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.

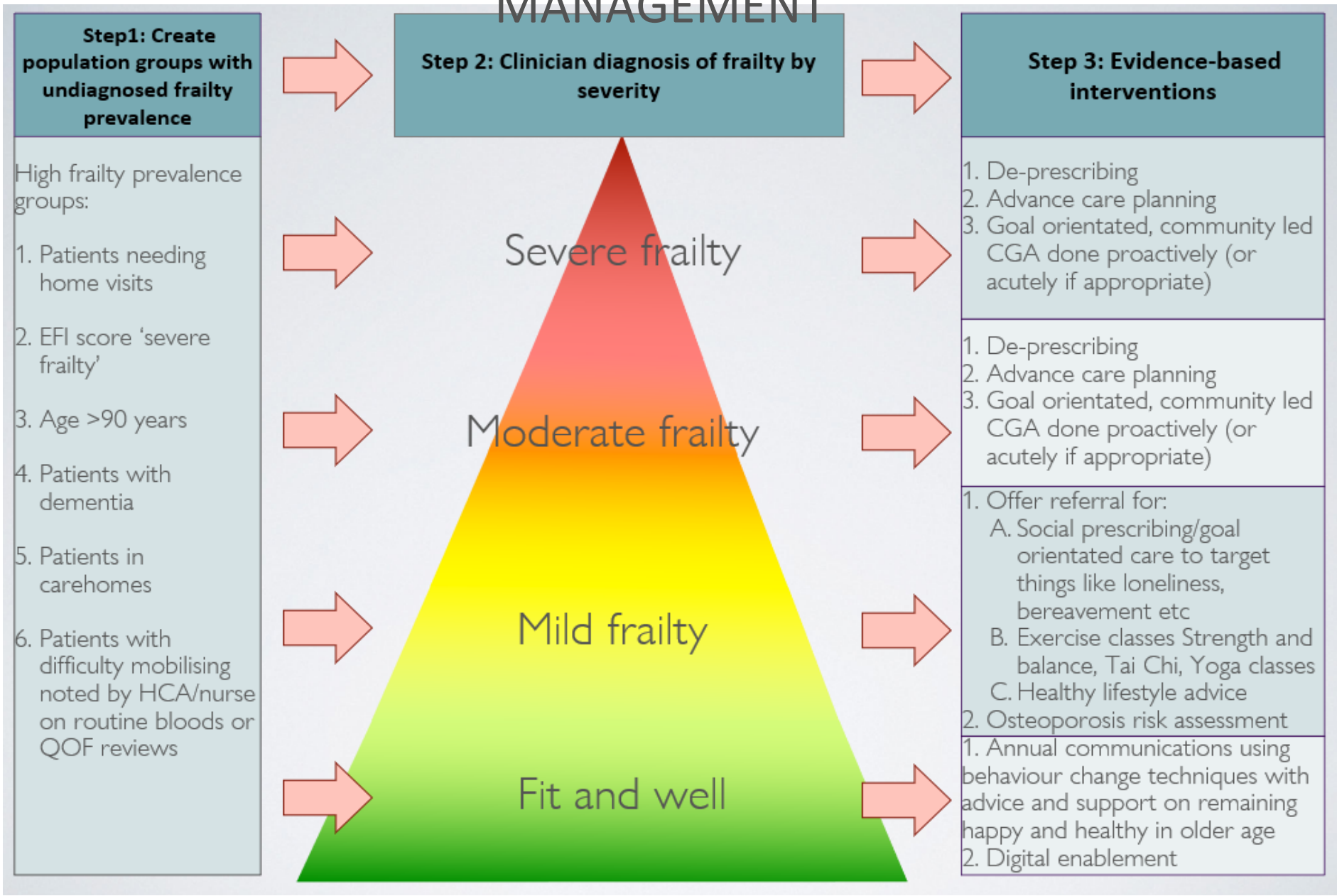
Introduction

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)

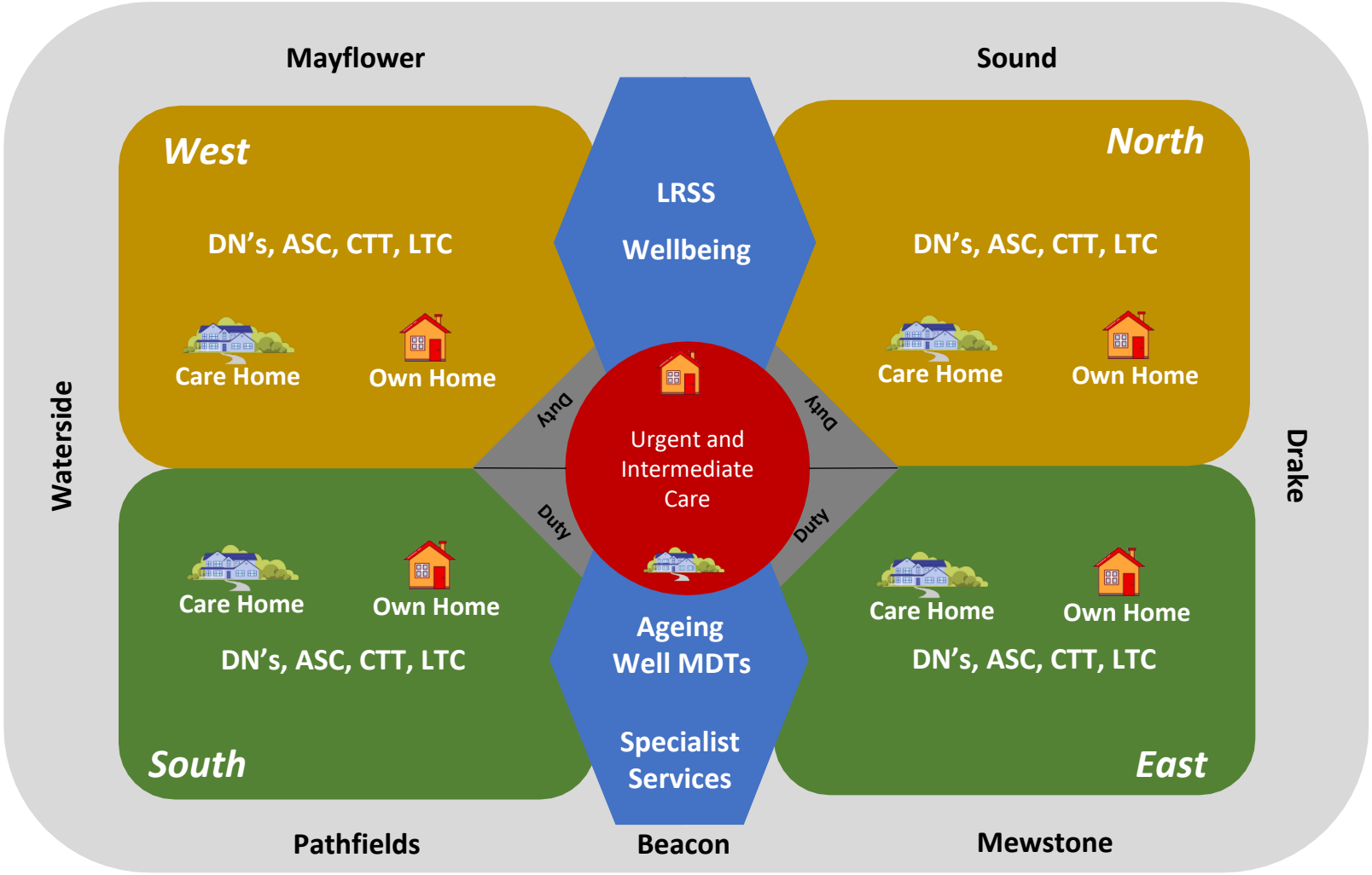
Care Homes	Bethany Christian Home	Charlton House	Clearview	Greenacres care centre
	Hamilton House	Hardwick View	Inglenook House	Laburnum Lodge
	Manor Court	Plymbridge House	Silvermead Residential Home	The Old School House

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

Livewell Southwest



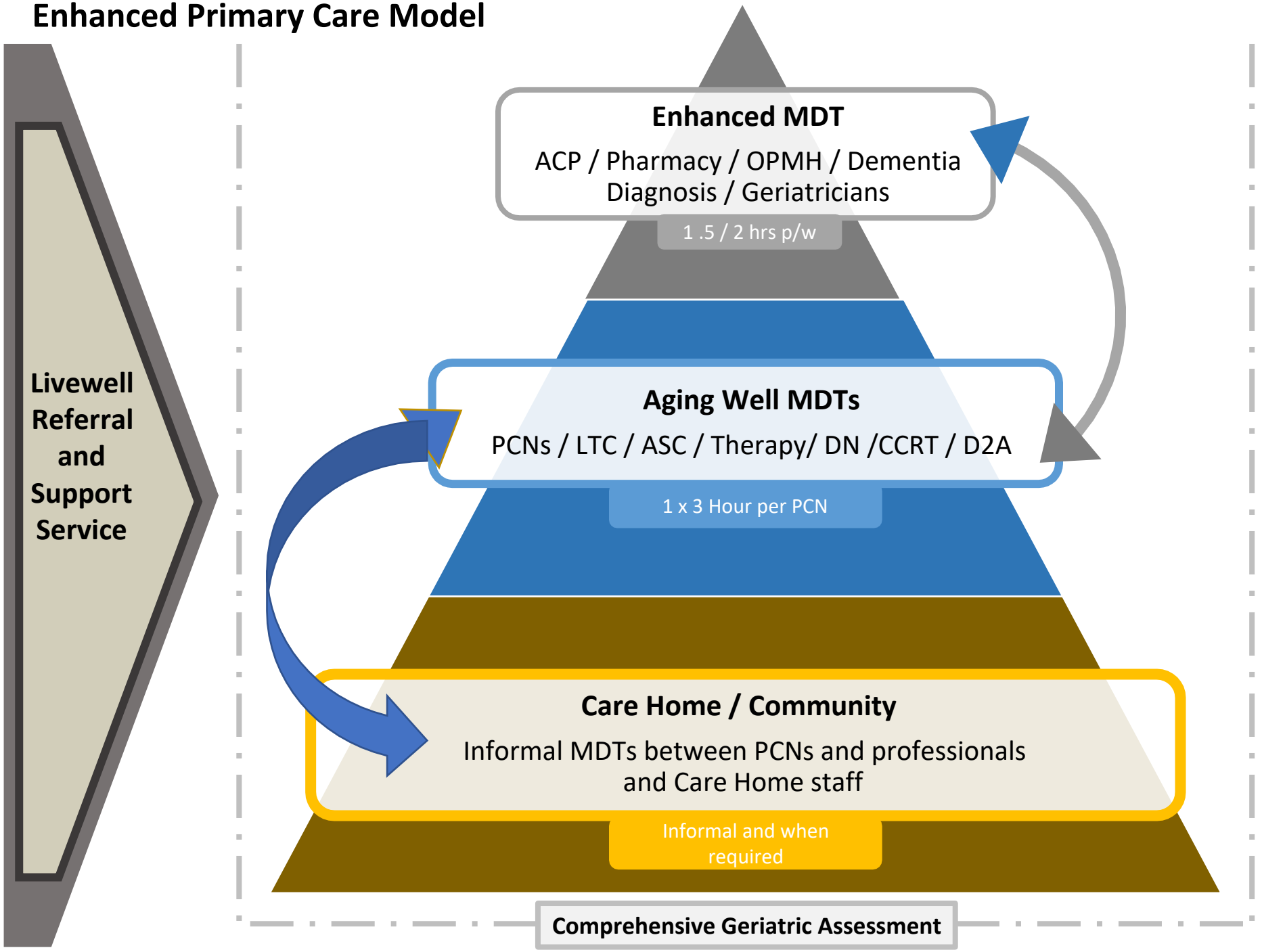
Work to address current challenges

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