

NHS Dorset Clinical Commissioning Group

## **Integrated Community and Primary Care Services**

# **Community Care Model: Key Features, Functions and Outcomes**



**Supporting people in Dorset to lead healthier lives**



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## Introduction

### Sustainability and Transformation Plan for local health and care

Our Dorset (Sustainability and Transformation Plan) sets out the vision for Dorset’s health and social care systems. It describes three programmes of work:

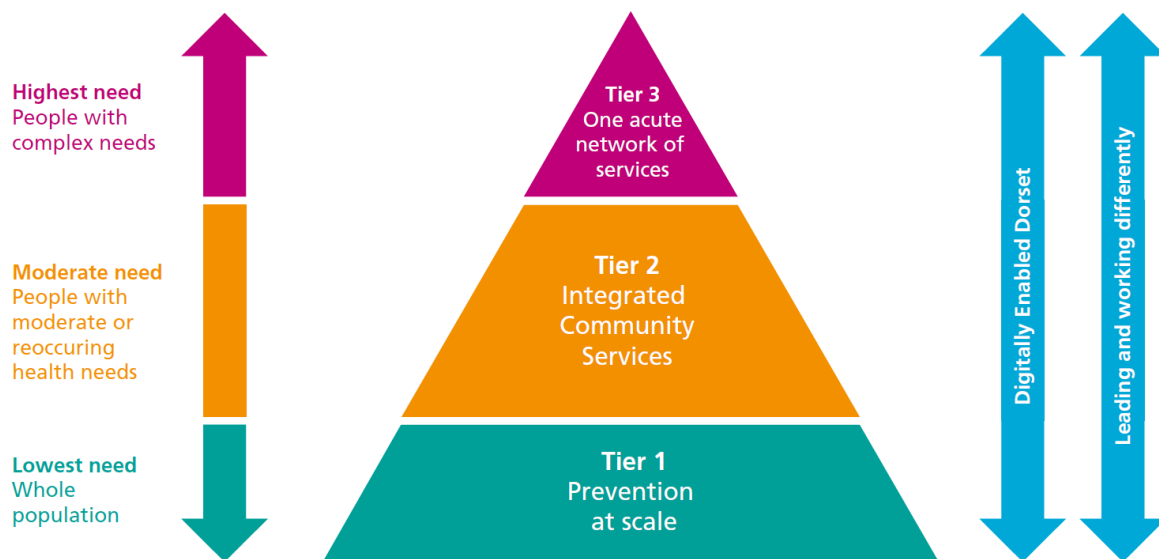
<ol style="list-style-type: none"><li>1. <b>The Prevention at Scale programme</b> will help people to stay healthy and avoid getting unwell</li><li>2. <b>The Integrated Community and Primary Care Services programme</b> will support individuals who are unwell, by providing high quality care at home and in community settings.</li><li>3. <b>The One Acute Network programme</b> will help those who need the most specialist health and care support, through a single acute care system across the whole country.</li></ol>	<p><b>Supported by two enabling programmes:</b></p> <ul style="list-style-type: none"><li>• The Leading and Working Differently programme focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care in an integrated health and care system</li><li>• The Digitally-Enabled Dorset programme will increase the use of technology in the health and care system, to support new approaches to service delivery.</li></ul>
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Dorset ‘s health and care system is working together to deliver this five year plan in order to meet national priorities in line with the scale of change required and to close the gaps in health and well-being, care and quality, and finance and efficiency.

A needs based approach to our interconnected programmes of work has been taken and is being supported by two enabling programmes:

- Leading and working differently – focusing on giving the health and care workforce the skills and expertise needed to deliver new models of care.
- Digitally-enabled Dorset – to harness the power of technology and support digital innovation to support new approaches to service delivery.

Figure 1: Diagram showing the three tiers of care in the new model. ICPS forms tier 2.



### What do we mean by Integrated Community Services (ICPS)?

Integrated community and primary care services from the middle tier of our plan (fig 1 diagram middle tier). This programme will transform general practice, primary and community health and care services in Dorset so that they are truly integrated and based on the needs of the local populations.

Community based services will be led by multidisciplinary teams of health and care professionals, working together to meet the needs of people who have short-term health needs, individuals with long-term conditions and those requiring specialist care for severe or complex health needs. We will deliver all of these services in a way that makes it easier for people to access care when and where they need to, with a consistent and high quality experience for patients as they move between different parts of the integrated system. Our priorities are to:

- Support people to better manage their own health, with access to appropriate information and support – we expect a 10% reduction in new outpatient attendances and a 25% reduction in follow-ups.
- Provide care that is based on the needs of our local population, with services delivered at the times and places people need them.
- Enable more people to receive care at home and in the community, and to self-manage long-term conditions, to avoid having to visit hospital or being admitted as an inpatient – we expect to reduce 25% unplanned emergency medical admissions and unplanned surgical admissions by 20%.
- Make sure our community services are able to support frail older people with long-term conditions so that more care can be delivered closer to home.
- Improve personalised care for people with complex needs, including individuals with learning disabilities.

- Adopt new technologies that will support a high quality, consistent patient experience throughout the health system, with standardised working practices and seamless communication between health professionals.
- Create integrated teams of professionals with the right skill mix (including students) in improved working environments, to support the delivery of the model of care as well as enhance skills acquisition and personal development opportunities.
- Make sure that our NHS buildings, resources and finances are used in a cost-efficient way, including by planning care on a larger scale to achieve cost savings. (Sustainability and Transformation Plan)

### *What are our aims?*

#### **The model of care we propose aims to:**

- Increase the number of people supported in community settings, such as their own homes or through community hubs, as an alternative to being admitted to major hospitals
- Increase the range of services on offer in the community
- Support health and social care staff working together across traditional organisational boundaries
- Provide a seven day service that is available for longer during the day
- Improve use of community hospitals as community hubs by consolidation of some or increased use of others
- Ensure that the mental health and wellbeing of patients is an integral part of local services.

### *Creating a network of community service hubs*

We will establish a network of community service hubs each providing a range of health and care services which will provide the following:

<b>ROUTINE CARE</b>
<b>RAPID SAME-DAY ACCESS</b>
<b>SELF-MANAGEMENT SUPPORT</b>
<b>OUTPATIENT APPOINTMENTS</b>
<b>URGENT AND UNPLANNED CARE</b>
<b>SECONDARY CARE CONSULTATIONS</b>
<b>REHABILITATION</b>
<b>SPECIALIST CARE AND SUPPORT</b>

To deliver our priorities we intend to create a network of community hubs throughout Dorset. These hubs will enable people to access a wider range of health services, from routine care to urgent and specialist care, closer to their homes.

Mixed teams of health and care professionals, will staff the hubs providing assessment and care for people who have physical and mental health needs. They will offer services for children, adults and our growing older population.

*The health and care system will address a wide range of different needs of our local population, including:*

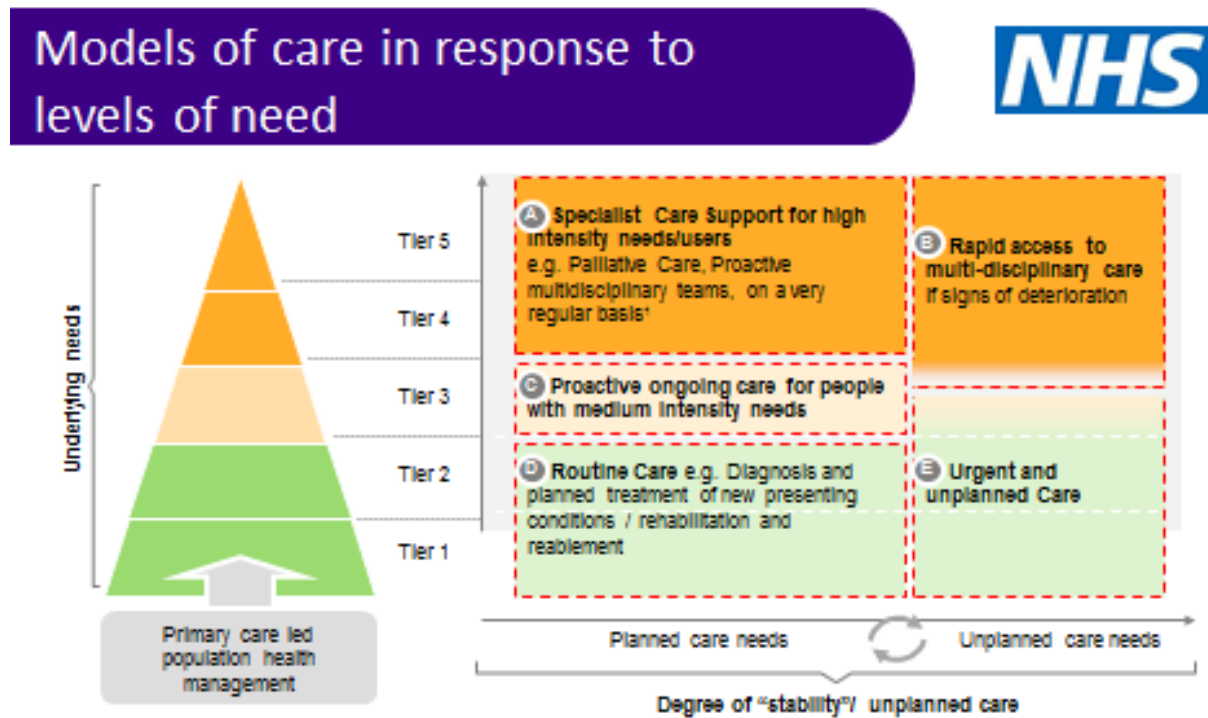
- People who are mostly healthy but with some episodic health needs, such as young children, pregnant women and people with short-term illnesses
- People at moderate risk of requiring higher sudden levels of care need, or sudden care needs, including those with long-term conditions, learning or physical disabilities, and frail older people
- People with a very high risk of deterioration in their health, which require regular supervision and support, including people at the end of life and those with multiple health and social care needs.

*The services will include:*

- Routine care including traditional primary care, screening, baby clinics and checks, contraception services and prevention advice
- Rapid same-day access to GP-led urgent care, with on-site diagnostic testing including imaging and x-rays
- Self-management support for patients with long-term conditions
- Outpatient appointments
- Urgent and unplanned care
- Secondary care consultations and minor procedures
- Rehabilitation and services to support recovery after periods of ill-health
- Specialist care and support for people with complex needs, including 24/7 crisis support to help people receive the urgent care they need without going into hospital.

## Key Features and Functions of Integrated Community and Primary Care Services

The integrated community services new model of care illustrated below has been developed to meet the different levels of need of our local population.

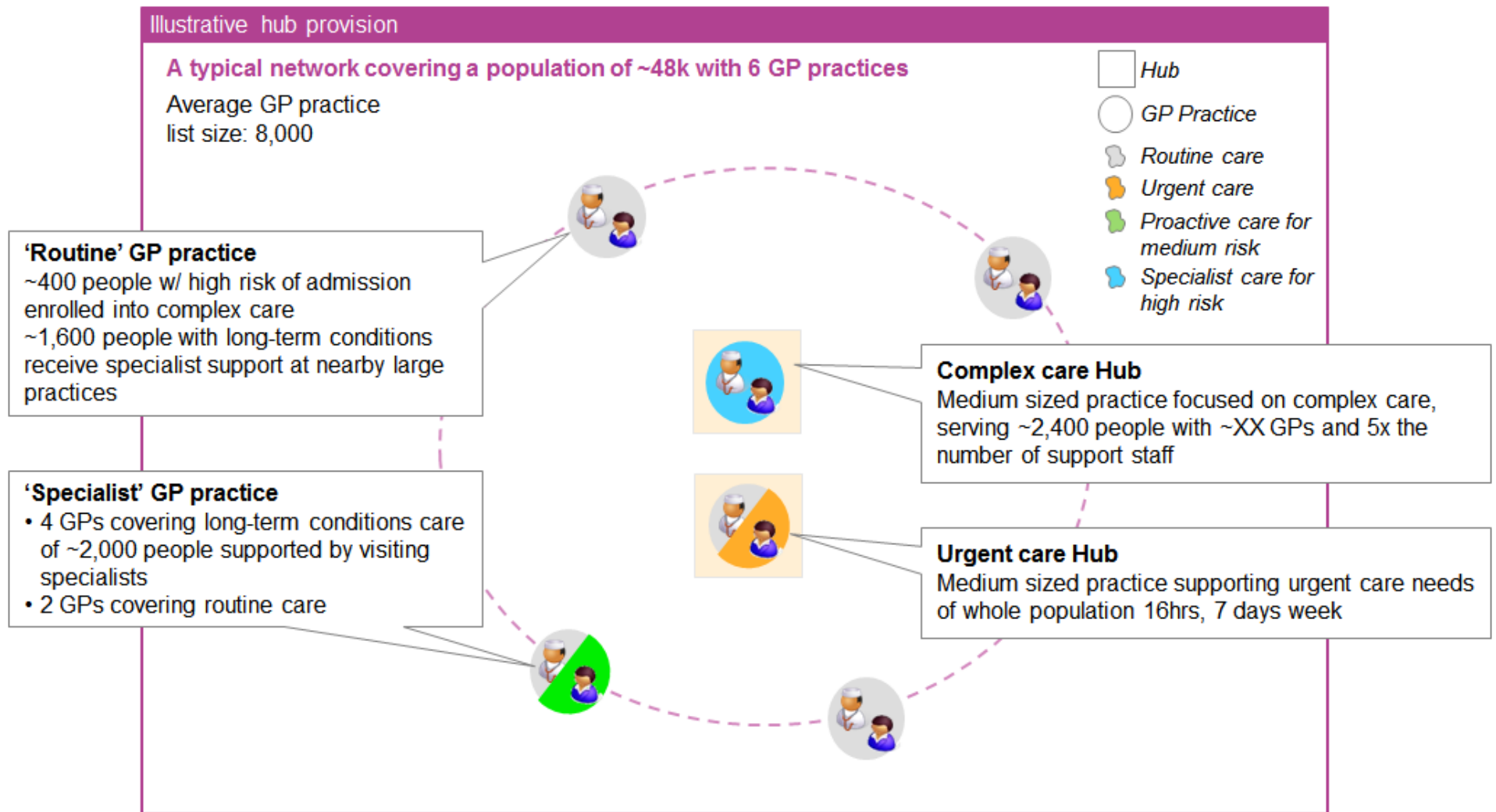


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Dorset's Health

It is recognized that people may move up and down the levels of need depending on their stage of health and wellbeing.

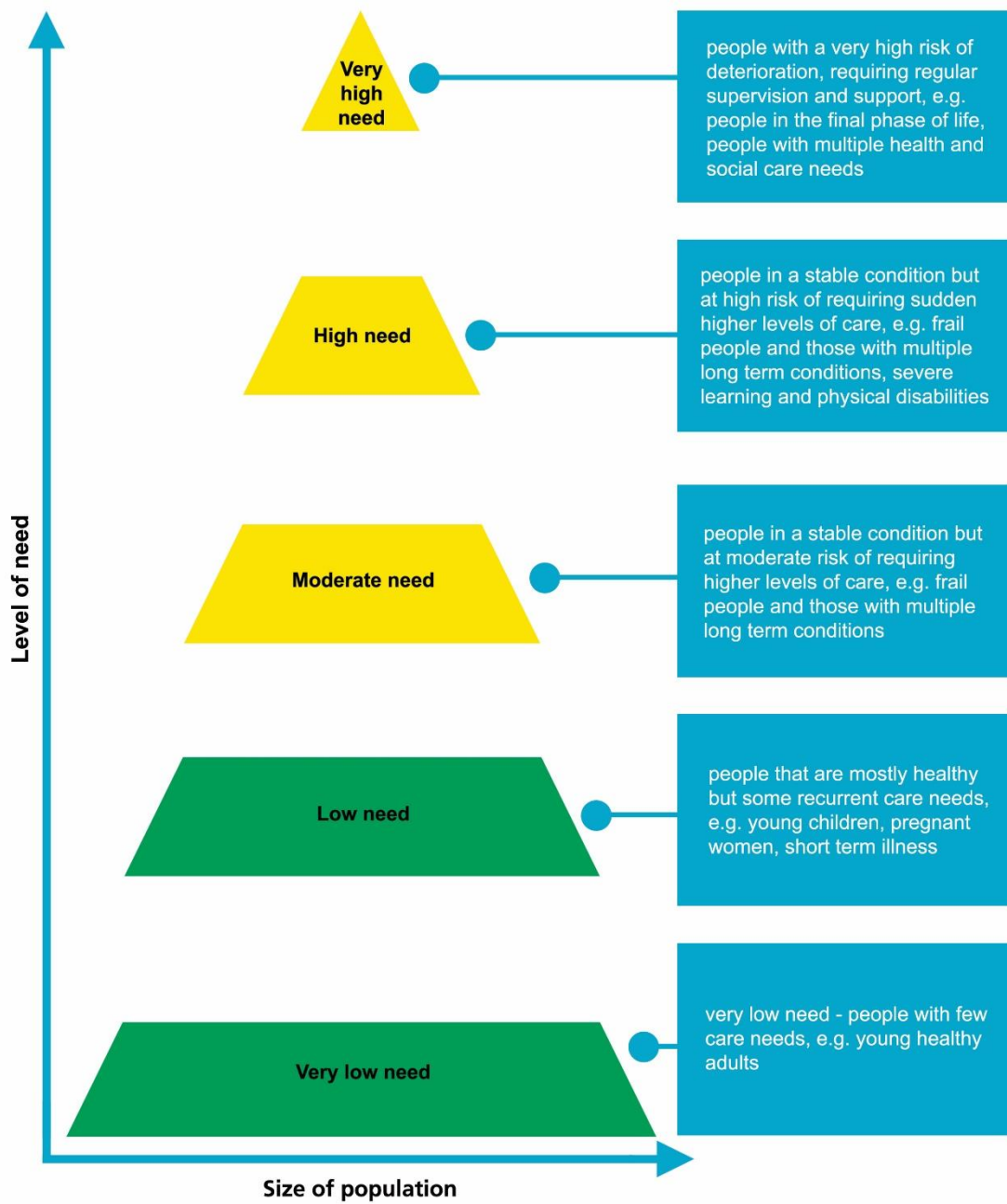


## Illustrative Hub Provision

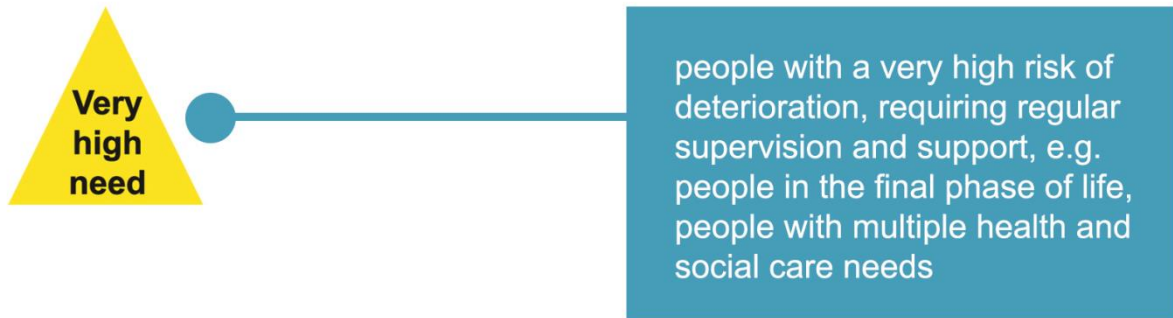


This diagram illustrates how the delivery models will operate together to better meet the care needs of the different populations within each area

## Levels of Need



## Very High Need



### *Definition*

Those people with a very high risk of deterioration, requiring case management, regular supervision and support, e.g. people in the final phase of life, people with multiple health and social care needs.

Individuals will have comprehensive care plans in place that are regularly reviewed – to include an escalation plan, urgent care plan and advance care plan.

Response will include rapid access to assessment and multidisciplinary care if the service user shows signs of deterioration/crisis.

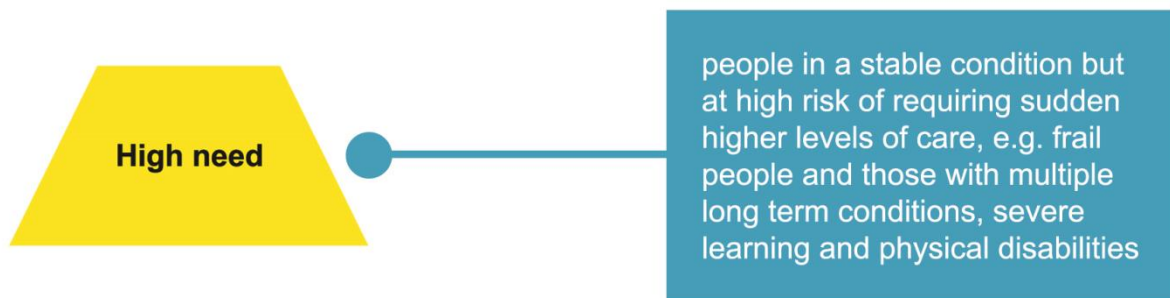
### *Workforce requirements*

Extended integrated primary care teams including GP, Geriatrician, GP with specialist interest, nurses, pharmacist, support workers, mental health professionals, Allied Health Professionals (AHP's -therapists) community and voluntary sector and social care with access to specialist advice and support – e.g. geriatrician, Mental health professional, rheumatologist, cardiologist, specialist nurses, dieticians, podiatrists, Emergency Care Practitioner, specialist palliative care.

### *Location*

- Initial assessment at home or usual place of residence.
- Access to step up beds within a community hub close to home may be required.
- More specialist assessment may be required within the day assessment/ facility of a community hub.

## High Need



### *Definition*

Those people in a stable condition but at high risk of escalating to higher levels of need and requiring more intense levels of care, e.g. frail people and those with multiple long term conditions, severe learning and physical disabilities.

Care, support, planning and provision for people with high intensity needs, who have complex care needs, such as those people with Long Term Conditions (LTCs). The provision of this element of the service will focus on personalised plans to reduce the risk of patients becoming unstable, pre-empting escalation requirements and to reduce the need for unplanned care.

### *Workforce Requirements*

Extended integrated primary care teams including GP, Geriatrician, GP with specialist interest, integrated community teams, pharmacist, mental health professionals, AHPs, support workers, community and voluntary sector and social care with access to specialist advice and support – e.g. geriatrician, Mental health professional, rheumatologist, cardiologist, specialist nurses, dieticians, podiatrists, Emergency Care Practitioner, specialist palliative care.

### *Location*

- Home or usual place of residence.
- More specialist assessment may be required within the day assessment/facility of a community hub.

### **Key features and functions for Integrated Community and Primary Care Services to support those with very high or high needs**

- Identification system in place e.g. Electronic Frailty Index (eFI)
- Case management approach to proactively managing the very high/ high need population identified through risk stratification processes
- Home based provision of care and rehabilitation
- Response will include rapid access to the MDT for assessment and care if the very high/high and medium intensity needs shows signs of deterioration/crisis. (See 'Definition of an MDT' on page 14)

## Key features and functions for Integrated Community and Primary Care Services to support those with very high or high needs (continued)

- The service will need to organise its workload/capability and capacity to ensure it can appropriately respond and manage both the planned/pro-active engagement with this group of people and their urgent care needs.
- Additional support if required from services delivered in the community hub, available 7/7 from 8.00 am – 8.00 pm, responds to request from senior clinical decision maker. The health and social care coordinator/case manager is informed and care plan updated by the relevant health or social care professional
- The team will follow patients through, if they are admitted to hospital, and work with ward staff to ensure timely and appropriate hospital discharge.
- Access to diagnostics
- Holistic assessment, planning and coordination of care from key health and social care worker with trusted and shared assessments e.g. Comprehensive Geriatric Assessment
- A completed 'Dorset Anticipatory Care Plan ' including
  - An escalation plan – what an individual and their carer might need to look out for; when and who to call or what to do if there is a problem
  - An urgent care plan – which summarises the individuals wishes in the event of a crisis with regards to their own health (i.e. do they want to go to hospital, under what circumstances would they want to stay at home, whether there is a DNACPR order in place) or in the health of the carer should this deteriorate
  - An advance care plan or end of life care plan – which could describe the individual's wishes with respect to their preferred place of dying and whether they have "just in case" medications in place
- Support for carers/family
- Voluntary sector support – social isolation, wellbeing and support
- Proactive and coordinated input to care homes / supplement the care to high risk patients in care homes (please see Care Elements for enhanced health in Care Homes table on page 13)
- Access to step up/step down and end of life care within a community hub with beds or short-term care home beds. ***Link to DRAFT Short Term Community Beds Key Features and Functions in below icon***



Short Term  
Community Beds Key

- Community Pharmacy providing and sharing medicine reviews including on discharge from hospital
- Identification of high risk individuals in the community, coming to the end of their life, working to support them to die at home - care home, in a community hospital or as close to home as possible for those, who are unable or do not wish to remain in their own home. Seamless working with the patient's GP and primary health care team to ensure seamless communication and high quality care. Working in an integrated way with specialist palliative care providers when required

**Table 1: Care Elements for enhanced health in Care Homes (The Framework for enhanced health in care homes, 2016)**

Care element	Sub-element
<b>1. Enhanced primary care support</b>	Access to consistent, named GP and wider primary care service
	Medicine reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
<b>2. Multi-disciplinary team (MDT) support including coordinated health and social care</b>	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
<b>3. Reablement and rehabilitation</b>	Rehabilitation/reablement services
	Developing community assets to support resilience and independence
<b>4. High quality end-of-life care and dementia care</b>	End-of-life care
	Dementia care
<b>5. Joined-up commissioning and collaboration between health and social care</b>	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
<b>6. Workforce development</b>	Training and development for social care provider staff
	Joint workforce planning across all sectors
<b>7. Data, IT and technology</b>	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

### *What is a Multi-Disciplinary Team?*

A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of organisational boundaries and reach solutions based on a new understanding of complex situations. Multidisciplinary working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers to redefine, re-scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient needs.

### *Roles within the MDT*

The MDT consists of GP/ GP extensivist or advanced nurse practitioner with medical prescriber role, geriatrician, community nurse, community matron, health and social care coordinator, therapists, social care worker and dedicated administration. Access to specialist advice and support – e.g. psychiatrist, rheumatologist, cardiologist, specialist nurses, dieticians, podiatrists, Emergency Care Practitioner, specialist palliative care.

### *Common Principles*

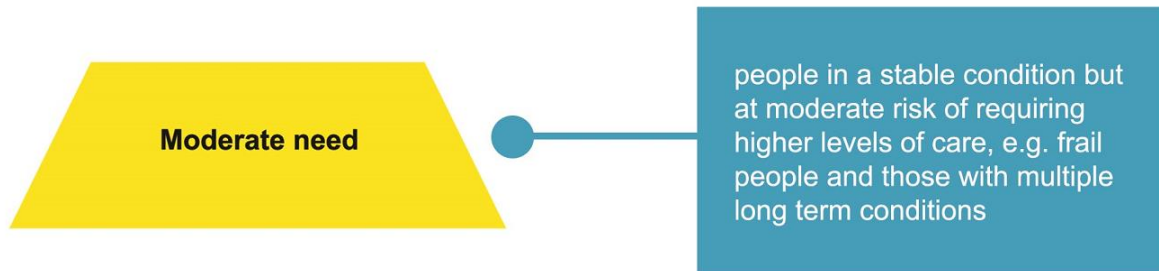
To be effective, every team needs core principles that adhere their functions, practice and delivery together.<sup>1</sup>

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<sup>1</sup> NHS England: MDT Development – Working toward an effective multidisciplinary/multiagency team: 7 January 2014

## Moderate Need

*Proactive ongoing care for people with moderate needs*



### *Definition*

#### **Proactive and targeted ongoing care**

For those people in a stable condition but at moderate risk of requiring higher levels of care, e.g. frail people and those with multiple long term conditions

By providing input in community settings to help manage care needs, support self-care, prevent exacerbations and need for tertiary care emergency intervention and help join up clinical care across primary and secondary settings, cutting down unnecessary appointments and hospital attendances.

### *Workforce requirements*

- Primary care/Extended Primary Care teams;
- Locality Integrated health and social care teams;
- Psychological support service e.g. IAPT/Steps to Wellbeing
- Early help/third sector support;
- Access to specialist support/advice

### *Location*

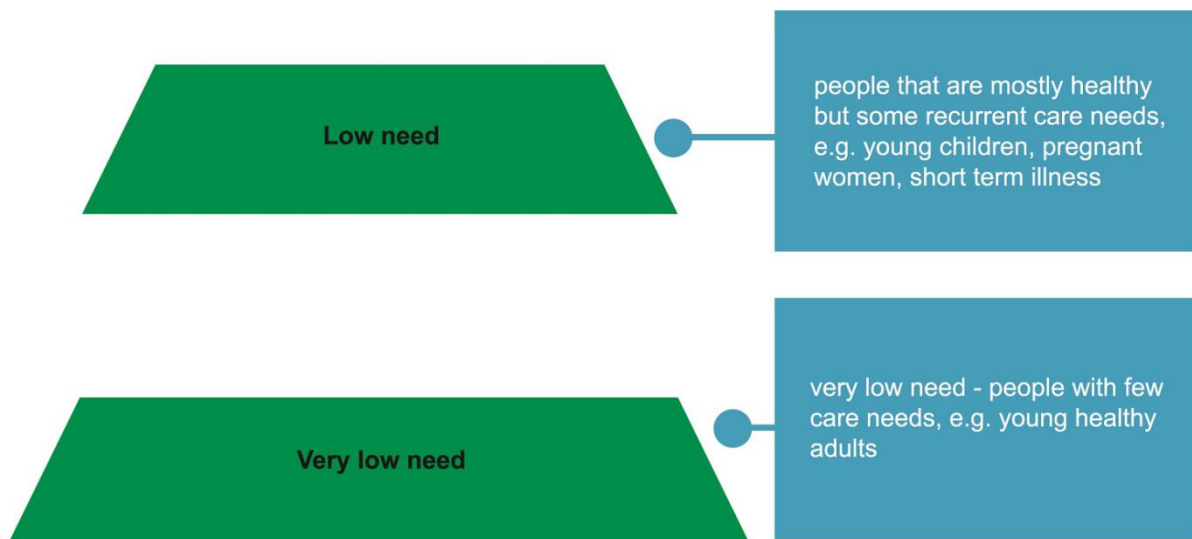
- It is expected that people will be supported to remain at home or their usual place of residence by accessing coordinated services as close to home as possible e.g. within locality/cluster area
- Early help – support, education, and signposting will be offered within local communities



## *Key features and functions for ICPS to support those with moderate needs*

- Case finding and risk stratification methods required to identify people requiring proactive care
- Named care coordinator approach to proactive assessment, care planning, intervention and review
- Person-centred, coordinated care – with personalised care and support plan documenting optimal maintenance of health and function – goal orientated rather than disease focused (support people to thrive, not just survive)
- Integrated MDT approach to proactive planned assessment and intervention
- Rapid access to the MDT team for people with medium intensity needs showing signs of deterioration/crisis
- Longer primary care consultations for individuals with multiple long-term conditions
- Named care coordinator from extended primary care team
- Trusted and shared assessments
- More focus on: Self-management (including apps/improved guidance), Telehealth, education, signposting including partnership working with the voluntary sector
- Support for carers and families
- Proactive input and support for care homes
- Access to diagnostics
- All individuals with frailty have at least an annual holistic review by their GP based on the principles of the Comprehensive Geriatric Assessment (medical, functional, psychological and social needs) with specialist support when needed. Includes identification of cognitive impairment and dementia
- Phone and email liaison approach for Primary care and MDTs to gain specialist opinions on complex cases
- Specialist presence on select MDTs (e.g. LD, mental health, diabetes specialist)
- People are able to access specialist opinions and services in the community, rather than having to go to the acute hospital for an outpatient appointment and receive care support, self-care and prevention advice
- Community Pharmacy providing medicine reviews including on discharge from hospital
- Safe and well visits – Dorset & Wiltshire Fire and Rescue

## Routine Care



### *Definition*

#### **Fast and effective, high quality, accessible planned services incorporating:**

- Routine primary care delivered by GPs, nurse practitioners, wellbeing practitioners but also using technology to provide advice at home
- Primary care practitioner focused rather than GP focused
- Delivering a focus on prevention activities with treatment advice and support. Promotion of self-management and self-care
- Primary care or community based diagnostics

### *Workforce requirements*

- Increasingly nurse focused and incorporating voluntary and third/independent sector support
- Better utilisation of GP's with Special Interest
- Social Care coordinators to be available across localities, networks and hubs, providing an interface for patients and service
- Early help services

### *Location*

- Routine care predominantly community based

## *Key features and functions for ICPS to support those with routine care needs*

- Services responding to the holistic needs of people to include consideration of social and psychological needs as well as their physical needs
- A significant focus on prevention through delivery of education, screening and the promotion of self-care and self-help activities. Focus is on primary care nurse delivered care, rather than GP delivered care, with the voluntary and Third Sector embedded in delivery of services
- Safe and well visits – Dorset & Wiltshire Fire and Rescue
- Education and group classes delivered through community based facilities such as community health centres
- Clear and accessible sign posting of services, prevention activities, education and group classes available through digital technology
- Diagnostics available closer to home and through community facilities such as integrated community hubs
- More planned care services, including low risk procedures, taking place in community settings closer to people's homes or in their communities
- Rehabilitation services available to people on their return from hospital to their normal place of residence
- Annual health checks and routine care services for those who require monitoring of their health and social care needs
  - Integrated IT and innovative use of technology to drive improvements in access to and sharing of information. Better utilisation of Telehealth, Tele-Care and digital technologies
- Clinical assessments and treatment taking place during same visit where possible and including diagnostics and pharmacy
- Access to other services co-located in a single location where appropriate
- Initial assessments taking place in primary care and only with GP if required

## **Urgent and Unplanned Care**

### **Urgent Care Centres**

Urgent Care Centres are community and primary care facilities providing access to urgent care for minor injuries and illness to a local population.

Urgent Care Centres should normally have a medical or non-medical prescriber present throughout their hours of operation. They will support the local community and provide quick competent assessment and treatment, linking to Rapid Response services.

Urgent Care Centre to be co-located within the Planned Acute Site or within community hubs. In non-co-located units use of telemedicine should be considered to develop and enhance services to prevent the need for transfer to the Emergency Department where clinically safe.

### **Urgent Primary Care**

Future blueprints are being discussed locally within Primary Care. There is the potential to “stream off” urgent primary care, providing it differently, perhaps at scale as part of a multidisciplinary approach as part of an urgent care system.

The urgent primary care offer may include a range of options for patients to access same-day care including telephone consultations, e-consultations, walk-in clinics and face to face appointments.

A clear mechanism is in place to ensure primary care takes part in the discharge planning of frail and vulnerable patients following an urgent / unplanned presentation.

### **Urgent Care visiting service**

Provided by the MDT, supporting people with very high and high intensity needs to provide an immediate response to people in the community, the aim of the service is to prevent patients, in their own home and under the care of their GP, from being admitted into hospital if they become unwell and are safe to remain at home.

Senior nurses, mental health nurses, therapists, rehabilitation assistants and social workers make up the teams. A person in need can be rapidly assessed by a senior nurse or therapist and a care plan and care package put in place to help the person remain at home. The community urgent care response team can also help in rehabilitation of people once home from hospital ensuring that people return to their daily routine as soon as possible.

An urgent care response here would result in rapid assessments by either health or social care either in the home or in a unit, and the right level of intervention undertaken. This way of working will ensure people access the services quickly and are assessed and enabled effectively.

### **Integrated Urgent Care Access, Advice, Assessment and Treatment Service (NHS 111 / GP OOH / Clinical Hub)**

An enhanced 111 will act as a Single Point of Access (SPoA) working in an integrated way with GP OOH, which will be required to use a visiting model which interfaces with Community Hubs and integrated locality teams.

Primary care out of hours services need to have arrangements in place with NHS111 to enable call handlers to directly book appointments where appropriate.

Additional clinical expertise will be available in/via NHS 111 call centre (e.g. Pharmacy, dental, MH and GPs, Dorset labour line).

Special Patient Notes (SPNs), end-of-life and anticipatory care plans are available at the point in the patient pathway which ensures appropriate care.

A Local Directory of Services that holds updated accurate information across all acute, primary care, community, and social care services including third sector organisations.

Clear protocols to direct patients to community pharmacies where these can appropriately respond to patients' needs.

### **Ambulance Service**

Maximising appropriate non-conveyance rates to ED is an important enabler to keeping patients out of hospital. By developing integrated community and primary care services, the ambulance service can become a "mobile urgent treatment service" (NHSE, 2014).

## *Key features and functions of Urgent Care Access, Advice, Assessment and Treatment Service*

- Provides access to a broad range of physical and mental illness and injury care for both adults and children for which clear pathways of care are present
- UCC open and staffed consistently for a minimum of 16 hours daily (365 days per year) – e.g. 08.00 – midnight)
- Where appropriate, provision of health and wellbeing advice and sign-posting to local community and social care services where self-referral is accepted (for example, smoking cessation services and sexual health, alcohol and drug services).
  - Provision of psychiatric liaison interventions in areas where need identified.
- Agreed working protocols with ambulance service to convey patients to UCC where patient's condition is suitable for primary care management.
- Agreed working protocols with ambulance service to facilitate rapid transfer to an Emergency Department
- Agreed escalation protocols that ensure seriously ill/high risk patients presenting to an UCC are assessed immediately and rapidly transferred to emergency centres where appropriate.
- Access to real-time support and advice from experienced doctors in primary and secondary care without necessarily requiring patients to be transferred to another service
- Agreed pathways to facilitate smooth transfer/access into other community-based and primary care services
- Integrated diagnostic facilities. Urgent Care Centres should normally have on-site plain film x-ray and blood testing, reporting and analysis.
- Immediate access to the following equipment at all Urgent Care Centres: a full resuscitation trolley; a defibrillator (this should be an automated external defibrillator); oxygen; suction; emergency drugs.
- Adopts a 'see & treat' approach (triage deemed inappropriate in UCC settings) with the aim of managing most patients within 2 hours of presentation
- Access to share and update electronic patient records – Dorset Care Record

## Integrated Community and Primary Care Services Community Care Model Outcomes

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### End of Life Care – outcomes based on national ambitions for EOLC

- Each person is seen as an individual - personalised care planning, mechanism for a person to review and update their wishes and preferences
- Each person gets fair access to care
- Each person and their family/ those close to them receive maximum comfort and wellbeing
- Care is coordinated and information is shared e.g. advance care plan
- Staff feel skilled and competent in the assessment and management of EOLC symptoms and to have honest conversations
- Families and communities feel supported and able to support those people approaching the end of life
  - **Outcomes measures developed by DHUFT in EOLC Vision and NICE Quality Assessment tool**
  - **Satisfaction survey**
  - **Primary care audit**

### Generic Community Care Model Outcomes: Admission Avoidance

- Decrease or maintain avoidable hospital admissions – for individuals with very high and high needs
- Decrease in readmissions for individuals with very high and high needs
- Staff groups are able to access the Summary Care Record and view the patients care plan where in place
- Reduction in time spent in hospital (bed days) – acute and community
- Safe transfer of individuals between acute care and community services
- Decrease in ED attendances
- Increase in number of polypharmacy interventions

## Generic Community Care Model Outcomes: Risk Stratification, Identification & Assessment and Care Planning

- System to identify frailty/vulnerable/deprived individuals in place e.g. eFI, encounter screening, triggers
- System in place to risk stratify the identified cohort of patients
- Agreed common approach to CGA in place and in use
- Universal agreement to and use of Dorset Care Plan across extended teams for high intensity users

## Generic Community Care Model Outcomes: Person Centred Care

- Individuals are engaged in decisions about their care and have a single care plan which can be shared AND is reviewed on an agreed basis
  - Care is coordinated through a single point of access
  - Each individual has a proactive care and support plan based on their needs, preferences and goals
  - A named accountable GP has overall responsibility for their care
  - Community health and social care staff work together to provide joined up care
  - A named care coordinator will make sure an individual's care is proactive and joined up
  - Individuals and their Carers are satisfied with the quality of service received
  - Individuals are less dependent on support from health and social care following an episode of reablement or rehabilitation
  - Individuals and their Carers have an improved quality of life as a result of the service received
  - Individuals experience improved function and well-being following intervention Individuals are given choice about how they manage their needs now and in the future.
  - Individuals feel able to self-manage
  - Prevention advice, early diagnosis and intervention is available – utilising technology eg Skype where available
  - Emotional, psychological and practical support is available when required - access to local community support and signposting
- **Dorset Anticipatory Care Plan completed**
  - **Quality reporting**
  - **Satisfaction survey**
  - **Number people accessing social prescription services**



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NHS England – NHS 111 Commissioning Standards (2014)

## Glossary of Terms (to be completed)

### Admission

Depending on circumstances, a patient can be admitted (to hospital) as:

- A day patient (day case) – patient given a hospital bed for tests or surgery, but will not stay overnight. This can include treatments such as minor surgery, dialysis or chemotherapy
- An inpatient – patient will stay in hospital for one night or more for tests, medical treatment or surgery.
- An outpatient – patient attends hospital for an appointment but does not stay overnight (NHS Choices)

### Advance Care Planning (end of life care)

Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs and preferences and deliver care to meet these needs. It is a structured discussion with patients and their families or carers about their wishes and thoughts for the future. <http://www.goldstandardsframework.org.uk/advance-care-planning>

### Anticipatory Care Planning

A process of discussion between an individual, their care providers, and often those close to them, about future care (NHS End of Life Care Programme, 2007)

### Comprehensive Geriatric Assessment (CGA)

A multidimensional assessment, treatment plan and regular review delivered by a multidisciplinary team. Although commonly conducted in hospital setting, there is evidence that provision of CGA to people with frailty in community settings could reduce hospital admissions.

### Discharge plan

Once a patient is admitted to hospital, their treatment plan, including details for discharge or transfer, should be developed and discussed with them. A discharge assessment and plan will determine whether a patient will need more care after leaving hospital. The patient should be fully involved in the assessment process.

### Frailty

A distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years will be living with frailty and for those people a minor event can frequently trigger major health changes or deterioration and therefore it is important to recognise and identify these changes early. (British Geriatric Society)

### MDT (Multi-Disciplinary Team)

A multidisciplinary team (MDT) is composed of members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations that facilitate quality patient care

<https://definitions.uslegal.com/m/multidisciplinary-team-mdt-health-care/>

A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations. Multidisciplinary working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers to redefine, re-scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient needs. NHS England: MDT Development – Working toward an effective multidisciplinary/multiagency team: 7 January 2014

### Mental Capacity/Mental Capacity Assessments

The Mental Capacity Act (2005) states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. You may need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone. Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, you will need to involve family, friends, carers or

other professionals. Under the MCA, you are required to make an assessment of capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be. (Social Care Institute for Excellence)

<http://www.scie.org.uk/publications/mca/assessing-capacity/>

### Minor surgery

Any surgical operation of short duration and minimal risk. Most minor surgery is performed under local anaesthesia. Collins Dictionary of Medicine

### Prevention at scale

The Prevention at Scale programme will help people to stay healthy and avoid getting unwell. Prevention is not a new idea, but with more people developing long term conditions our approach to prevention is now as much about promoting health and well-being as it is about preventing disease. We are committed to working in partnership to tackle the wider determinants of health – the complex and often interrelated factors that influence people’s mental and physical wellbeing, and in the longer term impact on their health and care needs. Our programme also aims to help individuals take control of their own wellbeing and make healthy choices that will keep them well for longer. As we plan and deliver services we will consider what effects we can have on the health of all our population. (Dorset Sustainability and Transformation Plan)

### Primary care

Primary care is often the first point of contact for people in need of healthcare, and may be provided by professionals such as GPs, dentists and pharmacists.

### Reablement

Providing personal care, help with daily living activities and other practical tasks, usually for up to six weeks, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and continue to live at home.

[\(www.communitycare.co.uk/2010/09/20/what-is-reablement\)](http://www.communitycare.co.uk/2010/09/20/what-is-reablement/)

### Rehabilitation

To help somebody to return to good health or a normal life by providing training or therapy (Encarta dictionary)

### Risk Stratification

Used to identify people with highly complex, multiple morbidity and/or frailty (and their carers), who might benefit from multi-disciplinary team support as part of case management and care planning;

- to identify and target specific service needs of patient groups, (e.g. for people with diabetes in order to improve their quality of care, experience of care and clinical outcomes);

- to identify suitable patients for the caseload of specialist nursing or medical services such as community geriatricians, community matrons or mental health practitioners for example, or for end of life advance care planning, use of the Electronic Palliative Care Co-ordination System (EPaCCS); or to reduce unnecessary unplanned admissions. <https://www.england.nhs.uk/wp-content/uploads/2015/01/2015-01-20-CFRS-v0.14-FINAL.pdf>

### Secondary care

Secondary care, which is sometimes referred to as 'hospital care', can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture

### Specialty Doctor

Specialty Doctors are doctors and dentists who generally work within one specialty, invariably in secondary care, under the supervision of one or more Consultants. (BMA definition).

### Unplanned care

Urgent and emergency healthcare which is not a programmed (scheduled) activity

### UTI

Urinary Tract Infection: Infections of the bladder (cystitis) or urethra (tube that carries urine out of the body) are known as lower UTIs. Infections of the kidneys or ureters (tubes connecting the kidneys to the bladder) are known as upper UTIs. UTIs occur when the urinary tract becomes infected, usually by bacteria. In most cases, bacteria from the gut enter the urinary tract through the urethra. (NHS Choices)