PACESETTER SCHEME 2020-2022 APPLICATION FORM	
Health Board	Powys Teaching Health Board
Pacesetter Scheme Title	Extended anticipatory care planning for remote rural areas
What is the problem the scheme will try to address?	This pacesetter proposals focusses on new learning around extending the fundamentals of virtual ward care in place across Powys to deliver an enhanced level of care to elderly patients living in extremely remote rural areas by proactively assessing and managing their heath needs; therefore reducing the reliance on remote general practice as an acute urgent care service provider and reducing emergency admissions to hospital. Evidence now suggests that frailty and age is not the primary factor influencing admissions, and a major factor is now co-morbidities. The scheme will support people to take greater responsibility and ownership of their own health and for that of their family and community in remote rural areas and aligns with the work of the Older People's Commissioner for Wales Rural areas are known to have a different age distribution of patients compared to urban areas with high numbers of over 70s. The elderly population is growing rapidly and the projected figures are alarming. Today, elderly patients are living with a much higher burden of disease and multiple comorbidities than in the past. In the past only relatively, healthy people lived to old age- with advances in medical treatments this is no longer the case. Patients are likely to be living with combinations of cancer, neurodegenerative disease, diabetes and cardiovascular disease, as well as the natural aging effect on balance and muscle strength. These multiple comorbidities go hand in hand with multiple medications. Evidence confirms that medication errors, for example, missing tablets, taking too many tablets, drug interactions are implicated in a high proportion of admissions. There is a clear recognition of the need to proactively support this population to improve quality of life as well as avoid unnecessary admissions which often lead to a deterioration in health. With a reduction in Geriatricians this care has been devolved to general practice. General Practice have unique access to a patient's history, living conditions and an ability to link with multiple clinicians involved in these patients. Rural general practice has been the most vulnerable to recruitment difficulties at all levels from GPs to all allied clinicians. However, the implementation of the Primary Care Model for Wales is supporting demand and capacity management, however has the opportunity to be fully utilised to support rural practice in the management of the elderly.

	As the elderly become more frail it becomes more difficult and burdensome to access GP practices for a holistic review. This is particularly evident in rural areas where poor transport, no local family support who work at a distance to the home, and a lack of carers compounds this issue. As the patient becomes more frail, the need for conversations regarding advance wishes and planning ahead with realistic conversations about likely outcomes becomes very important. This accompanies a change in focus on the need for medication and the risk/benefit balance of medication and medical interventions shifts. These processes take time and are undertaken often best over a period of time. Multi-disciplinary interventions from physiotherapy, occupational therapy, carer support, addressing loneliness, and social worker support, falls assessments and dietician input are all important to improve quality of life and avoid unnecessary admissions during this time. Prognosis is particularly challenging as unlike palliative cancer care, frail patients tend to have a much more variable pathway. To some extent primary care is still learning what this pathway looks like due to its variables and the sheer number of complex elderly patients requiring effective management to stay in their own home. This complex pathway is even more challenged in a rural setting and Llanfyllin is Powys' most remote and rural practice as well as being most rural in Wales, whilst serving a large population. Powys was one of the first health boards to introduce the virtual ward (VW) concept which is now a model well implemented across Wales. Lessons learned from the VW and the care Homes DES provide evidence to further inform the problem this scheme will try to resolve, as follows: • From reviewing admissions from virtual ward and an audit on deaths in hospital there is a suggestion that the reactive model of the virtual ward is when the patient often first comes to the attention of a practices clinical virtual ward team, i.e. when their health has deteriorated from an acute episode. • The Care Homes DES, introduced in April 2017 has enabled general practice to undertake regular structured assessment reviewing physical health, mental health, medication and frailty progression, incorporating advance care planning for patients in both nursing and residential homes. Lessons learned from the Care Homes DES in relation to advance care planning has included benefits realisation to the patients its serves and the wider healthcare economy, for example discussions with the patient and their families enabling open and honest discussions about what the future may hold, what choices the patient may wish to consider for their future care and the efficacy of their medication.

	• In extreme areas or rurality, patients experience challenges accessing other health care providers, other than their GP. This is due to travel distances and service provision, for example delays in ambulance service provision for urgent responses result in patients who are acutely unwell attending or contacting their GP practice for care. The average emergency response time from WAST is between 1.5 - 5hrs in parts of rural Powys. • Rural practice with a high proportion of elderly patients often have many patients living at home, some will not be actively in contact with their GP practice, and therefore will have no support packages. However, some will have a variety of support mechanisms but neither are equal to or meet the level of health care assessment received in a care home setting, or following placement on the virtual ward. Therefore, this scheme will provide the proactive care intervention for an increasing vulnerable group to avoid reactive health care provision.
Short description of the scheme. *(no more than half a page - embed 'Plan on a Page' if available or add simple template as annex 2)*	To provide an equitable assessment and appropriate care package to elderly patients living independently in remote rural areas to reduce escalation to Virtual Ward, reduce acute episodes of urgent care being presented at general practice and reduce emergency admissions to hospitals. It links into the broader health improvement agenda aimed at helping people to live healthier for longer through a modern preventative service which empowers and supports people to manage aspects of their own health in their own home. It will be delivered from a practice which covers a 700sqmile radius (equivalent to Cardiff, Newport, Vale of Glamorgan and Caerphilly combined). A summary of the practice profile includes - a higher than average and increasing number of elderly patients living alone in isolated areas, of multiple small hamlets - The nearest DGH being a 60minute drive away - The nearest community hospital being a 40-minute drive away. - The practice being the main provider of emergency care to the acutely unwell practice population - An average of 4-6 ambulances attending the practice directly on a weekly basis, and 2-3 ambulances attending patients directly at their homes.

Allocation requested (£)	£114k per annum, for 2 years.
Start date of the scheme.	The scheme will commence from April 2020
Duration of the scheme. *(maximum 2 years)*	This is a two year scheme proposal. The scheme will be initially be evaluated at the end of year 1 to ensure the outcome measure are being achieved and to further inform and adapt if necessary for year 2.
Overarching aim of scheme. *(What are you hoping to achieve?)*	To provide an equitable service to elderly patients living independently in a rural community by providing a multidisciplinary patient specific management plan incorporating structured assessment through reviewing physical health, mental health, medication and frailty progression and incorporating advance care planning. It will utilise the use of systems and information and technology to support the delivery of care at home as part of the community setting, where possible.
Objectives of the scheme. *(The steps you take to achieve the aim)*	Process measures will support the delivery of the expected outcomes. This will include • To undertake Patient self-reported PROMS and primary care patient reported experience measures (PREMS) before and after the episode of care to assess the the quality of care delivered on various areas. For example, this will include, mobility, self-care, usual activities, pain/discomfort, and anxiety/depression etc. • To review the practices current emergency admissions trend, for all Emergency Admissions and ii) those specialties targeted by the VW currently. This will provide the baseline data for the scheme. • To identify the High Cost users and Frequent attenders at individual patient level. It is noted that only some of these patients will currently be identified on the VW. • To identify full patient target group and their prioritisation, including age, co-morbidity and rurality • To develop a patient risk, register from the existing frailty only type approach to a more systematic and robust comorbidity risk register approach, incorporating local multi-disciplinary knowledge to identity patients.

	• To increase the number of Chronic Condition patient with Care plans, though a multidisciplinary patient specific management plan incorporating regular structured assessment, reviewing physical health, mental health, medication and, incorporating advance care planning.
Describe here how the scheme aligns to the wider strategic agenda and indicate which components of the *Primary Care Model for Wales, Strategic Programme for Primary Care, A Healthier Wales the scheme addresses.* *(refer to annex 1)*	The scheme aligns itself to both local and national strategic direction. It has a clear aim of testing aspects of wider care planning to deliver seamless care and support in line with the Primary Care Model for Wales with a particular focus on efficient and effective care being delivered in remote areas for an elderly population. The proposal targets the three main aims of the primary care fund namely: sustainability, improved access and more care being available in the community. PTHBs commitment as outlined in its Health and Care Strategy includes a vision and plan to improve health and well-being for Powys patients to enable them to 'start well, 'live well' and 'age well'. This scheme aligns itself to the 'age well' component which dovetails into the national agenda on maximising the opportunities for prevention and wellbeing as part of a health and social model of care, and maximises the opportunities to make every contact count The scheme also aligns to the PTHB IMTP which articulates an organisational priority to improve proactive care for those with complex needs. The scheme progress aims to achieve improvements in seamless working and builds upon the 'place-based care approach. Annex 1 further supports how the scheme aligns to the components of the Strategic Programme.
Describe how stakeholders, including patients and communities, will be involved in the design, delivery and review of the scheme.	This proposal has been developed with a GP practice as part of a wider cluster development approach. It will provide evidence of the intended outcome from this targeted investment to hopefully release funds to enable the mainstreaming of this investment in other isolated and rural areas across a cluster/wales. The scheme will reach patients who are being missed currently, therefore reductions, as detailed in the expected outcomes are expected. Ongoing Practice, cluster wider MDT and health board reviews will be pivotal in ensuring the delivery of the scheme progresses resolving the current problems as identified above. This will be progressed and include representation from,

	General Practitioners, Cluster lead. Community and social services lead. The proposed practice to progress this scheme has a well-established patient participation group who will provide the forum for the voice of the patient also
Describe expected outcomes. *(How will you know when you have achieved your aim - embed draft logic model if available – annex 2)*	The expected outcome and associated measures will demonstrate patient and health system benefits from this new approach, to include: Reduction in emergency admission equal to or below the national average for Emergency admissions: = > 6% Reduction in Prescribing: = > 3% Reduction in A & E attendances by = > 10% Improved patient satisfaction (measured from the uses of PROM/PREMS) Increased patient care plans (% will be identified following review of patient target group and their prioritisation and the existing care plans in place)
Has this idea been tested previously, locally, nationally or elsewhere in UK and if so how does this proposed scheme offer new learning?	Not aware of a similar scheme. Previous pilot studies which address the needs of the elderly population and the organisation of services providing for this population has not been 'rural proofed'. There has been little recognition and testing of the rural challenges and acceptance that a care model that supports a team covering for example 150 patients over 10 square miles is not an effective model for 150 patients over 600 square miles. This scheme will address the challenges as outlined in this application, which will inform new learning specifically for other rural areas both within Powys and across significant geographical challenged areas in HDUHB and BCUHB. The new learning will provide an evaluation from both a health care and financial perspective on the effectiveness of delivering an enhanced level of care to elderly patients living in extremely remote rural areas by proactively assessing and managing their heath needs; therefore, reducing the reliance on remote general practice as an acute urgent care service provider and reducing emergency admissions to hospital. The management of the frail elderly follow numerous and variable pathways. Primary Care is still learning what these pathways involve due to their individual complexity to enable the patient to stay in their own home. 50-60% of deaths still occur in the hospital setting, therefore this further reinforces the need and priority for this scheme.

Describe how this scheme is different to what is already in place locally or what has been tested elsewhere.	The virtual ward model has been very successful in linking the extended primary care team in looking after elderly patients in an acute crisis as well as coordinating the end of life care at home. It is a time efficient model for both the GP team, district nurse team, community nurse specialists and social services especially in areas where a home visit can be 50 minutes or more driving time, therefore reducing a duplication of visits has been a huge bonus. However, the virtual ward model looks at patients in acute need and on occasion it is too late to be able to effect a significant change in outcome and a hospital admission whether to secondary care or community hospital is often the only answer rather than admitting to the virtual ward. When a patient becomes housebound and more frail proactive reviews and care plans need to be in place (as per the level of proactive management provided through the Care Homes DES) and the reality is patient reviews for the required clinical management are undertaken less often compared to the increasing complexity and frailty of their needs. Therefore, the patient's vulnerability is increased, particularly in a rural area where travel distances add further complexity which often leads to an acute episode that may or may not be managed effectively through the virtual ward model. This scheme will trial a rural solution to the care needs of an increasing elderly population by starting regular reviews as soon as it is recognized that a patient is becoming more frail rather than waiting until a crisis is reached enabling the patient to follow a mutually agreed pathway of care transitioning into the end of life phase as necessary.
DETAILS OF THE SCHEME	
Describe the key stages of the scheme and timescales for each stage. *(quarterly or relevant intervals)*	This timetable assumes the outcome of the application will be known before the end of 2019.

Q4 19/20	• Lead GP Practice confirmed. • Lead MDT clinicians identified to support the scheme • Relevant baseline data sourced • Outcome reporting and agreed data collection confirmed. • Timeline for outcome reporting agreed
Q1 20/21	• Review of baseline data: current emergency admissions trend, for all Emergency Admissions and ii) those specialties targeted by the VW currently • Identify the High Cost users and Frequent attenders at individual patient level • Identify full patient target group and their prioritisation, including age, co-morbidity and rurality • Agree Patient self-reported PROMS/PREMS to be used

		• Commence development of a MDT patient risk register, through patient assessment. • Develop and implement appropriate Care plans, though an MDT approach
	Q2 20/21	• Ongoing identification, co-ordination, management and review of elderly patients • Completion of progress report **to** monitor scheme progress and inform evaluation • Cluster and PTHB review of scheme/report
	Q3 20/21	• Ongoing identification, co-ordination, management and review of elderly patients • Completion of progress report **to** monitor scheme progress and inform evaluation • Cluster and PTHB review of scheme/report
	Q4 20/21	• Ongoing identification, co-ordination, management and review of elderly patients • Completion of progress report **to** monitor scheme progress and inform evaluation • Cluster and PTHB review of scheme/report • Completion of year 1 evaluation • Scheme reviewed and refined, if necessary
	Q1 21/22	• TBC – dependent on findings following scheme review at the end of year 1
	Q2 21/22	• TBC – dependent on findings following scheme review at the end of year 1
	Q3 21/22	• TBC – dependent on findings following scheme review at the end of year 1
	Q4 21/22	• Programme evaluation commences
	Q1 22/23	• Programme evaluation completed
Describe the governance and project management arrangements for the scheme including lead roles. *(project support, clinical and non-clinical lead(s)*	• The ongoing governance and review of the scheme will sit within the Primary, Community Care and Mental Health Directorate • Project Management and overall co-ordination and day to day running of the scheme will be met by the providing practice and the Primary, Community Care and Mental Health Directorate	
Describe the plans and key milestones for monitoring progress and evaluation.	• As per the quarterly timetable above.	

(attach an outline logic model and evaluation plan, if available- see annex for template)	
Describe what resources (expertise and financial) has been allocated for evaluation.	• Scheme evaluation will include clinical expertise and critical peer review from cluster leads across Powys and senior primary care, community care and social care managers • Financial analysis and supporting data to confirm admissions avoidance, staffing resources etc • Patient experience review via PPG and PROMS/PREMS
Outline the ways you plan to share the learning locally and nationally.	• Pacesetter quarterly reporting • Regular reporting at Cluster level • Reporting through usual PC executive reporting routes • Reporting through RPB

Annex 1

COMPONENTS OF NATIONAL STRATEGIC POLICIES AND WAYS OF WORKING – ***Tick one or more of the relevant component which the scheme addresses***	
Primary Care Model for Wales	**TICK**
1. An informed public	
2. Empowered communities	X
3. Support for well-being, prevention and self-care	X
4. Local services (inc more services in the community)	X
5. Seamless working	X
6. Effective telephone systems	
7. Quality out of hours care	
8. Directly accessed services	X
9. Integrated care for people with multiple care needs	X
10. Estates and facilities support MDT working	
11. IT systems enable cluster communications and data sharing	
12. Ease of access to community diagnostics supporting high-quality care	
13. Finance systems designed to drive whole-system transformative change	X
A Healthier Wales - *The Ten Design Principles* (page 17)	**TICK**

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1. Prevention and early intervention – enabling and encouraging good health and wellbeing	X
2. Safety – healthcare does no harm, enabling people to live safely in families and communities	X
3. Independence – supporting people to manage their own health and wellbeing and remain in their own homes	X
4. Voice – Empowering people to understand, manage and make decisions about their health, wellbeing and care	X
5. Personalised – services tailored to individual needs and preferences	X
6. Seamless – services and information which is not complex and co-ordinated	X
7. Higher value – better outcomes and patient experiences	X
8. Evidence driven – understand what works, evaluating innovative work and learning from others	X
9. Scalable – Ensuring that good practice scales up	X
10. Transformative – news ways of working are affordable and sustainable and change or replace approaches	X
Aims of the primary care pacesetter fund	**TICK**
1. Sustainability – contracting general medical services at cluster level	X
2. Use of digital technology to improve access	X
3. Delivering more care in the community	X
The Strategic Programme for Primary Care	**TICK**
1. Prevention and wellbeing	X
2. 24/7 Model	X
3. Data & Digital Technology	x
4. Workforce & Organisational Development	
5. Communication & Engagement	X
6. Transformation & the Vision for Clusters	X