HEALTH AND SOCIAL CARE SCOTLAND

Embedded and emerging good practice in health and social care

Aligned to the *Framework for Community Health and Social Care Integrated Services*

Health and Social Care Partnership: North Lanarkshire				
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Name of good practice: Primary Care Frailty MDTs: Collaboration with Equals Advocacy in facilitating a person centered anticipatory care approach				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people		Older adults	√
	Younger adults			
SETTING	City		Remote & rural (incl islands)	
	Corporate		Urban	√
SERVICE AREA	Addictions		Management team	
	Admission avoidance		Mental health	√
	Community care services incl care at home/care homes	√	Physical disabilities	√
	Day services		Physical health	√
	Housing incl Homelessness		Primary care	√
	Intermediate Care incl Hospital at Home		Rehabilitation	
	Justice services		Social care services	√
	Learning disabilities		Supported discharge	
	Other – please specify	Voluntary sector		
ELEMENTS of FRAMEWORK	Anticipatory care planning	√	Live independently at home or in a homely setting	√
	Assets based approach	√	Manage own care	
	Connect with communities	√	Reablement	
	First point of contact		Seamless working with acute	√
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	
	Fully integrated community teams	√	Teams aligned with general practice	√
	Other – please specify			
ENABLERS	Agile working		Information sharing	√
	Aligned plans	√	Infrastructure	
	Clarity of vision	√	Management information	
	Clinical and care governance		Shared accountability	
	Collaborative leadership	√	Strong team ethos	√
	Culture and values		Technology	√
	Fit for purpose premises		Well-developed lead professional roles	
	Improvement capacity	√	Well-developed relationships	√
	Other – please specify			

HSCP

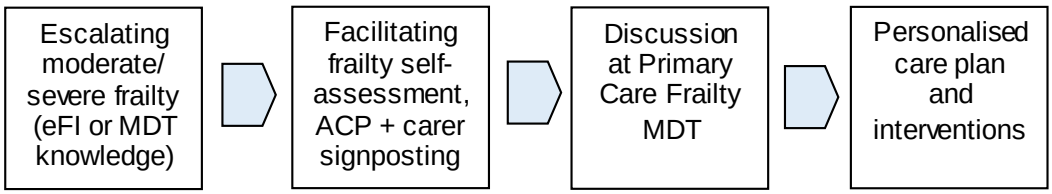
Developing a Primary Care Frailty MDT in conjunction with Advocacy Services

SITUATION

"Frailty is our global warming – services will be unable to meet growing demand and could 'fall over' in the medium to long term if we as a health and social care system do not change." (Midlothian General Practitioner)

North Lanarkshire HSCP primary care services have the second lowest rate of GPs per head of population in Scotland yet high levels of urban deprivation and associated demand. To address this challenge, we developed an innovative collaboration between the health/social care locality team, primary/secondary care professionals and a voluntary sector partner to provide person-centred, anticipatory care in a realistic medicine approach for community-dwelling older adults at high risk of deterioration.

The following 4-step model was developed:



Initially, the frailty self-assessment was completed by health visitor (band 5) staff. Wider changes in staffing since Covid-19 pandemic prompted an innovative partnership with Equals Advocacy (EA) who were already contracted by North Lanarkshire HSCP to provide advocacy support to those over 65 years old. EA had a track record in facilitating anticipatory care planning (ACP) and with initial support were able to undertake home frailty self-assessments during the pandemic.

ACTIONS TAKEN

- Worked collaboratively and creatively to use the expertise of all partners including the voluntary sector.
- Used quality improvement methodology to underpin tests of change and apply learning for service development – started with one older person at one MDT in one practice and incrementally spread over 2 years to four practices in two localities with up to five service users at each MDT.
- Developed 6 standard anticipatory care interventions for all and additional tailored interventions depending on need. We aim to be holistic addressing social, psychological, physical including housing needs. The advocacy worker ensures we remain focussed on 'What Matters to Me'.
- Moved to a virtual MDT format using Microsoft Teams, saving time and travel. Attendees include Advocacy Worker, Primary Care Senior Decision maker, Older People's Community Mental Health Team, Care at Home Manager, Advanced Clinical Services Pharmacist, Frailty Specialist, Community Nursing and Community Rehabilitation Team Lead.
- Developed the role of the Advanced Clinical Services Pharmacist within the MDT resulting in improved pharmaceutical outcomes and reduced inappropriate polypharmacy.
- Collaborated with NHS Lanarkshire Information Technology Team to develop an information technology system in conjunction with VISION.
- Collaborated with local Public Health Scotland LIST analysts for information to support the frailty MDT.
- Collaborated with academic partners on a formative evaluation.

OUTCOME / IMPACT	More older people with escalating levels of frailty are receiving person centred anticipatory care with a preventative and early intervention approach to improve their health, wellbeing and functional ability, support their unpaid carers and enable them to remain at home for longer. Professionals from primary care, secondary care, social care and voluntary sector are working together as an integrated multidisciplinary team that has built strong relationships and trust, and a good understanding of respective roles and expertise. The team share information about older people at risk of deterioration and offer a comprehensive assessment and tailored anticipatory care interventions. 143 people have been offered this support within 43 MDT meetings since starting in late 2019. Median age 80 with 59% female. The majority (64%) were identified by the electronic frailty index with a smaller number from the team's knowledge of service users.
MEASURES/ INDICATORS OF SUCCESS	• ACP rates in people with severe frailty increased to 25% in one practice. • North Lanarkshire HSCP eKIS rates were 2nd lowest in Scotland; rates in participating localities are now above the Scottish average. • Reduction in annual prescribing costs by £117 per individual. • Positive feedback from patients, carers and professionals: • *"It's so positive… this new way of working – how everybody is coming together… and I think it's the best thing"* (Carer). • Formal evaluation is underway.

Even better if …
(enablers to further the principles of integration and result in even better outcomes if …)

Sustainable funding for continuity of support from the voluntary sector partner

Staff had capacity to meet more frequently to develop individualised action plans. Ideally frailty MDTs with key stakeholders would take place weekly in every locality.

All staff involved in the MDTs had the capability to recognise and treat the common clinical manifestations of frailty.

Enhanced community capacity enabled all individuals with mild frailty to be able to access preventative interventions.

Interoperable information technology systems that allowed older people and their carers to be at the centre of our information sharing.

Anticipatory care service was complemented by an integrated locality response to subacute deterioration in those living with frailty.

NATIONAL HEALTH AND WELLBEING OUTCOMES

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	√
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	√
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	√
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	√
5. Health and social care services contribute to reducing health inequalities.	√

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	√
7. People who use health and social care services are safe from harm.	√
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	√
9. Resources are used effectively and efficiently in the provision of health and social care services.	√
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	√
2. Building stronger community care systems and primary care services	√
3. Establishing a new focus on mental health	√
4. Securing a sustainable acute hospital service and specialist care service	√
5. Strengthening future partnerships to ensure a modern sustainable workforce	√

Links to any published reviews/evaluations	Vimeo link: Changing the way we work: A proactive approach to frailty

Before submitting this example of good practice please ensure approval and sign-off by your head of service / chief officer.

Approved for online publication *(signature and position)*	Ross McGuffie, Chief Officer North Lanarkshire HSCP
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