encompass
Working together for better health and care

Encompass Multi Specialty Community Provider (MCP) Vanguard

Testing New Models of Care

Interim Legacy Report

2015 to 2018

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Contents

"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector".

0. Executive summary

1 **New Ways of Working**

Between January and September 2015, 50 vanguards were selected by NHS England to take a lead on the development of 'New Models of Care' **(1)** to act as the blueprints for the NHS moving forward, and to be the inspiration for the rest of the health and care system; Encompass Multi-Speciality Community Provider (MCP) Vanguard, being one of those selected to try out new and improved ways of working.

2 **Integrated Care**

The ambition set out by Encompass was to deliver an integrated health and social care model, delivering high quality care which met people's needs, was coordinated to avoid duplication, easy to access and that enabled people to stay well and live independently for as long as possible in their home setting, to avoid them going into hospital.

3 **Encompass Journey**

This document describes the three year journey of Encompass; the results and difference it is making to patients and staff, describing how this model is using resources more effectively, improving the quality of care for the growing population and future needs, as well as influencing the future of health and social care in Kent and Medway.

1. Why work differently?

1.1 The case for change

The NHS is under pressure

	**P**eople are living longer, many of them with long term conditions (LTCs) which use up 70% of the NHS budget. We need to change what we currently do to better support older people in our area
	**A**cross Kent and Medway, health and social care have £3.6bn in funding but overspent by £141m last year. Without change we will be overspent by £486m by 2020/21
	**T**here is a shortage of healthcare professionals, affecting the ability to recruit to all staff groups, including GPs and nurses
	**T**he wider healthcare system is also feeling the effects of cuts in social care funding, with consequent increased demand on the health service adding to the pressure.

To tackle the challenges in health and social care we need to change the way we work to **improve care** and get **better value** for the money we have available.

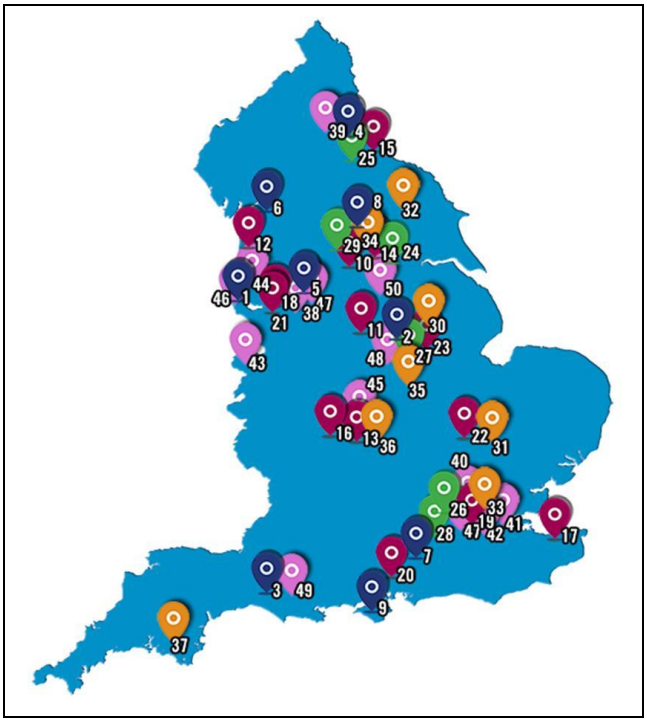
The NHS Five Year Forward View **(2)** advocates steps to break down barriers between organisations in order to release efficiencies, bringing **care closer to home** and **reduce the pressures on acute services**. This is also the vision for the 2016 Kent and Medway Sustainability and Transformation Plan (STP), **(3)** whose evidence base for its **'local care'** work stream suggest:

	**30%** of patients in acute hospital beds would be better looked after in an alternate location of care, either in a short term or step down bed or at home with community nursing or social care support
	**12%** of admissions through A&E are avoidable through more consistent decision-making at the front door, or better health and social care provision in the community
	**25%** of community hospital patients would be better cared for at home or in a community setting

Encompass has been testing new ways of working to integrate services, improve care and release efficiencies into the system.

2. Who are encompass

Encompass is part of the NHS 'vanguard programme' which means it made a bid to NHS England for transformation funding to improve the health of local people by testing New Models of Care.



Five Year Forward View

- New Models of Care are a key element of the Five Year Forward View
- Encompass (no.17 on the map) is one of 50 Vanguards in England selected to test new models of care
- There are 5 types of Vanguards:
  - Multispecialty Community Providers (MCP)
  - Primary and Acute Care Systems
  - Enhanced Health in care homes
  - Urgent and Emergency
  - Acute Care Collaboration

Encompass was established in 2015. It is a group of 14 GP surgeries across Ash, Canterbury, Faversham, Sandwich and Whitstable who are working together to test new ways of delivering services in communities and closer to people's homes.

Encompass has tested several changes including:

- Having joint health and social care multi-disciplinary teams looking at patients at risk
- Improving the way IT systems are accessed by everyone involved in care
- Looking at services outside of traditional health and social care (voluntary services, community groups etc.) which can provide relevant support (this is called social prescribing)
- Looking at net way of providing clinics locally (for example catheter and wound care) which previously would have required an outpatient appointment at a hospital
- Developing an app (Waitless) which gives local people up to date information on the best place to go for medical attention based on wait times and transport options.

The work done by Encompass up to September 2017 has led to:

1,189 Hospital admissions being avoided

8.2% Reduction in Hospital admissions

3. Who do we work with?

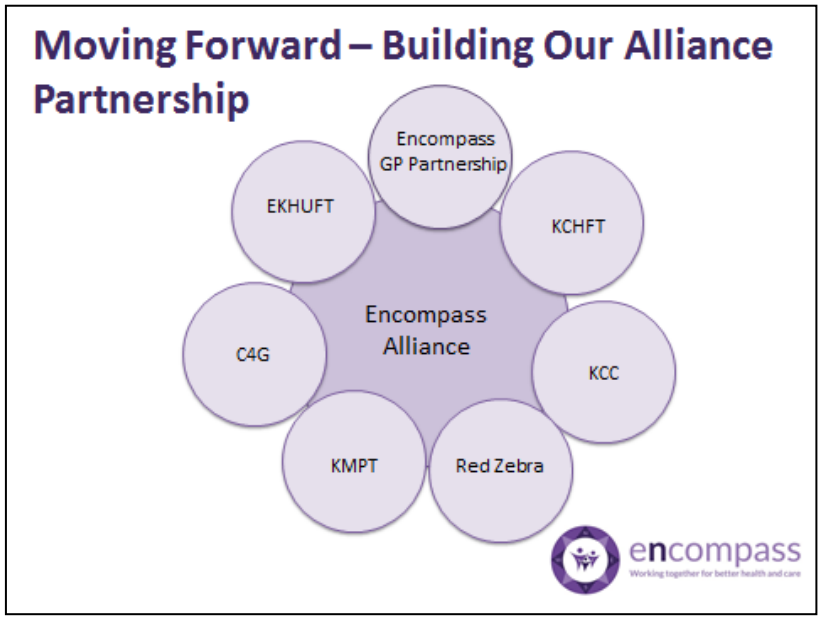
3.1 Practices

The practices listed below agreed to join Encompass with a view to forming a long term working relationship. The terms of the agreement were set out in a Memorandum of Understanding (MOU). An Encompass GP Partnership Ltd company was formed in October 2017 and will be one of the key partners in the overall Strategic Alliance.

- Ash Surgery
- Canterbury Medical Practice
- New Dover Road
- Northgate Medical Practice
- Sturry Surgery
- The Market Place Surgery
- University Medical Centre
- Canterbury Health Centre
- Faversham Medical Practice
- Newton Place surgery
- Saddleton Road Surgery
- The Butchery
- The Old School Surgery *
- Whitstable Medical Practice

*The Old School Surgery joined Encompass in October 2017

A Stakeholder Group and an Operational Group were formed to work with the partner organisations listed below. As the vanguard developed an Encompass Strategic Alliance and an Operational Alliance were formed in April 2017.

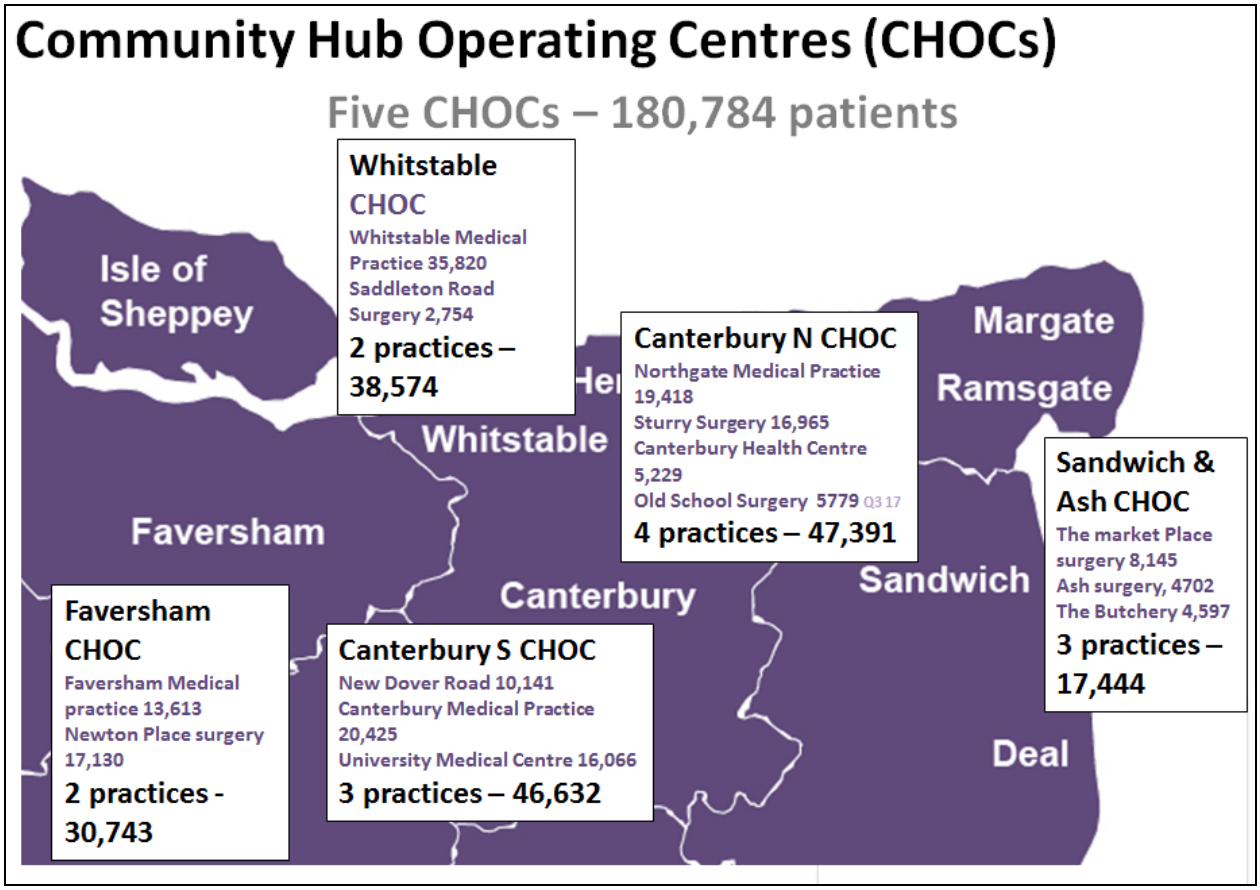


3.2 Partner organisations:

EKHUFT - East Kent Hospitals University NHS Foundation Trust
KMPT - Kent and Medway NHS and Social Care Partnership Trust
KCHFT - Kent Community Health NHS Foundation Trust
KCC - Kent County Council Public Health
KCC - Kent County Council Social Services
C4G - NHS Canterbury and Coastal Clinical Commissioning Group
SECAmb - South East Coast Ambulance Service NHS Foundation Trust
Red Zebra - Voluntary and community services

4. Our Geography

The Encompass practices are working at scale across the Canterbury and Coastal Clinical Commissioning Group (C4G) footprint in five 'community hubs' shown in the map below.



Based on Q3 2016 population data

5. Our Journey

Encompass is in the final year of a 3 year journey.

5.1 Practice momentum

The three founding practices were awarded MCP Vanguard status in April 2015. A core team was appointed and the value proposition for first year transformation funding was submitted to NHS England New Care Models Team (NCMT). The NCMT recommended that the MCP should look to scale up its population of approximately 53,000 patients. This lead to a number of engagement events. A further 13 practices signed up to the MCP Memorandum of Understanding (MOU) during July and August 2015. This increased the total number of practices to 16 with a patient population of almost 170,000. Over time some practices merged, consolidating the number to 13. More recently (October 2017) an additional practice signed the MOU taking the total number of practices to 14 and increasing the MCP patient population.

5.2 Transformation funding

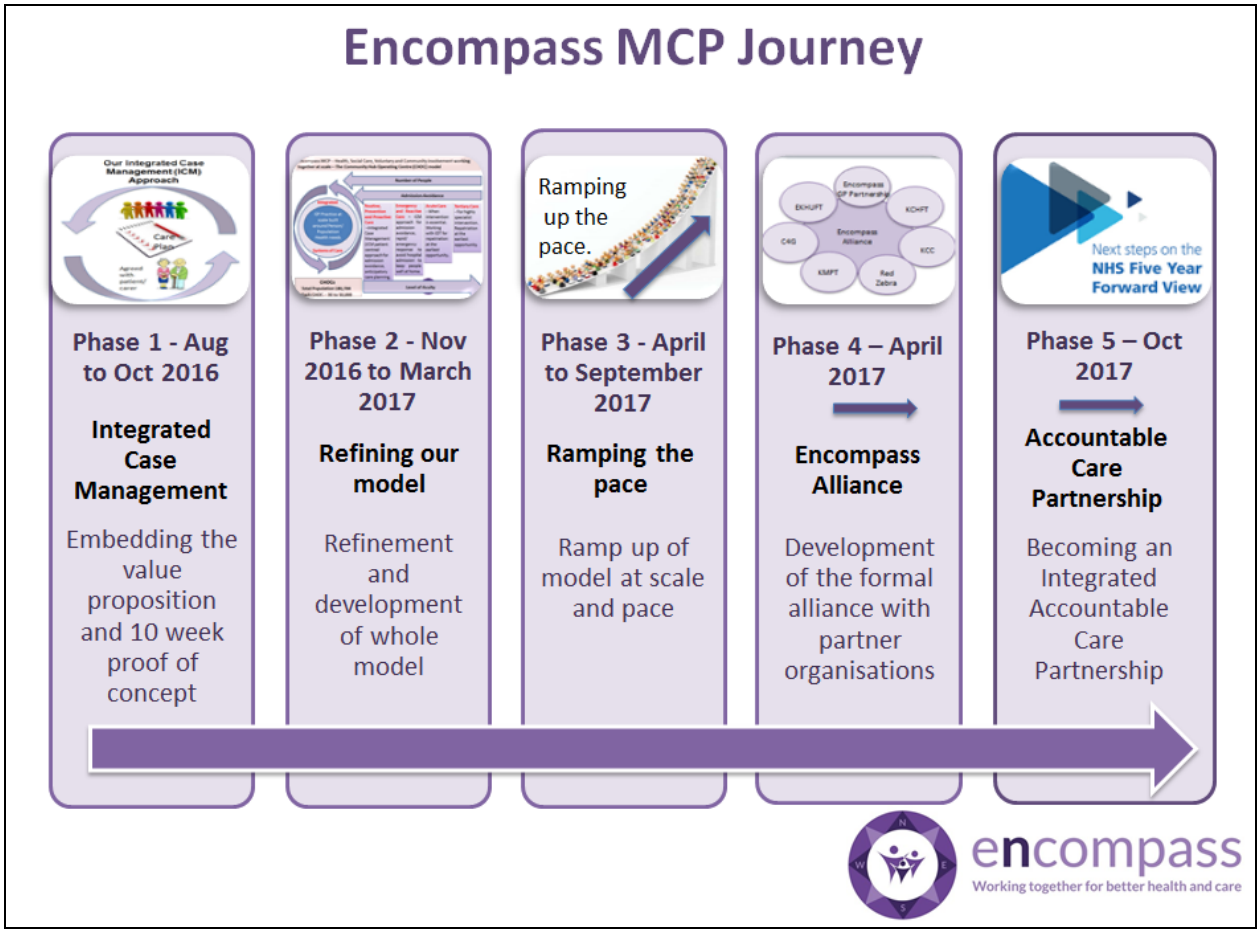
In November 2015 the NCMT approved the transformation investments needed to move Encompass new models of care forward. The funding was subject to a list of conditions aligned to progress against delivery milestones, sharing of learning and quarterly review meetings with the NCMT.

Encompass was required to submit two further value propositions for its 2016/2017 and 2017/2018 work programmes and was held to account by the NMCT for its delivery and outputs.

5.3 Mobilisation

Encompass has been working on a number of projects with partner organisations to mobilise new models of care across the MCP footprint. These are discussed further in section 6 of this report.

In August 2016 a significant proportion of the original Encompass core team moved on and a new team was put in place to focus on mobilising the 2016/2017 and 2017/2018 value proposition. The picture below shows the key phases of that journey.



6. Our Model

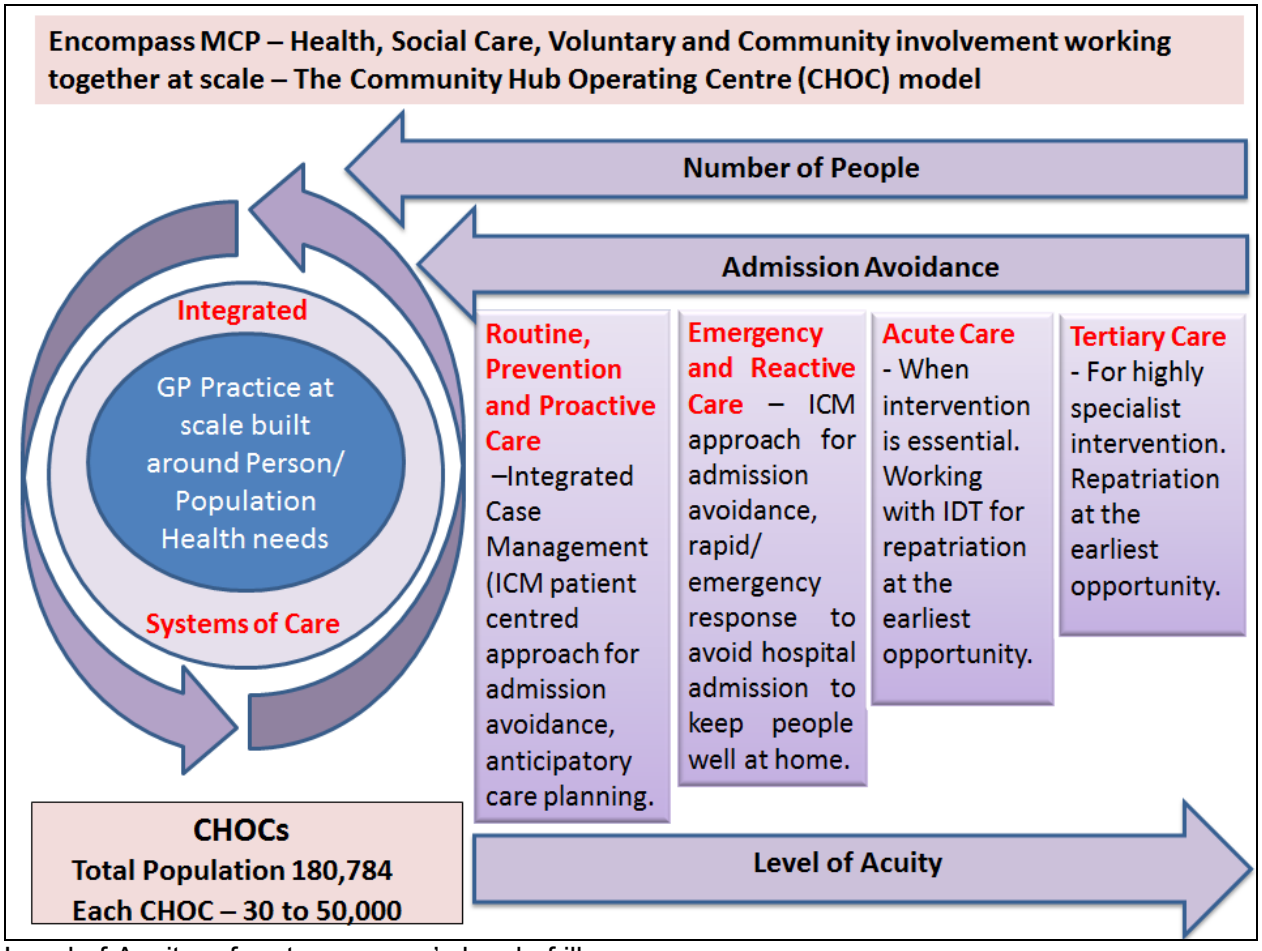
At its heart the Encompass model of care is about **integrated** working, **at scale** that is focused on delivering:

"High quality, outcome focused, person centred, coordinated care that is easy to access and that promotes wellness and enables people to live independently for as long as possible in their home setting".

The model operates across 5 community hubs of between 30,000 to 50,000 patient population groups. The Community Hub Operating Centres (CHOCS) were launched in geographical stages beginning in 2016 and bring together:

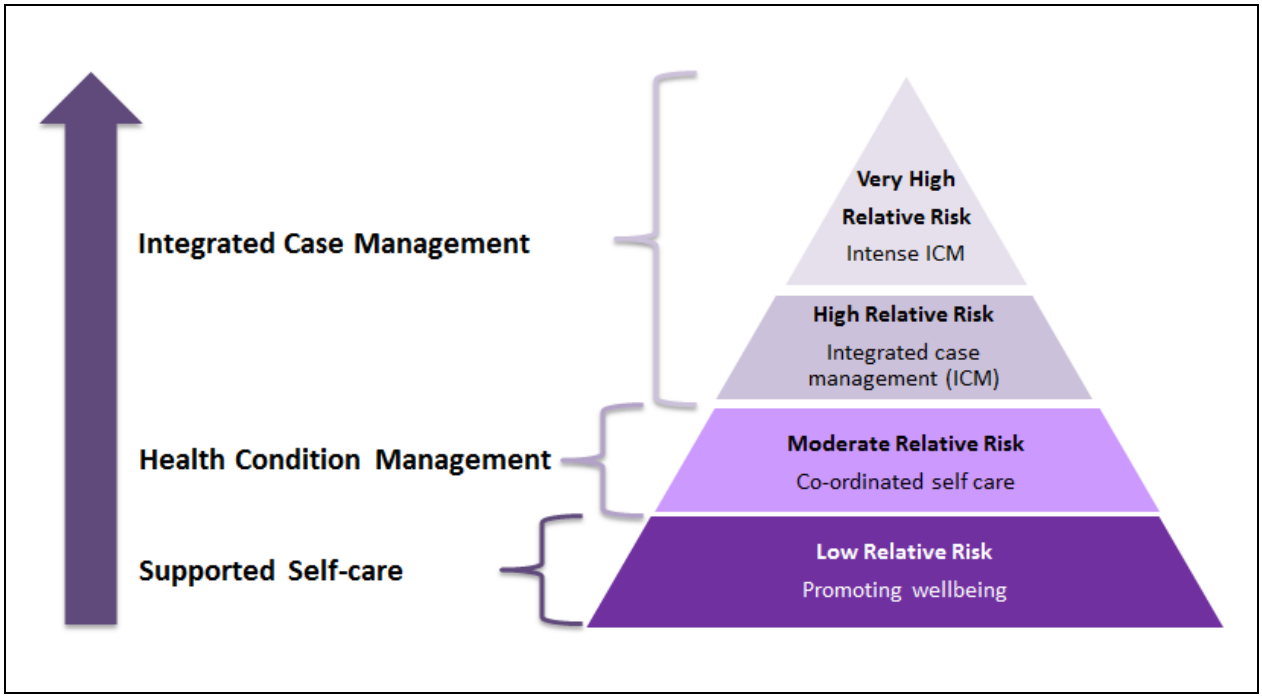
- Health
- Social care
- The voluntary sector
- Community involvement

These groups work together at scale as an integrated system of care around the patients' health needs, offering hub level services. As the picture below shows the level of need (in red) will determine the type of care provided.



Level of Acuity refers to a person's level of illness

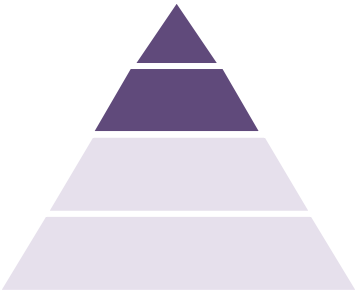
By working together at scale, CHOCs can identify cohorts of patients and manage them better in the community, closer to home, avoiding acute admissions. Patients can be referred into a CHOC by any health or care professional though the Local Referral Unit (LRU) provided the patient has consented. To ensure patients gain the most from this model of care the process begins by identifying patient's level of risk and health needs, shown in the triangle below.



The model seeks to deliver proactive care and support, focused on promoting health and wellness, rather than care and support that is solely reactive to ill health.

As the diagram shows there are three groups of interventions: Integrated Case Management, Health Condition Management and Supported Self-care.

6.1 Integrated Case Management



Integrated Case Management (ICM) aims to build relationships between health and social care professionals to improve health and wellbeing outcomes for patients at high risk of future emergency admission to hospital. Its success lies in the brining together of a Multi-Disciplinary Team (MDT) to support the management of patients who have:

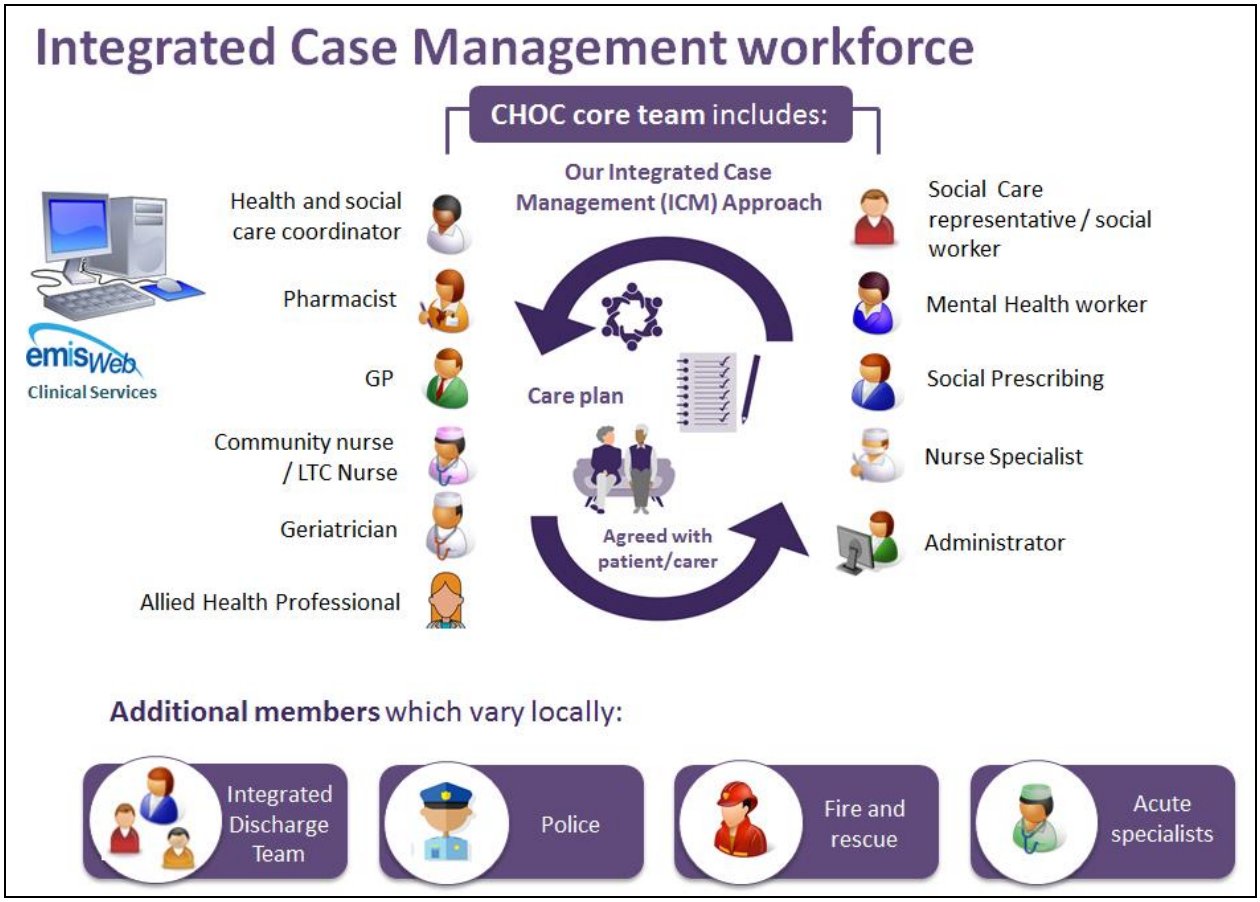
- the highest health complexity,
- with multiple co-morbidities,
- frequent hospital admissions,
- psychosocial issues,
- frailty, mental health conditions and
- poly-pharmacy.

ICM is initially aimed at the top 3% of the CHOC population with the highest risk stratification scoring or severe frailty. The service aims to reduce unnecessary hospital admissions, reduce avoidable A&E attendance, and facilitates early discharge from in-patient beds.

The Multi-Disciplinary Team

The concept is to prevent duplication from multiple services, prevent the patient having to repeat themselves, to co-ordinate the patients care, to put the patient at the very centre of their care, to identify any unmet need gaps and work as a team to address the patient in a cohesive way.
The patient is at the **centre of the plan of care** and is involved in the decision making process and the planning of their anticipatory **care management plan**.

The workforce consists of a core team in each CHOC locality and additional members with local variation as shown below.



The resources to run the meetings were sourced from the existing providers by working in a smarter more integrated way. Funding was available from the Vanguard to support some double running until Business as Usual commenced.

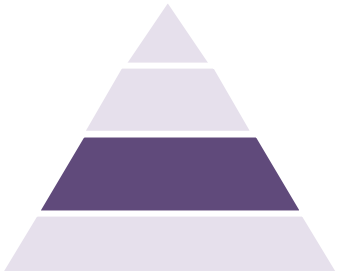
EMIS Clinical Services was funded and installed to support the CHOC process and data entry into the Clinical Care Plan. Data sharing agreements were put in place between the Provider Organisations and each Practice in order to support the viewing of the GP record during the meeting and from the practice.

6.1.1 ICM outcomes

- **1,900** patients have benefited from the ICM approach up to the end of October 2017
- The current case load for the service at any one time is around **150** patients each month
- Outcomes for the **29** patients that completed the initial 'proof of concept' programme have been tracked using their NHS numbers (with consent) and **76%** of these had not had any hospital admissions in the **12 months** since the completion of their intervention. (Data sources: local data collection and SUS data).
- There has been a marked reduction in emergency admissions (**8.2%)** and a reduction in short stay admissions of **33.1%**). (Data source: Secondary Uses Service data).

- **1,900** patients benefited
- **150** patient case load
- **76%** no admissions
- **33.1 %** reduction in short stays
- **8.2%** reduction in emergency admissions

6.2 Health Condition Management



Health condition management aims to support and empower people who have long term physical and mental health conditions, keeping them well and avoiding hospital admission.

Some of this involves moving some services, historically provided in a hospital, into the community and extending the roles of GPs and other healthcare professionals.

6.2.1 GPs offering additional services

Specialist GP services will mean that more people will be able to receive care from a GP surgery without the need to travel to hospital. This means that the skills and resources needed to deliver these services need to follow. Encompass has supported this training with matched funding for backfill and course costs for **12** practitioners across **seven** specialities including:

- Dementia
- Dermatology
- ENT
- Urology
- Ophthalmology
- Respiratory
- Cardiology

This will mean that outpatient appointments can come out of hospital settings and be delivered in practices close to home, only referring to hospital for more complicated conditions. The majority of the training commenced in September 2017 and will take on average 12 months to complete. Each practitioner signed a Learning Agreement committing to the training, guidance and providing a service once trained.

6.2.2 Catheter clinics

The catheter clinics were deployed following a phased approach across the CHOC localities beginning with Faversham in April 2016. The approach taken was to upskill practice nurses to the same level of competency as the community nurses.

It was designed this way to:

- Prevent unnecessary A&E attendance
- Prevent visiting the non- housebound by providing a catheter clinic within a GP surgery
- Provide access for any patient in the locality to attend a CHOC Catheter site even if they were not registered in that locality.

The practice nurses were trained by Kent Community Health Foundation Trust (KCHFT) community nurses in catheter care, funded by Encompass. Patients fitted with a catheter in EKHUFT, now leave with a catheter 'passport' and advice to go to their local CHOC for regular booked changes and also one of four sites with any catheter related issues if not near their local CHOC or if they have an emergency situation. An excellent working relationship has been established with the acute trust working closely with the Head Nurse of urology to arrange direct access to clinics if patients turn up unnecessarily. If a patient is discharged from Urology they contact the patients registered GP and pass on details of the catheter, size, make and frequency of change so a prescription can be raised to ensure stock is available in advance.

6.2.3 Wound care clinics

A task and finish group was set up to bring together community and practice staff to share learning and develop and set up a hub based model. A protocol and template were written to standardise competencies and frameworks across primary and community care so that patients have access to the same quality of care whether treated at the surgery or in their home.

Two licences for each practice were purchased for WoundMatrix software along with tablets for use within the clinics. WoundMatrix enables the secure capture, measurement and instant upload of wound images and data elements at the patient

point of care. The web-based mobile platform enables instant, accurate and reliable wound documentation and outcome tracking. Practices have been trained to use the software and work is being undertaken to explore the options of linking the software with the primary care clinical system.

6.2.4 Dementia support

Encompass has been working with Age UK to provide drop in dementia clinics. The Dementia Services Link Worker started working across the CHOCs in April 2017 providing holistic support for families and carers and signposting to additional support services. The majority of referrals are for Carers requesting ongoing one to one advice, information and support.

6.2.5 Group psycho-education

Encompass has been working with Invicta Health to support self-management / admission avoidance for individuals with a diagnosis of Bipolar Affective Disorder or Psychosis. The groups have helped individuals to be less isolated by meeting others with a similar diagnosis and have helped them to understand their condition and learn about relapse prevention to enable them to stay well and out of hospital. The groups have been running since January 2017. There is an example of a patient story with outcomes in **section 7.**

6.2.6 Community Paramedic Practitioner home visiting service

Helping patients stay out of hospital

Building on an earlier successful pilot a Paramedic Practitioner Scheme was developed by Encompass and the South East Ambulance Service (SECAmb). It was deployed across the CHOC localities in November 2015. The service involved a team of community paramedics undertaking urgent home visits on behalf of GP practices. This allowed GPs to focus on seeing patients in their surgery and patients to be seen more quickly in their own homes. Due to workforce and external pressure the provider needed to focus on core business and gave notice on the contract in March 2017.

Therefore practices started to employ their own paramedics to do house calls. A new Encompass GP Partnership Service Specification was written for a Paramedic Practitioner / Advanced Nurse Practitioner Service to reduce the pressure on member GP practices and 999 / 111 calls from patients unable to attend a surgery appointment or get a home visit; subsequently reducing hospital attendances and maximising GP time in surgery. The revised Rapid Home Visiting Service began in November 2017.

6.2.7 Community Pharmacist Service

KCHFT Pharmacy Team have been working with Encompass since August 2017 and are part of the core MDT workforce.

The team attend **CHOC** meetings to:

- build relationships with the other health and social care professionals
- actively participate in the MDT process, adding a pharmacy perspective to the discussions
- ask medicines-related questions
- highlight general medication issues
- act promptly to resolve questions that arise about a patient's ability to manage their medicines

The Pharmacy Team provide a domiciliary service, frequently **visiting patients** directly after the MDT meetings. The purpose of the visits is to assess the patients and to assist them in adhering to their medication regime potentially **reducing admission** or re-admission to hospital in the longer term. The team have achieved this in a number of ways:

- by optimising their regimens in conjunction with one of the prescribers present at the meeting. This also reduces prescribing costs;
- physically sorting their medicines out at home to reduce harm from medication; ensuring only those currently prescribed are available;
- promoting their independence by providing them with verbal and written information about their medicines and where necessary by supporting them to appropriately fill a multi-compartment aid (MCA), and;
- in cases where they are deemed unable to do this, to initiate a pharmacy-filled MCA or Medicine Administration Record (MAR) for carers to safety prompt/administer medicines.

Lead Pharmacist

"Allowing organisations to meet together on a regular basis has **broken down barriers** and **improved outcomes** for patients by enabling better **more informed care**."

6.2.8 Health and Social Care Co-ordinators

Health and Social Care Co-ordinators (HSCC) from KCHFT have been working with Encompass to support the CHOC localities since July 2016. They act as a key point of direct access for the CHOC receiving referrals / enquiries from the MDT meeting or via email for health and/or social care interventions.

The HSCC provide administration support to the CHOC MDT meetings such as minutes and actions logs. They are a key link liaising between social care, GPs, Community Nurses, Community Matrons, Case Managers, Occupational Therapists, Physiotherapists, Mental Health Teams and other key resources from the voluntary and private sector. This enables the HSCC to facilitate timely, effective and efficient use of collective staff resources within a community hub.

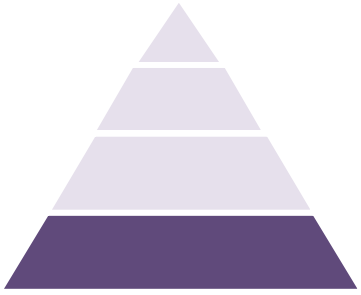
Health and Social Care Co-ordinators:

- Invite attendees to the CHOC meeting and ensure the smooth running of the meeting.
- Ensure the GP (EMIS) and Community (CIS) IT systems are working and available.
- Attend home / In Reach visits when required and referrals / actions.
- On occasions when required Chair the meetings
- Send referrals as discussed at the meeting
- Ensure EMIS has been updated
- Ensure CIS has been updated

6.2.9 Community Geriatricians

Community Geriatricians from KCHFT T have been working with Encompass to support the CHOC localities. They support medical decision making to keep people well in their own homes, liaise with relatives and carers, and communicate with: Community Continuing Health Care, Care Home Providers, the Acute Trust and identify and address Delayed Transfer of Care. The Community Geriatricians have been part of the core MDT workforce since quarter one of 2017.

6.3 Supported Self Care



Supported self-care is about supporting people to make healthier lifestyle choices to avoid preventable diseases. The aim:

- building strong social networks
- exercising more
- eating more healthy
- feeling more supported and in control of lives
- reduction in healthcare interventions for patients identified with social prescribing need

6.3.1 Social Prescribing

Encompass has been working with Red Zebra to provide a Social Prescribing service. Social Prescribing supports prevention and self-care, promoting independence and enabling people to connect with voluntary and community groups and other non-clinical services. It can help people to build social networks, keep healthy, reduce the need for medical care and address loneliness and social isolation.

350 activities delivered by 150 organisations are accessible via the social prescribing team and through an online directory, commissioned by Encompass, called 'Connect Well'. Connect Well is a public facing searchable website linking health and community in East Kent, this went live in March 2016. Healthcare professionals have been trained in using Connect Well to refer patients directly to services. Alternatively Red Zebra have coordinators who can arrange to meet individuals to help navigate the directory or patients can refer themselves online. The highest number of referrals has been from the CHOC MDT. Red Zebra started attending the CHOC MDT in July 2016. The Social Prescribing Coordinator is part of the core MDT workforce. To watch the Red Zebra social prescribing case study, go to: https://www.youtube.com/watch?v=Br4gAxRaAp8

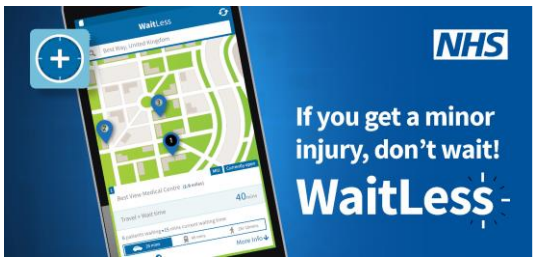
6.3.2 Health Trainers

The Health Trainer project began as a pilot in February 2016. The Health Trainer, from KCHFT, supported patients who wanted extra help to make lifestyle changes. Following the pilot the Health Trainer service was implemented across 3 CHOC sites from October 2017. The Health Trainers help motivate and encourage clients by setting goals and developing a personal health plan that suits the individual. Lifestyle changes include examples such as: weight reduction, stopping smoking, cutting down on alcohol or getting more active.

6.3.3 The Daily Mile

An initiative in schools to keep children active, bringing together Education, Public Health, NHS and Local Government to embed good health behaviours. The focus is to increase activity in school age children and supporting families. The CHOC MDT model is being used as a basis for moving this project forward to encourage integrated working across agencies.

6.3.4 WaitLess



WaitLess is a smartphone app designed to cut waiting times at Accident and Emergency (A&E) departments and Minor Injury Units (MIU) in east Kent. The WaitLess app combines up to the minute travel information with live waiting times so that patients can decide which urgent centre to head to for faster treatment for minor injuries.

The Clinical Lead for Encompass came up with the idea after seeing a similar app in use in Valencia, Spain. The app was co-designed by Encompass and patient groups in East Kent and developed by Transforming systems who enabled the real time feeds.

The app was launched in December 2016. This kind of innovation was the first of its kind in the UK and the potential impact was unknown. There have been over 15,000 downloads and 131,000 usages up to the end of October 2017. It was anticipated that perhaps 5% of patients attending A&E would be routed to MIU facilities. An overall shift of just over 6% of minor attendances from A&E to MIU facilities has been recorded up to end of September 2017.

The WaitLess app is free to download:

Download on the App Store https://itunes.apple.com/us/app/waitless./id1160745938?mt=8

ANDROID APP ON Google play https://play.google.com/store/apps/details?id=com.ts.waitless&hl=en

To watch the promotional video go to:
https://www.youtube.com/watch?v=jLWfILLC2fw

WaitLess promotional video

WaitLess also links to HEALTH *help* NOW. This app provides health advice and alternative treatment options.

7. Patient Stories

Valerie

Valerie is a 92 year old lady who cares full time for her husband who has dementia. She had stopped carrying out normal day to day tasks and needed trips to hospital after falling at home, all of which was impacting on her mental wellbeing.

She didn't understand all the different agencies visiting her and felt understandably confused by the system and complexity of visits from GPs, social workers and other professionals.

By brining those professionals **together** around the table to develop a **single care plan to meet Valerie's goals, it has transformed her life.** Her care plan focused on physical, mental and social needs, with a number of simple interventions that helped her feel more confident and able to cope at home. This includes a daily visit from a carer who speaks regularly to all the professionals involved in Valerie's care, and being given a falls wrist band and walking frame with a tray to help her to do normal day to day tasks.

To watch the Encompass video featuring Valerie go to:
https://www.youtube.com/watch?v=1xNnnFv8FCY&feature=youtu.be

"WaitLess"

"This app is so good. I broke my leg and needed it checked immediately and it told me what hospital had quicker service and how long it will be to wait – excellent"

Social Prescribing

Help with caring and tasks

"Amazed at how quickly things happened and we are extremely happy with the outcome / support."

Befriending and gardening

- A patient was calling his GP **3** to **4 times per week**, was **feeling lonely** and **isolated**.
- The patient was referred for befriending and gardening help.
- The GP described her patient as being much **brighter** since the support started and that he was talking about going on holiday. He **now calls once per week**, the **calls are shorter** and **more focused**.

"I look forward to the gardeners visit. The befriender is working well. My **confidence** is **increasing** and I go out for lunch once a week"

Mental Health Support

Group psychoeducation

A patient with a diagnosis of Bipolar disorder had two past admissions under section two of the Mental Health Act. She was a frequent attender at A&E (4 times in 2 months prior to intervention) and failed to attend routine health checks at her GP surgery.

The patient was invited to attend the Bipolar Psychoeducation Group and completed the group programme.

Outcome:

- **Reduced** medication by 25%
- **Maintained stability** in mental health by also incorporating healthy lifestyle activities discussed within the group programme
- Gradually **lost weight**
- Felt able to **return** to part time **work**

"I have an overall feeling of **improved quality of life.**"

8. What do others say

"Community Hub Operating Centre is the **highlight** of my week."

Consultant Geriatrician

"Hats off to you, **really good meeting** and **really good progress**, so **thank you**."

Aug 2017 Assurance meeting
New Care Models Programme Director NHS England

"

Working within the CHOC MDT has **improved delivery of person centred care**. CHOC facilitates **improved working relationships** between health, social care and the voluntary sector and **identifies gaps** in a patient's pathway that can lead to potential crisis. This is a meeting where **all voices are heard**, with no hierarchy.

CHOC meetings are not only about **meeting patient need** and **responding proactively**, they are also a useful forum for **sharing best practice**, discussing potential outcomes and evaluating pathways of care.

They are indeed **a weekly highlight** and I look forward to being part of its on-going evolution.

Long Term Conditions Lead Nurse

"

Smarter technology

Health and Social Care Co-ordinator

A lot of people assume that everyone involved in care can see their records already. But not only is that not true, it's also one of the most difficult parts about bringing the different organisations in health and social care together. The training on the new system has been fantastic. All the data for the patients who we are seeing through the Community Hub model is on there and we can add new patients as they get referred to us.

Data sharing means that if we're talking to a patient as a joined up team we all have access to the same information and can see if anything new has happened that we need to be aware of. It also means that when we decide on an action at the meetings we can notify their own GP immediately and ask them to put certain things in place.

Not all GPs could attend every meeting so this really helps spread awareness and get things actioned a lot quicker. As more and more people join the MDTs (hospice nurses have recently joined) we can see huge benefits for our patients in working this way.

"As a GP **I've never felt so connected to the community and voluntary sectors**. As I have passed over direct involvement with the MDT to a colleague, I'm pleased to see this connection continues thanks to updates being added directly to the medical record. **Let's hope this is the beginning of a new era of truly integrated working."**

Primary Care GP

"You are doing amazing cutting edge projects."

Sir Sam Everington
Chair Tower Hamlets CCG

Pharmacy

"The ability of the team to react in a timely way has been recognised by both colleagues and patients/family alike. Allowing various organisations to meet on a regular basis not only promotes pro-active thinking and doing, but also breaks down barriers and improves outcomes for patients by enabling better, more informed care.**"**

Lead Pharmacist

"It has been **great** to work as part of a functional multi-disciplinary team with great participation from so many providers.

I have seen first-hand how barriers are being broken down, networks created and as a result **patient care improved**, not only in its reactiveness, but also in anticipatory care-planning. The ability to get additional, up-to-date, information on patient's medical history or social situation from so many different agencies has helped colleagues understand their needs in a more **timely** way, in turn helping them to **deliver better care**. The flat hierarchy and revolving chair of the meeting ensure that **everyone's voice** is **heard** and **valued**. I really hope that this project is introduced as a permanent feature once this pilot finished."

Community Pharmacist

"5 star service"

"My mother received a 5 star service.**"**

Patient's daughter describes service

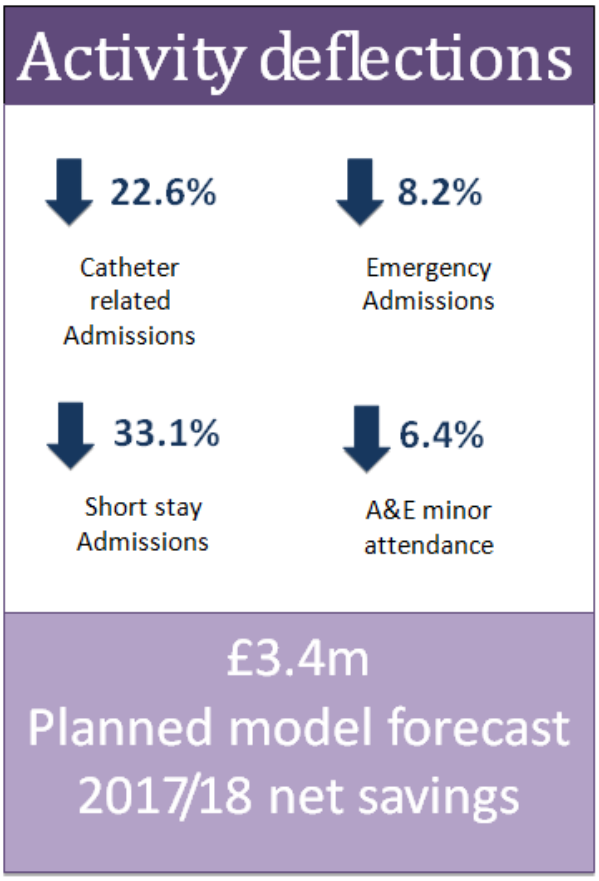
9. Our outcomes

Our progress has been monitored using a set of national outcomes, as defined by NHS England, with some additional outcomes that were agreed locally to reflect the local nature of our services.

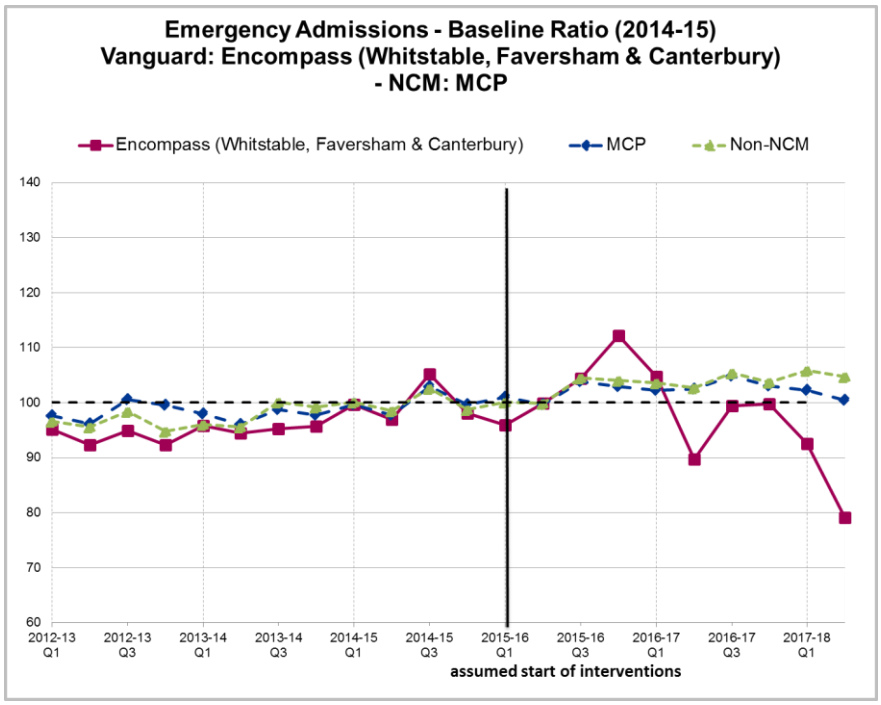
There has been a reduction against the emergency admissions national outcome of **8.2%** compared to the baseline period, with a greater reduction in short stay admissions (up to 1 day) in particular, primarily attributed to the ICM model.

Other developments have led to specific improvements in outcomes, for example a **22.6%** reduction in catheter related admissions compared to the baseline period, attributable to the catheter clinic service and a **6.4%** shift of minor attendances from A&E to MIU facilities, attributable to the WaitLess app.

We are on track to deliver the planned saving of £3.4m in 2017/18.



Our performance against the national emergency admissions outcome is shown in the chart below. Our **8.2% reduction** compares very favourably against the national **growth of 2.6%** for other MCP vanguard sites and **4.9% for non-vanguard sites**.



10. Enablers

10.1 Information Technology

Information Technology has been one of a number of key enablers in the development of New Models of Care.

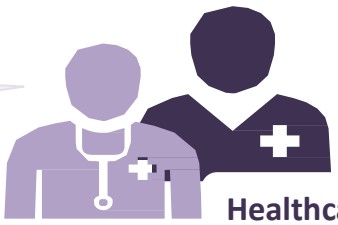
10.1.1 EMIS Clinical Services

emisWeb
Clinical Services

The installation of EMIS Clinical Services (discussed in section 5.1) has meant that:

- A virtual register of ICM patients can be created, maintained and managed to ensure the patient receives timely and effective care across the practices in the locality hub
- Key clinical information can be viewed **during** the CHOC MDT meeting
- The CHOC team have access to the same information and can see if anything **new** has happened that they need to be aware of
- When an action is agreed at the CHOC MDT meeting the patients GP can be notified **immediately**
- Updates can be added **directly** to the medical record
- Duplication is avoided by pulling in key information from the patients record into the overarching care plan
- The care plan can be viewed and updated by the CHOC team and **shared** with the patient and CHOC professionals involved in the patients care
- 'Improved Access' at a CHOC level is available to patients through a hub level booking system

"We can see huge benefits for our patients in working this way."

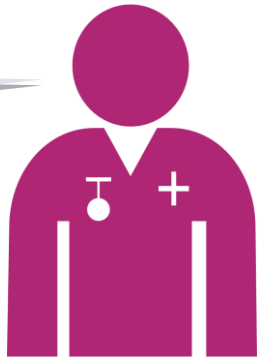


Healthcare Professionals

10.1.2 Medical Interoperability Gateway (MIG)

The MIG makes it possible for other clinicians treating patients to view parts of the GP clinical record, including the patients **care plan**. Clinicians from providers such as the Hospitals Trust, Pilgrims Hospice, Mental Health Trust, KCHFT, NHS111 and Out of Hours can see the patient's records, provided the patient has given permission.

The **MIG** GP record has helped us in pre-assessment **tremendously** for the following reasons …



Matron

Previously we may have sent pre-assessment patients with high blood pressure to GP's to get three baseline readings. If ok then proceed for surgery. However **now** we just need to check baselines **from GP records** if available and can proceed if within normal range. **Saving time, communication and appointments at GP Surgeries.** Also **reducing stress and time for our patients.**

Incomplete medical history can **now** be **checked on GP records. Improving safety** by reducing doubt, **time and communication**.
Can view any correspondence or summaries from outside east Kent such as from Kings etc. again saving time and communication.

I believe that overall this has **greatly helped both nursing and medical staff** within pre-assessment.

Pre-Surgical Preparation Matron

"Thank you for access to the records, long may this continue!**"**

"It is a **fantastic resource** that has greatly **improved patient care** and **safety**.
I have taught multiple doctors how to access the information, often accompanied by a **great sigh of relief** or **expression of delight** at the ease of the system.**"**

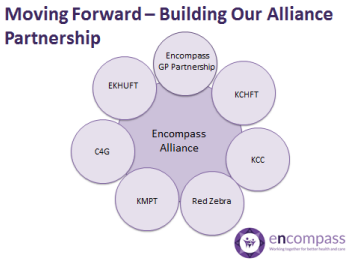
Consultant, EKHUFT

10.2 Data Sharing Agreement

To help improve quality and safety of care through more integrated working across organisations a Data Sharing Agreement was created. This was signed by each GP practice and local health and care organisation to allow the viewing of relevant, real time clinical information within a CHOC locality MDT meeting (as long as the patient gave consent). It also enables all the professionals involved in the multi-disciplinary teams to communicate and input data outside of the CHOC MDT meetings, where the patients are discussed. This has greatly improved efficiency and the ability to see more patients.

The agreement also enables those involved in the person's care to add to the record immediately during the multi-disciplinary meetings so that, for example, if the patient's specific GP is not at the meeting, the team can see exactly what happened and what the recommendations are.

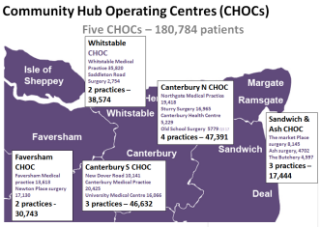
10.3 Alliance working



Encompass has developed a governance structure with partner organisations across statutory and non-statutory organisations to deliver the model of care. This Alliance approach is moving towards holding a formal contract to deliver services in collaboration. This approach has been shared and is being replicated across other localities

10.4 GP incentive scheme

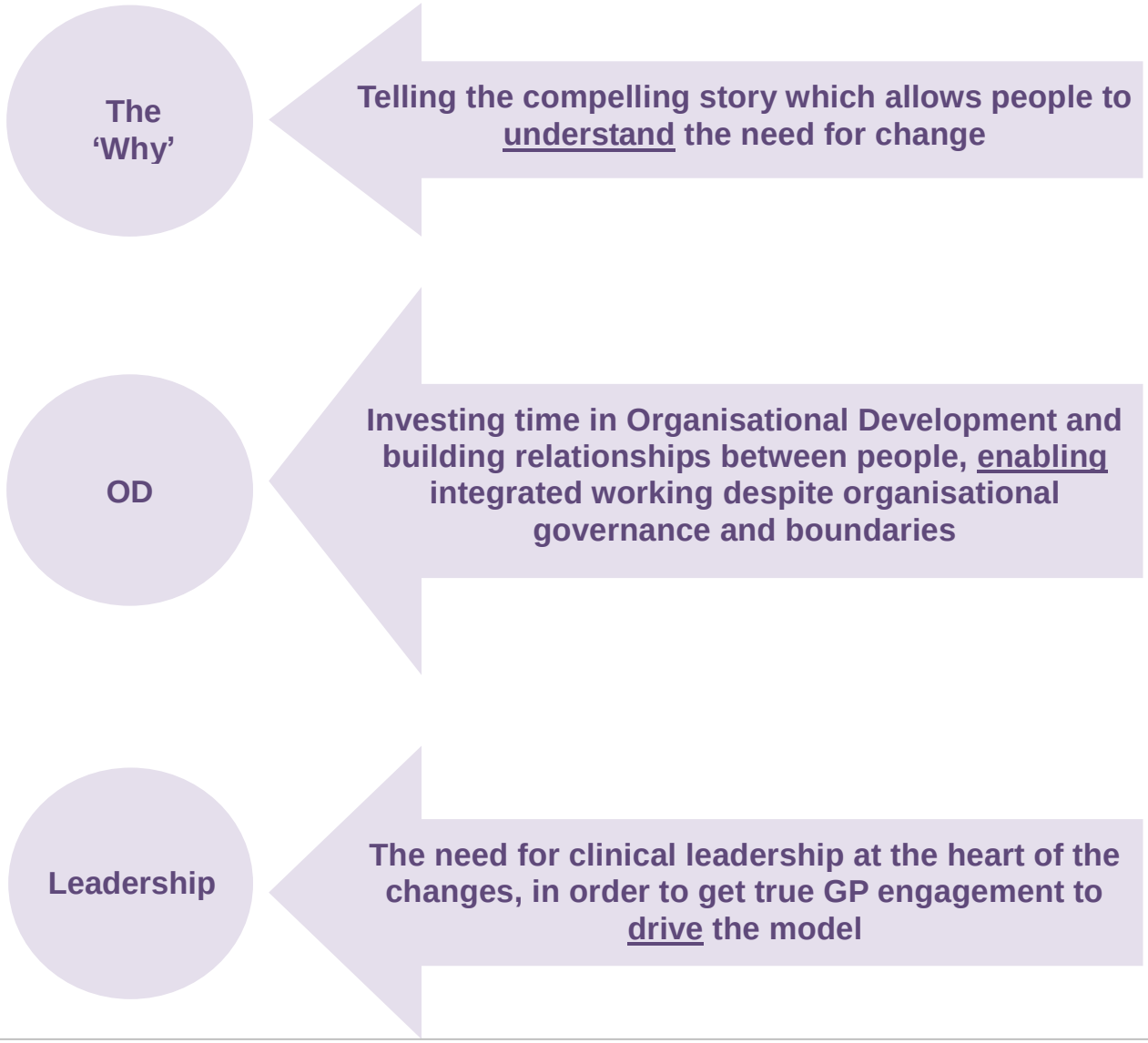
Encompass is implementing a three phase incentive scheme to enable and support Encompass practices to engage in, and deliver the local care model in line with the GP Forward View and STP vision. Incentives will be shared across the footprint and encourage joint working and sharing of resources.



10.5 Leadership and communication

During the Encompass journey we have observed **three** key factors for success in 'engagement in the model' to make it sustainable:

- The 'Why'
- Organisational Development
- Clinical leadership



All of the above takes time and sets a challenge in a system with pressure to change at speed and scale.

However, in order to tackle the system pressures outlined at the start of this report there is a need to work differently across a wider footprint and increase the scale and pace of transformation. A critical element in achieving this will be organisations proactively supporting their staff to align to the new ways of working. In Encompass the move to formation of a Strategic Alliance Board, including all key partners from across the health and care system, provided a catalyst for cultural change in shared accountability.

To ensure engagement of the model, relationship building cannot be underestimated. Nor can the **'ability to hold your nerve'** while putting the foundations in place to establish and grow New Models of Care. This can be especially true when the pressure is on to demonstrate results before the New Models have had sufficient time to develop, deliver and embed. Benefits of this time investment may not be apparent or measurable in the short term, however a lack of them will show in the medium to long term. The quote below was paraphrased by an Encompass clinician at the November (Q2) quarterly assurance meeting in 2017 with NHS England

"Not everything worthwhile can be measured, and not everything that can be measured is worthwhile"

11. Replicability and spread

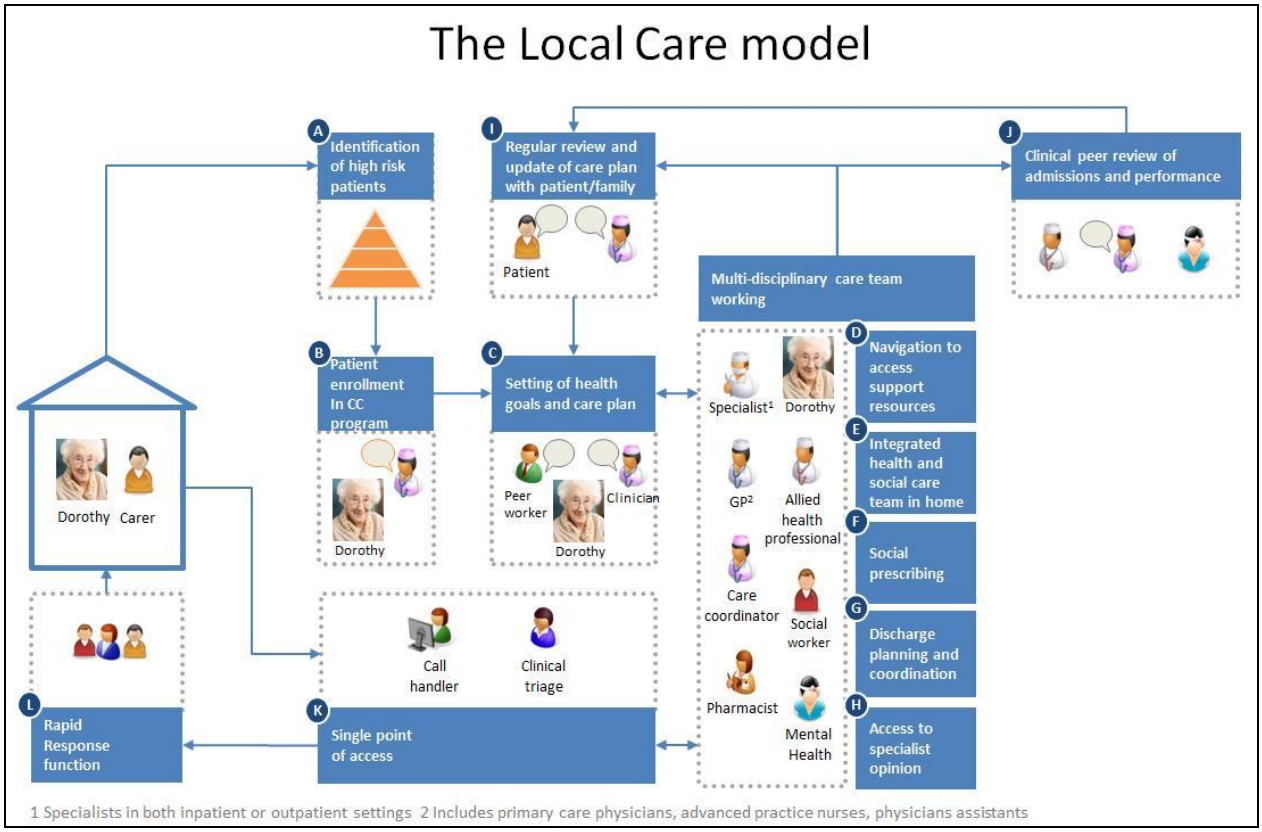
As a vanguard Encompass is expected to share learning. A selection of examples is given below of both local and national sharing of our work.

11.1 Locally

Locally this has been with:

- Partners in the Kent and Medway Sustainability and Transformation Partnership (STP) and influencing the STP work streams
- Statutory organisations such as Public Health, KCC and East Kent CCGs
- Members of the public at events such as Patient Participation Groups, Community Networks and Practice Open Day. Patient Leaflets into surgeries and the production of a patient focused film describing the New Models of Care
- The voluntary sector such as League of Friends, Women's Institute and Red Zebra (Umbrella org)
- The care sector such as the East Kent Carers Forum and Kent Health Watch
- Primary Care Practice engagement sessions locally and sharing the learning and resources developed across other localities and CCGs

The CHOC model is being used as the template for care of our most vulnerable (shown below), especially the frail elderly. This is at the heart of the frailty pathway, a multiagency pathway with focus to care for people in a community setting to avoid hospital admissions.



A number of promotional videos have been produced to share the learning, some of which have been mentioned earlier, such as the Encompass video in **section 7** and WaitLess video in **section 6**. The STP has made a 'Case for Change' video and the Encompass model is included in the video as a case study. A link to this video is in the box **below.**

To watch the STP 'Case for Change' video go to:
https://vimeo.com/226010439

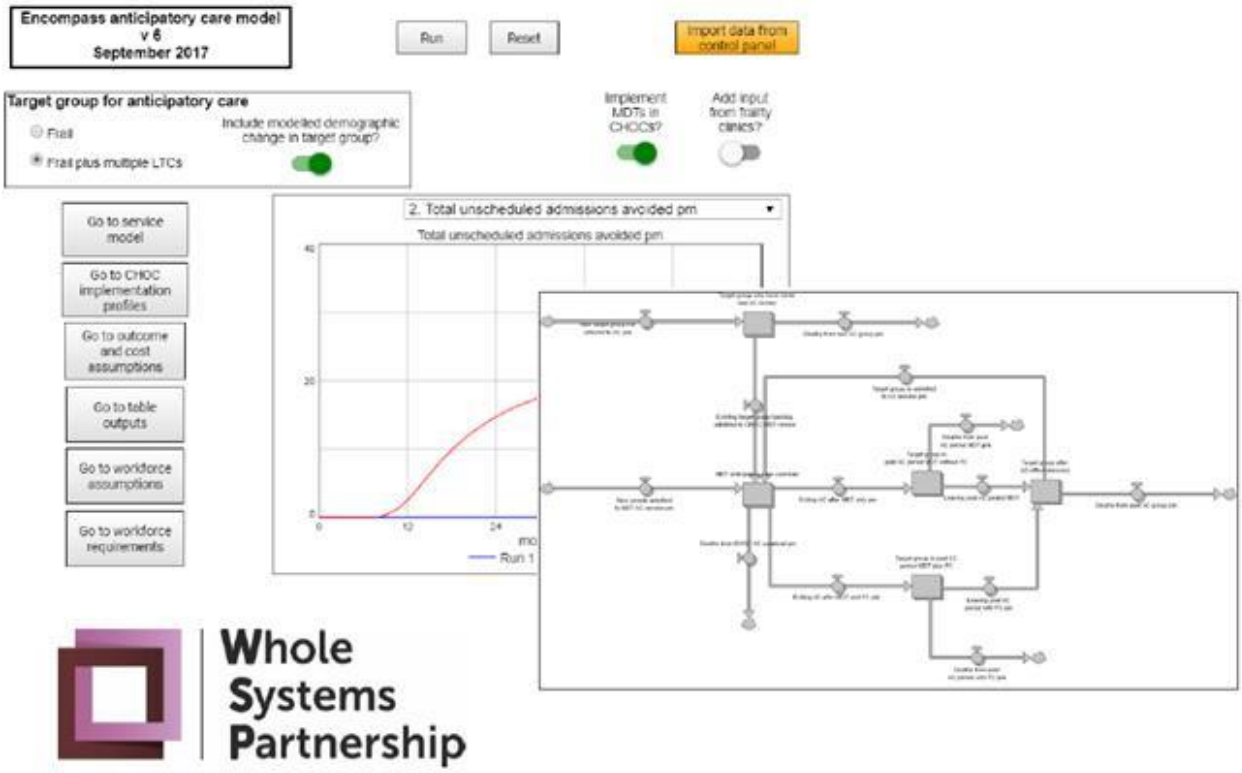
Encompass has been working with the STP and sharing learning from the New Models of care. We have produced a legacy slide set to explain the Models of Care and our journey and learning. This was presented at the STP conference in October 2017.

11.1.1 Understanding what services need to look like in the future

We have explored what the **demand**, **capacity** and **workforce** requirements would be for us to be able to continue to offer an ICM service to all patients that would benefit from it in the medium to long term. Working with 'The Whole Systems Partnership', we used a system dynamics modelling approach which draws on the rich data that is available from the Kent Integrated Dataset (KID) and from projections of underlying population health needs. The diagram **over leaf** shows the model developed by Whole Systems Partnership.

The model can also be configured to work in other geographical locations, helping with planning and implementation on a wider footprint to Encompass. It has been presented

to the East Kent STP Workforce Work Stream to consider whether the Tool might be utilised by the East Kent STP Workforce Work Stream in respect of workforce modelling for local care.



11.2 Nationally

Nationally we have spoken at forums and conferences. A number of articles have been published in specialist national media such as the Practice Nurse Journal, Primary Care Today and Pulse.

Secretary of State for Health - Visit

On 23 June 2016 Jeremey Hunt visited Encompass to learn more about the development of new ways of working to improve health and wellbeing services.

The event was attended by GPs from Encompass practices, leaders of partner organisations, representatives from the voluntary and community sector and members of the Encompass team.

Our website contains information about our services and case studies. We tweet our latest news on twitter and share good practice on the National e-newsletter **(shown over leaf)**. We have represented Encompass at Expo on a yearly basis and have produced a number of case studies for NHS England. We have been supporting CQC

with developing a regulation model for primary care at scale and have hosted a number of visits from other organisations to share the learning from our model.

National e-newsletter - example

Vanguards sharing good practice

New app gives people A&E waiting times

The WaitLess app designed by Encompass (Whitstable, Faversham, Canterbury, Ash and Sandwich) vanguard provides people with waiting times at all A&E departments and minor injuries units in East Kent. This is the first app to offer real-time updates combined with travel time information. It also uses a person's location to sign-post them to minor injury units if applicable, taking pressure off A&E services.

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The latest from the vanguards

- **Encompass (Whitstable, Faversham, Canterbury)** vanguard has produced a video about their work.

A number of documents and learning have been shared with NHS England and through presentations and discussions at our quarterly assurance meetings with NHS England. Clinicians on the front line delivering and shaping the New Models of Care have spoken at the assurance meetings about the benefits of the new ways of working.

At the Q1 and Q2 2017 assurance meetings it was noted that staff motivation and retention is a key contributor to sustainability of the model.

Q2 (Nov 17) assurance meeting quotes

"You should be really proud of what you have done. You have held your nerve and made **great progress across the model**."

Jane McVea, NHS England

"This work has reached a pivotal point; hold on to this, **this is the solution**. Hold onto local care as the solution."

Simon Perks, C4G AO

National recognition for work on local care – CCG Message 3 Oct 17

"

The way that **multidisciplinary** working at the Butchery Surgery in Sandwich is contributing to **high-quality care** has been highlighted in a new report published by the **CQC**.

The State of Care in General Practice 2014 to 2017 highlights evidence of practices, rated as **outstanding**, where **multidisciplinary team meetings** are having a **positive impact on care**.

As part of the work being led by **Encompass MCP**, the practice was involved in setting up a community hub operating centre (CHOC) within the town. This involved bringing together a team from different disciplines such as mental health, social care, community nursing, voluntary organisations and GPs to help make sure that the identified patients had a **joined-up care plan**, which met their needs, and focused on keeping them well at home.

Well done to everyone involved.

Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs

"

12. References

1. NEW CARE MODELS: Vanguards - developing a blueprint for the future of NHS and Care Services. 2016
   https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

2. NHS England (2014) Five Year Forward View [online] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

3. NHS England South (2016), Sustainability and Transformation Plans [online] https://www.england.nhs.uk/south/info-professional/stps/