Homerton Healthcare
NHS Foundation Trust

Proactive Care Team

Joel Reynolds
Operational Lead

Neighbourhoods

Health in Hackney Scrutiny Commission
12.2.24

Proactive Care in City & Hackney

- **Personalised care** for residents with mild-moderate **frailty** and **multiple long-term conditions**
- Focus is on **what matters** to residents
- Delivered through **multi-disciplinary** teams
- Working proactively **upstream** through **cohort identification** and **case finding**

Source: Public Health Sudbury & Districts www.phsd.ca

Rationale

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Patients with multiple morbidity / frailty needs often receive care that is reactive rather than proactive

Traditionally health and care systems prioritise treatment and crisis management as opposed early intervention and prevention

Support for residents is often based on need rather than based on what is important to them (i.e. strengths based)

Organisations can work in silos, leading to fragmented care as opposed to a person-centred approach across health, social care and wider support / services

Traditionally there is a focus on supporting people based on individual long-term condition pathways. But more people are living with multiple health and care needs and therefore need a more holistic, person-centred approach

Neighbourhoods

The Eight Neighbourhoods

Springfield Park
- Cranwich Road Surgery, N16 5JF
- Spring Hill Practice, N16 5SR
- Stamford Hill Group Practice, N16 6UA

Hackney Downs
- The Clapton Surgery, E5 9BG
- The Elm Practice, N16 7EA
- The Gadhvi Practice, N16 7EA
- Healy Medical Centre, E5 9DH
- The Nightingale Practice, E5 9BQ
- The Riverside Practice, E5 9BQ
- Rosewood Practice, N16 7EA

Woodberry Wetlands
- Allerton Road Medical Centre, N16 5UF
- The Cedar Practice, N4 2NU
- The Heron Practice, N4 2NU
- Statham Grove Surgery, N16 9DP

Hackney Marshes
- Athena Medical Centre, E5 0QP
- Kingsmead Healthcare E9 5QG
- Latimer Health Centre, E9 6RT
- The Lea Surgery, E9 6AG
- Lower Clapton Group Practice, E5 0PQ

Clissold Park
- Barretts Grove Surgery, N16 8AR
- Barton House Group Practice, N16 9JT
- Brooke Road Surgery, N16 7LR
- Somerford Grove Practice, N16 7UA

Shoreditch Park and City
- De Beauvoir Surgery, N1 5QT
- The Hoxton Surgery, N1 5DR
- The Lawson Practice, N1 5HZ
- The Neaman Practice, EC1A 7HF
- Shoreditch Park Surgery, N1 5DR
- Southgate Road Medical Centre, N1 3JS
- Whiston Road Surgery, E2 8AN

Well Street Common
- Elsdale Street Surgery, E9 6QY
- The Greenhouse Health Centre, E9 7SN
- Trowbridge Practice, E9 5NE
- Well Street Surgery, E9 7TA
- The Wick Health Centre, E9 5AN

London Fields
- Beechwood Medical Centre, E8 3AH
- The Dalston Practice, E8 1PG
- London Fields Medical Center, E8 4QJ
- Queensbridge Group Practice, E8 3XP
- Richmond Road Medical Centre, E8 3HN
- Sandringham Practice, E8 1PG

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Background

City and Hackney Neighbourhood team set up an Anticipatory Care (AC) pilot in Springfield Park Primary Care Network (PCN) following NHS England and NHS Improvement (NHSEI 2021) guidelines from October 2021 to March 2022

Succesfull Evaluation of the pilot led to joint funding for expansion across city and Hackney, funded via
- NEL ICB Ageing Well budget
- PCN Additional Role Reimbursement Scheme

Service is provided by Homerton, based in primary care surgeries and community sites working on a Neighbourhood footprint

Proactive Care Team

Homerton Healthcare NHS Foundation Trust

9 Care Coordinators
(Dee, Judith, Dion, Issaka, Verity, Michelle, Laura, Mark, Eunice)

2 Clinical leads Physiotherapist & Occupational Therapist
(Tom and Tim)

½ Operational Manager
(Joel)

Who do we support ?

NHS
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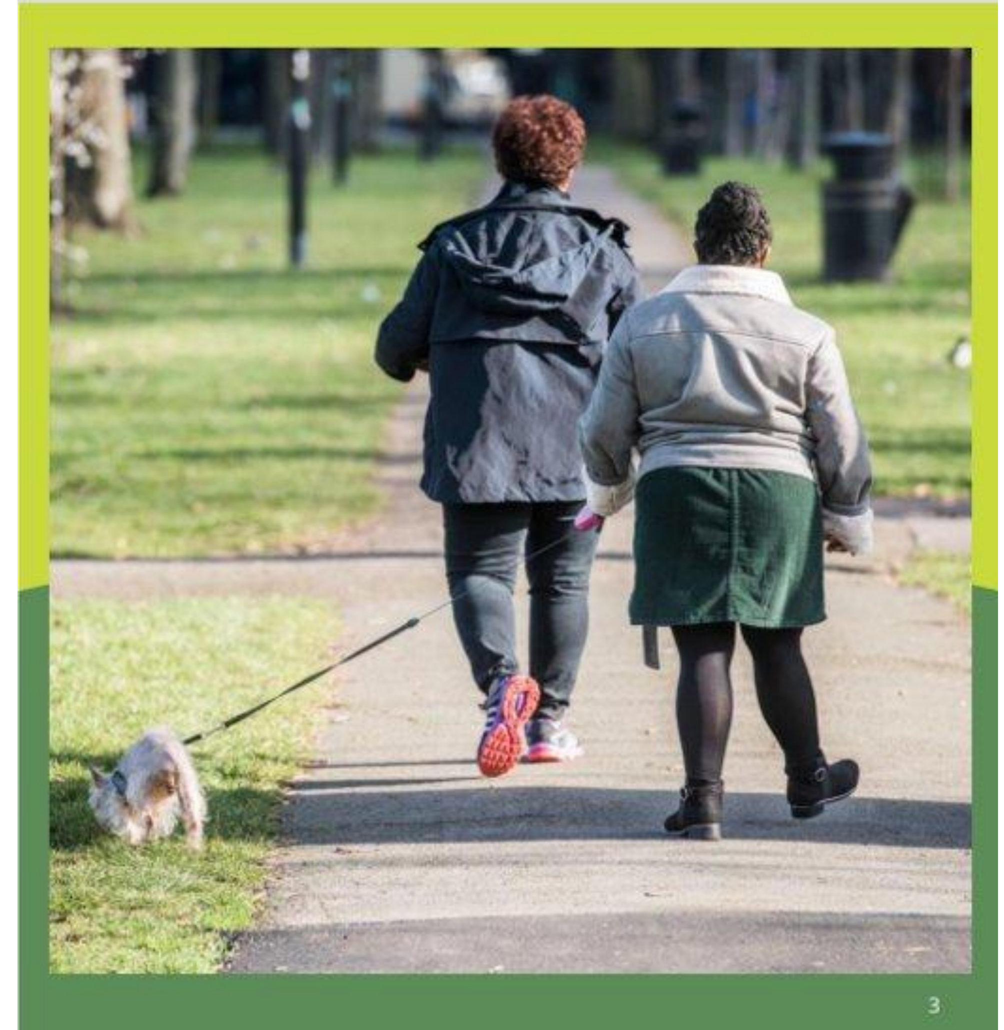
- -Adults aged **65+**
- -Moderate or severe **frailty**
- -Multiple **long term health conditions** (3 or more)



Neighbourhoods

er 2000 residents contacted since il 2024 - 53% of original group

What does it involve?

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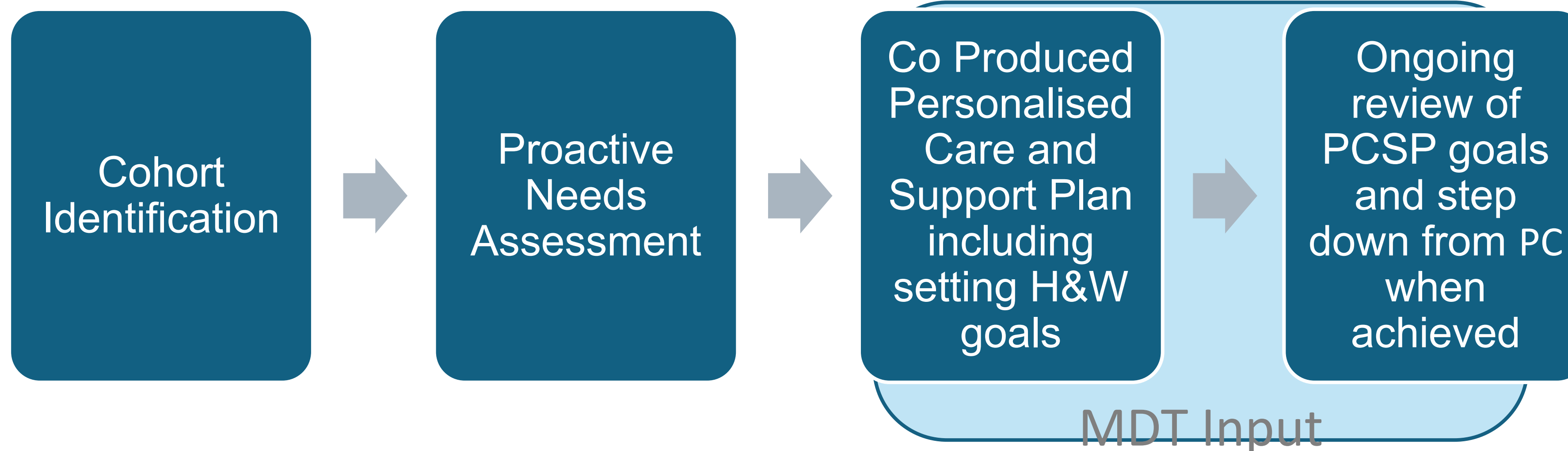
1. **Identify** people who meet our criteria (search health record systems)
2. **Contact** them (letter, phone, text)
3. Have a **conversation** with them (we call this a **Proactive Needs Assessment**)
4. If necessary (and with the consent) work with other services and professionals to support the person (Multidisciplinary Team)
5. Create a '**support plan**' to record what's most important to the person and log of any actions that need to be taken to support their health and well-being
6. **Review** the person's progress as time goes by – provide further support if needed



Neighbourhoods

"What matters to you?"

- Different from a typical meeting with a GP or other health professional
- Care Coordinators are trained to facilitate a structured conversation about what matters most to the individual.
- They support people to think about their health, well-being (and life in general!)
- Care coordinator then helps the individual make a plan to address key issues affecting their wellbeing

What matters most to you?

How do you keep yourself well?
Is there anything which makes that difficult?

Do you like to spend time with others?

Is there anything that stops you from doing
what makes you happy?

Common Concerns

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"I have a high energy bill that I don't understand"

"My balance is bad and I'm worried about falling"

"I'm expecting home adaptations, but I've heard nothing and feel frustrated"

"I'd like to reduce my back pain so I can sleep better"

"I am anxious about being overweight"

"I'd like to talk to someone about my mood and my relationship with my partner"

Neighbourhoods

Typical Interventions and Support

- Physio referral for support with MSK conditions
- Sign-posting to local exercise offers
- Referral to strength and balance class
- Help booking annual health checks
- Liaison with Adult social services OT
- Support using benefits calculator
- Sign-posting to NHS talking therapy services
- Supported to locate community groups

City & Hackney
GP Confederation
A community interest company

Neighbourhoods

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Proactive Care Team

Resident Involvement

- Inclusive Recruitment processes
- Resident Design Group
- QI Resident Advisor embedded into team

Shortlisted for HOSCAR award

Case Study

My Personalised Care and Support Plan

This is your plan which brings together the discussions between you and your Care Coordinator about what matters most to you. We are calling this plan the Personalised Care and Support Plan. It includes what's important to you and what might support you to stay as well as possible, doing more of the things you enjoy.

About Me

We will complete this section (in so far as possible) ahead of the discussion with you from information we already know.			
Name:	Full Name		
How would I would like to be known:	Calling Name		
Date of Birth	Date of Birth		
NHS Number	NHS Number	**Adult Social Care ID (if relevant)**	

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Mr B, – Verity
77 years old Jewish Man, Clinical Fraily Score (CFS): 5
Long Term Conditions: Parkinsons, OsteoArthritis (OA), Mild Cognitive Impairment, Coronary Artery Disease, Diverticulosis, Chronic Kidney Disease stage 5, hypercholesterolaemia, Hypertension (HTN), Obstructive sleep apnoea

Type of contact: Invited to pathway via letter, followed up with a telephone call to book initial appointment Time from letter to initial appointment: 5 weeks . Contact: 1 initial and 3 follow up sessions, 1 therapy home visit

Summary of support:
Social connection and family are important to the resident, and he has a good social circle and supportive relationship with his partner. Exercise was something he wanted to work on with regards to his health and care as he was aware of its health benefits, but knee pain and dizziness was affecting his motivation to get started.

The Care coordinator discussed the case with the clinical lead for the proactive care service and referred him for a physiotherapy assessment at home, which included an assessment of his dizziness. This meant that an appropriate group exercise intervention was recommended for his needs as well as a referral to the local MSK service to support the management of his knee pain. A potential barrier was the resident's cultural preferences as he is of the orthodox Jewish faith and wished to attend a male only exercise group.

The Care Coordinator used their local knowledge and connections to identify a male only strength and balance class running at a GP surgery in a neighbouring PCN which was willing to accept a referral for the resident.
The resident appreciated the care coordinator's local knowledge and the speed of the service they received.

Intervention delivered was informed by individual need and cultural preferences

Example of integration and multi-displinary working with GP, Homerton Therapies and community group involvement coordinated

Practice informed by :
DES Personalised Care
DES Enhanced Care
NHS-E Aging Well Priorities
Contract

Neighbourhoods

Health Inequalities Mitigation Projects

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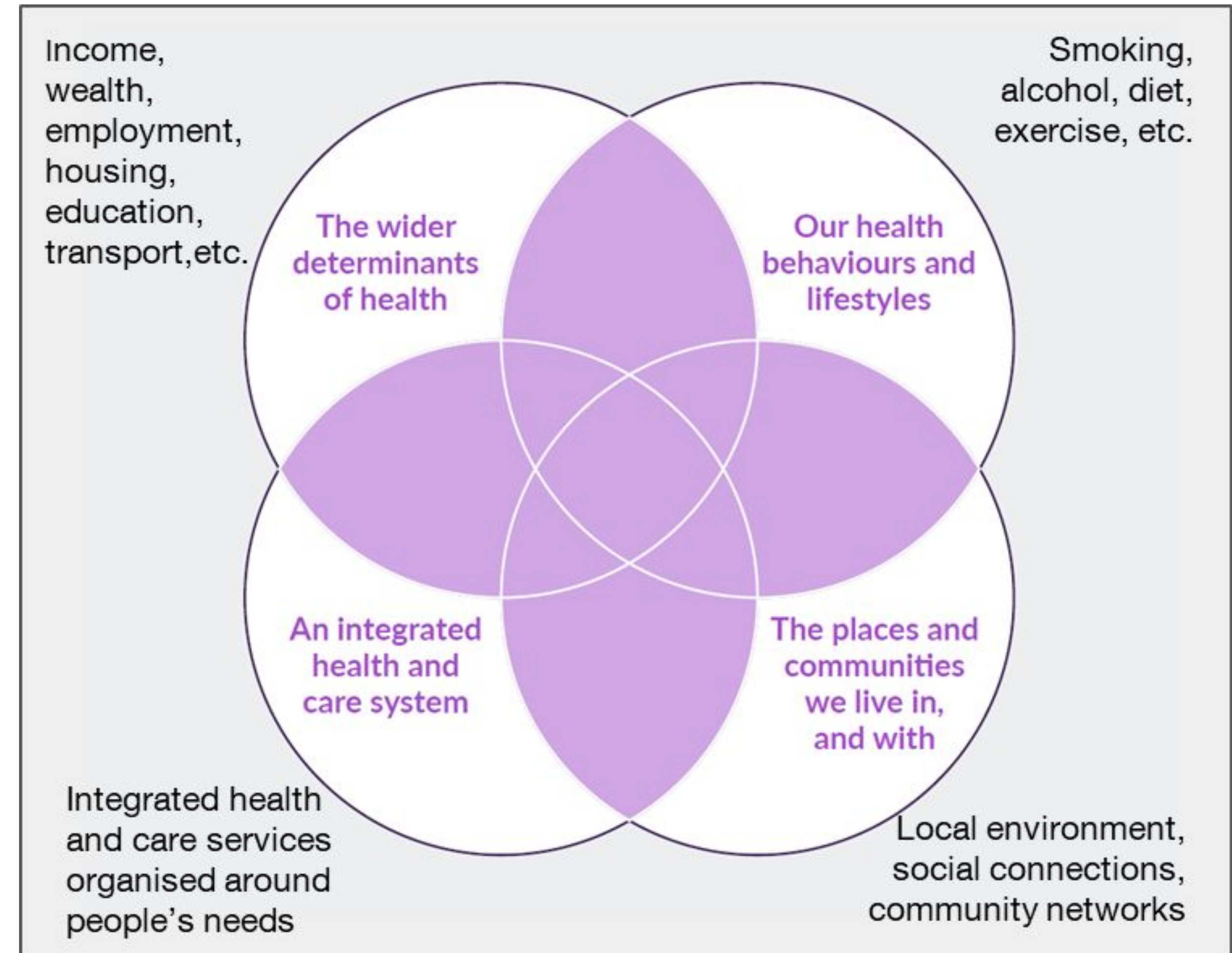

Operational Challenges

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- Building knowledge/skills/relationships across the system, at scale and pace
- Evidencing impact of preventative approach
- Ensuring equity of provision across different communities
- Sharing information across systems, and reporting on data
- Segmenting population to ensure people who need and will benefit from service the most receive it
- Ensuring financial sustainability of service,

Neighbourhoods

Wider supporting pathway
The Neighbourhoods Programme

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- University of East London are co-designing with residents an online training programme which takes an anti-racist approach to frailty awareness. This will be widely available aimed at residents, volunteers and all sectors.
- We are piloting personal budgets and researching how people use them so that we can tackle common barriers more strategically.
- The voluntary Sector help us to find people where there are particular health inequalities and barriers to taking up prevention
- We have worked with Renaisi an independent evaluator to research barriers to taking up prevention. They will also evaluate the impact of this pathway

Questions?

Thank You

Case Study

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Mr K, 67 – Michelle

67 years old Caribbean Man
CFS: 4 LTCs: Small vessel disease, OA, Type 2 Diabetes Mellitus, Left ventricular systolic dysfunction, Cervical spondylosis, HTN

Type of contact: Invited to pathway via letter, followed up with a telephone call to book initial appointment
Time from letter to initial appointment: 3 weeks (4 days between follow up call and initial appointment)
Contact: 1 initial and 4 follow up sessions

Summary of support:
The resident identified several outcomes they wanted to work towards; Resolving a long standing issue of damp in his home, improving his financial situation as he was struggling with the cost of living on a small pension and improving his physical health by losing weight.

The care coordinator supported the resident to identify the appropriate department to contact regarding the damp and helped the resident plan a timeline for contacting them and escalating his concerns. The care coordinator supported the resident to complete a self-assessment benefits calculator and when it was identified he was eligible for additional benefits linked the resident with the Hackney Money hub for support making a claim.

Using their knowledge of the PCN and GP practice the Care Coordinator helped the resident sign up to a weekly weight loss group run at the practice.
The resident was very pleased to find he was eligible for more benefits and appreciated the opportunity to plan an approach to working towards his outcomes with the Care Coordinator.

Action taken on wider determinants of Health:

- Reducing poverty
- Improving Housing
- Avoiding Isolation

Support with physical /mental wellbeing

Integration with Hackney Social Services, GP practice initiatives

Reflects Guidelines:
Personalised Care
NHS Aging Well Strategy
NHS LT Plan

Neighbourhoods

Case Study

NHS

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Ms Y, 73 – (Judith)

73 years old Turkish Woman
CFS: 6 LTCs: Bronchiectasis, AF, T2DM, HTN

The resident is a non-English speaker (first language is Turkish).
The care coordinator used a Turkish interpreter for her consultations and established she was struggling with low mood and anxiety. Her concerns related to chronic pain and also worry about a family member with health problems.

The resident expressed a wish to exercise more but was unsure where to start. The resident also had diabetes and was struggling with her diet and unsure of what foods she should and should not eat.

The care coordinator started by linking the resident with Derman (Turkish support service) which led to the resident accessing 1:1 Turkish speaking psychology and a chronic pain group for Turkish speakers.

The Care coordinator also supported the resident to contact her diabetes nurse and get advice on diet. After discussing the case with the clinical lead in the proactive care team, the resident agreed to be referred to a 'Staying Steady' strength and balance group run by community group

The Care coordinator arranged several follow up sessions with the resident to check on the progress and outcome of referrals. The patient was very grateful for the support she received and taught the Care Coordinator some Turkish words as thanks.

Example of supporting with health literacy, connection and mood

Additional time and resources were needed to overcome barriers to preventative healthcare

Reflects Guidelines:
Personalised Care
NHS Aging Well Strategy
NHS LT Plan

Neighbourhoods