Quarterly Review update
April 2016

This document provides an update on the work of the MCP and progress and impact following the 2015/16 funding allocation.
Since the 21 January Review, The Principia MCP Vanguard has:

- Increased the number of patients at end of life who have consented to their record and their preferences regarding their care being shared. Since March 2015, this has risen **from 27 patients (0.28 per cent of the population) to 889 patients (0.81 per cent of the population).** The number of patients who have died in their usual place of residence or referred place of care has risen from **19 per cent to 78.4 per cent.**
- Rolled out the GRASP-AF tool across all practices to assess the risk of AF-related stroke and effective management of atrial fibrillation (AF). High risk patients not on anticoagulation therapy have been identified, **with 137 patients** having been initiated on anticoagulation therapy since January 2016. Using the formula that for every 20 patients initiated one stroke is prevented, this **means 6.9 strokes will have been prevented** in the next year across Rushcliffe.
- In-reach by GPs and community nurses to Health Care of Older People (HCOP) wards at NUH – early analysis shows a **reduction in readmission rates of 8.7% in over 65s**;
- Maintained effective management of emergency admissions, which equate to **a 6.4% reduction in admissions** from all sources against 2014/15 volumes.
- Submitted its 16/17 **Value Proposition** (8 February) and supplementary financial information (15 April) which builds on 15/16 and further outlines the MCP model and associated return on investment.
- Worked to further develop the **governance framework** for the MCP and supported the development of PartnersHealth.
- Continued to **share areas of good practice** across the Greater Nottingham Footprint, regionally and nationally – including hosting visits from the Cabinet Office, Chair of the Royal College of GPs and the national Director for the New Care Models programme.
- Begun development of **a social marketing campaign** for 2016/17 focusing on four themes relating to Self Care.
- Received **outcome data** from the enhanced primary care specification with all 12 general practices participating.
- Started a system-wide diagnostic to understand **opportunities for efficiency and quality improvements**
- Members of the AHSN **regional Vanguard Network**.
- **Mobilisation of the new Trauma and Orthopaedics service** provided in the community by PartnersHealth in partnership with Circle and Nottingham University Hospitals clinicians for patients with hip, knee, upper limb (shoulders and hands) and musculo-skeletal conditions. Pilot data indicates a significant reduction in spells and associated costs in secondary care.
- Begun implementation of the **Connected Nottinghamshire Portal** programme to provide the IT infrastructure to support integrated working and information sharing across health and social care in Nottinghamshire.
- Established **training hubs** in two Rushcliffe GP practices to provide education and experience to student nurses as part of future workforce planning to increase recruitment of primary care nurses and developing flexibility of nursing role.

- The Fracture Liaison Service has been shortlisted for a national Royal College of Nursing award. The service was named as a finalist in the Community Nursing category of the 2016 RCNi Nurse Awards for its impact in improving patient experience, health outcomes and nursing practice.
- Achieved medicines management savings of £45k (care homes) and £47k (Medicines Management Service in general practices).

Principia MCP key facts:

1) Awarded £3.792m in November 2015 to support the development of its Multi-specialty Community Provider (MCP) model of care and is currently awaiting confirmation of the 2016/17 financial allocation.

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 brings 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 11 workstreams - each with clinical leadership and aligned to five overarching goals and triple aims:

2015/16 Progress and Impact

1. Development of Fracture Liaison Service

Outcomes and impact achieved by the Community Fracture Liaison Service for Rushcliffe was detailed in the last Quarterly Review Update.
The service was commissioned to provide intravenous iv zolendronate in community settings for initial treatment of osteoporosis with the aim of reducing the prevalence of hip fractures and hospital admissions, but also the costs associated with hospital attendance.
2016/17 will see the expansion of the service to include:

- The provision of IV medications currently only provided in secondary care for the treatment of oesteoperosis and other bone disorders eg. Denosumab, a type II membrane protein inhibitor.
- Treatment of patient referrals with spinal fractures through establishing links with spinal surgeons and increasing awareness among GP colleagues of the importance of recognition and treatment of spinal osteoporosis.
- Increasing capacity in the service to meet increasing demand and to ensure on-going compliance with quality standards advocated by NOS.
- Sharing the service model with neighbouring CCGs and supporting the potential for roll out beyond Rushcliffe.

The Fracture Liaison Service has recently been shortlisted for a national Royal College of Nursing award. The service was named as a finalist in the Community Nursing category of the 2016 RCNi Nurse Awards for its impact in improving patient experience, health outcomes and nursing practice. The winner is to be announced in London on 6 May.
The Principia MCP believes that this is the first service in the country offering intravenous iv zolendronate in community settings and is exploring opportunities to share learning and best practice wider than neighbouring CCGs through the New Care Models programme.

2. Outcomes from HCOP ward in-reach

This innovative in-reach programme sees a Community Matron and GPs at the interface of secondary, primary and community care services by attending the Health Care of Older People (HCOP) acute wards to facilitate timely discharge and provide learning for primary and community care on how an admission might have been avoided.

This initiative is not only helping to speed up transfers of care but also aims to reduce future emergency admissions of older patients. Significant learning from the initial five month pilot is being collated as part of evaluation to inform future provision. Since the service began we have seen better integration with community services, positive patient feedback and early data analysis shows readmissions of patients aged over 65 have been reduced by 8.7%.

The pilot has been extended in order to achieve robust data over a longer period to provide weight to evaluation results and an evidence base for next steps, including the potential for roll out across neighbouring CCGs.

3. PartnersHealth development and mobilising primary care delivery of new services

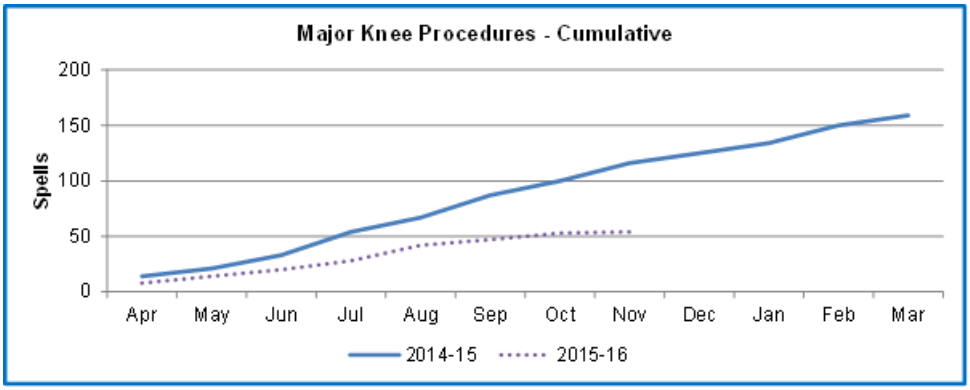
3.1 Community Trauma and Orthopaedic clinics

PartnersHealth is one of three providers jointly commissioned to deliver a new Trauma & Orthopaedic service in the community. The service is a joint venture with Circle and NUH clinicians and is offered from two primary care venues in the community – moving some

appointments previously provided in an acute setting closer to home. The Castle practice in West Bridgford provides upper limb and hand clinics fortnightly. Weekly lower limb clinics are provided from Bingham Surgery as well as West Bridgford.

Following a successful pilot of Lower Limb T&O Triage, Assessment and Treatment Services, the newly-commissioned service has been expanded to also include referrals for Upper Limb (shoulder, elbow and wrist) and hands Following triage, the service offers an appointment with an ESP Physio and/or consultant to provide diagnosis and treatment and, for those that require it, referral to secondary care.

The three year contract commenced on 1 April 2016 and includes the potential for a two-year extension. The pilots have shown reductions in knee procedures over 2015/16 as follows:



3.2 Roll out of Tele-dermatology

Partners Health are also supporting the implementation of tele-dermatology by working with GP practices to make tele-dermatology the single point of access for certain dermatological conditions.

Under the scheme, each practice has a camera attached to a dermatoscope which allows images to be taken in-house and sent electronically for review by a consultant dermatologist. An electronic clinical management plan is sent back and if appropriate, patients can then be managed within primary care by the GP.

This new referral process supports a better patient experience, reduces unnecessary referrals to secondary care and reduces waiting times for diagnosis and treatment for patients who don't need an onward referral.

As at 1 April 2016, 239 Rushcliffe referrals had been sent via tele-dermatology, with 31.3 per cent subsequently managed in primary care with advice and 48.9 per cent being referred on to a two-week wait pathway. This is a much reduced wait compared to a referral to a general dermatology pathway, where patients may wait up to 16 weeks for an outpatient appointment.

3.3 GP Enhanced Specification

PartnersHealth has led the review and refinement of the enhanced GP Specification for primary care services (long-term conditions). Improved data and metrics to assess quality in general practice were co-produced with general practice and agreed in November 2015 with all 12 practices participating in providing an enhanced and standardised primary care service across Rushcliffe.

Through the new contract and in collaboration with practices, PartnersHealth has defined a minimum standard across all practices and worked collaboratively to design and deliver sustainable healthcare solutions. The specification also supports managing clinical variation

and the provision of best care based on best practice and clinical evidence. The enhanced specification in 2015/16 has delivered:

- Improved patient access - All practices are open from 8am to 6.30pm (Monday to Friday) with no lunchtime or afternoon closures and offering appointments up to four weeks in advance.
- Consistency of care - Patient profiles for long-term conditions analysed and standardised templates for care planning in place.
- Increased recording of end of life preferences - Improved level of systematic recording of end of life discussions with patients regarding Preferred Priorities of Care (PPoC) – see End of Life section below.
- Stroke prevention - All practices using GRASP-AF tool to assess the risk of AF-related stroke and effective management of atrial fibrillation (AF) - 137 patients have been initiated on anticoagulation therapy since January 2016. Using the formula that for every 20 patients initiated one stroke is prevented, 6.9 strokes will have been prevented in the next year across Rushcliffe.
- Better use of resources - All practices identifying their Continuing Health Care (CHC) and fasttrack patients for discussion at MDT meetings.

PartnersHealth are leading the development of the 2016/17 enhanced specification which will be extending to include:

- Access beyond mandatory and improved home visiting model
- Long-term conditions risk profiling and risk stratification (Heart Failure and COPD) for care planning
- Long-term conditions extended case finding (for patients at risk of diabetes)
- EOL – expatiating patients in an acute setting (building on HCOP in-reach work)

3.4 Improving End of Life care

PartnersHealth have been instrumental in mobilising practices to implement a systematic and evidence-based approach to optimising care for all patients approaching the end of life. Practices are now using a nationally recognised, evidence-based approach to optimising care for all patients approaching the end of life using indicators related to individual prognosis to identify and conduct a review for suitability for end of life care planning. This has been introduced to ensure co-ordination and collaboration within and between healthcare teams and aims to reduce crises and hospitalisation, enabling more people to live well and die well in the place and manner of their choosing.

All practices are using a standard operating procedure as a guide to how they should review and how they should record their actions – all practices completed this work by 31 March 2016. The electronic palliative care coordination record (EPaCCS) used by GP practices is a whole-system approach that co-ordinates the sharing of vital information to all key healthcare providers. Since March 2015, the number of patients who have consented to their record and their preferences regarding their care being shared has risen from 27 patients (0.28 per cent of the population) to 889 patients (0.81 per cent of the population). The number of patients who have died in their usual place of residence or referred place of care has risen from 19 per cent to 78.4 per cent.

3.5 Supporting Student Nurse Learning in General Practice

In January 2016, Health Education England, East Midlands office awarded two GP Practices in Rushcliffe Training Hub status. This was following a successful bid that was made by PartnersHealth on behalf of all the Rushcliffe practices. Training Hubs have a responsibility to increase the number of learners in community health care settings as outlined in ‘Building the Workforce – the New Deal for General Practice’ (2015).

The scheme aims to provide resilience and succession planning within general practice and future workforce sustainability. Data collated from the Health and Social Care Information Centre minimum data set, published in September 2015 shows that in Rushcliffe 53.4% of nurses are over the age of 50 years. This equates to 23 nurses in total and of these nurses, 12 are over the age of 55 years. This means that 24% of the total CCG Nurse workforce is eligible for retirement - probably within the next 5 years. Placement opportunities within the training hubs aim to give nursing students exposure to the opportunities within general practice and promote practice nursing as a career choice on qualifying.

The emphasis of the scheme is on changing attitudes within primary care to hosting student nurses and highlighting the benefits of having trainees in practice. This includes raising the confidence of established practice nurses to mentor students and identifying the training required to support them in taking on mentorship.

Expected outcomes include: An increase in student nurse exposure to general practice and direct recruits on qualification - providing Rushcliffe with more 'home grown' nurses – and a more flexible and sustainable workforce model for the future as new staff are employed and extended roles developed within primary care nursing.

4. Medicines Management initiatives improving quality, effectiveness and efficiency

Between January and December 2015, 1240 medication review interventions were carried out for care homes residents. These multidisciplinary medication review interventions involve a GP, primary care pharmacist and one or more carers from the care home. Where appropriate, the pharmacist has met with the residents to seek their views on the medication they take. The reviews have provided an opportunity to optimise medication regimens, ensure monitoring is up-to-date and address issues such as swallowing difficulties and the need for alternative administration of medication. Cost savings of around £45k have been achieved so far.

The Medicines Management Team also provides a sustainable, efficient medicines management service within Rushcliffe's 12 GP practices which works in collaboration to deliver both cost and quality outcomes. The programme includes the provision of training, education and professional/technical support to the Medicines Management Facilitators located within each practice.

The benefits of this service include practice based staff having:

- more ownership of the issues being addressed
- better internal communication
- designated service provision time allocated
- specific training and education to deliver effective outcomes
- designated support from the Medicines Management Team, ensuring a quality and sustainable service

Provision of this service allows the introduction and spread of sustainable, effective medicines management outcomes, particularly in the three key areas of:

- Specific drug management systems within a practices
- Patient safety
- Waste medicines reduction

The development of this service has complemented and significantly enhanced the cost saving and quality outcomes currently being achieved - during 2015/16 savings of approximately £47k were made.

5. Connected Nottinghamshire and Local MCP IT developments

Connected Nottinghamshire continues to progress in supporting the development of Nottinghamshire's Integrated Digital Care Record. Focusing on support for Nottinghamshire's Vanguard programmes, developments are progressing well with the Graphnet portal solution with delivery in Rushcliffe accelerated through the provision of the 2014/15 MCP funding allocation. The hardware and software have been installed by the host Trust and work is commencing on the first connectors and change management arrangements.

Further benefit continues to be realised from the existing Medical Interoperability Gateway (MIG) deployment as increasing numbers of elective pathways start to use the system to access records. This work is also expanding to include HCOP (acute ward) access to GP records to support the MCP primary care in-reach initiative for improving discharge. In phase one of the Portal work, MIG will be made available through the portal realising a significant sharing milestone.

With support from the New Care Models Informatics team, led by Helen Arthur, Connected Nottinghamshire has reviewed the current programme governance, delivery so far and future plans. The post-review report has given assurance that work is progressing well and is well governed. A number of actions resulting from this around sharing Nottinghamshire's model and plans to support others have already been enacted, with other actions suggesting areas of improvement being built into future plans.

Connected Nottinghamshire is also facilitating the development of the Digital Roadmap in support of the MCP and wider STP footprint and triangulating learning from the Vanguard development work. This will show how we will become paperless by 2018 and give patients full access to their Care records by 2020.

6. Capturing improvements in patient experience through case studies

Patient case studies are being sourced from areas of initial MCP impact - including the Fracture Liaison Service and enhanced support to care homes - and shared locally and nationally as examples of service design driving improvements in quality and patient experience (appendix 1).

As highlighted in the last Quarterly Review Update, an integral part of the Care Delivery Group (CDG) model is the voluntary sector attendance at multi-disciplinary team meetings. AgeUK have been commissioned to provide guidance and support to individuals through their Living Well Care Navigator. AgeUK works directly with patients referred to the Navigator to identify any additional unmet needs. Recent patient experience feedback has highlighted the value of the service:

A patient who had pulmonary rehabilitation needs was planning not to attend the course provided because she was anxious about not knowing anyone. The AgeUK Living Well Co-ordinator went with her to the assessment and the first day of the course. Once she had met with other patients and felt more comfortable she was able to go to the following courses herself. Without this support the patient would not have accessed the course, which will be hugely beneficial to managing her COPD, as well as providing a social network.

A community services team had been having difficulty discharging a patient because she was very lonely and enjoyed the routine of their visits and wanted them to continue. Through the support of an AgeUK Living-well Co-ordinator they were able to identify some local support networks and introduce her to the groups. She now has a network to link in with and also

receives visits from a befriending service, both of which continue to support her in building confidence and getting out more.

7. Communications and Engagement

Workstream 1 - *Support to self-determination and self-management* – includes deliverables linked to the Self Care and Self-Management agendas (local MCP vision and *Five Year Forward View*). A Self Care Task and Finish Group, aligned to Workstream 1, has been established to promote the Self Care and Self Management agenda with the Rushcliffe population. The group includes clinical and patient representation and aims is to raise awareness of Self Care through the delivery of a social marketing campaign and supporting activity throughout the summer/autumn of 2016, culminating in Self Care week 2016 (14-20 November).

In defining 'Self Care' the Task and Finish Group used the Self Care Forum's continuum to agree that the remit of the group in promoting Self Care would extend up to and including long-term conditions management.

The national *One You* campaign has been developed by Public Health England (PHE) and was launched in March 2016. The campaign is targeted at all adults, with a focus on those aged 40-60. The theme of *One You* is that the lifestyle choices made during these years (40-60) have greatest impact on health later in life (post 60 years). PHE have developed messaging, creative and resources to support the campaign as well as an online presence at www.nhs.uk/oneyou. Local Authorities and CCGs are being encouraged to adopt the campaign creative and brand locally.

On the basis of cost effectiveness, and in order to have resources available in time to support a presence at a number of planned events across Rushcliffe during the summer, The Task and Finish Group have adopted the national *One You* social marketing campaign and associated creative as an 'umbrella' brand for a local campaign.

The *One You* campaign is being tailored for local use under the following four themes that support the MCP vision and will be delivered at public events:

- **Healthy lifestyles start with healthy choices** – including personal responsibility for choices.
- **Right Care, First Time** – including signposting to local services (get the right treatment / choose well), raising the profile of pharmacies and personal responsibility for the appropriate use of services.
- **My health, my responsibility** – including promotion of free NHS services available to adults e.g. screening and health checks.
- **Managing my long-term condition** – including regular monitoring, medication reviews, care planning, assistive technology signposting to support groups.

8. Clinical Leadership Forum and MCP Governance

A Clinical leadership forum has been established across the MCP stakeholders to support the development of the MCP governance model.

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Appendix 1 - Case Studies

Fracture Liaison Service

A newly commissioned community Fracture Liaison Service, piloted by East Bridgford Medical Centre on behalf of Rushcliffe GP Practices, works in conjunction with an established acute setting Fracture Liaison Service. It identifies patients with first/secondary low-trauma hip and fragility fractures in order to provide intravenous (IV) treatments in the community. The service aims to reduce the number of IV treatments provided in hospital or by out-sourced services, outpatient clinic follow-ups and the costs associated with these.

Sister Donna Rowe, the Osteoporosis & Fracture Liaison Nurse Specialist who runs the service, says: "We are consistently receiving more referrals than was originally anticipated. Initially, we were working reactively, predominantly receiving patient referrals from secondary care, but now I have developed the service to work far more proactively; I identified, at an early point in the programme, that there are other osteoporotic patients seen within other specialist teams within the hospital system whom the service could benefit, and particularly its potential to deliver IV therapies, where required."

Maximising opportunities for clinical engagement between key stakeholders has been fundamental to the success of this service. For example, by systematically identifying Rushcliffe patients who have previously been through the fracture clinic pathway , Sister Rowe has been able to work closely with GPs to optimise their treatment/management plans to reflect clinic-generated recommendations, and provide a quality follow-up service; all seeking to reduce/avoid further fragility fractures, resultant hospital admissions and reduced patient outcomes. Similarly due to the innovative working practices established by the service's Lead GP, Dr Ann-Marie Stewart, and QMC's Professor Sahota, Consultant Physician in Orthogeriatric Medicine the service is able to act as a primary care 'triage point' into the acute setting and can readily obtain an expert opinion via an effective 'virtual clinic' facility.

Adds Sister Rowe: "It was important the service could be regularly audited for quality, in order to evaluate and adapt the service to reflect the experiences and needs of its patients. We therefore ask all patients to complete a patient-friendly, likert-scale based questionnaire about how easy they found it to access the service, their experience of the service and the treatment itself. The feedback has been incredibly positive, particularly around the compassionate and personalised care provided, and the time taken to explain the treatment and answer patients' questions. Patients have described the service as being 'calm, friendly and kind' and say they are 'over the moon' at not having to travel to hospital, being seen closer to home and in a less overwhelming environment."

One patient who has benefitted from the new service is 66 year-old Richard.

Richard attended his GP practice with chronic back pain following a fall downstairs. Two lots of prescription painkillers failed to control his pain and he was referred to the local hospital for a biopsy, DEXA scan (to measure bone mineral density) and an x-ray.

Richard's x-ray showed multiple Osteoporotic fractures to his vertebrae and ribs and he was diagnosed with osteoporosis. He was prescribed two treatment medications; Alendronic Acid to strengthen his bones and reduce the risk of subsequent fragility, vertebral and hip fractures, alongside a Calcium/Vitamin D supplement, which is crucial to maximise bone health. He would also to attend for regular follow-up at the hospital Bone Health Clinic.

Richard found taking the Alendronic acid tablets difficult - he had to remember to take them once a week, early in the morning on an empty stomach with two glasses of water; Richard was unable to lie down or eat/drink after taking the medication for at least 30 minutes. Taking the Alendronic Acid caused a number of unpleasant side effects for Richard, which he often found to be painful and difficult to manage.

Following a Consultant review at the hospital, he was recommended for IV Zoledronate, and was referred to the Fracture Liaison Service based at East Bridgford Medical Centre. Within days Richard had a letter asking him to call to arrange a convenient appointment and, although he was willing and physically able to travel from his home a few miles away, he was delighted to be offered an appointment at his own local health centre. As well as not having to go far from home, Richard was also able to book a late afternoon appointment which meant he could fit in his treatment around work commitments during the day.

Says Richard of his treatment: ***"It was such a positive experience. The nurse really took on board my anxiety about needles and apprehension at having a drip. The treatment lasted about half an hour and she chatted to me to distract me the whole time. In the end I was very relaxed and it was all quite painless.***

"Now I only have to go back for treatment about every 18 months which is much better than having to remember to take pills every week. I certainly won't be anxious next time and have no concerns at all about having to have the treatment again.

"I don't use the NHS a lot as I'm not an 'ill' person, so it's wonderful that it all comes together and the service is so good when you do need to use it."

Enhanced Support to Care Homes

Enhanced support to care homes is offering an aligned GP practice for each care home, better care planning with residents and their families, regular clinical and medication reviews, improved communication of pathways and protocols to avoid emergency hospital admission and direct access to community health professionals including falls and district nursing.

Age UK Nottingham & Nottinghamshire (Age UK Notts) have been commissioned to provide independent representation, advocacy and a 'worry catcher' service to support residents and their families, such as Margaret.

Margaret has Alzheimer's and Raynaud's disease and recently moved to a care home in Rushcliffe after her previous care home in the City closed. Her sister and niece share a home in Rushcliffe and have been visiting and caring for her.

Margaret also has a son, living in the south of England who has expressed the wish that he would like Margaret to move into a care home near to him, but her sister and niece wanted her to stay in Rushcliffe. An Age UK Notts Resident Representative was asked by Margaret's social worker to attend a Best Interest Decision meeting with the sister, niece and son (via Skype) to help facilitate discussion and provide an independent perspective.

Prior to the meeting, the Resident Representative spoke with the senior carer at the Rushcliffe home and was assured that Margaret had settled in quickly – ascertaining that she liked to sit in the lounge with the other residents, appeared bright and was sleeping well. The Age UK Notts advocate also spent time alone with Margaret and found her to be happy. She was alert and smiling when talking about her sister and niece, but she did not react in the same way when asked about her son.

The resident representative was able to discuss her findings at the Best Interest Decision Meeting where each person presented their views on where Margaret would be happier living.

Prior to the Age UK service being in place the care home, family and social worker would have had to navigate potential conflicts in discussions around Margaret's future care, without the benefit of an independent perspective. Where other professionals may not have had adequate time to spend talking to Margaret in detail about her wishes and any concerns, the Resident Representative was able to provide an independent advocacy service and ensure that Margaret's own feelings and preferences were heard at the meeting and central to decision-making.

As the meeting progressed, it became clear that it was important for Margaret to be able to speak to people familiar within the area in which she has lived and worked all her life and would receive regular visits from her sister, niece and great nephews three to four times a week. Her son had said that he would be able to visit once a week. After three hours of discussion between all parties, it was agreed that Margaret should stay in Rushcliffe.

The Residents' Representative Service was able to support the social worker, care home, Margaret and her relatives to work through a potentially difficult meeting and ensure that the outcome for Margaret was in her best interests and reflected her own views on where she would prefer to live and be cared for.