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CLEAR Anticipatory Care – new models of proactive holistic care for patients while reducing pressure on primary and secondary care

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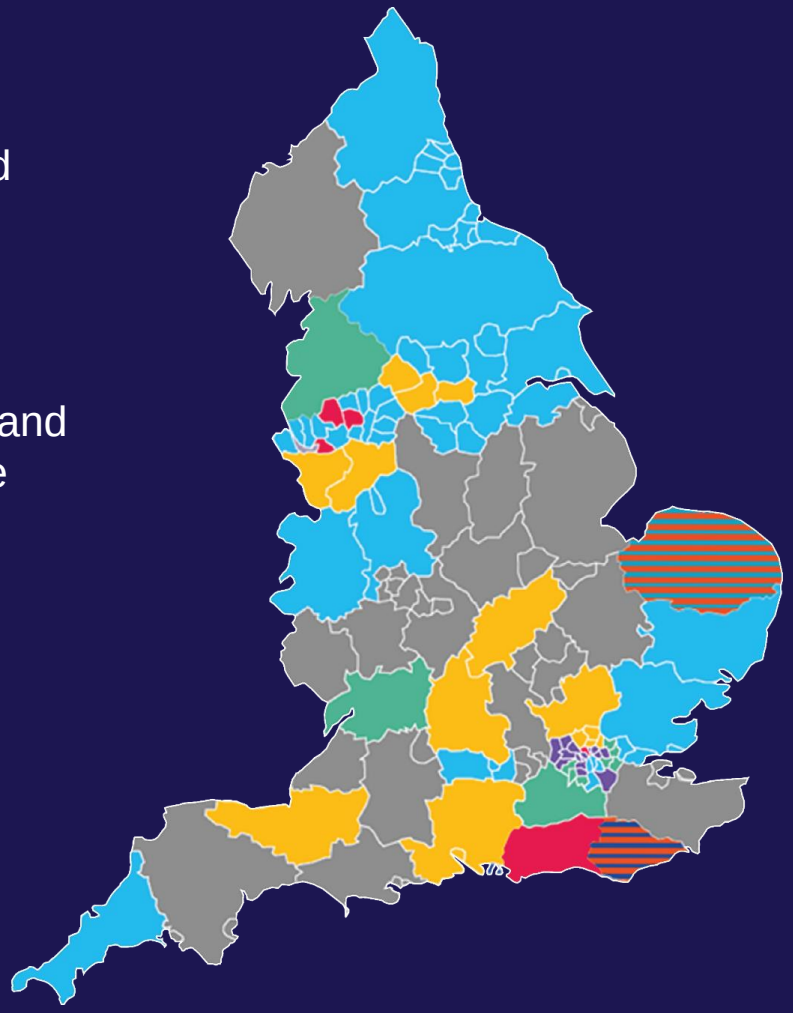
CLEAR is supporting the NHS across key priority areas

- The programme has provided rapid support and training to the NHS during the COVID-19 pandemic and continues to support the NHS in restoring and transforming services.

- 40+ projects have been completed across England empowering more than 100 clinicians with more projects underway in mental health, primary care, elective recovery, oncology and catheter care.



URGENT AND EMERGENCY CARE
CRITICAL CARE
MENTAL HEALTH
ANTICIPATORY CARE
OPHTHALMOLOGY
OPERATING THEATRES
BESPOKE PROJECTS

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CLEAR AC programme overview

- **5 PCNs** across England took part in the 26-week project between January and July 2022: Hyde, TABA, East Warrington, Camden and Regis.
- Clinicians from each PCN were trained in the CLEAR methodology, learning the fundamentals of clinical engagement and data analytics, **empowering them to redesign new models of care and workforce**.
- Case studies have been published on the CLEAR website.

East Warrington

Camden

Regis

TABA

Hyde

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Key challenges and findings - overview

Sites are experiencing a range of common and interdependent challenges that create pockets of 'vicious circles' with worsening service user outcomes, staff wellbeing and retention

1. **Variable integrated care and care coordination for patients with LTCs and complex needs resulting in more pressure on GPs**
   - Acute workload as a barrier to providing holistic care
   - Discharging of patients to primary care without this being communicated to other services

2. **Challenges with data collection, coding and information sharing**
   - Existing data not made available to all within the service/PCN
   - Incompatible data templates prevent care from being adequately standardised
   - 'Ad hoc' care planning as opposed to proactive planning
   - Duplication of work

3. **Inequity of access**
   - Inadequate tailoring of appointments and care plans to patient-specific needs
   - Particularly detrimental in relation to care for high intensity users

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Thematic overview of key recommendations

1. Communication – proactive care needs assessment, multi-agency working, common language – available to all, carers support at PCN level
2. Inter-collaboration ICS/PCN Level, record sharing, multi-agency working
3. Data sharing, system design and demand, using existing tools more efficiently
4. Understand local needs and challenges, community empowerment
5. Workforce – new ARRS roles – linking in with ICS, proactive approach, upskilling

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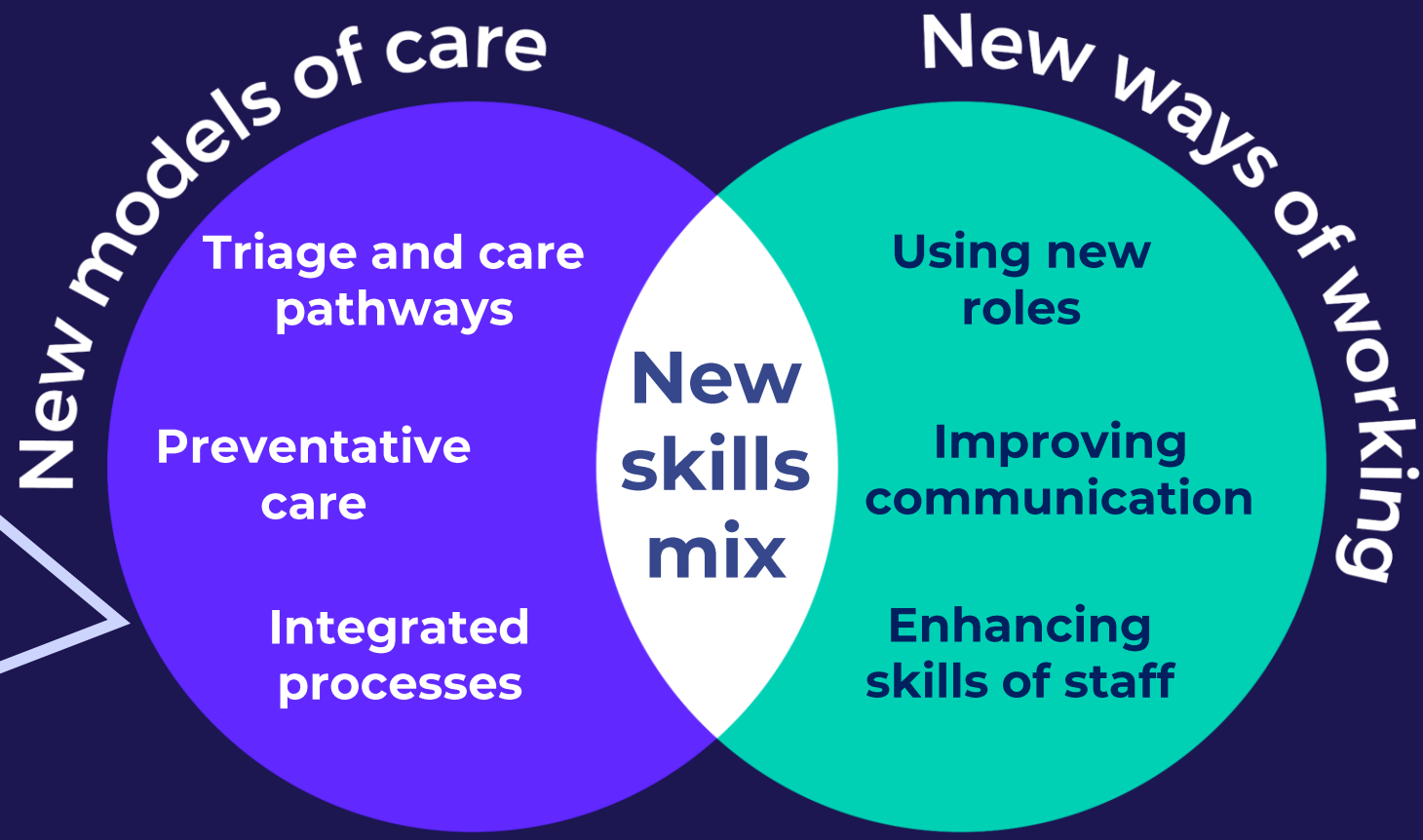
CLEAR recommendations for transformation

The outcomes of a CLEAR project include a set of recommendations which are presented to the executive board of the trust/system/PCN by the clinicians leading on the project .

New skills mix

- Optimise use of different roles to create a more flexible and engaged workforce
- Use skills within existing roles to full potential
- Enhance career pathways for progression in alignment with local patient need
- Harness potential of data
- Expand workforce and increase permanent workforce capacity
- Support transformation with capacity



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SR Melissa Lawton

Complex Case Nurse, Hyde PCN and CLEAR Anticipatory Care Associate

Hyde CLEAR Team

Dr Timothy Dowling (Clinical sponsor)
SR Emma Maguire (Buckley) (CLEAR Associate)
SR Melissa Lawton (CLEAR Associate)

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Hyde PCN – Greater Manchester

We cover a population of 70,000 patients through 8 member GP Practices – 7.7% come from BAME communities

1) 48.3% of Hyde's population live in the 20% most deprived Lower layer Super Output Areas (LSOAs)

2) Healthy life expectancy is below the national average by 5.3yrs for men (58.1/63.4) and 6.1yrs (57.8/63.9) for women

3) 720 have dementia = 0.99% of PCN population (England average 0.79%)

4) Tameside and Glossop has very poor outcomes in dementia care and were the 3rd worst in the country for acute admissions for dementia patients

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1. Communication

- Poor communication between organisations repetition of work
- Poor knowledge of roles in other teams

2. Lack of collaboration

- Rejected referrals without feedback
- Multiple services working with same patients,

independent of one another

3. Inequity of care

- Patients who lack capacity are treated differently to those who do have capacity
- Undefined referral criteria

4. Accessibility

- Location of services
- Restrictive referral criteria

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Summary of recommendation: Dementia case management service

3. Proactive care planning based on strengths and goals – identifies realistic outcomes

4. Dedicated healthcare professional phoneline and email – improves information sharing and reduces repetition of work

2. Hospital in-reach/outreach - baseline information for admission and support with discharge planning

5. Annual QOF dementia care reviews completed – meets QOF targets and reduces workload for practices

1. Single point of contact for patients, families and carers – reduces stress and burden on other services

6. Co-ordination of care across teams, services and organisations – enables joined up care and improved collaboration

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Dementia case management service

Proactively care for dementia patients who are not living in 24-hour care homes through co-ordination of their needs.

- Multidisciplinary team (MDT) to enhance therapeutic relationships and reduce unwarranted health and care outcomes.
- Dementia case manager (DCM) - works inclusively to ensure all stakeholders are part of formulation, implementation and assessment of a strengths-based plan, managing personal goals, wishes and expectations.
- 1.2 WTE band 8a nurse - leads the service and provides line management to the team in addition to managing a caseload, 2.1 WTE band 7 nurses - each hold a caseload with administrative support from the band 4 care coordinators (1.5 WTE) acting in the role of dementia case navigator supporting the nursing team and a caseload of approximately 354 identified from the PCN database.
- Based at the PCN Hub to support all 8 practices and operates Monday to Friday from 8.30am until 4.30pm with a suggested “on call” rota to cover out-of-hours contact.

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Margaret Macklin

CLEAR Anticipatory Care Associate representing East Warrington PCN

East Warrington CLEAR Team

Dr Raahki Raj (Executive Sponsor)
Margaret Macklin (CLEAR Associate)
Dr Emma Lynch (CLEAR Associates)

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The challenge

The PCN was facing unprecedented demand and struggling to prioritise the care of people living with frailty. Care was increasingly reactive and the PCN recognised that new approaches were needed to address complex underlying issues in a multi-agency setting. Coding of patients, data collection and sharing of information all needed improving to support holistic, person-centred approaches.

- East Warrington PCN recognised that new, holistic approaches were needed to address complex, underlying issues to improve wellbeing.
- Their successful bid to CLEAR was supported strategically within the Integrated Care System, with the Place Partnership committed to responding to recommendations.

Focus

People living in the community at increased risk of potentially avoidable acute or crisis care admission, where early identification and intervention can make a significant difference (Rockwood 3-7)

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Project Evidence Base

Clinical engagement	Data analysis
Over 50 people from frontline to managerial levels participated in individual interviews or focus groups. The interviews used semi-structured interview techniques and they were recorded, analysed and coded into themes. The team also met with a national group of people with lived experience to test out findings and recommendations as well as local strategic bodies under the auspices of Cheshire and Merseyside ICB.	Data relating to 31,020 patients was extracted from 3 GP practices (15/3/18 – 14/9/21). Specific patient cohorts were examined including extracts of patients coded with mild to severe frailty. The team also had a separate analysis of High Intensity Users from national CLEAR Faculty. In addition, the following data sources were used: • East Warrington PCN GP practice data • Examination of local health system and Quality Outcomes Framework / Network Contract Directed Enhanced Services (QOF/DES) data returns • Review of Warrington ICT (Integrated Care Teams) data project findings
Research	**Emerging models of care**
The team were supported to access a range of relevant research regarding frailty, interventions and impact.	The team were able to link to the national aging well programme and a number of national initiatives to deliver proactive care.

CLEAR faculty supported

- Qualitative / quantitative data gathering
- Data analysis and triangulation
- Access to key national bodies / networks
- System redesign and workforce modelling tools
- Evidence-based recommendations

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Key findings

Patients living with frailty take up a disproportionate amount of GP, A&E and secondary care resources that are not serving them well.

A specialist Ageing Well resource within primary care, delivering personalised, strength based care can:

- Improve access to support and care management at an appropriate level
- Support a shift from reactive condition based to proactive holistic approaches
- Reduce demand on GP and other acute and social care services
- Help deliver QOF/DES/LES requirements
- Improve staff recruitment, retention and job satisfaction
- Is a cost effective use of resources which can release capacity/costs in acute care and in social/community care.

To be most effective, there needs to be specific investment and support to carers from within primary care.

- When carers struggle to care, families turn to health services for help
- Patients living with frailty with carers, access more appointments in primary care than those who do not have carers
- System demand arises from shortage of services and access routes to carer support and advice
- There are opportunities through primary care to identify and support carers earlier, help them navigate complex systems and prevent avoidable carer breakdown

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East Warrington PCN recommendations

3. Improve connectivity between primary care and the wider health and social care network to support personalised, holistic care

2. Create specific capacity and pathways to deliver a proportionate, graded approach to anticipatory care

1. Agree a common approach to the identification and coding of people most likely to benefit from anticipatory care

4. Improve carer identification and strengthen support to informal carers from within primary care

5. Enhance the voice of primary care within the ICS and ensure that the development of AC is integrated within wider systems and complementary programmes

6. Embed community-led and strength based approaches that empower people to maintain their health and wellbeing

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Modelling for ageing well team

Staff Role	Total WTE
Advanced practitioner	0.5
Care coordinator	0.5
Carer coordinator	0.3
Admin	0.06
Salaried GP	0.05
Clinical pharmacist	0.25
Total cost ARRS eligible	**£61,125 (-55,623)**

Impact from baseline	Reduction for cohort (325)	Cost per episode	Total impact / cost equivalent for cohort (325)
GP appointments (50% reduction RW 6; 30% RW5)	1,025	£39	£39,975
Non-GP appointments (30% reduction)	276	£25.66	£14,164
ED attendances (30% reduction from baseline 318)	103 (63 (patient support) + 8 (improved carer support))	£400	£41,200
Emergency admissions (30% reduction from baseline 156)	49 (16 (patient support) + 2 (improved carer support))	£1,000	£49,000
Total			**£144,339**

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Progress

- The ICS Place Programme has accepted the recommendations and is building them into the strategic development of integrated care teams, community talking centres, virtual wards and High Intensity User support – there is a working group established
- They are still trying to identify funds to pilot the Ageing Well team in East Warrington PCN
- The PCN now links into the MDT team meetings to discuss people living with frailty with complex needs
- Warrington Carers Board has developed a workstream around carers and primary care
- Association of Directors of Adult Social Services (ADASS) - Carers Network has accepted the recommendation regarding carers as a priority in their delivery plan.

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Next session today

A view from the frontline – hear from clinicians who've chosen to be part of CLEAR and lead change

21/03/23

15:00-15:50pm

To view the full #CLEARweek 2023 programme and sign up to sessions, visit clearprogramme.org.uk/clear-week-2023