ELDERLY CARE MODEL FOR NEWCASTLE-UNDER-LYME: PROGRESS ONE YEAR ON

BE/ES Feb 2018

Our Vision

Our vision is to deliver a single, coherent and consistent approach to elderly care in Newcastle. This work involves the 20 practices of the three localities of Newcastle under Lyme, covering a population of 130,000+. Practices met initially in January 2017 to agree this approach and this document represents an update 12 months on.

As local clinicians, we know that care of the elderly can be fragmented and services do not always work together effectively. High numbers are admitted to hospital, often with long lengths of stay.

We feel that a single whole population approach will allow us to proactively identify issues and work with patients and carers to improve experience.

The underpinning work has been two-fold. As practices, we worked together to have a single approach to the new contractual requirements around frailty. We also shared local innovation that had occurred in the South of Newcastle around an 'elderly care facilitator' model to proactively assess this population and identify needs. The ECF model consider some elements of health and social care but also factors such as isolation and loneliness and links strongly back into our local communities and voluntary sector offers. A single delivery of this model will occur across our patch from April 2018.

We have also taken learning from the vanguards and are very grateful to Trish Hamilton in the New Models of Care Team and Ashley Moore and Jason Flannigan-Salmon in Fylde Coast: they have supported us to develop their 'extensivist' concept to our cohort of highest needs/most complex elderly.

To this end, we are developing a team to deliver a community-based multidimensional, multidisciplinary assessment on a cohort of highest needs elderly to allow the development of individualised, holistic plans. We have been supported by NHS Horizons in an accelerated design event to develop this concept and have now brought different elements of this team together from a range of partners and will implement our 'extensivist' approach in April 2018.

We feel that this approach will improve functional outcomes; rationalise use of the health and social care system and enable the local system to have a more effective urgent care response to individual's need. Most importantly, perhaps, will be the ability to empower patients and carers to better understand their care needs and improve their level of activation/engagement and ability to self-manage. This will improve patient satisfaction and allow them to utilise the local health and care systems more effectively.

Overall, our strategy aims to deliver a consistent, community offer to the elderly living in Newcastle-under-Lyme, meeting different levels of care need by using a stratified approach. We will achieve this by working collaboratively as a group of practices and in partnership with other providers and our communities.

Aims

To have a clearly articulated, consistent approach to the community management of elderly care across the population of Newcastle-under-Lyme, framed around the four levels of need described in the MCP care model.

To integrate this approach with other health and social care community providers including third and voluntary sector

To describe person- centred outcomes to ensure that service re-design starts with the patient. These can be described using the 'I' statements:

'I want to stay at home'
'I want one person to call and I want to know who they are'
'I want to be able to access services when I need them'
'I want to be treated as a whole person not a list of conditions'
'I want to tell my story once'
'I want to be involved in the decisions'

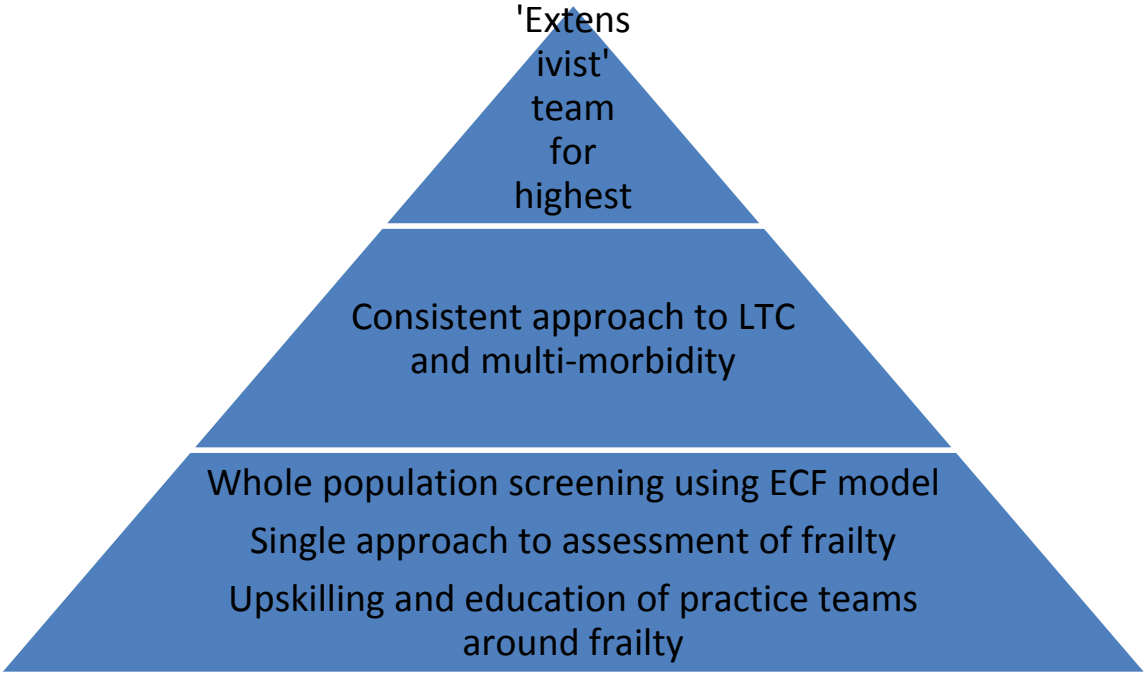
Identification of the Population

Within the three Newcastle localities there are 25,202 patients over the age of 65 with 3244 patients over the age of 85 (January 2017). There are many ways of risk stratifying this group however the CCGs favoured tool is Aristotle. This stratifies patients with respect to their use of acute and non-acute services as well as their co-morbidities. For clarity, the GP contract work on frailty considers the population aged 65 and over and our work streams will consider patients aged 75 and above.

Patients can be divided into high (>80%), medium (30-80%) and low risk (<30%). The three tiers can be equated with the suggested interventions that are being planned:

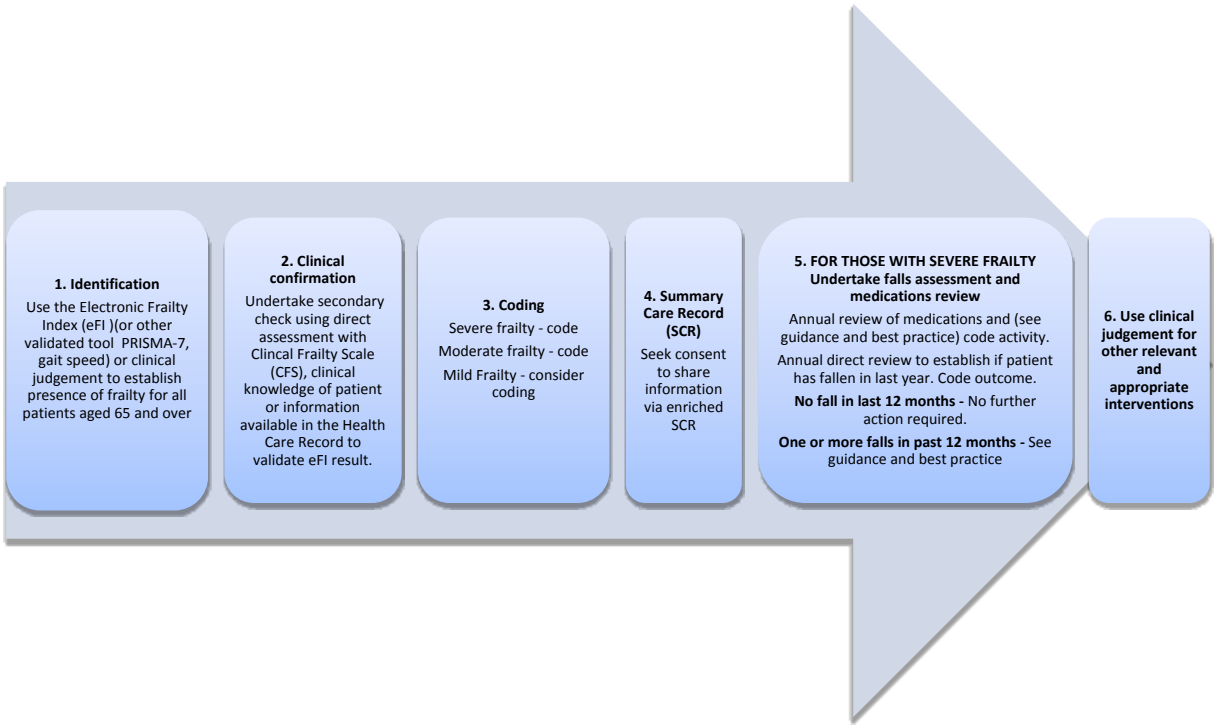
- Highest risk will be offered an extensivist intervention if appropriate (highest needs in the MCP model with some elements of urgent care needs)

- Most of the medium risk and low risk would receive the ECF and practice based intervention (whole population and ongoing care needs of the MCP model)


'Extens
ivist'
team
for
highest
Consistent approach to LTC
and multi-morbidity
Whole population screening using ECF model
Single approach to assessment of frailty
Upskilling and education of practice teams
around frailty

Frailty

As part of the new GP contract changes from April 2017, a six step process for the coding of frailty was introduced:



Over the last 12 months:

- All practices have used the eFI frailty tool to calculate the level of frailty within the group. This showed that there were significantly higher levels of frailty than expected. Further work was carried out with Dawn Moody as national lead for frailty. The guidance for frailty was amended to ensure that a clinical sense check was made rather than the eFI being the sole tool used to code frailty

- We have developed a common and consistent approach to the process of coding (see appendix 1)

- We have developed a template to help code and manage patients in line with the contract (see appendix 1)

- Secured funding from the CCG to undertake an educational event in April 2018 to support the work.

Over the next 12 months our aims are:

- Continue to use the template to code all patients over the 65 with their frailty assessment and manage accordingly

- Have monthly reports generated by the DQF to help understand how quickly the cohort are being identified

- Undertake an educational event in April 2018 to help practices understand the key concepts in frailty and how to manage this group of patients.

- Develop a single care plan for primary and secondary care based on the frailty passport developed in secondary care

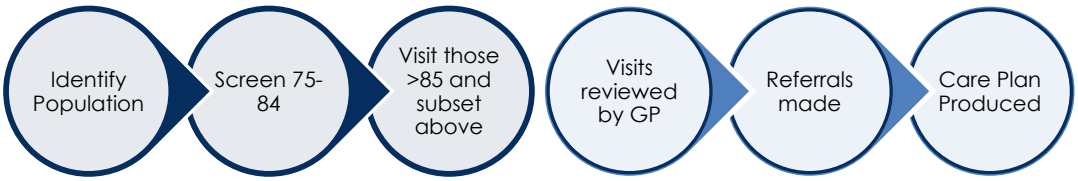
Elderly Care Facilitator (ECF) intervention

The ECF model forms the backbone of a whole population approach to elderly care.

It combines a **proactive**, early identification approach, helping us identify frailty and other issues earlier with a **care co-ordination** function that spots issues early and reacts and responds in an agile way.

ECF delivers whole population screening of patients aged 75 above and ensure that current social capital is understood and built upon. This service is strongly community and social care based.

There are six main steps:



The information will be documented on the GP IT system which will help to support the frailty work. There will be weekly GP and nurse time will be put in place to:

- Review patients to discuss needs and actions identified and ensure appropriate interventions and referrals, which may be completed within the practice or involve other members of the wider Primary Health Care Team referral or voluntary services.
- Determine frequency of future reviews to the level of risk identified at the time of assessment.

18/20 practices within Newcastle are developing their ECFs or already have ECFs working within their practice. Of the two remaining practices, one practice will have the ECF service delivered by a neighbouring practice.

Over the last 12 months we have:

- Undertaken an educational event in November 2017 where all practices sent along the staff who would be undertaking the ECF role. A small group of ECFs met to develop and agenda and lead the event. Patients were also present to give a patient perspective.

- A small group have updated the ECF template and this has been shared with practices

- A WhatsApp group has been set up between the ECFs to share best practice

Over the next 12 months our aims are:

- Develop a directory of services to be a resources for the ECF and all staff on the services that patients can be signposted to in their area

- Support the initial ECF work with a further educational event in October to share best practice amongst the ECFs

- Develop a single care plan for primary and secondary care based on the frailty passport developed in secondary care

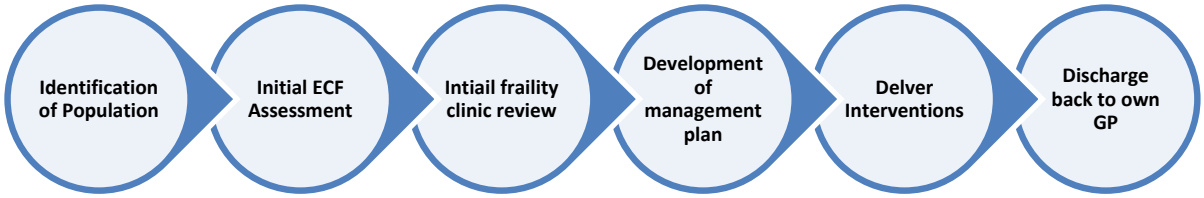
- To link with the Staffordshire Fire Service and local voluntary sector organisations to embed ECF into a wider community resilience offer, reduce duplication and enhance collaborative working across our populations

- To develop a single Newcastle application for CCG LIS 2018-19 to reflect our collegiate approach

Extensivist intervention

The most challenging element of the work has been around the extensivist model. We have brought together different elements of the health economy to both support and fund the service. Appendix 2 gives a detailed summary of the service to date.

A summary of the service is shown below :



There will be six main steps

- Identification of the patient group within primary care
- Holistic assessment of the patient in their own home by the practice-linked ECF
- Assessment of the medical and functional needs of the patient via clinicians in a community clinic- at this step patients will be identified as appropriate for management within this service or will be discharged back to primary care
- Developed of a management plan by an integrated MDT using both information sources above.
- Intervention team
- When pathway over, discharge back to primary care with appropriate care plan completed

Over the last 12 months we have:

- Held two workshops to develop and agree the concept- the latter being a nationally facilitated accelerated design event
- Reviewed the cohort at practice level and with community providers
- Liaised with the vanguard team in Fylde and presented to the CCG, Northern Alliance Board, STP and to Simon Stevens and the national team.
- Secured innovation funding for a GP fellow role to lead this service, agreement on hosting an honorary contract via SSOTP and support to advertise and recruit to this role from the federation (GPF)
- Identified other team members as resource in kind from partner organisations- this includes a coordinator, matron, therapist, voluntary sector and CPN support
- Secured evaluation support via CSU and IT solutions supported by the GPF

Over the next 12 months our aims are:

- To appoint a GP fellow as clinical lead for the service
- To agree a community location and work with the new 'team' to start implementing the service from April 2018
- To ensure this service dovetails into primary care and works for us and our patients, to improve patient experience and outcomes whilst also helping with GP workload and retain the flexibility and agility to adapt to local needs
- To ensure that this is a true 'bottom up' service that meets local needs
- To effectively evaluate the service to determine scope for expansion

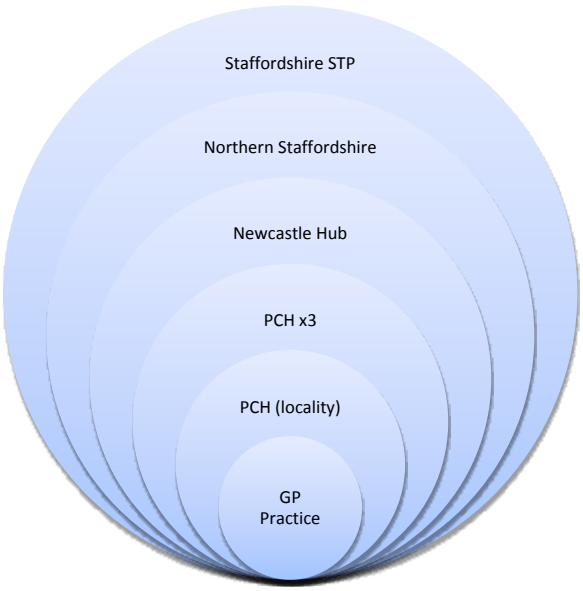
Primary Care Home

We have been accepted onto the PCH community of practice and been supported in an initial launch event in January 2018. We identified some key themes around:

- Communication
- Building trusted relationships
- Developing teams

We will work with MiDOS to facilitate the understanding of our wider teams and continue the work started by the practice managers and SSOTP to keep regular lines of communication open.

As individual PCH sites, the localities have agreed to consider areas to develop alongside the pan Newcastle Elderly Care work.



Community Hospitals

A piece of work is taking place to consider the future of the community hospitals within our health economy and there has been debate on where there will be preservation and investment in the five community hospitals and their future rules.

There is real opportunity for our local hospital, Bradwell to become a **super community hospital** and deliver a range of functions including health promotion, social prescribing, tier 3 clinics, phlebotomy etc. There is potential for it to become our GP extended access hub to cover weekends and bank holidays.

This model could have genuine **GP managed step-up beds** supported by physio and occupational therapy, which would link back into our Newcastle Elderly Care work. There is also potential to become one of 2 proposed **dementia centres of excellence** which links strongly with our previous innovation around community dementia services, the higher than average diagnostic rates within Newcastle and into our wider agenda around elderly care.

For this vision to come to fruition, it will need significant push and support from Newcastle practices.

Closing Comments

The last 12 months has been an exciting and frustrating time for Newcastle practices. We have managed to bring together a group of practices on a regular basis around a single area of working. Practices are meeting and sharing ideas.

The work underpinning this been met with enthusiasm from the provider arm but there has been a lack of clear structure and resource to allow us to deliver change. Towards the end of 2017 funding was finally released for the GP fellow aspect of the work and the educational event however the process was lengthy and disjointed.

A single admission of a frail elderly patient can lead to significant costs to the health economy and significant distress to the patient and their family. If a coherent approach described here can be supported with funding from the CCG significant costs can be saved for the CCG but more importantly a better service for our elderly population achieved.

Appendix 1: Frailty Identification and Assessment

1. Identification: eFI tool

- Clinician review of the list generated by the DQFs on the system /EMIS prompt
- Directly code a proportion of the moderately and severely frail cohort based on local knowledge. Add as a new problem, active indefinitely.

2. Clinical Correlation

If further assessment is needed to confirm frailty carry out when patient well using most appropriate tool:

- Assess the patient using the PRISMA-7 tool

1] Are you more than 85 years?
2] Male?
3] In general do you have any health problems that require you to limit your activities
4] Do you need someone to help you on a regular basis?
5] In general do you have any health problems that require you to stay at home?
6] In case of need can you count on someone close to you?
7] Do you regularly use a stick, walker or wheelchair to get about?
PRISMA-7: If score >3 consider frailty

- Assess gait speed: ***taking more than 5 seconds to cover 4 meters is a positive test***
- TUGT (timed up-and-go test): ***taking more than 10 seconds to get up, walk 3 metres, turn around and then sit down again is a positive test***
- Code results of these assessments
- ***Any mobility assessment will be affected by co-morbidities e.g. OA hip***

3. Coding Degree of Frailty

- Use the pictorial clinical frailty scale to assess ***degree*** of frailty –see overleaf
- Code those patients with moderate or severe frailty (new problem, active indefinitely)

4. Review patient with severe frailty

- Seek consent to share information via enriched care record
- Use embedded frailty template to code
  - Medication Review
  - Falls Review
- Further assessment and referral dependent on above

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Appendix 2: The Extensivist Approach

Newcastle has high numbers of A+ E attendances and non-elective admissions (NEL) in the population aged 75 and above and many have prolonged length of stay. We know that this causes deconditioning in patients with potentially poor outcomes compared to care in the community. In addition, we know that many of these patients have multi-morbidity and frailty and can be seen by a range of professionals without a single co-ordinated plan. This means that patients and their carers' are often unclear about their health and care needs and options on who to contact during a period of deterioration.

As a local health economy, admissions and long length of stay have a negative impact both economically and on flow in the acute care settings. Poor flow results in acute portals becoming 'blocked' which further drives A+E attendances and costs.

We also know that patient and carer experience can be suboptimal and that this cohort of patients utilise large amounts of primary care and community resource.

Intervention: applying an 'extensivist' type approach
Performing a community-based multidimensional, interdisciplinary assessment on a cohort of highest needs elderly will allow the planning and implementation of individualised, holistic plans for treatment, intervention, support and follow up. There is evidence that such an approach will improve functional outcomes and has the potential to avoid significant changes in life such as admission to a care home or hospitalisation.

There is also potential to rationalise current utilisation of the health and social care system, manage multi morbidly and polypharmacy and enable the local system to have a more effective urgent care response to individual's needs, including reducing bed days in the case of required admission. Empowering patients and carers to better understand their care needs is likely to improve their level of activation/engagement and their ability to self-manage- this is turn improves patient satisfaction and allows them to utilise the local health and care systems more effectively.

Cohort
Patients age 75 and over with an Aristotle risk score of 80% and above, excluding care home patients and End of Life care. This cohort is likely to also have multi morbidity and frailty. The proposal is to use this cohort initially but adapt this based on initial assessment feedback.

Pathway

a. Extensivist co-ordinator runs Aristotle risk stratification tool and identifies patients. This is cross- referenced with the D2A and High-Intensity User teams. If there is duplication, a decision is made about which service is best placed to meet patient needs. Of the remaining list, patients with increasing scores are sent to the practices for review and exclusion of patients who are unsuitable. This is then shared back with the co-ordinator. This occurs once a quarter.

b. Co-ordinator links with nominated ECF in practice to arrange initial home assessment: this mirrors the agreed practice ECF holistic assessment and would be completed using the agreed EMIS template. The ECF describes the extensivist service to the patient/carer and gains consent: this is then communicated back to the co-ordinator. If consent is not gained, the patient leaves the pathway at this point.

c. Co-ordinator arranges an appointment at the extensivist clinic- this is community based in Newcastle and uses EMIS web as the IT system of choice. Co-ordinator also contacts UHNM to gain information about existing and future planned activity.

d. Patient and carer attend the community assessment and have a functional assessment (physio/nurse/OT skills) plus a medical assessment (GP fellow) with access to both EMIS web, docman and information about current health service utilisation. These assessments would include an understanding of patient and carer ideas, concerns and expectations and their current level of activation.

e. Multi-disciplinary team discussion to understand a multidimensional assessment (physical, MH, functional level, social support network, living environment, level of participation and individual concerns, compensatory mechanism and resourcefulness that the individual uses). This will allow the team to:
    - understand necessary interventions and implement these
    - rationalise polypharmacy
    - rationalise out-patient activity- includes professional conversation with clinical colleagues
    - develop agreed care plan/ frailty passport and share- ability to enter/ share to existing EMIS record plus share with secondary care.
    - ensure patient/ carer understanding of health and social care needs and advance plans for deterioration/ acute intervention
    - consider advanced care planning
    - consider links with community resources/ voluntary sector to maximise activation

f. Patient will be reviewed in the community clinic and either:
    - Have all needs managed adequately and have no additional need from the service > discharge with care plan.
    - Require interventions- this would then be managed by the most appropriate practitioner from within the team.

Requirements for delivery

a. Engagement from practices and community providers. Support from commissioners and UHNM. Public and patient engagement.

b. **Location:** community based setting in Newcastle area with good accessibility and ability to use GP IT systems. It is proposed to use a GP premises for this pilot period.

c. **IT solution**: North Staffs GP Federation Hub system is used as the Clinical Record base for the Extensivist Service. This will need a new DSA and EMIS activation. Alison Yates, via GP

federation is supporting this work. For the 2 system one practices, a GP record viewer will be needed.

d. Team members:

Existing resources will be provided:

- GP practice – Elderly Care Facilitator
- SSOTP – Therapists/ Nurse with training in frailty/ social work, Co-ordinator (part time, band 3). Also matron to act as link with community nursing teams.
- NSCHT – Mental Health Worker/ Community Psychiatric Nurse- commitment gained but some issues with existing staffing numbers due to need to support care home service.
- UHNM – Geriatrician mentorship and support to GP fellow.
- Voluntary sector (Staffordshire Housing and VAST)

All will be utilised as 'resource in kind' with agreement via Alliance Board.

New resources:

- GP fellow (1 day per week) – SSOTP will hold an honorary contract for this role.

e. Wrap-around and links with other parts of the acute care system: this scheme will only deliver during specific hours and therefore needs to strongly link with other parts of the system to allow a more effective urgent care response. This may be via the realigned community nursing teams that now include matrons and links with Home First or D2A resource.

f. Governance

Clinical responsibility will remain with the registered practice during the time in the service, though the patient/carer would be given the extensivist co-ordinator contact details as a first point of contact. It is envisaged that the practice ECF would be a key contact point in the practice itself.