Principia
PARTNERS IN HEALTH

Principia Multi-specialty Community Provider

Dr. Jeremy Griffiths
Health and Wellbeing Lead
NHS Rushcliffe CCG

The Multi-specialty Community Provider (MCP): The Vanguard

- The Five Year Forward View outlines a number of new care models as options for delivering the necessary changes needed in the NHS
- One of these is the MCP, which aims to move specialist care out of hospitals and into communities
- NHS England invited localities and partnerships to apply to become a Vanguard site to develop one of these new models of care
- Rushcliffe, under the Principia name, was one of 29 successful sites – out of 260 applications
- The MCP and Vanguard programme is not a pilot – but a permanent, new way of working

Our Ambition

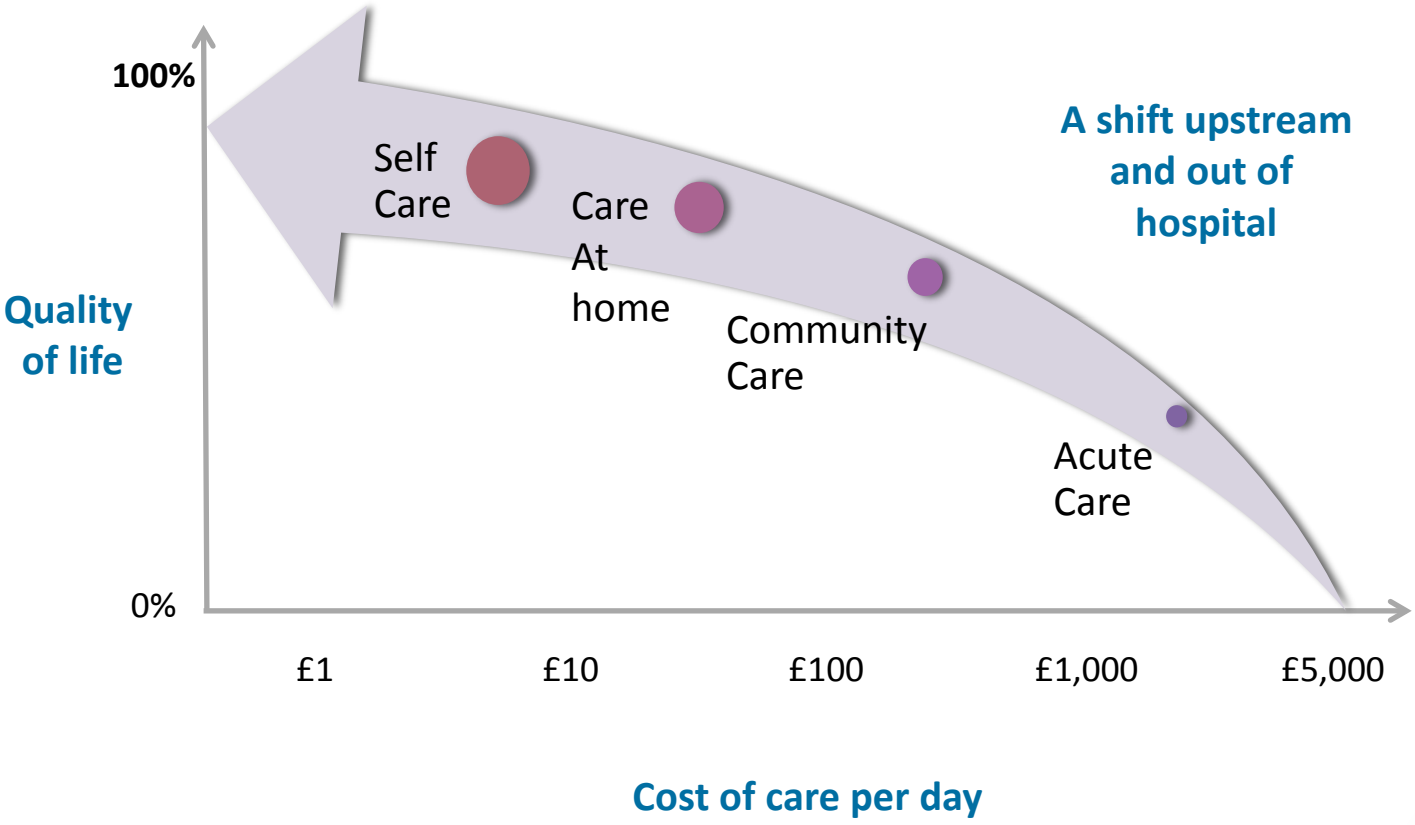
Our Vision
(What we want to achieve)

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.

Our goals and activities

Our Overarching Goals (Critical for us to do to change direction and mind-set)	**Our Work Programmes**
We will aim to: 1. Create a far more cost efficient and clinically effective models of care 2. Fully Integrate all local health and social care providers 3. Transfer all of our care to the right place 4. Focus on prevention, early diagnosis and management of risk factors 5. Target our resources more effectively based on detailed understanding of population need	We will focus on: 1. Support to self-determination and self-management 2. Primary prevention 3. Secondary prevention 4. Management of ambulatory sensitive conditions 5. Management of mental health 6. Integrated health and social care 7. Management of End of Life 8. Medicines management 9. Management of elective activity and referral quality 10. Management of urgent and emergency activity

Our Core Organisation Tenet



The Rushcliffe Model of Care

Self care

Technology enabled access to information and services

Care at Home

Home based Community Care Management

Community care

Networked Clinicians & Continuity of care services

Hospital care

Reserved for bed based care

Quality and Safety

A care system re-oriented upstream and out of hospital; founded on best in class, resourced and incentivised self, home, community and hospital care with increased capability and capacity; working in partnership with other providers in a culture of mutual accountability , commitment and pride bringing benefits to patients, professionals, staff and commissioners

Self-care:
Access to care and information

- Health for all
- Self determination , self help resources and tools
- On line before talk before walk
- E-consultation
- Skype and group appointments
- Same day access
- *(7 day services)* Review of weekend working pilot
- Emergency access including out of hours quality assurance
- Patient online services – The Rushcliffe Portal and App

Community Care:
Primary care clinical services

- Comprehensive care for acute and chronic conditions
- Prevention services and screening e.g. stop smoking services
- Consultant led community clinics e.g. dermatology, trauma and orthopaedic, and gynae services
- Diagnostic services
- Therapeutic services and support
- Tasks designated by skill set : HCAs, practice nurse, GP
- Signposting to and co-ordinating other services
- Helping patients navigate through the system

Community Care and Care at Home: Care Management

- Population management
- Wellness promotion
- Disease prevention
- Long Term Condition management
- Care co-ordination
- Patient engagement and education
- Self care, self determination
- Adopting quality improving, work-saving technologies

Community Care and Care at Home: Integrated Practice Units

- Multi-disciplinary team working together towards a common goal
- Maximising patient overall outcomes as efficiently as possible
- Common organisational unit taking full responsibility for full cycle of care
- Outpatient, inpatient, rehabilitation, support services, patient engagement and education all included
- Measures, outcomes, costs, processes
- Accepts accountability for outcomes and costs

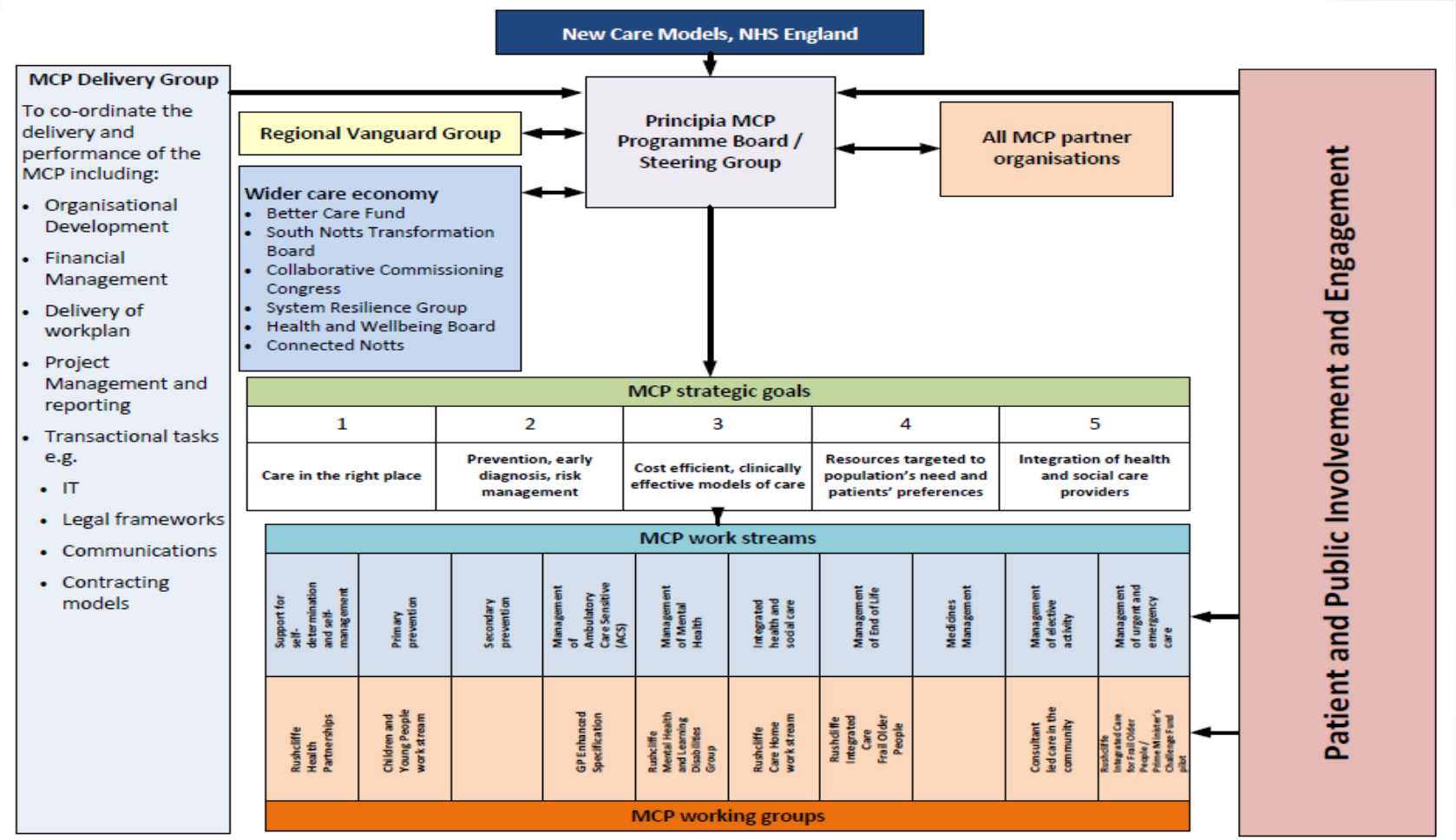
Community Care: Networked Clinicians

- Specialist consulting with local care professionals forming network of clinicians
- Drawing specialist knowledge out of the hospital and to patients in community
- Community based resources
- Collaborative relationships e.g. hospital care, mental health, specialist nurses, therapy services
- Specialist ambulatory care
- Case management

Principles of the MCP: Quality & Safety

- Evidence based practices
- Medicines management
- Patient satisfaction and feedback
- Clinical outcomes and analysis
- Continuous quality improvement
- Risk management
- Regulatory (CQC) compliance
- Contract (CCG,NHS England) compliance

Principia MCP – Governance Structure (draft)



- Proposal for the governance of the MCP
- System oversight of the strategic goals and delivery of work streams

Enablers for the MCP:

Getting IT right: Health Information Technology

- Integrated care record
- Single electronic health record accessible at all locations
- Professional to professional and professional to patient communications
- Electronic reporting
- Electronic prescribing and formularies
- Evidence based clinical decision support
- Disease registries
- Global intranet accessible on internet
- Patient Portal

Enablers for the MCP: Enhancing Primary Care

- Local site management
- Disciplined financial management
- Cost benefit decision making
- Increased revenues
- Contract, personnel, HR management
- Optimised office design
- PPI and carer involvement
- Effective communications
- Provider leadership
- Enhanced resilience

Benefits and Outcomes for our Stakeholders

Patients	Professional	Commissioners
• Local, effective care when and where I need it • Personalised care delivered in a safe and compassionate way • Joined up, timely care that minimises duplication • I feel fully informed and empowered about my care • I have a enhanced sense of health and wellbeing and self reliance	• A more complete environment in which to practice and develop skills • Time can be prioritised to those that need it the most • Real contribution to improvement in the overall system • Respect and sense of belonging to an integrated team • Better working day • Increase availability of resources	• Population health improvements for the people of Rushcliffe • Prevention frees up resources • Overall quality of care improves • Greater patient satisfaction • Fewer patients in hospital • Increased value for money • Clearer accountability

For all stakeholders; **Improved sustainability across the whole system**

How will we know if we are successful?

- Activity modelling and benchmarking is currently underway
- Established a ‘do nothing’ scenario
- Developed of a comprehensive dashboard of metrics
  - Clinical outcomes
    - e.g. a reduction in the rate of fractured neck of femur
    - e.g. cancer detection rates by tumor type and stage
  - Patient outcomes
    - e.g. patient opinion of online services
    - e.g. experience of care
  - System level metrics
    - e.g. a reduction in emergency admissions
    - e.g. a reduction the rate of outpatient first attendances
- Where success is achieved, our approaches will be shared locally and regionally

Next steps

- Submission of the Value Proposition – 11th September 2015
- On-going consultation and engagement of stakeholders – Thursday 1st October 2015
- September – December 2015:
  - Sign off of Value Proposition by New Models of Care Team (September)
  - Development of MCP project capacity
  - Development of MCP Programme Board
  - Development of IT functionality
  - Initiation of the Communications and Engagement plan
  - Implementation of work programmes through MCP working groups