

## Newquay Pathfinder Project

### Strategic Context

Cornwall and the Isles of Scilly have been adopted as an integration pioneer site. Fifteen organisations from across health and social care have made a commitment to transform the way health, social care and the voluntary and community sector work together. This is about relieving pressures on the system, making sure patients are treated in the right place, and preventing people from falling through the gaps between organisations.

The local prevention strategy is informed by a model promoted by the Institute for Healthcare Improvement in the USA, known as “Triple Aim”:  
<http://www.ihl.org/offerings/initiatives/tripleaim>

The development of the strategy will involve using the learning from a number of small-scale pilots, one of which is the [Newquay Pathfinder project](#). You can also view a short [film on the Pathfinder project](#) via YouTube. (approximately 14.47).

### Development process

The Newquay Pathfinder initiative began in June 2012.

The Pathfinder was originally funded by pump-priming from national Age UK, of £100,000. Two staff were employed by Age UK Cornwall who are called **“Promoting Independence Practitioners” (PIP workers)**.

A decision was made to pilot the approach in one practice. A steering group was created to deliver the Pathfinder, including a GP champion, Age UK, community health operational leads, and health and social care commissioners. A sub-group became responsible for developing the performance framework (see below).

The process began with defining the desired outcomes, using a social investment approach. The partners wished to test the hypothesis that this model of integrated care would:

- Help people achieve a better quality of life;
- Enable providers to be much more effective, and work together more co-operatively;
- Reduce activity and spend across the whole health and social care economy.

Work was undertaken (using data analysis) to understand which population groups and conditions to target, to maximise “return on investment”. This helped the GPs and other professionals with risk stratification; the scheme now targets people who have at least two long-term conditions that could be managed in a community setting, plus a “high risk of hospital admission.” But ultimately the staff have used their professional instincts and knowledge – for example, to identify people who frequently attend the surgery or hospital, for reasons that include multiple health and care issues, low-level depression, social isolation and potential carer breakdown.

### **The approach**

The initiative describes its approach as “case management in a peer-support model”.

The key feature of the initiative is a multi-disciplinary team approach within the practice, including highly-trained volunteers.

There is a “complex care team” which comprises doctors, the district nurse, the community matron, the primary care dementia practitioner, a social worker, the practice nurse, and Age UK. Fortnightly practice meetings are held, with Age UK workers and highly-trained volunteers (all described as “practitioners”) being considered as full members of the team.

Where people are identified as being at risk, the Age UK worker (or volunteer) visit to carry out an informal “guided conversation” which may cover many different aspects of the person’s life. (The conversation is “guided” by the person, not by the professional). The emphasis is on identifying people’s own goals and ambitions.

A plan is then developed to help the person resolve their health and wellbeing issues. There is an emphasis on helping people to access “free” resources such as local clubs to reduce their isolation - but where there are more complex health or care issues, the practitioners can make a straightforward referral back to their colleagues in the multi-disciplinary team. Many people receive falls prevention support, join exercise groups or find other ways of getting exercise. All have information and advice about benefits, to maximise their income. New resources – such as organised coffee morning and shopping trips – are set up. Ultimately, the solutions vary from one individual to the next,

with people being linked to activities that appeal and will make a difference for them.

### **Volunteer development**

The scheme benefits from having some highly trained volunteers, and this is one of the important building blocks. Some of the Age UK volunteers are qualified “health champions” and/or know how to look at health and safety issues within people’s homes, and source simple aids and equipment. An initiative called “Steady On” is training people to be training buddies – visiting older people and helping them exercise. Some volunteers are trained in “motivational interviewing” and cognitive stimulation techniques. In developing its volunteer development programme, [Age UK](#) works closely in partnership with [Volunteer Cornwall](#), which is achieving excellence in many areas:

### **Culture change**

The practitioners involved in this initiative all emphasise the importance of establishing a very different relationship with the people they serve – putting the patient at the centre of their own support. There is a strong emphasis on identifying and developing people’s assets – *“addressing the person rather than the symptom”*. The lead GP describes this as *“helping to support our “caring” community to prioritise the patient’s wishes – giving them permission to let go of the protective shell we put around people”*.

This changing professional ethos also involves letting go of hierarchical professional attitudes - so the team work together and feel able to challenge each other.

The impact of this change is illustrated in the video produced for the initiative, which reflects the perspectives of both the customers and the practitioners in the scheme.

***“Before I met young Caroline, it was getting boring and very lonely. Living so long...I needed more to interest me. A few calls daily from carers where they’ve no time to be bothered with you, wasn’t enough. I wanted people to talk to”.*** (Customer)

***“Some of the people we’ve worked with are supported by agencies 3 or 4 times a day, and they’ve had that for 10 or 15 years, and that’s the way their life is. It’s very difficult then to motivate them and try and encourage them to change the way their life is. Where people have had something happen to them more recently – like a bereavement or episode of ill-health - there’s a lot more opportunity to get in early and do things differently”.*** (PIP worker)

***“I’ve worked in the NHS most of my life. It’s been great to work with different people, especially Age UK, and get an “outside NHS” perspective”. It’s been absolutely brilliant – learning and developing our knowledge, to help people in the community gain resilience”*** (District Nurse)

***“For me personally it’s been really educational. I’ve really been encouraged to look at patients where I thought their dependency levels would only***

*increase, and see that actually (...) they can be encouraged back to a much lower level of dependency". (General Practitioner)*

## **Evaluation**

The scheme – which received initial funding of £100,000 (as above) has so far worked with 130 people. A very early evaluation – based on a small sample of 25 people – suggested a £4.40 saving for every £1 spent. However, the performance monitoring group know they need to develop their method and assess the results on a larger scale before they can confirm this conclusion.

Their emerging method is described below.

First, data is routinely collected relating to:

- People's reported **health and wellbeing** (using questions based on the Warwick/Edinburgh tool);
- **Staff satisfaction.**

In both these areas, there have been impressive results in the early stages (such as a 23% improvement in people's reported health and wellbeing, and high staff satisfaction – albeit within a very small team).

The group is also developing a method for assessing **reductions in activity (and associated costs)** across acute services, primary care services, community (including mental health) services and social care. Anecdotally, practitioners are confident that the Pathfinder group are making less use of expensive health and care resources; for example,

they pay fewer visits to the GP. The performance group is now exploring how to measure this more rigorously.

For an initial evaluation, the group looked at services received six months before, and six months after, the Pathfinder intervention and did find reductions in service useage. For example – there was a very significant reduction in non-elective hospital admissions for the first cohort of 25 people, plus a reduction in demand for social care packages.

The group has since developed this work, to try to compare the costs of the services received by this group with those expected for people with similar needs across the county. Retrospective analysis was done of the typical rate of non-elective hospital admissions for people with long-term conditions; this was translated into a cumulative cost projection (using the estimated unit cost of a hospital bed day). Looking at the cohort of people admitted to the Pathfinder scheme in its first year, their use of hospital was 40% lower than might be expected – and the cost of their ongoing social care packages was 5.7% lower – with a marked reduction in the rate of new social care packages. (This analysis was, however, complicated by the difficulty of establishing whether the Pathfinder group had the same level of need/risk as the wider comparator group).

The performance group believes this type of analysis might be possible for other interventions (such as GP attendances), although the limitations of the method, data and associated systems are acknowledged.

In the context of their “integration pioneer” mandate, local partners will be using this work as a foundation for the development of:

- Shared predictive modelling tools
- A single outcomes framework
- A shared hub for intelligence (with new information governance arrangements and shared personal records)
- An integrated performance monitoring framework.