CLEAR
Empowering staff to innovate care

CLEAR Proactive Care 2022

Central Camden Primary Care Network

Increasing personalised holistic care for patients living with frailty

AT A GLANCE

CLEAR CHALLENGE

Pressure on GP practices was resulting in unplanned care for patients living with frailty, with little time for care planning and a high number of GP appointments

KEY CHANGES

A new multidisciplinary anticipatory care team to provide better care for patients most in need with personalised care plans to reduce ED attendances and hospital admissions

FORECAST BENEFITS

More proactive holistic care for frailty patients with an estimated reduction of 14,000 PCN emergency appointments and £554k productivity savings

THE CHALLENGE

The primary care network (PCN) was looking to provide more proactive care for its patients living with frailty and complex needs.

Patients on the frailty register had on average 22.5 GP appointments a year compared with seven for the general population - but pressure on GP practices was resulting in little time for care planning.

Coding of patients and care planning was variable, with 78% of patients on the frailty register having no care plan. Collaboration with other providers could be improved.

WHAT THEY DID

The project team conducted 19 interviews with representatives from GP practices, local hospitals and Age UK.

Their findings were analysed alongside data from the PCN's clinical information systems. The data related to a 12-month period from April 2021 when the PCN had 83,000 patients including 882 on the frailty register.

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CLEAR RECOMMENDATIONS

An anticipatory care (AC) team could be established, consisting of a GP, pharmacist, advanced practitioner and care co-ordinator. This dedicated team would have the time and skills to identify and meet the needs of patients on the frailty register. Their focus would be on implementing personalised holistic care plans to reduce the rate of emergency hospital admissions and improve the quality of care.

The team would work closely with partners including Camden's frailty virtual ward, district nurses, Age UK and rapid response teams. An email address and phone number would be used as a single point of access for the seamless transition of frailty patients between the different services providing their care.

A standardised framework could be set up to improve the assessment and management of patients living with frailty - with the PCN proactively contacting the most vulnerable patients to identify any outstanding health and social care needs.

A new anticipatory care team to be created focusing on personalised care plans - estimated to save more than 14,000 GP emergency appointments each year as well as reduce ED attendances and emergency hospital admissions

FORECAST IMPACT

The care of 75% of frailty patients would be transferred from general practices to the new AC team. It's estimated across the PCN 14,343 emergency appointments would be saved each year - with a net productivity saving of £262,011 in the first year.

An expected reduction of 0.4 emergency department attendances per patient per year and a 0.2 reduction in emergency hospital admissions per patient per year would generate wider savings to the NHS of £292,060 in one year.

Better collaboration and information sharing would lead to increased efficiency, reduced duplication of work and an easing of PCN workload. Patients would receive better, personalised, joined-up care with health professionals from different services understanding their wishes, values and the whole context of their care.