Connected Care

a focus on new roles in primary care

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Wakefield vision and priorities

‘Person centred co-ordinated care’.

The Health and Wellbeing plan 2018 sets out the strategic direction and vision for health and care across the Wakefield District. With local services working together, focused on people and place, we aim to transform our plan to take a more proactive approach. The plan has four priorities:

• Give every child the best start in life

• Prevent ill health by focusing on early intervention and prevention

• Ensure there is a healthy standard of living for everyone

• Create and develop sustainable communities that support local residents to become healthier, resilient and empowered.
Challenges for the Wakefield population

- Wakefield district has an estimated resident population of around 336,834 (371,559 registered with the district’s 37 GP practices).

- 12% of the population are aged over 70 years. It is predicted that by 2021 over 22% of people will be aged over 65 years.

- Wakefield district ranks as the 65th most deprived district in England (out of 326), and over 40,000 people live in neighbourhoods that are in the top 10% most deprived in England. There are, however, neighbourhoods of considerable affluence and the overall trend is considered to be one of improvement and development.
Challenges for the Wakefield population

1. We are living longer, with more illnesses than ever before (elderly care)
2. People dying from lung cancer and cardiovascular disease in those aged under 75 is increasing
3. Mental ill health makes up a large part of morbidity faced by Wakefield district’s population
4. People experience unequal levels of health and duration of life
5. Smoking remains a problem for the Wakefield district
6. Excess weight in the population is a challenge
7. Alcohol harm and the violence associated with alcohol is increasing
8. Air pollution in Wakefield is linked to hundreds of deaths a year
9. Infectious diseases still pose risk to Wakefield and district residents
10. Dental health for children and adults in Wakefield is poor.
In order to develop a New Model of Care locally, a number of Wakefield health, social care, housing and voluntary and community sector providers signed an alliance agreement in August 2017 with Wakefield Council and Wakefield CCG to form a new Board to facilitate the development of an “integrated care partnership” system in Wakefield.

The scope of services within the agreement focuses on out of hospital community care services working together differently.

The New Models of Care Board acts as a forum through which partners can make decisions about the Wakefield New Model of Care. It further facilitates providers to work more closely together, in order to create greater standardisation and integration of pathways, resulting in improved outcomes.

The Board has developed the Connecting Care+ Business Plan 2018-2021 and has agreed to focus on five key priority areas (identified through the JSNA):

1. Lung Cancer
2. Mental Health
3. Elderly Care
4. Primary Care Home
5. End of Life Care
Connecting Care+ partners

- Connecting Care+ is made up of a range of partners, from health, social housing and voluntary and community organisations.
- These organisations work together as partners to deliver health and social care integration to deliver innovative methods of care to local people.
Connecting Care Hubs

1 Waterton Hub
2 Bullenshaw Hub
3 Hollywell Lane Satellite Unit
CC Hubs – PIC File

- The PIC file now covers 100% of the population, this was achieved in March 2019.
- A total of 3,896 referrals were made in 2018/19

Referrals by age and gender:

- Referrals in this period: 3896
  - Waterton: 1883
  - Bullenshaw: 2013

- Weekend referrals received = 129

- % of East referrals from GP Practice: 42%
- % of West referrals from GP Practice: 58%

- GP Referrals closed within 7 days: 164 (22.9% of closed GP referrals)
- GP Referrals closed within 30 days: 324 (45.3% of closed GP referrals)
Wakefield General Practice Strategy

• Sets out a vision for a new relationship between individuals and communities, prevention and treatment, physical and mental health, service users and service providers and generalists and specialists.

• This strategy provides details of some of the key initiatives that Wakefield CCG has been leading on. It describes five key priorities which will transform the way we deliver primary care services moving forward.

  ▪ The development of core teams to support GP Practices
  ▪ The establishment of Primary Care Homes
  ▪ Consolidation of community-based urgent care services
  ▪ Care navigation, digital access, self-care and social prescribing
  ▪ Closer Working with Specialists to Improve Pathways and Clinical Efficiency
Interventions

- Ensuring that all practices and their patients are benefiting from **wider core teams** including clinical pharmacists and primary mental health workers;

- Implementation of the **Primary Care Home (PCH)** model in Wakefield growing out from existing practice networks in partnership with community nursing, connecting Care + and care home services and focused on local health needs and disease prevention;

- **Streaming acute episodic low continuity urgent care** (including network level clinical assessment, home visiting services and Urgent Treatment Centre development) to make time for high continuity complex care;

- Health and **care navigation** including digital access, clinical triage, supported self-care and use of social prescribing;

- **Closer working with specialists** to improve care pathways and clinical efficiency (including hospital outpatient services and urgent ambulatory care).
Primary Care Homes

• Practices have been divided into 7 Primary Care Homes
• All registered with the National Association of Primary Care
• Network contracts have been agreed
• Leadership teams have been appointed
• Provisional priorities have been identified
• Partners and patients actively engaging
• Social prescribing service established

https://vimeo.com/337484298
Emerging Priorities

- WHA North: Obesity
- WHA Central: COPD
- WHA South: Improving mental health
- Brigantes: Improving mental health
- Five Towns: Support for people pre-diabetes
- Trinity Health: Smoking
- West Wakefield: Self care
Joint Working

**Partnerships**
- Joint working across practice and community nursing
- Aligning Connecting Care Hubs with PCHs
- Aligning Early Health Hubs with PCHs

**Social prescribing**
- Addressing social isolation
- Better access to voluntary and community services
- Enabling GPs to focus on people with medical needs

**Care Homes**
- Coordinated approach to supporting care home residents
- Reducing avoidable hospital admissions
- Better Advanced Care planning
PCH Transformation Programmes

- Clinical Pharmacy General Practice
- Late Visiting Service
- Care Homes Enhanced Service
- GP Care Wakefield
- Care Navigation
- Link Workers/Social Prescribing
Clinical Pharmacy in general practice model

Skill mix of pharmacists and technicians (3 per 50,000 population) employed by Federations

Technicians: cost-effective changes to meds through pre-approved protocols; simple queries

Better outcomes for patients through medicines optimisation

Senior Technicians: Post discharge medicines reconciliation; L&D for practice medicines coordinators; simple queries

Pharmacists: risk stratification tools to prioritise patients; level 3 medication review; de-prescribing; identifying unmet need; complex queries
Late Visiting Service

• 941 visits accepted in 2018/19

• There is one clinical co-ordinator each day, taking the call from the GP
• The team are able to follow up for 72 hours if required and monitor treatments
• The ACPs are now able to refer directly into ambulatory care
• The ACP's are multi-professional and able to offer generic, holistic assessment. (i.e. equipment provision, urine dip etc)
• NEWS2 is completed on all patients to identify deteriorating patients and use as a guide when discussing with GPs, and secondary care handovers.
• Self-referral- if patients are unwell who were previously known to the Community Matrons- the URT team are now accepting these rather than advising to contact the GP.
Care Homes

• Care Homes MDT team working proactively with 15 care homes in Wakefield to improve quality
• Red Bag transfer pathway rolled out to all 49 +65 care homes in Wakefield
• 90% of all care homes in Wakefield, including specialist homes, registered on the Capacity Tracker
• 1,510 care home residents received enhanced care via the local enhanced service
• Supplementary Network Contract
GP Care Wakefield

1. Direct access to a **Clinical Advice** and Booking Centre
2. **Same-day appointments** with GP and Advanced Nurse Practitioner (ANP)
3. **Routine Care** appointments delivered by practice nurses and Health Care Assistants.
4. **Delivered in partnership** with the Trinity Medical Centre team and Local Care Direct.
Streamlining Patient’s Journey

- **Open 7 days a week, every day of the year**
  - Monday-Friday 6pm-10pm
  - Weekends & Bank Holidays 9am-3pm

- **Access**
  - **Urgent Care**: Through GP practices telephone numbers and NHS 111
  - **Routine Care**: Through practice reception staff

- **Sites for face-to-face consultations**
  - Trinity Medical Centre
  - Pontefract General Hospital
Care Navigation

Practice based training has received great feedback and has led to surgeries starting to record care navigations much more quickly.
Link Workers/Social Prescribing

Model

• Integration of LWW service and social prescribing offer directly into PCHs
• A one year pilot for LWW to deliver the social prescribing link worker element within all PCHs with potential for longer term expansion
• LWW provide training and support to deliver personalised care and community asset based support to all PCHs
• 7 x community co-ordinators to deliver:
  ✓ Social prescribing approaches
  ✓ Address the needs and strengths of the individual,
  ✓ Connecting them to wider networks and facilitate community growth
  ✓ Empowering communities to develop and thrive

Outcomes

✓ Less administrative burden for practices
✓ Reduce avoidable GP visits by ensuring more people get the support they need without always needing to see their GP first
✓ One point of referral
✓ Strong and healthier communities means better health outcomes longer term supporting the sustainability of health and care services
✓ Easy access to LWW infrastructure to support both the resilience of the practice, the patient and the co-ordinator role
✓ Stronger links between VCS, PCHs and LWW
✓ Outcomes for personalised care supported by the LWW and agreed with PCHs networks
✓ Meet social prescribing requirements of NHS GP contract
Challenges/Considerations

- Partnership Working
- Leadership skills and ability
- Workforce Capacity
- Population health management … and the day job.
Questions & Comments