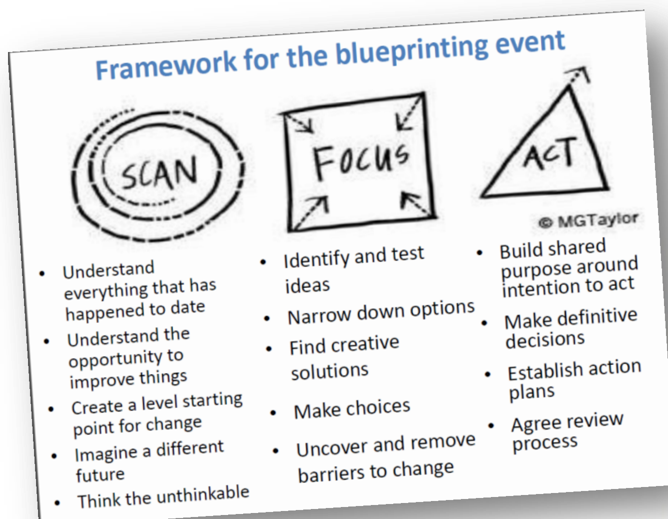
New Models of Care Briefing

Blueprinting Event



The CCG, together with key partners were part of a blue printing event which considered how care could be provided in a different way for frail people in North Tyneside. People at the event agreed that delivering care in a different way would benefit patients, carers and staff by maximising the use of existing resources within the existing North Tyneside health and social care economy.

It was agreed that frailty would be an appropriate mechanism to identify patients who could be supported by a new 'extensivist' team who would work in a different way together, to support patients to stay well and when required, provide intensive help in order to avoid unnecessary hospital admissions. However, when a person needs a hospital admission, they would work together across organisations to make sure that they were discharged with appropriate support as soon as possible in order to integrate them back into their community. An essential part of the team will be the volunteer programme, who will provide guided conversations to promote self-care, support the person to achieve what is important to them and connect them with their local community assets.

At the event there was significant commitment to support patients in this way as part of a pilot programme. Assurances were given that this will be a true pilot and would evolve over time as continuous quality improvements are identified and made. A robust evaluation would also underpin the pilot in order to inform ongoing developments as well as patient, carer, staff and system impact.

At the event, North West locality indicated that they would like to be involved in the pilot and agreed to take this for further discussion to their locality meeting. Individual GPs from the other three localities were keen to take this forward form a personal point of view; however they needed to go back to their localities and establish the views from locality colleagues.

Northumbria Healthcare NHS Foundation Trust, Newcastle upon Tyne Hospitals Foundation Trust, Northumberland Tyne and Wear Mental Health Foundation Trust and North Tyneside Local Authority are all keen to support this exciting development; as were the patients and the voluntary sector in attendance at the event. It was recognised in the group work that whilst this model is a different way to care for this group of people, it builds on previous work which formed firm foundations. Together we recognised that despite individuals best endeavours the whole system could not sustain care delivery and rising demand in the way it currently does.

The Model

The 'extensivist'[1] model (Appendix A) will provide pro-active care planning and co-ordinated care, wrapped around the patient with a single point of access, with the service fundamentally orientated towards supporting patients to have the confidence and knowledge to manage their own conditions. The 'extensivist' service will be provided by a multi-disciplinary team (MDT) able to provide specialist care in a locality setting to support patients with complex needs who are deemed to meet the moderate to severe scale on the frailty index. The team will provide a rapid response service in order to support patients to stay in their own home whenever possible. A named care coordinator together with MDT members across health and social care as well as regular contact with a worker from the 'volunteer programme'[2] and effective use of tele-health approaches will be some of the elements that make this service feel different from a patients perspective.

It was agreed that the 'extensivist' team would work in partnership with the patients GP when appropriate to do so. This will ensure continuity of care between the two services at the points of transition and when universal services are required. The patients will remain on the GP list and the integrity of the primary care record will be maintained. It was agreed that the model would be based in a local hub.

We expect this approach to result in a significantly improved patient experience, with patients being empowered to manage their own health and having an increased sense of wellbeing as a result. The system should also benefit from this approach with fewer planned and unplanned admissions, and fewer unnecessary outpatient consultations and investigations. It is anticipated that this way of working will have a positive impact on the workforce involved and in primary care which will be included in the evaluation. A real

[1] To be re-named in partnership with key stakeholders
[2] To be determined – match funding in place with Age UK.

example of patient contacts in primary care from a practice patient cohort who would be eligible for this service identified that on average they had 8 home visits and 18 practice appointments in the past year.

Risk Stratification

Risk stratification was discussed during the blueprinting event using the electronic Frailty Index (eFI). This was generally accepted as a good way to model and validate the patient cohort. At the time of the cohort the eFI was available within SystmOne and they were queries in relation to EmisWeb. Confirmation has since been acquired that the eFI tool can be accessed in EmisWeb and we now have the algorithm to test the tool with EmisWeb practices. It has also been established via Professor John Young that thresholds are also included in this which will indicate mild, moderate and severe frailty.

Workforce

The composition of the ideal multi-disciplinary team was identified however, this will be refined further in partnership with the pilot sites and the organisations involved with the emergence of the operational group. It is anticipated that a number of staff will be able to be realigned to the new team out of existing contracts. Others will require pump priming to make the realignment happen whilst others will require new funding.

Operational Issues

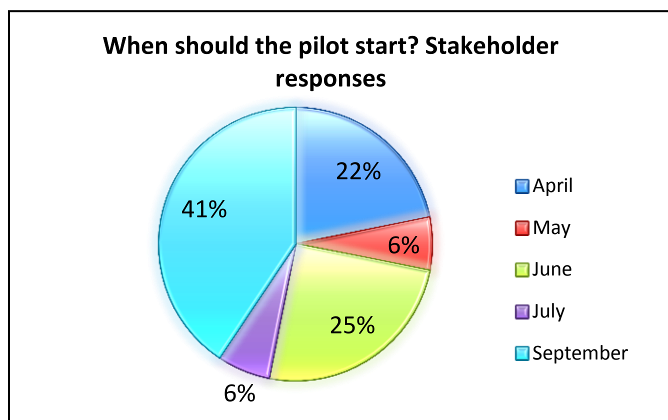
Operational issues that arose during the four days included finance, IT/patient records and leadership. NHS England gave an update in relation to the support available from the NHS Leadership Academy for those involved based on identified needs. The issue of primary care Quality Outcomes Framework (QOF) was discussed and feedback from a teleconference with a NHS England national lead and Yeovil Foundation Trust was discussed with the indication being, that for the pilot sites, QOF could be agreed locally to preserve

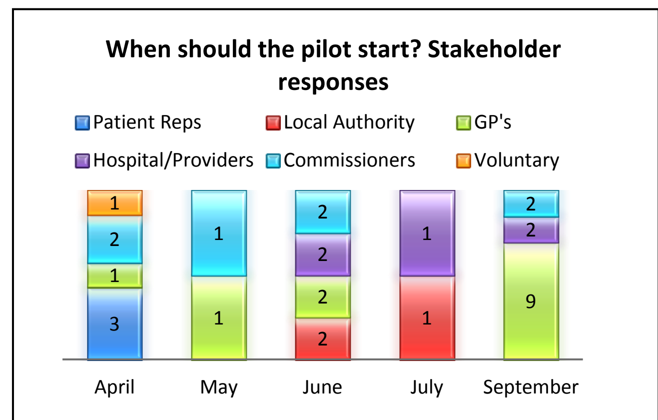
current QOF income in return for delivering against proactive care and other mutually agreed local objectives. This is ahead of any co-commissioning delegated functions that the CCG will assume.

Finance was discussed at length in view of the need for investment in the pilot given the CCG's financial position. I it was recognised that this new service model would be part of a longer term invest to save plan as well as respond to the increasing system pressures and changes in population profile.

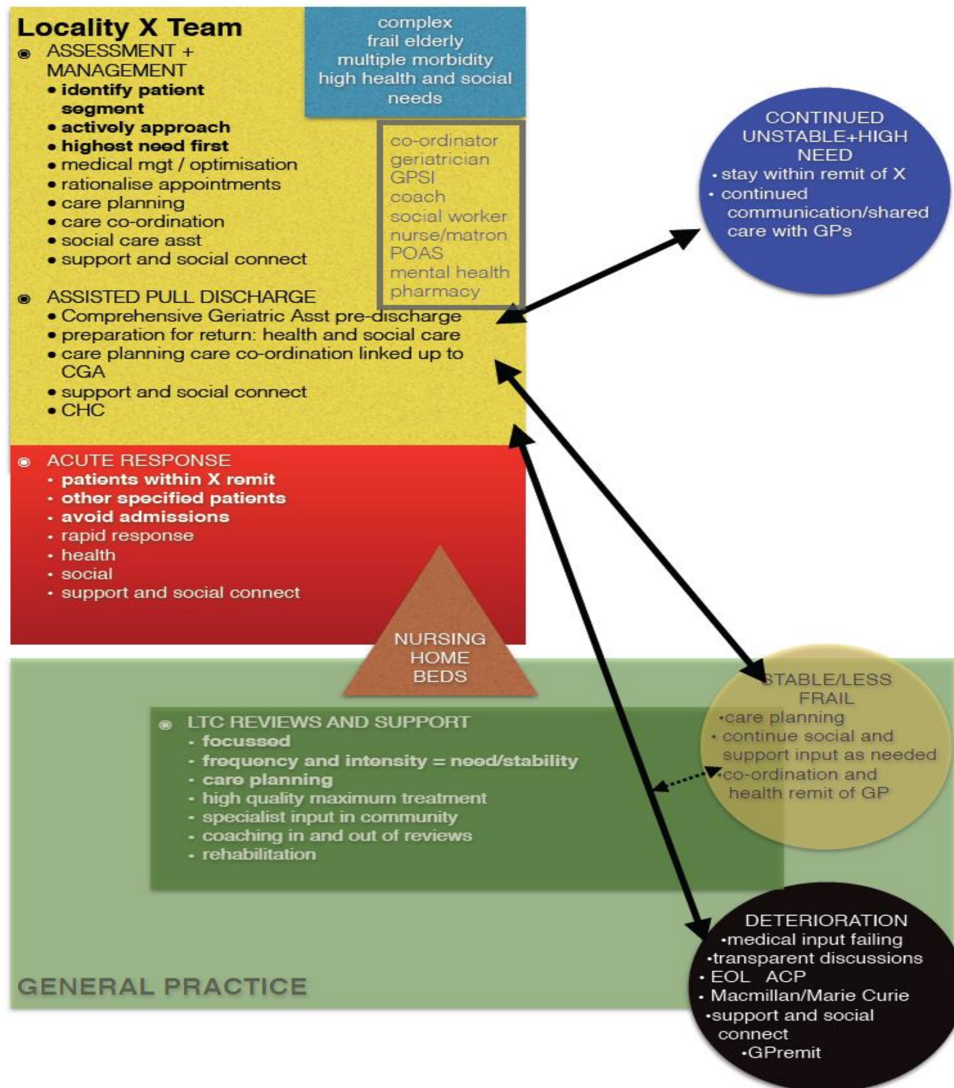
Next Steps

It was agreed that the GPs present would take their findings back to their locality meetings and establish support or otherwise to become a pilot site. The other staff representing their organisations would do the same. During the event a timeline was displayed asking participants when the 'extensivist' pilot should be stood up. This is shown below. As can be seen, all of the patient reps and members of the voluntary sector who completed the response, wanted this to start in April, recognising the opportunity this affords. However, from a GP perspective, 69% of the responses and 41% of the responses overall were for a September start date; therefore in order to develop robust implementation plans in partnership pilot site(s) we need to receive ***expressions of interest from the localities by the 10th April***. Following this an operational group will be formed in order to develop the detailed implementation plan with key stakeholders.





Appendix A- Extensivist Model



- X team are separate, to accommodate high demand:
  - to actively seek out and assess, **care co-ordinate and care-plan** complex frail segment
  - manage and support high level needs of this segment consistently
  - available 24/7 - although team makeup may alter through day
- **Locality based** with high visibility, accessibility and buy in across system for patient and health practitioners. **GPSI** hopefully from locality
- Where patients are very **vulnerable and unstable**, it makes more sense to keep under high demand X Team support [BLUE CIRCLE] but with communication and shared care where appropriate with their practice. Patients who become stable enough will move back into General Practice care [YELLOW] but retain social and supportive care as needed
- **Stable and less frail** elderly patients [YELLOW] will dovetail with Long Term Condition care co-ordination, planning and review in General Practice, but will be able to access social support and coaching etc as need
- **Deteriorating** patients [BLACK] who gain little from specialist medical help can revert back to General Practice, but again would retain other support
- Any patient who leaves the X Team, can be accepted back in if deemed appropriate [2way arrows]
- ACUTE RESPONSE for X Team but also others eg yellow and black or perhaps some patients in green who can avoid admission through this help eg acute asthmatic attack
- **Coaching/support workers** are crucial to keep patients supported
- **IT** and communication vital: interoperability of systems; Telehealth needs to be developed actively
- **Prescribing** mechanism for very frail who remain in X Team needs to be finalised

- NEED TO:
  - define X Team segment criteria so that it picks up frail patients who will get benefit from this team, make an impact in General Practice, but not overwhelm the new service; this probably will mean adding local knowledge, especially from General Practice and social care, overlaid on frail tool data
  - aligning current services and resources to reduce inefficiencies and repetition in assessments and maximise current investment, using sensible skill mix and working to limit of license
  - consider issues of social care payments by patients
  - which patients should be able to access ACUTE RESPONSE
  - keep size of pilot practical so it stays within budget, investment and available resources, without loosing impact
  - remember that this is a true pilot, which means trying things: stopping or adapting those that aren't working and keeping those that are through continuous review and improvement

- OUTCOMES:
  - High complex patients assessed and risks supported pre-emptively
  - High complex patients continue to have high demand management from whole X Team
  - reduced admissions through medical, social and community support and connection
  - reduced admissions through acute response and coach support
  - General Practice less overwhelmed with vulnerable complex patients
  - General Practice able to deal with LTC and less frail elderly better with resources