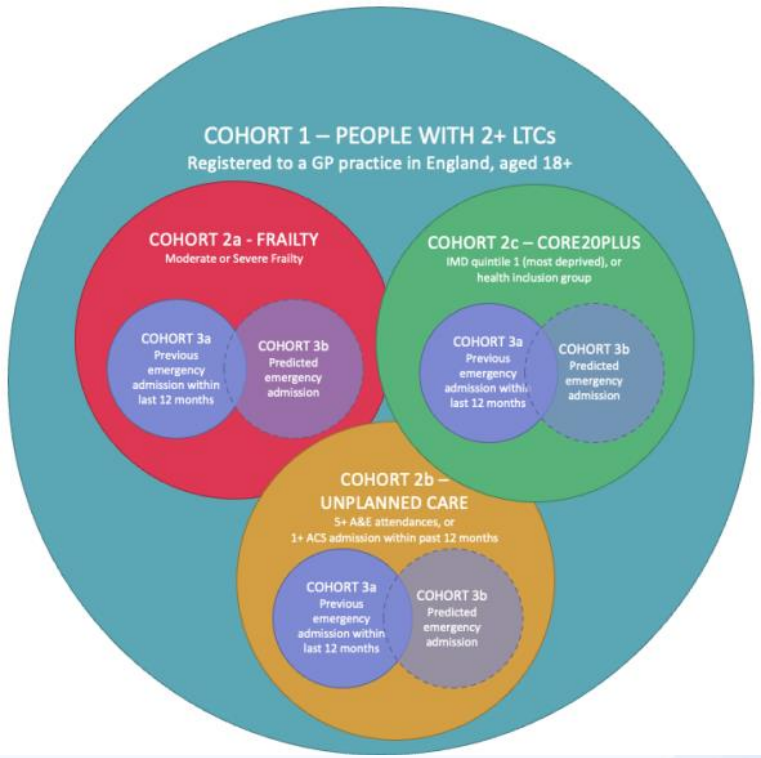
The aims of proactive care are to improve health outcomes and patient experience by:

1. Delaying the onset of health deterioration where possible
2. Maintaining independent living
3. Reducing avoidable exacerbations of ill health, thereby reducing use of unplanned care.

New Guidance Dec 2023 - Proactive care: providing care and support for people living at home with moderate or severe frailty was published by NHSE in December 2023.

Proactive Care – shift to frailty..

Anticipatory Care



Proactive Care

Focus is on people living at home with **moderate or severe frailty**

To further prioritise this cohort, systems should analyse their **unplanned care** datasets to identify locally which patient cohorts could have been supported earlier in the community through proactive multi-professional support

New Guidance Dec 2023 - Proactive care: providing care and support for people living at home with moderate or severe frailty was published by NHSE in December 2023.

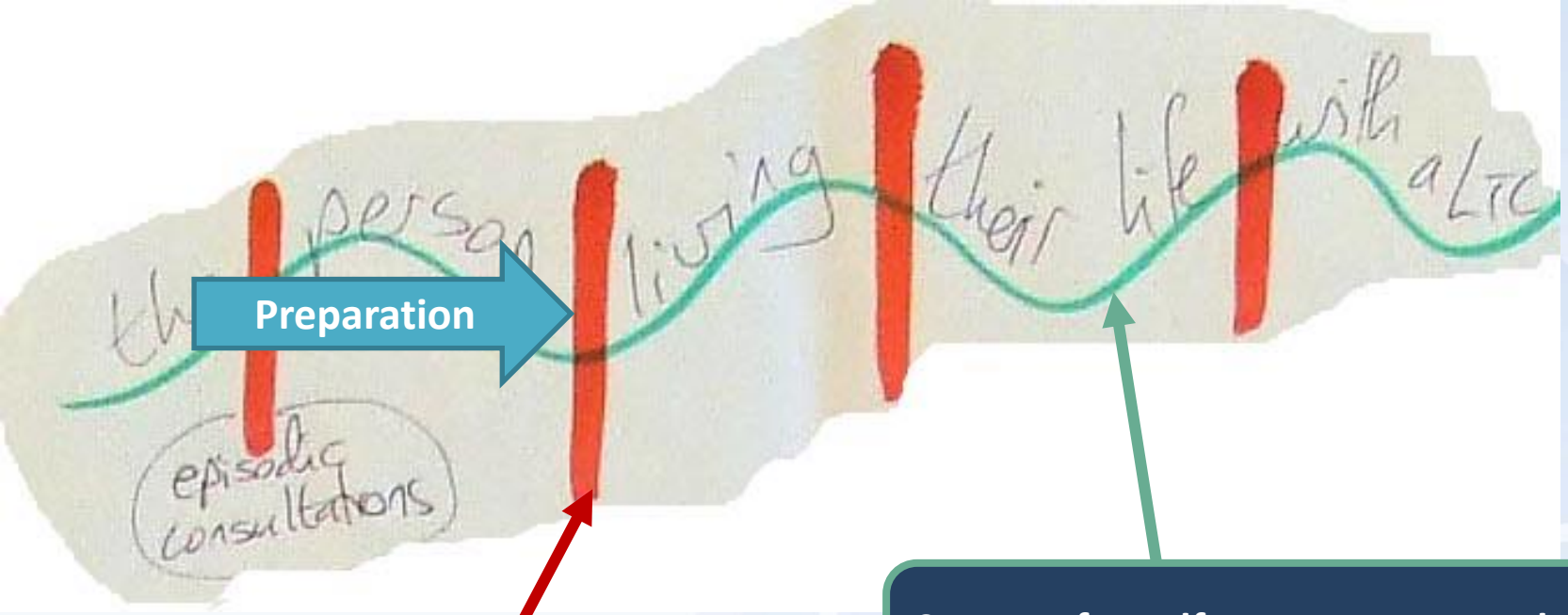
What did the programme aim to achieve?

To evaluate the feasibility of implementing a model of proactive care in primary care and community settings using the Year of Care approach to personalised care and support planning (PCSP)

At the end of this piece of work we hoped to have:

- Designed, described and delivered a way of providing personalised proactive care to people in the identified group
  - How we identify people/testing a regional tool/what does the cohort look like?
  - What PCSP pathway looks like for this group of people and how it includes anticipatory care planning
  - What it takes to make it happen (training/resources/people)
  - What we might want to measure going forward
- Capture learning as part of evaluation and have this to support regional implementation

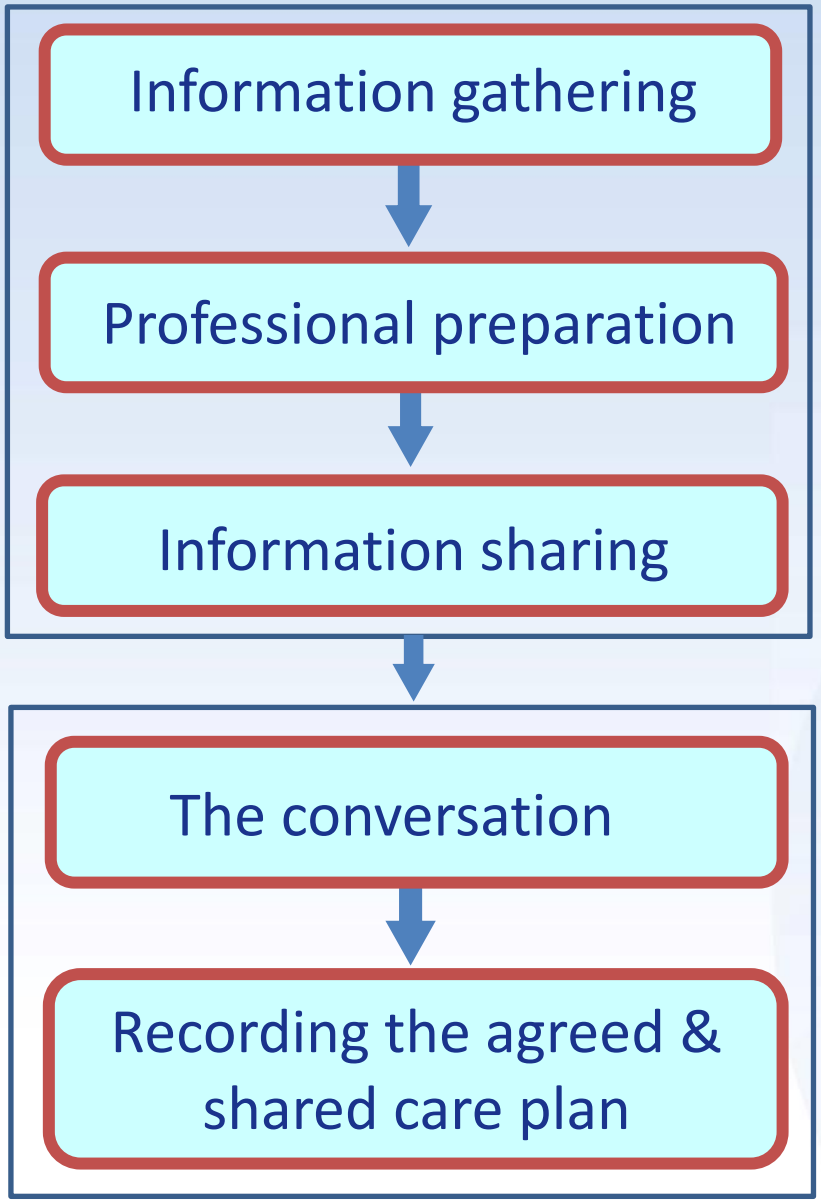
Year of Care Principles

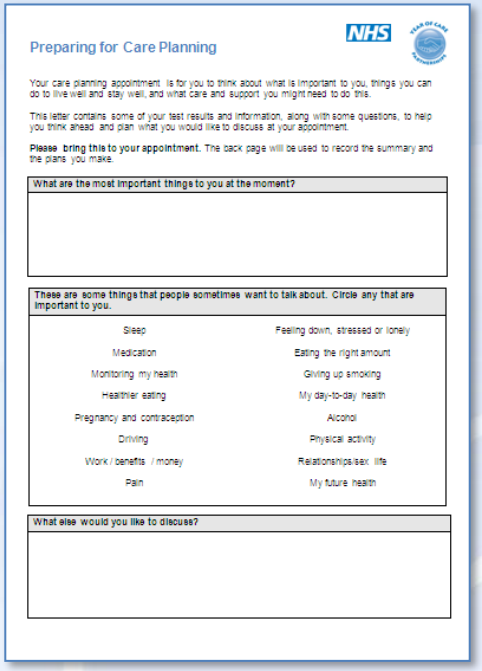


More meaningful conversations "Personalised care and support planning"

Support for self-management and to live well

PCSP: the process





NHS

Preparing for Care Planning

Your care planning appointment is for you to think about what is important to you, things you can do to live well and stay well, and what care and support you might need to do this.

This letter contains some of your test results and information, along with some questions, to help you think ahead and plan what you would like to discuss at your appointment.

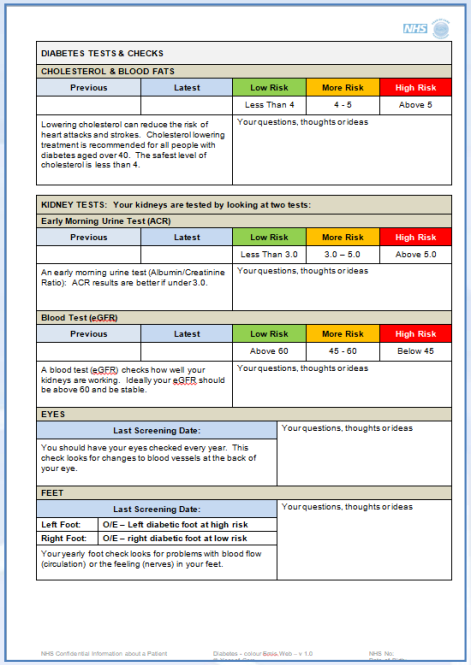
Please bring this to your appointment. The back page will be used to record the summary and the plans you make.

What are the most important things to you at the moment?

These are some things that people sometimes want to talk about. Circle any that are important to you.

Sleep	Feeling down, stressed or lonely
Medication	Eating the right amount
Monitoring my health	Giving up smoking
Healthier eating	My day-to-day health
Pregnancy and contraception	Alcohol
Driving	Physical activity
Work / benefits / money	Relationships/sex life
Pain	My future health

What else would you like to discuss?



NHS

DIABETES TESTS & CHECKS

CHOLESTEROL & BLOOD FATS

Previous	Latest	Low Risk	More Risk	High Risk
		Less Than 4	4 - 5	Above 5

Lowering cholesterol can reduce the risk of heart attacks and strokes. Cholesterol lowering treatment is recommended for all people with diabetes aged over 40. The safest level of cholesterol is less than 4.

Your questions, thoughts or ideas

KIDNEY TESTS: Your kidneys are tested by looking at two tests:

Early Morning Urine Test (ACR)

Previous	Latest	Low Risk	More Risk	High Risk
		Less Than 3.0	3.0 – 5.0	Above 5.0

An early morning urine test (Albumin/Creatinine Ratio): ACR results are better if under 3.0.

Your questions, thoughts or ideas

Blood Test (eGFR)

Previous	Latest	Low Risk	More Risk	High Risk
		Above 60	45 - 60	Below 45

A blood test (eGFR) checks how well your kidneys are working. Ideally your eGFR should be above 60 and be stable.

Your questions, thoughts or ideas

EYES

Last Screening Date:

You should have your eyes checked every year. This check looks for changes to blood vessels at the back of your eye.

Your questions, thoughts or ideas

FEET

Last Screening Date:

Left Foot:	**O/E – Left diabetic foot at high risk**
Right Foot:	**O/E – right diabetic foot at low risk**

Your yearly foot check looks for problems with blood flow (circulation) or the feeling (nerves) in your feet.

Your questions, thoughts or ideas

NHS Confidential Information about a Patient Diabetes - colour Basic Web – v 1.0 NHS No:

Carlisle Healthcare

- YOC approach to LTC well established however felt they had “lost momentum” following the pandemic
- Dedicated “Home Visiting Team” within the PCN, so focused on frailty (and LTC)
  - 1 nurse, 1 experienced care coordinator
  - working with an MDT based within the PCN- regular huddles/ meetings.
  - Overseen by G.P- clear lines of medical accountability/worked closely together to develop the service
- Some changes of staff – opportunity to refresh the approach/focus the purpose of the work

Keswick and Solway PCN

- Brand new team: integrated service between PCN and community services
- Utilised ARRS funding to develop new "Your Health Matters" team
  - 3 O.T's , 4 care coordinators
- No formal G.P/frailty nurse support
- No allocated MDT support

Why Personalised Proactive Care is Important

The aim of Personalised Proactive Care is to support people to be able to manage their health conditions and to live well for longer.

High quality proactive care should aim to:

- Notice people who are living with complexity and who are at risk of using a lot of unplanned care
- Provide earlier support; offering the right care from a small team who know the person well
- Ensure good clinical care, based on what can really make a difference and focusing on what is most important to the person
- Avoid duplication and improved coordination of care
- Work with people to understand their preferences and wishes for the future and their care needs

Identifying the Population

- Tool developed in RAIDR based on the July 2022 cohort
- Significant delays in roll out of tool relative to project (launched June 23)
- Data sharing agreements required between sites

- Some early challenges:
  - ❖ Frailty coding
  - ❖ Health inequalities data
  - ❖ Exclusions not always appropriate e.g. care homes

PCN Search Data

Carlisle Healthcare PCN

	Experiencing Health Inequalities	Frailty (Moderate or Severe)	Reliant on unplanned care
Aged over 18 with 2 or more LTCs	1787	1317	209
2 or more emergency admissions	32	36	25
Admission risk (High/Very High)	352	378	45

Keswick & Solway PCN

	Experiencing Health Inequalities	Frailty (Moderate or Severe)	Reliant on unplanned care
Aged over 18 with 2 or more LTCs	467	672	192
2 or more emergency admissions	10	25	36
Admission risk (High/Very High)	168	222	47

Local Intelligence/criteria deemed important to help identify cohort

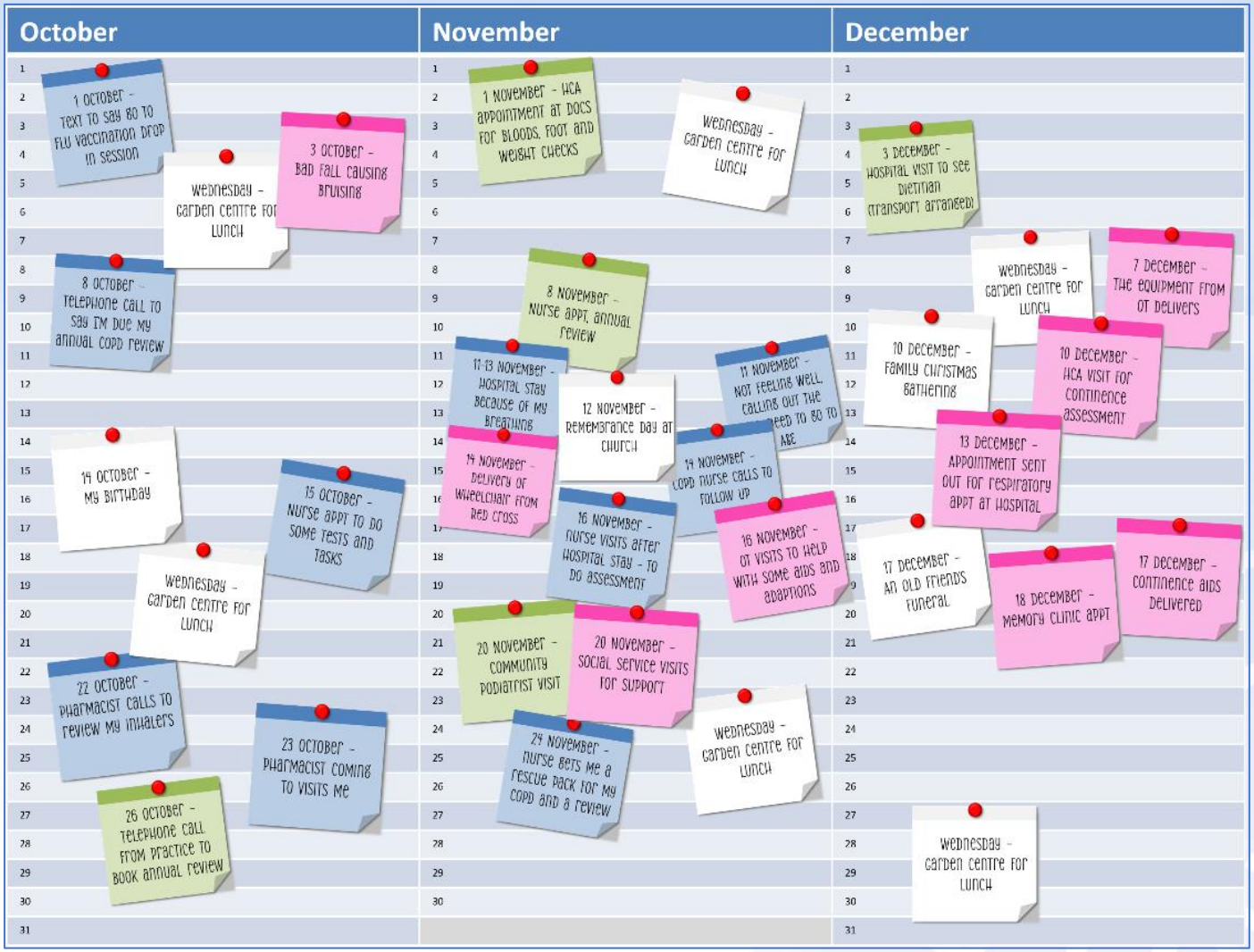
Local Criteria

- People with long term conditions
  - who were no longer able to attend the surgery for planned review (housebound and usually frail)
  - who had ceased to engage with the practice
- Those identified by MDT discussion/contact with practice staff including those reliant on unplanned care (admissions/A@E/practice)
- Hospital discharges (triaged for appropriateness)
- Moderately or severely frail (clinically validated)
- People aged over 80 who were not known to practice (proactive contact as an offer)
- Care homes - managed by a separate team, working in an overlapping role

Eric

- Eric is 84 and lives alone in sheltered housing.
- He has mild dementia, high blood pressure, type 2 diabetes, COPD and has been hospitalised 5 times in past year. He suffers from back pain and has had 3 falls in the last 2 months.
- He is widowed but has a supportive friend (Julia) who visits regularly; his daughter also lives nearby.
- Eric is still largely independent but is finding his memory is becoming more of a problem; he does not always take his medications correctly and is finding functional tasks more difficult.

Eric



Eric has (over a 3 month period):

- 24 separate contacts
- 13 assessments
- 20 different professionals
- Several referrals made to other services

Eric's concerns

- You're not sure what's happening, you're a bit bewildered but remain grateful for all the help you get
- You feel that nobody explains who they are and ask you the same questions over again
- You are not sure what is going on with your overall health and you can't remember all the information you're given
- You are worried about your memory and what might happen in the future, you want to be independent are very concerned about going into a care home
- You cannot remember at what stage you were meant to use the rescue medication for your breathing
- You haven't been sleeping well and are not sure what all your tablets are for
- You wish you could get out more and speak to your family more often
- Having falls has affected your confidence – you are very nervous and feel reluctant to go out and about now

The next 12 months without proactive care…

Diabetes

- No longer attending screening
- Difficulty managing medications
- High blood glucose levels
- Recurrent UTI's/nocturia
- Associated delirium

COPD

- Regular community reviews
- Finds it difficult to remember how to use rescue pack- exacerbations lead to hospital admissions
- Muscle loss impacts on breathlessness

Other

- Reduced confidence - no longer goes out; spending more time in his chair
- Deteriorating memory
- Increased pain
- Not managing medication well
- High number of falls, low mood

- **Functional decline**
- **Hospital admissions**
- **More people involved**
- **Carer burden**
- **Psychological impact**

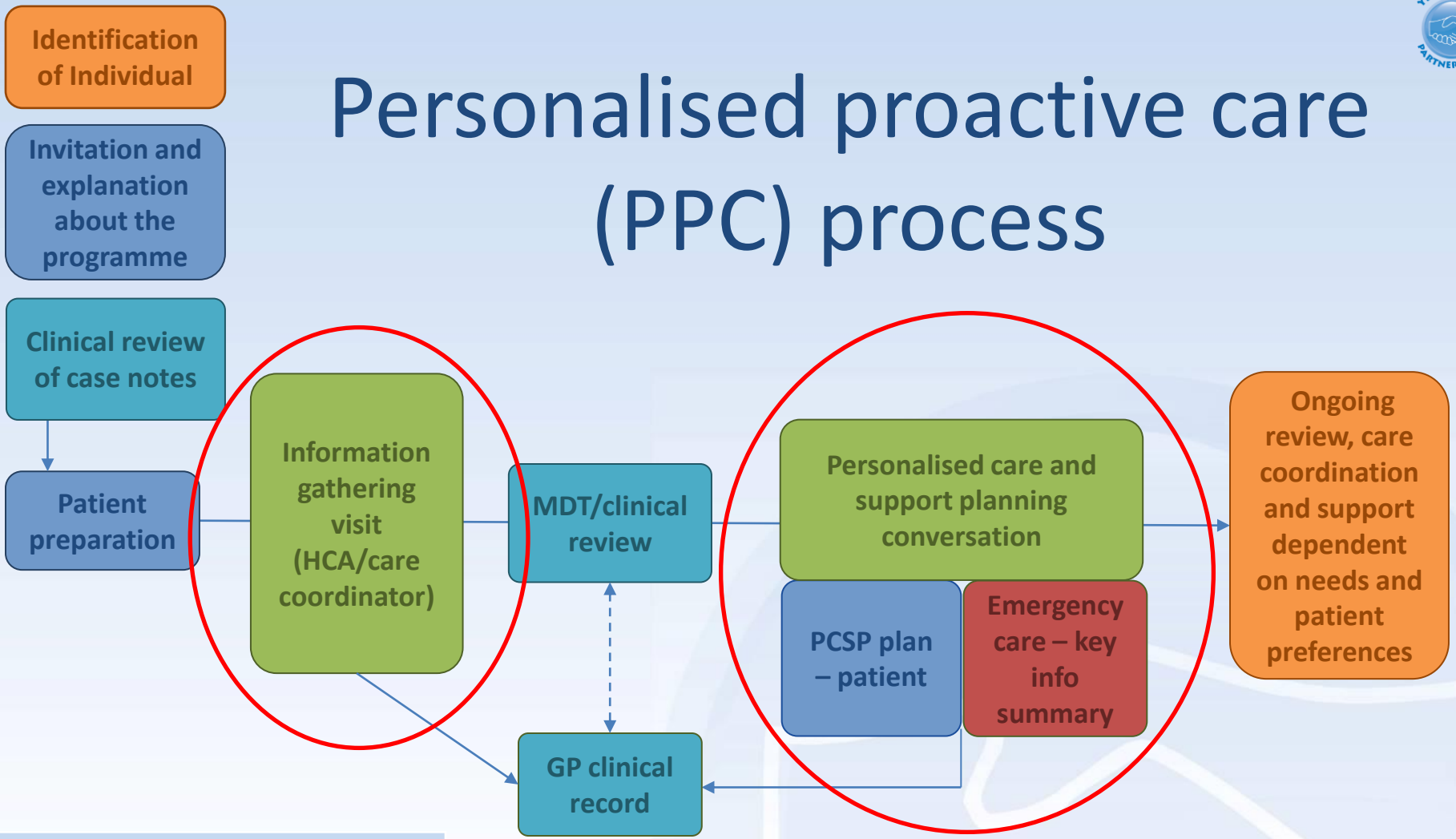
Principles for Proactive Care

- Proactive, preventative
- Coordinated and ongoing
- Personalised and individual – focused on what matters and what will make a difference
- Assessments separated from conversation
- Meaningful conversations with prepared patients
- Holistic – not just the medical elements (clinical, social, spiritual and psychological wellbeing)
- Context- recognising other members of households and community support
- Supporting people to live and die well as well as self-management

And what to avoid:

- Just ticking a box
- Reactive care based on episodes of care provision
- Multiple assessments, visits and professionals
- Duplication
- MDT making decisions for patients
- Taking over, creating dependency

Personalised proactive care (PPC) process



Key	
Orange	Prior to and post PACP
Dark blue	Documentation for patient
Green	Face to face appointments
Turquoise	Clinical work and records

Invitation and explanation about the programme

(clear and consistent narrative about the approach)
Phone call from care coordinator backed up with letters/texts/fliers/website info
Also consent to take part

Purpose:

- Help individuals understand the support offer and how it might help or be of benefit to them
- Help individuals understand what would happen and how the PCSP planning would work
- Help people see the connection of the MDT and service to their own GP practice
- Give people the opportunity to take part in or decline the service and involve carers, friends and relatives to the degree they wanted to (consent to take part)

Clinical review of case notes

Identification of gaps in tests, assessments and checks
Any professional concerns/early red flags identified

Purpose:

- Gather overview/understanding of key information about the patient (e.g., been in hospital, medications, long term conditions etc)
- Identify gaps in tests, checks and assessments (such as have they been attending their annual reviews)
- Safeguarding information

Eric

Long-term conditions

- Diabetes (type 2)
- COPD
- Dementia & frailty
- 5 hospital admissions in the last 12 months due to COPD/falls
- Moderate frailty (eFI)

Medicines

- Metformin mg – 1g twice daily
- Atorvastatin - 20mg
- Perindopril - 8mg once daily
- Frusemide - 40mg once daily
- Bisoprolol - 5mg once daily
- Amitriptyline - 40mg at night
- Salbutamol PRN (inhaler)
- Duoresp Spiromax (inhaler) - one puff twice daily
- Paracetamol 1g four times daily

Results recorded

- Pulse – 78
- O2 sats - 95%
- CAT score 18 – scores poorly on sleep and feeling breathless and slowed down by it

Results **not recorded** at all/within last 6 months

- BP
- Rockwood score
- HbA1c
- Cholesterol/lipid profile
- TFT and LFT
- Weight
- BMI
- Foot screening (diabetes)
- Retinal screening (diabetes)

Patient preparation

[Insert your practice logo here]

[Insert team Name]

Our team

We are a group of senior health care professionals who work with your usual GP and GP practice. *[Insert images of teams with forenames and surnames and role below]*

Full name Role	Full name Role	Full name Role	Full name Role

We can visit you at home for a health and well-being appointment. This will be to review your health conditions, including doing blood tests and measurements and checking that your medication works for you. You will also be given the chance to talk about any worries or concerns you have.

We will contact you to arrange a home visit. We will send you some information in advance to help you think about what is important to you and to note down any issues you would like to discuss.

We will write down a summary of the conversations we have with you. This will include making sure any preferences and plans about your future health are included in your healthcare record.

Please contact [insert number] if you have any questions about this service.

[insert address]

NHS

Preparing for Care Planning

Your care planning appointment is for you to think about what is important to you, things you can do to live well and stay well, and what care and support you might need to do this.

This letter contains some questions, to help you identify what you would like to discuss at your appointment.

Please bring this to your appointment.

What are the most important things to you at the moment?

These are some things that people sometimes want to talk about. Circle any that are important to you			
Bathing and hygiene	My current care	Looking after family, carers and pets	Support to stay at home
Finances	Independence	Getting out and about	Pain
Feeling low or anxious	Feeling scared	Feeling hopeless	Mobility
Medication	My future health	Eating and drinking	Loneliness
Keeping warm	My memory	Hearing	Smoking
Staying steady	My weight	Slowing down	My sight

What else would you like to discuss?

TBM

Information gathering visit (HCA/Care Coordinator)

- Informs the person about the process of proactive care and what happens next
- Begin to explore a person's life story and develop a trusted, meaningful relationship
- Provide opportunity for the person to express concerns and priorities (using patient preparation)
- Ensure all relevant assessments, tasks and tests associated with the combination of long-term conditions (QOF) and frailty (CGA) are completed (holistic assessment)

Eric

Strengths

- Family and friend's support
- Enjoys socialising and staying active
- Determined/ motivated

Vulnerabilities

- LTC's- COPD not well managed
- Recurrent falls
- Memory
- Lives alone

What's bothering him

- Finances
- Sleep/ continence
- Memory
- Medication/ COPD rescue pack
- Getting outdoors/ seeing his family

What's bothering you

- High risk of admission- falls and COPD
- Not wearing pendant
- Lack of heating
- Sleep
- Medication

MDT/Clinical review

Purpose:

- Share the information gathered (results and assessments) and learn about the patient issues identified by the care coordinator.
- Review the results of any tests and assessments completed.
- Initial review of medicines informed by tests/patients concerns
- Share the expertise of different professionals and identify any clinical or functional concerns and any potential options for these, ahead of the PCSP conversation.
- Identify which professional might be best placed to do the PCSP

No decisions are made for Eric as a result of the MDT meeting

Eric

Concerns

- He's not sleeping well
- He wants to be able to get out more and speak to his family
- Not sure about his tablets- worried about when to use rescue pack
- Losing his confidence going out because of falls
- Concerned about his memory and plans for the future

Medicines

- Metformin mg – 1g twice daily
- Atorvastatin - 20mg
- Perindopril - 8mg once daily
- Frusemide - 40mg once daily
- Bisoprolol - 5mg once daily
- Amitriptyline - 40mg at night
- Salbutamol PRN (inhaler)
- Duoresp Spiromax (inhaler) - one puff twice daily
- Paracetamol 1g four times daily

Long term conditions

- Diabetes (type 2)
- COPD
- Dementia & Frailty

Results

- HbA1c – 85
- Cholesterol 3.5
- TFT and LFT normal
- Weight 75 kg (some weight loss), BMI 28
- BP lying 156/92, standing (128/69)
- Pulse – 78
- Foot sensation diminished
- Not attended retinal screening
- Rockwood score – 5 (mild frailty)
- O2 sats - 95%
- CAT score 18 – scores poorly on sleep and feeling breathless and slowed down by it

Eric: medication review

Falls

- **Review Furosemide**: may help to reduce
- **Consider reducing Perindopril**
- **Review Amitriptyline-** can contribute to falls

COPD

- **Review COPD medications**, consider a triple therapy inhaler (LABA/LAMA/ICS)
- **Ensure rescue pack** in place

Sleep

- **Review Furosemide**: Check timings- ensure not being taken later in the day or evening
- Consider reducing Perindopril
- **Review Amitriptyline-** not seemingly helpful for sleep
- **Review Atorvastatin-** could try taking this in the morning as can cause sleep problems for some people
- **Review COPD medications**, consider a triple therapy inhaler

Diabetes

- **Check he is taking his Metformin**
- Consider DPP4i

Personalised care and support planning conversation

Completed by most appropriate professional
Informed by preparation and information gathering

Purpose:

- To work in collaboration with the patient to create a meaningful plan that supports an individual to live well for as long as possible, to know how to manage their long-term conditions and exacerbations and to think about their preferences in relation to future care and dying
- To explore what matters to the patient and their goals
- Introduce professional concerns generated by MDT, including medicines
- Generate actions for both the professional and the patient and document in the PCSP plan

Care Plan

For patients

- Self-management, social prescribing and prevention (day to day life and living well)
- Managing deterioration and exacerbations (Contingency and “Just in Case Medicines”)
- Future preferences about care and dying (Including the Deciding Right Documents around advanced care planning)

For professionals/emergency services

- Key information summary/what normal looks like
- Understanding patient preferences
- Advanced Care Plans (e.g.- Deciding Right documents)

Care Plan

NHS North East and North Cumbria

PERSONALISED PLAN AND EMERGENCY CARE PLAN FOR

The information included in this care plan is correct as Short date letter merged and should be used as a guide thereafter in your clinical assessment. If any significant changes develop after this date, please discuss with the relevant health professional involved in your care.

The purpose of this document is to give you the opportunity to let your doctor and health care team know about your priorities and preferences for your healthcare *and* how you would choose to be looked after in the future.

- The first section is helpful should an emergency ever happen.
- The second section records your own plans for living with your health conditions.

Please keep this document somewhere prominent in your house for use in an emergency.

IF YOU ARE UNWELL AND NEED ADVICE OR SUPPORT

If you are unwell	
During office hours GP practice	
Out of hours contact. CHoC direct	0300 30 34 365

For any other queries, advice or support (during office hours)	
Single Code Entry: Name of care coordinator	

In an emergency who would you like us to contact?

Name	Contact number
Emergency contact	
Next of Kin (if different)	
Carer details (if appropriate)	

NHS North East and North Cumbria

KEY INFORMATION SUMMARY

WHAT YOU WOULD LIKE PEOPLE TO KNOW ABOUT YOU

My family is very important. I have a daughter who lives nearby and a daughter in Wales.

I want to stay at home and be as independent as possible.

I can't always hear very well and don't always remember what people have said, write things down.

WHAT IS IMPORTANT TO YOU IN AN EMERGENCY SITUATION

Please contact my daughter Fiona Mouse. Ask her to look after the budgie.

SUMMARY FROM GP RECORD

Problems

Active

Date	Problem	Associated Text
18-Jul-2023	Dementia	
03-Sep-2020	COPD - Chronic obstructive pulmonary disease	
16-Sep-2010	Type 2 diabetes mellitus	

Past

Date	Problem	Associated Text
25-Sep-1996	History of road traffic accident	Back injury

ALLERGIES

Date	Description	Associated Text
10-Sep-2014	Allergy to penicillin	

MEDICAL SUMMARY (including what normal looks like)

Prone to exacerbations of COPD. Has type 2 diabetes managed with medicines. Manages well at home with support of daughter and friend for shopping. High risk of falls. Mobilises using a stick outside. Likely to be more fatigued in morning. Worried about memory

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WHAT TO DO IF YOUR HEALTH SUDDENLY GETS WORSE

Health issue:

COPD flare up. This may be caused by an infection or changes in the weather

What symptoms or changes should you look for?

- More out of breath
- Chesty cough
- More phlegm/stickier or different colour phlegm. Look out for phlegm that is dark, yellow or green

What actions do you take?

Speak to Jenny to help me take my rescue medicines.

More out of breath	Use **reliever inhaler/ blue inhaler more** often	Salbutamol
More out of breath even though you are using the reliever inhaler	Start **rescue pack steroids**	Prednisolone 30mg one per day for 5 days
More phlegm or change in colour (dark yellow or green)	Start **rescue pack steroids and antibiotics**	Prednisolone 30mg one per day for 5 days AND Doxycycline 200mg one tablet then the 100mg tablet for 5 days

Chestier cough

1) keep calm and use ways to **control my breathing**.
2) Breathe in through your nose, breathe in through your mouth.
3) One of these positions might help:

If I cough up blood at any time, I should contact my G.P.

If I feel very unwell, I should call 999

Contact person and number if you need this:

Joanne Smith, community nurse 07654987123

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EMERGENCY CARE PLAN

INFORMATION FOR PROFESSIONALS

Full name: Mr Eric Mouse	**NHS number:** 123 765 9876
Known as: Eric	**Date of birth:** 01-Sep-1939
Telephone numbers: Home: 01228603000 Mobile: 0776578909	**Key safe/door access code:** 666
Communication needs: None	
Language: English	**Interpreter needed:** No interpreter needed
Dependants: None	**Pets:** Budgie- Tweetie Pie
Capacity: **Impaired cognition** - Patient identifies memory concerns	
GP Practice: Maglona House, Kingstown Broadway, Kingstown Industrial Estate, Carlisle, Cumbria, CA3 0HA	

GUIDE FOR FUTURE CARE & EMERGENCY DECISIONS

DNACPR:	12-Jul-2023 **Not for cardiopulmonary resuscitation**
CPR discussed:	25-Sep-2023 **Discussion about resuscitation** 25-Sep-2023 **Discussion about resuscitation with carer** Hospital consultant Dr Lung discussed with Fiona Mouse
LPA (Health & Welfare):	25-Sep-2023 - Bronwyn Mouse - Daughter who lives in Wales
Deprivation of Liberty (DoLs) in place:	No record of DoLs in place
Advanced Decision to Refuse Treatment (ADRT):	No record of ADRT completed
Emergency Health Care Plan (EHCP):	12-Sep-2023 - Completed for COPD
Preferred place of care:	Preferred place of care - home
On palliative care register:	Not on palliative care register

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PERSONAL PLAN

What issues are important to me or what I want to work on:

25-Sep-2023 - I want to be able to stay at home and look after myself

1) Keep in contact with family and friends, would like to learn how to use video calling.

2) To get out more to see friends and be a bit steadier on my feet.

3) To try to get a better night's sleep

4) To know when I use the rescue pack for my COPD

Personal plan

1) Keep in contact with family and friends, would like to learn how to use video calling.
   - I am going to ask my friend Julia to help me set this up and sit with me whilst I do this once a week.

2) To get out more to see friends and be a bit steadier on my feet.
   - To work with the care coordinator to improve my balance when I am walking and I would like to be able to walk to the corner shop on my own again
   - Grab rail at front door
   - The care coordinator will ask the lady from Age UK to call me about transport to the local Leek Club

3) Try to get about 6 hours sleep
   - I will try the new equipment to see of this helps with my breathing and going to the toilet (back rest and bottle)
   - I will reduce the amount of whisky I put in my hot toddy every night
   - I will try to go to bed at 10pm every night and read if I am struggling to sleep
   - I am happy to meet with Age UK to discuss money and ways to keep warm

4) Understanding my medicines better
   - I am happy for the community nurse to visit to go through my rescue medications for my COPD and breathing.
   - The care coordinator will speak to my daughter and ask if she can sort a container that stores my pills so I know what to take once the doctor has checked if I need to be on different pills

What my key professional contact will organise for me:

25-Sep-2023 - Ask community nurses to visit and explain how to use COPD rescue medicines. Ask GP to review medication (falls & drop in BP, pain, diabetes control)

25-Sept-2023- O.T to arrange grab rail at front door, back rest for bed and urine bottle for use at night

Referral made to:

Recording the Conversation(s)

- EMIS template developed with PRIMIS
- Information gathering covers all aspects of CGA; LTC management
- Specific pages for the care planning elements which populated the physical patient PCSP plan

Care Plans

Active | MOUSE, Jimmy (Mr) | Preferred Name Jimbo | Born 07-Aug-1984 (39y) | Gender Male | EMIS No. 4

^Proactive Care & Support Planning Pilot

Pages: Demographic & Social; Carers & Services; Capacity & Consent; Examination; Physical & Mental Health; Functional Ability; Care Plans; Future Care Decisions; Advanced Care Plan Documents; Version & Disclaimers

Care Plans

- *Patient story (what's important to me and what I'd like people to know about me) — 03-Aug-2023
- *Professional story (summary of concerns & issues from HCP and what normal look like?) — 03-Aug-2023
- *Goals - add brief summary numbered 1,2,3 etc. — 07-Sep-2023
- Personalised care & support plan agreed / reviewed — 07-Sep-2023 Review of Pe...

Add details of agreed actions directly into the Proactive Care & Support Plan document once merged.

- *Health professional actions — 07-Sep-2023
- *Onward referrals — 07-Sep-2023
- *Care plan review date — Follow Up — 03-Aug-2024 — Existing follow up: 03-Aug-2024
- Dementia Advance Care Plan — No previous entry
- Mental Health Care Plan — No previous entry
- Emergency Health Care Plan — 03-Aug-2023

Out of Hours Notified

- Out of hours service notified — 03-Aug-2023

Future Care Decisions

Active | MOUSE, Jimmy (Mr) | Preferred Name Jimbo | Born 07-Aug-1984 (39y) | Gender Male | EMIS No. 4

^Proactive Care & Support Planning Pilot

Pages: Demographic & Social; Carers & Services; Capacity & Consent; Examination; Physical & Mental Health; Functional Ability; Care Plans; Future Care Decisions; Advanced Care Plan Documents; Version & Disclaimers

Guide For Future Care & Emergency Decisions

Summarise the conclusions from discussion with the patient about their priorities when considering their future care. This should include reference to the patient's views with regards to both emergency and non-emergency aspects.

Tip: If the maximum number of characters is reached and you want to add more text, this can be added to by editing the relevant entry in consultation once the template is closed.

- *What's important to the patient in an emergency situation — 07-Sep-2023
- Advice given to patient about if they become unwell — 07-Sep-2023

Preferred Place of Care

- Discussed with patient — 03-Aug-2023 Preferred pl...
- Discussed with family — 03-Aug-2023
- *Preferred place of care — 03-Aug-2023 Preferred pl...

Preferred Place of Death

- Discussed with patient — 03-Aug-2023 Preferred pl...
- Discussed with family — 03-Aug-2023
- *Preferred place of death — 03-Aug-2023 Preferred pl...

Anticipatory Medicines

- Anticipatory drugs prescribed - steroids — 03-Aug-2023
- Anticipatory drugs prescribed - antibiotics — 03-Aug-2023
- Palliative care drugs prescribed — 03-Aug-2023

Proactive care process for Eric

Eric is contacted by the care coordinator and is sent a preparation prompt with a time for his visit

→ The care coordinator meets with Eric, collecting relevant information and performing all assessments, tests and tasks

→ A health care professional meets with Eric and works with him to develop his own personalised care and support plan

→ Eric is put in touch with Age UK

→ A community nurse meets Eric to help him use his inhalers and rescue pack

→ An occupational therapist visits to help improve Eric's functional ability

Eric's care coordinator is his key contact to support him to navigate his health care and ensures his advanced care plan made with the specialist team is available in his health record

The Impact of Proactive Care: Eric

October	November	December
Care coordinator called and sent out a preparation prompt Care coordinator visit and does assessments, tests and tasks HCP apt to develop my own personalised care and support plan	Community nurse visits to help with inhalers and rescue pack Occupational therapy visits to help with my balance and organise home aids age UK Community transport	7 December - The equipment from OT delivers

Eric now has:

- 8 separate contacts
- 1 holistic assessment
- 4 different professionals and practical support from third sector organisations.

Training Overview

Session	Title	Key areas
A 3.5 hrs	What do we mean by proactive personalised care?	• Drivers for change and why proactive care matters (Case for change quiz) • Eric game to "set the scene" • Underlying principles and process for delivering proactive care using a Year of Care approach. • Philosophy exercise • Start to explore first 1-2 steps of the process
B 3.5 hrs	Hearing the patient's story	• Focused on preparation and the "information gathering" steps, using Eric • Preparation – role play • Building trust and rapport / skills for the conversation • Assessments vs conversations • Structure of information gathering conversation- step by step with opportunity for skills practice
C 3.5 hrs	Planning with people	• Follows remaining steps in the process • Role of the MDT • Focus on the PCSP conversation, including the structure and style and how to bring in professional concerns • Shared decision making - what it is/ what it isn't and how it links to proactive care • Goal setting and action planning • Constructing a good care plan • More than medicine for the proactive care group • Advanced care planning and how this fits into the proactive care process

Keswick & Solway ICC/PCN Your Health Matters Team

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- Proactive care team developed utilising ARRS funding in a collaboration between Primary Care Network(PCN) and Integrated Care Community (ICC)
- Structure of 3 Occupational Therapists (OT's) and 4 Care Coordinators (CCo). Admin post to be recruited.
- Home visit based delivery structure to best utilise OT core skills of considering the person, environment and occupational demands to empower patients and their families to live healthier, more satisfying lives.

Role of OT within team

- Planning and management of service.
- Development of input
- Holistic Assessment and care planning
- Complex intervention delivery
- Supervision and training of Care coordinators
- Bringing of OT skills further upstream in care system to prevent problems before they become embedded or irreversible in a manner which is built around that patient's unique situation making them meaningful and sustainable.

Role of Care Coordinator

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- Coordination of patient journeys with detailed knowledge/familiarity with the patients' health and wider life situations, values, habits and roles
- Contact point for patient
- Acting as the glue between wider ICC and other health services to smooth journeys and support patients' individual needs are met in the most holistic manner
- Delivery of interventions
- Completion of bloods and physical observations
- Support for patients to access digital health services
- Escalation where concerns apparent
- Avoiding GP Home Visits – initial basic triage and feedback of information

Collaboration PCN and ICC

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- Benefits:
  - Wider group of stakeholders
  - Access to resources
  - Double support
  - Easier problems solving with PCN and ICC,
  - Medical mgmt. from PCN
  - PPG Patient representative
- **Patient at centre of care rather than having to overcome barriers of who does what**

- Challenges:
  - Navigating multiple systems
  - Expectations of staff roles
  - Misaligning expectations of what team should be delivering
  - Regional project has meant less direct influence on templates to fine tune to local need
  - Not based in GP surgeries
  - Care Coordinator development

Feedback

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Over 4kg weight loss in 3 weeks

Bottle of whiskey reduced to 1 glass of wine

Blood sugar reduced 17 to 8.6 and 3.2kg weight loss

- Patient – feedback via feedback forms, good stories board
- Patients feel nice to know team available to contact:

"first people to really listen"

"top service"

"great to have been sorted out and I didn't have to even see a GP"

Metrics – work to be completed on this, currently a lot of qualitative data

- Outcome measurement, Measures to be completed pre and post involvement
- EQ5D (Health related QoL measure)
- Patient Specific Functional Scale (PSFS)
- Health today scale
- Rockwood score improvement
- Colleague
- Feedback on individual cases
- Review of input for each surgery

Prior knowledge
What would have helped?

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- Knowledge of IT systems barriers before – ICC staff writing into GP notes
- Restrictions of ARRS roles funding – needing to navigate restrictions of ARRS and ICC has led to recruitment of administration personnel very protracted
- Understanding of current use of care plans/long term condition reviews in our surgeries and more engagement of colleagues delivering this
- Sequence of recruitment – OT's vs CCo's
- Wide range of skills required to set up new service diverse from starting into established service
- Single professional led service – frailty nurse

Year of Care Involvement Implementation Support

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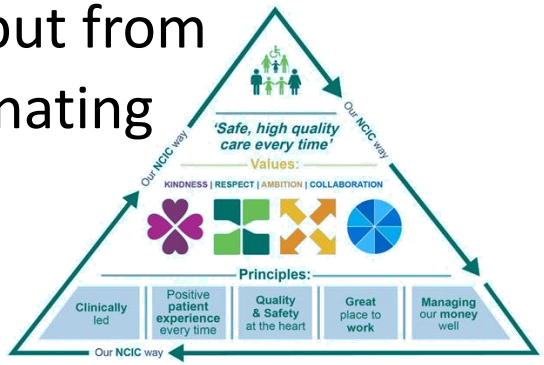
- Bringing resources and knowledge to the group related to proactive care approach
- Supporting link building across and beyond the geographic area to ensure considered service built upon good practice
- Care planning experience
- Point of reference to consider implications of our proposals on service delivery and patient care
- Kept team on task, coordinated meetings, prepared for and summarised sessions to ensure learning and reflections captured, helpful with initial set up of service
- Medical focus sometimes challenging to incorporate as OT's

The Future

North Cumbria Integrated Care NHS Foundation Trust

- Emerging service, striving to push impact into broader health systems
- Care planning embedded, live and syncing
- Patient led/written care plans
- MDT link into practices
- Links with acute/ICC therapists
- Linking in more with social prescribers based in GP surgeries – ensuring services are complementary and reducing duplication
- Diversifying roles - ?frailty nurse/Physio
- End point with patients – when significant input from community teams mean they are better coordinating



Key Learning Themes

Coherence and purpose	• Strong sense of purpose around working in a more planned, proactive way • Desire to be more person centred • Lower levels of coherence around the detail- the “who” and the “how”
Benefits to patients	• More holistic, personalised, more in control and engaged • Being seen in own home- shifted control and allowed for more holistic view • Reducing treatment burden • Self-management and knowing what to do in a crisis
Coordination of care	• Having a named contact can help reduce treatment burden and improve patient experience • Can be a function of the process rather than a single member of staff
MDT	• Viewed as critical for the delivery of proactive care • Complexity requires a range of expertise with means of access e.g. huddles, formal meetings etc • Medical accountability is key for risk management- this can be provided by the GP
Purpose of the care plan	• Should be relevant for both patients and professionals • Should include some elements for “self-help” and living well, as well as important information for professionals, such as “what does normal look like”
Training needs	• PCSP • Frailty and LTC’s, recognising deterioration, awareness of local supporting services • Coaching/ behaviour change • I.T systems, templates

Key Learning from Implementation

Coherence:

- Coherence around purpose is essential at the outset
- This should inform recruitment of staff
- LTC and frailty management should be considered as an essential component

I.T & Digital:

- The RAIDR case finding tool offers useful insights but is limited by changing criteria, useability and issues with coding
- Local intelligence is essential
- The team needed access to the GP clinical system
- Data sharing needs to be improved to reduce duplication

Key Learning from Implementation

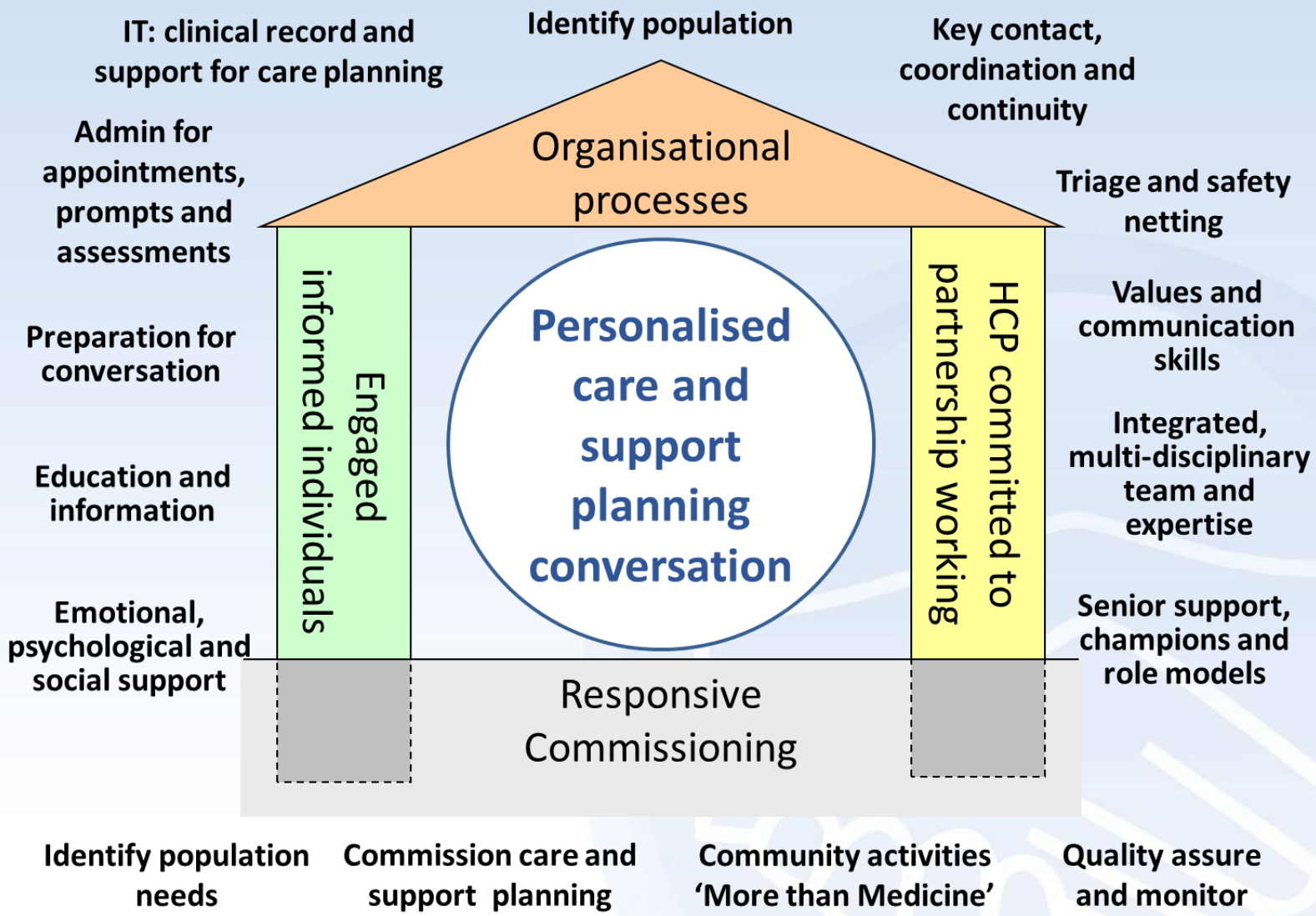
Role and Remit of the MDT:

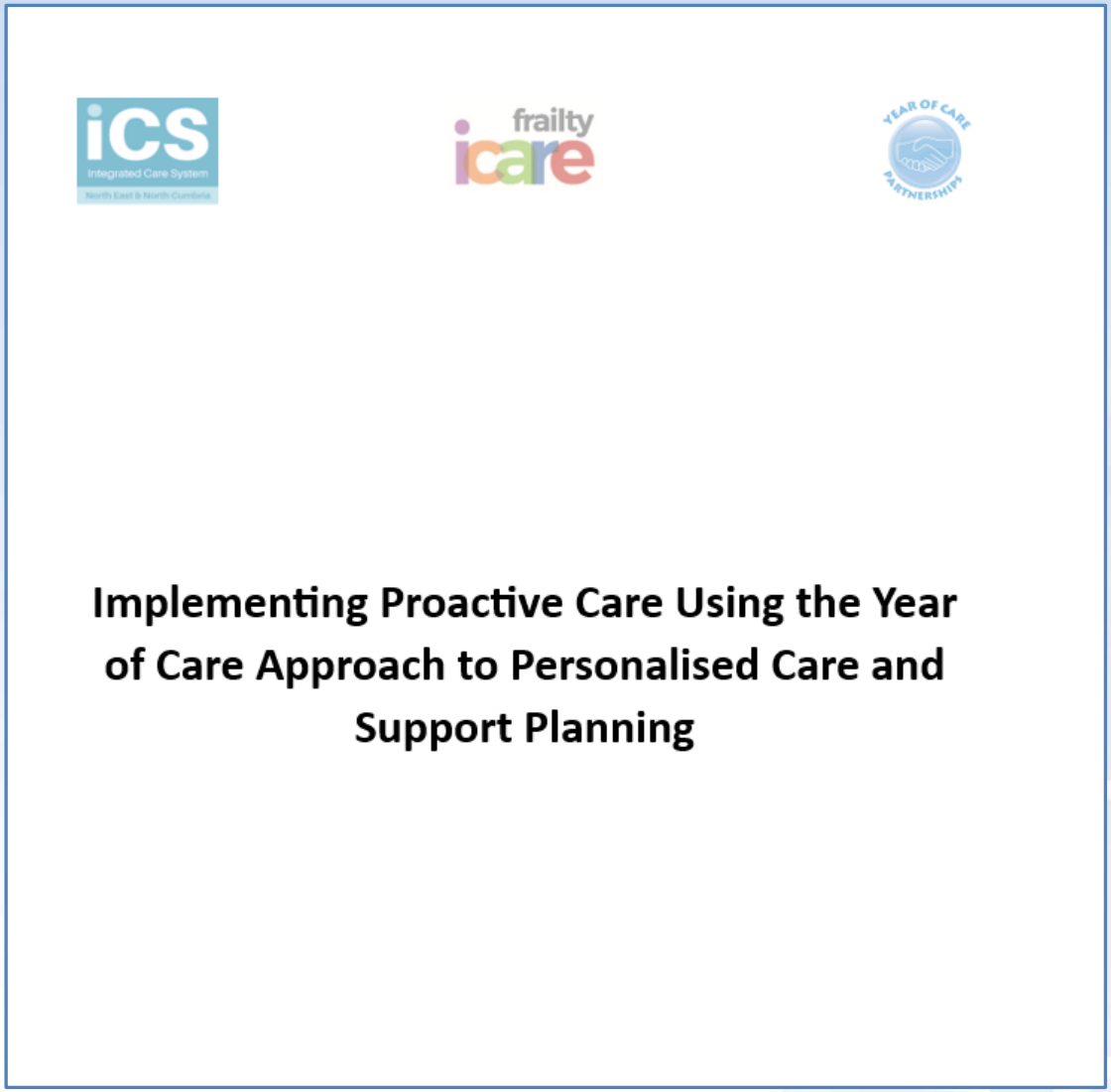
- This is new work which requires funding
- Services delivering planned and urgent care should be distinct but closely linked
- Support from an MDT is essential inc. senior medical support
- Good care coordination is a crucial component
- Teams should be integrated in primary care and linked to 3rd sector: INT's

Workforce and Training:

- Training on personalised proactive care supports successful implementation
- The team need skills around frailty and LTC's – Link with EnCOP
- Role extension is required
- The care coordinator role is complex and may benefit from dedicated training programme

Recommendations





Proactive Care Pilot Programme report V1.0 final May 2024_0.pdf (yearofcare.co.uk)

NENC Proactive Care Tool Kit Development

- Work is underway to develop a tool kit to support PCNs/INTs to implement their proactive care model.
- The Toolkit will take into consideration key findings and learning from the Proactive Care Pilot Programme undertaken in North Cumbria.
- Tool Kit sections for the tool kit being considered are shown below.

Context	Populations and people	Teams and training and technology	An individual's journey	Advice, support and care that works	Making a difference
National policy and the case for change	Identifying individuals who would benefit	Enabling the proactive care and support planning process and conversation	The proactive care and support planning process	What works for individuals, families, carers and wider support networks	Measuring 'what matters' for all

Time scale for completion – end of June 2024.

Questions ?

enquiries@yearofcare.co.uk

Consolidating Learning:

Reflection on the session & considering application to practice & what this means 'your people'

- Think about this session in relation to your own role
- How much of this was revision?
- What have you learned today ?
- How will this help you in your role ?
- Think about your EnCOP self–assessment; consider which performance indicators this session may relate to and how this can be used as part of your own development / competency achievement.

EnCOP
Enhanced Care for Older People

Reminder of linked EnCOP domains

A. Values, attitudes and Ethics
B. Understanding and supporting evidence – based practice; leadership & improving care & support for older people
C1: Partnership working and communication with older people , families and friends
C2: Interprofessional and interorganisational working, communication and collaboration
D1: Ageing Well – Understanding Frailty - Prevention, Identification and Recognition
D2: Ageing Well : Assessing, planning, implementing and evaluating care and support
D3. Ageing Well - Promoting & Supporting Independence, Autonomy & Community Connectivity for Older People
D4: Ageing Well: Promoting & supporting holistic physical health and wellbeing with older people
D5: Ageing Well: Promoting and supporting holistic psychological health and wellbeing with older people
D6: Ageing Well – Promoting & Supporting Older People with Medicines Optimisation
D7:End of life care: Older people and frailty – recognition, assessment and care planning

EnCOP
Enhanced Care for Older People

Date & Time	Session	Presenter(s)
Wednesday 17th July 2024 1.30 – 3pm	Vision and frailty	Stephanie Cairns , Clinical Lead, Low Vision Optometrist
Wednesday 21st August 2024 1.30 -3pm	Menopause and ageing well	Jacqui McBurnie , Menopause Lead , NENC ICB
Thursday 26th September 2024 1.30 – 3pm	Health Coaching: What it is ! What it is not!	Rebecca Lander
Tuesday 22nd October 2024 1.30 – 3pm	Effective assessment and management of pain with older people	Faye Travis, Adult Pain Specialist Nurse , STSFT
Tuesday 19th November 2024 1.30 – 3pm	Managing cancer symptoms with older people living with and without frailty	Dr Dan Jones, GP, NCIC
December 2024 Date To be confirmed	Ageing Well : Impacts of housing and fuel poverty	Mary Fairfield Public Health Practitioner , South Tyneside LA and Phil Hodgson Associate Professor, Northumbria University

EnCOP
Enhanced Care for Older People

Feedback about today's session and any future sessions you may like to see included in our webinar series….

All feedback welcomed; You may want to consider the following –

Was it easy to book onto the session?
Did you find the session went well in this online format ?
Was the content of the session relevant to your area of practice / job role?
Did you enjoy the session?

Thinking about future webinar's, which topics linked to older person's care would you be most interested in? Please put any suggestions in the chat.

Please comment in the chat today or feel free to email us: ghnt.encop@nhs.net

More information can be found within the Frailty icare website

www.frailtyicare.org

Our EnCOP pages are located in the workforce section

EnCOP Library of Learning & Development Resources can be found at:
EnCOP Assessment Toolkit Domains « I-Care (frailtyicare.org.uk)