Latest news from Principia

December 2016

This document provides an update on the work of the MCP and progress and impact since November 2016. Since our last update, the MCP has:

- Received confirmation of an allocation of £3.530m from the New Care Models programme to develop and scale the Principia MCP during 2017/18
- Received feedback on its first local metrics data submission
- Welcomed Mark Holmes from Healthcare Trust - seconded two days a week to Principia and working on developing the mental health 1within the MCP model
- Received Integrated Care Pioneer funding to implement a Disability Sport Rehabilitation pilot for 12 months
- Achieved a reduction of 3.3% below plan in GP referrals to first outpatient appointments through PartnersHealth peer to peer reviews of clinical variation
- Received the Greater Nottingham Health and Care Partners Accountable Care System design phase two report
- Commenced planning with PartnersHealth GPs on the delivery model for increased access to GP services from 1 April 2017, as one of a number of accelerator sites across England
- Received a first quarter performance report from the Primary Care Psychological Medicine (PCPM) Service which launched in September 2016 showing 64 appointments were provided during the service in its first three months
- Received an update on the progress made by the Continuing Health Care – interim home care pilot since mobilisation in late November 2016
- Received confirmation from Pritti Mehta at the New Care Models Programme that Principia has been successful in its bid for additional support as part of the empowering people and communities (EPC) workstream.
- Received data showing that GP referred outpatient first attendances for Trauma and Orthopaedics are 235 referrals below plan at month seven (October 2016), representing a 17.4% reduction in acute activity. This equates to £347,800 based on average referral cost.
- Received data showing that the development of a community gynaecology service has reduced outpatient first attendances by 312 referrals below plan (at month 4), representing a 20.6% reduction. This equates to a secondary care saving of £105,456 based on the cost of an average referral.
- Attended the Early Adopter Orientation day for the Integrated Personal Commissioning model in London on 6 December to progress implementation of the IPC approach.
- Received an update from the Connected Nottinghamshire programme which supports MCP enabling workstream 11 (appendix 1)

- Produced resources for practices to display supporting the expansion of the One You campaign to include winter self-care messages and responsible use of NHS services (appendix 2)

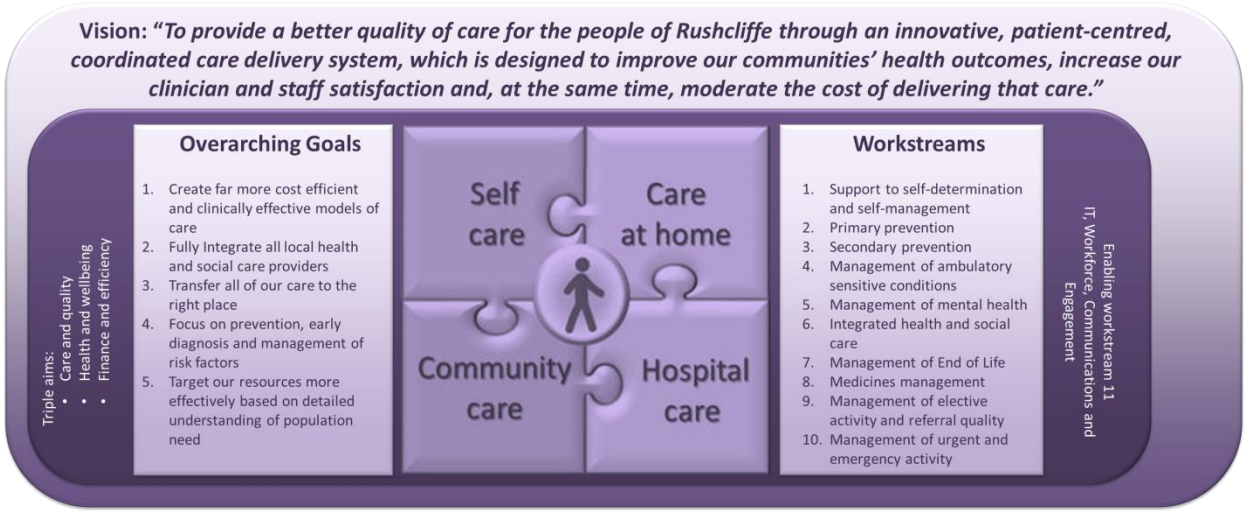
Principia MCP key facts:

1) Awarded £3.53m in June 2016 to support the development of its Multi-specialty Community Provider (MCP) model of care during 2016/17.

2) The MCP Vision is: *"To provide a better quality of care for the people of Rushcliffe through an innovative, patient-centred, coordinated care delivery system, which is designed to improve our communities' health outcomes, increase our clinician and staff satisfaction and at the same time moderate the cost of delivering that care."*

3) Our ambition is to create a care system which is re-organised and out of hospital, founded on best in class with increased capability and capacity, working in partnership with other providers in a culture of mutual accountability and commitment and bringing benefits to all. The MCP will be accountable for the health care provision for the local population. Risk will be mitigated through the empowerment and involvement of primary care, patients and local providers.

4) Delivery through 10 workstreams - each with clinical leadership and aligned to five overarching goals and triple aims:



Progress and Impact

1. Increased access to primary care – accelerator site

Increased access to GP services will be commissioned from 1 April 2017, across Rushcliffe as one of a number of accelerator sites across England.

NHS England requires us to ensure the population is provided with access to same day and pre-bookable routine appointments outside of core hours (8.00am-6.30pm) during

weekdays and weekends. For urgent care needs, patients should still access out of hours services.

The MCP is currently in the planning phase with PartnersHealth to develop the delivery model which will need to ensure ease of access for patients including: all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services.

Following agreement on the model, a communications plan will support implementation to ensure that services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community.

2. Reduction in GP first out patient referrals through peer review

Peer to peer reviews of clinical variation in first outpatient referrals established by PartnersHealth have continued to support Rushcliffe GPs in reducing referrals which have been consistently below plan for the last 3 months. Averaged across all 12 practices outcomes show a reduction in both elective first outpatients and clinical variation – with GP referred first outpatients down by 527 referrals in October 2016 representing a performance of 3.3% below plan.

A GP referral triage pilot was explored as a mechanism for further reducing referrals but did not provide return on investment. Therefore focus will remain on the successful peer review approach which has also seen improved relationships and accountability between PartnersHealth GPs.

3. Continuing Health Care – fast track home care pilot early results

This service went live Rushcliffe from 21 November 2016. Early data shows that there are currently 11 patients on caseload as at the end of December through referrals obtained from community and acute sector partners. At least three patients have been discharged from the service following review. A patient case study demonstrating the impact of the service is attached as appendix 3**.**

4. Medicines management

Latest analysis shows the implementation of the Optimise RX prescribing system across Rushcliffe GP practice is expected to deliver twice the initially predicted return on investment – with expected savings of around £80k.

The Electronic Medicines Administration Record (eMAR) system is due to roll out in two Rushcliffe care homes as part of an evaluation pilot. This will allow care home staff to access the medicine regimes of residents – detailing the medications they need and when they need them. This helps medicine rounds become a simpler and quicker and improves safety through reduced risk of administration error. The University of Nottingham will provide the MCP with evaluation of the impact data and outcomes.

In addition, a pilot site is in the process of being identified for the launch of a repeat prescribing POD (prescription ordering direct service) and a pre-reg student has been

appointed to start in July 2017 as part of the hospital/community pharmacy pre-registration placement initiative to develop primary care pharmacist skills from outset of professional training.

5. Empowering people and communities (EPC) application success

Principia submitted an expression of interest in receiving additional support from the New Care Models Programme as part of its Empowering people and communities (EPC) workstream and has been chosen as one of nine 'intensive MCP sites' nationally to take forward this agenda at pace. The workstream aims to support vanguards in delivering two key sub-elements of the MCP and PACS frameworks and the corresponding implementation grid:

- **Build public health through community engagement:** clinical services alone have a limited impact on the health and wellbeing of a population. There are a range of social and economic determinants that make a significant impact on an individual's health. An integral part of the care models are community engagement in community health as both a preventative measure and to offer non-clinical community support for patients;
- **Support self-care and patient activation:** people living with long term conditions who are engaged in managing their own health and wellbeing enjoy a better quality of life and make fewer unwarranted demands on formal services than those who are less engaged.

Two groups of 'intensive sites' are being established to offer rich learning and development opportunities along with additional national support. Principia will attend the first meeting on 18 January to start to deliver against the programme objectives of:

- Implementing nine key actions, over a 12-18 month period with the support of national team;
- Demonstrating 'what works' (and what doesn't) and sharing the learning;
- Developing the scaling or adaptation of what could work and be adopted in other communities in partnership with the national team.

To support Principia in this work the national offer will provide:

1. Specific support from the EPC delivery team focussed on the implementation of these key actions. A timescale of activities is also outlined below;
2. Provision of the patient activation measure for its population cohorts;
3. Increased opportunities to accelerate delivery and learn and problem solve directly from other vanguards in this cohort;
4. Increased opportunity to profile development of its person and community-centred approaches at regional events and communities of practice meetings as well as;
5. Opportunity to develop elements of the EPC support offer to other vanguards in partnership with the national team.

6. Fracture Liaison Service (FLS) – roll out.

In December 2016 the South Nottinghamshire County CCG FLS was launched. The service, which was originally just for Rushcliffe patients, has been extended to cover patients in Nottingham North and East and Nottingham West. The service was commissioned to provide a total of 354 iv zol infusions, (based on National Osteoporosis Society calculator of likely number of cases) for this population of patients, for those presenting with first fragility fracture.

There is a FLS team of community nurses (1x WTE Band 7, and 2.8WTE Band 6) and x1 WTE admin support. There are some established bases now in each CCG. Capacity of the virtual clinic has doubled, and now involves a hospital specialist osteoporosis nurse with the Consultant providing overall clinical responsibility.

The community team operates from its base in East Bridgford Medical Centre, where the lead GP is involved in running the community arm of the service. The extension of the service to cover the additional CCGs has resulted in an annual cost reduction for Rushcliffe from £120.6K annually to £96.2K.

Referrals are being received from all 3 CCGs via virtual clinic and directly from primary care.

Although the service has been primarily commissioned to intervene at first fracture, the established links between primary and secondary care has enabled additional service developments at currently no additional staffing costs:

1. Facilitating discharges form secondary care-cohort of patients with established osteoporosis who have been attending regularly for iv zol infusions-these are now been discharged from OS clinic into primary care for follow up by the FLS.
2. All referrals to Clinical Assessment Service are being directed to the FLS with initial advice is provided by community fracture liaison nurse, who can escalate to hospital specialist nurse and to the hospital Consultant where appropriate.
3. Requesting GPs refer all queries /referrals for ‘osteoporosis’ via the specialist referral template on Systemone.

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Appendix 1 – Connected Nottinghamshire December Newsletter

Latest News December

2016 - Issue 4

Vicky Bailey

Rushcliffe CCG Chief Operating Officer & Programme Owner

.....our December 2016 newsletter which provides you with a snapshot of our 2016 IT Summit, which took place last month, and all of the news about progress in Connected Nottinghamshire. A full report of the Summit is now being put together, which will be shared with you all very soon.

As we approach the end of the year, we're pleased to say that many of the Connected Nottinghamshire core interoperability projects are also approaching their final stages of delivery and in this month's newsletter we have provided a summary of each project and its progress.

Andy Evans

Programme Director

Savi Cartwright

Programme Manager

Dr Ian Trimble

GP and Chair Executive Committee

"It's not about "more things" - it's about getting people to know, learn and use what we have." That was the rallying call from **Vicky Bailey, Senior Responsible Officer for the Connected Nottinghamshire programme** as she closed a hugely successful 2016 Summit last month.

The theme for the whole event was about enabling technology to support the delivery of the transformation plans for health and social care across Nottingham and Nottinghamshire.

The Summit heard from **David Pearson, Lead for the Nottinghamshire Sustainability and Transformation Plan (STP)** who stated that health and social care services together faced a challenge to improve the healthy life expectancy of local people within increasingly constrained budgets. David said, "We are very lucky to have one of the best Local Digital Roadmaps in the country here. And we need to take full advantage of this, as well as support the benefits technology brings with other interventions such as prevention."

What did the Summit discuss?

As well as the big picture strategy, which set the scene for the day, the Summit focused on the practical delivery of innovation from amongst more than 150 projects currently being delivered across the Connected Nottinghamshire partners. Here's a summary of the presentations and workshops from the Summit.

Community Portal

Dr Mike O'Neil

GP and SIRO

Councillor Alex Norris

Portfolio Holder for Adults, Commissioning and Health

Councillor

the Community Portal and how it is starting to help transform care in acute medicine services at the Trust.

Whilst the focus was on the developments in Acute Medicine, the Portal is also being piloted in Pharmacy at Sherwood Forest Hospitals, in Accident and Emergency at Nottingham University Hospitals and with two local GP practices, as well as potential expansion to include Nottinghamshire Healthcare services.

Jeremy Lewis, consultant in Acute Medicine at Nottingham University Hospitals, explained how the Portal enables a range of additional data to be incorporated into the electronic patient record, accessible to clinicians through the existing clinical systems. As well as avoiding different information being in different places, this also means only one log on!

More information about the patient, including current medications, recent hospital and social care contacts and support, with test results available to clinicians at the touch of a button, means the clinical teams in hospital can make more informed decisions.

The future development of the Portal is to integrate social care and mental health care information; it will also be a key enabler to achieving a paperless clinical environment by 2020, one of the national standards for digital technology.

The Summit packed in discussions on the benefits of digital technology which are being demonstrated in other Connected Nottinghamshire projects including:

Muriel Weisz

Chairman of Adult Social Care and Health Committee

Councillor Alan Bell

Vice Chair of Adult Social Care and Health Committee Member for Mansfield East Division

in planned care services at Sherwood Forest Hospitals is being used to trigger pre-operative/pre-intervention discussions for discharge.

This project is building the information delivery around the clinical needs, supported by direct clinical involvement to deliver projects at pace.

Recap

Recap is supporting data and information sharing amongst allied health professionals resulting in a consistency of approach and supporting the delivery of integrated services.

GPRCC

Sharing patient data across health and care services is supporting identification and effective holistic management of patients with long term conditions, through end of life care, or at high risk of hospital admission.

TPP EPR Core and Medical Interoperability Gateway (MIG)

As part of the wider project to integrate patient data, this technology is providing access to patient records in real time for the wider teams providing care across primary, community and hospital care.

Assistive Technology

This technology covers everything from devices people wear to monitor or diagnose their condition, to telemedicine and diagnosis, health apps and access to information to support better health at home. Implementing this technology where it has the most benefits to patients, will significantly transform

Benefits Realisation/Change Management toolkit

Connected Nottinghamshire, working with Nottingham University Hospitals NHS Trust, is developing a toolkit to support all digital projects to follow a systematic process, focused on identifying, tracking and most crucially realising the benefits from each technological development.

The toolkit is now available to support teams currently planning their project or programme as part of the overall change management approach that Connected Nottinghamshire is developing with its partners.

Development of the Local Digital Roadmap

Andy Evans, Programme Director for Connected Nottinghamshire, closed the Summit by explaining that the LDR is a catalyst to unlocking a range of further support and resources to make the changes local patients need over the next five years. The Nottinghamshire LDR includes bids to NHS England for funding totalling £80 million to support this work; the likely scale of funding awarded to Nottinghamshire is due to be confirmed over the next few months.

Andy explained the recent history of the LDR and its development to focus on five main workstreams:

Access to information for patients and the public

Digital maturity

Assistive technology

Infrastructure

As a result the LDR development won't stop and the delegates at the Summit spent the afternoon discussing, debating and developing ideas to keep the LDR moving forward in 2017. This process of sharing ideas and having direct input into the priorities, the way that the LDR is delivered and the projects that are taken forward, has been developed over the last two years, with the annual Summit the occasion where it all comes together.

Round-up of other news

There has been a lot of activity over the last few months with some major projects are now approaching delivery to local clinicians and patients.

The Medical Interoperability Gateway (MIG) project has completed a one month notice period with Nottinghamshire GP practices to enable an additional End of Life supportive care dataset to be available to be included. This additional dataset will also include any free text a practice may have entered against those codes too.

This work to configure GP practices started on 28 November and will take approximately two weeks to complete for all practices in Nottinghamshire. This means that first organisations to use MIG will be ready to view this new dataset from 13 December (this includes NEMS, Nottingham University Hospitals, DHU, NHS111 and EMAS) with the remaining organisations

CareCentric, Orion and Rio clinical system suppliers to enable full access to this new End of Life dataset.

Over 90% of GP practices are now signed up to the **GP Repository for Clinical Care (GPRCC) project** The aim is to have 100% coverage by the end of the year.

The major IT infrastructure upgrade scope of work for the Data Management Team at Rushcliffe has commenced with NHIS and we hope this will be completed by end of December 2016 with a new EMIS analytical tool (replacing the existing old model) in place ready to test from the beginning of 2017.

We continue to work closely with our County Council colleagues and hope to have a test dataset for elderly patients who are in receipt of a social care service feeding into e-Healthscope. All the other data feeds are currently live, helping to provide a richer and more holistic view of the each patient is receiving and so supporting clinicians to have the information they need to make decisions about future care options with their patients. We hope to have the first test data feed live by the end of 2016.

The Transfer of Care project, supporting electronic delivery of e-Discharge summaries between Primary Care and Acute, Mental Health and Community providers, is progressing well. This initiative is fully aligned the National Information Board and NHS England Five Year Forward View and is a core part of the Connected Nottinghamshire LDR.

All organisations will have met the 1 December national deadline for discharge summaries and early next year

Thank you

It was great to bring 2016 (almost) to a close with such a fantastic IT Summit event; celebrating our successes and the achievements we've made in the last 12 months simply goes to illustrate the distance that we have all come in such a short time.

So it only remains for us to say a very big thank you from Connected Nottinghamshire to you and to wish you **a healthy, happy and peaceful Christmas**. We look forward to working with you more and achieving even more results in 2017.

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United Kingdom

Appendix 2 – One You winter campaign

Appendix 3 – Interim Home Care case study

Patient A (female) was referred to CTEM on the 23 November. This lady had breast cancer with liver and brain Mets. She lived with her husband who was her main carer, and they had four children, two of which still lived at home. Their youngest child required counselling to support him at school as he was struggling with his mother's prognosis.

On the 23 November the district nurse contacted CTEM prior to our planned visit on 24 November to ensure CTEM CSWs had a clear understanding of potential challenges with patient A. Patient A had previously refused care but had now reached a point in her health where support with personal care morning and evening was essential.

Patient A had always had a very strong personality; due to brain Mets this had affected her behaviour by causing her to become even further agitated. She would challenge all requests, could be verbally abusive, and was generally very reluctant to accept any support. She appeared in denial and felt she was managing her personal hygiene with no issues. The district nurse involved had known Patient A for quite a while and knew how to manage her behaviour. Patient A refused any other nurse's support, so the district nurse was strongly expecting Patient A to decline support or make it very difficult for CTEM to help.

The Carer's Trust arrived to complete the initial assessment alongside the DN. On being introduced to Patient A and her family, Patient A was already stating she didn't need help, but working with the nurse they were able to agree visit times of a morning call at 9:00 for 45 minutes and a PM call at 20:00 for 30 minutes. This was agreed to support Patient A with personal care and monitoring pressure areas. The nurse gave her number to the CSW to be a source of support with this package of care.

Patient A was mainly in bed but was able to roll to each side, sit up, and communicate. Two days later, Patient A began to adjust to the support. Her mood was much lighter, and she was enjoying talking to the carers. She even told her daughter she looked forward to seeing the carers. From 1 December, the district nurse coordinated her visit around the times of CTEM CSW visits to enable her to give Patient A an enema.

Patients A's health was deteriorating quite quickly at this stage. Following this procedure, the district nurse and CSWs felt an increase in visits would be necessary. They jointly discussed this with Patient A's husband who also agreed the increase of 4 times per day and 2 CSWs. During the night of 1 December, CTEM CSWs were unable to roll Patient A and noticed the continence aid Patient A was using had marked Patient A's skin. The CSWs called the nurse who had given her number to support when required. The district nurse arranged to attend the AM calls going forward to assist the 2 CSWs with moving and handling. She also sourced a different continence aid to support following the CSWs feedback.

Over the weekend, Patient A began to get distressed when being moved. This was fed back to the nurse, who visited and managed pain relief making it easier to move Patient A. In the early hours of 5 December, Patient A passed away.