

Extensivist Model of Care – Summary Report

(Based on Clinical Blueprint v.11)

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1. Outline of key features of service for agreement

This summary report based on the care model blueprint (v11) provides an overview of the following key details and assumptions around the Extensivist Model of Care:

- We will establish two initial Extensivist services on the Fylde Coast as part of phase 1 of the programme
- They will be initially focused on the frail elderly populations with multiple long term conditions
- The services will cover:
 - Lytham, St Anne's and Ansdell neighbourhood – at Lytham Primary Care Centre
 - North and Far North Blackpool neighbourhoods – at Moor Park Primary Care Centre
- They will be:
 - Planned between July 2014 to January 2015
 - Launched in February 2015
 - Then supported by roll out of the next group of services to cover phase 2 of the programme from April 2016

An overview summary of the model is provided below for context.

- The Extensivist Service will provide pro-active and co-ordinated care wrapped around the patient with a single point of access
- The service will be fundamentally orientated toward supporting patients to have the confidence and knowledge to manage their own conditions
- Once the patient has consented to be part of the service, full clinical responsibility will pass from the GP to the Extensivist
- The Extensivist service is provided by a team of clinicians and non-clinicians skilled in supporting patients with complex needs and having clear accountability on behalf of the system for providing and coordinating this care
- Regular contact with a Well Being Support Worker (recruited for the individual's emotional intelligence) and effective use of telehealth approaches will be some of the elements that make the service feel very different
- We expect that this approach will result in significantly improved patient experience, with patients being empowered to manage their own health and having an increased sense of wellbeing as a result
- For the system this should also result in patients having fewer unnecessary outpatient consultants and investigations, and fewer planned and unplanned hospital admissions

2. Patient Cohort/Target Population

The cohort of patients will be defined by those who will benefit most from the care offered by this tailored service and will be identified by a combination of pro-active data analysis and local GP knowledge to ensure that patients are identified pro-actively (ahead of unnecessary admission or crisis) as much as possible.

The patient cohort, based on the Aristotle risk stratification tool, is defined by the following criteria:

Age	≥ 60	It should be noted that this will need to be evaluated during the proof of concept, as there is a concern that the age of entry may need to be lowered in order to have greatest impact in neighbourhoods with low life expectancy.
Long term conditions	≥ 2 of the following: Coronary Artery Disease Atrial Fibrillation Congestive Heart Failure COPD Diabetes Dementia The following are NOT to be included: Cancer Chronic Kidney Disease Epilepsy	CKD has been excluded since the Clinical Redesign Team considers it to be associated with aging and/or medication regimes linked to other LTCs. Therefore, it is considered to skew the risk of future admission, and could result in patients with 1 LTC + CKD being included. Epilepsy has been excluded since the Clinical Redesign Team considers that NICE guidance should be followed in relation to management of this condition by a neurologist.
Predicted risk of non-elective admission within the next 12-months	Risk ≥ 20	Patients with a score of ≥ 30 appear to already be users of secondary care activity, with evidence of multiple A&E attendances and NEL admissions. Patients with a score of 20 – 30 appear, in the majority, to be managed outside of secondary care. Therefore, selection of a risk score of ≥ 20 should address those patients who are currently accessing secondary care services as well as offering a service that will prevent future high intensity use.

Use of these criteria will result in the following numbers of patients in each proof of concept location:

	Risk Score										Total Patients	Total Extensivist Patients
	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100		
Lytham	583	405	269	153	67	48	35	24	14	3	1601	613
Moor Park	685	463	272	150	85	68	37	28	20	12	1820	672

Assuming an uptake rate of 75% (half way between the Swedish and US care models) each service will be managing approximately 500 patients.

It should be noted that the referral criteria will be reviewed as part of the evaluation of the proof of concept services.

3. Extensivist Service Team & Activity

3.1 Service Ethos

The service ethos outlines the values and attitudes of the people who will work in the Extensivist service. It is what will set this service apart from others and will help it deliver the level of care this blueprint outlines. The service ethos for the Extensivist service is:

- The Extensivist service will bring together insightful, emotionally intelligent, and empathetic health professionals. They will listen to patients and act as their advocate and enabler throughout their Extensivist care term
- The staff will balance leadership, autonomy and independence with team working to provide the best all round care effectively for their patients
- The ideal candidates will be motivated to provide comprehensive complex care in this evolving environment, whilst being flexible and innovative within this service

3.2 Team Overview

The core clinical team is comprised of staff in three roles: clinic leaders, clinical care coordinators and Well Being Support Workers. There will also be a number of wider team members bringing specific clinical or care skills to the team to support care planning, provision of care and development of core skills within the team.

The Extensivist team will be required to work in a significantly different way from staff in the majority of health and care services today

In order to achieve this staff will be recruited for their:

- Emotional intelligence and empathy
- Leadership, resilience and the ability to influence
- Drive to act as patient advocates
- Ability to work in a team and balance input from a range of sources
- Comfort with uncertainty and motivation to innovate

3.3 Core roles

The table below sets out the core team roles:

Note that role and function descriptions, along with qualifications and professional requirements have been developed for each of these roles.

Position	Role / responsibilities
Extensivist	<ul style="list-style-type: none"> • Senior medical team leader • Lead care planning • Work with the multi-disciplinary team to manage all the needs of frail elderly patients with complex needs

	<ul style="list-style-type: none"> • Ensure continuous service improvement • Clinics will have two “Extensivists”: one Consultant and one GP, so their skill sets can complement one another in the running of the clinic
Advanced Practitioner	<ul style="list-style-type: none"> • Make differential diagnoses • Coordinate patient care • Take a leadership role within the team • Be required to lead and oversee swift reaction
<p>Care Coordinator (function)</p> <ul style="list-style-type: none"> - Nurse (coordinator role) - OT (coordinator role) - Physiotherapy (coordinator role) - Social worker (coordinator role) - Pharmacist (coordinator role) - Dietician (coordinator role) 	<ul style="list-style-type: none"> • Coordinate patient care • Deliver specialist care in-line with individual training (e.g. as an OT) • Sub-specialists will cover the most complex patients with the disease they specialise in within their case load • Sub-specialists will also be a source of expertise for the team and the other care coordinators • Provide expert input into the care plan development and review process • Provide specialist patient care • Any sub-specialties not covered within the Clinic team will be provided through a linked service • Staff will be recruited from a range of backgrounds (including nurses, therapists, pharmacists and social workers) and collaborate on providing care for patients in parallel with their case-load role –the numbers and mix of backgrounds within each team will be driven by the needs of the local cohort of patients • N.B. Social workers also responsible for forming links with social care teams
Well Being Support Worker	<ul style="list-style-type: none"> • Build a strong supportive relationship with the patient • The point of contact for the patient and their family/ carer • Responsible for self-management support (patient activation) • Bridge the gap between the clinician and the patient • Assist in navigation of the health and social care system

Core team administration

Position	Role / responsibilities
<p>Service Manager</p> <p>(could fulfill the analyst role as well)</p>	<ul style="list-style-type: none"> • Manage the operations of the service (performance management) • Report performance via the management infrastructure • Support continuous improvement

Analyst	<ul style="list-style-type: none"> • Conduct regular analysis of performance • Complete bespoke analysis to support service improvement • Additional tasks TBD during implementation and iterated through proof of concept
Administrator(s)	<ul style="list-style-type: none"> • Support the day-to-day operations of the clinic • Cover reception and incoming calls • Supporting processes regarding clinical information e.g. collection from GPs • The number of administrators per clinic depends on the extent to which technology is used by the clinic and patients • Additional tasks TBD during implementation and iterated through proof of concept

3.4 Training and development

Education and training will be at the core of the operating approach, and the service will seek to develop a specific Extensivist training programme for all roles in the team, to support expansion and maintain the pipeline of staff for the service.

For all the staff joining the Extensivist clinic, there is a base level of training they would all benefit from. This will set them up with the skills and the confidence required to treat patients with complex health problems.

Patient facing elements:

- CBT and behavioural support- to be apt at dealing with and understanding patients with mental health issues
- How to support patients with dementia
- End of life planning- including how to handle emotional support
- Patient activation and motivation

Other elements:

- A general understanding of all the main conditions the patient cohort may have- to be in a position to understand their needs and refer effectively within the Extensivist team
- Leadership training – for all staff
- Team working and principles of continuous improvement
- Use of IT systems, including EMIS and home monitoring systems

3.4.1 Specific role qualifications, competencies and training

Role	Competencies, training and qualifications
Extensivist	<ul style="list-style-type: none"> • Competency- using input and support from specialists to develop specialist type skills in managing diabetes, CHF, COPD, CKD and mental health in target patient group
Advanced	<ul style="list-style-type: none"> • Qualification- V3000 non-medical prescribing

Practitioner	<ul style="list-style-type: none"> Competency- Willingness and motivation for self-development and upskill e.g. if they have not completed the Advanced Practitioner course, a willingness to complete this course or learn some of these skills, especially in specialist type skills in managing diabetes, CHF, COPD, CKD and mental health <p>NB- completion of this course is not a requirement for appointment to this role</p>
Care Coordinator	<ul style="list-style-type: none"> Qualification- V3000 non-medical prescribing Specialist qualification in COPD, diabetes, heart failure nursing, or dementia specialist skills Competency- Willingness and motivation for self-development and upskill to acquire the specialist skills
Well Being Support Worker	<ul style="list-style-type: none"> Advocacy training- how best to represent their patients in front of the rest of the Extensivist team, as well as linked and wider services Competency- Willingness and motivation for self-development and upskill

3.5 Service Activity

The core hours of the Extensivist service are:

Full Service	Monday to Friday 8am – 7pm	See below for definition
Out of Hours	Saturday / Sunday / BHs 9am – 1pm	See below for definition
No extensivist service	All other hours	See below for definition

3.5.1 Full Service

This is when all members of the team are on duty, including senior clinicians such as the Extensivist or the Advanced Practitioners.

5pm until 7pm is popular for elderly patients who are either being transported by working family members or elderly patients whose family members are required for additional information/ input into assessment.

It is felt that by pro-actively managing patients more intensively during core hours there would be less impact on services outside of these times.

3.5.2 Out of Hours

Well Being Support Workers and Care-Coordinators will be available during this time, with clear protocols regarding escalation to wider services where required.

During these hours the clinical care co-ordinator would be the most senior clinician on duty within the team and would be the main point of contact for unwell patients and for co-ordinating the care provided by linked services.

3.5.3 No Extensivist Service

It is felt that the requirement for input from the team overnight would be minimal. The point of contact for unwell patients and linked services would be the FCMS Care Co-ordination service.

For the out of hours period a copy of all care plans for these patients would be made available to FCMS. This care plan would be extensive regarding care requirements and out of hours actions and will be reviewed regularly to ensure current.

A discussion would need to be held with NWS to discuss the care plans and any specific issues this may cause for the ambulance service as well as agreeing who to deal with out of hours.

3.5.4 Evaluation

A full review of the opening hours will be undertaken as part of the evaluation, including patient and carer views on suitability.

4. Core service design

The Clinical Redesign Team has produced the following flow charts to provide a high level overview of how patients will be referred, assessed, managed and then stepped-down from the service.

4.1 Patient identification, Referral & Enrolment

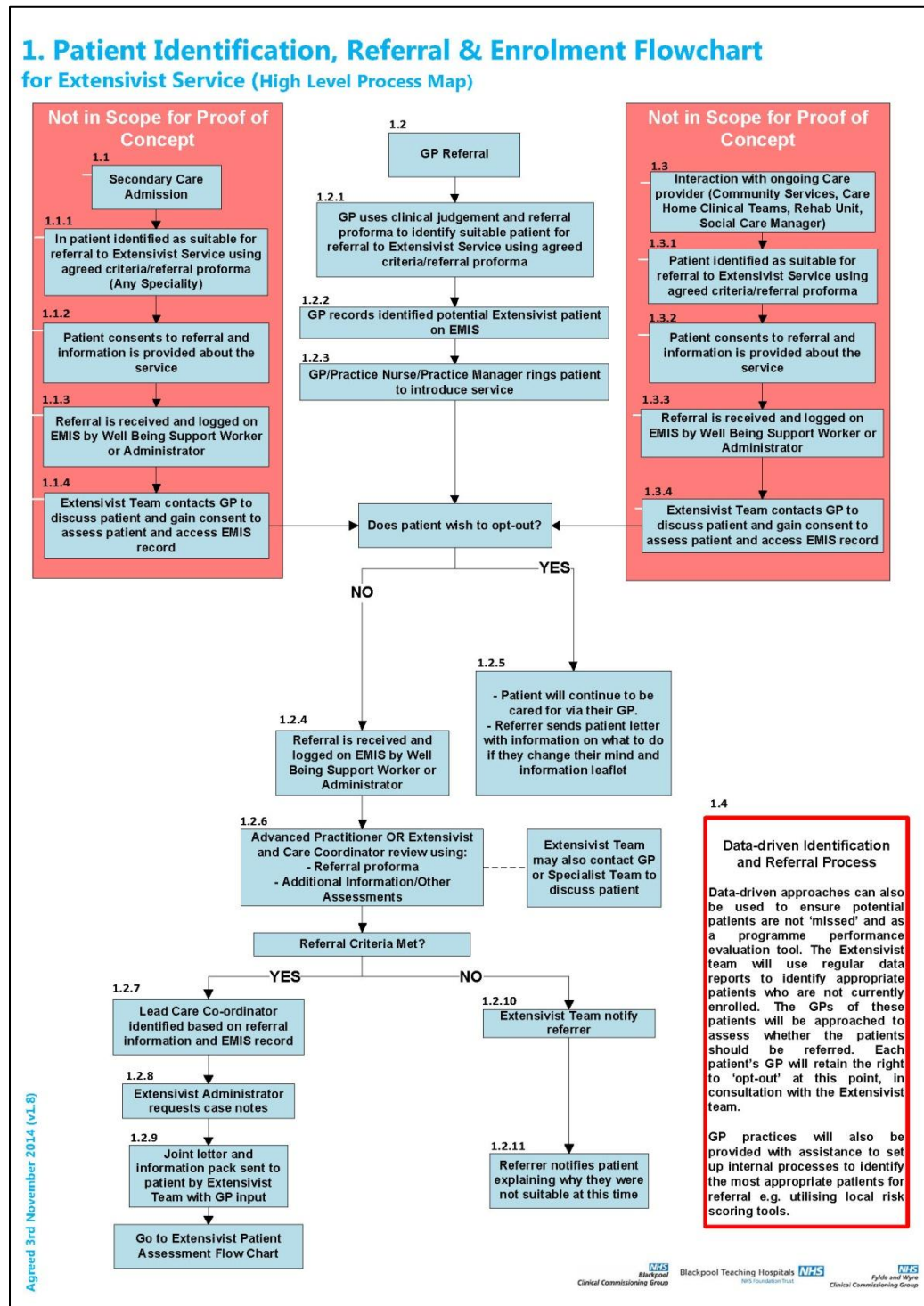


Figure 1: Patient identification, Referral & Enrolment Flowchart for Extensivist Service

For the purposes of the proof of concept it has been agreed that only the patient cohort's identified through the risk stratification tool will be referred into the service (as outlined in Section 2 which details the proposed referral process once the service is rolled out beyond the proof of concept phase.)

4.1.2 End-state process (different from the proof of concept process)

Patients may come to the service through several routes:

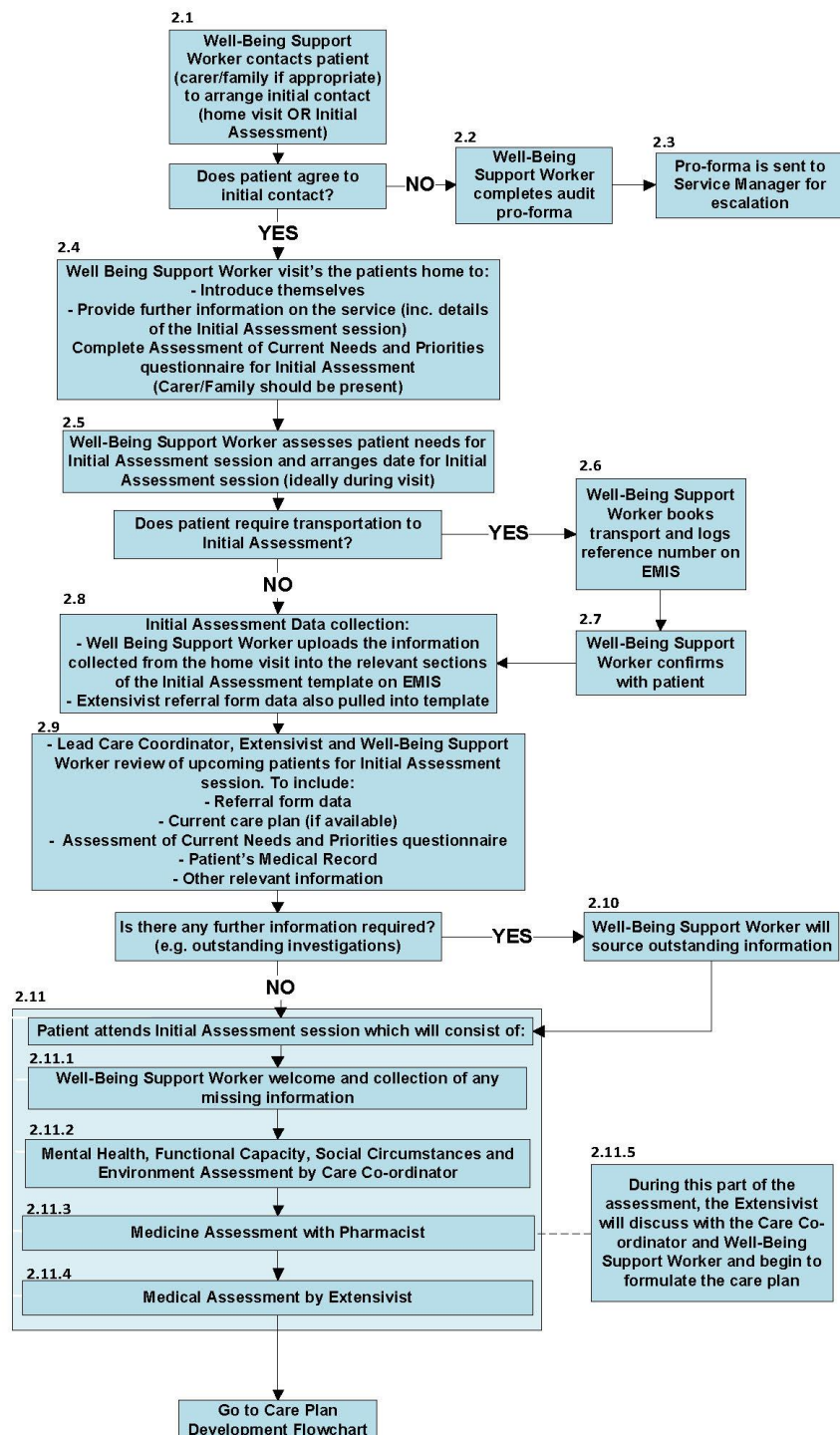
Recruitment channel	Process
GP Referral	<ul style="list-style-type: none"> The Extensivist Service's primary source of referrals will be primary care. GPs in the area will be provided with detailed information on the service and how to refer into it. GPs will use their clinical judgement to identify those patients with the greatest needs. Once a patient is identified and has agreed to a referral into the service, they can be referred to the service wither via an electronic referral form through the EMIS clinical system or with a single phone call direct to the Extensivist clinic. GP practices will also be provided with assistance to set up internal processes to identify the most appropriate patients for referral e.g. utilising local risk scoring tools.
Secondary Care Admission	<ul style="list-style-type: none"> Hospital specialists will be able to refer patients into the Extensivist service (e.g. after an A&E or a non-elective admission) with the consent of the patient's GP. The process for secondary care referrals is illustrated in diagram 1. To facilitate a smooth referral process through secondary care standing agreements and referral protocols will be set-up with GPs wherever possible.
All Other Services (e.g. Community matrons, district nursing, rehab teams, therapy, etc.)	<ul style="list-style-type: none"> Where community service personnel encounter an Extensivist appropriate patient, they inform the patient's GP The Extensivist team approaches the patient's GP who can 'opt-out' or arrange to obtain initial patient information sharing consent Upon GP agreement the Patient Engagement and enrolment process is initiated. The process for secondary care referrals is illustrated in diagram 1. To facilitate a smooth referral process through these service standing agreements and referral protocols will be set-up with GPs wherever possible.

In addition to the above, data-driven approaches will be used to ensure potential patients are not 'missed'. The Extensivist team will use regular data reports to identify appropriate patients who are not currently enrolled. The GPs of these patients will be approached to assess whether the patients should be referred. Each patient's GP will retain the right to not refer the patient in discussion with the Extensivist team.

Following referral, the Extensivist team will use available data (via information sharing across the system) and referral details to evaluate the appropriateness of the referral and respond within 24 hours to confirm whether the patient has been accepted for assessment. The patient engagement and recruitment process will then be initiated by the Extensivist team.

4.2 Patient Assessment

2. Patient Assessment Flowchart for Extensivist Service High Level Process Map



Agreed 3rd November 2014 (v1.8)

Figure 2: Patient Assessment Flowchart for Extensivist Service

Once a patient is accepted for assessment the formal engagement and enrolment process commences after patient consent has been obtained for their information to be shared between healthcare services with the Extensivist Clinic. Patients may opt-out at any point during this process.

The first introduction will be by the Well Being Support Worker who will visit the patient's home and provide further information on the service. The Well Being Support Worker will also collect and record information to be fed into the assessment and care plan development process.

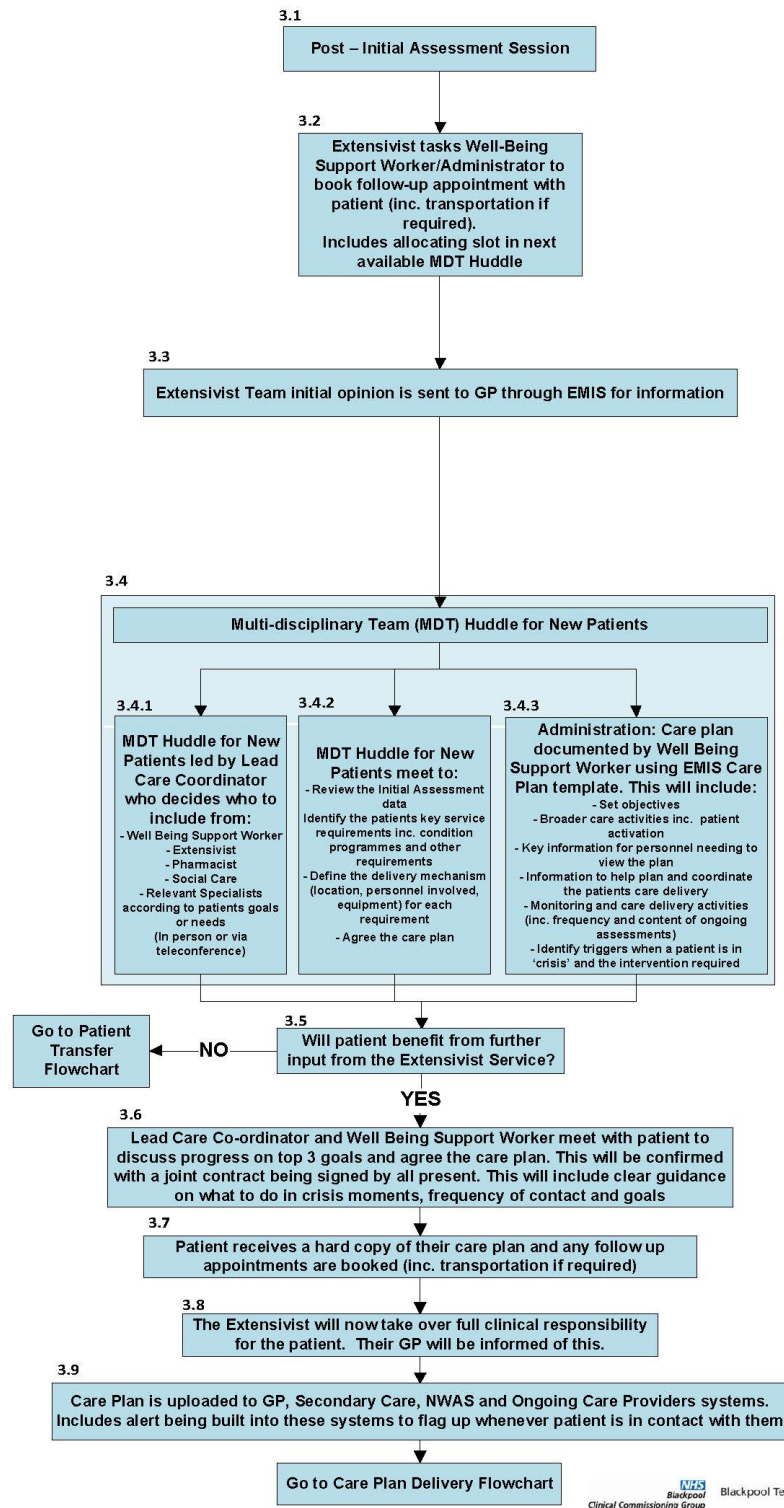
The initial assessment will be done at the Extensivist clinic (where possible). New patients will receive a comprehensive assessment, built on principles developed by the British Geriatric Society and using evidence based cognitive, social and physical assessment tools to ensure that unnecessary and conflicting pre-existing medications and care delivery are removed.

Existing care plans will be reviewed as part of this process. These existing care plans will be superseded by the care plan developed by the Extensivist team and agreed by the patient.

A key element of information gathering will be discussion of the patient's goals and aims. This part of the process will be completed by the Extensivist in order to allow them to use their clinical judgement to support patients in aiming to become as independent as possible.

4.3 Care plan development

3. Care Plan Development Flowchart for Extensivist Service (High Level Process Map)



Agreed 3rd November 2014 (v1.8)

Figure 3: Care Plan Development Flowchart for Extensivist Service

The Extensivist team is responsible for planning and coordinating the full range of each patient's care as well as a large proportion of its delivery (dependent on conditions and severity). The care plan development process is therefore undertaken by a multi-disciplinary team, with composition based upon the needs of the patient. The team will include the patient's Well Being Support Worker, Care Coordinator and Extensivist, as well as other health and social care professionals, identified by patient's goals or needs. This team will meet either in-person or via video-conference to review the information collected and agree the care plan.

During the meeting the team will identify the patient's key service requirements incorporating condition programmes and other requirements (e.g. social care) to create a complete picture. The delivery mechanism (location, personnel involved) for each action in the care plan is then defined. This is conducted taking account of the patient's needs, mobility and preferences. Wherever possible care will be delivered in the patient's home. Additionally the team will aim to minimise the number of different personnel involved in each patient's care, they will therefore aim to utilise core team members as much as possible, engaging linked or wider services personnel only as required.

The care plan must then be clearly explained, reviewed, agreed and signed by the patient (and/or any other key stakeholders such as carers) in a care plan discussion meeting before it is enacted.

The care plan covers medical, psychological and social aspects of a patient's health and has very clear instructions for the patient, their carer and other health and social care professionals regarding actions to be taken and services to be accessed under normal circumstances and in times of exacerbation or crisis. The care plan will:

- Provide a tool for the patient and their care team to set objectives and agree the plan
- Include broader care activities such as education (to contribute to patient activation), exercise and social activities
- Provide key patient information for health and social care personnel who need to view it
- Act as a tool to help plan and coordinate all the patient's care delivery
- Define how each element of care will be delivered (e.g. by the core Extensivist team or a linked service)
- Identify the monitoring and care delivery activities that need to be put in place while a patient's health is within agreed 'stable' parameters (including the frequency and content of ongoing assessments)
- Identify the triggers which define when a patient's condition has exacerbated or the patient is in 'crisis' and intervention is required and provide a suitable action plan
- Define protocols for the required intervention for each trigger

4.3.1 Patient consent and enrolment

Once the care plan has been agreed by the patient and following agreement by all parties, the patient is officially enrolled into the Extensivist service and their GP is alerted.

It is at this stage that the Extensivist takes on full clinical responsibility for the patient. Up until this point clinical responsibility will have remained with the GP.

4.4 Care Plan Delivery

4. Care Plan Delivery Flowchart for Extensivist Service (High Level Process Map)

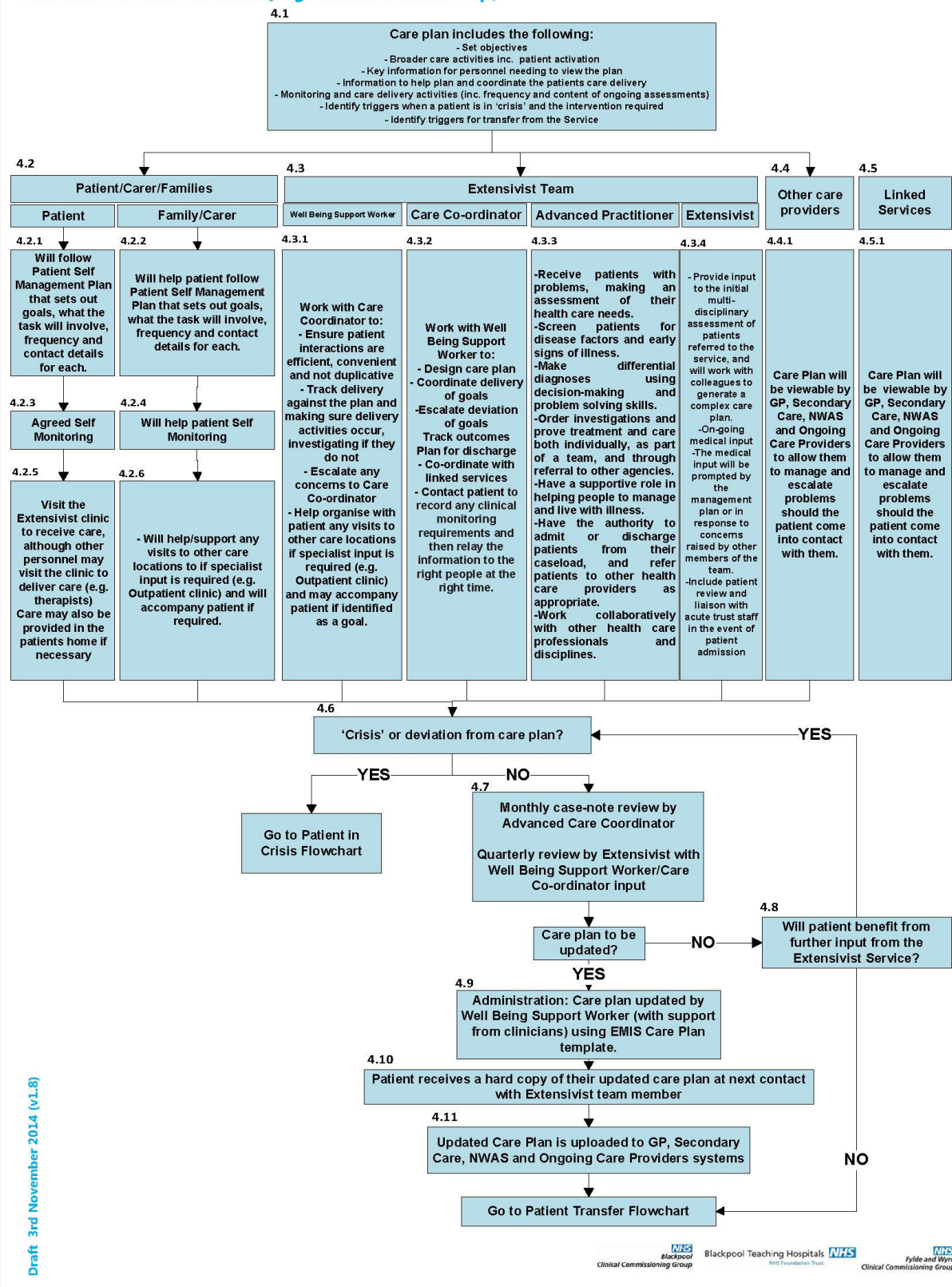


Figure 4: Care Plan Delivery Flowchart for Extensivist Service

4.4.1 Ongoing care provision

Ongoing care will be driven by regular, planned interactions focussed on delivering a patient's goals and maintaining them in a "stable" or "on plan" state. There will also need to be mechanisms for escalation if a patient experiences a rapid deterioration or crisis

These ongoing "stable" or "on care plan" interactions will be focussed on pro-actively driving dynamic delivery of the patient's goals as set out in their agreed care plan, through four components:

- Patient empowerment: led by the Well Being Support Worker, patients will receive training and support to build the confidence and skills to better manage their own health. This will include signposting to relevant voluntary sector services to assist with their empowerment.
- Care delivery: provision of a proportion of the central elements of care for the patient to make best use of each patient contact e.g. provision of foot checks, COPD physiotherapy etc.
- Monitoring: patient confidence building and care delivery will be underpinned by ongoing monitoring. Well Being Support Workers and care coordinators will be expert in supportively monitoring patients to ensure that goals are met while continuing to build patient confidence in managing their own care
- Care coordination: ensuring that all elements of care required by the patient are in place and operating appropriately, e.g. community nursing and social care support is in place, patient education sessions are booked and attended, that blood tests are carried out etc.

Rapid escalation to resolve issues proactively forms the remainder of ongoing provision, this will be achieved through:

- Daily "huddle" meetings where previous day and same day priorities will be discussed with the extensivist.
- "Swift reaction" time for clinical team members to arrange escalation for patients who may be about to enter crisis
- Weekly MDT Huddle meetings, where the patient's whole core team meet with any specialists (likely by videoconference) to discuss complex cases and agree courses of action in an integrated fashion.

4.4.2 Care coordination

Patients in the Extensivist service receive a range of care services from the Core Extensivist team, care programme teams and through linked and wider services e.g. ensuring that community nursing and social care support is in place, patient education sessions are booked and attended, that blood tests are carried out etc.

One of the key roles of the Extensivist core team is to ensure that these care delivery services are coordinated. This role is fulfilled by the Well Being Support Worker and the Care Coordinator who work as a team for their patients to:

- Use 'Smart' scheduling to ensure patient interactions across providers and settings where necessary are efficient, convenient and not duplicative.

- Track delivery against the plan and make sure planned care delivery activities occur, investigating quickly and correcting if they do not.
- Ensure care provision personnel have all the information they need to do their job effectively
- Try and provide the majority of care for the patient outside of hospital where possible

4.4.3 Care plan delivery

Three major categories of care plan delivery are described in more detail in this section:

1. Delivered in the Extensivist Clinic
2. Delivered elsewhere
3. Delivered in the patient's home

4.4.3.1 Delivered in the Extensivist Clinic

Patients will visit the Extensivist Clinic regularly to receive care. Care activities will mainly be delivered by the Advanced Practitioners and Care Coordinators. These activities will align with the specialities of these personnel which include OT, physiotherapy, nursing, etc. Well Being Support Workers may also be involved in simple care delivery activities where appropriate.

Where necessary or possible other personnel may visit the Extensivist Clinic to deliver care and education to Extensivist patients. For example, a specialist may conduct a session in the clinic to provide specialist input for a number of Extensivist patients.

4.4.3.2 Delivered elsewhere

Where necessary patients may visit other locations. For example, if the demand for specialist input is too low to justify a session in the Extensivist Clinic, patients may see the specialist in an outpatient clinic, potentially accompanied by their Well Being Support Worker (if consent is received) either in person or via video conferencing.

4.4.3.3 Delivered in the patient's home

Where necessary, care will be delivered in a patient's home. Where possible this will be delivered by Extensivist core team members at the same time as other activities (e.g. monitoring). Where necessary other personnel will be engaged via linked and wider services (e.g. Community nursing).

4.4.4 Monitoring & Coaching

The first aim of the monitoring activity is to ensure the Extensivist Team keeps track of patient goals and objectives so they can be adjusted and updated as required. The second aim is to ensure the Team stays up-to-date with developments and new information so that they can:

- Meet a patient's needs more effectively.
- Identify emerging factors that could negatively impact upon a 'stable' patient's health outlook, intervening as necessary.
- Detect deterioration and instigate appropriate action.

- Monitor the patient's progress versus the care plan objectives.
- Identify when patients should step-down from the Extensivist service.

The second category of monitoring will focus on physical, psychological and social 'triggers'. These are pre-defined events or criteria / thresholds (e.g. HbA1c levels) which indicate attention or intervention is required. Triggers to be monitored may include:

- Non-compliance with treatment / care plan (e.g. 2 non-compliance events in 1 week)
- A change in social circumstances (e.g. a carer falls ill)
- A non-elective admission/999 call/A&E attendance
- A prompt for medication or to attend appointments outside of the patient's care plan

For each patient the care plan will define the trigger events, thresholds and associated interventions (e.g. a 1kg weight gain in 2 days in a heart failure patient triggers a medication review or discussion by the Extensivist team). Wherever possible a graduated response will be used so that triggers are referred to and dealt with by the Well Being Support Worker (particularly where a pre-defined protocol exists). Where the care plan does not include a protocol Care Coordinator or Extensivist opinion is more likely to be required. Over time, it is expected that the service will 'learn', improving and adding to the pre-defined protocols.

Monitoring activities fall into 3 major categories, each described in more detail in this section.

1. Information collected alongside care delivery activities
2. Actively contacting the patient
3. Patients contacting the Extensivist clinic

4.4.4.1 Information collected alongside care delivery activities

- Patients will be interacting with a number of care providers
- Personnel interacting with the patient will be asked to collect key information for the Extensivist clinic, the Well Being Support Worker will coordinate this activity
- Telemonitoring can be used as a source of passive information collection from the patient

4.4.4.2 Actively contacting and coaching the patient

- The objective of this activity is to supplement the above as necessary to ensure the Extensivist team remains up-to-date with the patient's wellbeing
- The Care Plan will specify the amount of contact needed to stay up-to-date
- The Well Being Support Worker will lead on this as main point of contact and may use telephone as well as in-person contact

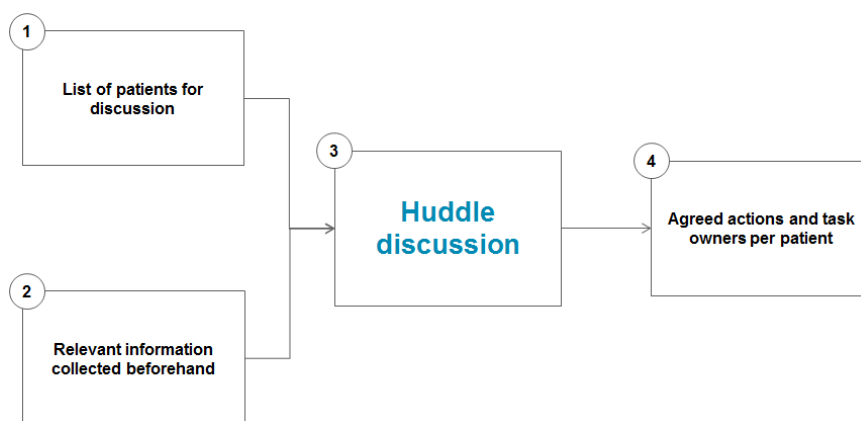
4.4.4.3 Patients contacting the Extensivist clinic

- It is important patients can contact the clinic easily whenever they have concerns
- The first point of contact will be the patient's Well Being Support Worker
- Telemonitoring can send alerts to the Extensivist team without patient input e.g. if they have not gone to bed yet, if their blood pressure is too high/ too low etc.

4.4.5 Huddle

Two types of 'Huddles' will exist within the Extensivist service:

- Daily 'Huddle' is a meeting of the core Extensivist team held every day in the Extensivist clinic. The purpose of the Huddle is to discuss previous day and same day priorities with the Extensivist with emerging issues actioned in a timely fashion enabling the team to intervene effectively. It is important to note that, in urgent situations, patients may be discussed outside the Huddle to avoid any delays – the Huddle is intended as an enabler of rapid action and must not be a barrier to this.
- Weekly MDT Huddles are larger meetings which will discuss ongoing patient related priorities, new patients requiring care plans to be finalised and patients suitable for 'step down' from the service. The patient's whole core team will meet with any specialists (likely by videoconference) to discuss complex cases and agree courses of action in an integrated fashion.



4.4.5.1. List of patients for discussion

Patients are selected for discussion by members of the core team based upon monitoring activities (usually the Well Being Support Worker). If a trigger is detected or attention is required for an alternative issue the patient can be added to the Huddle agenda for the next morning.

4.4.5.2. Relevant information collected beforehand

The Well Being Support Worker for each patient to be discussed will collect the information required for the Huddle, this will include:

1. The Patient's current care plan
2. Details of the issue or trigger
3. Other new information (e.g. specialist input)
4. Recommended actions (developed in collaboration with the Care Coordinator or others)

This information is collected in a timely fashion so that it can be shared live during the meeting.

4.4.5.3. Huddle discussion

The meeting will need to be highly action orientated and efficient. A chair-person will be nominated for each Huddle and will be charged with ensuring the meeting runs efficiently and to time.

The Huddle will be conducted in a meeting room with audio-visual and conferencing equipment enabling personnel to view information in-person, or remotely if necessary. The IT system must also support efficient real-time note taking and virtual attendance. The attendees at the Huddle will be:

- Extensivist
- Advanced Practitioners
- Care Coordinators (for relevant patients)
- Well Being Support Workers (for relevant patients) updates record/ records actions

The team will work through each patient on the agenda assessing the information, agreeing the actions and assigning ownership. It is expected that most patient discussions will take 1-2 minutes, with more complex cases taking 3+ minutes.

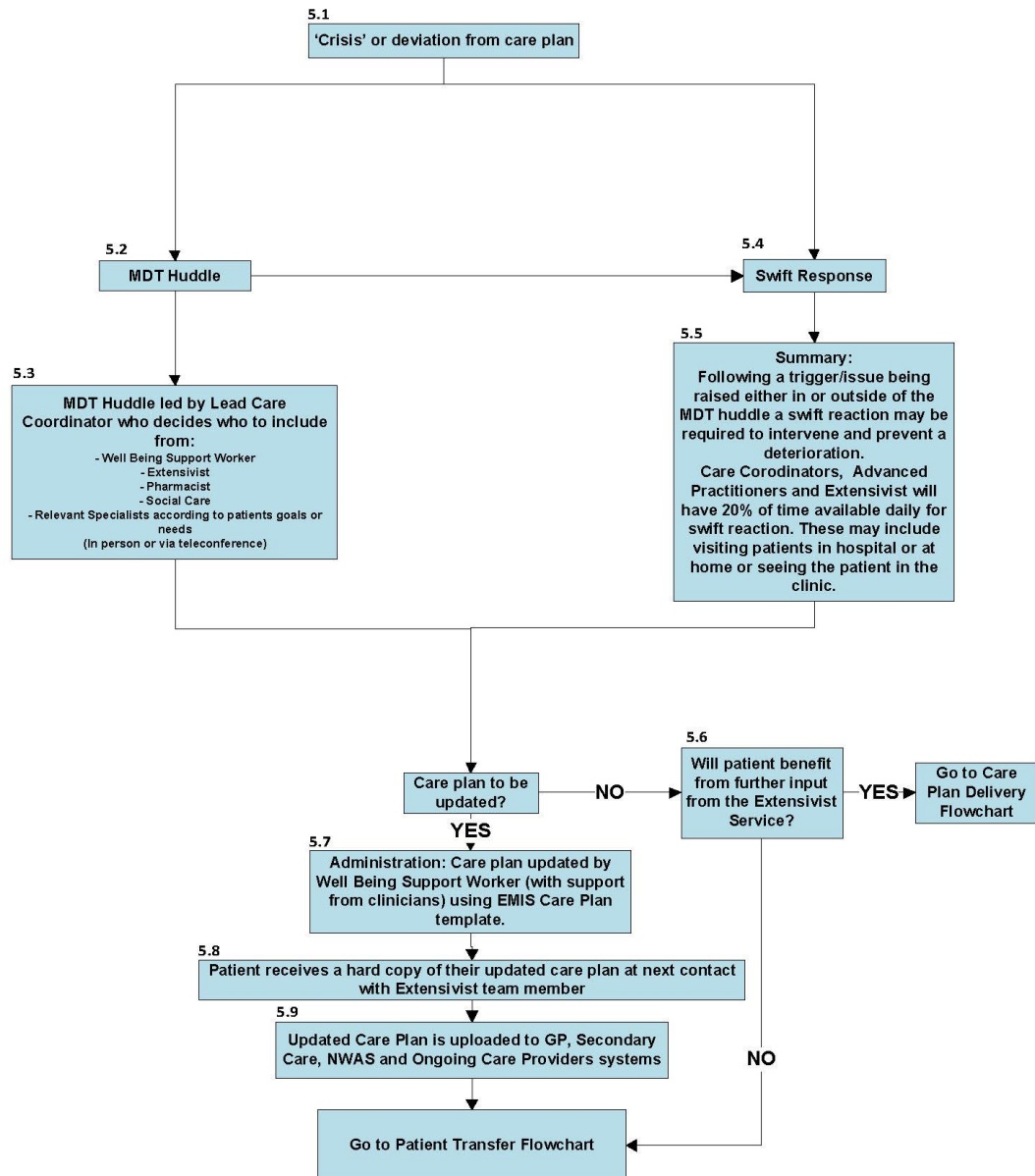
4.4.5.4. Agreed actions and task owners per patient

Clear responsibilities for actions will be defined during the Huddle. Following the meeting, the patient's Well Being Support Worker will ensure all actions are carried out as agreed.

Actions may include rapid intervention, making use of core Extensivist personnel's dedicated "Swift reaction" time (see the Swift reaction section). Additionally, as a less immediate action, the patient's care plan may need adjustment. In this case, the patient is passed on for multi-disciplinary discussion and care plan adjustment (see the Care plan adjustment section)

4.5 Patient in Crisis

5. Patient in Crisis Flowchart for Extensivist Service (High Level Process Map)



Agreed 3rd November 2014 (v1.8)

Figure 5: Patient in Crisis Flowchart for Extensivist Service

Following a trigger / issue being identified or a Huddle (Note: a Huddle is not required to launch a swift reaction), a swift reaction may be required to intervene and prevent further patient deterioration or an unplanned event. To ensure the Extensivist team can respond quickly in these situations, the Care Coordinators, Advanced Practitioners and Extensivist will have time allocated every day for 'Swift reaction'.

Initially it is estimated that 20% of personnel time will be allocated to 'Swift reaction', this will be adjusted in response to learnings from the proof of concept. This time will be kept available until the beginning of each day and will be scheduled with interventions which arise during the morning Huddle and throughout the rest of the day. These may include (not exhaustive):

- Visiting Extensivist patients in hospital to be involved in treatment decisions and discharge planning
- Visiting Extensivist patients at home to deliver urgent care

Following a Swift reaction intervention, the patient either:

- Returns to the 'on care plan' status
- Requires further action, approved by an appropriate member of the Extensivist team
- Is put on the huddle list for the next morning to define next steps
- Requires a care plan adjustment- likely in most cases

Note: In the case where patients have had an unplanned hospital admission staff will in-reach and rapidly deliver changes to the care plan to allow the patient to come home more quickly, while ensuring that their care is appropriate for any change in their situation

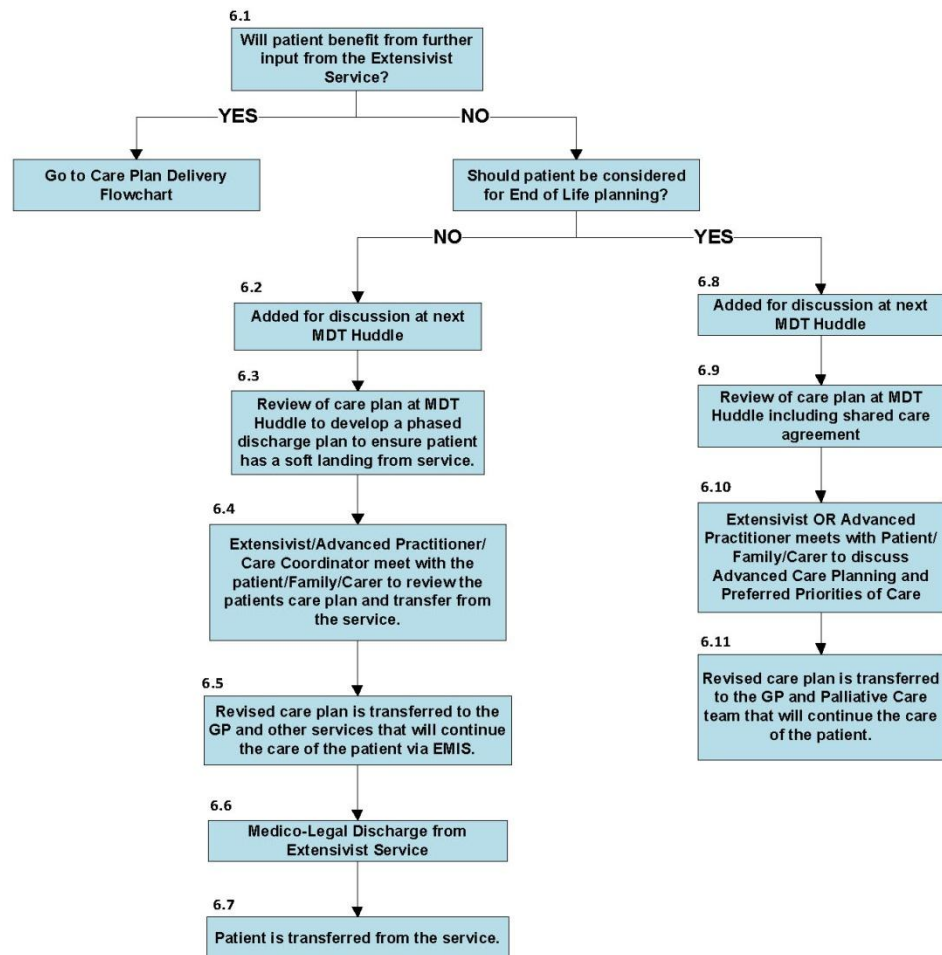
4.5.1 Care plan review and adjustment

Following a Huddle or other event a patient may be referred for Care plan review and adjustment. In this situation a process similar to the original care plan development process is conducted. The Well Being Support Worker collects the updated information; a multi-disciplinary team is then convened and develops an updated care plan which is then discussed and agreed with the patient.

A patient's care plan may also require changes when a goal or objective needs adjustment. In this case a more simple process led by the Well Being Support Worker is completed in collaboration with the patient and any other relevant personnel.

4.6 Patient Transfer

6. Patient Transfer Flowchart for Extensivist Service (High Level Process Map)



Agreed 3rd November 2014 (v1.8)

Figure 6: Patient Transfer Flowchart for Extensivist Service

The aim of the Extensivist team is to help each patient reach a point where they no longer need the intensive support provided by the Extensivist service. As a patient's health stabilises and improves, their Well Being Support Worker, Care Coordinator and Extensivist will monitor the patient and determine whether they still require the Extensivist Service. This is not as simple as when the patient has achieved all their objectives as the patient may still benefit ongoing higher level care. If it is decided the patient can be transferred out, the extensivist will meet to develop a phased transfer plan. The aim of this process is to ensure the patient has a 'Soft landing' when they leave the service. The development process will include detailed discussions with the patient (and carer if appropriate) and their GP to ensure their care plan is transitioned smoothly. The GP will be consulted on the discharge plan, probably by a phone call, and when the plan is agreed the GP will be notified when the patient has been transferred out of the Extensivist Service and returned to their care.

Patients entering End of life care will have a different transition. Please see the End-of-life care programme section for details (section 5.7)

4.6.1 Agreed Exit Criteria

The Clinical Redesign Team is keen to ensure that the extensivist service has well-defined exit criteria in order to ensure that the service is providing appropriate levels of support to those patients who can benefit from being enrolled with the service, and in order to maintain a manageable number of patients at any given time.

Having considered the success criteria of the extensivist service, the Clinical Redesign Team agreed the following exit criteria:

1	End of Life Care	
a	End of Life Care	The anticipatory care plan is at EoLC stage and all tasks can be effectively completed within primary care. It is anticipated that this will be c.25% attrition rate in a 12-month period.
2	Patients who are making successful progress within the extensivist service	
a	Goal achievement	The patient is demonstrating consistent achievement (across a 3-month period) of the goals identified in their care plan.
b	Risk of admission	The patient's risk of admission within the next 12-months falls below that defined in the referral criteria. Given that the patient's age will increase, and their LTC will not be removed, the driving factors in reducing the risk score will be: <ul style="list-style-type: none"> - A reduction in 999 calls - A reduction in A&E attendances - A reduction in NEL admissions - A reduction in OPD activity - A reduction in EL activity <div style="display: flex; justify-content: flex-end;"> <div style="margin-right: 20px;">Likely to be influenced</div> <div style="margin-right: 20px;">Likely to be influenced</div> <div style="margin-right: 20px;">Likely to be influenced</div> <div style="margin-right: 20px;">May be influenced</div> <div>Unlikely to be influenced</div> </div>
c	Required level of input	The patient can be effectively supported by one or more services outside the extensivist service.
3	Patients who are NOT making successful progress within the extensivist service	

a	Goal achievement	The patient is NOT demonstrating consistent achievement (across a 3-month period) of the goals identified in their care plan.
4	Relocation of patients	
a	GP practice register	The patient leaves the practice register of GP practices assigned to the extensivist service.
5	Patient / carer choice	
a	Patient / carer choice	The patient and/or their carer selects to opt out of the service.

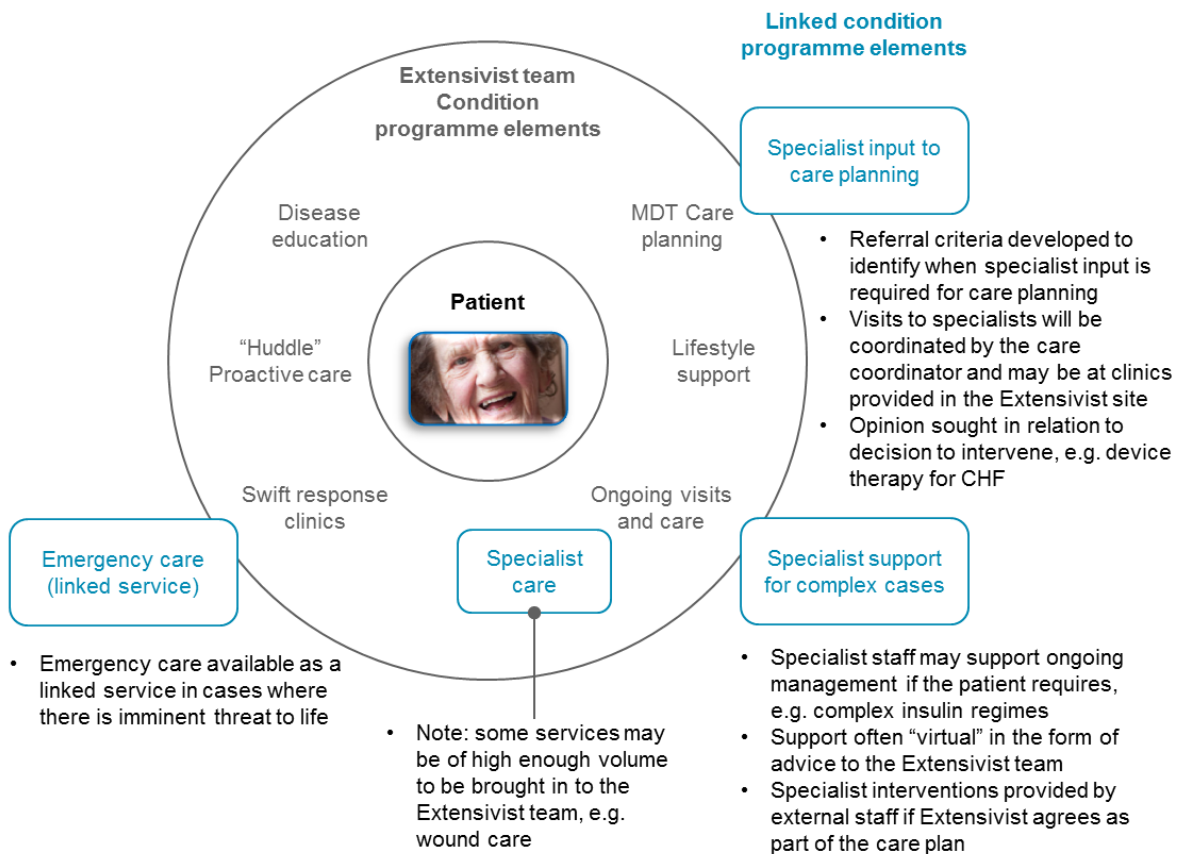
5. Care programmes (6 common LTCs, Dementia and End of Life Care)

5.1 Care programmes – common elements and overview

The purpose of the Extensivist service is to deliver and coordinate individualised holistic care for complex patients. In order to achieve this and deliver the best care for each specific LTC the patient lives with, the Extensivist service will develop individualised care plans for patients that draw on a number of core programmes for the most common co-conditions. These programmes will differ from single condition programmes provided in EPC models because they will be specifically designed for the individual mix of co-morbidities and wider needs of each patient.

The core principles upon which the care programmes are all built:

- Care will be wrapped around the patient at all times – driven by the Extensivist team as the core coordinating service providing this holistic whole person care service
- The Extensivist team will provide the ongoing care through a core general skillset within the team (provided by the clinical care coordinators, advanced practitioner and Extensivist) – this will prevent patients being “referred out” to specialist services and reduce the risk of their care being fragmented again
- Specialist input will be essential in managing the most complex patients, and in identifying the most appropriate therapies and treatment ceilings in these cases. The relationship between the Extensivist specialists will be as “teammates” in delivering the best possible care plan for patients, overall decision making will sit with the Extensivist team but they may invite the specialist to care planning “MDTs” to deliver the best plan. Part of this relationship will involve training and development for the Extensivist team staff – so that they develop their understanding of what is possible for each condition and increase the range of skills in their “core” skillset allowing specialists more time to manage higher acuity/less stable patients
- Certain conditions will require interventions and management that need specific skillsets (e.g. vascular intervention for foot problems) that can only be provided by specialist staff. A key role of the Extensivist and Advanced Practitioner is in identifying the point to refer for specialist input – to ensure that patients receive the best possible treatment available for their conditions. These referrals will be managed as per the core elective intervention process [see section 6.1].
- A final central offering to patients is lifestyle support and management – this will be essential for all condition programmes and the offering will be consistent for all programmes. Disease education will also be offered alongside this and this will be specific to each condition



This section could be read as a series of "single disease" models of care, but it is not intended to be that way. The core principles are built to achieve a model that provides "whole person" care while delivering the specific needs of individual conditions. In this sense the condition programmes could be thought of as a set of protocols for the most common conditions managed by the Extensivist team.

Programme element	Diabetes	Cardiac Conditions (CHF, CAD, AF)	Chronic Kidney Disease (CKD) and ESRD	COPD	Dementia	End of life
Enrolment	Pre-existing diagnosis automatically enrolled – all patients have severity and stability defined on entry to service					Through core Extensivist process – ongoing visits to monitor and identify point at which to discuss
	Glucose testing for all patients on first enrolment to Extensivist service then annually	CHF - All patients screened for relevant symptoms/signs and if heart indicated offered blood test for measurement of BNP.	Pre-existing diagnosis as CKD stage 3 or higher, and renal function test on enrolment	TBD	Initial screening to be completed in the Extensivist clinic	
Care planning	Extensivist to drive care planning through standard processes and only request specialist input if criteria are met All care plans have the aim of achieving or maintaining stability of the given condition Referral criteria: TBD, but will take account of NICE guidance etc.					Care planning, advanced care planning and ceilings of treatment – core process
Lifestyle management	Provision of programmes for smoking cessation, diet and exercise Patients to participate actively in these programmes					Information and education, discussion of priorities
Ongoing monitoring	Core patient monitoring for all conditions: BP, Renal Function, Respiratory, mood, mobility plus: TBD Less frequent care: vaccinations, medications review					<ul style="list-style-type: none"> Review of symptoms Medication optimisation Additional support (voluntary sector) Psychological support Spiritual support
	<ul style="list-style-type: none"> Glucose, HbA1c Insulin management Foot checks Eye checks Liver function Specialist input to complex insulin regimes 	CHF - Three core elements: <ul style="list-style-type: none"> Weight monitoring Blood pressure monitoring specific symptom monitoring 	<ul style="list-style-type: none"> Blood pressure Urinalysis and MSU Serum creatinine and eGFR FBD and electrolytes and lipids and glucose Cognitive impairment-monitored	Regular checks and tests: <ul style="list-style-type: none"> Peak Flows BP ABGs TBC 	<ul style="list-style-type: none"> Guidance and assistance from appropriately trained individual on a regular basis Personnel trained in behaviour management 	
Timely escalation	Ability to access emergency care, out of hours care as per linked services processes					

	<ul style="list-style-type: none"> • Insulin initiation and dose changes • Medication • Foot problem resolution and intervention • Wound care • Escalation to vascular and eyes specialists (referral criteria TBD) 	<p>CHF - As condition changes in level of severity consideration of adjustments in:</p> <ul style="list-style-type: none"> • Monitoring strategies • Medical therapy • Consideration of surgical interventions 	<ul style="list-style-type: none"> • Fluid overload, metabolic bone disease and acidosis • Anaemia • Depression • Falls and fractures • Cognitive impairment <p>Escalation to specialist: criteria TBD</p>	<p>For unstable patients or patients with recognised disease progression additional care will need to be provided:</p> <ul style="list-style-type: none"> • NMPs • Uptitration • Sx control • Consideration for intervention 	<p>Escalation to specialist clinician for individuals with highly complex needs</p>	<ul style="list-style-type: none"> • Preferred priorities of care discussed • End of life care at home (through DNs) • Referral to specialist/ hospice: criteria TBD
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5.2 Care programme: Diabetes

5.2.1 Agreed Local Pathway for Extensivist Service (based on National Map of Medicine Pathway)

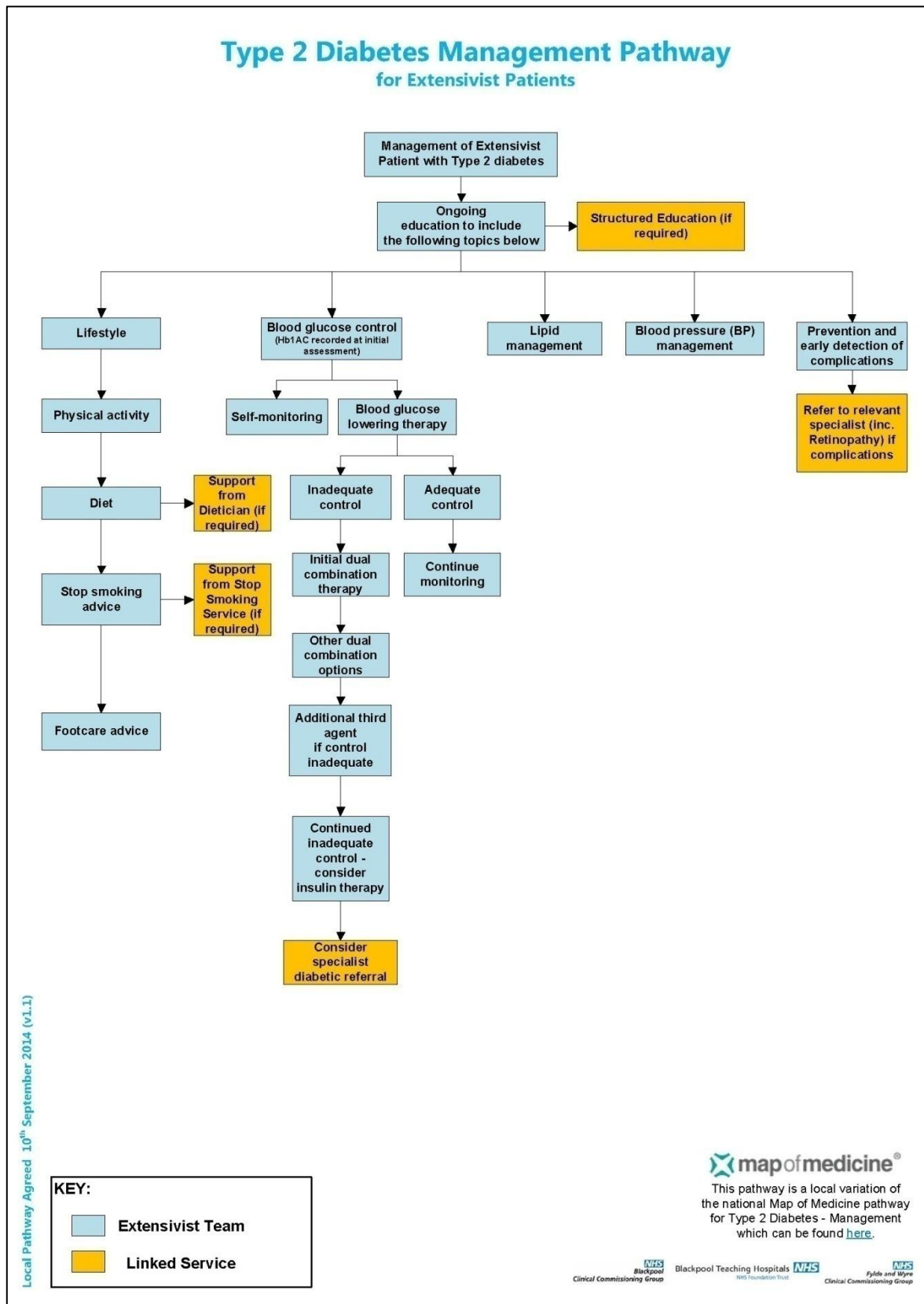


Figure 7: Local Diabetes Pathway for Extensivist Service

5.2.2 Specific care programme components

The specific components of the diabetes condition programme are set out in the table below. The core principles and approach to managing the condition with the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Enrolment		<ul style="list-style-type: none"> • Pre-existing diagnosis • Fasting glucose, and glucose tolerance test on enrolment to Extensivist then every 12 months 	
Care planning	<ul style="list-style-type: none"> • Partner in developing care plan 	<ul style="list-style-type: none"> • Led by Extensivist through MDT 	<ul style="list-style-type: none"> • Referral criteria for specialist opinion: TBC
Lifestyle management	<ul style="list-style-type: none"> • Participate in lifestyle management, including smoking cessation, diet and exercise 	<ul style="list-style-type: none"> • Provision of programmes for smoking cessation, diet and exercise 	<ul style="list-style-type: none"> •
Ongoing monitoring and checks	<ul style="list-style-type: none"> • Disease education programme • Blood sugar testing • Blood pressure testing • Feet sensation monitoring 	Regular checks and tests: <ul style="list-style-type: none"> • HBA1c • Foot care/ foot assessment • FBC • Fasting lipids • Fasting sugar Insulin maintenance • Renal function • Liver function tests • Urinary dip Annual/less frequent: <ul style="list-style-type: none"> • Medication review • Vaccinations (including flu jab) 	<ul style="list-style-type: none"> • Support with complex insulin regimes as defined in care plan
Timely escalation and intervention		<ul style="list-style-type: none"> • Insulin initiation and dose changes • Medication • Foot problem resolution and intervention • Wound care e.g. leg ulcers 	<ul style="list-style-type: none"> • Referral criteria for specialist input at this stage: TBC Note: referrals to cover both • Vascular • Eyes

5.3 Care Programme: Cardiac Conditions (CHF, CAD, AF)

5.3.1 Agreed Local Pathway for Cardiac Conditions (CHF, CAD, AF) for Extensivist Service (based on National Map of Medicine Pathway)

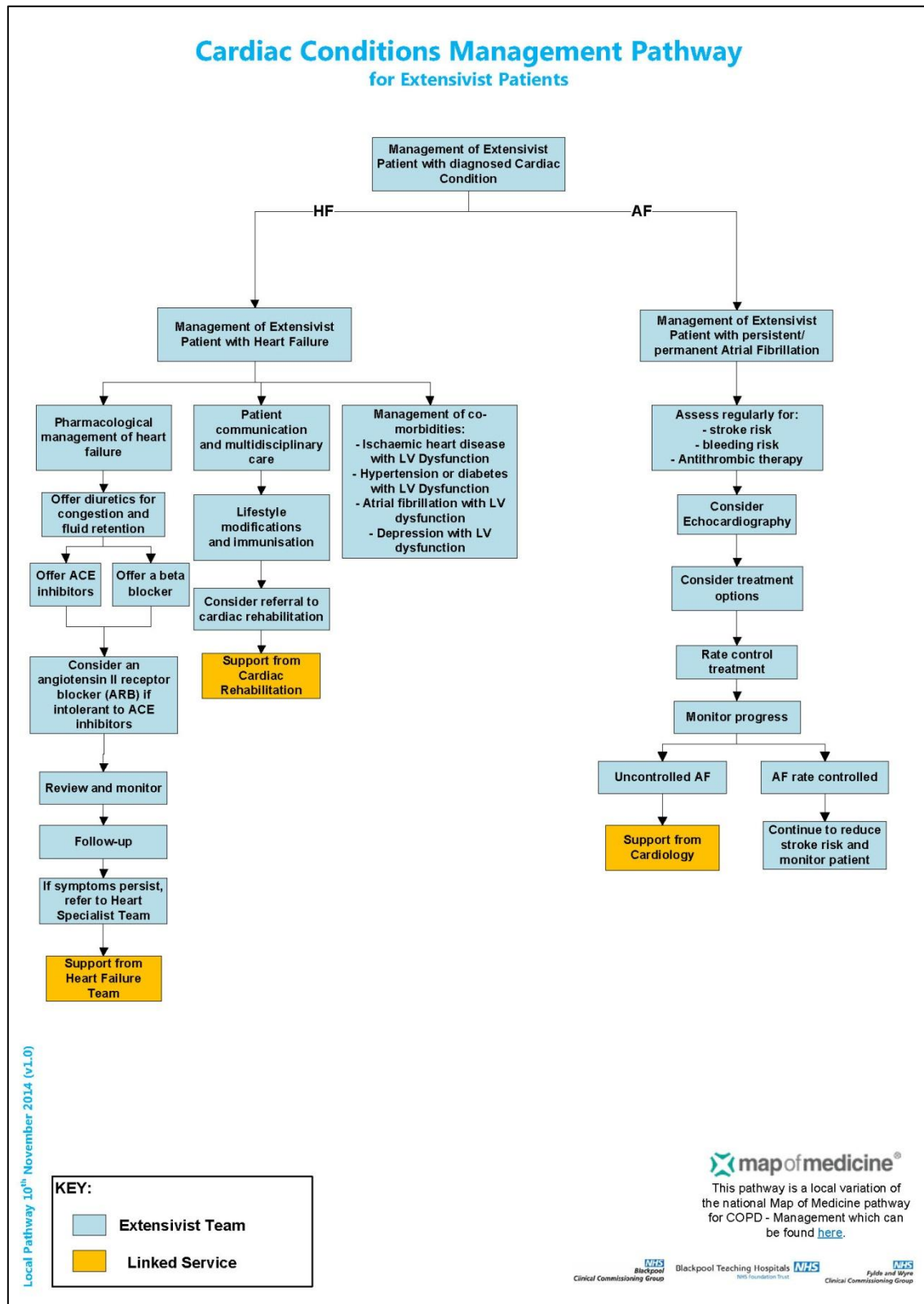


Figure 8: Local Cardiac Conditions (CHF, CAD, HF) Pathway for Extensivist Service

5.3.4 Specific care programme components

The specific components of the CHF condition programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Extensivist patients with CHF will benefit from

- 1) Early, accurate diagnosis, with detailed condition specific care plan
- 2) Condition specific education and surveillance strategies, delivered by the Extensivist team
Well Being coach in line with the care plan, supporting improved patient engagement, stability and early recognition of change in condition.
- 3) Immediate access to specialist CHF teams in response to triggers identified in care plan or unexpected events requiring specialist assessment.

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Enrolment		<ul style="list-style-type: none"> Pre-existing diagnosis Upon enrolment all patients will be screened for relevant symptoms/signs and if heart indicated offered blood test for measurement of BNP. The result will trigger referral to rapid access heart failure diagnostic clinic (HFDC) according to the NICE 2010 guideline 	
Care planning	<ul style="list-style-type: none"> Partner in developing care plan 	<ul style="list-style-type: none"> Led by Extensivist through an ongoing 'care planning escalation process' 	<ul style="list-style-type: none"> Referral criteria for specialist opinion: TBC
Lifestyle management	<ul style="list-style-type: none"> Participate in lifestyle management, including smoking cessation, diet and exercise 	<ul style="list-style-type: none"> Provision of training programme for management of CHF Provision of programmes for smoking cessation, diet and exercise 	
Ongoing monitoring and checks	<ul style="list-style-type: none"> Weight gain BP Ability to lie flat overnight Simple list of other symptoms to prompt reporting 	<p>Three core elements:</p> <ol style="list-style-type: none"> 1) Weight monitoring 2) Blood pressure monitoring 3) specific symptom monitoring <p>Regular check-ups at Clinic:</p> <ul style="list-style-type: none"> patient condition review (to include pulse check +/- ECG, renal function, medication monitoring and review, and confirmation of progress against the care plan) The frequency of each check will be set through protocols developed by the CHF team 	<ul style="list-style-type: none"> Support with complex care regimes as defined in care plan In certain cases specialist interventions will be required. These will be agreed by the Extensivist with specialist input and then scheduled as an elective procedure and carried out in line with the "specialist intervention" wider services protocols found in section 5.8

	and implemented through the care plan	
Timely escalation and intervention	<p>As condition changes in level of severity consideration of adjustments in:</p> <ul style="list-style-type: none"> • Monitoring strategies • Medical therapy • Consideration of surgical interventions • The clinical care coordinators carrying out reviews will be skilled in the management of multiple conditions and able to understand the interactions between CHF and other common comorbidities, particularly COPD. 	<ul style="list-style-type: none"> • Referral criteria for specialist input at this stage: TBC • CHF specialist nurses will provide input and support in these cases, including reviewing complex patients

5.4 Care Programme: Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD)

5.4.1 Agreed Local Pathway for Chronic Kidney Disease (CKD) for Extensivist Service (based on National Map of Medicine Pathway)

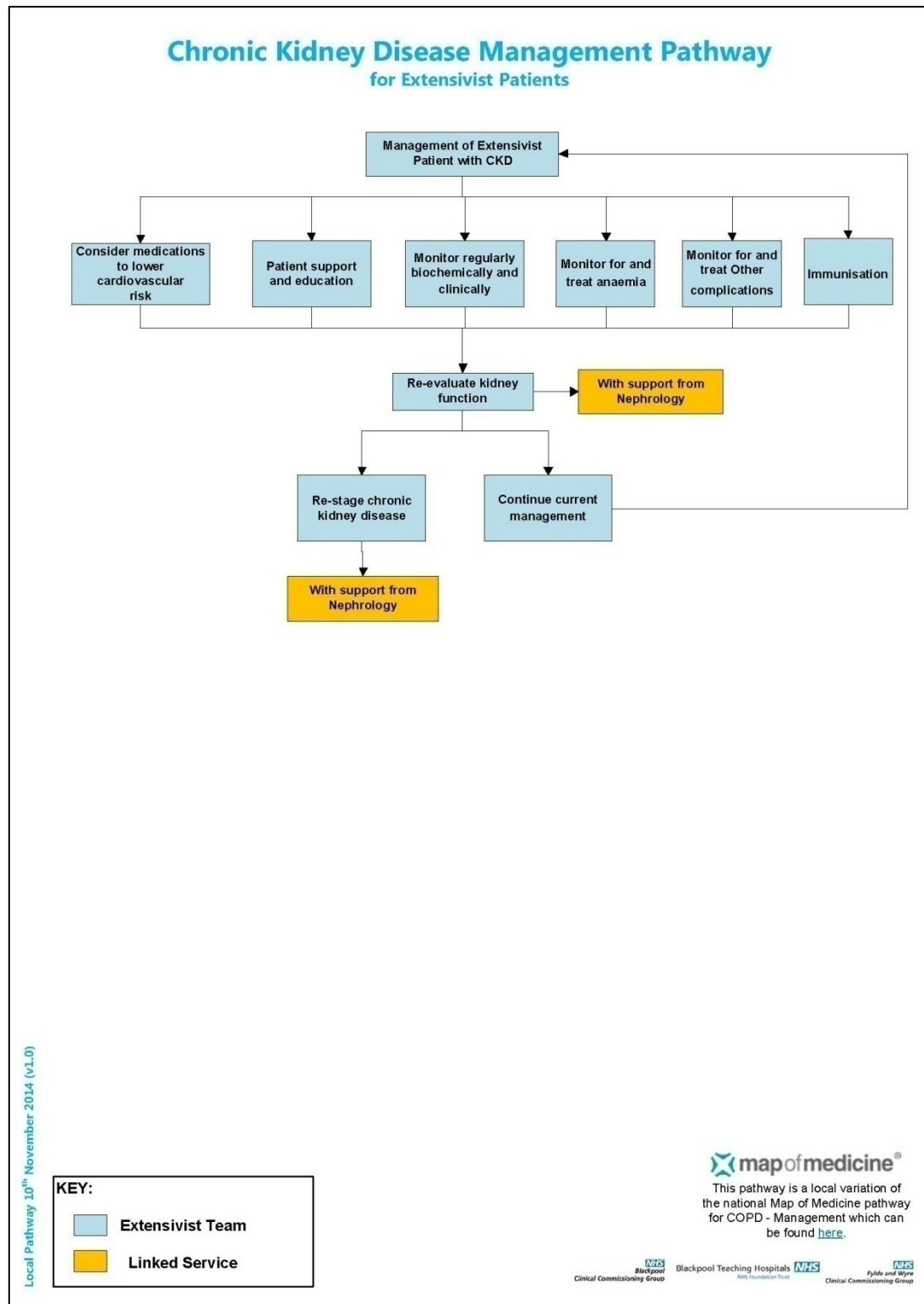


Figure 9: Local CKD Pathway for Extensivist Service

5.4.2 Specific Care Programme Components

The specific components of the CKD programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Enrolment		<ul style="list-style-type: none"> • Pre-existing diagnosis of CKD Stage 3 or higher • Renal function testing on enrolment (serum creatinine, eGFR and proteinuria) 	
Care planning	<ul style="list-style-type: none"> • Partner in developing care plan 	<ul style="list-style-type: none"> • Led by Extensivist either as part of enrolment or through an ongoing care planning escalation process (when patient reaches CKD stage 4 or 5) • Will need to include consideration of common complexities in management of CKD patients 	<ul style="list-style-type: none"> • Referral criteria for specialist opinion: CKD Stage 4 or 5: criteria TBD
Lifestyle management	<ul style="list-style-type: none"> • Participate in lifestyle management, including attending group classes on: Management of co-morbidities, diet and exercise programmes 	<ul style="list-style-type: none"> • Provision of programmes for managing co-morbidities, diet and exercise 	
Ongoing monitoring and checks	Monitoring of the following with support from Well Being coach <ul style="list-style-type: none"> • Mobility • Cognitive impairment- monitored by family/ carers • Mood 	Regular checks and tests: <ul style="list-style-type: none"> • Blood pressure • Urinalysis and MSU • Serum creatinine and eGFR • FBD and electrolytes and lipids and glucose • Frequency of checks depends on patient situation and presence of risk factors e.g. diabetes Annual/ less frequent: <ul style="list-style-type: none"> • Renal function testing in annual check up 	<ul style="list-style-type: none"> • Referral criteria for care planning input and support with decision to initiate dialysis: TBD • Referral criteria for Support with complex medications TBD • Provision of dialysis
Timely escalation and intervention		<ul style="list-style-type: none"> • Fluid overload, metabolic bone disease and acidosis • Anaemia • Depression • Falls and fractures • Cognitive impairment- can be wrongly attributed to ageing instead of CKD 	<ul style="list-style-type: none"> • Referral criteria for specialist input is subject to disease progression and when increased stages of CKD are entered into, criteria: TBD

5.5. Care Programme: Chronic Obstructive Pulmonary Disease (COPD)

5.5.1 Agreed Local Pathway for Chronic Obstructive Pulmonary Disease (COPD) for Extensivist Service (based on National Map of Medicine Pathway)

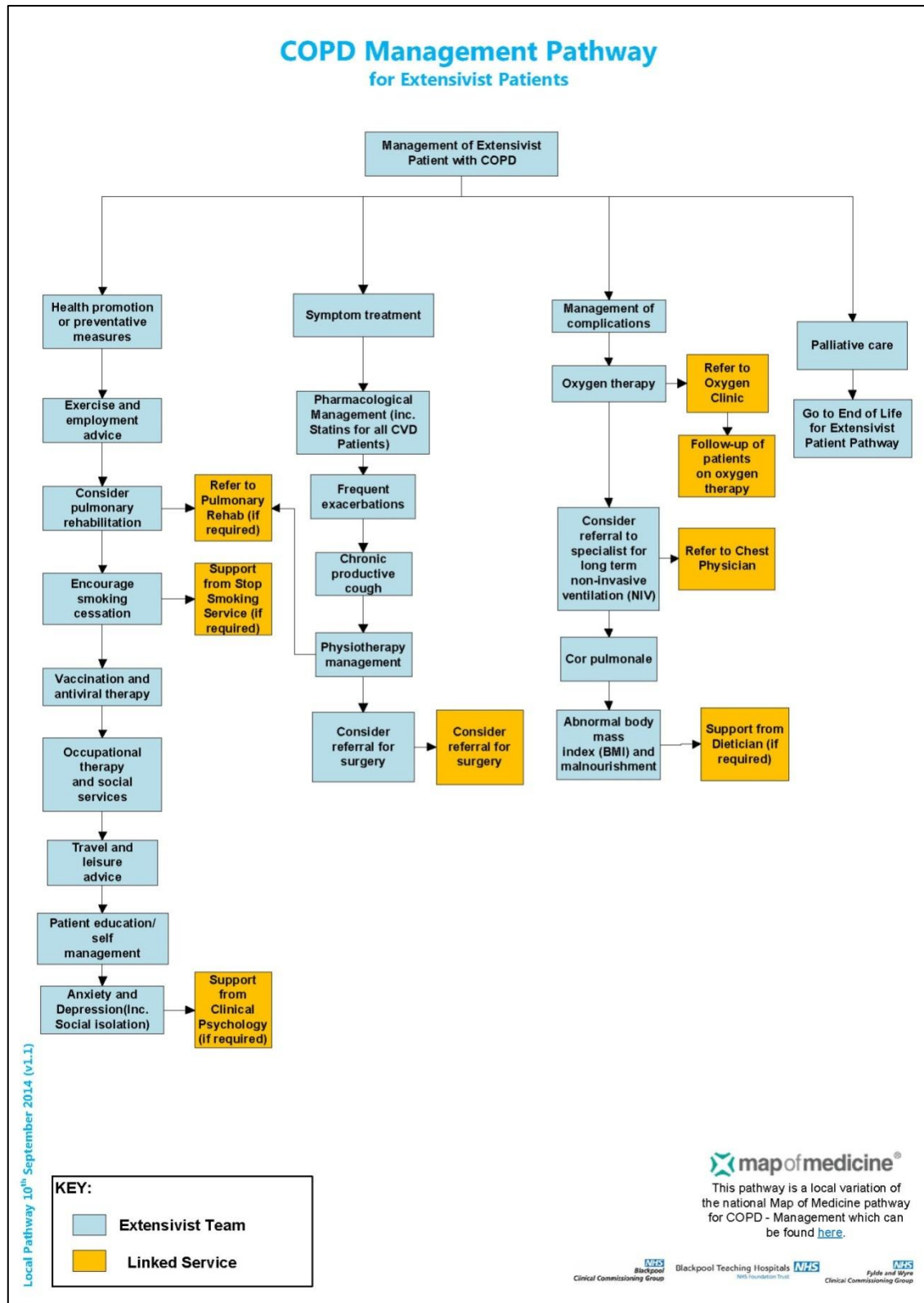


Figure 10: Local COPD Pathway for Extensivist Service

5.5.2 Specific Care Programme components

The specific components of the COPD programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Enrolment		<ul style="list-style-type: none"> • ??? 	
Disease education	<ul style="list-style-type: none"> • Patients as advocates/mentors 	<ul style="list-style-type: none"> • Well being Support Worker 	<ul style="list-style-type: none"> • Community/third sector resources
Lifestyle management	<ul style="list-style-type: none"> • Participate in lifestyle management, including attending group classes on: Management of co-morbidities, diet and exercise programmes 	<ul style="list-style-type: none"> • Provision of programmes for managing co-morbidities, diet and exercise 	
Regular ongoing self-monitoring of disease control	<ul style="list-style-type: none"> • Patients provided with equipment/ technology to self-monitor and report readings to the clinic – peak flow meters 	<p>Regular checks and tests:</p> <ul style="list-style-type: none"> • Peak Flows • BP • ABGs TBC <p>Annual/ less frequent:</p> <ul style="list-style-type: none"> • ??? <p>For patients where telemonitoring is not a suitable / preferred approach regular monitoring will be carried out by the care team (Nurse with specialist skills)</p>	
Regular check-ups		<ul style="list-style-type: none"> • Nurses with specialist skills • Check progress against care plan • Identify any need for change in plan, e.g. deterioration requiring titration of inhalers, steroids and prescription of antibiotics • Confirm patient understanding of self-monitoring 	<ul style="list-style-type: none"> • Referral criteria for specialist input is subject to disease progression and when exacerbations of COPD
Well-being, lifestyle and behaviour change support	<ul style="list-style-type: none"> • Patients provided with equipment/ technology to support behaviour change 	<ul style="list-style-type: none"> • Assessment and advice for well-being, lifestyle and behaviour, incl: <ul style="list-style-type: none"> • Diet • Exercise • Smoking • Depression • Medication effectiveness monitoring 	

Timely escalation and intervention	<ul style="list-style-type: none"> • Advanced Practitioner • Extensivist • Triggered by changes in patient state and/or increased care utilisation e.g. A&E visits, non-elective admissions • For unstable patients or patients with recognised disease progression additional care will need to be provided: <ul style="list-style-type: none"> • NMPs • Uptitration • Sx control • Consideration for intervention 	<ul style="list-style-type: none"> • Referral to specialists i.e. Respiratory Physician or COPD Nurses if req.
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5.6 Care programme: Dementia

5.6.1 Agreed Local Pathway for Dementia for Extensivist Service

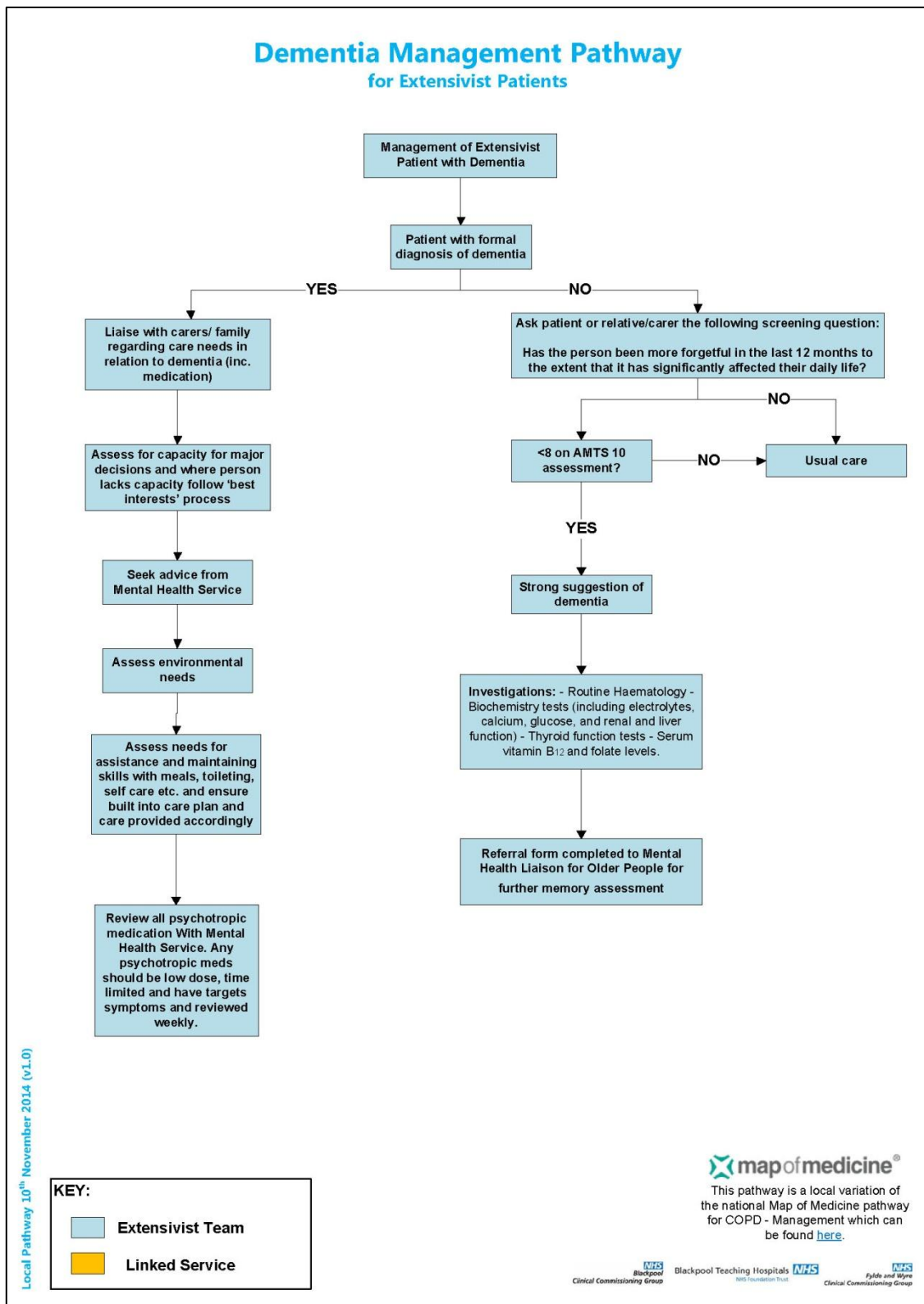


Figure 11: Local Dementia Pathway for Extensivist Service

5.6.2 Specific care programme components

The specific components of the Dementia programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Diagnosis		<ul style="list-style-type: none"> Initial screening to be completed in the Extensivist clinic Extensivist team to refer for diagnosis Care coordinator to track referral to ensure action is completed Care coordinator to complete feedback loop 	<ul style="list-style-type: none"> Formal diagnosis to be complete within Memory Assessment Service CT scans likely to be completed elsewhere
Enrolment		<ul style="list-style-type: none"> ??? 	
Support for ongoing management	<ul style="list-style-type: none"> Partner in developing care plan 	<ul style="list-style-type: none"> Provided by Extensivist core team members through ongoing interactions Guidance and assistance from appropriately trained individual on a regular basis Personnel trained in behaviour management 	<ul style="list-style-type: none"> Community/third sector resources
Care planning input	<ul style="list-style-type: none"> Partner in developing care plan 	<ul style="list-style-type: none"> Specialist input into care planning discussions (without other service delivery) Extensivist team seeks input in particular cases In the Extensivist clinic at scheduled planning discussions & huddles or via video-conference or Skype Care Coordinator schedules specialist attendance at meetings 	<ul style="list-style-type: none"> Specialist expertise in dementia care planning
Managing Medication	<ul style="list-style-type: none"> Partner in developing care plan 	<ul style="list-style-type: none"> Extensivist team to refer for review 	<ul style="list-style-type: none"> Expertise in dementia medication review Review of medication Recommendation on alterations
Timely escalation and intervention		<ul style="list-style-type: none"> Extensivist team refers to specialist Care Coordinator ensures interactions are incorporated into the patient's care plan 	<ul style="list-style-type: none"> Escalation to specialist clinician for individuals with highly complex needs Specialist service delivery skills e.g. complex behaviour management

5.7 Care Programme: End of Life Care

5.7.1 Agreed Local Pathway for End of Life Care for Extensivist Service

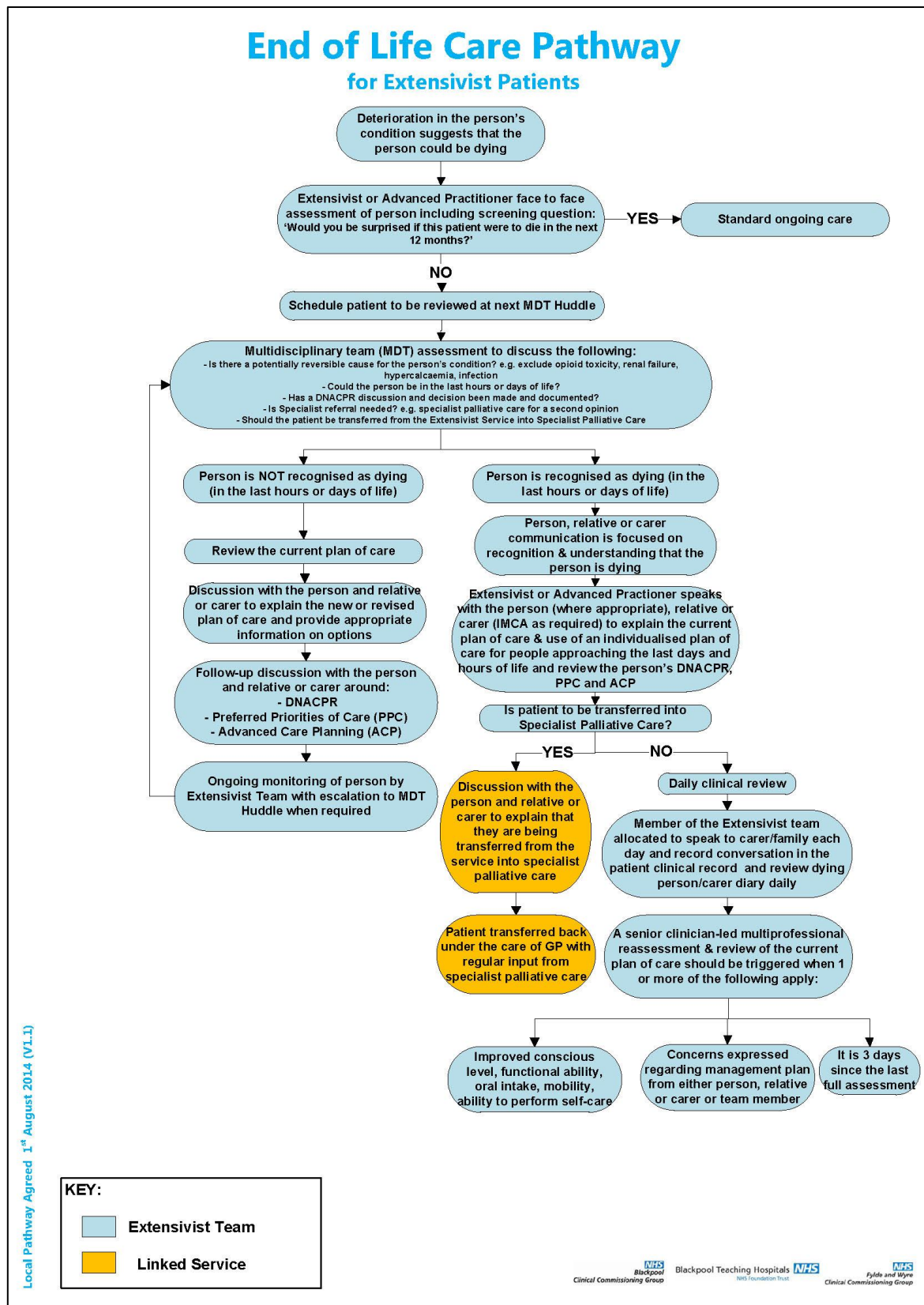


Figure 12: Local End of Life Pathway for Extensivist Service

5.7.2 Specific Care Programme Components

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Enrolment	<ul style="list-style-type: none"> Partner in developing care plan 	<ul style="list-style-type: none"> Screening during on-going visits – with escalation to MDT discussion for change in care plan (including discussion with patient and carers) 	
Care planning	<ul style="list-style-type: none"> Partner in developing care plan Provide priorities of care 	<ul style="list-style-type: none"> Led by Extensivist through MDT process Must be driven in partnership with patients and carers Agree ceilings of treatment (inc DNACPR) 	
Information and support	<ul style="list-style-type: none"> Patients are signposted to further information regarding all aspects of EoL care 	<ul style="list-style-type: none"> Appropriately trained individuals to signpost patients, carers and families to appropriate information 	
Ongoing support and checks		<ul style="list-style-type: none"> Review of symptoms and pain management Medication optimisation 	<ul style="list-style-type: none"> Additional support (voluntary sector) Psychological support Spiritual support
Timely escalation and intervention		<ul style="list-style-type: none"> Provision of securely stored “just in case” drugs in line with care plan and protocols (TBD) 	<ul style="list-style-type: none"> End of life care at home (through DNs) Out of hours non-clinical support (Night service) Referral criteria for care planning input, specialist palliative care support, and hospice: criteria TBD

6. Linked and wider services

The Extensivist Clinic will operate collaboratively with multiple linked and wider services as part of their care of their patient cohort. These services can be grouped into three areas:

6.1 In hospital

6.1.1 Emergency care

This specification has been written in the context of a core Extensivist service that is functioning properly, delivering pro-active care through regular contacts with patients significantly reducing the need for urgent attends and admissions at hospital.

Extensivist patients will nevertheless require input from acute trust, ambulance and out of hours based urgent and emergency services on an unplanned basis at any point during their care with the Extensivist service. It is essential that patients have access to urgent and emergency services when they need them, and that these are strongly linked with the Extensivist service.

The key components of the urgent and emergency care services are access to senior clinicians, at point of urgent need, who can assess patients and decide upon and instigate therapy to make them stable and safe, and access to highly specialised clinicians and equipment for specific urgent needs including stroke, MI, trauma and emergency surgery.

These services will be provided by ambulance, acute and out of hours services, in each case seeking an opportunity for discussion with Extensivist staff if the need would more appropriately be met by the Extensivist team in an urgent appointment on the same day or next morning.

Communication between the Extensivist service and urgent and emergency services will be achieved through use of existing IT systems (EMIS and ERIS) that provide the opportunity for any clinician to see and understand key elements of the Extensivist programme and a clear programme for escalation to the Extensivist service.

Where patients have been admitted to hospital there will be an immediate flag on the ES IT system to allow for swift commencement of the core care plan adjustment process at the next huddle to speed discharge and ensure patients are brought home as quickly as is appropriate.

6.1.1.1 Patient or carer perceives the patient to be in a life threatening situation and calls 999

The patients care plan will specify likely scenarios when phoning 999 is the correct course of action. In these situations, or any other situation, where the patient or carer feels that a life threatening emergency exists then phoning 999 is the correct course of action.

A flag on the NWS data base (ERIS) would alert the ambulance service that a care plan exists. The function of the care plan in these situations is purely to give information about the patients relevant medical history, current medication, adverse drug reactions and anticipatory care arrangements. This information would be of value to the paramedic on site at the patients home and would also be available within the Emergency Department.

6.1.1.2 A clinician has decided that an acute hospital admission is required but the patient does not have immediate life threatening symptoms or signs.

In this situation there is time for the admitting clinician in the community or in A&E to contact the most senior clinician on duty within the Extensivist Team and discuss the most appropriate course of action. This could include admission to an acute hospital bed or a community based in-patient bed.

The patient could then be admitted directly to the most appropriate hospital ward if no acute management of diagnostics are required, or be seen within a Clinical Decisions Unit (or Frail Elderly Unit) if a further work up prior to admission to the ward is required.

Upon admission to the ward the Extensivist Team would be contacted in order to facilitate the commencement of an “in-reach” service.

6.1.1.3 Patients being discharged from A&E

The Extensivist Team should also be alerted if patients were being discharged from A&E so that the patient could be discussed at the following days huddle.

An IT solution needs to be developed so that the Team are aware of such a situation and also to facilitate the sharing of information.

6.1.2 Outpatient Specialist Consultations

The Extensivist service will have patients within it who by the complex nature of their needs will be attending specialist outpatient clinics. These patients and others may at some point require input from an outpatient specialist consultation or a review of their ongoing requirement to attend outpatient services.

Some of the ongoing support for patients requiring outpatient specialist consultation will be provided by appropriately trained members of the Extensivist clinic team (the Extensivist, Care Coordinator or other clinical team members).

Where necessary the Extensivist or appropriate team member will make a referral to a specialist for review and advice, e.g. diagnosis, management opinion, specific intervention request. Specialist outpatient consultations will in the majority take place in a secondary care setting.

The consultation should be performed by the specialist with the most appropriate level of expertise (for example orthopaedic consultation request to senior orthopaedic clinician not via normal musculoskeletal pathway).

Whenever referrals to other personnel are made the Care Coordinator will monitor to ensure the any actions generated are carried out and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

6.1.3 Diagnostic Services: Radiology and Pathology

Extensivist patients will require a range of investigations to support their management.

Requesting: Whilst many of these will originate from medical staff, requesting rights for some investigations will be available to senior clinical non-medical staff (e.g. advanced practitioners) by prior arrangement with the provider and following agreed protocols.

Access: the majority of pathology and radiology will be provided by or through Blackpool Teaching Hospitals NHS FT. On site plain radiology and ultrasound is available at some of the primary care centres being used by the Extensivist Service, although access times are variable. Near patient blood testing is also available at primary care centres and local testing will be used where appropriate.

However, the turn around time needed for each investigation will have to be decided on a case by case basis. It is expected that the majority of testing will be done by BTH at the Victoria Hospital site, although blood and most microbiology specimens will be taken in extensivist premises or at the patient's residence. Most will use current access arrangements for primary care investigations.

Investigations needing a quicker than routine turnaround time will be arranged individually (e.g. radiology reporting).

6.1.4 Elective Admissions

The Extensivist service will have patients within it who by the complex nature of their needs will be admitted electively for example for procedures or investigations.

The Extensivist team will need to be aware of any planned admissions for any reason into any clinical setting. The team will need information regarding the reason for admission and the outcome of such admissions (including any complications or reasons to prolong the admission if for example due to an acute deterioration).

It may be appropriate in certain circumstances to review the necessity of the planned admission with the patient and the clinical team overseeing the admission.

Dependent upon the nature of the elective admission the Extensivist team may be required to provide additional care for the patient. For example, if a patient is planned for a procedure a period of optimisation of health may be required prior to admission. Additionally if a patient is undergoing pre-operative assessment the Extensivist team will require details of the outcome of that assessment. If the assessment leads to a postponement of an intervention then the Extensivist team will require details of what criteria is required for the patient to be eligible to receive the intervention.

When a patient is electively admitted the Care Coordinator will monitor the progress of the patient and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

Ultimately the Extensivist team with the patient should make the final decision on the appropriateness of the need for elective admission and fitness for an intervention.

6.1.5 Rehabilitation/Continuing Care

During their care term in the Extensivist Service, some patients will be admitted to acute care wards in hospitals. These patients will need overnight and care provisions during the transition between hospital and their return to home life with their normal level of Extensivist care. These transition services will take one of two forms depending on the situation of the patient:

- 1) Patients who need rehabilitation after an acute care stay e.g. stroke, will have beds and specialist nursing provided in a community location, as well as access to medical opinion on a planned basis
- 2) Patients who are awaiting placement in residential care will be provided a nursing home bed equivalent with general nursing care in a community location

A third potential type of continuing care is for patients with special clinical needs who may require 1-2 days in an environment with higher provisions of care than could be achieved within their homes. The Extensivist Service does not intend on admitting any patients without a clinical need. The emphasis will instead be on care provided in the patient's home. However it is realised that this level of service at home may not be viable, especially during the start-up months of the service, and therefore this third type of community admission remains a possibility.

6.1.6 Hospital Discharge Team

There will be two cohorts of patients that the hospital discharge team will interact with:

1. Existing Extensivist patients with an active care plan – where the Extensivist team will provide the hospital discharge function, but may need specific input in relation to continuing health care assessment or equipment provision
2. Patients identified as requiring referral to the Extensivist service in secondary care – these will be discharged to a referral to the Extensivist service in line with the secondary care referral process set out in section 3.1.1

For both types of patients the major drivers of need for the target cohort are:

- Continuing health care assessment:
- Equipment Provision:
- Safe transfer of care:
- Transport – linked to discharge

6.1.6.1 For existing Extensivist patients

Extensivist team patients will require effective discharge planning should the patients' health needs result in admission to hospital. The majority of care co-ordination and agreement of an expected

date of discharge (EDD) to support effective discharge and safe transfer of care to home or another setting will continue to be provided by the hospital discharge team but with support from appropriately trained members of the extensivist team, either by in-reach into the ward area, attendance at board or ward rounds and attendance at MDT meetings. This can be effectively facilitated by Skype or tele-conference or face to face communication. The extensivist team will be responsible for continuing to have on-going dialogue with the patient's relatives/carers whilst the patient is in hospital.

They may be called upon to support the clinical care coordinator by providing continuing healthcare assessments or equipment provision, working in partnership with the Extensivist team.

6.1.6.2 For patients requiring referral

The hospital discharge team will lead on their normal functions in supporting discharge as set out above, with a referral to the Extensivist team carried out in line with the process set out in section 3.

Please note: This will not feature in the proof of concept phase of the programme.

6.2 Out of hospital

6.2.1 Primary Care

Extensivist patients will require input from Primary Care upon enrolment to the Extensivist service, through input to initial care plans (sometimes provided virtually via provision of notes and care plans, other times in person) as well as remaining the patients registered practice for when they are discharged back to primary care and enhanced primary care models. These key interfaces are described through the enrolment and discharge processes within the core Extensivist service, see sections 3.1 and 3.3 of this document.

A proportion of Extensivist patients will stabilise and see sufficient improvement in their health to be discharged from the service. In this case they will be discharged back to an Enhanced Primary Care model as they will still have ongoing needs in management of their Long Term Conditions. Patients will access this service through the core Extensivist discharge process.

6.2.2 Specialist Therapies

The term Specialist Therapy Services includes MSK Physiotherapy, Podiatry, Speech and Language Therapy, Nutrition and Dietetics and the Podiatric Foot and Ankle Surgery Team.

Whilst all clients under the Extensivist Team will not require access to all the Specialist Therapy Services as part of their care plan it is acknowledged that the Extensivist cohort of patients are likely to need episodic intervention from these services to effectively manage their physical, social and psychological wellbeing.

Patients who are being cared for by the Extensivist Team may also require input from the Specialist Therapy Services to manage effectively specific problems and so improve their health and reduce the necessity for hospital admission. Once a patient is referred into any of these services a 'shared care' arrangement would effectively be in place whereby the referring clinician from the Extensivist Team would monitor patient progress against defined goals which have been agreed between patient and Specialist Therapy Service Clinician. It is unlikely that the specialist nature of this care will be provided by the Extensivist Team yet as this team develops this may become a possibility with appropriate training and supervision from specific Specialist Therapy Services.

In order for this shared care to work effectively, it is essential that communication links between the Extensivist Team and the Specialist Therapy Service are effective and that a shared patient record and comprehensive care plan is in place. The Care Coordinator from the Extensivist Team will monitor any shared care arrangements, as described above, with any changes in the patient's condition being fed back to the Extensivist team and reflected in the care plan where necessary. Any significant changes may be reviewed at the Extensivist team huddle to determine if a review of the care plan is required, with Specialist Therapy Service clinicians being invited to care planning meetings as required.

6.2.3 Mental Health – Community Based

Extensivist patients may require a range of specialist mental health services to effectively manage their mental health needs. The majority of ongoing support for patients with low level needs will be provided by appropriately trained members of the Extensivist clinic team (the Extensivist, Care Coordinator, Other clinical team members or Well Being Support Worker), either in the clinic or at the patient's home (or via video link or Telephone). To ensure Extensivist team interactions continue to support patients in managing their mental health, team members will receive training in behavioural interventions and support for Dementia, Depression and Anxiety.

Where necessary the Extensivist or Care Coordinator will make a referral to other personnel for specialist input, e.g. for diagnosis of dementia, or for consultation around treatment planning for patients with more complex needs (for example where Community Mental Health Team service is required). Wherever possible these specialists will visit the Extensivist clinic (potentially via a regular scheduled in-clinic session) or the patient's home. If this is not possible patients will visit other facilities. Whenever referrals to other personnel are made the Care Coordinator will monitor to ensure the action is carried out and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

There may be patients for whom it is appropriate to access longer term support from Specialist Mental Health services e.g. depression in parallel to the Extensivist intervention. In these situations the Extensivist team will ensure that the care plan reflects both elements of intervention and that there is excellent liaison and communication between services.

There may be patients for whom an acute MH admission might be required. In these situations the Extensivist team will ensure that they in-reach to the acute setting (as they would for any acute medical admission). The Care Coordinator will provide input into care and discharge planning and participate in any multi-disciplinary meetings as appropriate.

6.2.4 Social Care

The Extensivist team will be integrated with social care providers supporting the social care needs of the identified cohort of people with multiple and/or complex health conditions. The social care aspect of the core team will support them across traditional boundaries such as primary and acute health care, community and residential care, and chargeable social services. The service will be responsible identifying patients that require social care input during the initial assessment stage and as part of their ongoing care. The Extensivist service will need both social and health models of intervention and processes to ensure that people receive the right support at the right time.

6.2.5 Community Nursing

The Community Nursing Service includes District Nursing and Community Matrons. There are both generalist and specialist Community Matrons in various parts of the Fylde Coast.

Patients who are being cared for by the Extensivist Team may require input from the wider community nursing services to effectively manage their general nursing requirements. Many of these patients will already be known to the Community Nursing Service. It is envisaged that ongoing general nursing support for these patients will be provided by appropriately trained members of the Extensivist Team either in the Extensivist clinic or at the patient's home. However, there may be circumstances when a 'shared care' arrangement would be more appropriate – for instance, where the patient requires daily injections or regular dressings. In such cases, the District Nurse would visit the patient at home on a regular basis unless the patient was having contact with the Extensivist Team on that day, in which case a member of the team would carry out the required intervention.

In order for shared care to work effectively, it is essential that communication links between the Extensivist Team and the District Nursing Team are effective and that a shared patient record and comprehensive care plan is in place. The Care Coordinator from the Extensivist Team will monitor any shared care arrangements to ensure the required interventions are carried out and any changes in the patient's condition are fed back to the Extensivist team and reflected in the care plan where necessary. Any significant changes may be reviewed at the Extensivist team huddle to determine if a review of the care plan is required, with Community Nursing being invited to care planning meetings as required.

The role of the Community Matron is more aligned to the enhanced primary care model and it is unlikely that patients under the care of the Extensivist Team will also receive care from the Community Matron Service. A patient may transfer from a Community Matron's caseload into the care of the Extensivist Team for a period of time and later move back to the care of the Community Matron once the critical episode is over. In other cases, patients may be referred to the Community Matron Service by the Extensivist Team once they have been stabilised as part of the enhanced primary care model. In any case, the Community Matron should be involved in the care planning and effective links between the Community Matron and the Care Co-ordinator are essential to ensure a smooth handover either into or out of the Extensivist service.

The Community IV Therapy Team will provide IV therapy treatment to patients who are under the care of the Extensivist Team providing they meet the access criteria for the service. This treatment may be carried out either in the IV Therapy suite at South Shore Primary Care Centre or in the patient's home. Where a patient requires more than two infusions per day, a shared care model may be put in place. The Care Co-ordinator will be responsible for liaising with the IV Therapy Team and feeding progress back to the Extensivist Team. The IV Therapy Team will be involved in multi-disciplinary discussions concerning the patient if required.

It is very important that all aspects of the patient's care are captured clearly in the care plan and that the care plan is shared with all services providing care to the patient. The Care Co-ordinator will play a pivotal role in ensuring that the care plan is clear, comprehensive and shared appropriately and that communication between the Extensivist team and the wider linked Community Nursing Service is timely and effective.

6.3 Specialist

6.3.1 Mental Health – Specialty

Extensivist patients may require a range of specialist mental health services to effectively manage their mental health needs. The majority of ongoing support for patients with low level needs will be provided by appropriately trained members of the Extensivist clinic team (the Extensivist, Care Coordinator, Other clinical team members or Well Being Support Worker), either in the clinic or at the patient's home (or via video link or Telephone). To ensure Extensivist team interactions continue to support patients in managing their mental health, team members will receive training in behavioural interventions and support for Dementia, Depression and Anxiety.

Where necessary the Extensivist or Care Coordinator will make a referral to other personnel for specialist input, e.g. for diagnosis of dementia, or for consultation around treatment planning for patients with more complex needs (for example where Community Mental Health Team service is required). Wherever possible these specialists will visit the Extensivist clinic (potentially via a regular scheduled in-clinic session) or the patient's home. If this is not possible patients will visit other facilities. Whenever referrals to other personnel are made the Care Coordinator will monitor to ensure the action is carried out and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

There may be patients for whom it is appropriate to access longer term support from Specialist Mental Health services e.g. depression in parallel to the Extensivist intervention. In these situations the Extensivist team will ensure that the care plan reflects both elements of intervention and that there is excellent liaison and communication between services.

There may be patients for whom an acute MH admission might be required. In these situations the Extensivist team will ensure that they in-reach to the acute setting (as they would for any acute medical admission). The Care Coordinator will provide input into care and discharge planning and participate in any multi-disciplinary meetings as appropriate.

6.3.2 End of Life

This summarises the Extensivist programme's linked end of life services not provided by the core Extensivist team through the End of Life Care programme (See Section 5.7). The patient will be referred out to the End of Life Care service when the patient is deemed to be in the red care bundle. End of life care is support for people who are approaching death. It helps them to live as well as possible until they die, and to die with dignity. It also includes support for their family or carers.

End of life care includes palliative care. If the patient has an incurable illness, palliative care will help to make them as comfortable as possible by relieving pain and other distressing symptoms, while providing psychological, social and spiritual support for them and their family or carers.

This section focusses on the specific elements not provided by the Extensivist team:

- Specialist palliative care input to care planning
- Hospices
- Specialist palliative care provided at home
- Additional support, psychological support, spiritual support for patients and carers

A patient has the right to choose where they want to receive care and where they want to die. The palliative care team provide end of life care to patients and their families in hospitals, care homes, hospices and at home.

The identification, discussion and signposting for patients at end of life will be delivered by the Extensivist care programme team. Once identified, appropriately trained members of the extensivist team will follow the North West End of Life Care Model which includes having the conversation with patients and carers/families and discuss and amend their care plan accordingly. These discussions will include deciding preferred priorities of care and advanced care planning. The Extensivist or Advanced Practitioner will also review symptom management, optimise medications and agree ceilings of treatment (inc. DNACPR). The extensivist team will also signpost patients to palliative care services (inc. hospice care) for complex patients, social care support, psychological support and spiritual support.