The Carlisle Story

Care and support planning at the heart of an integrated care community

In 2016 Carlisle Healthcare embarked upon their implementation of an integrated approach to personalised care and support planning (CSP) for those with multi-morbidity and frailty who would otherwise be unable to attend their usual surgery for routine care. This built on an established approach to care and support planning for people with long term conditions.

Carlisle Healthcare

Background

Carlisle Healthcare formed in October 2016 following the merger of three existing general practices in the city. They provide GMS services for just under half of the population of Carlisle (approx. 37,000 people). Being a larger organisation has allowed them to look at different ways of working at scale aiming to provide high quality care to the registered population.

Where did they start?

The team identified the housebound/elderly frail from practice registers and co-ordinated a birth month based annual CSP home visit - this is preceded by a home visit from a health care assistant to take blood, capture key metrics and leave information about the CSP process as well as some reading material about last years of life (Deciding Right booklet).

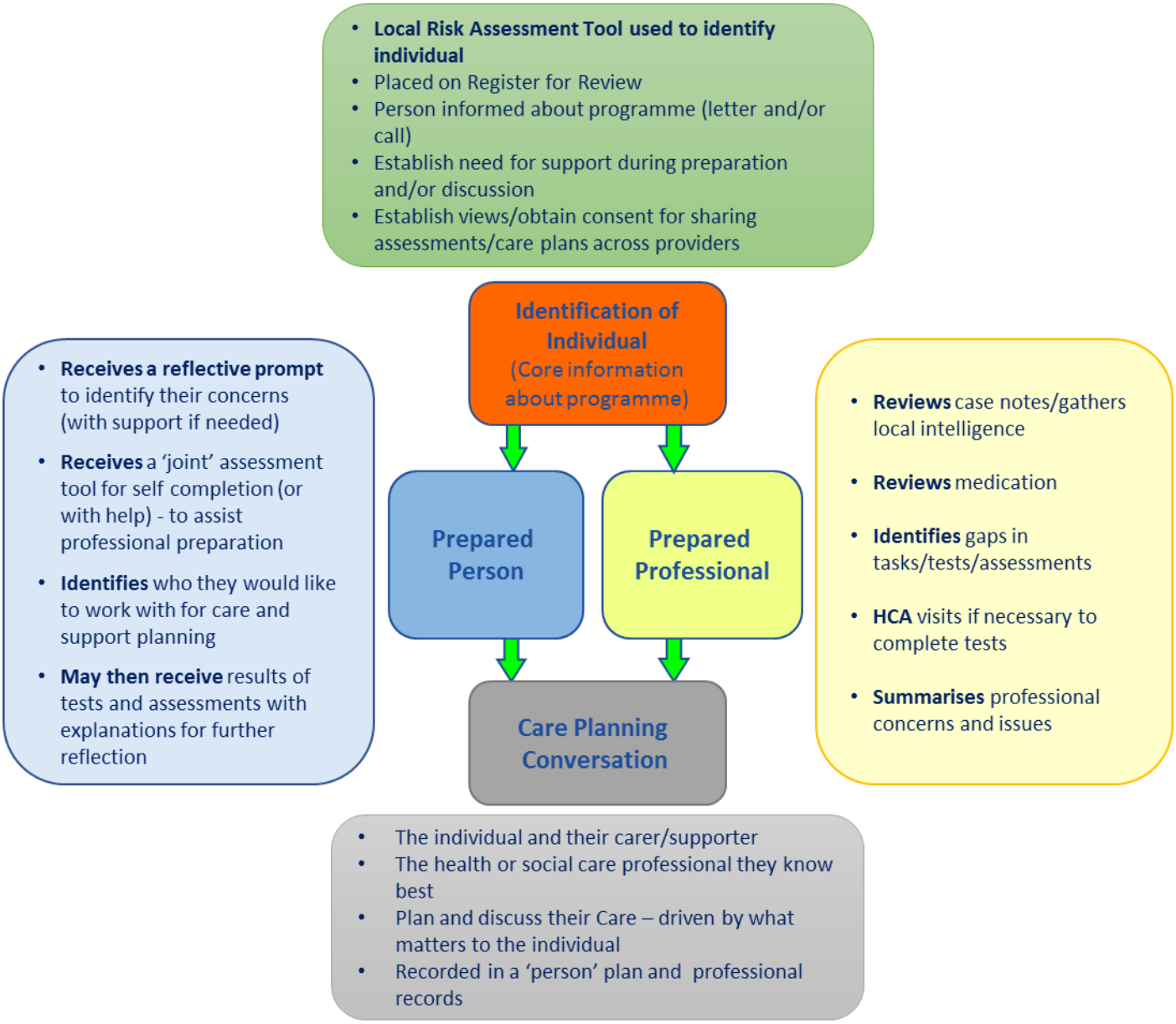
Preparation and the CSP visit

Metrics for appropriate co-morbidities are then posted to the patient along with a generic CSP cover sheet and the usual prompt / goal setting sheet. This allows time for reflection with friends and family if necessary before the CSP conversation. The health professional (usually a senior nurse or advanced nurse practitioner) then undertakes the CSP visit, completes documentation and then shares this with the patient and, with permission, the local out of hours organisation. The document provides a summary of the medical record as well as patient goals, actions, preferred place of care, future health preferences etc.

> ***"We're still developing, learning and growing, but sowing the seeds for an integrated approach to personalised care and support planning."*** **Robert Westgate, GP**

Generic steps for care and support planning for those living with frailty or complex needs

The team designed their local pathway using the steps and process described in a piece of development work completed by a Year of Care Partnerships working group in 2014 (outlined below). This emphasises the need for both professional and patient preparation which happen in parallel and are equally important.



Skill mix and teamwork

Carlisle Healthcare has struggled with GP recruitment and used funding from unfilled GP posts to appoint 2.4 whole time equivalent senior nurses to undertake CSP for the housebound. In addition these staff now provide a co-ordinated acute response on behalf of the GPs via an acute visiting service. As the service grows and the population enjoys several cycles of CSP, acute visits should increasingly be delivered by a familiar face.

Daily multidisciplinary team meeting

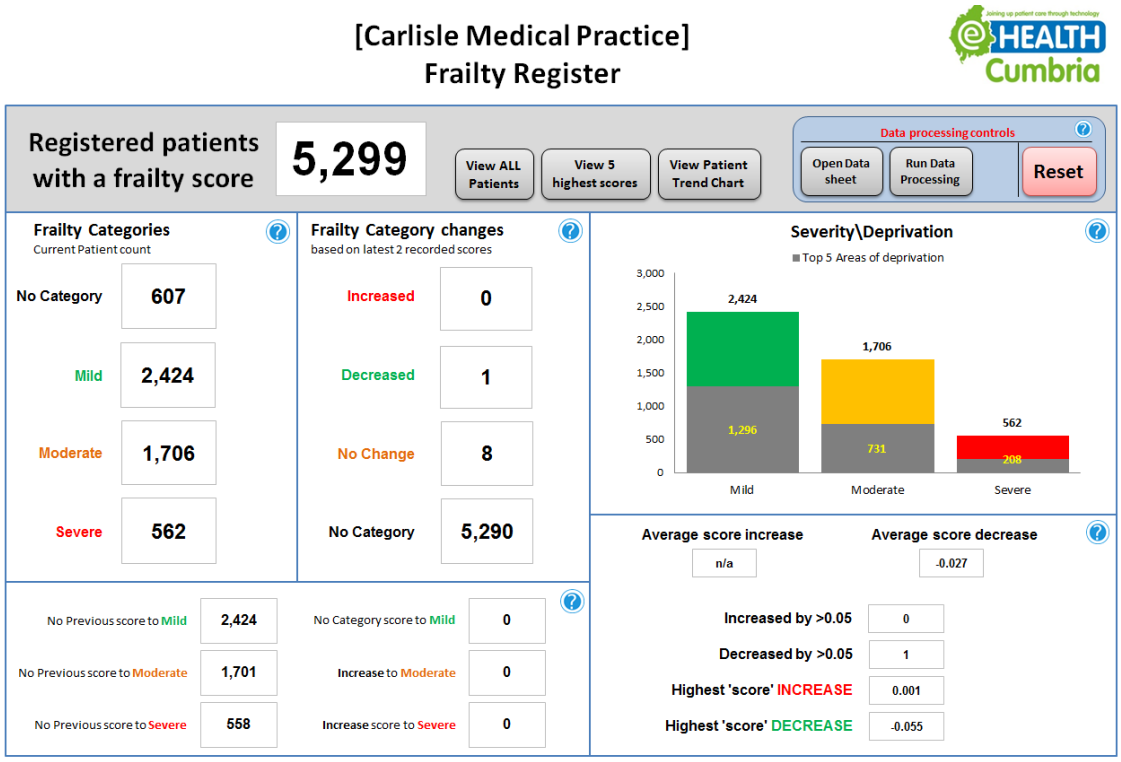
Carlisle Healthcare have convened a responsive daily weekday morning care coordination meeting (attended by a GP, nurse practitioner, community nurses, a representative from social care and older adult's mental health).

This meeting is informed by overnight contacts of the elderly frail population with the out of hours service, recent hospital discharges and admissions, people causing professionals concern and people with active palliative care needs. This allows for discussion of patients causing concern and has allowed earlier interventions and a more rapid response to patients at high risk of unplanned hospital admission.

In addition the meeting facilitates effective communication, enabling decision making between professionals and identifying a lead clinician (e.g. GP or nurse practitioner) to work with some of the most vulnerable people. There is ongoing work to develop a care co-ordination administrative hub (based on the general practice patient database) which will be allow information to be shared between organisations and help to direct health and care professionals and other support agencies in their work.

Using IT intelligently to identify people at risk

Carlisle Healthcare are currently undertaking some work using the electronic frailty index (eFI) within the GP clinical system (EMISWeb). In particular they are looking at trends in frailty, aiming to identify people who are not otherwise known to health and care services and whose frailty score is increasing (with a view to being more proactive and supporting people to keep well). This work is at an early stage and is being supported by Primary Care Informatics in Cumbria (PRIMIS - sample screenshot below).



A positive user experience

Carlisle Healthcare has recently carried out a survey of people who have completed care and support planning. 86% of respondents reported that they were able to "tell their story" and were given the time and encouragement to describe what is important for them, both currently and in the future. 70% of respondents reported that "the clinician helped me to take control (exploring with me what I could do to improve my health and well-being)". 80% of respondents agreed that they "were fully involved in decisions about them and their future healthcare needs".

> ***"It was very helpful especially 'end of life'"***
>
> ***"It has already proved useful on a recent ambulance visit to hospital"***
>
> **Feedback from people who have recently completed CSP**

Strong team working

The meeting has strengthened team working through regular communication and also developed greater understanding of the roles of different health professionals. The members of the District Nursing team also feel it is an opportunity for shared learning which has been a positive and beneficial experience. The morning MDT has also helped develop and grow a close working relationship with other health and social care professionals serving the same population.

> ***"Participation in the daily MDT meeting has assisted the District Nursing team to deliver patient centred care by enabling the sharing of information and reviews of MDT care plans.***
>
> ***It has provided a dedicated time for discussion of patients causing concern which has allowed earlier interventions and more rapid responses to patients at risk."*** **District Nurse**

Summary

This approach ensures that the benefits of MDT working are based on a truly patient centred approach designed around systematic CSP. It provides continuity of care both as the person ages but also between acute and routine care using the GP register throughout.

The success is built on strong human relationships both with individuals and between professionals, supported by tailored IT and information systems.

Acknowledgements

Produced by Year of Care Partnerships in conjunction with Dr Robert Westgate FRCGP, Medical Director, Carlisle Healthcare, St Paul's Square, Carlisle CA1 1DG.