CLEAR
Empowering staff to innovate care

CLEAR Proactive Care 2022

East Warrington Primary Care Network

Improving the care of patients living with mild to moderate frailty

AT A GLANCE

CLEAR CHALLENGE

GP practices and other providers were facing unprecedented levels of demand with people living with frailty needing a high number of appointments

KEY CHANGES

A whole system shift towards integrated, holistic interventions and a new ageing well team to target proactive, personalised care when needed

FORECAST BENEFITS

Increased confidence and wellbeing for people living with frailty with reductions in GP appointments, ED attendances and hospital admissions

THE CHALLENGE

The primary care network (PCN) was facing unprecedented demand. Patients with mild to moderate frailty had at least three times more GP appointments and 2.5 times more non-GP appointments than the PCN average. They also accounted for a disproportionate amount of ED attendances and emergency hospital admissions.

Coding of patients, data collection and information sharing needed improving to support person-centred approaches. Carers required more support to reduce the number of crisis appointments and to help them access services to maintain confidence and wellbeing. The PCN recognised new approaches were needed to address complex underlying issues.

WHAT THEY DID

More than 50 people from a broad range of services and from operational to strategic level took part in interviews or focus groups. The CLEAR team discussed the project with local and regional strategic bodies. Data relating to 31,000 patients was extracted from the PCN's three GP practices and two specific data sets produced, one focused on patients with mild to severe frailty over a three-year period and the other on the medical interventions received by patients with mild to moderate frailty over a 12-month period.

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CLEAR RECOMMENDATIONS

The team recommended the creation of a specialist 'ageing well' team supporting primary care to provide personalised, proactive care for patients with mild to moderate frailty.

Consisting of an ageing well advanced practitioner, a care coordinator, a carers' care coordinator, a clinical pharmacist and administrative support, the team would link to a dedicated frailty lead GP in each of the three practices. It would oversee the systematic triaging of patients living with frailty to identify those most at risk and those needing referral to other services.

A uniform approach to coding frailty patients should be adopted to enable earlier diagnosis as well as greater collaboration between primary care and health and social care partners to provide a more holistic service. This would ensure integration of proactive care into the wider healthcare system.

> "The CLEAR programme presented a unique opportunity to work with local stakeholders on one of the biggest challenges currently facing primary care and other health and care services"
>
> **Margaret Macklin, CLEAR Associate representing East Warrington PCN**

FORECAST IMPACT

Patients most in need, including those who are housebound or living with dementia, would receive a better, more proactive and coordinated service - with the wellbeing and confidence of patients and carers improved.

The need for GP appointments and crisis support, including emergency department attendances and hospital admissions would be reduced. The workload of GP practices would ease and staff morale as well as retention improve.

Through the creation of an ageing well team, it is estimated that the PCN could achieve a 50% reduction in GP appointments for moderately frail patients, a 30% reduction for mildly frail patients and a 30% reduction in ED attendances and emergency hospital admissions – resulting in total productivity savings of £144,339.