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

Hollie Poole, Integrated Programme Delivery Manager, PCN Community Teams, West Sussex, and Dr Haydn Williams, GP and Clinical Director, Hatters Health Primary Care Network
Dr Manraj Barhey, GP and Clinical Director, Medics Primary Care Network (BLMK)
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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
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

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

Senior Mental Health Practitioners
Senior Social Work Practitioners
Social Workers
Case Coordinators
Housing Coordinator

Community Link Workers

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

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.

PCN Community Team

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.

Specialist teams

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

- GP
- Mental Health
- Therapists
- Clinical Leads
- Community Link Workers
- Paramedics
- Falls Service
- Social Workers
- Community Nurses
- Community Geriatrician
- Specialist Nurses
- Pharmacist
- PCN Coordinator
- Hospices
- Responsive Services
- Care Homes
- Dementia Crisis
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

<table>
<thead>
<tr>
<th><strong>Occupational Therapist/Physiotherapist</strong></th>
<th><strong>Psychological Therapist</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Functional assessment</td>
<td>• Biopsychosocial formulation</td>
</tr>
<tr>
<td>• Wheelchair advice</td>
<td>• Psycho education</td>
</tr>
<tr>
<td>• Support to improve mobility</td>
<td>• Management of anxiety</td>
</tr>
<tr>
<td>• Mobility goal setting</td>
<td>• Two weekly visits</td>
</tr>
<tr>
<td>• Indoor movement and outdoor</td>
<td></td>
</tr>
<tr>
<td>mobility assistance</td>
<td></td>
</tr>
<tr>
<td>• Equipment provision</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical Nurse Lead</strong></th>
<th><strong>Social Worker</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wellbeing referral</td>
<td>• Direct payments resolved</td>
</tr>
<tr>
<td>• Carer assessment and support</td>
<td>• Respite care</td>
</tr>
<tr>
<td>• Community Nurse liaison</td>
<td>• Day care</td>
</tr>
<tr>
<td>• Podiatry support</td>
<td>• Emergency respite</td>
</tr>
<tr>
<td>• Pressure relief</td>
<td></td>
</tr>
<tr>
<td>• Glucogel acquisition</td>
<td></td>
</tr>
<tr>
<td>• NIPY liaison</td>
<td></td>
</tr>
</tbody>
</table>
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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Sussex Community NHS Foundation Trust

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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.
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.**

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**A Framework for Frailty in Luton: Ambition**

<table>
<thead>
<tr>
<th>Mode</th>
<th>Fit</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>0 - 0.12 Fit</td>
<td>0.13 - 0.24 Mild Frailty</td>
<td>0.25 - 0.36 Moderate Frailty</td>
<td>&gt;0.36 Severe Frailty</td>
</tr>
<tr>
<td>Edmonton Frail Score</td>
<td>0 - 7</td>
<td>8 - 9</td>
<td>10 - 11</td>
<td>12 - 17</td>
</tr>
<tr>
<td>Rockwood Score</td>
<td>1 - 3</td>
<td>4 - 5</td>
<td>6</td>
<td>7 - 9</td>
</tr>
<tr>
<td>Clinical Assessment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Support Services</td>
<td>Ageing Well Advice &amp; Signposting</td>
<td>Supported Self-Management</td>
<td>MDT Care &amp; Support Planning</td>
<td>MDT Case Management &amp; End of Life Care</td>
</tr>
</tbody>
</table>
**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
  - A&E attendance
  - Recent Discharge
- GP or Rapid Response
- 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
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???

Frailty Homepage

Menu & How to use

Navigation options

If you want to go to a specific page on this template, click on the name of the page below which will take you directly to that section. Or you can navigate through the template using either this menu page or by clicking on the tabs at the top of each page to move on to the next page, in the usual way.

To return to this homepage at any point click on the link at the bottom right of each page.

- What matters to me: Year of care
- Frailty Screening Tools
- Medical Summary / SCR consent
- Medication
- Mobility, Falls & Urinary Health
- Memory
- Function & Physical Health
- Advance Care Plan
- Advance Care Plan 2
- Emergency Health Plan
- Summary of Key actions
- Other useful links
- Reference page
Focused anticipatory plan to share.......eSCR

**GERIATRIC 5Ms**

<table>
<thead>
<tr>
<th>MIND</th>
<th>Mentation, Dementia, Delirium, Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOBILITY</td>
<td>Impaired gait and balance, Fall injury prevention</td>
</tr>
<tr>
<td>MEDICATIONS</td>
<td>Polypharmacy, De-prescribing, Optimal prescribing, Adverse medication effects and medication burden</td>
</tr>
<tr>
<td>MULTI-COMPLEXITY</td>
<td>Multi-morbidity, Complex bio-psycho-social situations</td>
</tr>
<tr>
<td>MATTERS MOST</td>
<td>Each individual's own meaningful health outcome goals and care preferences.</td>
</tr>
</tbody>
</table>

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GP Practice
Risk Stratify Cohort
(Severe Moderate mild frail or Fit)
– Assessment & Share
See appendix 1

Practice MDT

GP Practice

Risk Stratify Cohort
(Severe Moderate mild frail or Fit)
– Assessment & Share
See appendix 1

Practice MDT

High Risk (Task AHF)

Practice MDT

ESC R

Pro forma

Task AHF

Task RMS

ESC R

ESC R

Task AHF

Task AHF

Daily Hudl

Hot Clinic

Weekly MDT

CCS Team Specialist

CCS

Providers:
Pharmacy
Voluntary
Mental
Health
Total Well-being

5 Questions

Email across

PROACTIVE CARE

REACTIVE CARE

GP Practice

Coding/Sharing
See appendix 2

GP for Clinical Assessment

Daily Hudl CCS

Unscheduled care in Primary care or hospital discharge letter

RR /Diabetes /Falls

Pro forma
NAPC ANNUAL CONFERENCE 2019

at Best Practice