**The Arnewood Practice**

***Older people***

***Practice Ward –*** the practice meets 3 times a month with the Community Nurses, Therapists, Consultant Geriatrician, Palliative Care Nurse and Social Worker. We discuss as a Multi Disciplinary Team patients who are vulnerable, have complex needs, those whose needs are not being met and those who are receiving end of life care.

Patients admitted to the ward are RAG rated (Red, Amber and Green) – different meetings focus on different groups.

***Sharing of common health record –*** two year project to move the community nurses to the same electronic record as the three practices in New Milton – now we can see each others records – aim to reduce duplication, improve sharing of information, creation of a single care plan, improve quality and safety. The ability to read/write into the records needs to be followed up with messaging, alerts and scheduling.

So far have implemented the data sharing and this allows the read write capability and we are working to enable the messaging, scheduling and alerts.

Signed a data sharing agreement produced leaflets, posters etc, worked with the media. Pilot supported by CCG and also Community provider. Included the Hospice who are about to go live and therefore will be able to improve the End of Life care. This is a core plank of our Multi speciality Community Provider (MCP), looking to work with local hospital to put his system in place in out patients, on the wards and in the medical assessment unit.

Co-ordinated agreement and support from information commissioner, IG leads CCG and Community provider, Oakhaven and Caldecott Guardian leads in each practice.

***Frailty GP –*** as part of the transformation fund – we have 1 day a week of GP time whose role is to focus on the housebound and frail elderly to provide time and expertise in improving the quality of care to this vulnerable group and ensure their needs are met. This post is fill by one of the partners in the Practice who then links with the local community team and Consultant Geriatrician and Care Navigator. This post will then link to the Frailty service (FRAIT) service being developed by the MCP.

***Care Navigator –*** Again part of the transformation fund, Dawn works part time in the practice and provides a valuable bridge between the clinicians and social care and the voluntary sector. She is able to spend time with families and carers and is able to direct them towards where there needs are best me.

The links to social prescribing are important and we are working with the Local Authority to pilot a community information hub working with CAB and the local Library to provide information and help about local voluntary services, advice where to see help and information about local groups for example local befriending services and memory groups.

***Extended primary care team (EPCT) –*** Over the years the district nurses became part of the community team who moved from being practice bases to geographically based and has integrated with the mental health services. The consequence of this is that there has been a loss of the close working relationship that existed between general practice and district nurses. Evidence shows that 10% of patients seen by GPs or Community nurses the work is duplicates and 30% of patients could have been more appropriately seen by a different member of the team.

As part of the MCP we are trying to create the EPCT or “One Team”. Working in partnership with the Community provider the concept would be for a locality (New Milton) to work together, 3 practices, community team supported by the common health records to create a single team to support the delivery of better care. This should also be more efficient.

Breaking down barriers between practice nurses and community nurses, working as a single team with shared resources. Allowing local leadership and innovation.

Some proposals:

* Single record, sharing information, asking patient once, shared templates
* Better communication – face to face, messaging, appropriate roles
* Common care plans
* Wound care clinics
* Continence clinics
* Specialists nurses embedded in community and practices
* Acute visiting service which would include community nurses

By developing a more effective and efficient service we can free up clinicians time to spend more time with patients and meet the unmet demand.

***Pharmacists –*** working with the CCG and MCP we are re deploying the Medicine Management Team, supplemented with additional clinical pharmacists and technicians in each practice. They with link with the hospital and community pharmacists. There will also be a link to the pharmacists who are based in the other practices

Aim to improve quality:

* Repeat prescribing
* Reduce poly pharmacy in elderly
* Reduce waste in care homes
* Improve compliance
* Reduce waste and unnecessary requests for medication
* Facilitate discharge medication
* Improved knowledge in clinicians
* Support the management of long term conditions

This is funded through the MCP with the sustainability element being funded by savings on the prescribing budget.

***Working age people***

***WebGP and e-Consultation –*** to improve access for patients, this allows patients to seek information and direct patients to the place where they can seek help. This will also allow patients to complete an online questionnaire and create an e-consultation that will be responded to by a GP within 1 working day. This has been shown to reduce demand by up to 10% but also allows working age people to access help outside normal working hours and hence improves access.

***MSK extended scope practitioner –*** The practices has tried to improved access by working with the MCP to trial having an MSK extended scope practitioner working in the practice, they offer direct access to patients. The practitioner can take a history, examine, investigate and diagnose conditions and can also treat patients by advice, self help, steroid injection or referral to physiotherapy or orthopaedic choice. This has particularly helped working aged people in that this has shown a reduction in referral to physiotherapy and orthopaedic choice and also meant a reduction in the number of times the patient needs to be seen.

The aim is to expand this service and link it to the community physiotherapy service and embed this in local practices.

***The practice at Lymington Hospital –*** developed as a branch surgery of 7 local practices, working at Lymington Hospital. We are developing this as a primary care access hub as part of our MCP with additional services. The service is on offer 8am to 8pm seven days a week. It has shown to be highly popular with patients esp. those of working age as this service offers routine and urgent care services. The patients seen there have their clinical data recorded on the practice system and hence this improves safety and quality.

***Family, children and young people***

***Schools –*** we work with local schools as part of the health schools week that takes place every February.

We have been working with local schools to support children who are not attending school and the reason being given is health related.

Will describe the system in place.

***Child and Adolescent Mental Health Services –*** as a practice we have been working with the CCG and other local practices to improved access to CAMHs as part of a national pilot. We are working with 10 local schools to help train teachers and also provide and a psychologist to work with the schools and the CAMHs service and general practice.

***Safeguarding –*** as part of our commitment to children we have a lead GP and deputy – they meet regularly with the Health Visitor and then every quarter as part of our practice ½ day training we have a safeguarding session that included the health visitors. This meeting allows an MDT approach to the management of children who are in need or at risk.

***Sexual health clinic –*** although the practice has a high number of elderly patients there are also a number of younger patient who need to access sexual health services, these are offered through the practice but in addition we have worked with the local specialist service to have a regular clinic based in the practice.

***People with Long Term Conditions***

***Hypertension –*** patients are invited for an annual review. This used to involve a blood test then 2 weeks later an appointment with the nurses who would measure their BP and their weight and height. If there were any abnormal findings the patient would be asked to see their GP. So often this could involve 3 appointments associated with verbal advice.

We have tested a new system, patients attend an appointment with an HCA and have their blood taken, their height and weight are measured. The GP is then notified – the blood tests are reviewed with the blood pressure, BMI and QRisk 2 – following this an automated care plan is produced advising the patient of their Blood pressure, BMI, Cholesterol and QRisk 2 – these are shown with targets for their results.

Standard advice is given for normal and abnormal results. This is then sent to the patient with additional advice.

Over the last year over 100 patients have been surveyed to seen if they prefer the new system or the old one and the results show overwhelming support for the new system.

For other conditions such as CVD, stroke, asthma and COPD and diabetes patients are invited in the month of their birth for an annual review and provided with an updated management plan.

***Pharmacists –*** they will provide additional support and improve the quality of long term conditions.

***Diabetes –*** we are working with other local practices to improve the care for the housebound and the most vulnerable. In addition we are working with the MCP to “delayer specialist services”.

Our aim is to have a community based team that includes specialists (Consultants and nurses), GPs and practice nurses (with an interest) and for these clinics to be based in a practice or in a clinic but for them to use then GP record and use this to create a common care plan.

We are also looking at RAG rating patients to focus care on those who will gain maximum benefit. The particular focus is to improve outcomes and reduce complications by focusing on BP, Cholesterol and HBA1C.

***Vulnerable***

Our most vulnerable patients are those who are elderly, especially those that live alone and those who have dementia. The other group that is particularly vulnerable are the patients with learning disabilities.

***Frailty GP and Care navigator –*** these roles has been described.

***Practice Ward –*** this plays a key role in the identification and management and care planning for the most vulnerable in our society.

***Learning Disabilities review and care plans***

There are close to 100 registered patients with learning disabilities. This is higher than would be expected in the average practice and this was a result of the policy of closing down institutions in the 1980’s and a result a number of LD Homes were created in New Milton.

As a practice we work closely with the homes and aim to provide the best possible care to this group of patients.

Our Nurse Practitioner arranges to visit these homes and undertake a comprehensive annual review. This includes a physical and mental assessment and appropriate investigations and medications review and also will include a review of the person’s care plan.

As a vulnerable group all patients with LD should have a care plan. This would also assess how vulnerable the person was and at that point in time what their mental capacity was at that point in time. Included in this would be whether they had a DOLs in place which should be recorded in the clinical records.

We have reviewed our scheme with the CCG, the Area Team and also with the providers of the LD service.

***People with poor mental health***

This group of patients have both physical and mental health needs. It is estimated that between 20-25% of a GPs time is focused on mental health. This ranges from the child, to the adult and also the older persons.

The practice has been concerned for some time about the lack of services for children and the fact that the wait for CAHMs can be very long with a threshold for access which means there is a lot of unmet need.

What have we done?

* Working with the health visitors – regular meetings to discuss individual children and families.
* The work we have done with schools as an individual practice and in partnership with other local practices and the CCG and CAMHs service.
* Its your choice – counselling service – widely used locally

For adults we have been working with the local practices, the MCP, the CCG and the Mental Health providers to try and improve the service for our patients.

One of the partners is one of the mental health leads for the MCP.

We are focusing currently on services for those with personality disorders and the crisis support. We are keen to develop a service that better addresses the needs of the people with personality disorders.

The crisis café idea has been developed successfully in North Hampshire and we are looking to develop this locally.

Talking Therapies are based in the practice and used extensively by the practice. We are looking to develop these services and create a presence at the Practice at Lymington, and also to include adult mental health as part of the extended primary care team.

The pilot in Gosport of having a mental health worker place in a practice has been successful and has been shown to reduce demand on appointments with GPs and also reduce the referrals to the specialist mental health services.

As a practice we are keen to support such a placement and hope this will become a reality with the GP Forward View.

The practice has a GP mental health lead and as a practice we have tried to ensure that people with significant mental health needs have their physical health reviewed and any issues addressed. We have tried to ensure this small but important group of patients have an annual physical review but this has proved difficult to achieve the effective engagement.

**Dementia** –

With a high elderly population the major issue for the older peoples mental health service is dementia.

Some years ago a number of issues were raised:

* Need for early diagnosis
* Improve the knowledge and understanding of patients with dementia and the differ types of dementia
* Better use of drugs to slow the progression of dementia
* Review and reduce the use of anti psychotic medication and ensure their use if required was reviewed regularly
* Support for carers
* Change the focus from “suffering from dementia” to “living well with dementia”.

We organised an afternoon for the practice (from receptionists, GPs, nurses etc) to focus on dementia.

This started with a meeting between the clinicians in the practice and the OPMH Consultant to discuss all aspects of care and to address the issues detailed above.

This then followed by a session with the Dementia advisor and then a meeting with all the practice staff to discuss the support for patients and their carers.

Outcomes:

* Improved early diagnosis
* Review of all patients on anti psychotic drugs and ensured the risk had been assessed and where appropriate the drugs had been withdrawn.
* Dementia advisor offered a regular “slot” to be available in the surgery and her details given to newly diagnosed patients
* Worked with the CCG, Area Team, Academic Health Science Network and Clinical Network to design a programme for practices to be assessed as dementia friendly.
* Practice has been accredited as dementia friendly.
* Asked the Town Council to consider making New Milton a dementia friendly town
* Developed an LMC lunch and learn on dementia – trailed on the practice – now available to over the whole of the region and this has been downloaded by over 100 practices and used to spread the message amongst their staff.
* As a result of the work undertaken in the practice the LMC arranged a regional conference focused on dementia – addressing all the issues above – had over 120 GPs and nurses attending very positive feedback.
* Become one of 3 practices within West Hampshire CCG to develop services for dementia.
* All signage has been reviewed and updated

The practice is a partner in the Hampshire Health Action Zone.