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Fylde Coast Extensive Care - One Year On

your care our priority

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Lytham Road Pharmacy
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Blackpool
Welcome to
South Shore Primary Care Centre

We're live!

In July 2015, partners across the Fylde Coast launched the new extensive care service – an integral part of our new care models which will revolutionise local healthcare.

These new models of care will not only improve the patient experience and outcomes but also deliver the necessary change the local healthcare system requires.

Health and care organisations across the region have long shared a collective vision to transform out-of-hospital services, through more coordinated and proactive support for the communities of Blackpool, Fylde and Wyre. The launch of extensive care was the first step on this journey towards delivering truly integrated out-of-hospital services.

Whilst the last year has not been without its challenges, we have already seen early indications of the positive impact extensive care is having on clinical outcomes as well as the experiences of our patients and staff.

About extensive care

Extensive care is a fundamentally different way of delivering care for patients with some of the most complex healthcare needs. The aim is to support these patients with proactive, coordinated care, which provides a single point of access, to reduce the likelihood of unplanned hospital admissions and out-of-hours contacts.

To be eligible for the service, patients must be over 60 years of age with two or more of the following long-term conditions:

- Heart problems such as coronary artery disease, atrial fibrillation or congestive heart failure.
- Respiratory problems, such as chronic obstructive pulmonary disease (COPD)
- Diabetes.
- Dementia.

The original service blueprint specified that suitable patients were also required to have a risk score of more than 20. However, this criteria was amended in January 2016 following feedback from GPs. Patients can now also be referred regardless of their risk score if they meet the age and long-term conditions criteria and have had two or more out-of-hours, A&E or non-elective contacts in the past three months.

Patients are referred to the service by their GP and an initial multidisciplinary assessment is then carried out with the patient. Once a patient joins the service, lead responsibility for the coordination of their care is transferred to the extensive care team from their GP practice (similar to the way in which care is provided when a patient is admitted to hospital).

With the support of their dedicated wellbeing support worker, patients are encouraged to set a number of goals and aims that they will work towards. These form part of a comprehensive 'My Plan' care plan which is developed in conjunction with the patient and carer to meet all of their health, wellbeing and social care needs. It also outlines the triggers that define when a patient's condition has worsened, and the action to take to support and stabilise them. The aim is to encourage the patient to self-manage their own condition and lifestyle wherever possible with the ultimate aim being to help patients reach a point where they no longer need the intensive support of the service.

The service operates from 8am-7pm, Monday-Friday, and 9am-1pm on weekends and bank holidays. The service was initially launched at two sites on the Fylde Coast, Lytham Primary Care Centre in Fylde and Moor Park Health and Leisure Centre in Blackpool before being rolled out to two further sites, Blackpool's South Shore Primary Care Centre and Wyre Civic Centre in April 2016.

The extensive care service sees a range of health and care professionals working together in one harmonised team. This includes:

- a lead consultant;
- sessional GPs;
- advanced practitioners;
- clinical care coordinators;
- pharmacists;
- wellbeing support workers;
- and administration staff.

Why the change?

For the Fylde Coast, the ambition to transform out-of-hospital services is a key part of how local partners plan to meet the challenges which the area faces.

The challenge we face across the Fylde Coast is significant. While the health of our residents is generally improving, it is still worse than England's average. Blackpool is still England's largest and most popular seaside resort attracting 11 million visitors annually. There is a considerable amount of transience, including movement in and out of the town, as well as movement within it. This, coupled with high unemployment and rising prevalence of long-term conditions, has led to significant levels of deprivation and health inequalities that rank among the worst in the country. Blackpool has the worst life expectancy in the country for men and the third worst for women.

Within the most disadvantaged areas of Blackpool men can expect to live 13.3 years and women 8.3 years less than people in the least disadvantaged areas. Not only do people in Blackpool live shorter lives, they also spend a smaller proportion of their lifespan in good health and without disability. In the most deprived areas of the town disability-free life expectancy is around 50 years.

In contrast, 57 per cent of the population in Fylde and Wyre live within two of the most affluent quintiles. But, there are more than 16,800 people living in neighbourhoods that are classified as being among the fifth most disadvantaged areas in England, with men dying on average, 10 years younger than those in more affluent areas. For women, the difference is six years. A higher percentage of people in Fylde and Wyre are affected by long-term health problems than the national average. These include diseases of the heart and blood vessels, diabetes, kidney disease and stroke. The number of people with dementia is also higher than the national average.

It is also predicted that the number of over-65s within the whole Fylde Coast population will rise to between 31 per cent and 35 per cent by 2028. As partners we recognised that continuing to deliver more care in its current form is not financially sustainable. We know more people are cared for in hospital than is necessary and that care can often be provided more effectively in the community or at home. The care we provide is not always as coordinated as well as it could be and this can lead to poor experiences for patients and their families too.

We reviewed successful models of care from America and Europe and undertook an analysis of how these could be implemented to meet the needs of our local population and of the wider health and social care system in the UK. During the development of the CCGs' five-year strategies, our vision was advanced and tested by extensive engagement with a wide range of partners, patients and the public. Hearing their experiences of local services has helped to shape how our new models of care look now.

Our challenges

An increasing number of people living with complex long-term conditions.

A population with a growing number of older people.

Different communities with varying needs.

Men living in the most deprived areas die around 10-13 years younger than those living in the least deprived.

Many patients with long-term conditions are not managed well and cared for in hospital when they could be better supported in the community.

Poor experiences for patients and families because care is not always co-ordinated well.

Financial challenges across the whole health and care system.

Women living in the most deprived areas die around 6-8 years younger than those living in the least deprived.

One year on... the successes

The introduction of our extensive care model has not only been new to us on the Fylde Coast but to the NHS across England. Launching four new service sites across the area whilst ensuring the necessary staff and skills were in place to deliver the effective service we aspired for has been a substantial achievement in its own right.

From the early indications wehave already started to see some positive outcomes too, including:

- A 13 per cent reduction in A&E attendances.
- A 25 per cent reduction in non-elective admissions.
- An 18 per cent reduction in out-patient appointments.

In addition, of those patients who qualify but are yet to be referred to the service, nearly 90 per cent recorded some acute activity. This is compared to just 74 per cent in patients receiving extensive care.

One big success over the last 12 months has been the service workforce. To date we have recruited 81.3 whole-time-equivalent staff across a variety of roles.

All staff undergo a thorough induction process and we have evolved this through three waves of recruitment to focus on developing a workforce which possesses generic skills. This means all staff in the service are able deal with varying patient needs but it has been particularly important within the role of our care coordinators.

The introduction of the wellbeing support worker role has been a huge success too. This is a completely new role to healthcare organisations on the Fylde Coast and plays a pivotal part in making sure that patients not only receive support which meets their health needs but equally focuses on their general wellbeing. Each wellbeing support worker develops an in-depth understanding of the patient through their regular contact, and tailors their one-to-one support accordingly. This is often wide-ranging and can include; reminders to attend appointments and take medication; acting as an advocate; accompanying to activities such as wellbeing exercise sessions; encouraging new interests and hobbies and confidence building. Combining health and wellbeing support in this way has meant that we are able to make a true difference for patients.

"We've seen great achievements since we launched the service. Without the hard work of service staff and the collaboration of partner organisations on the Fylde coast, the last 12 months would not have been possible."

Dr Andrew Weatherburn,
clinical lead.

A further positive development has been the evolution of our medical consultant roles. The clinical lead was previously a secondary care geriatric consultant but has seen the role develop into a community based, primary care hybrid type role. This has not only allowed the clinical lead to benefit from the development of new skills but also allowed for strong working relationships with both primary and secondary care colleagues.

All four of the service sites sit within modern community facilities. Three within existing primary care centres and a fourth within a shared local authority building. This has allowed for close working between the service staff and other professionals.

The service has also established strong links with older adult mental health services, to the benefit of patients and staff over the last 12 months. This has included the regular attendance of older adult mental health professionals at weekly service MDT meetings. This has greatly supported our holistic approach to patient care.

The patient experience

Since the launch in July 2015, the service has cared for 577 patients with 98 per cent saying they would recommend the service to friends and family. Here's what some of these patients and staff within the service had to say about their experiences over the last 12 months:

John Kellow, 67-year-old Blackpool resident:
"If it wasn't for the extensive care service then I don't know where I would be… they take the time to listen to me and my issues. I have come on an unbelievable amount. They really are a lifeline. They have given me the confidence to take control of my life."

Rachel Howarth, wellbeing support worker:
"I really enjoy the work as it is very positive and person-centred. I get the luxury of having the time to spend with the patient and it is nice to build those relationships. Now when the patients are ringing us we know it is for a good reason as they have been empowered to deal with many things themselves."

Stuart Bradley, 64-year-old Freckleton resident:
"The goals are just simple things, but things that have become incredibly difficult in recent years. And the speed of the service is incredible. I know if anything goes wrong I can ring a number, 24/7, and someone will help me. I am not waiting a month to see a doctor any more. It is instant and for me, and Beryl, that provides huge security as I know in that place there is someone there if I need them."

Lee Jones, wellbeing support worker:
"This service is fantastic as, with myself and the other wellbeing support workers, we are able to get right to the very root of the problem and get it sorted. In a 10-minute appointment with a doctor, all they can do is diagnose a health complaint and arrange treatment, but through developing a relationship with Stuart I have been able to look at more preventative measures so, in the main, he is able to look after his conditions and avoid the need for emergency treatment."

"At first I didn't want to come to the extensive care service and I said no we're alright. I said I'll ring if I need help. You think you can do it, you think you don't need anybody. Well I did need help. I came in and they were absolutely wonderful. I'd recommend it to anyone!"

Lily Greenwood, wife and carer.

One year on... the challenges

Introducing a new way of working as we have with extensive care does not come without tests. Whilst we have had plenty of successes there have also been areas of challenge which we have had to embrace and adapt to accordingly since the launch.

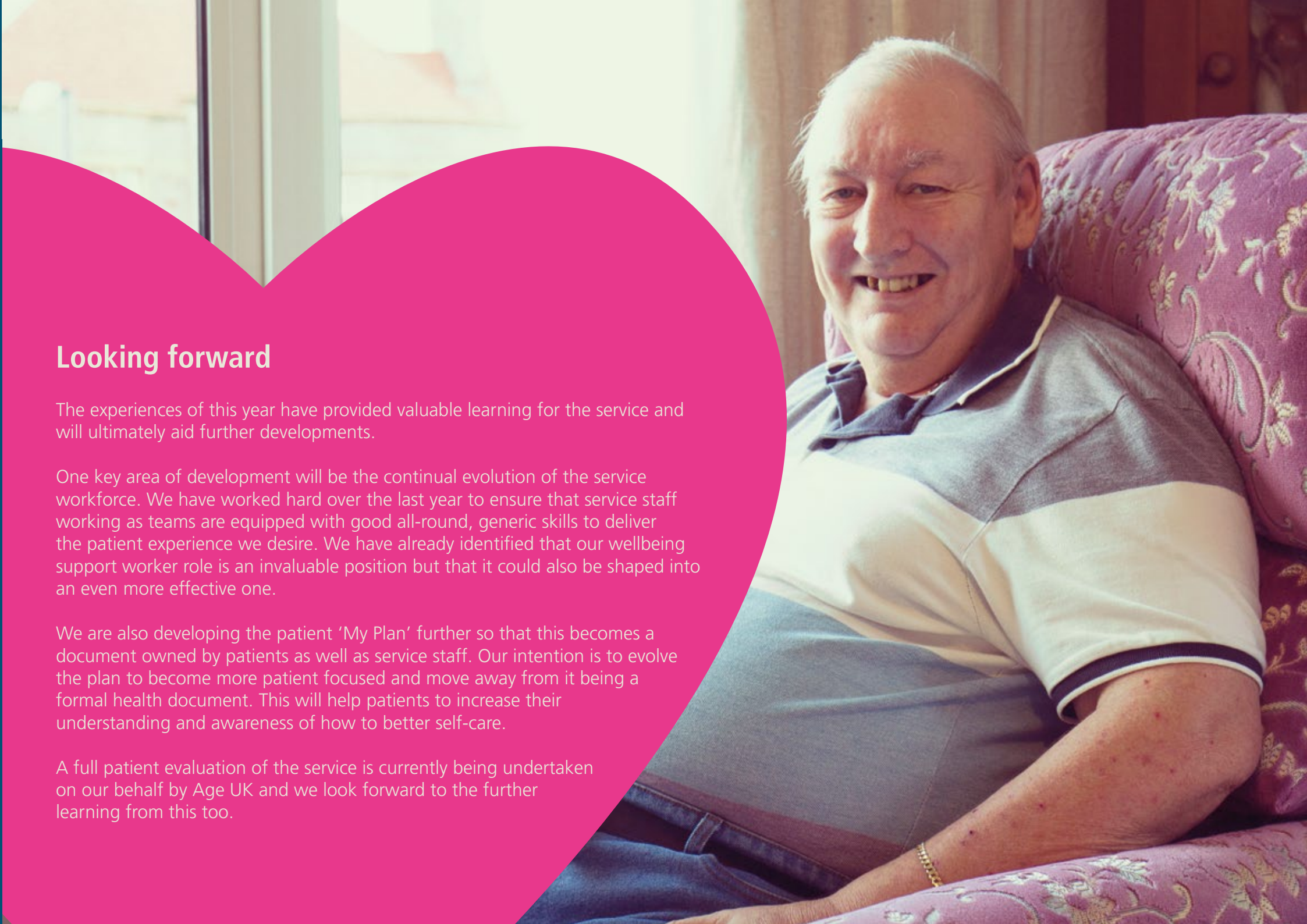
One particular area of challenge has been referrals to the service. The overall number of referrals received by the service to date is less than expected. This has been due to a number of issues. Feedback from primary care colleagues told us that they found the referral criteria too rigid and that the lists of suitable patients they received based upon, risk stratification scores, data wasn't timely enough. As a result we flexed the referral criteria to allow practices to take a more subjective approach to potential referrals.

Patients are now able to be referred to the service regardless of their risk score if they meet the age and conditions criteria and have had two or more out-of-hours, A&E or non-elective contacts in the last three months. We are also now moving towards more real-time data flows across the local system which we hope will further aid the referral process.

Practices also told us that trying to 'sell' a new service to patients, the concept we had adopted from having studied international models, was time consuming and often resulted in the service being declined through patient choice.

Engagement between primary care professionals and the service has also been a challenge with the original positioning of the service presenting a barrier to good relationships initially.

We have also experienced difficulties with the interoperability of different IT systems. As a community based service, extensive care uses EMIS Community. However, primary care colleagues use a separate GP EMIS system and each practice has their own GP EMIS system which they manage. The GPs system and the extensive care system therefore do not 'talk to each other'. This has caused frustration for staff on both sides. As a result updating patient records, particularly with prescribing changes, has proven an onerous task. The current process means extensive care prescribers are required to have a separate login for every single GP EMIS system meaning they require a large number of individual logins each. This is obviously not the easiest or most convenient method.



Looking forward

The experiences of this year have provided valuable learning for the service and will ultimately aid further developments.

One key area of development will be the continual evolution of the service workforce. We have worked hard over the last year to ensure that service staff working as teams are equipped with good all-round, generic skills to deliver the patient experience we desire. We have already identified that our wellbeing support worker role is an invaluable position but that it could also be shaped into an even more effective one.

We are also developing the patient 'My Plan' further so that this becomes a document owned by patients as well as service staff. Our intention is to evolve the plan to become more patient focused and move away from it being a formal health document. This will help patients to increase their understanding and awareness of how to better self-care.

A full patient evaluation of the service is currently being undertaken on our behalf by Age UK and we look forward to the further learning from this too.

Evolving our health and care system

The introduction of extensive care forms one part of our approach to implementing new models of care on the Fylde Coast.

In Autumn 2016 we will launch our enhanced primary care model which will be a universal service available to patients over 16 who require a greater level of support for the management of long-term conditions. Locally based neighbourhood care teams will be located within the 10 neighbourhoods on the Fylde Coast to deliver this enhanced level of support alongside GPs.

When both our enhanced primary care and extensive care models are implemented together we envisage a seamless care system which wraps care around patients according to need. This will enable GP capacity to be freed up so that they are available to better manage and support more complex patients, assuring adherence with best practice to improve outcomes.

Sharing our learning

As a vanguard site, we are committed to sharing our learning from the development and implementation of our new care models as we progress along our journey.

The extensive care team have facilitated a number of visits from other health and care economies looking to learn from the launch of the service on the Fylde Coast.

This has aided these other areas to develop their own thinking towards new models of care. Samuel Keong, service redesign programme manager, NHS Birmingham Crosscity CCG: "The extensive care service kindly hosted us when we came to see how their model worked. The learning was incredibly beneficial and has heavily influenced the way we're co-designing the service with partners on how this can be delivered effectively.

"The lessons they've learnt provided a better starting position for us, warning us of the potential pitfalls and key challenges that needed resolution in order to succeed."

The extensive care service team have also benefitted themselves from the learning of colleagues in both Yeovil and Selby who have also introduced similar extensivist models of care.

“We wanted to understand in more detail the work that the Fylde Coast team had done to establish the service and learn from them about the improved outcomes for patients and benefits realised to date. We were not disappointed.

“We have taken on board everything they’ve told us and have now set up our own Visioning Workshop later this month, to draft a model of extensive care that will support the patients of Tameside and Glossop. I’m sure our working relationship with the team will continue to grow as we build our service and hopefully we will be in a position to give them something back from our experience.

“We thank the Fylde Coast extensive care team so much for sharing their learning with us. They’ve given us the insight and inspiration to go ahead and develop a service that meets our local population needs.”

Angela Brierley, head of service transformation, Tameside Hospital NHS Foundation Trust.

If you would like to arrange an opportunity hear more about the learning from extensive care on the Fylde Coast then please contact the service directly via telephone on 01253 951400 or email extensivecare.service@nhs.net.

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