Borth Medical Practice

Multi-agency Primary Care collaborative working

Dr Sue Fish - General Practitioner

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**Introductions**

I am Sue Fish and I'm a GP in Borth surgery and I was the project lead for the Bevan Commission exemplar, planned care project.

My name's Claire Bryant. I'm an Advanced Nurse Practitioner and the clinical care co-ordinator for the Borth multi-agency team.

**Identifying the unmet need**

Sue: I was very aware there were a lot of different ways that organisations work together, a lot of different multidisciplinary teams happening, but they were all working in silos, and we needed to develop a more proactive patient-centred way of working. We set up the Borth multi-agency team and stopped a number of these different multidisciplinary teams and held it together as one meeting.

Claire: I was employed as the clinical care coordinator for this project to help develop and facilitate the multi-agency team meetings.

Sue: There was quite a long lead in time to the project prior to Claire being appointed. It took about a year of work, and it was around identifying what multidisciplinary team meetings already existed and working through our networks and building relationships with individuals to get them to see that we could try doing it different and in a more patient-centred way.

**Developing the concept**

We're a GP practice, so we don't have patients accessing our services. We have a population that we look after. Anybody that is registered with us in the surgery has the opportunity if we feel it's appropriate to either attend or being discussed at the multi-agency team meeting. But we also allow any member of the multi-agency team to bring a patient they think would benefit from discussion to the meeting to be included on the agenda as long as they're registered with us in Borth surgery.

Claire: What we've been able to do because we're focusing on the surgery population is we've been able to focus in a preventative, proactive way to find out what's important to the population. By me working within that facilitatory, clinical care coordinator role and engaging in building relationships with the population who often are also working within the area and as well as registered within the area because we're a rural practice. Then finding out what's important and how we can proactively support people in a multi-agency way to prevent crisis from happening, being very patient-centred and working on individuals' needs. Rather than thinking about a referral process, it's very much about building relationships and understanding what's important to people and how we can meet their needs. For the project when we started working in this multi-agency team way, we focused on certain cohorts of people within the population, and we were able to work in slightly different ways depending on what people's needs were. Particularly for the more older frail population, I was able to go and meet people at various different events within the community but also at times where they were coming in for annual reviews within the surgery and find out what was important to them and what their concerns or issues might be and then invite them into the multi-agency team to come and tell us what was important to them.

That was fundamental to work that way, to really understand and listen to what the population's needs were and what individuals' needs were in a person-centered way and then support them in a multi-agency team way, often supporting them with other members of the community in third sector organisations and then obviously using organisations such as local authority, health, nursing, doctors and other healthcare professionals. That was one way of us approaching the access to the multi-agency team working and then the other which I think is really important because when we talk about our outcomes that was something we were able to demonstrate very well was around looking at people in the population who had been admitted to hospital and focusing on their needs at the point of admission as opposed to at the point of discharge. And that's changing the way that we work, that's looking at thinking about things in a slightly different way and focusing and bringing together that knowledge base from the community into secondary care and having those conversations early and building up those relationships. I think that's fundamental and key in changing the way we're working to keep in a person-centered way to improve the population's outcomes and also prudent healthcare and delivering prudent care.

Sue: I think it's also important to add the importance of having a person whose job it is to become clinical care coordinator because they're able to ensure that the actions that people are doing for that person are actually being put in place and also having the outcomes for that individual that we want them to have. As GPs we’ re very busy, we have seen a lot of people during the day and we're not able to keep such a focus on whether everybody is doing what they've said they're doing to help these people.

Claire: Having a clinical care coordinator employed in primary care is fundamental to changing the way that we work, to staying patient-centred and to work in a preventative and proactive way.

Sue: Because they're employed in primary care, we don't have to worry about do they meet the criteria for referral because they are our patients anyway. We can be very reactive because we don't have a process, they have to go through that could take several weeks to actually being part of that team. Also, we have access to their patient records. We have a lot of knowledge about their various health conditions.

**Identifying local population needs**

Claire: We have an older population compared to the national average within this area and also rural, so higher farming, rural population. There are different challenges and different needs compared to perhaps an urban practice. I would say that there is a whole array of individuals needs and it would be impossible to focus, specifically on a need. But what I would say is by working in this way, what we're able to do is we're able to prevent a crisis happening. We're actually able to act and support individuals in their needs and what's important to them and almost stop something happening in the future, be it a fall and a fractured hip, be it gradual deterioration and not being able to cope within their own home, whereas that's what they want to do. I wouldn't say that there's one specific area that we can focus on, it's very much a multi-agency approach and trying to prevent this silo working and us focusing on the person that we're helping and supporting as opposed to thinking about us within our roles or within our organisation is bringing it back to the person.

Sue: What the demographics show is that we have a lot of fit older people in North Ceredigion. If you compare it to South Wales, our patients will always report much better health and they have a longer length of life, but they become frail elderly and they are late presenters to the health service. By us working across health, social care and the third sector, we can all work together to identify people's needs earlier and support people to maintain their independence as long as possible. We looked at the various groups as Claire has mentioned, not because we were categorising people that only those groups could come, but it allowed us to look at the different groups and the benefits to those individuals that were attending the multi-agency team meeting.

**Benefits to the system**

We also surveyed the health professionals that were part of it. The health professionals found it very beneficial. They enjoyed being able to treat the person holistically. They enjoyed feeling part of a wider team discussion with that person and we're hearing the benefits from their perspective all the time and they waste a lot less time on the telephone waiting for people to phone them back. I suppose one thing we haven't mentioned is that the criteria for the meeting is that we have an hour slot once a week when we discuss these patients and everyone knows that at two o'clock on a Wednesday afternoon it's the Borth multi-agency team meeting. We keep things within the hour. We can adjust the agenda so that we don't overrun and that's the only restricting factor on how many people we discuss.

From the hospital inpatient's point of view, we have shown that we have significantly and statistically reduced the length of stay of the patients that are in hospital and that then allows them to come home with more independence because they're not staying in hospital for as long. The complexity of the social care packages that our patients are requiring is less than in other surgeries. We have looked at the increase in referrals to the third sector and the involvement of the third sector in supporting those people, which has increased significantly. The primary care appointments in that the frail elderly which were that we discussed, we identified because they were high users of GP appointments that we were able to demonstrate over time as the other people, quite often the third sector were able to put in additional support, combat loneliness, that sort of thing with these people. Their requirement for visiting the GP fell off as well.

**Benefits to the multi-agency team members**

Claire: From the members of the multi-agency team involved, we sought feedback from them through surveys and also through a discussion. The feedback showed that a really positive response to working in this multi-agency team way everyone felt that they're part of being part of the team was as important as everyone else. There was this shared ownership of what we were doing. Everyone felt that they were making a difference to people within the population. Everyone reported time saving. They felt that what they were able to bring to the multi-agency team and discuss within that hour meeting saved them from multiple hours of contacting people individually to find out information to share. It was about having that space, that forum, to speak and to work in a coordinated way and be very focused. Facilitating that meeting as the clinical care coordinator and making sure that it was smart and specific and focused was very much a key part of my role and something that was fed back from everyone that was involved, that that was really important for the positive experience of working in that multi-agency team way because we're all very, very busy. We're all working within our organisations, but we were able to, and we are still able to keep person focused and keep to that time with a set agenda. That was really good. The outcomes from people that were involved was very positive.

**Benefits for patients**

Then most importantly, the people that we're here to support and the feedback from the people that came in, we focused specifically on the frail elderly population who actually came into the meeting and told us what was important to them. We asked them for their feedback and the feedback from them was mostly positive. I think the important learning for us was that what we thought was going to be really helpful by them coming into the meeting and telling us what was important was some people found that really intimidating. I think a really big learning for us was that what we think is going to be important to people or helpful to people isn't necessarily always. My role as the clinical care coordinator changed slightly in the fact that now I advocate more for people. I will go and speak and meet and talk to people and invite them to come to the meeting. But a lot of the time people are happy or would rather meet advocate for them at the meeting rather than them attending. It's an evolving process, but the most important is it's patient-centred, it's proactive, it's preventative, and it's all of us working together in a shared way to support the population.

**Lessons Learned**

Sue: The main lesson is that it works, and we didn't find anyone that we looked at or any group of people that we looked at for which it wasn’t beneficial. People have felt from working in the service that they feel far more valued and that they enjoy their job a lot more because they come from the patient point of view, it gives them, meets their needs, gives them the support, keeps them independent. It reduces, we're all very busy and we've all got very heavy workloads. It's by giving up one hour's time to all sit in a virtual space, because we run the meetings on Teams, because we're a rural area, we're not all in the same building. It's worked very effectively doing it this way by sitting in that virtual safe. It saves us all time in the long run. It is very slow to roll out across Hywel Dda, which is the health board that we're in. We had rolled it out to one their GP surgery, which we did during the duration of the project. There are plans to roll it out to a third surgery, but it requires investment in general practice in order to do it. It requires somebody who can dedicate their time to be in the clinical care coordinator to really see the benefits and the cost saving that comes out of it. We are going to go to the Hywel Dda board meeting next week to discuss it as well. But it needs to roll out faster if other people are going to benefit from it.

**Conclusions**

We've established an hour-long multi-agency team meeting that has representatives from health, primary care, secondary care, local authority, third sector, patient representation and advocates to discuss proactively what the needs of the patient are and how we can best address them.

Claire: We've been able to develop a different way of working in the community, which is patient-centred, which focuses on individuals' needs and what's important to them in a proactive and preventative way, coordinating and disintegrating silo working in a one-hour meeting that is focused and that results in multiple actions that then see positive outcomes for the population and is encouraging a different way of working to prevent crisis from happening.