Community and Primary Care Nursing: Leading and shaping new models of care – responding to the five year forward view

Hilary Garratt
Director of Nursing: Commissioning & Health Improvement

March 2015

Twitter: #5YFV #shapeofcaring #FutureNHS
Housekeeping
Aims of the day:

- Bring people together
- Time to think
- Take Action
Mrs Andrews Story: What went wrong

https://www.youtube.com/watch?v=Fj_9HG_TWEM
Five Year Forward View

One of the key aims is:

- To enable general practice, community pharmacy and other primary care services to play a much stronger role, at the heart of a more integrated system of community-based services.
Focus on prevention and public health
• Behaviour change to tackle lifestyle factors

Empowering patients and citizens
• Support and information for self-management and personalised care

Engaging with communities
• Partnership with the voluntary sector and public engagement

New models of care
• MCPs/PACs/VsH/Care Homes

Leadership at a local level
• Influence in driving integrated care
• Supporting development of a modern workforce

Improving quality
• Patient safety
• Patient experience
• Clinical effectiveness
New Models of Care

Charlotte Williams
New Models of Care Programme Manager
NHSE
NHS Five Year Forward View

• The NHS Five Year Forward View was published on 23 October 2014

• One of its great successes was that it is a shared vision for the future of the NHS across six national NHS bodies

• The challenge is now implementation; we know:
  • It will not be easy
  • We need to learn from the past
  • We’re going to need a different approach
  • We’re up for it
The future NHS

The core argument made in the Forward View centres around three ‘gaps’:

1. **Health & wellbeing gap**
   - **Radical upgrade in prevention**
     - Back national action on major health risks
     - Targeted prevention initiatives e.g. diabetes
     - Much greater patient control
     - Harnessing the ‘renewable energy’ of communities

2. **Care & quality gap**
   - **New models of care**
     - Neither ‘one size fits all’, nor ‘thousand flowers’
     - A menu of care models for local areas to consider
     - Investment and flexibilities to support implementation of new care models

3. **Funding gap**
   - **Efficiency & investment**
     - Implementation of these care models and other actions could deliver significant efficiency gains
     - However, there remains an additional funding requirement for the next government
     - And the need for upfront, pump-priming investment
New Models of Care

Initially the new models of care programme will focus on:

**Multispecialty Community Providers**
- Blending primary care and specialist services in one organisation
- Multidisciplinary teams providing services in the community
- Identifying the patients who will benefit most, across a population of at least 30,000

**Integrated primary and acute care systems**
- Integrated primary, hospital and mental health services working as a single integrated network or organisation
- Sharing the risk for the health of a defined population
- Flexible use of workforce and wider community assets

**New approaches to smaller viable hospitals**
- Coordinated care for patients with long-term conditions
- Targeting specific areas of interest, such as elective surgery
- Considering new organisational forms and joint ventures

**Enhanced health in care homes**
- Multi-agency support for people in care homes and to help people stay at home
- Using new technologies and telemedicine for specialist input
- Support for patients to die in their place of choice
Principles of New Models of Care

The vanguard sites chosen for new models of care will need to show:

- **Ambitious vision**: Highlighting what you want to change in order to meet clear identified needs and preferences of your local population.

- **Strong local relationships & delivery partners**: Support from a diverse range of active delivery partners, local commissioners and communities.

- **Credible plan & tangible progress**: To allow the programme to move at pace and make rapid change during 2015; including progress toward new ways of working.

- **Strong leadership**: Effective managerial and clinical leadership and the capacity and capability to deliver change.
What we are trying to achieve

There are three key elements to the New Models of Care programme

1. Dissolving traditional barriers
   - A need to manage systems of care not just organisations
   - Integrated services around the patient giving the patient greater control
   - Addressing pre-existing barriers to change

2. Co-designing local services
   - Harnessing the ‘renewable energy’ of communities
   - Targeted prevention initiatives
   - Investment and flexibilities to support implementation of new care models
   - Active patient involvement

3. Applying learnings across the health system
   - Promote peer learning with similar areas
   - Fast learning from best practice examples
   - Applying innovations and learnings across the system
What does success look like?

A range of new care models that are locally delivered across the country and can be replicated across the system

1. New care models
   - A need to manage systems of care not just organisations
   - Integrated services around the patient giving the patient greater control in their care

2. Locally delivered
   - A focus on meeting local population health needs
   - Support from a diverse range of active delivery partners, local commissioners and communities
   - Active patient involvement

3. National replicability
   - Fast learning from best practice examples that can be applied to other areas across the country
   - Applying innovations and learnings across the system
Review Principles for selecting Vanguard systems

We are reviewing the ‘vanguard’ applications using the following principles:

• The process will be as transparent as possible
• Patients and clinicians will be engaged throughout
• Regional teams will be invited to provide local insights
• Additional insight will be sought from a wide range of partners, including the national NHS bodies, NHS IQ and Think Tanks
• The New Models of Care Board will take the final decision on who we will work with as ‘vanguards’ in the first year
• Final decisions will be a value based, taking into account all evidence received throughout the process
On 26 January, invitations for expressions of interest to become a vanguard site were opened.

Applicants were asked to complete a 6-question ‘register of interest’ form, describing the key objectives they were trying to achieve with their new care model plan, current progress, planned outcomes to be achieved April 2016, the nature of support they need.

Submissions closed on 9 February, with a total of 268 received nationwide. 63 were short-listed after a national and regional review reviewers including clinicians, patients and representatives from the community, and colleagues from local government.

<table>
<thead>
<tr>
<th>Care model</th>
<th># submissions</th>
<th># attending workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multispecialty Community Providers (MCPs)</td>
<td>170</td>
<td>33</td>
</tr>
<tr>
<td>Primary and Acute Care Systems (PACS)</td>
<td>46</td>
<td>17</td>
</tr>
<tr>
<td>Viable Smaller Hospitals (VSH)</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Enhanced health in care homes (CH)</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Unspecified</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>268</strong></td>
<td><strong>63</strong></td>
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First cohort Vanguard sites

<table>
<thead>
<tr>
<th>Care model</th>
<th>Applicant</th>
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</thead>
<tbody>
<tr>
<td>PACS</td>
<td>Wirral University Teaching Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>PACS</td>
<td>Mansfield and Ashfield and Newark and Sherwood CCGs</td>
</tr>
<tr>
<td>PACS</td>
<td>Yeovil Hospital</td>
</tr>
<tr>
<td>PACS</td>
<td>Northumbria Healthcare NHS Trust</td>
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<tr>
<td>PACS</td>
<td>Salford Royal Foundation Trust</td>
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<tr>
<td>PACS</td>
<td>Lancashire North</td>
</tr>
<tr>
<td>PACS</td>
<td>Hampshire &amp; Farnham CCG</td>
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<tr>
<td>PACS</td>
<td>Harrogate &amp; Rural District CCG</td>
</tr>
<tr>
<td>PACS</td>
<td>Isle of Wight</td>
</tr>
<tr>
<td>MCP</td>
<td>Calderdale Health &amp; Social Care Economy</td>
</tr>
<tr>
<td>MCP</td>
<td>Derbyshire Community Health Services NHS Foundation Trust</td>
</tr>
<tr>
<td>MCP</td>
<td>Fylde Coast Local Health Economy</td>
</tr>
<tr>
<td>MCP</td>
<td>Vitality</td>
</tr>
<tr>
<td>MCP</td>
<td>West Wakefield Health and Wellbeing Ltd (new GP Federation)</td>
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<tr>
<td>MCP</td>
<td>NHS Sunderland CCG and Sunderland City Council</td>
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<tr>
<td>MCP</td>
<td>NHS Dudley Clinical Commissioning Group</td>
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<tr>
<td>MCP</td>
<td>Whitstable Medical Practice</td>
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<tr>
<td>MCP</td>
<td>Stockport Together</td>
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<tr>
<td>MCP</td>
<td>Tower Hamlets Integrated Provider Partnership</td>
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<tr>
<td>MCP</td>
<td>Southern Hampshire</td>
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<tr>
<td>MCP</td>
<td>Primary Care Cheshire</td>
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<tr>
<td>MCP</td>
<td>Lakeside Surgeries</td>
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<tr>
<td>MCP</td>
<td>Principia Partners in Health</td>
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</tbody>
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<table>
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<tbody>
<tr>
<td>Care Homes</td>
<td>NHS Wakefield CCG</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Newcastle Gateshead Alliance</td>
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<tr>
<td>Care Homes</td>
<td>East and North Hertfordshire CCG</td>
</tr>
<tr>
<td>Care Homes</td>
<td>Nottingham City CCG</td>
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<tr>
<td>Care Homes</td>
<td>Sutton CCG</td>
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<tr>
<td>Care Homes</td>
<td>Airedale NHS FT</td>
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## Themes of the support programme - transactional support (1/2)

<table>
<thead>
<tr>
<th>Key theme</th>
<th>Known Barriers</th>
<th>How we might overcome known barriers?</th>
<th>What organisations could support?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning, contracting and payments</td>
<td>• Current mechanisms are not conducive to enabling new models across multiple organisations; multilateral gain-risk share arrangements&lt;br&gt;• PbR versus block contracts; prime or alliance contracts&lt;br&gt;• concerns over competition procurement law&lt;br&gt;• true joint commissioning models with local government</td>
<td>• Establish a community of practice to share learning and expertise, offering expert and legal advice&lt;br&gt;• Accelerate development of new payment systems such as capitated budgets, polled budgets and integrated personal commissioning.&lt;br&gt;• Review current rules on procurement and tendering, and consider possible waiver for commissioners to deviate from those rules</td>
<td>• Aligned national support across ALBs&lt;br&gt;• IHI&lt;br&gt;• King’s Fund</td>
</tr>
<tr>
<td>Information technology and information governance</td>
<td>• IT systems have low inoperability capability across organisations and systems;&lt;br&gt;• Limited holistic data sets/means in order to track patient-level activity and costs across multiple settings;&lt;br&gt;• Information governance prevents necessary sharing of secondary data across organisations</td>
<td>• Self assessment and diagnostic&lt;br&gt;• A nationally led programme under the remit of the National Information Board</td>
<td>• Aligned national support across ALBs&lt;br&gt;• National Information Board</td>
</tr>
</tbody>
</table>
## Themes of the support programme - transactional support (2/2)

<table>
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<tr>
<th>Key theme</th>
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<tbody>
<tr>
<td><strong>Transparent measurement</strong></td>
<td>Evaluations have often been towards the end of long term programmes, with real-learning not capitalised in a timely way</td>
<td>• Programme evaluation approach &lt;br&gt; • Formative evaluation throughout NCM implementation that includes population outcomes and patient experience</td>
<td>• RAND &lt;br&gt; • NHS IQ &lt;br&gt; • Health Fdn &lt;br&gt; • IHI</td>
</tr>
<tr>
<td><strong>Rigorous delivery</strong></td>
<td>Ensuring appropriate individuals have local capacity to deliver effective programme management, without an industry of paperwork and numerous reporting lines</td>
<td>• Robust consistent programme management approach &lt;br&gt; • Clear business case &amp; gateway process</td>
<td>• Aligned national support across ALBs &lt;br&gt; • NHS IQ &lt;br&gt; • HSCIC</td>
</tr>
<tr>
<td><strong>Comms &amp; engagement</strong></td>
<td>Ensuring appropriate individuals have local capacity to deliver consistent comms, clinical and patient engagement and change management</td>
<td>• Self assessments of readiness &lt;br&gt; • Mentorship and coaching &lt;br&gt; • Communications development</td>
<td>• NHS IQ tools &lt;br&gt; • NHS LA &lt;br&gt; • TLAP</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>There are limited holistic comprehensive workforce models that span health, social care, public health, the voluntary sector &lt;br&gt; Key issues include: professional regulation, indemnity, recruitment processes, training programmes and training time lags</td>
<td>• A revised approach to modelling that considers the formal &amp; informal workforce, and to include the design of new roles</td>
<td>• Aligned national support (led by HEE) &lt;br&gt; • NHS IQ &lt;br&gt; • NHS Employers &lt;br&gt; • Royal Colleges &lt;br&gt; • Patient representative groups &lt;br&gt; • Voluntary sector groups</td>
</tr>
</tbody>
</table>
Themes of the support programme - transformational support (1/2)

<table>
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| **Leadership for change**      | Local health and care economies need to be able to agree and move together on actions that will led to new models that very likely change current patterns of activity and funding flows. Cultural issues could either be at a number of levels eg within a new clinical team, within an organisation, or across organisations. | • Prioritise the development of system leadership both for the NHS as a whole and in LHEs, including learning from other sectors.  
• New styles of provider leadership supported by national bodies to avoid the wrong kind of regulation. | • Aligned national support across ALBs  
• NHS Leadership Academy  
• Clinical Leadership  
• Programmes led by HEE, Royal Colleges and/or AHSNs  
• King’s Fund & Health Foundation |
| **Spread of innovation**       | Often innovative approaches are not shared or communicated in a timely way nor easily replicable to be implemented elsewhere.                                                                                      | • Self-assessment of the readiness and likely success of spread and adoption.  
• National learning sets  
• Guidance for strengthening areas that need attention. | • ALBs  
• NHS IQ  
• NHSLA  
• Health Fdn  
• IHI  
• Haelo  
• Nesta  
• AHSNs  
• CLARCs  
• NHS Confed |
| **Improvement methodology**    | There is a need to rely less on external pressures such as targets and inspection and more on support from leaders and staff.                                                                                  | • Develop a strategy for quality improvement to foster a learning institution on the basis that it will provide national support through small teams of credible experts to local delivery. | • Aligned national support across ALBs  
• NHSIQ  
• Health Foundation  
• Whole System Intervention support |
## Themes of the support programme - transformational support (2/2)

<table>
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</thead>
</table>
| **Transparent**      | Evaluations have often been towards the end of long term programmes, with real-learning not capitalised in a timely way | • Should be a commitment of discovery not design with a commitment to real-time evaluation and learning throughout | • RAND  
• NHS IQ  
• Health Foundation  
• IHI  
• Haelo  
• AHSNs  
• CLARC  
• AQuA  
• Royal Colleges |
| **measurement**      |                                                                                |                                                                            |                                                                       |
| **Comms & engagement** | Ensuring appropriate individuals have local capacity to deliver consistent comms, clinical and patient engagement and change management | • Self assessments of readiness  
• site diagnostics  
• Mentorship and coaching  
• Communications development | • Aligned national support across ALBs  
• NHS IQ  
• NHSLA  
• TLAP  
• Health-watch  
• Patient groups  
• Voluntary sector |
| **Workforce**        | There are current challenges both with an insufficient number of staff and not enough staff trained in multi-disciplinary and generalist care. | • Self assessments of readiness  
• Learning sets  
• Specific training programmes | • Aligned national support across ALBs  
• NHS IQ  
• NHS Employers  
• Royal Colleges |
New Care Models (NCM) Support programme framework

- **Vanguards**: Dedicated support
- **Community of Practice**: Nationally commissioned specific support provided by partners across the system
- **Community of Interest**: A shared central platform that signposts to existing information and aligned system support available to all

Draft for discussion
Find out more…

http://www.england.nhs.uk/2015/03/10/new-era-of-patient-care/

http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/
Transforming Nursing for Community & Primary Care

Sarah Elliott
Regional Chief Nurse
NHS England South

March 2015
New Models of Care
Contribute to the development and implementation of the models

Good Practice
Sharing and learning in line with the 5YFV

The Shape of Caring
Consider the implications of the review for community and primary care nursing

Compassion in Practice
Embedding the Action Areas and 6Cs
What we know

- Meeting the health and care needs of people in their local communities will require a different approach
- Ageing population requires an emphasis on frailty
- Needs of communities changing – secondary prevention
- Need to engage and mobilise Community and Primary Care Nursing
- Partnership approach required
Where do we need to be?

- New Models of Care - right skills, values and behaviours to deliver them
- Engagement with patients, carers and citizens
- Focus on well being and prevention
- Personalised care planning & self management
- Upskilled Workforce – across all care sectors
- Working across organisational boundaries
What have we done so far?

**Commissioning Development**
- Shared good practice
- Pricing & Incentives
- Frail Older People
- Supporting Community & Primary Care Nursing

**Prevention**
- Securing clinical leadership
- Commissioning tools & levers
- Working in partnership
- Action planning
- Supporting carers

**Integration**
- Joint medical & nursing collaboration
- Service component handbooks

**Workforce**
- Education & career pathways
- Workforce planning
Commissioning Development

...is supporting commissioning

- QNI review of workforce planning (2014)
- Community Nursing Workforce Commissioning Specification
- Consolidated literature on out of hospital care for commissioners (2014)
- Working with the Commissioning Nurse Leaders Network (CNL Network)
- Sharing good practice
- Working with the national pricing and incentives team
- Guidance and toolkit for frail older people
Commissioning Development

...is working to support general practice nursing

- Raising awareness of and supporting the use of the Primary Medical Services Assurance Framework for nursing in primary care
- Established a National Forum for Community and Primary Care Nursing
- Providing leadership for general practice nursing
- Contributing to delivering the Ten Point Plan for primary care
Integration

...is working to support care-planning, risk stratification and multi-disciplinary team working

- Collaboratively developed handbooks on:
  - Case finding & risk stratification
  - Multidisciplinary team working
  - Personalised care & support planning
- Accountable clinician for out of hospital care
Workforce

...is ensuring the right skills in the right place

- Education and career pathway for district and general practice nursing
  - Education commissioning service specification
  - Career framework
- Future workforce planning
Prevention

... is focusing on those at risk and those with long term conditions

- Secure clinical leadership for secondary prevention
- Using commissioning levers for successful outcomes
- Behaviour change – partnership working
- Supporting carers
- Framework for Personalised Care (DH/PHE)
FIVE YEAR FORWARD VIEW

Prevention
Empowering Patients
Local Leadership
Aligned National Leadership
Modern Workforce
Engaging Communities
Use of Innovation
New Models of Care
Exploit Info. Revolution
Drive Efficiency
# What does it mean for us?

<table>
<thead>
<tr>
<th>Focusing on prevention</th>
<th>Empowering patients</th>
<th>Engaging communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incentivise healthier individual behaviours</td>
<td>• Improve information: personal access to integrated records</td>
<td>• Support England’s 5.5m carers – particularly the vulnerable</td>
</tr>
<tr>
<td>• Strengthen powers for Local Authorities</td>
<td>• Invest in self-management</td>
<td>• Supporting the development of new volunteering programmes</td>
</tr>
<tr>
<td>• Targeted prevention programmes – starting with diabetes</td>
<td>• Support patient choice</td>
<td>• Finding new ways to engage and commission the voluntary sector</td>
</tr>
<tr>
<td>• Additional support people to get and stay in employment</td>
<td>• Increase patient control including through Integrated Personal Commissioning (IPC)</td>
<td>• NHS reflecting local diversity as an employer</td>
</tr>
<tr>
<td>• Create healthier workplaces – starting with the NHS</td>
<td>• New relationships</td>
<td></td>
</tr>
<tr>
<td>• Staff as role models</td>
<td>• Sharing the leadership space with patients</td>
<td></td>
</tr>
<tr>
<td>• Staff as expert in behaviour change</td>
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</table>

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For today

- Communication and engagement
- The next steps we should take for the Transforming Nursing for Community and Primary Care programme
- Engage with the National Forum for Community and Primary Care Nursing
- How we mobilise together to have maximum input into the Five Year Forward View and New Models of Care
What next for the South

• A number of local examples of how new service delivery models are benefiting patients in the South will be described throughout the morning
• Our Vanguard sites will be accelerators
• Purpose of workshops this afternoon is to refine our thinking on the challenges and opportunities that the forward view and new models of care offer nursing
• 3 priorities each for commissioners, education and providers
• Establish a partnership steering group to oversee delivery of a 9 point concordat/manifesto
Developing the Detail

• Accelerate a programme of support and development across the South
• Commissioners, educationalists and providers to work together to exploit every opportunity to develop and integrate services
• Skills in delivering supported self management programmes, behavioural change and personalised care and support
• Frailty screening
• Continence
• Integrated nursing
• Core foundation programmes for Community and Practice nurses
The Shape of Caring Review: What will this mean for primary and community nursing in the next 5 years?

Lisa Bayliss-Pratt
Director of Nursing
Health Education
England
Forward View into Action: Examples from the South
General Practice and Community Nursing Transformational Change programme – Devon, Cornwall and Isles of Scilly

Magdalena Wood Programme Lead

12th March 2015, Community and Primary Care Engagement Event
General Practice and Community Nursing Transformational Change programme across the SW Peninsula

Working together in a way that makes sense for all
NHS England Devon, Cornwall and Isles of Scilly Area Team
General Practice and Community Nursing Development Programme
To Advance the Implementation of the 5 Year Forward View


Primary Goals

- Enhance Person Centred Co-ordinated Care
- Facilitate Nursing Workforce Development
- Identify and Improve Efficiencies

Secondary Goals

1a. Improve Patient Experience
1b. Influence the alignment of Frailty and Living Well agendas
2a. Enhance Skill Mix of Nursing Staff
2b. Strengthen Innovation
2c. Improve Recruitment, Retention and Succession Planning
3a. Identify and share best practice
3b. Influence Commissioning Practice
3c. Minimise Duplication

Projects

- Support new ways of working for front line General Practice and Community nursing staff (1a)
- Assist to embed Frailty Toolkit into Primary Care (1ab)
- Identify opportunities to strengthen links with voluntary sector, care homes and independent sector (1ab)
- Develop and embed simple guidance for General Practice on MDTs and facilitation (1b)
- Equip General Practice and Community nurses to promote self care – giving them skills in: Motivational Interviewing, Self Management Plans and Coaching for Nursing Leads (2ab)
- Improve access and equity (for practice nurses) to information, training, job opportunities and peer support via the new General Practice Nursing website (2abc)
- Nurture Nurse Leaders: Recognise and support existing nurse leaders, Identify and promote leadership opportunities, Facilitate a forum for nurse leaders and Encourage nursing presence at board / decision making meetings (2abc)
- Create opportunities for joined up training courses for General Practice and Community Nurses (2bc)
- Identify opportunities to increase number of students in General Practice and Community Nursing (2c)
- Map out education providers for General Practice and Community Nurses (2c)
- Share learning from the Living Well project (3a)
- Support and enhance local networks to improve services (3ab)
- Identify opportunities to improve communication and reduce duplication (3abc)
- Influence development of proposed career frameworks (3b)
- Implement Peninsula wide PGD (Patient Group Directions) (3bc)

Engage General Practice and Community Nursing in a rolling programme of conferences and events (Secondary goals: 123)
General Practice and Community Nursing Transformational Change programme across the SW Peninsula

**Primary Goal 1**

**Secondary Goals**

- **1a. Enhance Patient Experience**
  - Improve Patient Experience
  - Assist to embed Frailty Toolkit into Primary Care (1ab)
  - Identify opportunities to strengthen links with voluntary sector, care homes and independent sector (1ab)

- **1b. Influence the alignment of Frailty and Living Well agendas**
  - Support new ways of working for the General Practice and Community nursing staff (1a)
  - Develop and embed simple guidance on Multidisciplinary Team Meetings and facilitation for primary care (1b)

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General Practice and Community Nursing Transformational Change programme across the SW Peninsula

**Primary Goal 2**

**Mobilise and Activate Nursing Workforce**

**Secondary Goals**

- **2a. Enhance Skill Mix of Nursing Staff**
- **2b. Strengthen Innovation**
- **2c. Improve Recruitment, Retention and Succession Planning**

**Projects**

- Equip General Practice and Community nurses to promote self care – giving them skills in: Motivational Interviewing, Self Management Plans and Coaching for Nursing Leads (2ab)
- Improve access and equity for practice nurses to information, training, job opportunities and peer support via the new Practice Nursing website (2abc)
- Nurture Nurse Leaders: Recognise and support existing nurse leaders, Identify and promote leadership opportunities, Facilitate a forum for nurse leaders. Encourage nursing presence at board / decision making meetings (2abc)
- Create opportunities for joined up training courses for General Practice and Community Nurses (2bc)
- Identify opportunities to increase number of students in General Practice and Community Nursing (2c)
- Map out education providers for General Practice and Community Nurses (2c)
General Practice and Community Nursing Transformational Change programme across the SW Peninsula

Primary Goal 3

Secondary Goals

3a. Identify and share best practice to inform new models of care

3b. Influence Commissioning Practice

3c. Minimise Duplication

Projects

- Share learning from the Living Well project across the Peninsula (3a)
- Support and enhance local nursing networks to improve services (3ab)
- Identify opportunities to improve communication and reduce duplication (3abc)
- Influence development of proposed career frameworks (3b)
- Implement Peninsula wide PGD (Patient Group Directions) (3bc)

Engage General Practice and Community Nursing in a rolling programme of conferences and events (Secondary goals: 123)
A brand new Practice Nursing website for Devon and Cornwall

www.devoncornwallpn.co.uk
Thank you for listening

Magdalena Wood
Practice Nursing Development Programme Lead

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Symphony Integrated Care for People with Long Term Conditions in Somerset

Lucy Watson
Director of Quality, Safety and Governance

12 March 2015
Vision

“People in Somerset will be encouraged to stay healthy and well through a focus on healthy lifestyle choices and self-care. When people need to access care or support this will be through joined up health, social care and wellbeing services. The result will be a healthier population with access to high quality care that is affordable and sustainable.”
CCG Strategy 2014-2019

• We will commission co-ordinated and person-centred care, which will be delivered through new partnerships

• We will drive changes that focus on improved patient experience through developments in the way that organisations and services work together, and the way that patients and professionals work together, to get the best health outcomes for Somerset

• We will develop collaborative approaches to commissioning and provision
Symphony

• Project focus on the population of South Somerset
• Symphony created a combined dataset across health and social care– now extended to the whole Somerset population
• Identified drivers for use of services and cost were the number of long term conditions people have not age
• Outcome Set agreed collaboratively between patients and clinicians, this is mapped to the CCG Outcome Indicator set
• Developed a complex care model to serve multiple long-term condition patients, based on care co-ordination hubs
Person centred coordinated care

“\textit{I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.}”
Outcomes

A group of representatives from all parties worked through options for a hierarchy or framework.

They chose a modification of Michael Porter’s hierarchy of health outcomes.

It combines a strong focus on what people say matters about their care with other outcomes that represent value to commissioners and providers.

They link back to the aims of the project.

Tier 1: Wellbeing status
- Independence
- Wellbeing
- Health outcomes

Tier 2: Process of care
- Right care
- Right time, right place

Tier 3: Sustainability of services
- Cost
- Staff
- Learning organisation
Tier 1: Wellbeing Status

**Independence**
- People are activated to manage their own health
- People are actively involved in and have choices about their care
- People participate in work or other meaningful activities
- People live in a place of their choosing

**Quality of life**
- Quality of life for people is maximised
- Quality of life for carers is maximised

**Health outcomes**
- There are reductions in:
  - Mortality from conditions amenable to healthcare
  - Admissions for ambulatory care sensitive conditions
  - Unplanned readmissions
  - Emergency/unplanned admissions for cancer
Summary

• Significant transformation agenda to deliver improved outcomes for people with long term conditions
• Commissioning for outcomes
• Test and learn to engage and reflect local need
• Governance arrangements to monitor/ drive delivery and ensure shared learning
• Clinical leadership and workforce development
Tier 2: Process of Care

**Right care**
- Positive relationships: People have one key person who takes ownership for co-ordinating their care and is trusted
- Seamless co-ordination: People report that their care feels seamless and well-coordinated

**Right time, right place**
- People and carers find access to services easy
- Staff are able to arrange care when needed
- There is 7 day access to appropriate services
- Care is provided with minimal disruption and travel to people and carers
Tier 3: Sustainability of Services

- **Cost**
  - Actual costs of the service are equal to or less than target costs
  - Total commissioning cost of person to whole system is maintained or reduced
  - Fixed costs in the health and care economy are maintained or reduced

- **Staff satisfaction**
  - Staff report increasing levels of satisfaction

- **Learning organisation**
  - Improvements are made resulting from feedback from people and carers
  - Improvements are made resulting from staff feedback or made by staff
Care Model
What were we trying to achieve

• Better health and quality for life for patients
• Patients able to take more control
• Better job satisfaction for staff
• Enable people to stay at or near home
• Reduce cost to the system
• Deliver the Symphony outcomes
Symphony – Core Functions
Key features of the model

• Cohort of patients – intensively supported with focus on self-management, proactive care planning, escalation plans, proactive response at times of crisis, and co-ordinated care as close to home as possible

• Single care plan, single pathway – primary / community / acute / social care, plus self-management and community support

• Four hubs – GP clusters

• Supported by integrated community teams (health and social care and expert generalist medical input

• One care-coordinator – manage transition from current pathways to single pathway across all elements of health and social care

• Key workers acting who build relationships and act as health coaches
The Symphony Complex Care Hub Network

- **Shared Support**
  - Symphony shared support
  - Shared infrastructure and support functions.
  - Central business functions and Symphony management, e.g., Care model refinement, geographic expansion, planning for extension to new cohorts, etc.

- **Local Expert Care Hubs**
  - Location for co-located multi-skilled Care Coordinator and Key Worker teams to enable effective team working
  - Initial point of contact for all patient needs, e.g., Questions, concerns, urgent enquiries, carer concerns
  - Locally accessible to cohort patients, e.g., Delivery of care as part of care plans, Meeting core team members for review
Summary of the Care Model

• Population group – people with 3 LTCs – all people with LTCs and people with frailty
• Risk Stratification to identify patients
• Assessment and personalised care planning
• Care coordination
• Care provision
• Self management
We want to expand integration programmes across the County

We wanted to roll this out at scale across the county through existing projects which are seeking to deliver:

• Person-centred care
• Early identification of need through data analysis
• Reablement

Through:

• Symphony
• Independent Living Teams
• Somerset House of Care (long term conditions)

Developed Four Local Implementation Groups (LIGs) with innovative ideas to:

• Build on the existing work and knowledge already gained
• Be aware of limitations of (e.g. social care programmes to adapt to many local models
• Have some consistency across the County
LIG areas
Multi-agency LIG membership

- Primary Care
- CCG
- Nearest acute trust (Taunton and Somerset, Yeovil, RUH Bath, Weston)
- Somerset Partnership
- Somerset County Council
- District Councils
- SWAST
- Independent domiciliary care providers (RCPA)
- The voluntary and community sector
Commissioning Strategy

• To make a step change in the provision of person centred care
• Capitated outcomes based commissioning COBIC to drive integrated working
• 3 test and learn pilots with clearly identified host provider overseen by LIGs
• Must include collaboration between providers
• Implementation plan based on the Symphony Pathway for Frail Older People
• Symphony – South Somerset have applied to be a Vanguard site for PACS - integrated primary and acute care systems
Challenges

- Two test and learn pilots led by primary care and one led by an acute trust
- All using patient cohorts identified through the primary care unplanned care enhanced service
- One test and learn looking at practice nurses to be long term conditions nurses in care hubs, others looking at nurses as care coordinators
- Development of peer supporters for self management, peer support network of support groups and portal
- Project sites understanding the need for workforce development to deliver change
Sustaining High Quality Affordable Care

• Quality impact assessment for service transformation and pathway redesign
• Clinical leadership
• Workforce development
• New roles: care coordinators, and care navigators
• Development of primary and community nursing roles to deliver person centred care
Workforce Development

- Knowledge, skills and expertise in providing person centred care, care coordination and escalation plans for people with long term conditions and for people with frailty
- Clinical leadership development to lead multi agency integrated teams and to lead cultural change across teams
- Co production and outcomes based delivery
- Competencies and development for key workers and care navigators
- Engaging UWE through the primary and community workforce development contract to shape delivery to meet the needs of the Somerset transformation project
Summary

- Significant transformation agenda to deliver improved outcomes for people with long term conditions
- Commissioning for outcomes
- Test and learn to engage and reflect local need
- Governance arrangements to monitor/ drive delivery and ensure shared learning
- Clinical leadership and workforce development
COMMUNITY AND PRACTICE
NURSING:COMMISSIONER PERSPECTIVE

Contacts;
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Quality Directorate
Dorset Clinical Commissioning Group
Current workforce

- The CCG care homes quality team undertakes joint quality assurance visits with the 3 local authorities in Dorset against an agreed shared service specification.
- Aspects of workforce development are included as part of the quality monitoring e.g. standards of supervision, recruitment, staff training.
- The aim is to ensure workforce development meets expected service standards and improves service user experience.
- The CCG hold annual care home manager development days to ensure current best practice is shared between care providers.
- A Care home newsletter is circulated quarterly which includes information on a variety of topics.
- A dedicated webpage which included links to useful resources and best practice guidance.
- There are excellent links for the care homes with CCG staff providing expert advice on areas such as; Safeguarding, Infection Prevention and control, medicines management, risk and safety, end of life care and dementia.
Future workforce

Careers promotion in developing community roles
• Linking with social care to promote routes to healthcare professional roles
• Local workforce and education groups
• Expanding student placement opportunities

Added value
• Joint working with education providers
• Student experience feedback on a variety of health and care provider services
• Mentor experience
• Benefits for placements
• Quality improvement

Staff engagement – whole health system
• Promotion of values based recruitment
• Valuing staff
• Effective retention in health community
Professional Development

The CCG quality team provide professional support and advice to staff as required

• Professional practice lead
• Infection prevention and control specialists
• Safeguarding leads
• Medicines management
• Quality improvement and assurance managers

Professional development events are supported by the CCG including;

• Care home managers events
• End of life care workshops
• Events that support accreditation

Revalidation for Nurses and Midwives

• CCG feedback into both stages of consultation
• NMC speaker at Care homes event
• Support to providers in implementation of processes to ensure requirements for revalidation are met
• Support and facilitation to ensure independent providers have access to appropriate third party confirmation
Practice Nursing: New Frontiers

Julia Barton
Chief Quality Officer/Nurse
Opportunities or threats?

- PN role - value adding functions
- System wide out of hospital strategy
- Emerging primary care models - federations
- Workforce challenges – roles and recruitment
- NMC Code of Conduct and Revalidation
- Recruitment – situation critical
- Culture
- Morale
- Line management v professional leadership
Our local approach:

Wessex Practice Nurse Development Steering Group and CCG Practice Nurse Steering groups

- CCG Practice Nurse Facilitator role
  - Mock CQC inspections
- PN role and development framework
  - Essential and core skills
  - Leadership and management
  - Modelling e.g. non clinical time /Cassandra
- Education
  - Target; e-learning; Links to the Alliance
  - System to assure education quality
- Lead Practice Nurse role and development
- Communication and networking - PN Fora & web resource
- Safety: reporting & feedback (Quasar System) – local contract
AvOCET Project
Action on Community Education and Training

• HEI refresh of community and PN modules
• Community based RN Post Graduate Cohort
• Primary care learning networks
  • Community and primary care student placement pathways
  • Mentorship development
  • HEE PN training needs analysis
• Integrated care teams – ICT coordinator role and FdSc
• Support workers and common competencies
• Pilot clinical apprenticeships
• Return to Practice cohort
• Advanced practice framework with IoW
Please contact us if you want to know more or share ideas...

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Building the House of Care for diabetes and respiratory conditions in Berkshire West CCGs

12th March 2015
Allwin Mercer
Clinical lead nurse NWRCCG
Nurse Practitioner
We have come a long way since 2012

• Berks West identified as 3rd worst performing PCT in England for attainment of HbA1c

• This was our ‘burning platform’ to do better
We found our burning platform...

...we needed to do things differently!
What happened then

• Redesign of services began in July 2012 and launched at TIPS in May 2013 at scale and pace!!

• The current service now attracts national attention for all the right reasons!
The House of Care is central to the vision.

It gives a cohesive, rational, overarching model of care centred on the patient.
Building the House of Care for diabetes in Berkshire West

Organisational and supporting processes

- Stakeholder network
- Metrics & monitoring - Eclipse
- Eye screening
  - Dietetics
- Podiatry
- Monthly newsletter
- HCP Education
- Community specialist
- Link to secondary care
- Diabetes
- Specialist Nurses
- Website
- Virtual clinics
- Meds management
- Community pharmacy

Person-centred coordinated care

- Engaged, informed individuals and carers

Commissioning

3rd sector support - DUK

Care planning

DAFNE

X-PERT

CarbAware

Talking health

Website

Coherent commissioning led by network supported by CSU
The biggest change in practice

For Patients, Clinical staff and admin staff

Has been the introduction of CARE PLANNING
Quick revision: what’s care planning?
Here’s what it’s not:

• It’s a verb not a noun: a process, not a list
• It’s not the same as a care plan, but the process of care planning leads to a care plan
• It’s nothing to do with the 2% DES
...and this is what care planning is (in a nutshell)
Progress is being made

- Proportion achieving HbA1c ≤59mmol/mol increased from 46.5% (06/12) to 59.5% (12/14)
- \textit{HbA1c down by 18\% among X-PERT attendees: 67.5 before course, 55.5 6 months after X-PERT}
- HbA1c reduction 6 months after CarbAware course of 13mmol/mol among Type 1 patients
- \textit{HbA1c reduction 6 months after virtual clinic MDT consultation of 10 mmol/mol}
- Proportion achieving total cholesterol ≤5 increased from 46.3% (06/12) to 79.3% (12/14)
More...

• Care planning is now established in nearly 90% of practices in Berkshire West as the standard process of annual review in diabetes
Benefits:

• Patients taking more interest in their care
• Improvement in patients health
• Upskilling of staff and patients.
• Effective new way of working with patients
• Future alignment of care planning reviews for different LTCs into one appointment!
What's next?
The steady transformation of the management of long term conditions (LTCs) by applying the House of Care model, using care planning as the process for annual review.

Building on the experience gained in using the House of Care and care planning in diabetes, the process will begin with respiratory conditions, specifically, COPD.
Issues in COPD

• £1.4m spent on COPD admissions – but estimated 25% are avoidable

• Need for quality spirometry diagnosis and analysis

• 95% of people do not use inhalers adequately leading to inaccurate prescribing and increased costs

• Growing demand for respiratory team input with fixed resource – they are stretched beyond planned capacity
Planned provision

• 3 additional nurses for the respiratory team
• Investment over two years for 125 HCAs and PNs to attend spirometry assessment or spirometry assessment and analysis as appropriate
• Use of Eclipse to identify patients needing extra support (with practice permission)
• Roll-out of training for practices to be able to offer care planning for COPD (and then to other LTCs in the long term)
Building the House of Care for respiratory conditions

Organisational and supporting processes

- Stakeholder Network
- Metrics & monitoring - Eclipse
- Spirometry training for HCAs
- Spirometry training for PNs/GPs
- Additional capacity in community resp team
- Website
- Monthly newsletter
- Strong links to 2° care

Person-centred coordinated care

Engaged, informed individuals and carers

Health and care professionals committed to partnership working

Commissioning

Coherent commissioning led by network supported by CSU

Care planning

Website

3rd sector British Lung Foundation

Pulmonary rehabilitation

Stop smoking services

3rd sector

British Lung Foundation

Stop smoking services
Thank you

www.breatheberkshirewest.org.uk
www.berkshirewestdiabetes.org.uk
Developing the Primary Care Workforce across Kent, Surrey & Sussex

Eileen Clark
Head of Clinical Quality, Clinical Governance & Patient Safety
Surrey Downs CCG
12th March 2015
Local Context - Kent, Surrey and Sussex

- 640 practices across the area of which approximately 100 are single handed

- 3,350 GPs (approx. 3,000 WTE); 22% are aged 55 or over

- 1,800 practice nurses occupying 1,000 WTE; 20% are aged 55 or over

- Large vacancies of practice nursing and health care assistants

- Shift of services and long-term conditions dealt with in primary care

- Ageing demographic with associated increase in frailty requiring the need for longer consultation times

Ref: KSS Survey - 2012
There are approximately 4.3 million people in Kent, Surrey and Sussex.

On a typical day:
- **80,000** people will visit their GP or Practice nurse
- **3500** people will be referred by their GP to a specialist
- **5,000** people will attend Accident and Emergency departments
- **800** people will be admitted acutely to hospital
One Local Solution

• A five Year Workforce Programme initiated by Health Education Kent, Surrey and Sussex to:
  • improve education and training for all of the workforce
  • increase placements in primary care and the community for the future generation of clinicians including Nurse students, GP Trainees, Paramedic Practitioners students and Health Care Assistants
  • put in place a robust plan for the future workforce planning in primary care and community that supports future models of care
The Primary Care Workforce Tutor Programme

- Primary Care Workforce Tutors have been employed within CCGs across Kent, Surrey and Sussex
- Funded by HEKSS and affiliated to partner universities
- Initially funded for 2 years with option for posts to become fully established
Main Areas of work

• Facilitation of the development of the infrastructure within GP practices through the recruitment of nurse mentors, sign off mentors and practice educators; and the creation of more student nurse placements within GP surgeries.

• Raising the profile of practice nursing by offering a flavour of the Primary Care environment to students and ultimately assisting in the recruitment of workforce in the future.

• Supporting the development of the primary care workforce through identification of current workforce skills gaps through training needs analyses; education and development programmes and the commissioning of training and development opportunities.
Main areas of work contd.

• Working closely with practices to implement and support appropriate educational activity for the whole GP Practice Team.

• Working with partner Universities to facilitate pre-registration student nurse placements within general practice and developing short and long-term courses relevant to practice nursing.

• Development of a Practice Nurse Pathway as a joint project with 4 Universities that equips nurses with the necessary skills and competencies to meet the needs of their practice populations.
Additional Benefits

• Support and supervision for an important and sometimes forgotten workforce
• Networking opportunities
• Sharing good practice and learning from incidents
• Raising the profile of nursing within our Clinically led organisations
Prevention in clinical work

- Learning from clinical experience – partnership with patients, clients and communities
  - Understanding the context and circumstances
  - Explaining what could make a difference
  - Supporting arriving at solutions and strategies
  - Reinforcement and encouragement
  - Patients, clients, communities determining their own health and well-being
  - Supported by structural change

- Nurses as uniquely well placed to give help and support
Prevention in the Forward View

• Seventy percent of the NHS budget is now taken up by long-term health conditions rather than those susceptible to a one-off cure.

• Health behaviours

• Radical upgrade in prevention: failure would result in:
  • stalling of recent progress in healthy life expectancies;
  • health inequalities widening,
  • and an inability to fund the treatment and care that people need because we will be spending billions of pounds on wholly avoidable illness.
Reality: co-morbidity underpinned by cluster of behaviour

Increasing risk:

- Smoking: lung and other cancers, heart disease, stroke, COPD
- Alcohol: hypertension; CVD, dementia, diabetes, liver disease, cancers - breast and gastrointestinal tract; depression, anxiety, trauma
- Obesity: diabetes, CVD, hypertension, dementia, cancers, MSK
- Physically active lifestyle reduces risk including CHD, stroke, type 2 diabetes, some cancers, obesity, MH and MSK conditions.
The Forward View challenges the divide between patients and professionals: better health through increased prevention and supported self-care.
NHS role in prevention

- Local authorities and Public Health England - clear role to play in improving the health of the population

- NHS has role supporting those with risk factors, illness or LTCs maintaining or improving their own health and wellbeing.

- Mandate: *staff should use every contact they have with people as an opportunity to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more.*

- 15-16 planning guidance: CCG action plans: *behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress.*
NHS England approach to behaviour change

• Systematic specific approach:
  • updated NICE guidance on individual behaviour change
  • topic specific guidance pathway on obesity, alcohol related harm and on smoking.

• Pathway approach,
  • Identification, assessment of risk, delivery of evidence-based intervention
  • behaviour change interventions of progressive intensity according to the clinician’s relationship with the patient and the client’s assessed level of risk.

• Supported by training and development
Pathway approach to behaviour change

• **Very brief interventions** (MECC) opportunistic

• **Brief intervention**: regular contact with those assessed at risk

• **Extended brief interventions**: regular and longer contacts: assessed higher risk, for example a long term condition with co-morbidities.

• **High intensity interventions**, >30 minutes, number of sessions; behaviour change service; assessed high risk of eg BMI >40; or serious medical condition that needs specialist advice and monitoring
Progressive competency framework

- Listening skills
- Understanding determinants of health
- Motivational interviewing
- States of change model
- CBT

- Distance learning: e-learning for health; RCN; PHE etc
- Bespoke training courses
Prevention integrated in to LTC management

- High % of professional care
- Complex cases with co-morbidities
- Equally shared care
- High risk cases
- Self care

- 80 - 90% of cases

Increasing limited capacity for behaviour to effect outcomes, emotional wellbeing, feelings of control. Quality of life becomes important. Influenced by use of personal budgets, attitudes of carers, clinical teams.

Individual has greater ability to affect health outcomes by changing behaviours

www.england.nhs.uk
Barriers to implementation

- **Patients don’t want to change?** Identify readiness to change, patient activation.
- **Patients might be offended.** Use of listening skills and motivational interviewing techniques.
- **Nurses’ own lifestyles.** Organisational support.
- **Too busy.** Reorganising LTC management around people not diseases.
- **QOF drives disease centred management:** Co-commissioning for personal centred, preventive approaches.
Commissioners

- Commissioning behaviour change as an integral part of care pathways.
- Using commissioning levers: revisit QOF, CQUINs, KPIs etc
- Using contracting tools: specs, LESs etc
- Commission for: delivery of behaviour change interventions by front line clinicians; competencies; staff health and wellbeing.
Providers

- Embed behaviour change in pathways, protocols, service design and care planning.
- Organisational support; PDRs, objective setting, PDPs.
- Accredited training and development - acquire and maintain the skills.
- Support staff as well as patients in behaviour change - opportunities for developing healthier behaviours.
NHS England are supporting you:

- Clinical leadership: making the case for change to nurse commissioners and providers
- Commissioning tools and levers: identifying and sharing good practice, providing templates.
- Partnership working: with HEE, PHE, DH and others clarifying roles and ensuring infra-structure in place especially re training and development
And the practice…

Over to Helen….

Prevention in relation to older people living with frailty

What can community and practice Nurses contribute?
Preventing and delaying onset and deterioration of frailty – the nurses role

- NICE prevention guidance
- Preventable components of frailty
- What nurses can do – self management, personalised care and support planning
- Social isolation
- Examples from practice
‘Dementia, disability and frailty are not inevitable consequences of ageing…there is sufficient evidence to show the risk of developing them can be reduced through changing common behavioural risk factors.’

- quitting smoking,
- increasing physical activity,
- reducing alcohol consumption
- having a healthy diet
- maintaining a healthy weight.
NICE Public Health Draft Guideline: Dementia, disability and frailty in later life – mid-life approaches to prevention

• Beginnings of ill health can occur in midlife:
  ☀ start of a decline in cognitive functions (such as memory, reasoning and verbal fluency) by age 45
  ☀ age-related decline in walking speed has been observed after the age of 30

Mid-life is not too late for people to make meaningful changes. People often need more than one attempt to change, and mid-life can be the period in which change is finally sustained

‘However, key messages about risk reduction, particularly for dementia, are not well publicised or understood by health and other professionals or the public, unlike the link between smoking and cancer.’
Where is frailty?

“I know it when I see it but what I see may not be the same as what everyone else sees”

Community dwelling adults aged 65+ = 7% - 12%
Community dwelling adults aged 85+ = 25% - 50%

The Frailty Paradox
Not recognised
Not diagnosed
Not recorded

Frailty – why prevalence is increasing


www.england.nhs.uk
Frailty – a complex syndrome of increased vulnerability

Prevent/delay frailty
Primary prevention
Health promotion

Life course determinants:
- Biological
- Genetic
- Psychological
- Social
- Environmental

Delay onset

Decline in physiologic reserves +
- Multiple long term conditions

Candidate markers:
- Nutrition
- Mobility
- Activity
- Strength
- Endurance
- Cognition
- Mood

Adverse Outcomes:
- Disability
- Morbidity
- Hospitalisation
- Institutionalisation
- Death

Delay/prevent adverse outcomes

Reversibility

www.england.nhs.uk

A definition of frailty

• Frailty is not a disease but a combination of the natural ageing process and a variety of medical problems.
• It focuses on the loss of reserve, energy and wellbeing.
• A useful definition is: “Multidimensional loss of reserves - energy, physical ability, cognition and health”

Rockwood et al (2005)
Frailty is a loss of physiological reserve

Clegg, Young, Rockwood Lancet 2013
Frailty as a Long Term Condition?

A Long Term Condition is:
“A condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies” (DH 2012)

Frailty is:
• Common (25-50% of people over 80 years)
• Progressive (5 to 15 years)
• Episodic deteriorations (delirium; falls; immobility)
• Preventable components
• Potential to impact on quality of life
• Expensive
Proactive interventions in frailty

“Ten years ago”

“Two years ago”

“One month ago”

“Dad is slowing down”

“He is a fall waiting to happen”

“I’m not as steady on my feet as I was”

Frailty as a Long-term Condition

FUNCTIONAL ABILITIES

Independent

Dependent

“Minor illness”
Primary care electronic Frailty Index (eFI): survival plots ($n=227,648; >65y$)

**Proportion alive**

- **Supported self-management**
- **Care & Support Planning**
- **Case Management/EoL care**

**Time**

5 yrs
Supported Self Management for Frailty

What it's not….

Provision of information; leaflets, booklets, web links etc

What it is…..

About acknowledging the person’s central role in the management their own care and empowering them and their family and carers to handle their condition as effectively as possible.
What to focus on…..

Potentially modifiable risk factors associated with functional decline in community dwelling older people.

- Alcohol excess
- Cognitive impairment
- Comorbidity
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems
Try this at home

Have you noticed it’s taking longer to get to the bus stop than it used to? Or that your weekly supermarket shop takes longer than before?

These can be signs that you’ve started slowing down.

If you’ve noticed you’re a little slower than you used to be, or even if you haven’t, you may want to try this simple test which will let you know if the ‘slow-down’ process of later life is affecting you. It is called the Walking Speed Test. You can do it easily at home. All you need is a tape measure and a watch with a second hand or mobile phone with a stopwatch function.

Using a tape measure, mark out on the ground two lines 4 metres (1.3 feet) apart.

Stand next to the first line.

Walk at your usual speed (using a walking aid if you usually use one) until a few steps past the 4-metre mark (don’t slow down as you approach the mark).

Your friend/helper should say “Go” and start timing you.

As you pass the 4-metre mark, your friend/helper should stop timing you.

Repeat three times, allowing sufficient time to recover between tests.

If you take more than 5 seconds to walk, at normal speed, a measured distance of 4 metres (1.3 feet), then it is likely you are affected by the slowing down process of later life. Of course, some people walk slowly for other reasons – perhaps knee or hip arthritis, for example. But the test will give you a good indication of your general fitness. If you have slowed down you may want to try some simple exercises. If you have any concerns, you may wish to see your GP or nurse to discuss things further.
Supported Self Management for Frailty: Key Messages

1. Language:
   • “I am frail” v “slowing down”, “things taking longer” or “less energy.” This is reflected in the guide. Focus on “health and wellbeing” in later life.

2. Self-discovery and self-activation:
   • Gait speed test, then menu of items – the person’s choice

3. Independence:
   • focus on maintaining and promoting independence - this is an issue that is both important and well understood by older people.

4. Social Isolation and Loneliness
Loneliness and Social Isolation

- 59% of older adults who report poor health say they feel lonely some of the time or often compared with 21% who report excellent health.
- Social isolation is one of the top five causes for admissions to care homes.
- People who are socially isolated visit their GP more often, use more medication and have more falls.
- Lacking social connections is a comparable risk factor for early death to smoking 15 cigarettes a day and is worse for our health than obesity and physical inactivity.
Living Well
Pioneer for Cornwall and the Isles of Scilly

OUR THREE AIMS

IMPROVED HEALTH AND WELLBEING
IMPROVED EXPERIENCE OF CARE AND SUPPORT
REDUCED COST OF CARE AND SUPPORT

THE PRINCIPLES

STOP CREATING NEW LAYERS • support existing groups and connect people together
COMMUNICATE WHAT’S AVAILABLE and where in a way that people find useful
ENCOURAGE LOCAL LEADERSHIP AND ENGAGEMENT
BE BOLD AND BE BRAVE!

SO FAR WE ARE SEEING...

RECRUITED COHORT NOW AT 800
20% OF PEOPLE IN THE PROGRAMME GO ON TO BECOME VOLUNTEERS THEMSELVES

Living Well Penwith

WELLBEING
20% improvement

ACUTE HOSPITAL COSTS
41% reduction

COMMUNITY HOSPITAL

SOCIAL CARE COSTS
8% reduction

INPATIENT ACTIVITY
28% reduction

EMERGENCY
36% reduction

NON-LECTIVE ADMISSIONS
49% reduction

OUT-PATIENT
13% reduction

LENGTH OF STAY
20% reduction

CONVERSATION AND GOAL SETTING

AIDING RECOVERY WITH HELP FROM VOLUNTEERS

COMMUNITY SUPPORT AND NETWORK DEVELOPMENT

CARE CO-ORDINATION BY INTEGRATED TEAM

CULTURAL CHANGE ELEMENTS

LOCAL PEOPLE LOCAL CONVERSATION

PRACTITIONER CO-DESIGN

BUILDING TRUST AND RELATIONSHIPS

LOCAL AREA RP

STRONG GP BUY-IN

INFORMATION SHARING

OUR BUILDING BLOCKS

THE CRITERIA

A MINIMUM OF 2 LONG TERM CONDITIONS
from the following: diabetes, dementia, respiratory (COPD), heart failure, stroke, memory loss, parkinson’s, hypertension, osteoporosis, have a history of falls, risk of repeat infection (urinary tract infection or pneumonia)

A SOCIAL CARE PACKAGE IN PLACE WHERE
- The value is £50 per week or below.
- The value is £200 per week or above.
- This includes lunchtime visits.
- The person has received support from the Early Intervention Service 3 times or more within the last 12 months.
- The person has been supported through an urgent response or emergency duty 3 times or more within the last 12 months.

£2500+
AVERAGE UNPLANNED HOSPITAL ADMISSION COST FOR THIS COHORT

£400
THE MAXIMUM COST OF SUPPORT PER PERSON

WE ARE SEEING
A 3:1 RETURN ON INVESTMENT

THE FACTS

670 COMMUNITY GROUPS MAPPED IN PENWITH

31,000 HOUSEHOLDERS DESCRIBING THEMSELVES AS OFTEN OR ALWAYS LONELY

34,000 PEOPLE AGED 65 OR OVER LIVE ALONE

£1.7m WHAT VOLUNTEER TIME GIVEN SO FAR WOULD EQUATE TO BASED ON THE MINIMUM WAGE

PROJECT TEAM SPANS HEALTH, SOCIAL CARE, INDEPENDENT AND VOLUNTARY SECTOR, DRIVEN BY LOCAL GP CHAMPIONS

ONLINE REPOSITORY
THE [KNOWLEDGE BUCKET]
WWW.KNOWLEDGEBUCKET.ORG

WINNER OF HEALTH SERVICE JOURNAL AWARD 2013 FOR MANAGING LONG TERM CONDITIONS
SHORTLISTED FOR HEALTH SERVICE JOURNAL AWARD 2014 FOR PRIMARY AND COMMUNITY SERVICE REDESIGN

FIRST LOCAL SCHOOL OF HEALTH AND CARE RADICALS FOR NHS IMPROVING QUALITY
SHOWCASED IN NHS ENGLAND’S FIVE YEAR FORWARD VIEW AS A FUTURE MODEL OF CARE

60+ ORGANISATIONS ACROSS THE UK LOOKING TO US TO SHARE A NEW WAY OF WORKING

SO FAR 6 CLINICAL COMMISSIONING GROUPS IN THE UK HAVE AWARDED REVENUE FUNDING OF OVER £0.5M TO LOCAL AGE UK AND OTHER CHARITIES, BASED ON OUR MODEL

Information correct as of January 2015
Frailty Prevention in Practice
Cornwall ‘Living Well’

• Community nursing activity has increased in the LW areas possibly due to shift in care from acute to community but there is less crisis and a more planned care approach.
• The impact of Living well on Community nurses is the importance of behavioural change.
• Instead of following a structured assessment they have learnt better communication skills and a different approach to personalised care despite service pressures.
Any questions?
The 6 C’s for Everyone

Dr Andrew Coley
Chief Clinical Officer
NHS Clinical Leaders Network
6Cs for Everyone
Values for the Future of the NHS
So you know the 6Cs
But what does the future hold?
Things need to change and quick
But who are the Clinical Leaders?
It’s you, it’s always been you
We are here to help
Sustainable and Improved Care

FIVE YEAR FORWARD VIEW
Does the truth exist in numbers?
Good Care…

comes in a can?
Commissioning

How do you commission?
How do you set the targets?

Palliative Care
A change in culture
Not just for Nurses...

• If it was just based on numbers, who is most important?

1. **53 million** Patients in England
2. **1.5 million** Social Care Workers in England (not just NHS)
3. **369,686** Nurses in the NHS
4. **171,567** AHPs registered with the HCPC (of which 86,920 are in the NHS, and the remainder mostly in Social Care)
5. **153,472** Scientific, Therapeutic and Technical Staff
6. **148,075** Doctors
7. **37,314** Managers
The 6Cs: values for compassionate care

**Care**
Care is our core business and that of our organisations; and the care we deliver helps the individual person and improves the health of the whole community.

Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

**Compassion**
Compassion is how care is given through relationships based on empathy, respect and dignity.

It can also be described as intelligent kindness and is central to how people perceive their care.

**Competence**
Competence means all those in caring roles must have the ability to understand an individual’s health and social needs.

It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

**Communication**
Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say. It is essential for ‘No decision without me’.

Communication is the key to a good workplace with benefits for those in our care and staff alike.

**Courage**
Courage enables us to do the right thing for the people we care for, to speak up when we have concerns.

It means we have the personal strength and vision to innovate and to embrace new ways of working.

**Commitment**
A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.

We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

@6CsLive /6CsLive Clinical Leaders Network
It’s a journey we must face together
It’s in your hands!

• What is your ambition?
• How are you going to achieve it?
• Who are you going to take on your journey?

Share your thoughts and connect with us on social media or email:

england.sixcslive@nhs.net
Commissioning Workshop

Top 3 Priorities for Development/Action:

1.

2.

3.
Education Workshop

Top 3 Priorities for Development/Action:

1.

2.

3.
Provider Workshop

Top 3 Priorities for Development/Action:

1.

2.

3.