#healthyplym

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HEALTH AND WELLBEING BOARD - SUPPLEMENT

Thursday 3 March 2022
10.00 am
Warspite Room, Council House

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Tracey Lee
Chief Executive

Health and Wellbeing Board

Health and Wellbeing Board

Thursday 27 January 2022

PRESENT:

Councillor Nicholson, in the Chair.
Councillor Dr Mahony, Vice Chair.
Councillors Dr Buchan and James (substituting for Councillor Downie) and Mrs Aspinall (vice chair of scrutiny).

Apologies for absence: Councillor Downie, Ruth Harrell, Ann James and Michelle Thomas.

Also in attendance: Alison Botham (Director of Childrens' Services) – joined the meeting virtually, Rob Nelder (consultant Public Health), Craig McArdle (Director for People), Tony Gravett MBE (Healthwatch), Dr Sarah Wollaston (Chair, ICS Devon) Jo Turl (Devon Clinical Commissioning Group), Mandy Seymour (Livewell South West), Jo Colin (Active Devon) Kevin Baber and Sue Wilkins, Plymouth Hospitals NHS Trust (UHP) and **Louise Higgins (Livewell SW)**

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

66. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

67. **Chairs urgent business**

There were no items of Chair's urgent business.

68. **Minutes**

Agreed that the minutes of 7 October 2022 were confirmed.

69. **Questions from the public**

There were no questions from members of the public.

70. **Update from Board Members**

Heathwatch

- Healthwatch Devon, alongside Healthwatch Somerset carried out a survey on the NHS 111 service provided by Devon Docs. The report will be released during February.

- As groundwork for overview and scrutiny review of mental health. An analysis of patient feedback from April 2020 has been carried out. Further work will be carried out to review the issues around access and children's' services which were identified.
- How Healthwatch integrates and works with the Integrated Care System will be a key priority for the coming months.

Rob Nelder, Consultant Public Health, Plymouth City Council

- As of the 26th of January have been a total of 59,169 Plymouth residents who have tested positive since the start of the pandemic.
- The Plymouth rate was considerably higher than the regional and national averages.
- The Omicron variant was the dominant variant and a significant number of care setting were in outbreak.
- 85% of Plymouth residents aged 12 plus have received one dose of their vaccine, 79% of received two doses, 58% of received a booster.
- Outreach vaccination clinics were taking place every day more than 100 people were attending the vaccination clinics when held.

Craig McArdle, Director of People, Plymouth City Council

- Winter pressures were being experienced in addition to Covid-19. Services were experiencing high outbreaks of COVID in care settings resulting from high prevalence rates generally.
- New care home guidance around visiting was being implemented, but infection control measures in care settings will need to be remain for the foreseeable future.
- Delayed discharges and flow through the hospital continue to be a problem.
- Campaign around recruitment was still ongoing and a second round of the Recruitment and Retention Fund was a further 1.6 million worth of investment in the sector.
- The Clinical Commissioning Group have provided additional funding for the voluntary and community sector during winter which has enabled additional befriending services, carers services and new carers groups.
- Adult social care reform will begin this year (2022), which will require further discussions at the Board. The Care Quality Commission will be moving towards OFSTED style inspection of local authorities and adult social care functions.

Kevin Baber and Sue Wilkins, Plymouth Hospitals NHS Trust (UHP)

- Maternity services, like all services, have been hugely impacted by Covid.
- Pandemic impact on the birth rate became visible in January 2021 and saw the lowest number of births seen at UHP. The rate has gradually increased since January 2021 and has returned to normal with an increasing trajectory
- Interruptions to supply chain, continual changes to the availability of PPE, and getting used to providing care to families wearing PPE were all impacts of the pandemic felt in maternity services.

- There had been no maternal deaths as a result of Covid infection, however there have been women in labour with Covid. On an average day this was approaching half the women in labour. The red zone on labour ward demonstrated it was possible to have a red zone in any environment within the hospital and care teams were able to operate effectively in that environment.
- Visiting was probably the most complicated and tricky issue to manage throughout the pandemic. The guidance from the NHS and professional colleges differed which led to difficult conversations with colleagues on the differing approaches across the health service. Restrictions in birthing companions and visiting has impacted on patients' emotional support. It increased vulnerability of birth and the post-natal period and there had been no antenatal/post-natal groups providing emotional and practical support, and these are a lifeline for many.
- Interruptions in programs of workforce education will take many years to rebalance.
- Staff fluctuations alongside rapidly changing guidance, both local and national, had led to difficult decisions being made to balance both actual and perceived risk. There is a risk women have made choices that they wouldn't have made pre-pandemic such as birthing at home against medical advice.
- Exemplary teamwork has been seen across the organization. People have supported each other to deliver the very best for families.
- Mass vaccination programme - half a million vaccines have been administered at home park and 200,000 at the hospital site.
- During the pandemic the trust treated 2728 Covid in-patients there were sadly 358 deaths in that group.
- The burden on intensive care has decreased and that 171 patients is the highest number throughout the whole pandemic. The numbers of people waiting for treatment at Derriford now is in the region of 40,000 just over 3000 have been waiting over a year for their treatment and there are 461 patients who've now waited over two years for their treatment.

Louise Higgins (Livewell SW)

- Working through staff groups in relation to mandatory vaccination and identified 34 staff members that have not and will not have a vaccine. To ensure that we have the flexibility to move staff to the most vital service delivery areas and to support UHP with managing flow, keeping people out of the hospital and in the community as long as possible collaborative work with UHP and the voluntary sector is ongoing.
- Mental health services are busy post-christmas and not particularly because of the COVID pandemic. There has been an overall increase in use of our services and people seeking support and help across the pathway
- Flow is being managed across mental health beds so that people are staying in those beds for as little time as possible.

Alison Botham, Director for Childrens' Services, Plymouth City Council

- COVID impact was predominantly in primary schools, advice was being well received and schools were working well with public health and managing well in the circumstances.
- There were major capacity issues within children social care services. They were being addressed but the Council were facing the same national issues around recruitment as other neighbouring authorities in the region as well as nationally.
- Enormous pressures was being felt and there continued to be placement sufficiency issues.
- The Competition and Market Authority were looking at the market and how it was meeting the needs of children in care. Officers were that national strategies in relation to both workforce and placement sufficiency were brought forward.

71. **Towards an Active Plymouth**

The Health and Wellbeing Board were provided a presentation on the work underway to integrate and connect physical activity, sport and leisure to play a role in supporting action on health inequalities.

In response to questions from the Board it was reported that –

- The approach was an appreciative enquiry looking at the strengths of what was already in existence across Plymouth, engaging with stakeholders, community groups and internal staff to identify opportunities and gaps.
- There were great things happening in Plymouth, with examples in the City's green space and investment in blue space as part of the National Marine Park.
- People in Plymouth who are generally active are served very well. The underserved, those who are active for less than 30 minutes a week, are not being connected to opportunities for active lifestyles.
- The City was the 5th most active of the English coastal cities based on activity rates.
- The next step was to agree draft outcomes and begin work with partners and stakeholders to position the city for investment from bodies such as Sport England.

The Board thanked Jo for the presentation.

72. **Primary Care Strategy Refresh**

Dr Sarah Wollaston and Jo Turl (ICS Devon / NHS Devon CCG) provided the Board with a presentation concerning a refresh of the Primary Care Strategy for Devon. It was reported –

- There were six main pillars in the strategy, these overarching themes would remain but the situation has changed since the initial strategy development.

Learning from the pandemic would inform how different primary care could and should be.

- There had been an extraordinary increase in pressure on system and the opportunity to take stock and revise the strategy was now, to prevent the implementation of a rigid model going forward for many years.
- The new strategy would recognise what works for Plymouth, which may be completely different to what works in in small isolated coastal communities or even isolated rural communities. It was accepted that one size would not fit all.
- Through the Integrated Care System there would be a greater focus on co-design and all stakeholders would be involved in the development of the strategy.
- Workforce pressures and skill mix meant that primary care would not look the same in the future and would be delivered through a model that works for all the areas dependent on the type of community being served.

The Board agreed to continue to support the development of the Primary Care Strategy refresh.

73. **Work Programme**

The Board noted the work programme and were requested to email Ross Jago to add items to the work programme.

74. **Exempt Business**

Members of the Board passed a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business (Mayflower Group of Practices) on the grounds that it involved the likely disclosure of exempt information as defined in paragraph(s) 1 and 3 of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

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WELCOME

Alternatives to Admission (A2A) Services

Health and Wellbeing Board March 2022

ALTERNATIVE TO ADMISSION (A2A) SERVICES OVERVIEW

Livewell Southwest

Introduction:

Alternatives to Admissions (A2A) services in Plymouth run over 24/7 across 2 main services:

- Urgent Care Nursing Service (UCNS) and the Community Crisis Response Service (CCRT)
- Both services are designed to prevent unplanned admissions to both acute and community hospitals
- They aim to work with people as close to home as possible. This includes providing care in nursing and residential care settings
- They work with existing community-based teams providing some of the more acute care that can keep patients at home as an alternative to admission

URGENT CARE NURSING (UCNS)

- The Urgent Care Nursing Service is available 24/7
- It has 2 main elements: technical nursing, including intravenous (IV) therapies and out of hours Community Nursing. It's services are used for alternatives to admission and also to reduce length of inpatient stay, with early supported discharge for patients from hospital

- Following medical assessment and diagnosis and with agreed medical cover, the IV therapies service can offer:
    - Intravenous Hydration Therapy
    - Intravenous Antibiotic Therapy up to three times daily
    - Other Intravenous Therapy including diuretics
    - Tests and investigations to aid medical diagnosis, including ECGs

- The Out of Hours (OOH) element of the UCNS provides a high-quality nursing service to adult patients.
- OOH medical cover is provided by the out of hours service, currently Devon Doctors.
- The out of hours community nursing service can offer:
    - End of life care
    - Catheter management
    - Wound care and assessment
    - Medicine administration
    - Chest Drain management
    - Bowel care

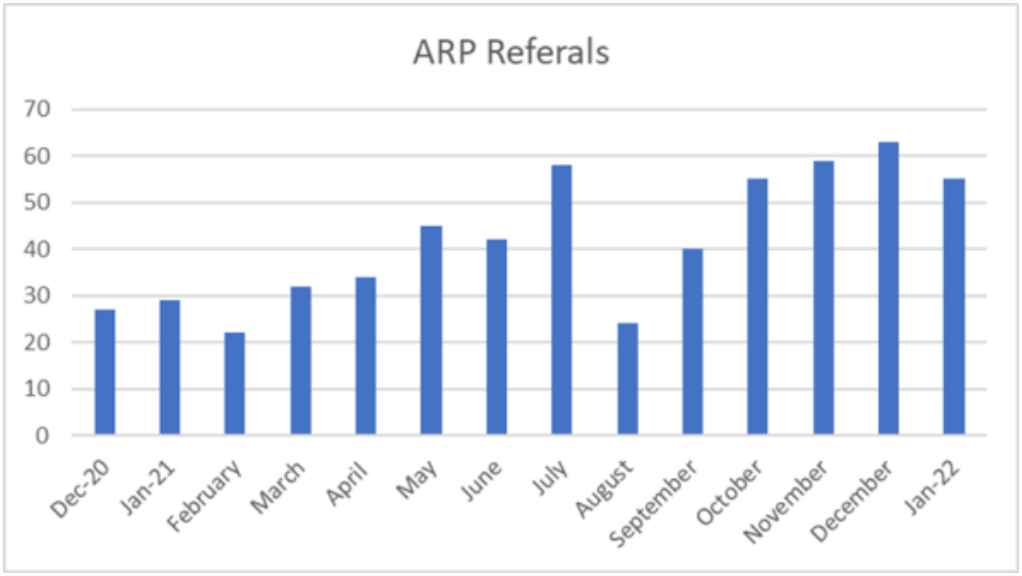
COMMUNITY CRISIS RESPONSE TEAM (CCRT)

- The aims of the team are:
  - To prevent unnecessary hospital admissions
  - To support people in crisis to remain in their usual place of residence, reducing admissions to residential or nursing care
  - To support people through a period of intermediate care and identify long term needs
- CCRT work 8-8 7 days a week
- Provide 2hr urgent crisis response in line with national UCR standard
- Provide intermediate care for up to 6 weeks
- Support primary care through the Acute Response Practitioner role (ARP) who are clinicians with extended clinical assessment, diagnosis and treatment skills and can prevent the need for a GP visit or call
- CCRT have community based workers, and workers in the emergency department to support turning people back to community services if they do not require inpatient treatment
- The team is multidisciplinary, with acute response practitioners, nurses, social workers community care workers, physiotherapists, occupational therapists, paramedics, community support workers, administrative team and coordinators
- The team's community support workers can provide bridging packages of care alongside intermediate care plans, so that people can stay at home rather than having to go into a care home or hospital, whilst a longer term package is sourced
- The team work closely with partners such as SWASFT to jointly avoid admissions

ACTIVITY

CCRT:

- Meeting 2hr UCR response time (in place 5 months ahead of national guidance)
- Current caseload size: 128 – all avoided admissions
- In the last 3 months (Dec –Feb) the savings of having support workers bridging versus the cost of a residential placement are £68,105.14
- ARP activity continues to support primary care and reduce GP visits - referrals by month:



UCNS:

- In Jan 2022 saved 127 bed days (cumulative bed days 12,737) in the IV service
- Receive on average 150 out of hours referrals per week to avoid admission evenings/overnight. Peaked at 184 per week in the last month

AREAS OF FOCUS/ISSUES IN ALTERNATIVE TO ADMISSION SERVICES

- Urgent Crisis Response Implementation (UCR) in CCRT – The service are anticipating and increase in demand that is likely from the expansion of UCR criteria which includes responding to non-injury falls, UCR via NHS111 and direct public access to crisis response service. Working through this as part of the pan-Devon UCR implementation as this potential growth is currently unknown

- Wider system challenge with the growth in demand for reablement and dom care has led to people waiting to exit intermediate care. Currently CCRT are holding 26 people waiting for long term packages to exit the service

- ARP role has been very successful, about to have 2 more qualify, but to note this does impact on wider generic hours available in the team for intermediate care

- Increased complexity across A2A services– people who have delayed getting help now have higher level of need. this has led to more people requiring input from multiple professionals in the team and having long term needs on completion of intermediate care

NEXT STEPS AND FUTURE PLANS

CCRT will continue to work pan Devon on UCR rollout

- Joined up as part of pan-Devon UCR rollout
- NHS 111 access to UCR and then public access

CCRT to develop community falls pathway as next steps for UCR

- Purchase of falls lifting equipment
- Community post-falls training programme dates planned for delivery to all CCRT workers
- Developing standard operating procedure for falls and competency sign off post training

UCNS:

- Linked in with Devon work around increasing use of outpatient intravenous therapy (OPIT) and virtual wards
- Work with SHWD and commissioning colleagues around commissioning gap

Alternatives to Admission (MENTAL HEALTH OVERVIEW)

FIRST RESPONSE SERVICE

- Since 1 May 2020
- 0800 923 9323
- 24/7 single point of contact for people experiencing a mental health crisis, as well as their families and their carers
- Advice and information to professionals, agencies and organisations
- Aims to meet people's urgent mental health needs using a holistic health and social care approach – in communities/people's own homes – providing alternatives to hospital admission/attendance
- Video/Telecoaches and First Responders (registered mental health practitioners)
- The First Response Service promotes a dynamic and innovative way of working, triaging and responding to crisis referrals (including providing brief psychological interventions), using both tele-coaching and video communication technology (Livewell Connect app) (24/7) as well as face-to-face assessments (Monday to Sunday; 8.00 am to 8.00 pm)
- Available to people aged 18+, who are either registered with a Plymouth GP, reside at a Plymouth address, and/or are currently in Plymouth at the time of mental health crisis

ACTIVITY
12 MONTHS – 1 JAN 2021 TO 31 DEC 2021

Initiative	Numbers of Patients Seen/Spoken To	Confirmed ED Avoidance	Comments
First Response (111)	283	283	High degree of certainty due to 111 coding – 100% avoidance
All First Response	Average 1600 calls per month Approx. +20,000 calls a year <5% abandonment rate	(not collected)	(cannot extract all ED avoidance outcomes from data)
Joint Response Unit	615 Average 3 to 4 callouts a night	48	High degree of certainty – data captured direct from clinicians
A2ED	37*	37*	(* 6 weeks data only) - 100% avoidance

FRS - SUCCESSES/CHALLENGES

KEY SUCCESSES	CHALLENGES
Rapid implementation in response to Covid-19 Pandemic	Band 6 recruitment and retention impacting on full 24/7 roll out of face to face assessments ACTIONS TAKEN: Rolling recruitment programme; urgent assessment provision enhanced by JRU/A2ED
Part-implementation of 111 IVR Pathway (focused on calls that would ordinarily have been directed to ED as first priority)	Staff resilience / wellbeing – impact from high demand periods together with nature of calls (eg crisis situations and also aggressive callers) ACTIONS TAKEN: Samaritans resilience training planned for Summer 2022; monthly Psychologist facilitated reflective supervision sessions in place
Recruitment and in-house training of non-registered band 5 staff to provide a video/tele coaching service	No dedicated medical/consultant psychiatrist input to the service ACTIONS TAKEN: 0.5 WTE funding secured; also considering alternate roles eg NMP/AP
Co-location of First Response Service and Livewell AMHPs (including Joint Response Unit vehicle)	High level of frequent callers and callers open to services ACTIONS TAKEN: Monthly frequent caller data capture; new Practice Lead in post to start reviewing etc

FRS - NEXT STEPS AND FUTURE PLANS

FRS will continue to work with DPT on service development

- Continued joint working between LSW and DPT together with CCG regarding next steps for service development across Devon & Plymouth

FRS will move towards a fully ageless service

- Working with CYP colleagues to develop one phone service response for all ages (outside of COT operating hours) (Summer 2022)
- Secondment of CYP B7 for 6 months to FRS to progress
- Training of FRS staff and protocol to be developed to support by CYP B7

FRS will continue to work towards full 111 implementation

- Continued multi-agency working with Devon Docs (current 111 contract provider), DPT and CCG

JOINT RESPONSE UNIT VEHICLE

- Since 6 November 2019
- A dual-agency resource (Police/Livewell) providing acute assessment, care and support to people experiencing mental health crisis in the community
- In Plymouth, the AMHPs provide the mental health professional input to Plymouth's Joint Response Unit.
- The service operates from a police vehicle that can be mobilised across the city and responds to people of all ages and can see people in both public and private places (including their own homes).
- Operational hours are currently Monday, Wednesday and Thursday 4.00 pm to 0.00 am and Friday 5.00 pm to 1.00 am.
- The Joint Response Unit vehicle receives its referrals via 101 or 999 (ie Police mental health referrals); in addition the First Response Service can now also access the Joint Response Unit via direct contact with the AMHP on shift.

A2ED

- Since 18 January 2022, initially on four evenings a week
- 01752 435423
- Professional referrals only including FRS, ED, ambulance, police, JRU, 111
- Plymouth, West Devon and East Cornwall patients of 18+
- Provides face-to-face, very urgent expert assessment, advice and guidance in a therapeutic environment to individuals who may have historically attended the emergency department
- For people who do not have urgent physical health needs and who consent to attendance
- Joint approach with Headspace peer support workers from 1 March 2022, offering links to community third sector support. Friends and family welcome to attend. User feedback 81% very good, others good
- Now operational on 5 evenings a week 5.00 pm to 1.00 am – Tuesday, Wednesday, Friday, Saturday and Sunday. Last patient seen at 10.30 pm
- Impacting favourably on the number of people attending the ED for mental health assessment and therefore waiting times for patients and emergency workers. Since launch, 37 people have been diverted from ED and seen within the hour, giving a very conservative estimate of 130 emergency clinician hours saved

WELCOME

Transformation of Enhanced Primary Care:
Ageing Well MDTs and Care Home Support

Health and Wellbeing Board March 2022

Introduction

Enhanced Primary Care (EPC) will form the foundation of the service model with teams working in close partnership with the Primary Care Networks (PCNs).

The service offer is designed to support the PCN specification, with each of the 9 PCNs having a dedicated management team (MDT) which will coordinate a shared-care response via assessments and ongoing coordinated care delivery.

The EPC operating model will operate on a Locality based model designed to take account of the resilience of teams (to ensure that specialists can work effectively as part of MDTs), geography and rurality, and PCN formation.

EPC will adopt a population-based delivery model to ensure that services work together to support the person and their family and their journey, providing greater continuity and coordination of care across the different elements of care.

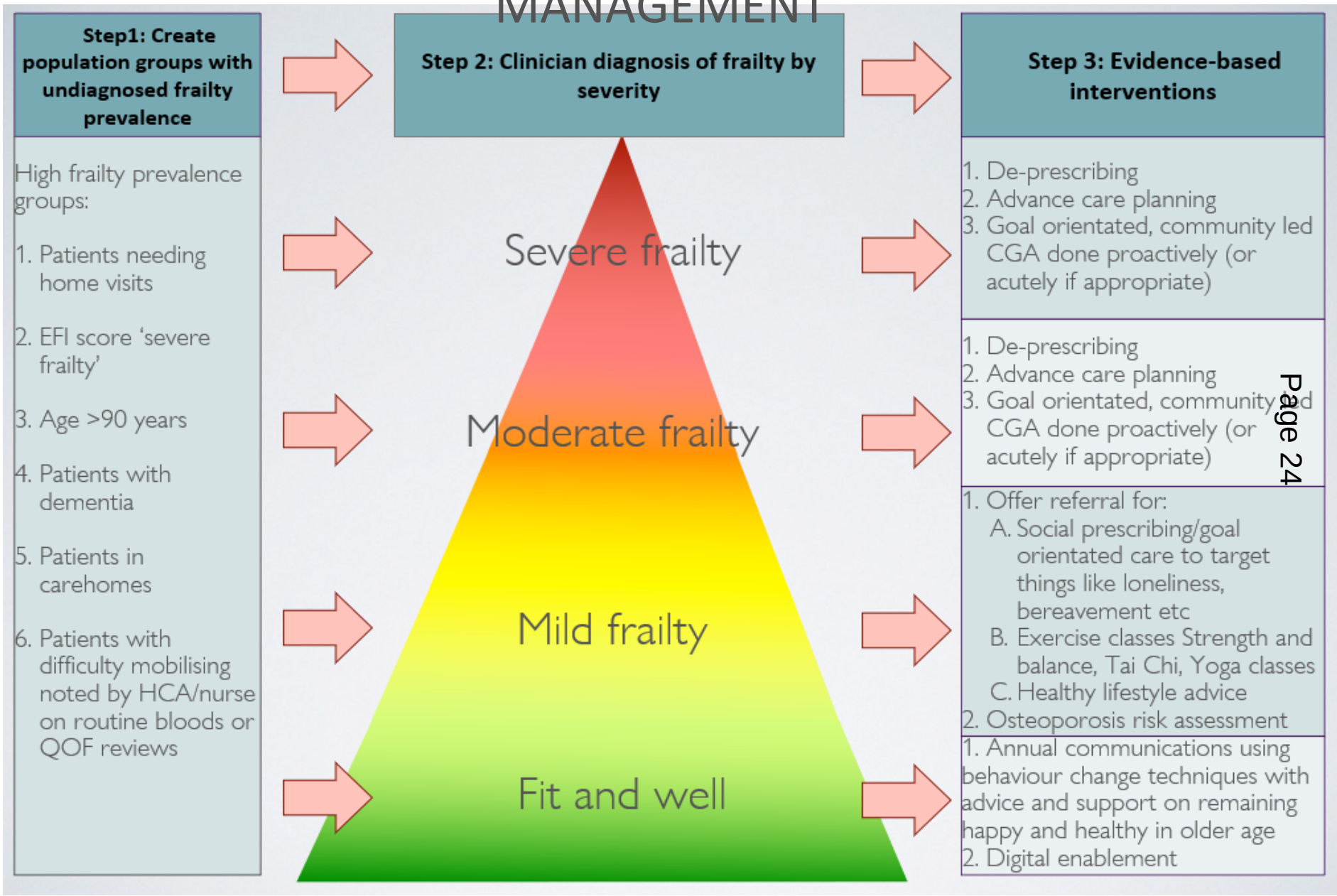
Introduction

The dedicated Care Home Service is a core part of EPC, aligned to frailty, supporting everyone in a care home, regardless of whether they require an urgent care response or have long-term care and support needs.

It is a **multidisciplinary team (MDT)**, working together with care home partners, to ensure that every adult in a care home receives the very best care, support and treatment to maximise independence and quality of life. Key features include:

- creating a systematic, MDT-driven approach to care homes, identifying issues early, before further intervention is required
- ensuring robust care, escalation plans and advanced care planning are in place
- creating dedicated care home teams to build robust and trusting relationships
- expanding support and opportunities for care home staff to support those with complex conditions and to reduce escalation.

WEST DEVON STRATEGY FOR POPULATION HEALTH MANAGEMENT



Progress to date – Mobilisation of Ageing Well MDTs

Active MDTs	Signed up to iCOPE	Opted Out of iCOPE
• Pathfields • Waterside • Beacon • West Devon	• Mayflower* • Sound*	• Drake • Mewstone • South Hams

* PCNs to confirm when ready for mobilisation – medical backfill is the delay in MDT mobilisation

E.G. PATHFIELDS AGEING WELL MDT TEAM

Name	Team
Dr David Attwood	GP (MDT Chair)
Jacqueline King	MDT Co-ordinator
Jason Hodges	District Nursing
Jill Robinson	Community Therapy
Steph Gallini Jo Bailey Hannah Meek	Adult Social Care (Rotational Cover)
Ruthy Pritchard	Long Term Conditions
Anna Fort	ARP – Urgent Care

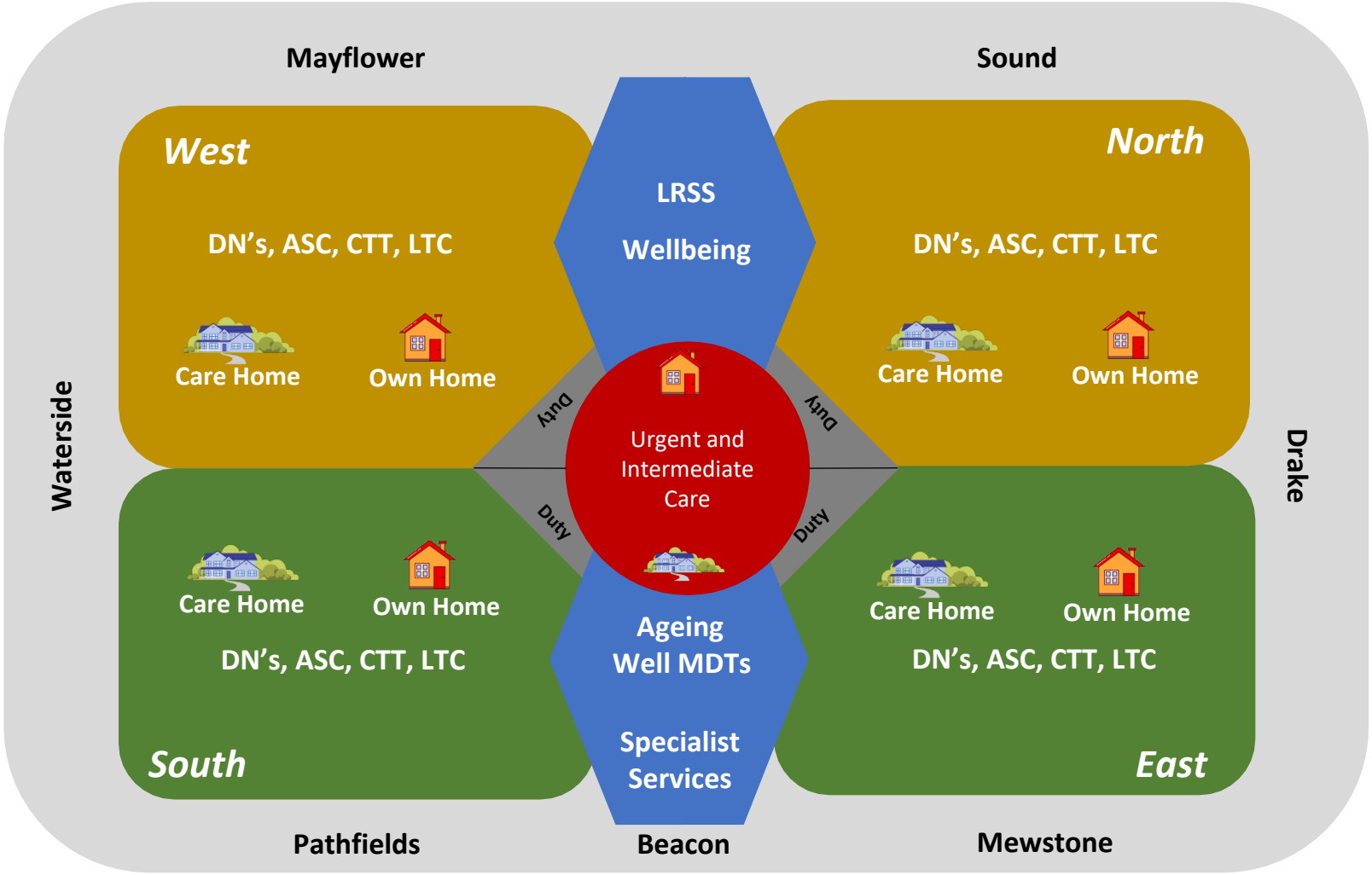
Contact Details	
Email	livewell.pathfieldsageingwellmdt@nhs.net
MDT Co-ordinator Tel:	01752 435661/07825 106880
Pathfields Professionals Line only (not to be given to anyone else outside of the MDT core group)	01752 341474 (Press 1 for professionals line)

Care Homes	Bethany Christian Home	Charlton House	Clearview	Greenacres care centre
	Hamilton House	Hardwick View	Inglenook House	Laburnum Lodge
	Manor Court	Plymbridge House	Silvermead Residential Home	The Old School House

Progress to date

- Referrals to services via a single point - dedicated contact number for care homes and professionals
- Creating a systematic MDT- driven approach for people in care homes and own home. Ensuring robust care, escalation plans and advanced care planning are in place.
- Multi-professional care plans supported by Comprehensive Geriatric Assessments shared with system partners ED, SWAST, DDOC, St Luke's, identifying issues early, before complex intervention is required and placement breakdown increased.
- Creating dedicated care home team to build robust and trusting relationships with care homes supporting improved professional practice
- Dedicated Care Home waiting lists and Caseloads across Adults Frailty and Specialist services with aligned workforce.
- Reducing footfall in care homes - providing efficiencies and reducing duplication of activity
- Identified LSW link workers for each care home and PCN's and supporting Enhanced Health in Care Homes (EHCH) model of working

ADULTS FRAILTY & SPECIALIST SERVICES DELIVERY MODEL



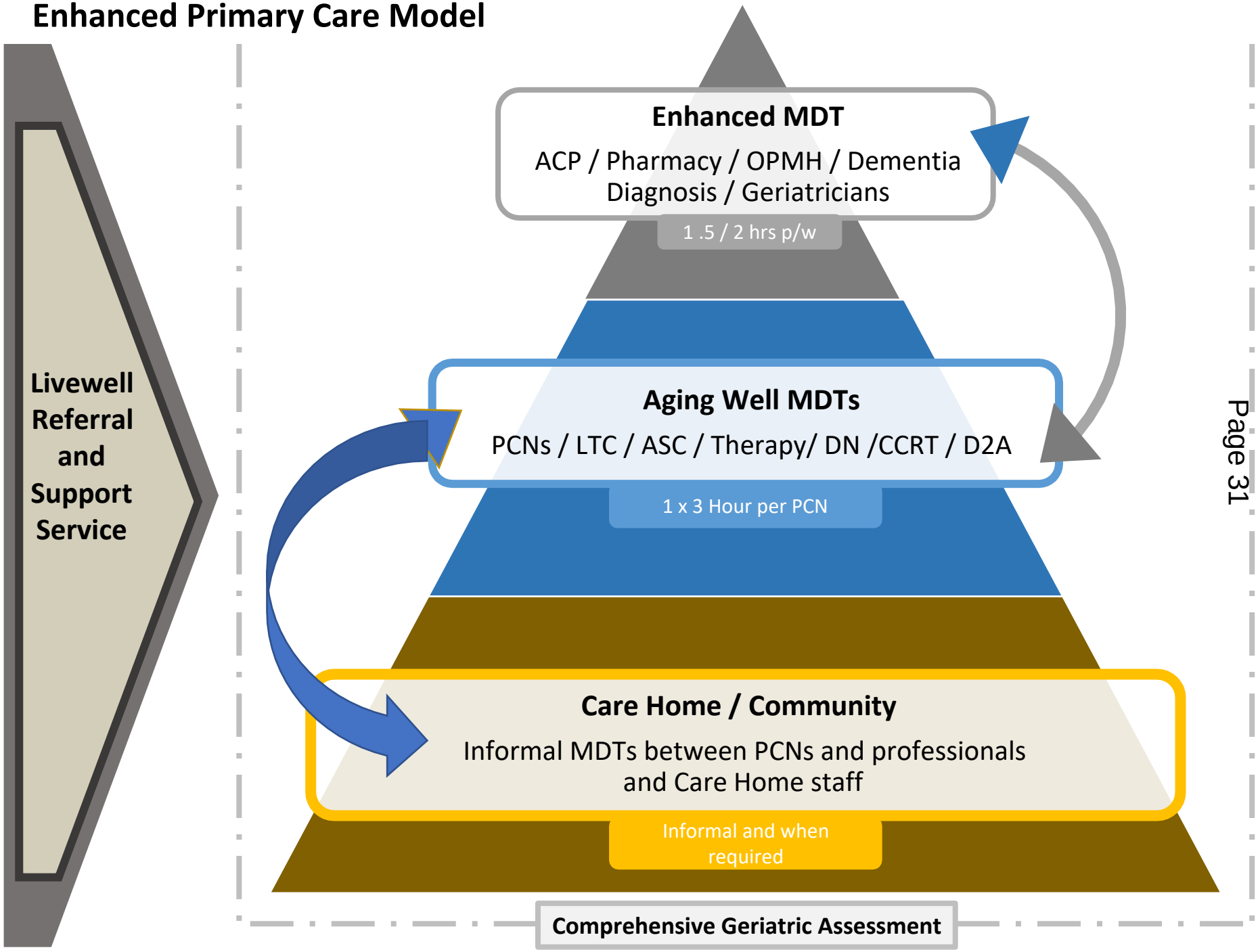
Work to address current challenges

Challenges		Work to address current challenges
Systems Interoperability	• **Multiple systems** used across the ICP creating gaps in patient/client information continuity due to multiple systems across the ICP • LSW community teams recording clinical informal on CF6, not visible to GP practices and wider system partners (Social Care – phase 2 for Shared Care record, so interim solution required.	Development of ICP Digital Strategy Group Development of Orion (shared Care record)
Resource	• **Experienced/skilled workforce** to meet growing demand to support people in the community. • **Workforce resilience** within Primary care, Community and Care Home and Dom Care Sector • **Provision of Dom Care Providers** and alignment of patients with complex needs to PCN care homes	➢ Anticipatory and ECH investment. ➢ RESTORE 2 ➢ ICP systems approach/aligned priorities

Future Plans

- **Development of a Frailty Data Warehouse to enable linked datasets across Primary, Community and secondary care (detailed in iCGA slides) – Warehouse development due to be completed April 22**
- **Development of Enhanced Ageing Well MDT – due to commence March 22 (Refer to pyramid slide)**
- **Implementation of RESTORE2 -** training from April 2022
- **Review of outbreak support for Covid-19**
- **Ensure established links with PCN's to support virtual ward and develop robust MDT approach.**
- **Engagement with UCR to support 2 hour care response.**
- **Support development of Falls Strategy to include Care Homes.**
- **Develop care home service feedback**
- **Strengthen referral model/process. Ensuring interfaces with partner agencies and services are clear and prevent unnecessary duplication.**

Enhanced Primary Care Model



Allocated Care Home Support

MDTs: 32 Care Homes involved currently

Livewell professionals will attend by invite if professional input is required

- Deliver Care and Social needs from multi-professional team (Care Home staff, Primary Care, Community Core MDT team – DN, LTC, ASC, CTT) with links to specialist services as required such as Cardiac, LTC, TV, Continence
- Provide support and where appropriate education to care home staff e.g. Tissue Viability, use of appropriate dressings
- RESTORE2 training to be delivered to care homes in SHWD and Plymouth to support earlier identification deterioration via observation and understanding soft signs to reduce avoidable hospital admission and accessing appropriate support sooner.
- Collaborative working with QAIT/Safeguarding teams
- Attend Covid Out-break meetings to support homes with Operational challenges and clinical assessment.
- Support two hour response to care homes
- Review of daily care home activity to reduce footfall into homes
- Scope in the future to dovetail DTA reviews to support people returning home

Ageing Well MDTs

MDTs: 1 session = 3 hours per week per a PCN (x7)
GP (Representing PCN), DN, LTC, CTT, ASC, Ageing Well co-ordinator (Administrator), Urgent Care rep (CCRT/ DTA)

- Seven Networks in Plymouth – one MDT once a week per network
- Referrals from PCN for people with a moderate or severe frailty diagnosis
- Completion of Comprehensive Geriatric Assessments (CGAs) shared with system partners ED, SWAST, DDC, Patient, St Luke's
- Review of medications/de-prescribing
- Community staff can refer into the MDT when they require wider professional input into a person's care plan
- In-reach into the Health Care of the Elderly ward to discuss people who have been admitted (unplanned) to support earlier discharge and share information
- Collaborative working with FUSE team to support people with repeated unplanned admissions
- Signposting to voluntary and third sector organisations

Specialist Enhanced Support

Enhanced MDT: 2 hours per week
Consultant Geriatrician, OPMH, ACP, Pharmacist

- Provide expert advice and guidance to Ageing Well MDTs
- Provide expert advice and guidance to CHLS teams
- Pharmacy training/advice and guidance to PCN pharmacists
- Provide education and support relating to dementia and frailty
- Complex structured medication reviews
- Support the wider Livewell teams with their complex polypharmacy frail patients (pharmacist support to ageing well MDTs)
- Provide a link between Secondary and Primary Care to aid transfer of care – we know this is a key area that medicine issues occur and would reduce readmission rates due to preventable medicine issues (Pharmacists)

ENHANCED PRIMARY CARE BENEFITS FROM THE AGEING WELL MDTS AND CARE HOME SERVICE (DATA FROM PATHFIELDS)

Livewell Southwest

Living Longer: 23% one year survival in patients with severe frailty

Living Better: Patients undergoing iCGA had an extra 30 days alive and in their own homes (NOT hospitalised) at one year with patients with severe frailty having the most benefit - an extra 71 days at one year alive and at home.

Getting the End Right: More patients meeting their advance care planning preferences and dying in their place of choice (10% absolute improvement)

Reduction in Healthcare Utilisation: 36% absolute reduction in total hospital admissions and 26.5% absolute reduction in bed days

Enablers: The key enabler for all the above was moving to a "one BIG NHS team" model of care with shared staff using shared IT

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