REPORT TO HEALTH AND WELLBEING BOARD

31 JANUARY 2018

REPORT OF THE CHIEF EXECUTIVE OF HARTLEPOOL AND STOCKTON HEALTH

Purpose of Project:

This preventative service identifies individuals considered at high risk of going into hospital and works with those patients to create a person centred plan to help them to live safely and happily at home. The scheme is designed to work alongside the medical support provided by the patient's surgery, and focuses on the things that patient's identify themselves as being day to day issues and worries.
Working alongside local authority, charitable and voluntary services, the Care Coordinators provide expertise in the local support available that individuals may not be aware of and can help them to gain more freedom and a better quality of living.

Service Description/Scope:

- Large scale social prescribing service embedded within all local GP practices and run by the local GP Federation.
- Full population coverage, Hartlepool & Stockton.
- Team of 20 FTE inc. Team Managers based in practices with IT equipment to enable remote working at patient homes, where most meetings take place.

Expected Outcomes and Benefits:

- Reduction in unplanned admissions for the identified patient cohort by production of person centred care plans for 4,000 patients per annum, with interim follow-up, with associated system cost savings.

Evaluation of Outcomes and Benefits Realisation:

- 4,012 person centred care plans were delivered and followed up to ensure patients were completing agreed actions.
- Care Coordinators embedded in 34 of 35 practices locally.
- This project has strong links with other projects such as Hospital at Home, MDS, CH Ambassadors, 7 Day Extended GP Access as well as Community and Voluntary sector organisations locally.
- The team has played a strong role in the NESTA 100 Day Challenge and McKenzie Group Pilot.

Quantitative Evidence:

- The team has developed relationships with practices to identify, gain agreement and complete person centred care plans. Patients refusing the service once contacted by the Care Coordinator are <10%.
- 4,012 patients benefitted in Year 1 to end August 2017 v target of 4,000.

- Data is unavailable to track admissions for the specific patient cohort, however please see Woodlands Family Medical data from Nesta 100 Day Challenge project below:

  - **Reduction in A&E attendances:** In a town based practice, 41% reduction in A&E attendances for people benefiting from IPC approach to personalised care and support
  - **Reduction in zero-day admissions to A&E:** 19% reduction in zero-day admissions to A&E
  - **Potential savings through integrated working:** Integrated extended hours service, focused on a specific cohort of older people identified through IPC proactive coordination of care, resulted in an indicative annual saving of around £90k – through reduced GP attendance, hospital admissions and subsequent costs – based on extrapolating from an 8 week trial.

Main KPI	Year	Baseline KPI	Target KPI	Actual KPI
Care Plan numbers	16/17	N/A	4,000	4,012
Referrals to VCS (local KPI)	16/17	N/A	N/A	2,319
Patients declining service	16/17	N/A	N/A	260
Quality Audits	16/17	N/A	40	65

Qualitative Evidence

- Patient feedback - via questionnaire given to the patient at the end of their 13 week Care Coordinator support period, and we introduced a freepost envelope service in May. The option of electronic feedback was generally not welcomed. Brief summary of 388 responses below:

	Not at all	Slightly	Vastly	Life changing
How helpful was the service?		5%	80%	15%
How helpful was your Care Coordinator?		3%	67%	30%
	Yes		No	
Would you change the service?	6% (extend support period)		94%	

- Practice / GP Feedback – a survey is currently live but comments received are:

> "I have been very impressed with the service. Once patients engage with our Care Coordinator they are very positive."
>
> "We couldn't do without her – she gets things done for our patients that we would never have the time for".
>
> "Please don't take this away!"
>
> "It feels as though patients get a bit of a social sort out. It is about signposting all of those things out there that may help- we as GPs know and can identify the gap, we may even know of the services that are available (but not all of them by any means) but it is beyond a 10 minute app to go into the detail the patient may need".

- Wider system feedback – McKenzie Group pilot identified the role of the Care Coordinator as key to scaling up the project to complete person centred care plans and bring a "patient voice".
- Wider system feedback – the recent Hartlepool Local Review by the CQC into care of elderly patients praised the role of the Care Coordinators in facilitating support for this vulnerable group.
- Wider system feedback – the role of Care Coordinators was highlighted under the Prevention priority in Professor Colin-Thome's report on the *Hartlepool Matters* Plan as one of "the overall excellent achievements that stand out as they significantly enhance integration of individual staff and of organisations"

Conclusion

Successful Foundations

- The project was particularly successful in building strong links with the voluntary and community sector as evidenced by 2,319 referrals in 2016/17.
- Patient feedback (and carer / family feedback) has been consistently highly positive.
- Team development has been a success. Coordinators were recruited for their positive, can-do attitude and ability to build relationships, coupled with a

strong motivation to help and an ability to persevere. They were then given bespoke training and the time to get to know all the local services in their area. Strong team management has supported this development and in Year 1 not a single negative comment regarding the Care Coordinators has been received on patient feedback.

Challenges Year 1

- We have overcome the initial reluctance of some practices to buy-in to the concept and the remaining issue of low patient numbers from some areas has now been resolved. All practices except 1 in Hartlepool are engaged.

Future Benefits

- Identified patient numbers in the revised frailty cohort are already sufficient to sustain the service for the next 12m and beyond – the vast majority of these patients are unlikely to access local services that would reduce isolation or improve standards of living without signposting support and encouragement. The knock-on effect of the support that Care Coordination also provides to local carers to enable them to keep their relatives living safely at home would also be lost.
- We have worked hard over the first year to encourage the practices to understand, support and promote this service, and this work is now embedding with positive feedback from Practice Managers, GP's and Nurses in particular. The Care Coordinators working closely with practices on their frailty requirements should now release time for clinical professionals in primary care. In addition we intend to make closer links with Pharmacy professionals which should reduce unnecessary or inappropriate prescribing in this cohort.
- Wider system support – as Practices begin to work together at scale, the Care Coordinator role is vital in completing care plans and facilitating future Multi-disciplinary team working, as evidenced by the Nesta 100 day challenge and the McKenzie House initial evaluation. No other existing role currently has the capacity or expertise to fulfil this requirement.
- Wider system support – the Care Coordinators are the delivery arm for Integrated Personal Commissioning care plans and Personal Health Budgets.

In summary we believe this service, one of the largest social prescribing projects in the North, is now an embedded part of our system wide approach to keeping patients living safely and happily at home for as long as possible. It should also become a key role at the heart of coordinating future developments in at scale working and linking primary care / secondary care / community / voluntary sector.

Appendices

Appendix 1 – Detailed Patient Journey

Summary:

Partially sighted gentleman, living alone in sheltered accommodation. No family close by. Not able to use cooking appliances due to poor sight. Not able to read mail. Not able to take medication correctly, recent falls.

Norman was feeling unwell when I first met him. He was distressed over medication and missing hospital appointments. Norman had had a recent fall in his bathroom becoming unsteady on his feet after using the toilet causing him to fall resulting in a hospital admission.

Norman had missed several hospital appointments for reviews on his eyesight. He was not able to read his post and often forgot about appointments due to failing memory issues.

I liaised with family members to raise my concerns. Norman's nephew took the news on board and admitted contact had been made outside of Norman's home for some time as he had concerns for his family dog picking up tablets that were often found on Normans floor when they visited. He had not realised how things had got on top of Norman nor had realised how Normans house was becoming cluttered and post piling up.

Norman relies on a neighbour to cook a meal for him each day. He states when he feels well enough he is able to go out on the bus into town where he will also get a hot meal each day. However he was not managing this when I first met him due to his recent fall.

Actions:

I liaised with Normans nephew to encourage contact was made again with a cleaner to allow Norman's house to be free of clutter to reduce risk of falls.

I liaised with GP to gain Norman a medi pac for his medication to enable him to take his medication properly to maintain his condition of AF and diabetes at a safe level, avoiding admission to hospital.

I organised Norman's mail, weekly, making sure appointment dates and times were made clear enough for Norman to see in a large diary, this cut down on a lot of wasted appointments Norman was missing.

I completed a memory assessment with permission from GP and referred Norman to the memory clinic. Norman has had a CT scan and awaiting results.

I organised o/t to arrange a raised toilet seat to enable Norman to use it more safely to avoid any future risk of falls and hospital admissions.

Attendance was applied for and higher rate achieved. I advised Norman he could use this to have care support.

I referred Norman to social service for sensory support. Support and advice was given to Norman to have a carer once a day to ensure he was getting a hot meal, to maintain organisation of his post and appointments and ensure Norman was safe in his home

reducing any future risk of falls. Norman is thinking about having carers and is in discussion with his family and under review from social services.

Appendix 2 – summary patient journeys

- Mrs A before Christmas walked around the block with her Care Coordinator – it has been so long since she left the house on foot that she did not know a new estate had been built. She now has confidence to do this on her own.
- Mr B was found by his Care Coordinator living in one room with makeshift furniture and an unsafe gas fire – his fire was replaced before winter and his home adapted to his needs.
- Mrs C had become isolated and anxious about leaving her home – her Care Coordinator took her to a lunch club which she now attends on her own, and she also meets weekly with new friends she made at the club. She believes her pain is lessened now that she is active and moving about.
- Mr D had become housebound and dependent on neighbours as his wheelchair was faulty, and also his central heating was condemned. He couldn't chase up repairs on his own. He was able to swap to a manageable wheelchair, allowing him to access the garden and do his own shopping. Fire Service arranged an electric heater pending repairs to heating.
- Miss E was on l/t absence from work with arthritis and increasing levels of anxiety. She was helped to self-refer for counselling, agreed other pain relief methods and was encouraged to speak to her Manager – she now works 2 days pw from home.
- Mrs F had become unable to walk far alone but would not admit problems to family. Her Care Coordinator took her for an induction on a shopmobility scooter and she now gets out to do shopping and meet friends.
- Mr G had recently moved but been unable to arrange utilities with no help and was living without heat – his Care Coordinator arranged connection.
- Mr and Mrs H had become confused with multiple medications and inhalers. Care Coordinator agreed Meds review with Pharmacist, and monthly blister packs were arranged. Practice nurse appt booked for inhaler education and also flu jabs, patient confidence increased and rescue inhaler now used less.