Nuffield Road Medical Centre

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Minutes from Patient Group Meeting January 15th 2015

Present; Kirsty Trigg Chair, Tony and Jennie Jenks, Michael Dawson, Greta Evans

Apologises; Nasreen Bawa, Mr and Mrs Le Witt, Suzanne Christie

Minutes; from Meeting 16th October 14 – agreed

Greta was able to update the group on;

Uniting Care Partnership, The Older Peoples programme.
UCP are looking at providing 18 Neighbour hood teams to provide community staff. UCP are currently working to map the 18 neighbourhood teams against GP practices, taking into account patient populations, social care clusters and deprivation scores. We are also working out the clinical team requirements to fit the 18 neighbourhood teams.

EHospital;
Although there are still problems with ehospital and the letters and results being sent, the situation has improved greatly. Addenbrookes are working hard to resolve the issues. The problems did have a major workload impact on the practice.

Cam Health;
Unfortunately neither Greta nor Kirsty had been unable to attend the last cople of meetings. Cam Health is still working hard on various projects, looking at the plans for 15/16. It is still hoped that the Alzhiemers support woker bid is progressing.

Greta informed that group that she will leave the practice at the end of May. The partners are starting the recruitment of a new practice manager in the next few weeks. Greta has been with the practice since August 1993.

Guest speaker Jennifer Abel Lead for the SAFE team at Addenbrookes Hospital.

The SAFE team seek to provide integrated support to all frail elderly irrespective of presenting complaint and location within the hospital who are not otherwise receiving specialist Department of Medicine for the Elderly input. This would allow patients to be supported along their whole pathway from the point of admission through to discharge and integrate with community services.

This will be achieved through these key interventions:

- Operating a 7 day service, including bank holidays.
- Provide early assessment for all patients aged 75+ (or otherwise identified as frail) who attend between 08:00 and 22:00 within the emergency department
- All patients aged 75+ will be reviewed on the ward by a SAFE team practitioner within 24 hrs of admission if:
  - They are identified as having ongoing needs by the SAFE team in the Emergency Department
  - Have not had a review by a SAFE team practitioner so far during admission.

- All frail patients identified at pre-operative assessment will be given a bespoke perioperative plan of care. This will include pre-habilitation, anaesthesia, analgesia, rehabilitation and discharge planning.

The benefits of this are:

- Initial assessment by SAFE team may facilitate immediate discharge for a patient by a specialist practitioner owing to better intelligence regarding their baseline, or greater awareness of out-of-hospital support.
- Early mobilisation, and early initiation of long-term planning, capitalises on the initial window of opportunity and reduces the risk of de-conditioning due to prolonged admission.
- Early intervention by a SAFE specialist facilitates discharge at the earliest possible point in the admission and drives down length of stay.
- Enhanced communication with relatives and community services, along with more robust discharge planning, reduces the risk of re-admissions - especially where previous discharge plans have proven inadequate.
- Future admission avoidance plans may be suggested and communicated with community staff. This may include:
    - Discussions around preferred place of care and the Gold Standard Framework in line with national palliative care strategy. This facilitates future provision of care in a more appropriate environment, possibly avoiding admission to the acute sector. It also empowers patients to decide how they are managed.
    - Liaison with community specialist services.
    - Escalation policies can be devised for anticipated events e.g. recurrent seizure or asthma attack, which may enable them to be managed in the community.
- Awareness of other specialist services.
- Supporting patients in-situ, and only transferring those with the very highest need to DME beds, improves the quality of experience and avoids the negative impact of multiple moves highlighted by the King's Fund.
- By engaging with medical, nursing and allied health professional teams on non-DME wards, the SAFE team is able to provide training and support. This increases the skill base of the whole workforce and will embed skills at managing frail elderly and complex discharge planning in practitioners outside the current DME bed base. The overall result being the provision of excellent and dignified care to older patients throughout the entire Trust.
- Maintaining lists of patients waiting for community services (e.g. rehabilitation or interim beds) and undertaking regular review of ongoing suitability reduces inefficiency, increases utilisation of these resources and reduces delays in transfer of care.

Date of next meeting; April 16th 6.45pm

Meeting closed.