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Anticipatory care: working with community services to provide enhanced care for complex high risk patients

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PCN Community Teams, West Sussex

Sussex Community
NHS Foundation Trust

Primary Care Network - community teams providing anticipatory care

Hollie Poole

Head of Primary Care Network community teams in West Sussex

Sussex Community NHS Foundation Trust

Excellent care at the heart of the community

Background

- Sussex Community NHS Foundation Trust is the main provider of NHS community health and care services across Sussex.
- We provide a wide range of medical, nursing and therapeutic care to over 9,000 people every day. We work to help people plan, manage and adapt to changes in their health, to prevent avoidable admission to hospital and to minimise hospital stay.
- We have aligned our multidisciplinary Communities of Practice teams to reflect new Primary Care Network (PCN) structures where operational and geographic constraints allow. Patients now have access to a multidisciplinary team (MDT) made up of both Primary Care staff and the multiple organisations already within the Communities of Practice teams.
- PCN community teams are extended community teams, bringing together the care resources of community and mental health services, social care services, community pharmacies, third sector organisations, and paramedics focused around a registered population.

PCN community teams – multiple organisations - co- located

Sussex Community NHS Foundation Trust

- Team Lead
- Community Nurses
- Clinical Leads
- Occupational Therapist
- Physiotherapist
- Psychological Therapists
- Case Coordinators

Sussex Partnership NHS Foundation Trust

- Senior Mental Health Practitioners

west sussex county council

- Senior Social Work Practitioners
- Social Workers
- Case Coordinators
- Housing Coordinator

West Sussex age UK

- Community Link Workers

NHS CCG

- Pharmacists

PCN community teams sit within a wider model of community-based care

They are intended to create a more coordinated service to improve patient experience and outcomes, with patients seeing the right person first time rather than undergoing multiple assessments and appointments.

Responsive Services	PCN Community Team	Specialist teams
SCFT Provide short term crisis intervention to avoid unnecessary hospital admissions, and facilitate early discharges following necessary admissions. SPFT Provide responsive care through their Assessment and Treatment and Dementia Crisis services.	Multidisciplinary teams based around and working closely with groups of general practice to: • Provide coordinated anticipatory care in the community for complex patients • Support patients to better manage their own conditions to reduce avoidable hospital admissions, unwarranted A&E attendance, and multiple GP appointments • Free up capacity, deal with demand, and reduce duplication, hand-offs and disjointed care This enables GP practices to have more personalised relationships with a wider team of professionals. Rather than seeing everyone, GPs can increasingly focus on clinically complex patients, care planning, and difficult diagnoses.	SCFT Provide specialist rapid response working with Responsive Services when a patient has an exacerbation of their condition. This supports rapid assessment and treatment, avoiding unnecessary hospital admissions, and optimising the transition home following necessary admissions, thereby reducing readmissions. SPFT • Living Well with Dementia • Mental Health Liaison Practitioners

Key elements of the PCN community teams

- Risk stratification
- Case management and anticipatory care planning for all patients with a risk score over 50% or those with complex health and social care needs
- Onward signposting for patients who do not require ongoing case management
- Monthly complex patients MDT meetings, coordinated in partnership with Primary Care and Community Services
- Community Nursing Service
- Responsive huddles

Anticipatory care

- Care is tailored to different segments of the population using our risk stratification tool, Artemis. This helps our team to offer care based on patient need and level of complexity, focusing on early intervention, living well at home, and avoiding unnecessary hospital use with specialist care in the community. Our risk tool has been refined to consider risk of admission, but also risk factors associated with frailty, end of life, and social isolation. Our teams use this analysis to maximise their impact.
- We devise an anticipatory care plan for each patient including risk identification, mitigations and contingencies to ensure patients know how to manage their condition and situation pre-crisis, and a named point of contact in a GP practice or within the wider PCN team.
- We provide pre-crisis support, based on IBIS alerts or soft intelligence, for patients whose condition has deteriorated and are heading towards a health or social crisis. We ensure that they are seen within a responsive time scale, and that appropriate services are put into place.
- Patients who have been in contact with or admitted to secondary care will receive a post-crisis review of their anticipatory care plan within 72 hours of discharge, based on system intelligence and operational procedures.

Huddles

A short meeting or telephone conference to discuss patients on the case load who are at risk of admission or who have an urgent social care need that requires action on the same day or within the next few days. Professionals can then use this information to prioritise and allocate their work based on patient need throughout the day and into the week. The facilitator will then coordinate the services as needed from different organisations, on behalf of the patients and their carers, and track outcomes accordingly.

Objectives

- Coordinate and plan care effectively
- Respond swiftly to patients' health and social care needs
- Minimise hand- offs and duplication
- Manage risk as a team and as a system

Key questions

1. What is the immediate concern for this patient?
2. What actions have been taken already?
3. What actions are required now?

Huddles

Therapists

GP

Mental Health

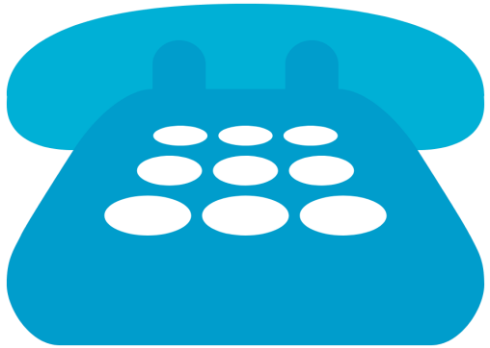
Paramedics

Falls Service

Clinical Leads

Social Workers

Community Link Workers



Community Nurses

Hospices

Community Geriatrician

PCN Coordinator

Responsive Services

Specialist Nurses

Dementia Crisis

Care Homes

Pharmacist

Integrated and anticipatory care for a complex patient

Reason for referral

- Patient risk of admission score 76.5%
- Frequent hospital admissions
- Risk of carer breakdown
- Social isolation
- High anxiety

Medical history

- 53-year-old female
- Diabetes type 1 since childhood
- Registered blind
- Sleep apnoea
- History of falls
- Peripheral oedema – lower calf
- Progressive neuropathy due to diabetes
- Previous respiratory arrest
- Recent discharge following a fractured femur
- Polypharmacy

Social history

- Lives with her mother – her main carer – in an isolated location
- Reliant on her mother for all activities of daily living
- Cannot be left alone for more than 20 minutes due to anxiety around social isolation and sleep apnoea
- Lives downstairs in property as unable to use stairs
- Socially isolated, not engaged in social activities

Integrated and anticipatory care for a complex patient

Occupational Therapist/Physiotherapist

- Functional assessment
- Wheelchair advice
- Support to improve mobility
- Mobility goal setting
- Indoor movement and outdoor mobility assistance
- Equipment provision

Psychological Therapist

- Biopsychosocial formulation
- Psycho education
- Management of anxiety
- Two weekly visits

Clinical Nurse Lead

- Wellbeing referral
- Carer assessment and support
- Community Nurse liaison
- Podiatry support
- Pressure relief
- Glucogel acquisition
- NIPY liaison

Social Worker

- Direct payments resolved
- Respite care
- Day care
- Emergency respite

Integrated and anticipatory care for a complex patient

Outcomes

- Anticipatory plan made available to South East Coast Ambulance Service
- Patient and carer taught to recognise signs and symptoms of deterioration and act accordingly
- Carer support put into place
- Increased self-care and management
- Improved confidence with mobility, regular social interaction, anxiety management
- Appropriate equipment and access to ongoing support provided
- Reduction in risk of admission score
- Life line in place

Contact details

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ANTICIPATORY CARE
Care Planning for Elderly Frail

Dr Haydn Williams: Hatters Health Network Luton
Dr Baz Barhey: Medics PCN Luton

Table 1: PCN service specifications

3. Anticipatory care

2020/21 •• Practices in PCNs to collaborate to offer more care, and more proactive care to patients at high risk of poor health outcomes.

Patient Story – Follow the Frailty Timeline

Anticipatory care:

- *Identifying what we can all see*
- *Taking a holistic view*
- *WHAT MATTERS MOST?*
- *Tools are there, its about changing the culture*

Luton Story - Collaborative Work

1. **At Home first** - 'Better together' **MDTs with care coordinators for Frail Elderly** from Cambridge community service

2. **Luton Provider Alliance – Enhanced models of care: collaborative working with community services, DME, frailty unit, rapid response, daily huddle**
   risk gain share incentivising CCS..

3. **CCG commissioning and implementing a frailty framework**
   eg falls prevention, maintaining fitness, bone health, targeted approach to mod and severe frail, EHCH.PCIS.

4. **PCH** - our clusters now **PCN's implementing primary care home**
   with a focus on frail elderly population health and proactive care planning.

A Framework for Frailty in Luton: Ambition

Older People: Over 65's

The main aim of this programme is to **promote healthy ageing, to case find frail elderly, proactively manage their care and reduce the need for older people**, those aged over 65, to be urgently admitted to hospital.

This will be achieved through system-wide agreement, development and implementation of a **Framework for Frailty in Luton;** clearly describing the interventions and services across health & social care that will **support older people with healthy ageing and to remain in their own home for as long as possible**.

And where this is no longer possible, **ensuring that the best possible care is provided for older people in residential & nursing settings.**

The framework describes the offer for each frailty cohort; fit, mild, moderate and severe.

A Framework for Frailty in Luton

	Fit	Mild	Moderate	Severe
Cohort identification	✓eFI score: 0 - 0.12 Fit ✓ Plus: Choice of Frailty Assessment Tools e.g. ➢Edmonton Frail Score: 0-7 (0-5 Not Frail, 6-7 Vulnerable) ➢Rockwood Score: 1 - 3 (1 Very Fit, 2 Well, 3 Managing well) ✓Plus: Clinical judgement	✓eFI score: 0.13 - 0.24 Mild Frailty ✓ Plus: Choice of Frailty Assessment Tools e.g. ➢Edmonton Frail Score: 8-9 (8-9 Mild Frailty) ➢Rockwood score: 4 - 5 (4 Vulnerable, 5 Mildly Frail) ✓Plus: Clinical judgement SystmOne Icon	✓eFI score: 0.25 - 0.36 Moderate Frailty ✓ Plus: Choice of Frailty Assessment Tools e.g. ➢Edmonton Frail Score: 10-11 (10-11 Moderate Frailty) ➢Rockwood score: 6 (6 Moderate Frail) ✓Plus: Clinical judgement SystmOne Icon	✓eFI score: >0.36 Sever Frailty ✓ Plus: Choice of Frailty Assessment Tools e.g. ➢Edmonton Frail Score: 12-17 (12-17 Severe Frailty) ➢Rockwood score: 7 - 9 (7 Severe Frail, 8 Very Severe Frail, 9 Terminally Ill) ✓Plus: Clinical judgement SystmOne Icon
Core Offer	Ageing Well Advice & Signposting	Supported Self-Management	MDT Care & Support Planning	MDT Case Management & End of Life Care

Frailty Process

Proactive

Identification using
Practice efi Frailty register
and **pivot table**
(care coordinator + GP)

↓

Coordinator 5 qus by phone offer
- Matron (housebound) visit
- Practice HCA assessment
- Care home GP / MDT assessment

↓

Holistic Assessment using CGA
Care plan – written and shared

↓

At home first MDT
Sharing assessment
referring to relevant service

Reactive

Deteriorating patient

↓

GP or Rapid Response

↓

- A&E attendance
- Recent Discharge

↓

Daily Huddle
Weekly Consultant MDT

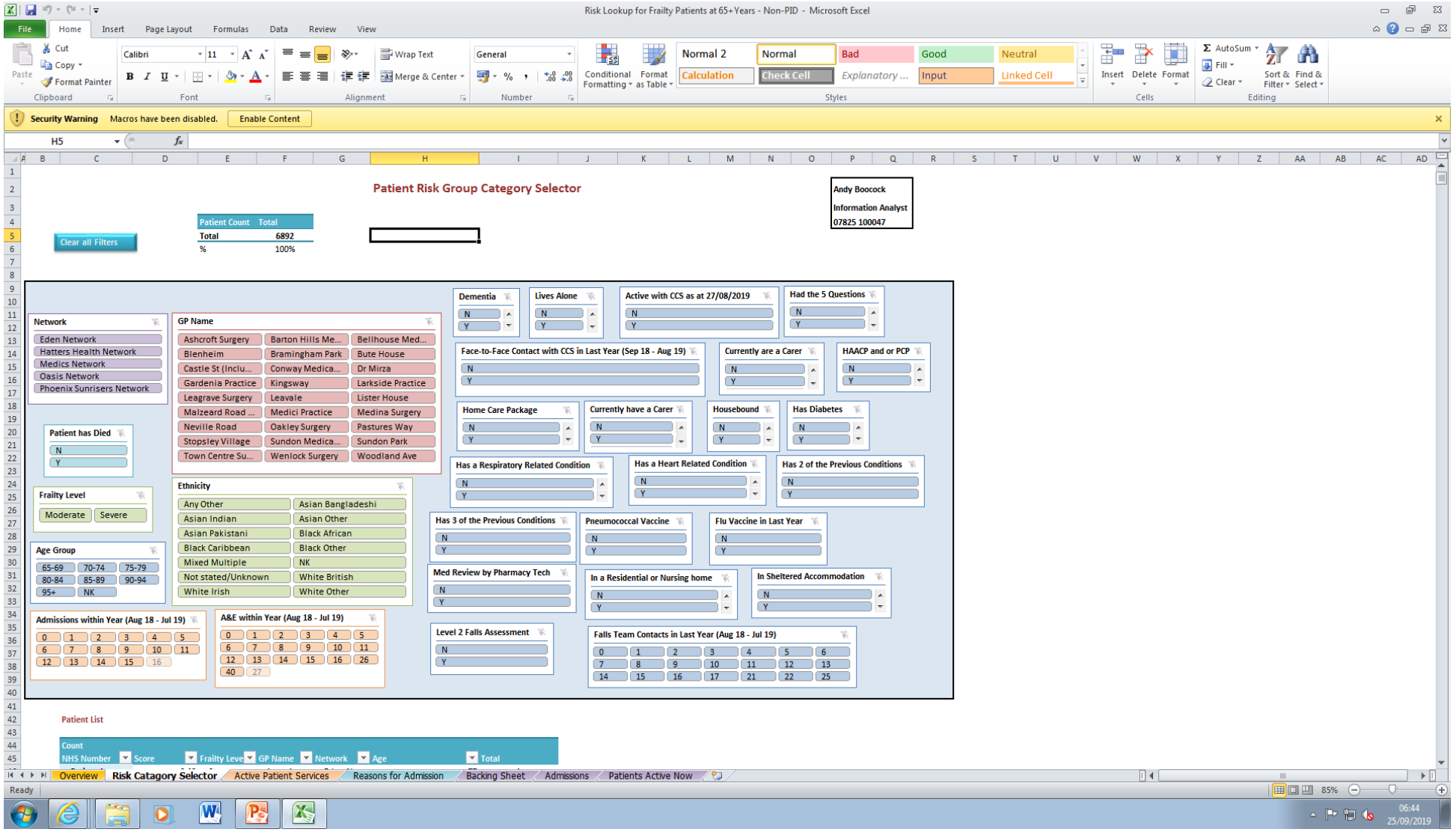
↓

Referral to appropriate member of integrated team for
Holistic Assessment using CGA
Patient monitored & stabilised
Care plan – written and shared

↓

At home first MDT
Review until stable

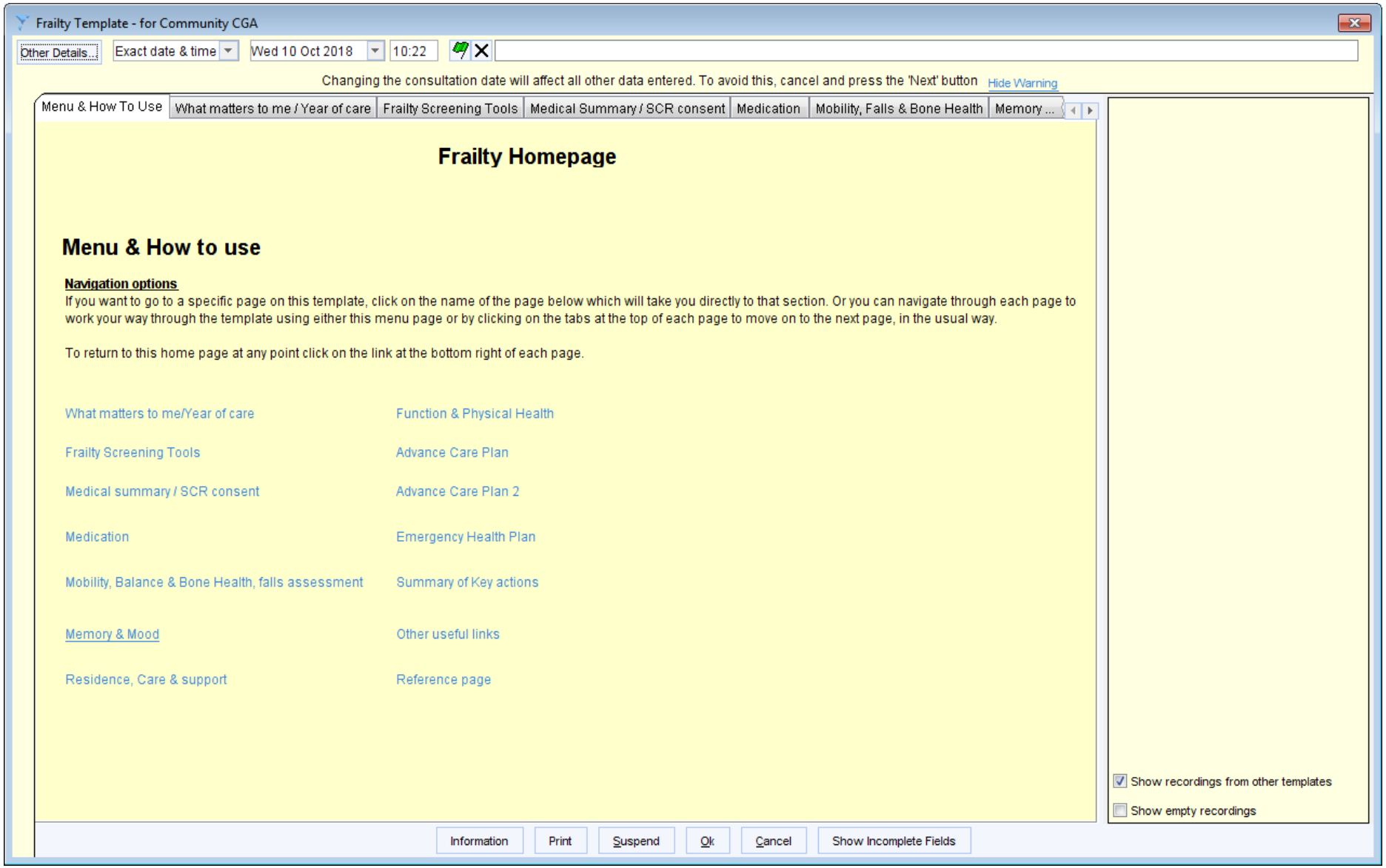
Pivot table


Risk Lookup for Frailty Patients at 65+Years - Non-PID - Microsoft Excel
Security Warning Macros have been disabled. Enable Content
Patient Risk Group Category Selector
Andy Boocock
Information Analyst
07825 100047
Clear all Filters
Patient Count Total
Total 6892
% 100%
Network
Eden Network
Hatters Health Network
Medics Network
Oasis Network
Phoenix Sunrisers Network
GP Name
Ashcroft Surgery
Barton Hills Me...
Bellhouse Med...
Blenheim
Bramingham Park
Bute House
Castle St (Inclu...
Conway Medica...
Dr Mirza
Gardenia Practice
Kingsway
Larkside Practice
Leagrave Surgery
Leavale
Lister House
Malzeard Road ...
Medici Practice
Medina Surgery
Neville Road
Oakley Surgery
Pastures Way
Stopsley Village
Sundon Medica...
Sundon Park
Town Centre Su...
Wenlock Surgery
Woodland Ave
Patient has Died
Frailty Level
Moderate
Severe
Age Group
65-69
70-74
75-79
80-84
85-89
90-94
95+
NK
Ethnicity
Any Other
Asian Bangladeshi
Asian Indian
Asian Other
Asian Pakistani
Black African
Black Caribbean
Black Other
Mixed Multiple
NK
Not stated/Unknown
White British
White Irish
White Other
Admissions within Year (Aug 18 - Jul 19)
A&E within Year (Aug 18 - Jul 19)
Dementia
Lives Alone
Active with CCS as at 27/08/2019
Had the 5 Questions
Face-to-Face Contact with CCS in Last Year (Sep 18 - Aug 19)
Currently are a Carer
HAACP and or PCP
Home Care Package
Currently have a Carer
Housebound
Has Diabetes
Has a Respiratory Related Condition
Has a Heart Related Condition
Has 2 of the Previous Conditions
Has 3 of the Previous Conditions
Pneumococcal Vaccine
Flu Vaccine in Last Year
Med Review by Pharmacy Tech
In a Residential or Nursing home
In Sheltered Accommodation
Level 2 Falls Assessment
Falls Team Contacts in Last Year (Aug 18 - Jul 19)
Patient List
Count
NHS Number
Score
Frailty Level
GP Name
Network
Age
Total
Overview
Risk Catagory Selector
Active Patient Services
Reasons for Admission
Backing Sheet
Admissions
Patients Active Now
Ready
06:44
25/09/2019

Uses of the Cohort Risk Database

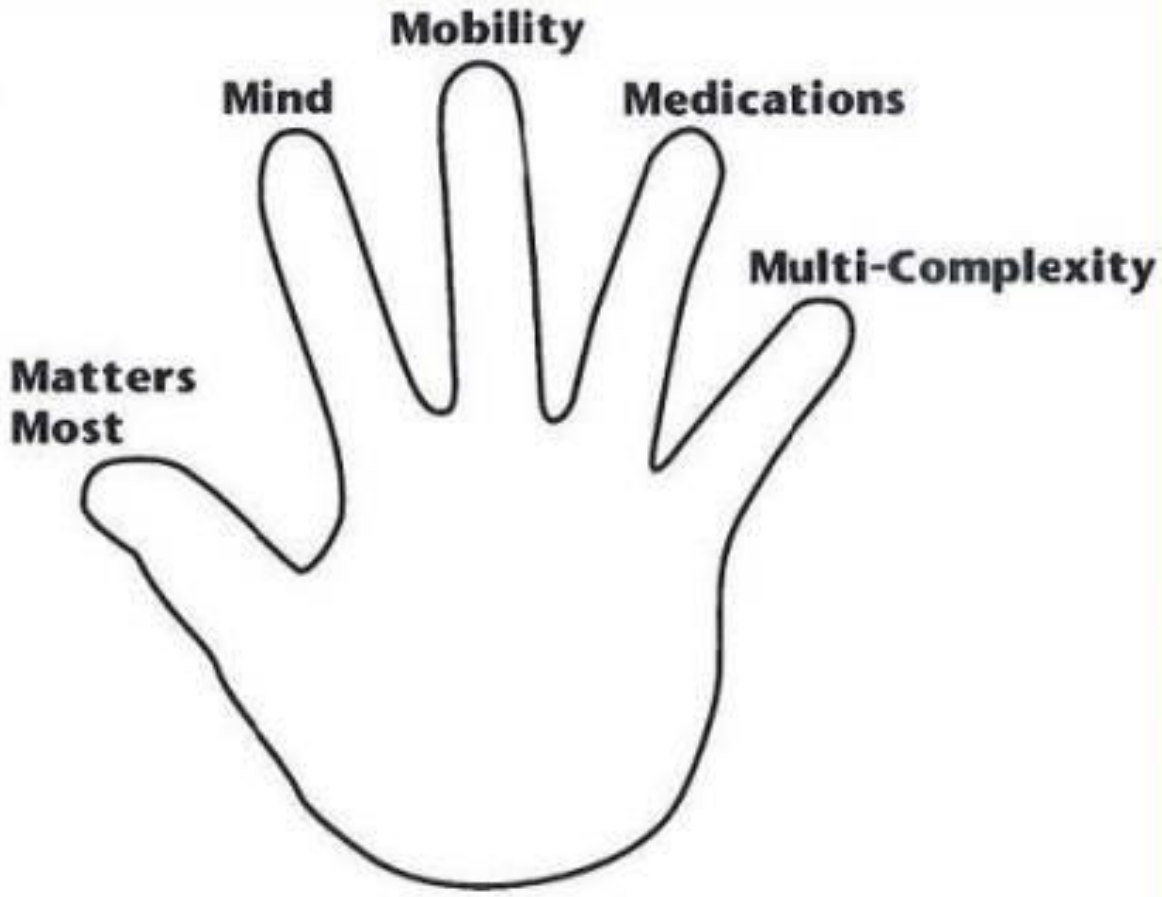
- Identified vulnerable carers
- Identified people with dementia living alone
- Using it to guide community matrons proactive approaches
- Using it to target people with respiratory issues prior to winter
- Looking for it to help with priorities for medications reviews

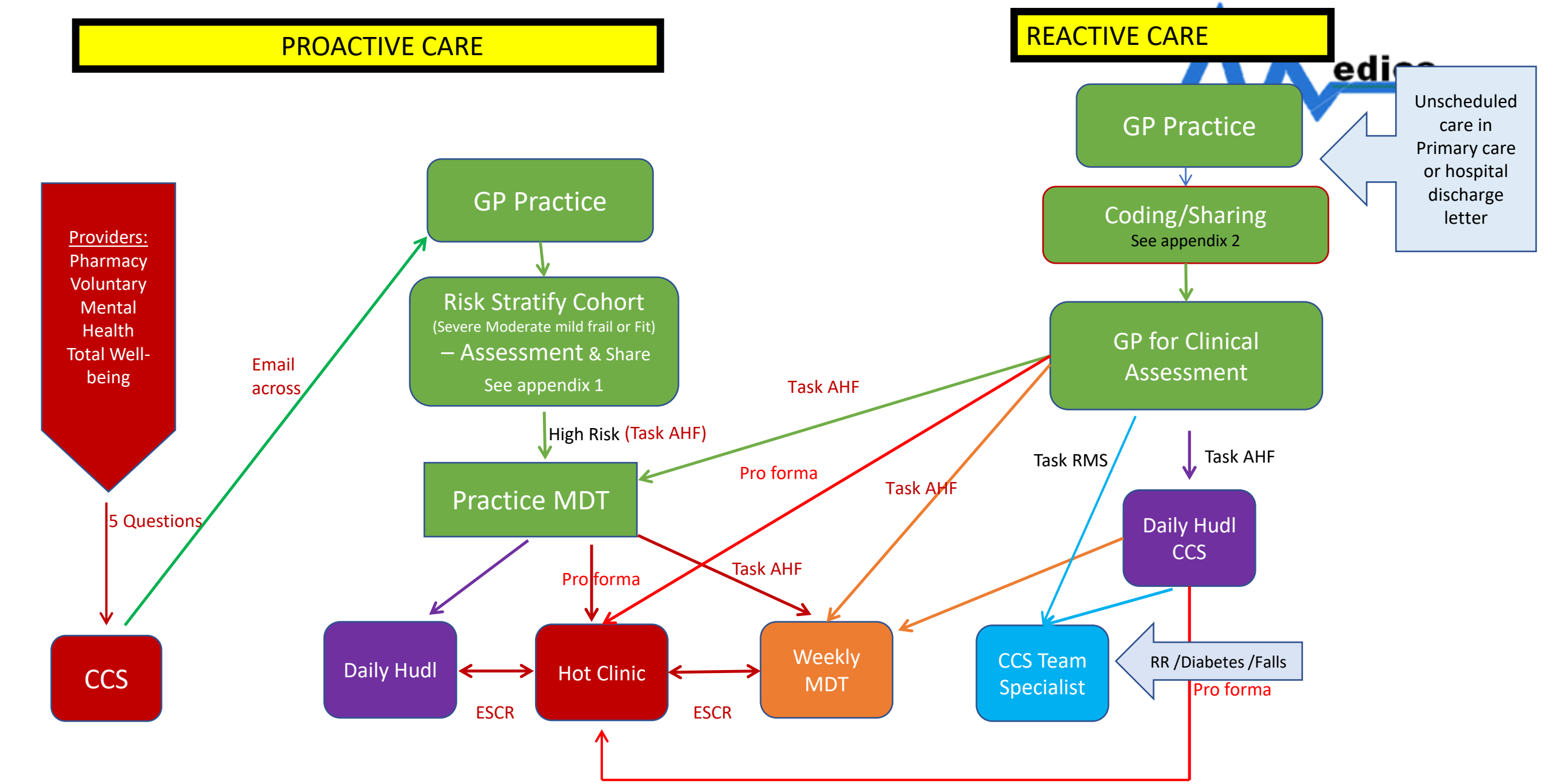
Data Recording or Data Sharing???



Focused anticipatory plan to share…….eSCR

GERIATRIC 5Ms©	
MIND	Mentation, Dementia, Delirium, Depression
MOBILITY	Impaired gait and balance, Fall injury prevention
MEDICATIONS	Polypharmacy, De-prescribing, Optimal prescribing, Adverse medication effects and medication burden
MULTI-COMPLEXITY	Multi-morbidity. Complex bio-psycho-social situations
MATTERS MOST	Each individual's own meaningful health outcome goals and care preferences.




PROACTIVE CARE
REACTIVE CARE
Providers:
Pharmacy
Voluntary
Mental
Health
Total Well-
being
5 Questions
CCS
Email
across
GP Practice
Risk Stratify Cohort
(Severe Moderate mild frail or Fit)
– Assessment & Share
See appendix 1
High Risk (Task AHF)
Practice MDT
Pro forma
Task AHF
Task AHF
Pro forma
Task AHF
Daily Hudl
Hot Clinic
Weekly
MDT
ESCR
ESCR
GP Practice
Coding/Sharing
See appendix 2
Unscheduled
care in
Primary care
or hospital
discharge
letter
GP for Clinical
Assessment
Task RMS
Task AHF
Daily Hudl
CCS
CCS Team
Specialist
RR /Diabetes /Falls
Pro forma

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