Happy Healthy atHome

Wessex Academic Health Science Network

Wellbeing and Wealth

Evaluation Symposium

Out of Hospital Urgent and Integrated Care

Agenda

10:15	Welcome
10:30	**Out of hospital urgent care** – *how do we look after our patients when they're in crisis?*
	Safe Haven
	NHS 111 Triage – North Hampshire Urgent Care
	Urgent Care Centres in Yateley and Farnham
	Paramedic Rapid Home Visiting Services
12:20	Lunch
13:15	**Out of hospital integrated care** – *how do we look after our most vulnerable patients?*
	Enhanced Recovery & Support at Home
	Integrated Care Teams
14:30	NHS England New Care Models Team
14:45	Workshops (and refreshments)
15:30	Plenary & Close
16:00	Finish

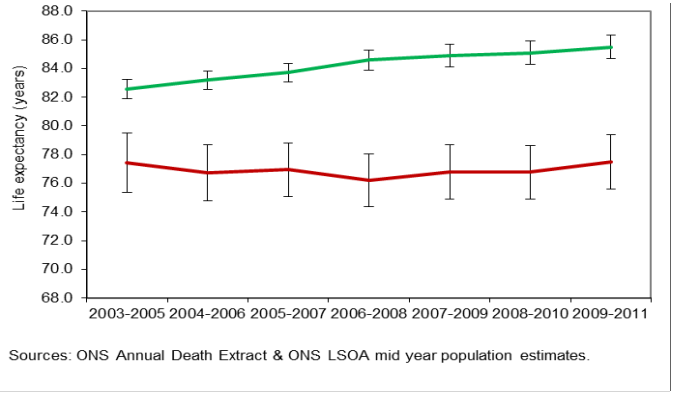
Keith Douglas - Vanguard Programme Director

EVALUATION SYMPOSIUM WELCOME

Our Geography

Issues Driving Vanguard

A gap in outcomes for our population



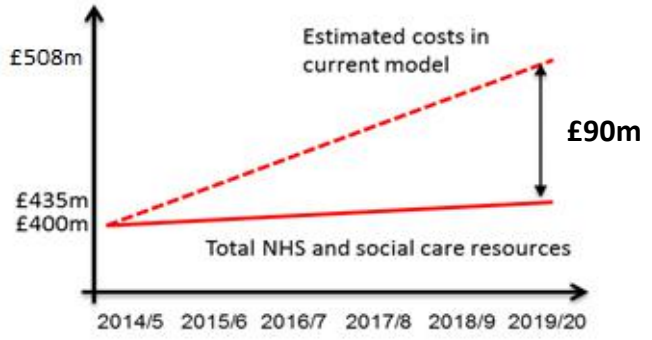
6 year life expectancy gap and 12 year disability-free years gap within NE Hants & Farnham

Demand rising as we live longer with more complex needs

Gaps between services for local people

Local people tell us they believe that health and social care services need to be more integrated, and need to bring together people, communities and the public, private and voluntary sectors.

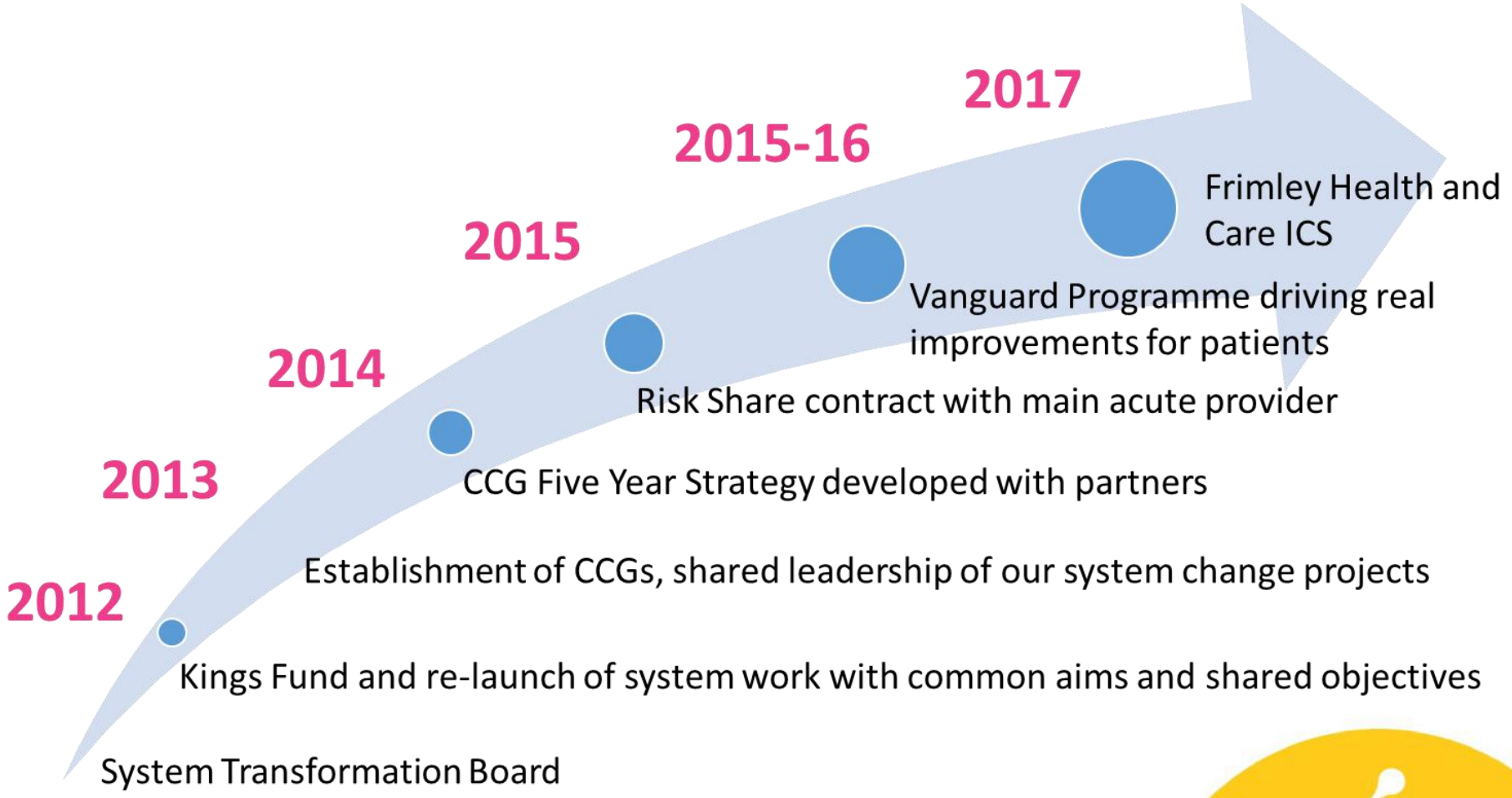
A financial gap in 5 years of £90m



Our vision: Happy, Healthy, at Home

Our vision is that local people are supported to improve their own health and wellbeing, and that when people are ill or needs support, that they receive the best possible joined up care.

Our Journey


2012
System Transformation Board
2013
Establishment of CCGs, shared leadership of our system change projects
2014
Kings Fund and re-launch of system work with common aims and shared objectives
2015
CCG Five Year Strategy developed with partners
2015-16
Risk Share contract with main acute provider
2017
Vanguard Programme driving real improvements for patients
Frimley Health and Care ICS

Our new care model: Happy, Healthy at Home

We are taking targeted action to prevent ill health and promote self care:

- Social Prescribing
- Recovery College Courses
- Crisis Café
- Support to carers and staff

We are strengthening local primary and community care:

- Practices working together
- Separation of on-the-day urgent primary care from planned primary care
- Integrated Care Teams
- Proactively managing the health and social care needs of the population

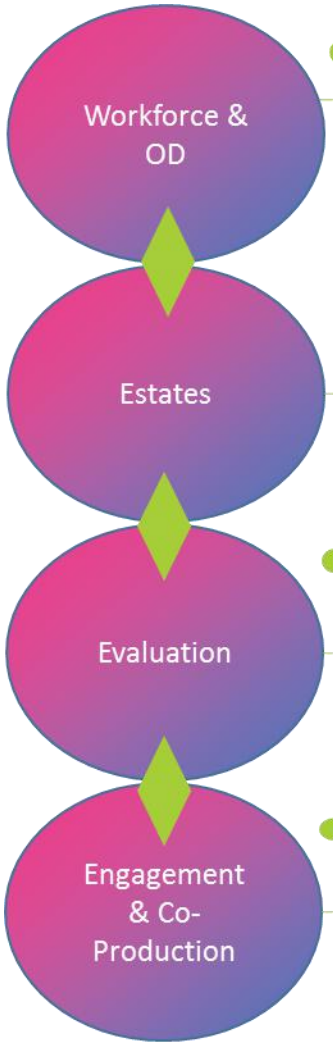
We are improving services for patients in a crisis and those who need specialist care:

- Expanding the capacity of community and social care response services, and extending their working hours to 8am-9pm
- Redesigning the interface between hospital care and primary care – e.g. hospital consultants supporting locality hubs, GPs working in hospital

We are making the right information available at the right time for clinicians

- GP Viewer in A&E
- ICTs sharing data
- Risk Stratification tool

Happy, Healthy, at Home Enablers



Redesigning the workforce and ensuring the behavioural changes needed to deliver the new model of care happen:

- Integration Leaders programme
- Workforce profiling & planning
- ICT locality development programme
- 2020 leadership programme

Ensuring the estate we have is fully utilised to accommodate the new models of care:

- Co location of integrated teams
- Identify estate that is not fit for purpose
- Ensuring estates are fully utilised

Evaluating the impact of the changes:

- Understand the impact on patients and staff of the new models of care
- Understand the impact on the wider system and health economy
- Share learning to spread best practice across NEHF and beyond

Working with the community to design and deliver new models of care:

- Culture change to facilitate true co-production of services
- Engaging hard to reach groups to understand their health needs
- Communicating the Happy, Healthy, at Home programme to the wider community

How we are delivering the new model of care

Creating a system where fewer services are delivered in an acute provider setting…

..and more are delivered at….

Frimley Park Hospital

Home

GP surgery

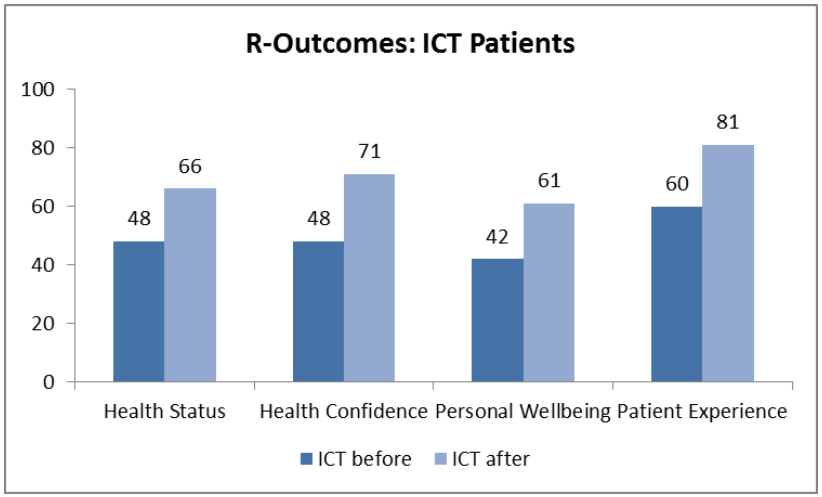
Community-based services

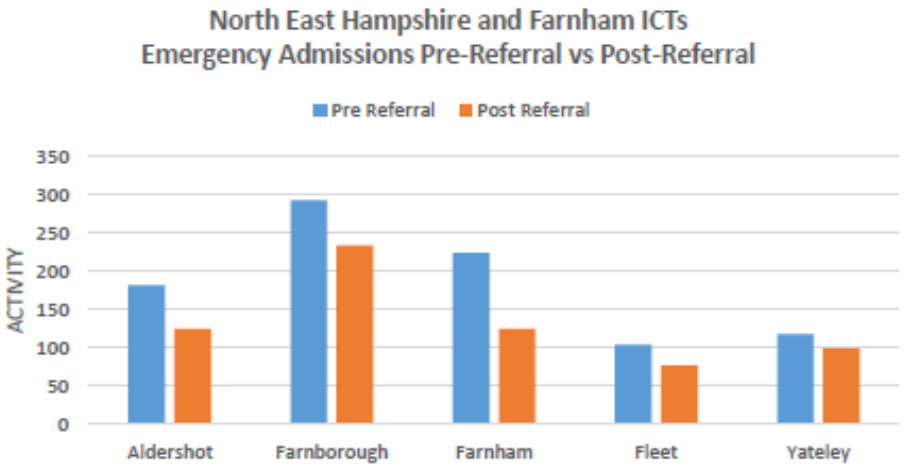
Benefits for local people

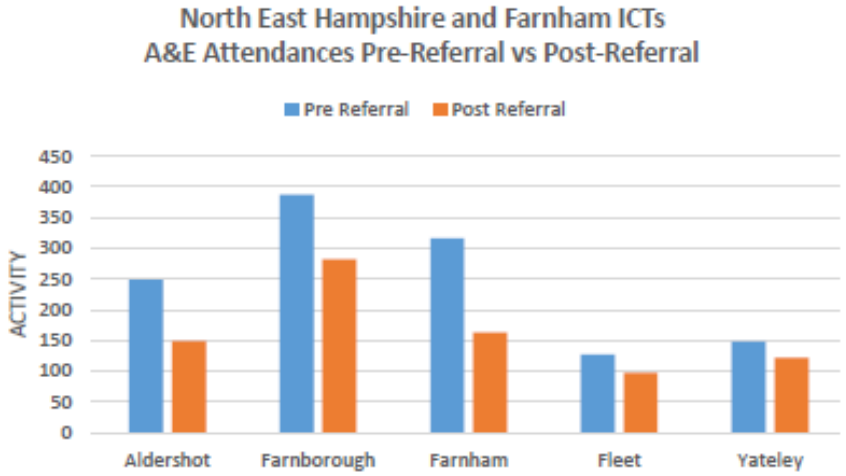
For local people the programme will mean they experience:

- Support at home and in the community available 7 days per week enabling them to better manage their own physical and mental health and wellbeing
- Care coordinated around individuals and targeted to their specific needs
- Care that is responsive, proactive and joined up
- Services in which the mental as well as physical health needs of individuals are fully addressed at every stage
- Improved outcomes (living longer, happier, healthier lives)
- Improved experience of health and social care services

Benefits for our patients







The Patient Story

"There is nowhere like home, I'd rather be there than a hospital bed. I'm very glad they were there to help me get home."

"I really didn't want to go home, I didn't think I was ready. She helped me see that I was and I could cope and would be happier there. I have a lot to thank her for."

"It happened very quickly, my wife was discharged and that same day we were told a nurse practitioner would be with us that afternoon. Well, I'd hardly got back to the house and they were there. Later a carer arrived and asked what we required and took it from there. I was very impressed."

"I'd got to know her [ERS@H staff member] and a friend of mine was having a baby girl and I was knitting a jumper for her but didn't have any buttons. On her way to see me she went to the shop, bought some buttons and brought them here. It was so kind of her, that really made me smile, I was really pleased."

"I think they saw the whole situation, including my home situation, and not just my health problems. That helped a lot."

Assessing impact

Apr 16 - Dec 16 vs Apr 17 - Dec 17

#	Metric Name	2016/17 YTD	2017/18 YTD	% Variance against Last Year	% Variance against CCG Target	% Variance against Project Target	RAG
5	A&E Attendances (All Providers)	48,166	48,374	0.4%	-0.6%	2.3%	
6	Emergency Admissions (All Providers)*	15,227	14,951	-1.8%	-2.8%	-0.3%	
9	ACS Emergency Admissions (All Providers)**	2,730	2,466	-9.7%	-10.6%	-	
10	Emergency Readmissions within 30 Days (All Providers, Nation Definition)	1,879	2,988	59.0%	58.0%	-	
	Emergency Readmissions within 30 Days with 1+ Days LOS (All Providers, Nation Definition)	1,815	1,913	5.4%	4.4%	-	
7	Total Occupied Bed Days (All Providers)***	74,061	68,972	-6.9%	-7.5%	-	
	Non-Elective Occupied Bed Days (All Providers)***	63,824	58,727	-8.0%	-	-	
8	Delayed Transfers of Care - Days (Frimley Park - Acute Only)	8,264	7,808	-5.5%	-5.5%	-	
11	GP Referrals (All Providers)	30,545	29,280	-4.1%	-6.2%	-	
12	Permanent Admissions to Nursing/Residential Homes (Hants)****	Requested from Hampshire County Council but not received					
12	Permanent Admissions to Nursing/Residential Homes (Surrey)****	172.0	137.3	-20.2%	-	-	
13	Proportion of People Still at Home after 91 Days (Hants)****	Requested from Hampshire County Council but not received					
13	Proportion of People Still at Home after 91 Days (Surrey)****	78.0%	74.4%	-3.6%	-	-	

Headlines:

- We are maintaining our strong position with the majority of our key metrics (for which we have regular reliable data) RAG rated as green , showing we are on target or bettering our target.
- Emergency Admissions is the key metric for NHS England and we have consistently performed well for eleven months now as our locality plans continue to deliver improved services to their populations.
- Where we are seeing our biggest impact is on emergency admissions for ambulatory care sensitive (ACS) conditions (also known as "avoidable" emergency admissions), indicating that our new models of care are successfully treating people in the community as opposed to them being admitted to hospital. This is further reinforced by our very good position on occupied bed days.
- Following ongoing issues with Emergency 30 day Readmission data we have chosen to split out overnight readmissions i.e. Readmissions with one or more days length of stay. This is consistent with reporting by our main provider, Frimley Park Hospital, and overcomes the ongoing coding issues resulting from new ways of working at Frimley, which has seen planned ward attenders incorrectly coded as emergency readmissions with zero length of stay. Looking at the data this way highlights a need for further work to understand why we are above target for overnight readmissions.
- We are also having an impact on planned care activity with GP referrals consistently below target all year to date.

Closing the funding gap

- Vanguard programme has spent £13.5m over the past 3 years.
- Has delivered on targets to manage activity in secondary care services by increasing provision of care in the community. CCG would not have been able to balance financial plans without this.
- CCG will spend £3.6m to continue funding of schemes in 18/19. Requirement for schemes to continue managing activity growth for CCG to meet financial plans.

Vanguard Programme 2015/16 to 2017/18

Programme Area	2015/16	2016/17	2017/18	Total
	£000			
Localities	453	1,241	1,920	**3,614**
Enhanced Recovery at Home	-	230	350	**580**
MSK Extended Scope Practitioners	-	-	300	**300**
Making Connections	49	178	165	**392**
A&E Emergency Streaming Index	-	-	160	**160**
Recovery College	45	120	120	**285**
111 Triage and Pharmacists	-	143	100	**243**
MISSION	-	-	80	**80**
Pump Priming	1,095	-	-	**1,095**
Estates & IT	248	1,096	865	**2,209**
Project Management Office	517	780	490	**1,788**
Evaluation	89	247	200	**536**
Workforce & OD	441	149	200	
				-
Other Enabling Projects	446	1,152	635	**2,233**
Total	**3,383**	**5,337**	**5,585**	**13,514**

2015
Safe Haven

April 2016
GP on the Wards in FPH

April 2016
Recovery College

July 2015
ICTs in all 5 localities

2015
Enhanced Recovery @ Home Interim Service

June 2016
Farnborough Physio Pilot

June 2016
EMIS Viewer live in Out Of Hours

May 2016
Yateley Virtual Urgent Care Centre

July 2016
Farnham Referral Management Service

July 2016
Making Connections

June 2016
EMIS Viewer live in A&E

Sept 2016
Yateley Physio Service

Sept 2016
ESI in Frimley A&E

Sept 2016
MISSION Pilot Clinic

Sept 2016
Yateley Community Paramedic

Sept 2016
Farnham Pre Diabetic Education Programme

Feb 2017
Yateley Urgent Care Centre

April 2017
Oasis

April 2017
Farnborough Community Paramedics

Feb 2017
Yateley Help Hub

June 2017
Farnham Integrated Care Centre

July 2017
WebGP Pilot

June 2017
Enhanced Recovery @ Home Full Service

2017
Prescribing Pharmacists Out of Hours

Autumn 2017
Rapid Home Visiting Service in all 5 localities

Oct2017
111 Triage

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MISSION Clinics

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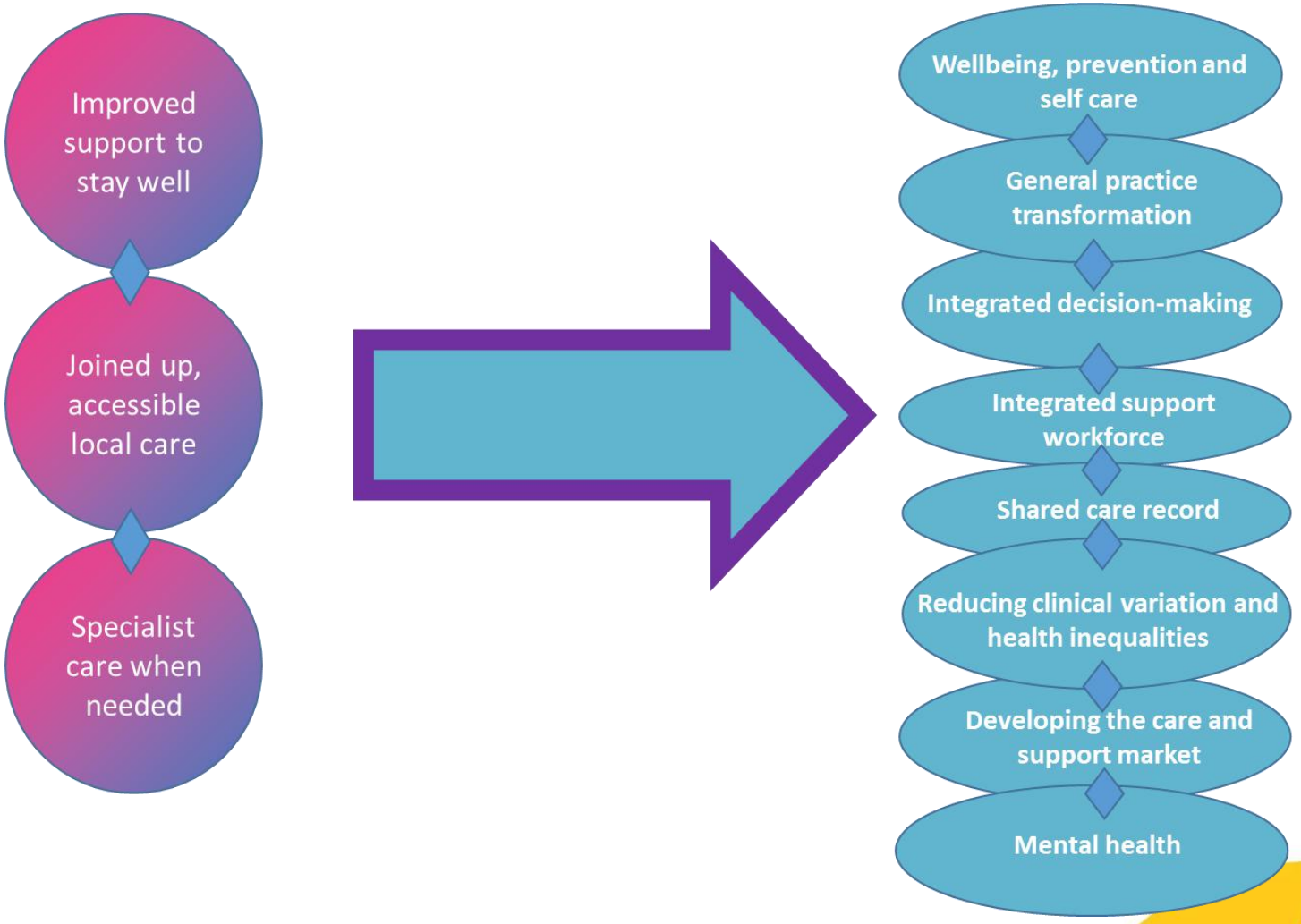
Continuing the journey ⇨

⇨ Frimley Health & Care STP/ICS



Sharing learning + Evaluation

- Critical that what we have done is not lost when the programme ends

- Sharing what we have done via
  - Conferences
  - Local meetings
  - One to one discussions
  - News media and other outlets
  - Case studies

- To share we need to be able to describe what happened and if possible id cause and effect
  - Evaluation is key to this
    - Sometimes seen as a chore but without we are nothing
    - Wessex AHSN as our External evaluation partners have
      - Provided unbiased approach
      - Provided the rigour of process and inputs
      - Been honest about the conclusions that can be drawn
      - Been instrumental in helping the system to focus on those programmes that should continue

Sharing learning + Evaluation

- Evaluation has been
  - A mix of deep dives and shallow dives into different programmes and projects
  - Complemented by monitoring and measurement via regular routine dashboards
  - Backed up by work from other parties e.g. IAI review of ICTs

- Final summative evaluation report July 2018

The Evaluation Team

- Philippa Darnton, Programme Manager Wessex AHSN
- Joe Sladen, Programme Manager Wessex AHSN
- Andrew Lilies, Consultant Wessex AHSN
- Dr Andrew Sibley, Programme Manager Wessex AHSN
- Alison Griffiths, Programme Manager Wessex AHSN
- Tim Benson, R-Outcomes Ltd
- Dr Catherine Matheson, Senior Research Fellow, Centre for Implementation Science

Out of hospital urgent care

How do we look after our patients when they're in crisis?

Felicity Greene, Chief Executive
North Hampshire Urgent Care

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NHS Surrey and Borders Partnership NHS Foundation Trust

Wessex Academic Health Science Network

Stanley Masawi, Safe Haven Manager, Surrey & Borders Partnership NHS Foundation Trust

Alison Griffiths, Programme Manager Wessex AHSN

ALDERSHOT SAFE HAVEN

The Safe Haven Service

- Launched in 2014
- An evening drop-in service providing people aged 18 years and over with mental health support out of hours, 365 days a year
- Partnership working between Surrey and Borders Partnership NHS Trust, Andover MIND and Catalyst
- NHS staff, along with voluntary sector partners, are on site to provide **crisis support and to help people maintain their mental health (prevention),** with the aim of avoiding the need for emergency NHS care
- Video: https://www.youtube.com/watch?v=qvYw-eTqHR4

The Safe Haven Service

- Drop in service – no appointment necessary
- Carers can attend on their own or with the person they support
- Several ways in which support is offered:
  - People are able to chat with others, providing peer to peer support
  - Sit by themselves, in the knowledge that support is available and they are in a place of safety
  - Talk to a member of staff
  - Develop Crisis Plans
  - A person's GP or mental health team can be contacted
  - If appropriate, a formal mental health assessment can be undertaken by the onsite clinician

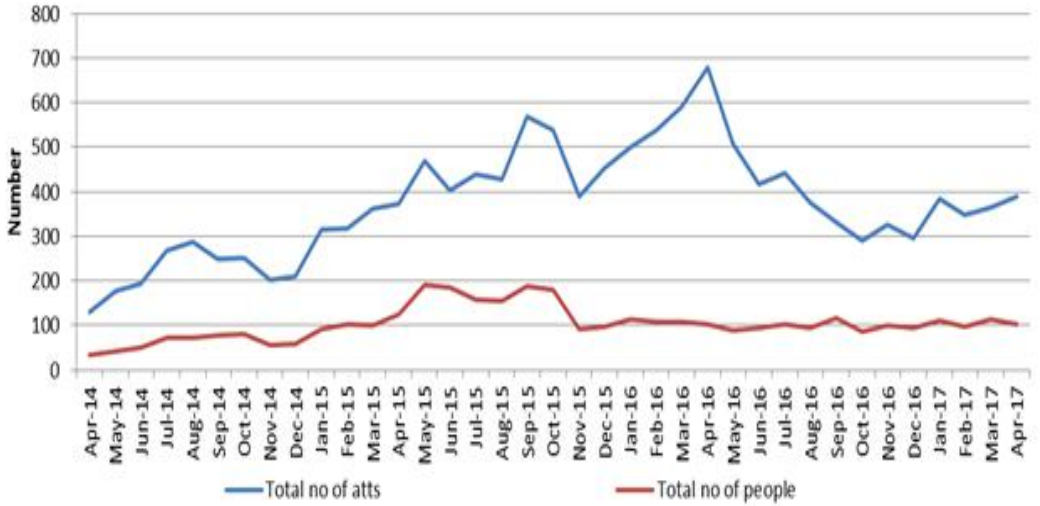
Aims of the service

- Offer a **supportive environment** for people experiencing deterioration or a crisis in their mental health
- An **alternative to the Emergency Department**; providing a more responsive and tailored approach for people experiencing mental health difficulties
- **Prevention and earlier access** to treatment and interventions
- Encourage **self management** and independence
- Where necessary, **onward referral** to other appropriate services
- **Care Planning**/Crisis Plan development
- Establish **strong links** with other NHS organisations and other local services

Evaluation outline

- **Attendances**
- **Emergency Department (ED) Activity**
- **Psychiatric Admissions**
- **Police data:**
  - *Mental health related calls to the police*
  - *Police deployments*
  - *Section 136 suite detentions*
- **Financial modelling**
- **Service user feedback**

Total number of Safe Haven attendances and total number of people using the service each month:

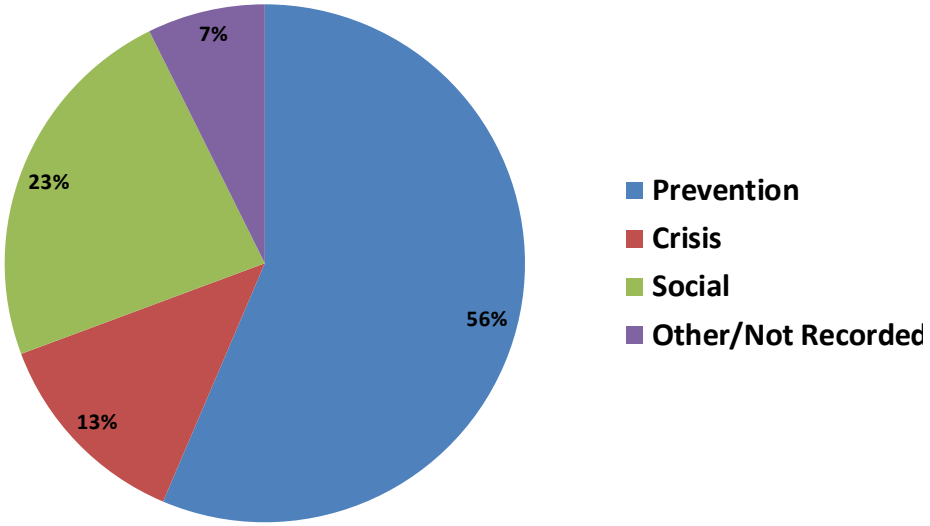


NHS South, Central and West Commissioning Support Unit

- The graph shows that people attend the service on average more than once.
- A person may attend the service several times until their crisis has abated.
- On average 13 people per shift attend the service (April 2016 - March 2017).

Reasons for attendance

The data relates to August 2016 to July 2017. During this time period there were 4275 attendances at the Safe Haven Service, by approximately 670 unique service users.



Reason for attendance	Number of attendances	% of attendances
Crisis	552	13%
Prevention	2411	56%
Social	999	23%
Other/Not Recorded	*313*	*7%*
Total	**4275**	**100%**

Emergency Department Attendances

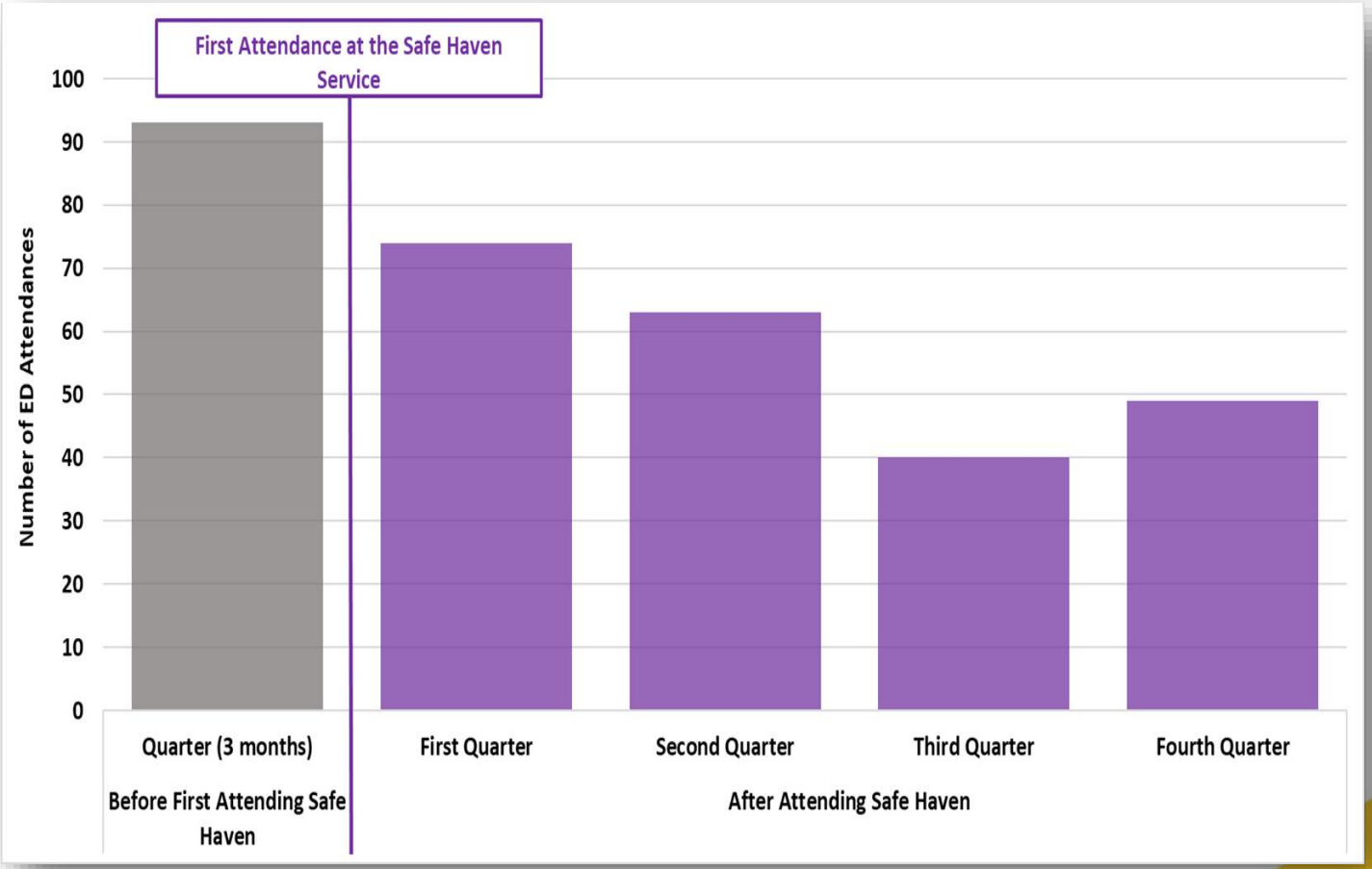
- **NHS numbers not routinely recorded at the Safe Haven**, therefore SABP provided NHS numbers for service users who had been referred on to them from the Safe Haven service.

- It is important to note that **this group were likely to have a higher level of need** as they required an onward referral.

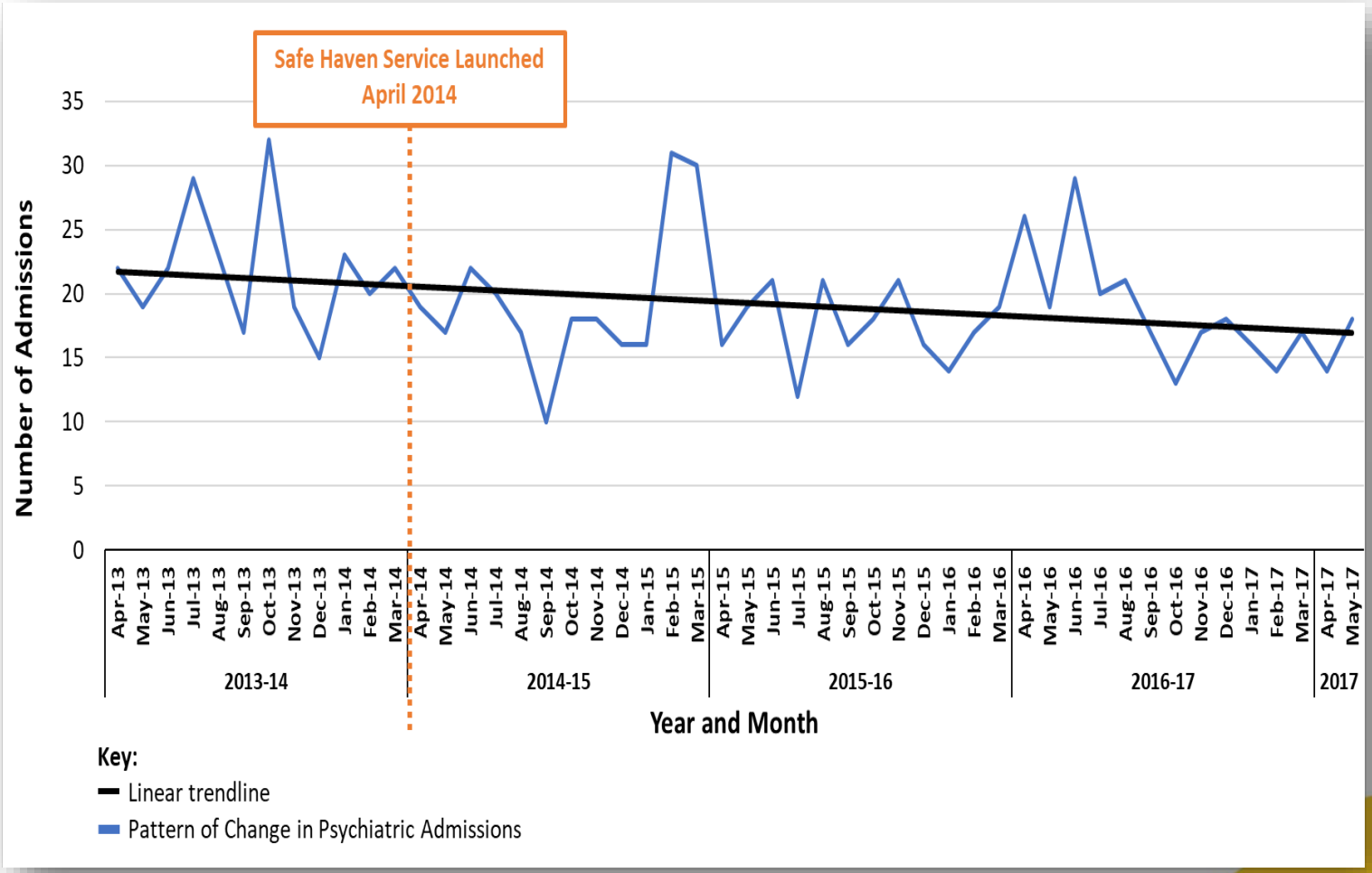
- **92 service users were included** in the cohort analysis. **62 of these 92 visited Frimley ED** on at least one occasion in the year prior to visiting the Safe Haven.

- Frimley Health NHS Foundation Trust Emergency Department activity for the cohort was analysed for **a year before and for a year after the person's first attendance at the Safe Haven service**.

Graph showing the number of times the cohort of patients attended Frimley Health Trust Emergency Department each quarter:



Graph showing monthly Psychiatric Admissions for NEHF CCG:



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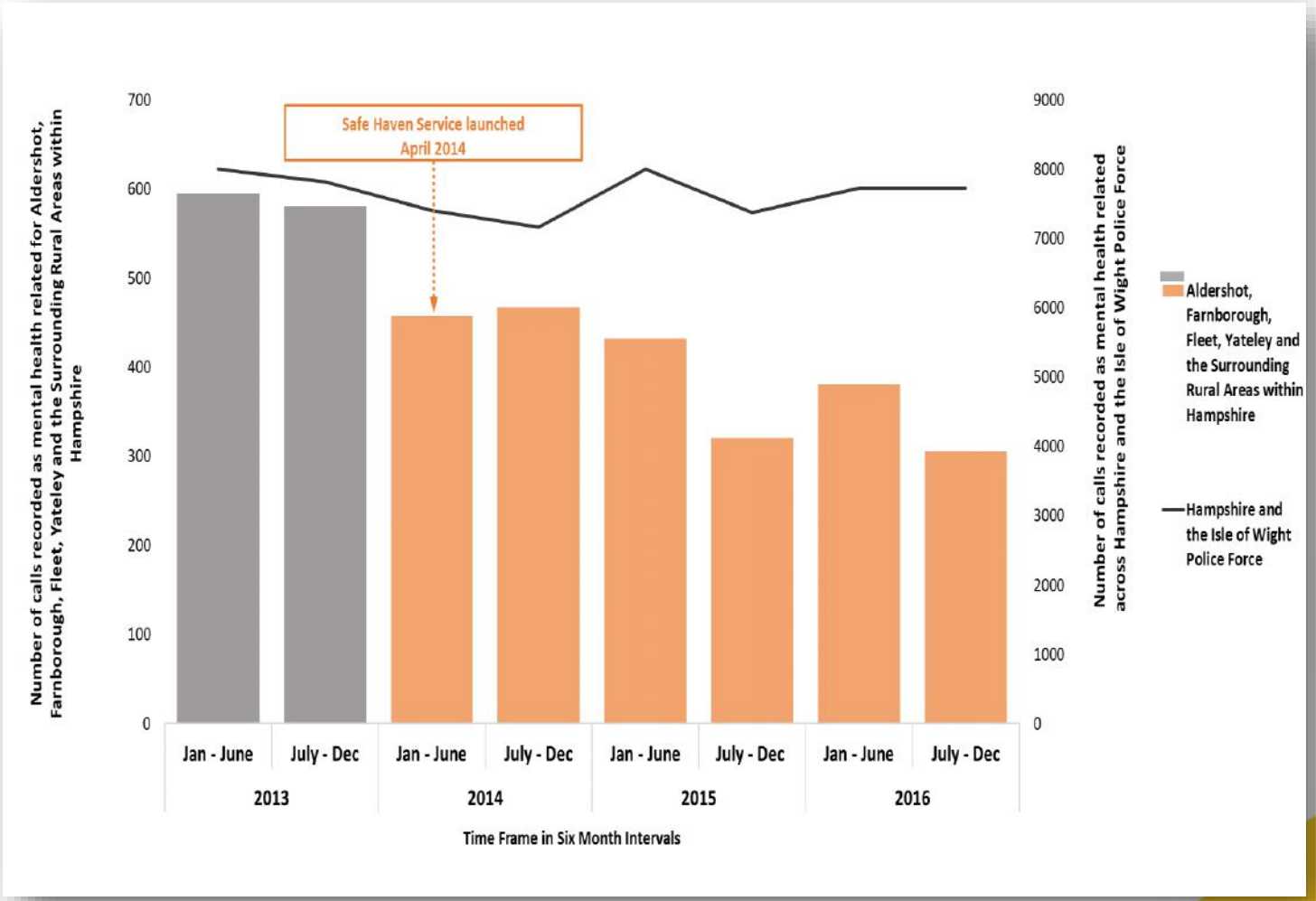
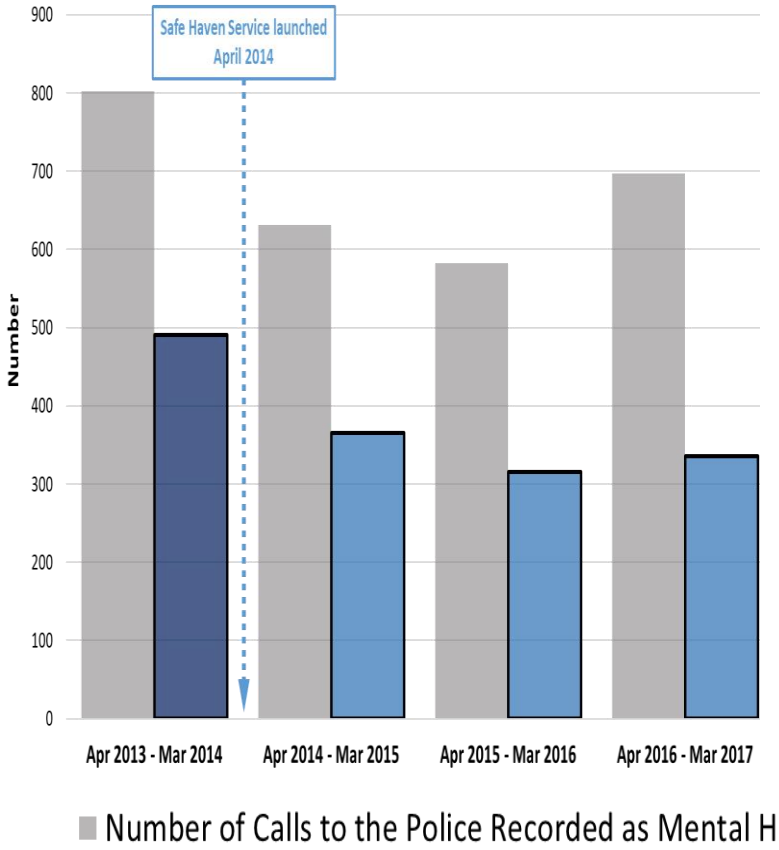
The total number of calls to the Police that are recorded as 'mental health related', by year and month, for the Aldershot, Farnborough, Fleet, Yateley and Surrounding Rural Areas, compared to the total number of calls to the whole Hampshire and Isle of Wight Police Force

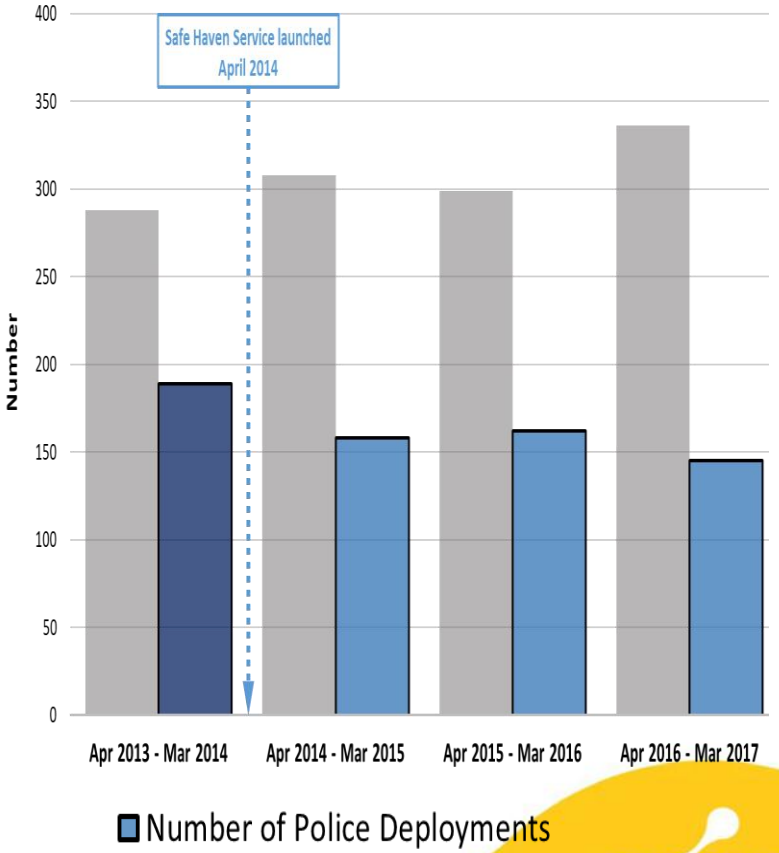


Number of Police Deployments Relative to the Number of Calls to the Police Recorded as Mental Health Related for:

Rushmoor



Aldershot



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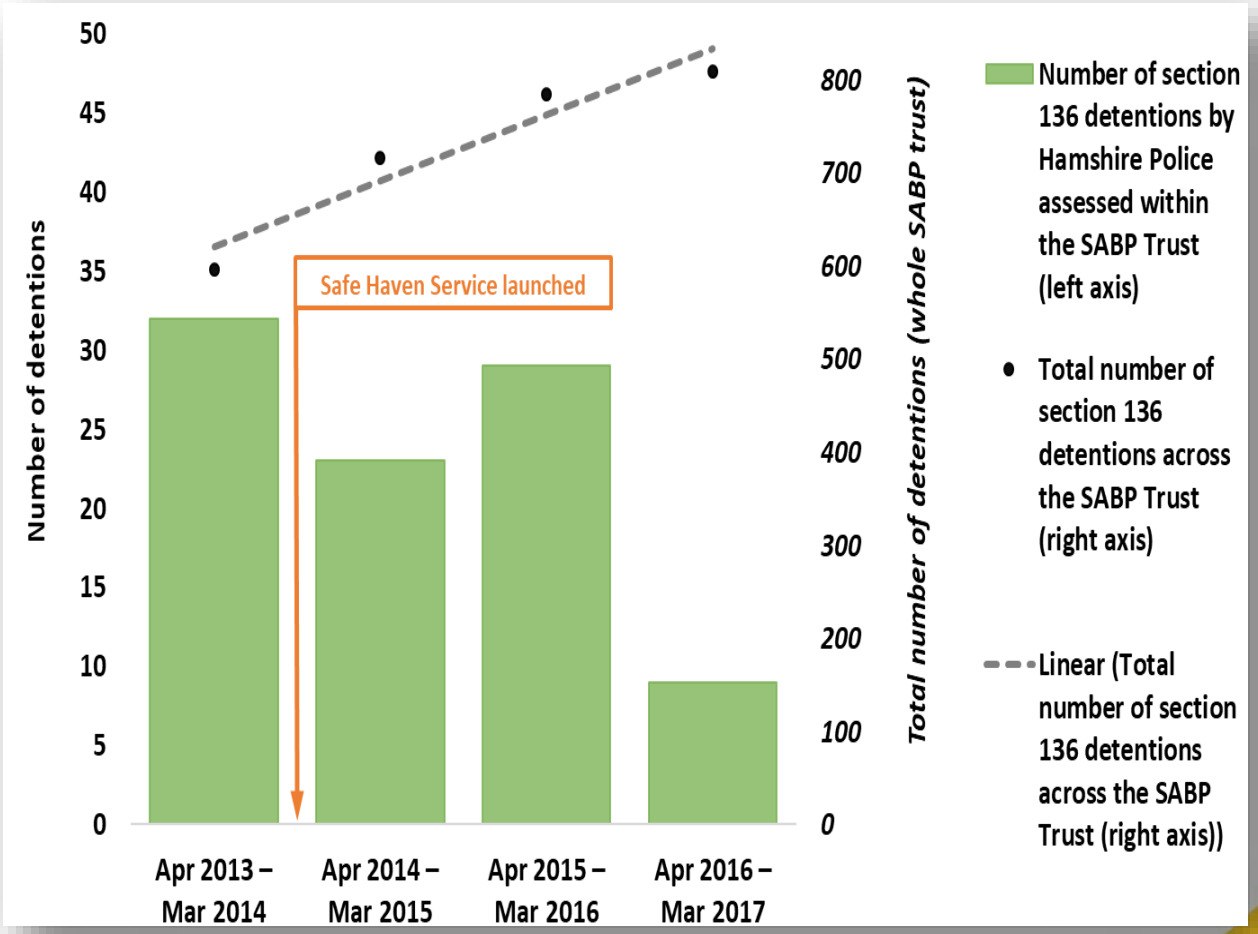
The graph shows both the number of 136 suite detentions by the Hampshire Police which were assessed within SABP preferred places of safety and the total number of 136 detentions across the whole SABP Trust:



Financial analysis

- Difficult to analyse accurately as we have only been able to analyse subsets of attendances or aggregate data
- However, we do know how many people presented in Crisis (reason for attendance recorded by a member of staff on all attendances)
- Modelling to look at admission avoidance in 5% of Crisis attendances

Financial analysis

- **552** people were recorded as attending in Crisis (Aug 16 – July 17)
- 5% of crisis attendances = **27.6**
- Average admission = **£15,909**: cost of a bed day (£377) x average LoS (42.2 days)

Number of attendances at Safe Haven for crisis	5% of Safe Haven crisis attendances	Predicted admission costs avoided between August 16 and July 17
552	27.6	£439,088

- Predicted avoided admission costs **£439,088**
- The 5% figure is provided as an example.
- To cover the Safe Haven's annual cost of £237,000 the service would need to **prevent 15 admissions per year** (or just over one admission per month).

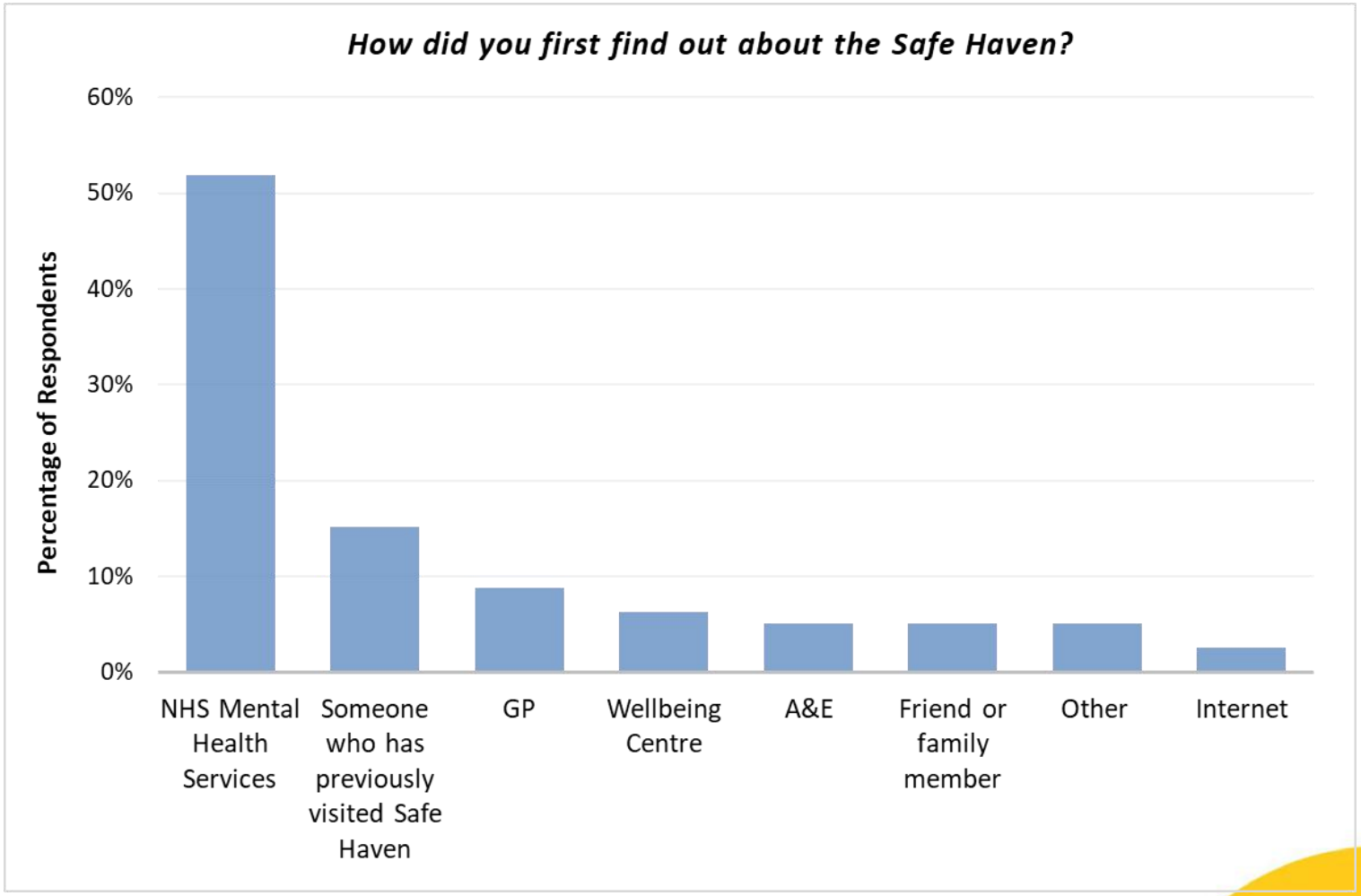
Financial analysis - limitations

- Emergency Department savings can be worked out in a similar way
- There may also be avoided costs related to other health services, for example GP attendances or community mental health resources. However, these are impossible to quantify within this report.
- There will also be cost savings related to the reduction in section 136 suite detentions (that could also result in admission avoidance for some people).
- These scenarios do not consider the impact of the service on people attending for prevention.

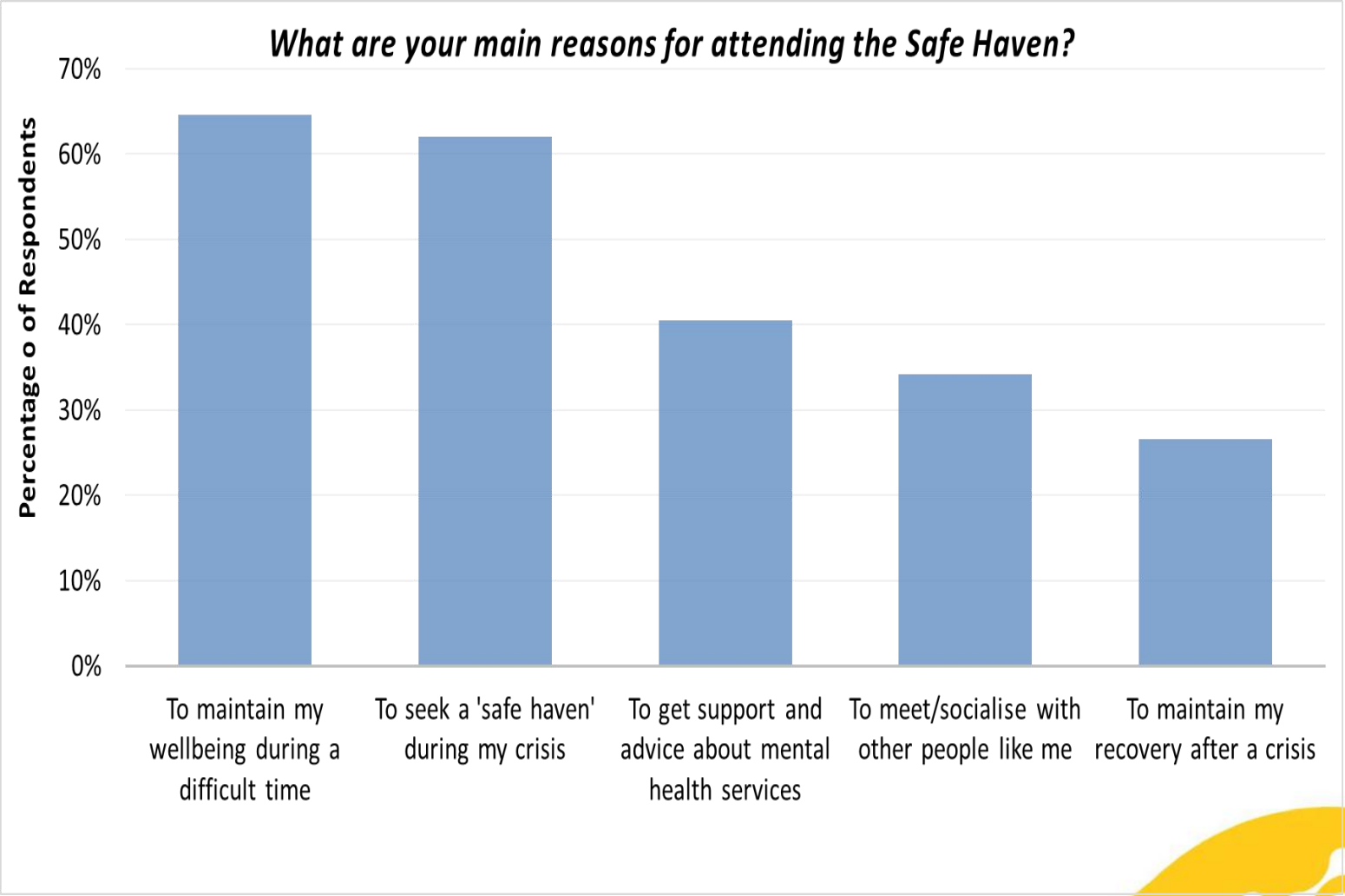
Service user feedback

- Since July 2016, Safe Haven Service User feedback has been collected via an iPad survey, consisting of 33 questions, producing both quantitative and qualitative data
- The iPad is kept on site and the survey is completed on a voluntary basis
- The findings discussed in this section cover the period 1st July 2016 to the 27th July 2017
- A total of 79 responses were collected with consent for anonymised data to be shared

Service user feedback



Service user feedback



Service user feedback

- **85%** agreed or strongly agreed that the Safe Haven service had prevented them from being in crisis
- **89%** agreed or strongly agreed that the Safe Haven had helped them manage a difficult time
- **90%** felt better equipped to manage their mental distress having visited the service
- **97%** felt they had been treated with warmth and compassion

Evaluation conclusions

- Feedback demonstrate that service users value the service.
- Where hospital numbers were available, analysis of service user Emergency Department usage showed an overall downward trend following attendance at the Safe Haven service.
- Psychiatric admissions have reduced for the Safe Haven service catchment area; however, there are other factors that may have influenced this.

Evaluation conclusions (cont.)

- Mental Health related police deployments have reduced within the Safe Haven catchment area.

- Section 136 suite detentions have declined for North East Hampshire, which goes against the national trend and the trend seen across the wider Surrey and Borders Partnership NHS Foundation Trust.

- To cover the Safe Haven's annual running costs of £237,000 the service needs to prevent 15 admissions per year (or just over one admission per month).

General conclusions

- The service offers a **valuable and credible addition to the pathway** for people in crisis
- The **preventative aspect of the service** is very important
- The service offers **compassion, care and kindness** as a core value
- The service **decreases barriers to accessing treatment** and other services
- Offers **parity of esteem** with physical health services

Next steps

- Continue to promote the service, increasing awareness in service users, carers and partner organisations
- Understand the nature and impact of the interventions offered – to continue to increase value to people using the service
- Examine if collecting more service user information would allow for more comprehensive evaluation (without deterring people from using the service)

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Thank you.

Any questions?

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To view the full evaluation: http://wessexahsn.org.uk/

Happy Healthy atHome

NORTH HAMPSHIRE URGENT CARE
Delivering essential healthcare services

Wessex Academic Health Science Network

Felicity Greene, Chief Executive North Hampshire Urgent Care
Joe Sladen, Programme Manager Wessex AHSN

NHS 111 TRIAGE

Agenda

- Introduce the GP Triage service
- Identify service objectives
- Contextualise within future of urgent care services (IUC)
- Present evaluation findings

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NORTH HAMPSHIRE URGENT CARE
Delivering essential healthcare services

Wessex Academic Health Science Network

North Hampshire Urgent Care (NHUC) is a not-for-profit independent Organisation working in partnership with the NHS.

Any surpluses generated are re-invested in health care. The Organisation was founded in 2006.

NHUC provide the GP out of hours (OOH) service for North East Hampshire and Farnham GP Practices.

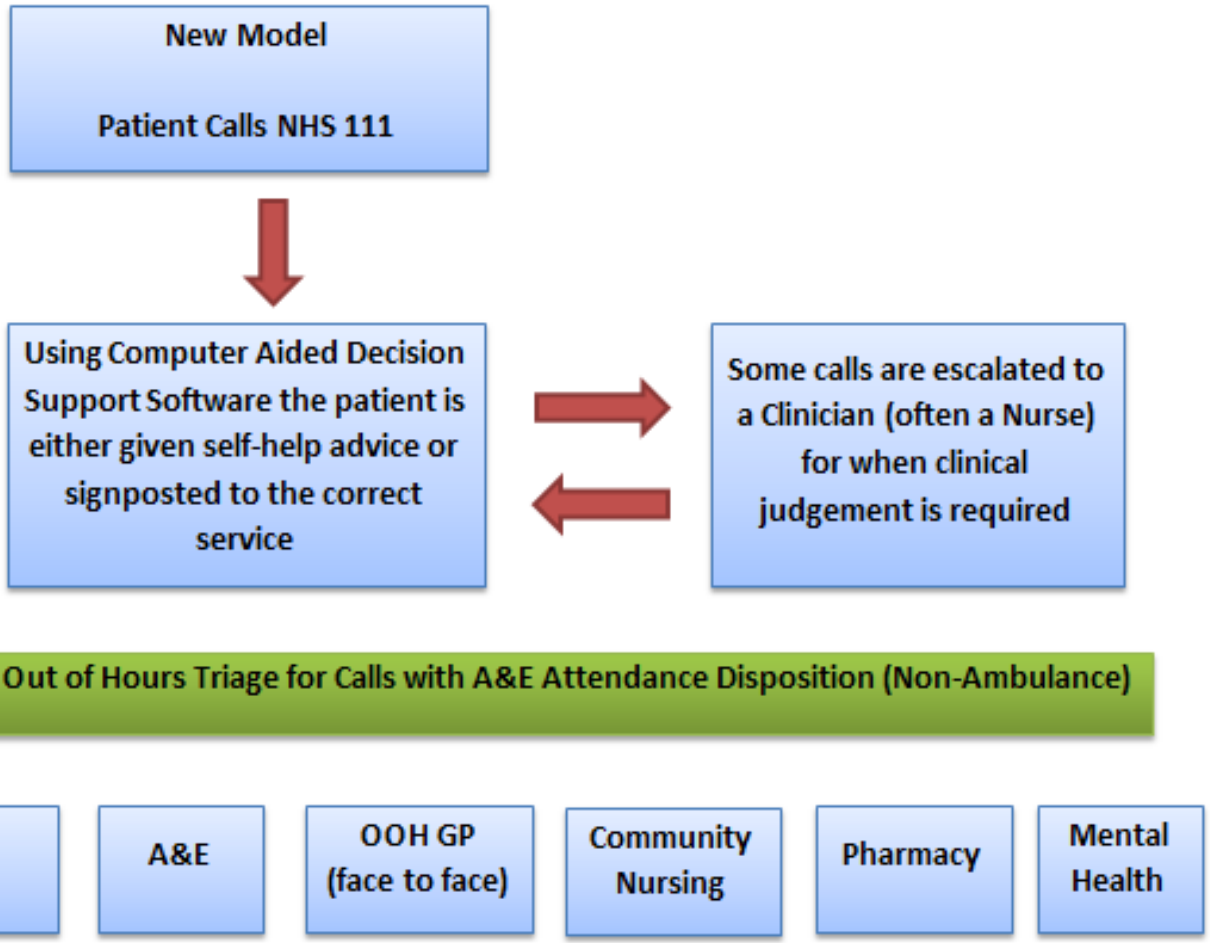
The out of hours treatment centre is co-located with the ED at Frimley Park Hospital.

NHUC Vanguard Projects

The Vanguard Programme has funded the NHS111 ED Triage

NHS 111 ED Triage - An enhanced clinical triage service to supplement the current 111 service. Patients that are assessed by the 111 algorithm as needing to take themselves to ED are instead offered a phone call from an NHUC Clinician within 15 minutes.

Service Model



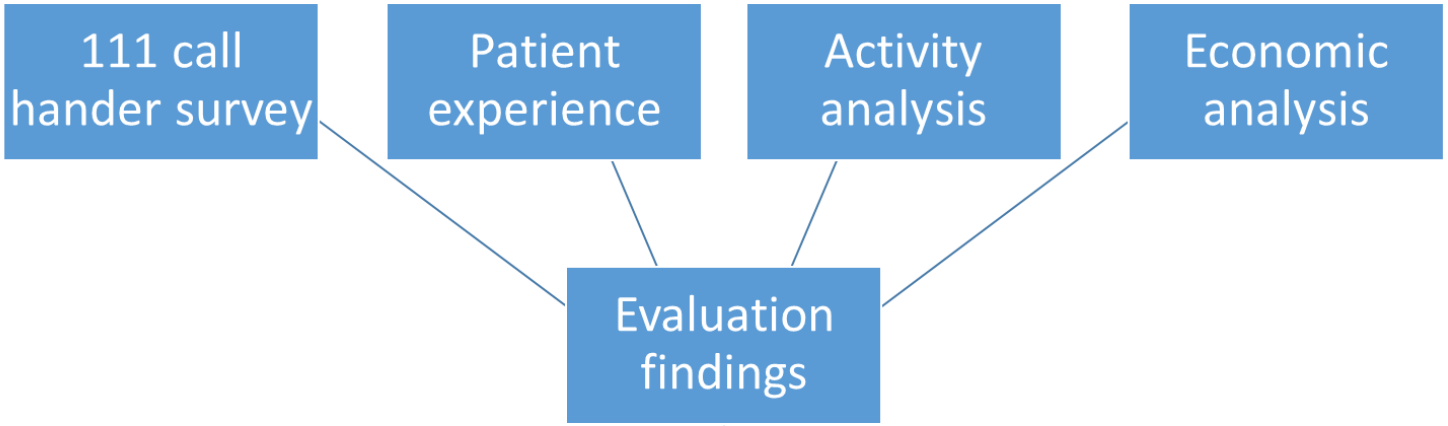
Service Goals

The intended aims

- Reduce ED attendances from NHS111 by 30%
- Reduce ED workload
- Reduced wait for treatment times
- Increase in patient satisfaction
- Provide an educational function to reinforce the correct pathway
- Patients empowered to self manage
- Improved confidence of NHS 111 service
- Shared knowledge/ learning within the OOH team
- Change in behaviour/ culture of 111 call handlers
- Alignment with new models of care, ahead of time

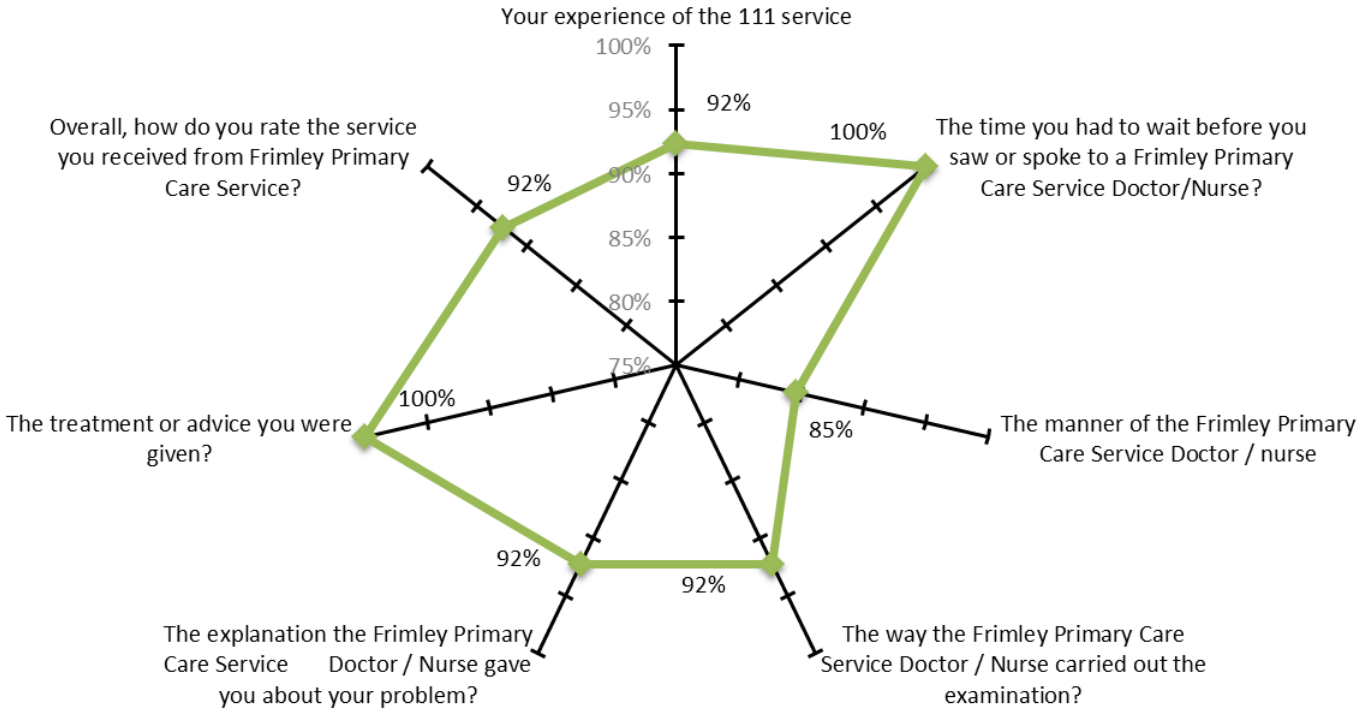
Service Evaluation

- AHSN led mixed method evaluation
- Comprising primary and secondary data
- Synthesised to one set of findings



User Experience

- 13 patient experience survey
- Collected by service Sept - Nov 17

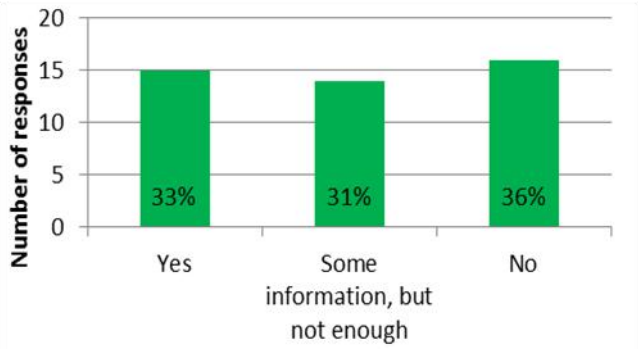


111 call handler survey

47 / 205 responses

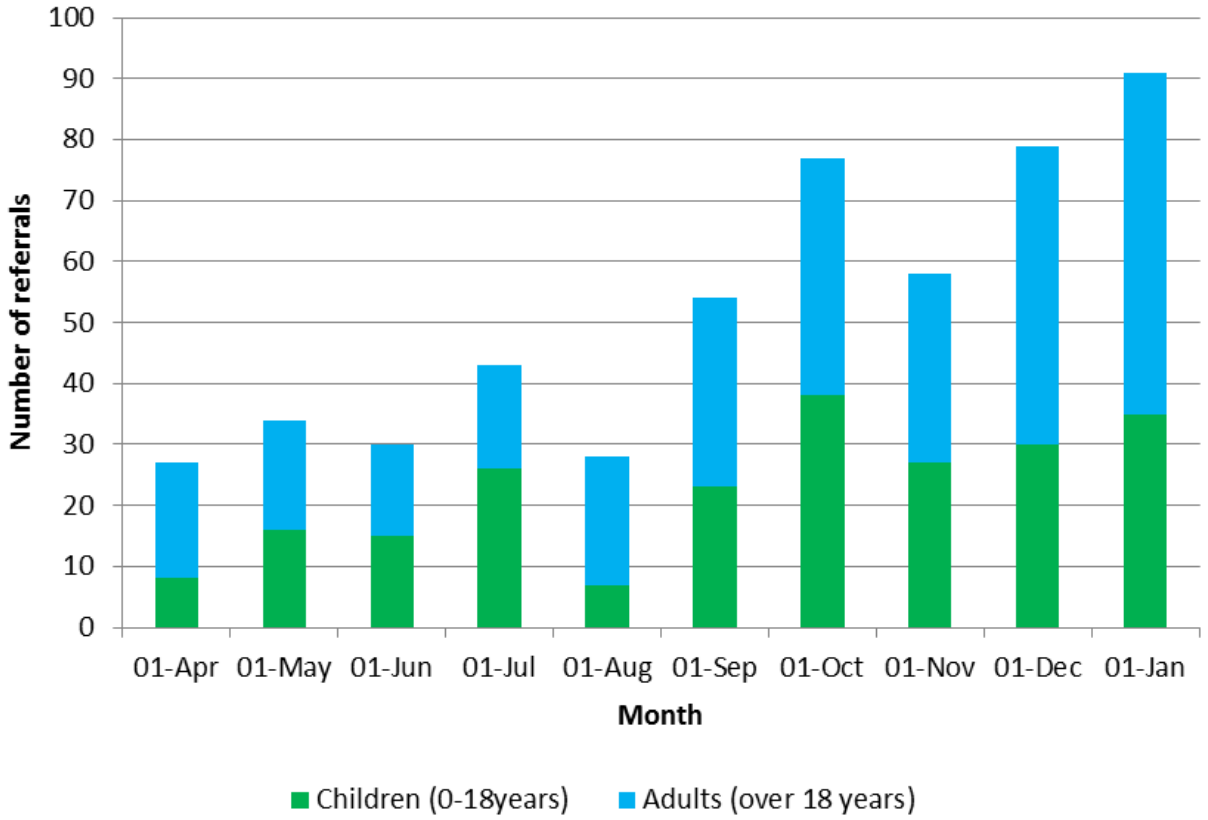
- Opinions
- Limited awareness and staff confidence
- Usage
- Low referral numbers and infrequent use
- Nearly all respondents unaware of the call back timeframe
- Impact
- Most have a neutral opinion of whether the service has reduced patient waiting times to speak to a doctor.
- Most think GP triage service is an effective way to reduce inappropriate referrals to ED, despite limited knowledge of the service

Have you had enough information the service to be able to refer patients to it?



Activity

- AHSN analysis of service data from April 17 to Jan 18
- 521 calls



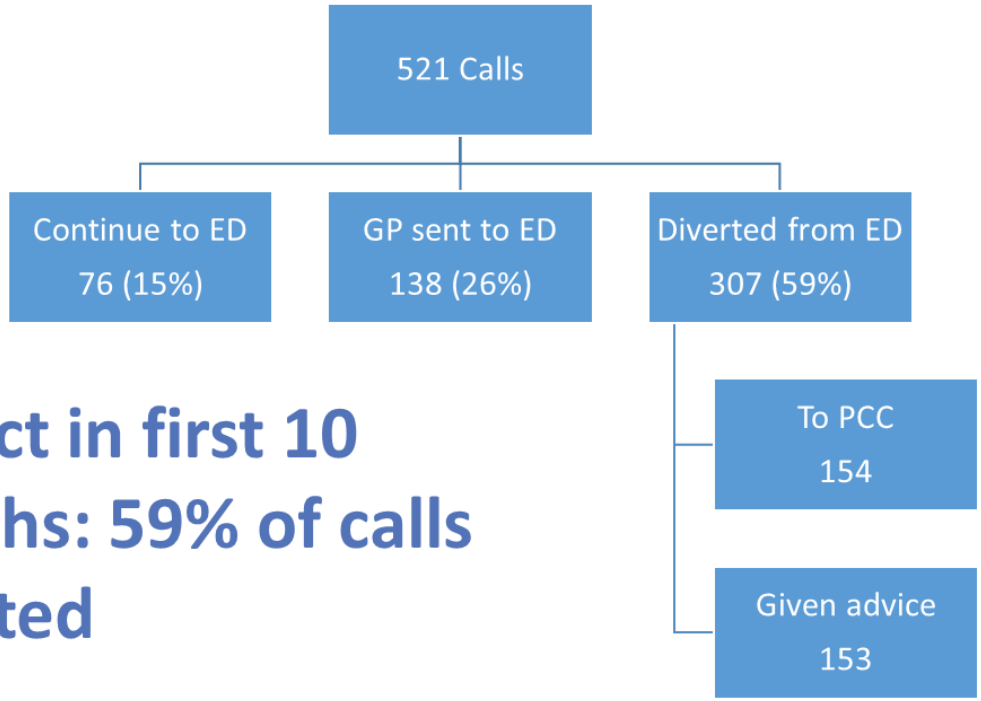
Activity (2)

- 76 of 521 calls not handled by NHUC
- Related to issues of misunderstanding

Theme	Number of cases
Patient went direct to ED/ Already at ED / told to go to ED by call handler	67
No contact made (inc. 2 unknown outcomes)	7
Out of Hours GP advice or went to NHS Urgent Care Centre	2
Grand Total	76

Activity (3) Pathway Shift

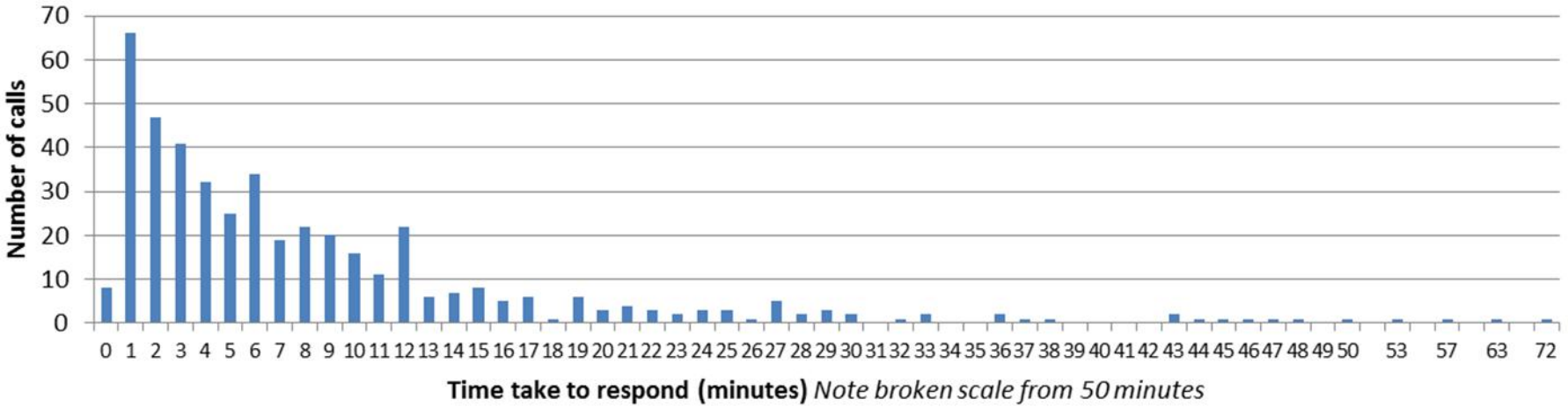
- During planning - assumed that 30% calls could be acted upon and avoid an ED attendance



- **Impact in first 10 months: 59% of calls diverted**

Activity (4) Response Times

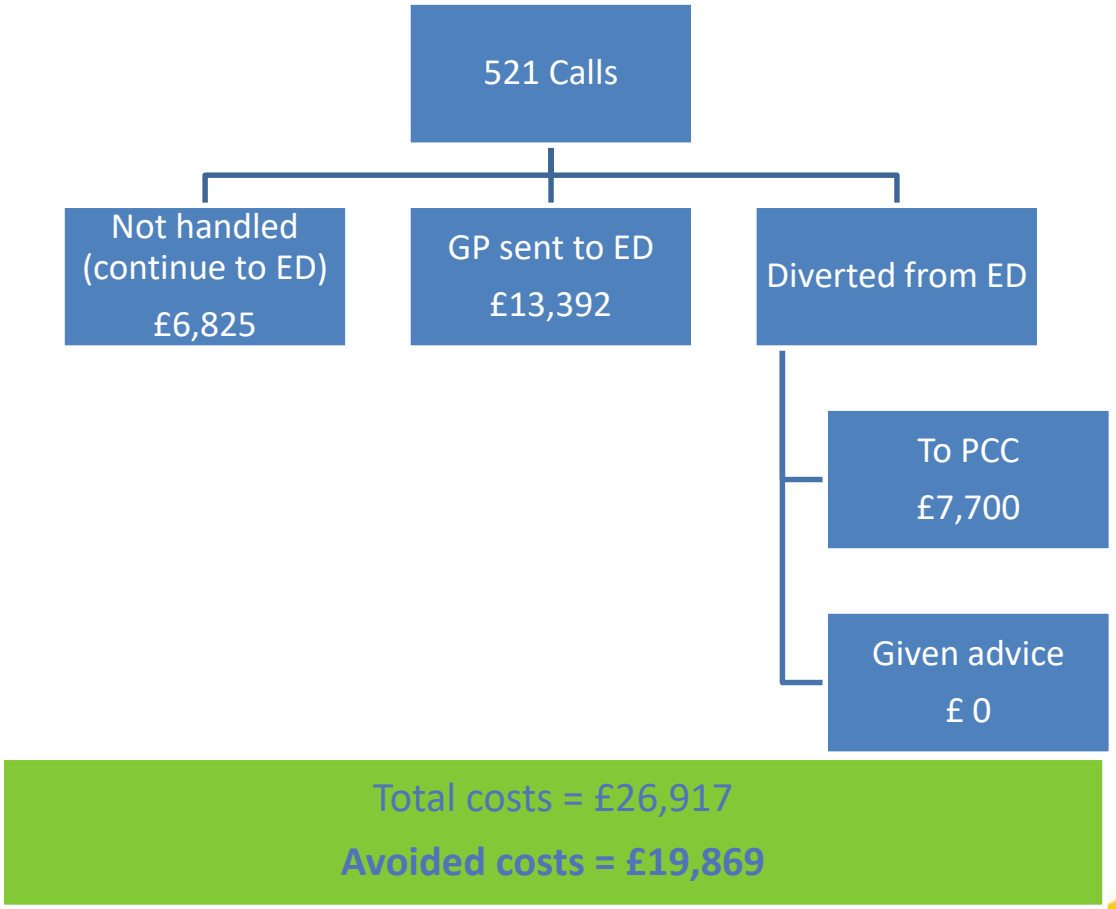
- Target: less than 15minutes
- 85% < 15 minutes



- Average call back time = 8m 54s

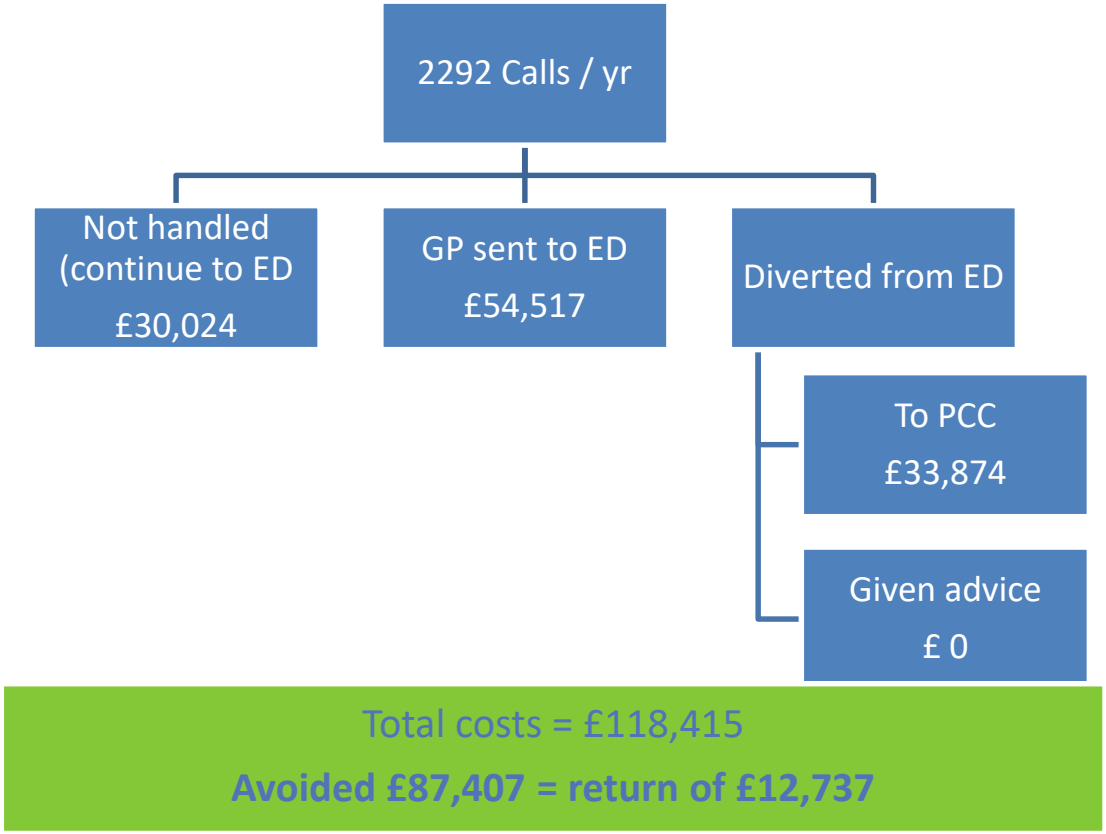
Economic analysis

Cost of old pathway for 521 calls = **£46,786**



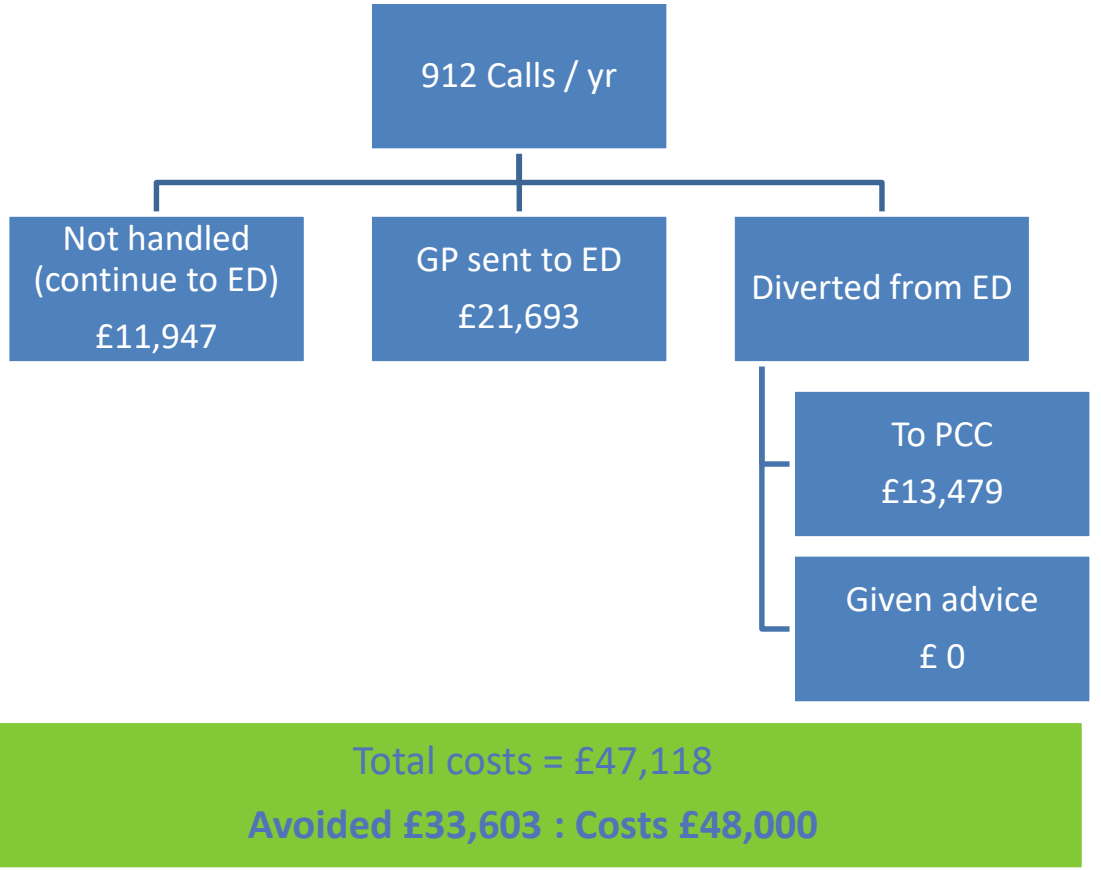
Economic analysis – scenario 1

- Modelled benefits for 191 calls / month
- Cost of old pathway = **£205,822**



Economic analysis – scenario 2

- Cost of service 18/19 is less
- Issues corrected in Sept 18 = higher referral rate (76 / month)
- Break even point = 109 / month



Summary

Set out to determine impact of GP triage service:

Plan	Evaluation finding
• 191 patients per month suitable for redirection to the GP Triage service	• 52 patients per month in first 10 months, - evidence of an upward trend
• Reduce ED workload: 30% of patients would not go to ED	• 59% of patients dealt with by the GP
• Reduce wait times • 15 minutes call back target	• 85% of calls were made within 15 minutes • Average call 8m 54s
• £91,000 savings	• £19,869 in first 10 months activity levels (£23,842 annualised)
• Improve patient satisfaction, and confidence of 111	• Those who have fed back, are satisfied with service
• Change of culture amongst 111 call handlers	• Beginning to see a shift

NHS 111 ED Triage – Lessons Learnt

Successes

- Helping the System prepare for and understand the National Model ahead of time
- Protecting the front door through admission avoidance
- Positive patient feedback

Challenges

- A number of technical issues have affected the amount of calls received
- The forecast project savings may not be met

What would you change if you were to do the project again?

- Wider Symptom Group from the beginning
- Communication with call handlers

Thank you

Any questions?

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Salus MEDICAL SERVICES

fics farnham integrated care services

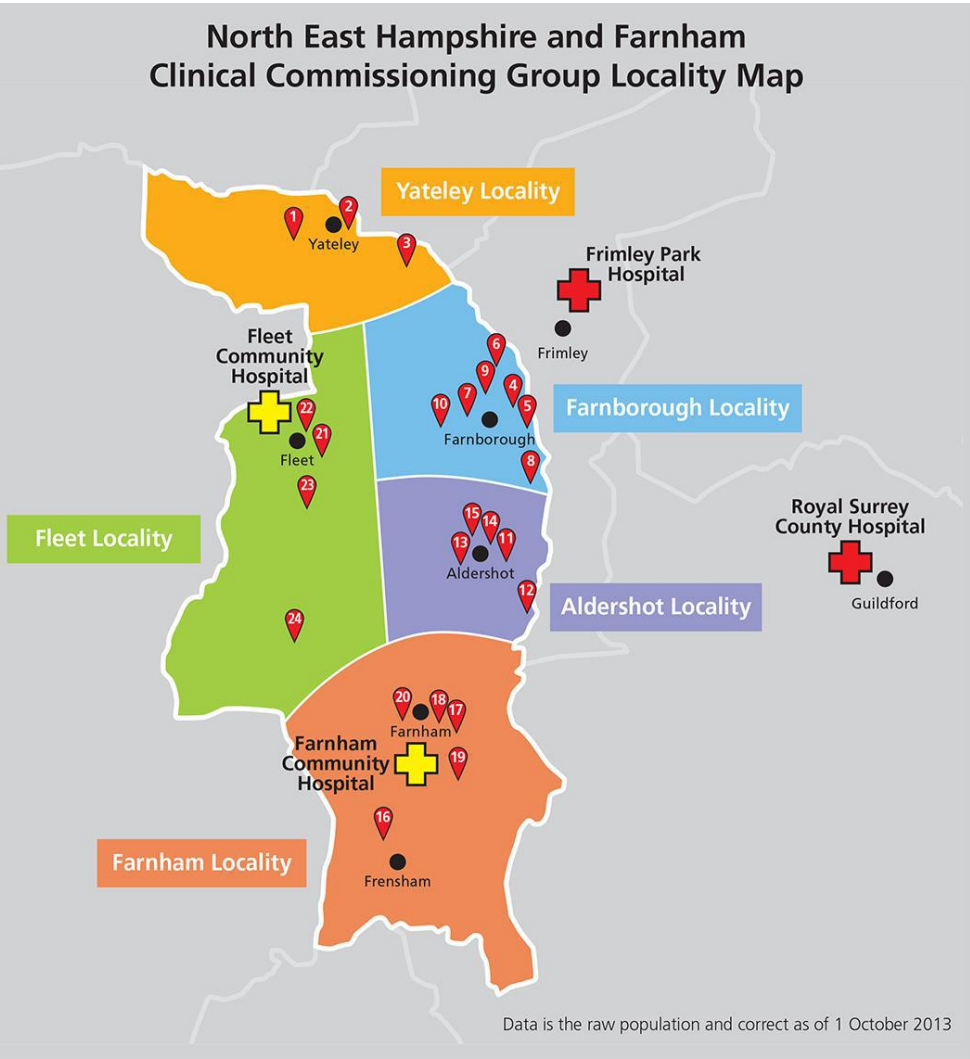
Wessex Academic Health Science Network

Dr Gareth Robinson, Yateley Clinical Lead
Dr David Brown, Farnham Clinical Lead
Andrew Lilies, Consultant Wessex AHSN

URGENT CARE CENTRES

Oakley Health Group Urgent Care Centre

Locality		GP Practice	Total Population
Yateley Locality	1	Monteagle Surgery	5976
	2	The Oaklands Practice	10632
	3	Hartley Corner Surgery	11561
Yateley Total			28169
Farnborough Locality	4	Alexander House Surgery	9410
	5	Milestone Surgery	11128
	6	Mayfield Medical Centre	9179
	7	Jenner House Surgery	10298
	8	North Camp Surgery	4567
	9	Giffard Drive Surgery	8338
	10	Southwood Practice	6260
Farnborough Total			59180
Aldershot Locality	11	Southlea Group Practice	14228
	12	The Border Practice	8614
	13	Princes Gardens Surgery	7821
	14	Victoria Practice	8172
	15	The Wellington Practice	3130
Aldershot Total			41965
Farnham Locality	16	Holly Tree Surgery	5645
	17	River Wey Medical Practice	6534
	18	The Ferns Medical Practice	10642
	19	Farnham Dene Medical Practice	11602
	20	Downing Street Group Practice	12492
Farnham Total			46915
Fleet Locality	21	Branksomewood Healthcare Centre	12592
	22	Fleet Medical Centre	14767
	23	Richmond Surgery	12403
	24	Crondall New Surgery	4259
Fleet Total			44021
North East Hampshire and Farnham Total			220250

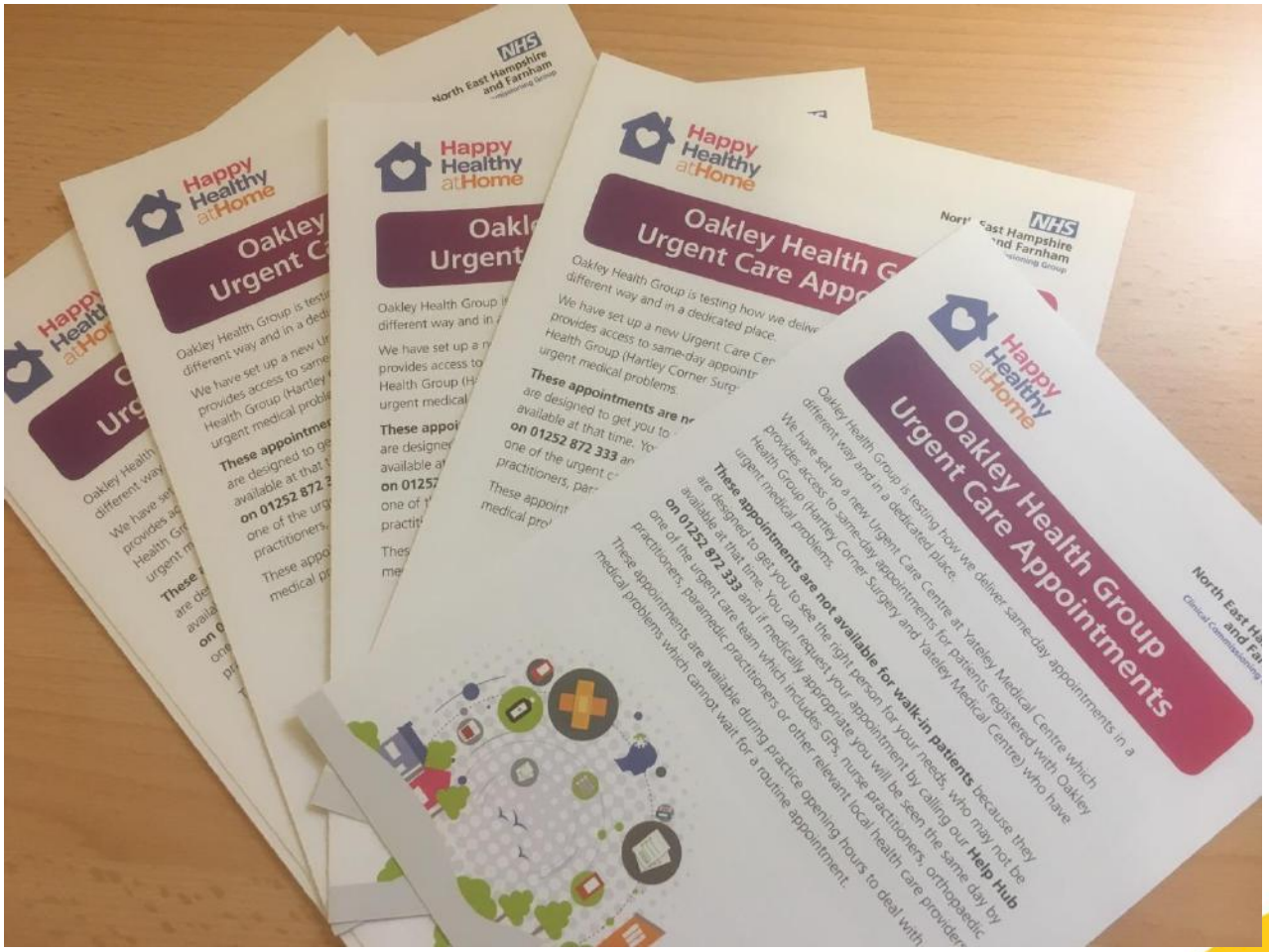


Oakley Health Group Urgent Care Centre

Oakley Health Group Urgent Care Centre

- ‘Medically Urgent’ on the day
- 8 to 8 – Monday to Friday, 08:30 to 11:30 Saturday morning
- Multi skilled team
- Rapid home visiting

Urgent Care Centre/A&E



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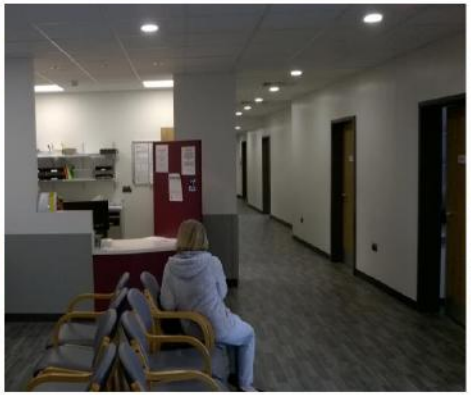
Rapid Home Visiting

Farnham Integrated Care Centre


New way to see a doctor

By Chief Reporter Daniel Gee

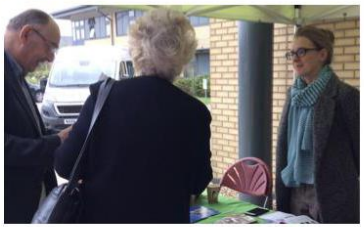


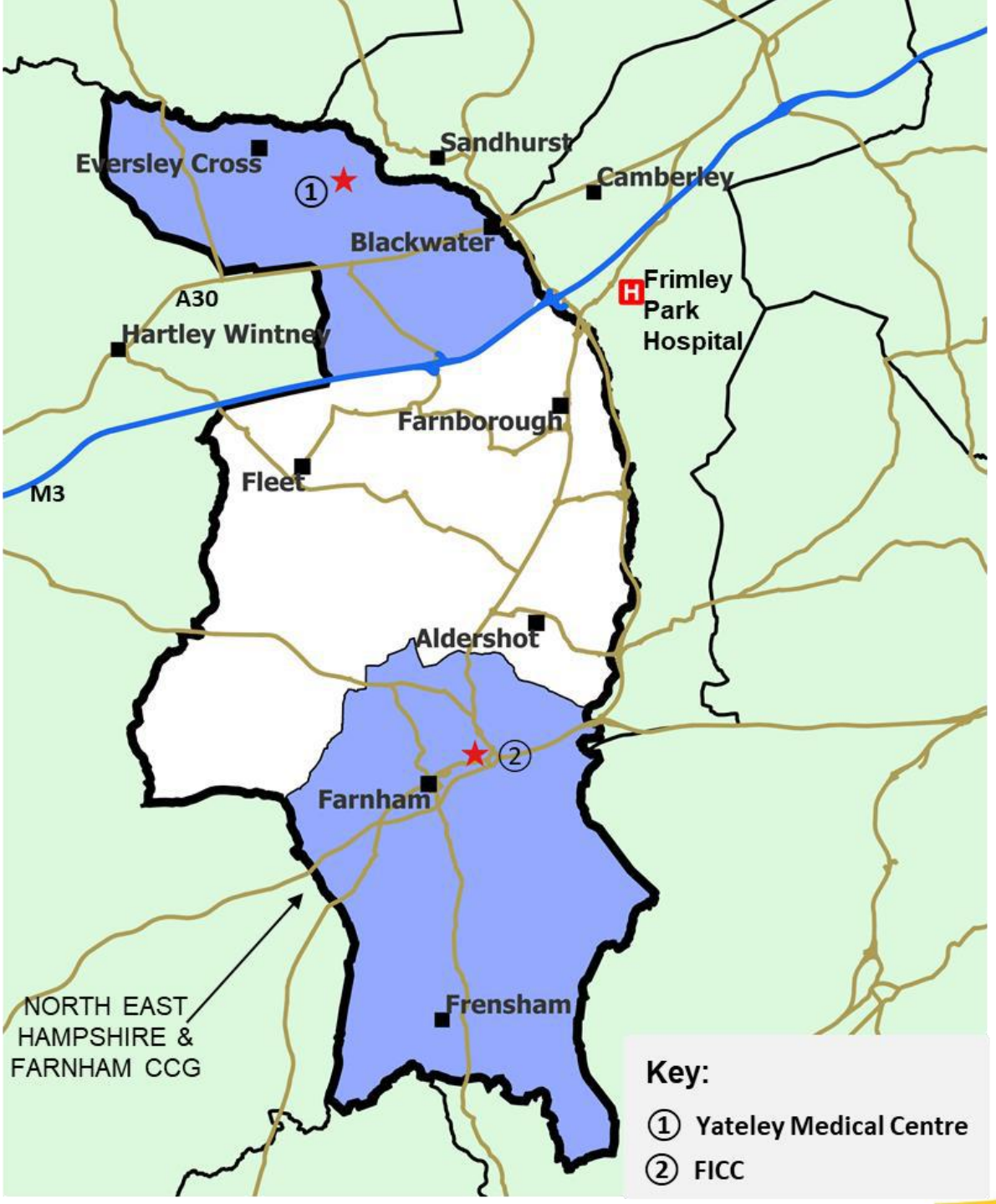
Farnham Integrated Care Centre

Health event was a mine of information

DEMONSTRATIONS about how to use a defibrillator, talks from medical experts and information about topics ranging from community transport to Alzheimer's were just some of the highlights of Saturday's health and well-being event.

FARNHAMHERALD.COM





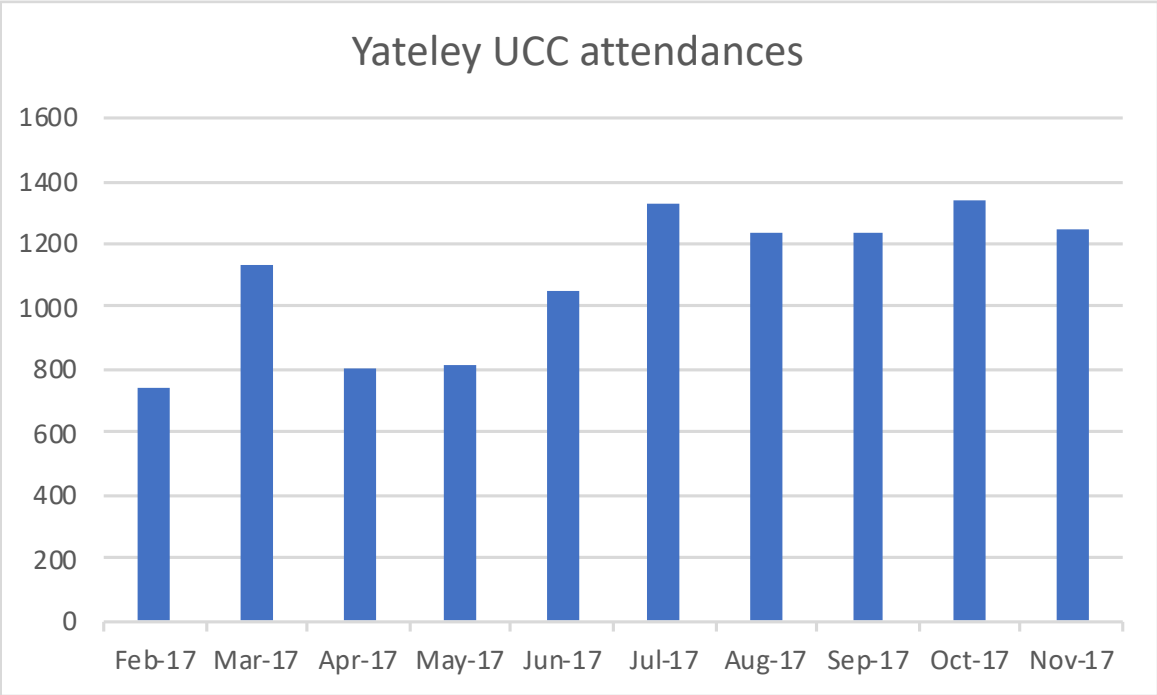
Wessex Academic Health Science Network

Yateley - 22,000 patients

Farnham

- **4 practices 41,000 patients**
- **3 practices 31,000 patients**

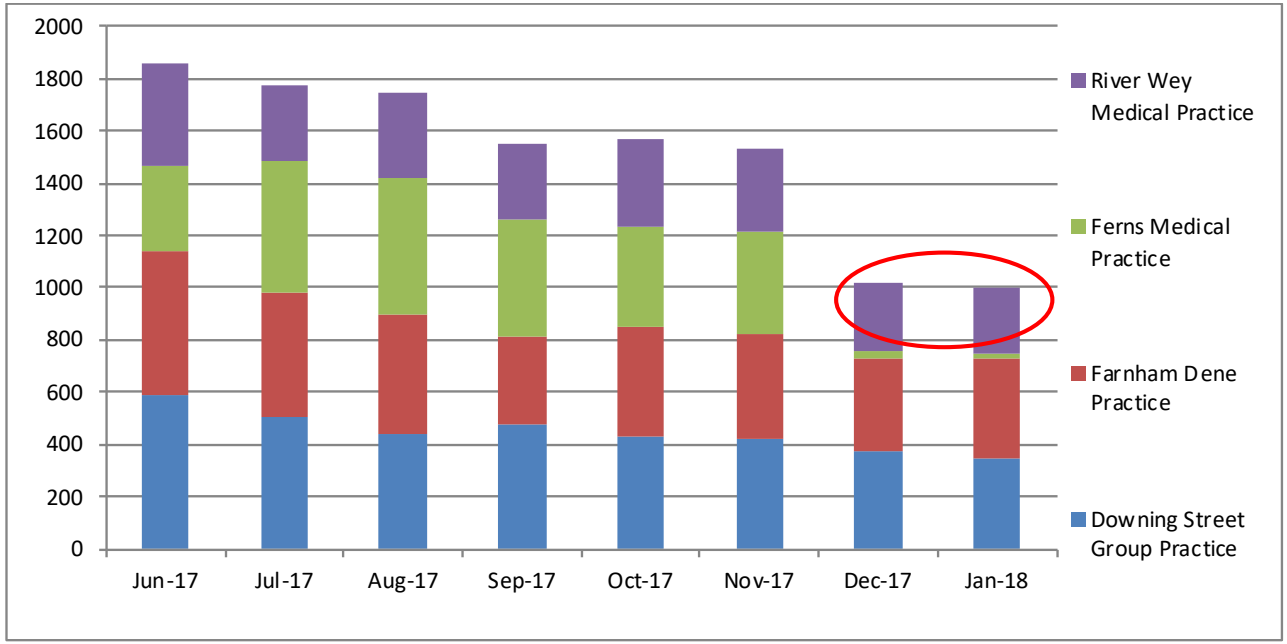
Yateley - attendances



Age	Female	Male	Total
0-4	345	366	711
5-19	451	396	847
20-49	1267	688	1957
50-64	602	437	1039
65-74	526	353	879
75+	750	541	1291
Unknown			968
Total	**3540**	**2549**	**7058**

	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Total	744	1130	801	815	1050	1328	1232	1235	1338	1245

Farnham – attendances



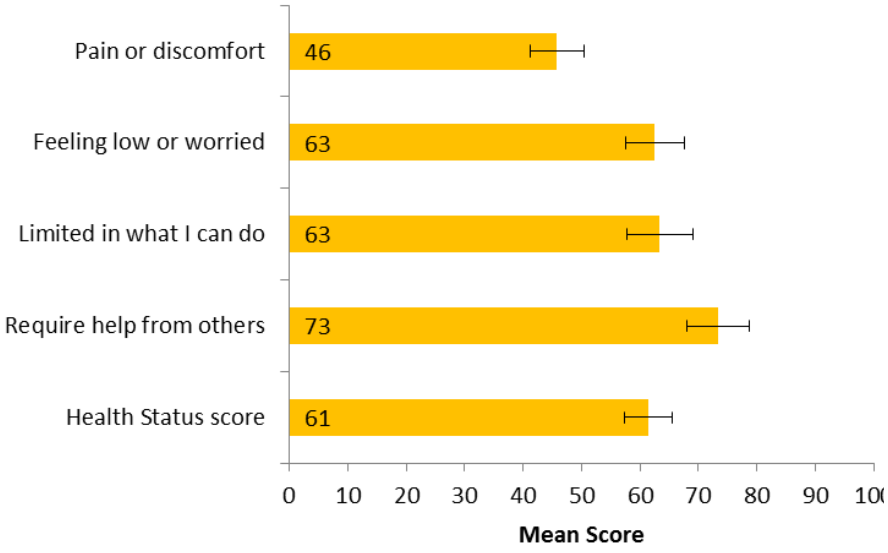
	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18
Total	1854	1776	1750	1552	1569	1527	1018	1000

Age	Female	Male	Total
0-4	651	703	1354
5-19	2328	1203	3532
20-49	1010	705	1715
50-64	831	791	1622
65-74	648	491	1140
75+	750	541	1291
Unknown			1328
Total	**6218**	**4434**	**11982**

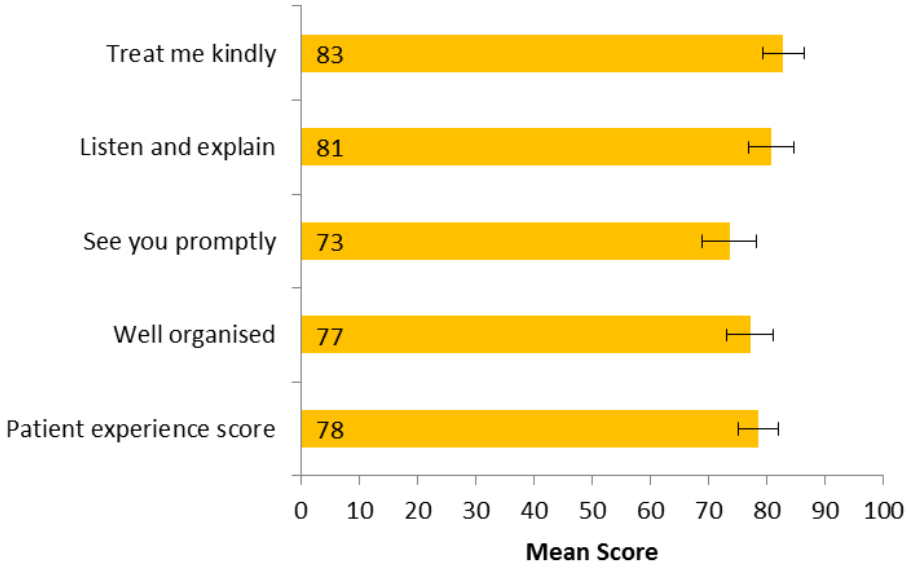
Yateley – patient reported outcomes

123 patient reported outcomes in Yateley Urgent Care Centre

Health Status



Patient Experience

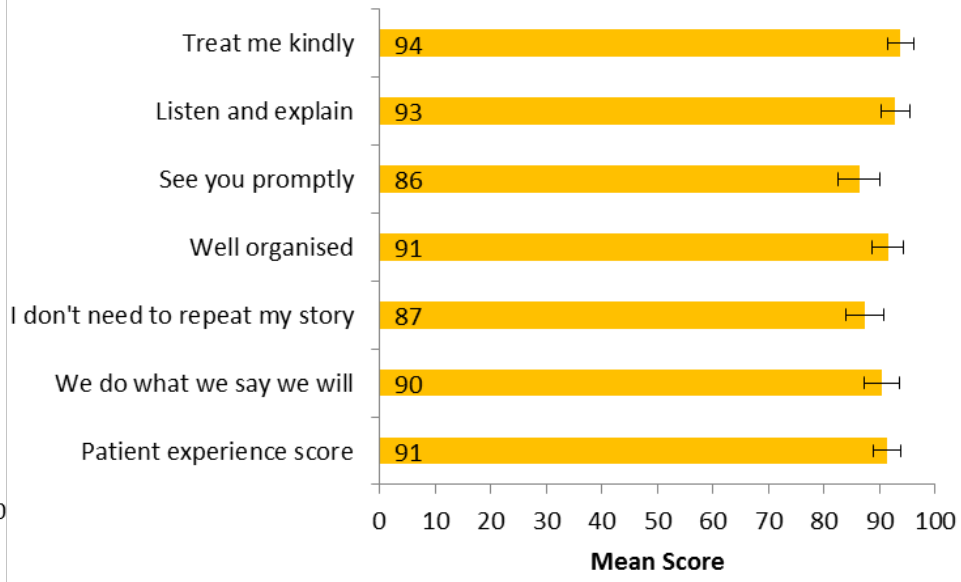


Farnham – patient reported outcomes

141 patient reported outcomes in Farnham Integrated Care Centre

Health Status

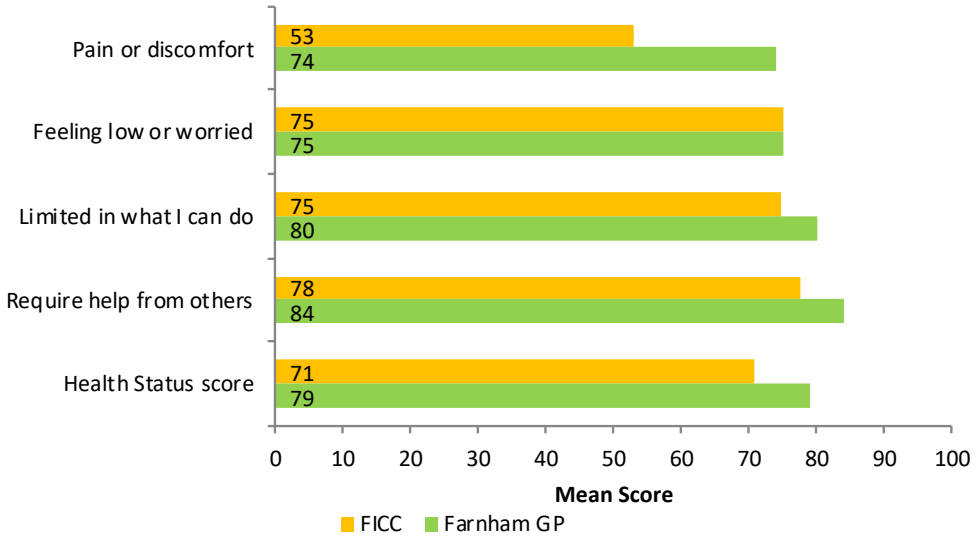
Patient Experience



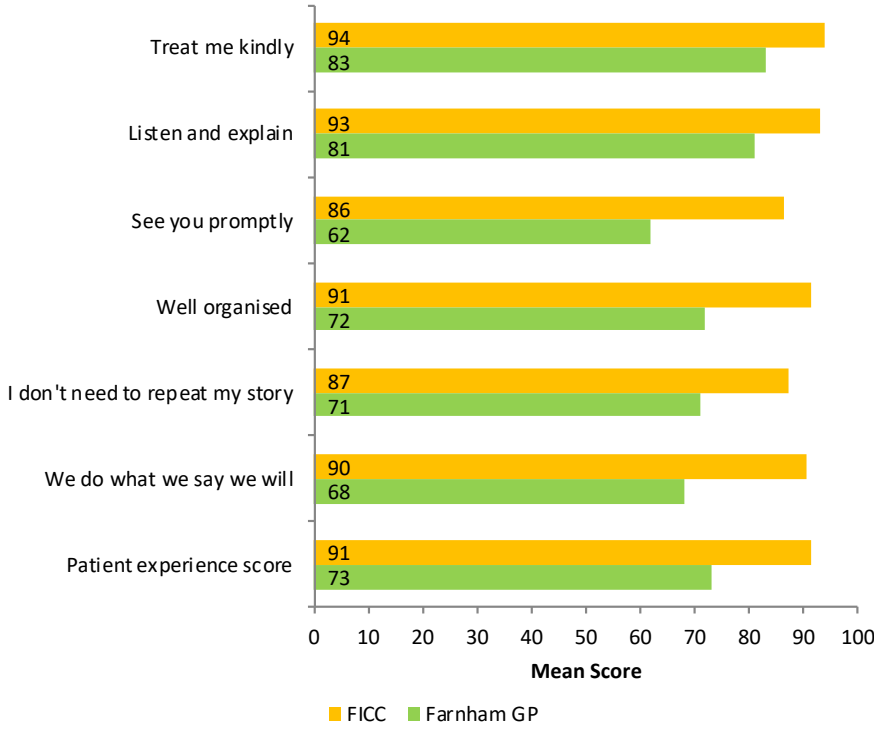
Farnham – patient reported outcomes

Comparing 141 FICC patients with 960 Farnham GP patients

Health Status

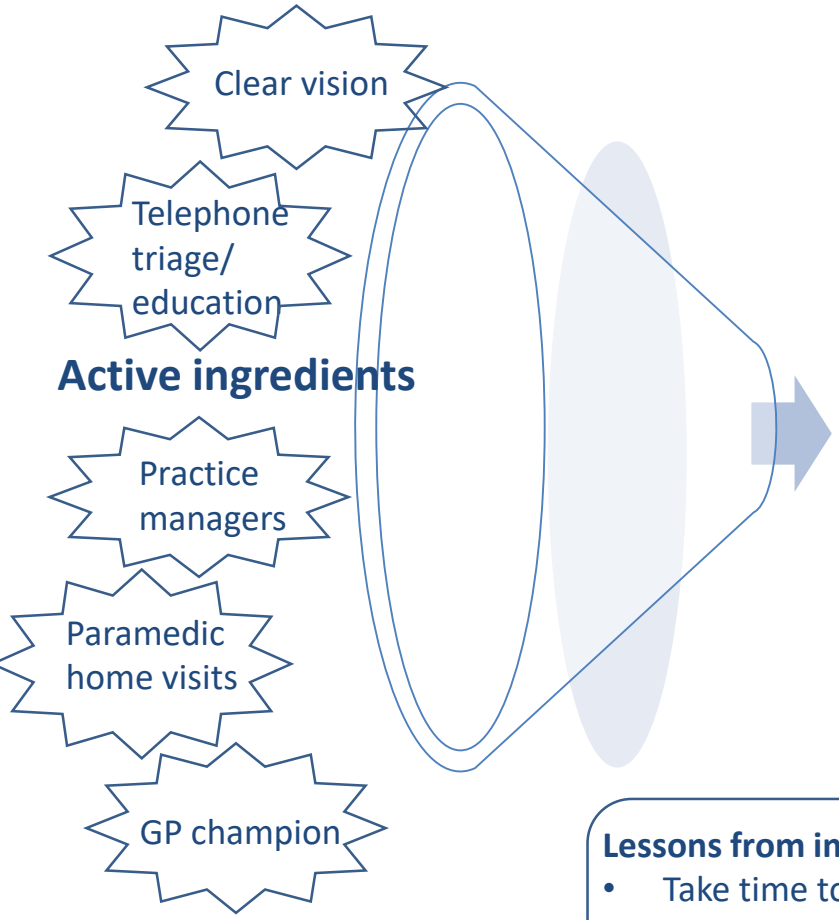


Patient Experience



Qualitative synthesis

- **Interviews with 6 GPs and 3 Practice Managers**
- **Patient survey (n=82)**
- **GP survery (n=19)**



Practice impacts:

- Half of calls dealt with on the phone
- Practice is a calmer environment
- Good to work with a wider range of GPs
- Complex patients can be given time
- Less interruptions during consultations
- A better quality of life for GPs

Patient impacts:

- Confident can get same day appointment
- Mums happy
- Better signposting to mental health
- Access good and well organised – booking, call back from GP, appointment

Disruptive factors:

- Time it took to build the centre
- Slow IT
- Practices sharing patient records and responsibility
- GP concerns about continuity of care

Lessons from implementation:

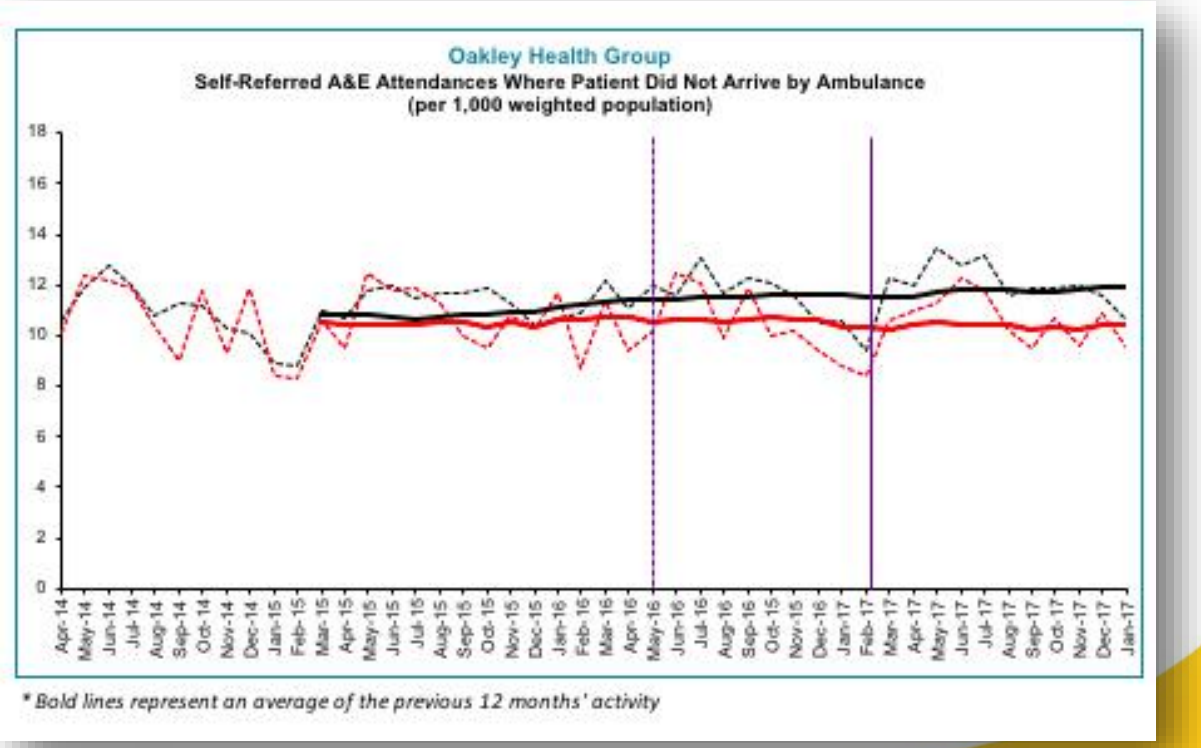
- Take time to investigate wider implications
- Front-load administration support
- “Bring staff with you”
- Feel financially secure to enact change

Farnham – impact on A&E

Pre & post time	No. of patients	Pre A&E attends	Post A&E attends	Difference	%
+/- 90 days	8593	1168	1121	-47	**-4%**
+/- 120 days	7057	1187	1154	-33	**-2.7%**
+/- 150 days	5423	1158	1105	-53	**-4.6%**
+/- 180 days	3899	954	940	-14	**-1.5%**

Yateley – impact on A&E

Pre & post time	No. of patients	Pre A&E attends	Post A&E attends	Difference	%
+/- 60 days	4950	566	593	+27	**+4.7%**
+/- 90 days	4257	607	686	+79	**+13%**
+/- 120days	3566	629	709	+80	**+13%**



** Bold lines represent an average of the previous 12 months' activity*

Link between UCC and A&E

King's Fund – "What's going on in A&E", March 2017.

2016 GP survey - ↓ people's ability to get an appointment from 88% to 85%; and 4% of these people say they go to A&E instead. Doesn't explain current pressures in A&E. In 2017, the number that said they go to A&E went they can't get a GP appointment increased to 5% (NEHF 3%).

NAO Investigating the impact of OOHs GP services on A&E. Sept 2015

- Demographics explain most of variation – age, sex, deprivation
- Satisfaction with GP services significantly associated with A&E attendance. 1% increase in satisfaction with opening hours associated with a 1% reduction in A&E attendances
- Other factors include proximity to A&E

Access to Primary Care an Visits to Emergency Departments. Cowling et al June 2014.

2010/11 GP Survey

The practices in best 20% for access had 10.2% fewer self-referred A&E attendances than the worst 20%.

Link between UCC and A&E

Yateley and Farnham had relatively good levels of satisfaction with access before they opened their urgent care centres

GP Survey Question	Yateley	Farnham	National
Find it easy to get through on the phone?	71%	74%	71%
Able to get an appointment to see or speak to someone?	90%	88%	84%
Last appointment was convenient?	83%	83%	81%
Experience of making an appointment was good?	77%	76%	73%
Feel they don't normally have to wait long to be seen.	79%	58%	58%
Last GP they saw or spoke to was good at giving them enough time.	93%	92%	86%
Satisfied with surgery's opening hours.	88%	75%	76%

Peter Glover, Farnham Proactive Case Lead
Dr Andrew Sibley, Programme Manager Wessex AHSN

PARAMEDIC RAPID HOME VISITING SERVICE

Video

https://www.youtube.com/watch?v=9Mc8JKLHkKA

Rapid Home Visiting service

- 5 paramedic practitioners interviewed in Farnborough, Aldershot and Fleet
- 30 case studies (10 in each locality)
- Synthesised findings into one thematic analysis
- Approx 30 themes per locality identified
- Largely similar findings in key elements and impact (some differences)
- On average, in Farnborough & Aldershot, 85% are complex cases (multiple LTC, house bound, under multi-disciplinary teams)
- On average, 80% of referrals can be supported (remainder need detailed GP support)

Rapid Home Visiting service - Themes

Higher order theme	Themes
High motivation	1. Clear purpose
	2. Satisfied with role
The nature of the role	3. Evolving ability to craft the role
	4. Assessment and identification
	5. Complex case focused
	6. Prevention / promoting self-care
	7. Have time to take a holistic approach
	8. Supporting care plan development
	9. Providing support to ambulance crews
	10. Collecting and delivering samples and medications
Key facilitating factors (AIs)	11. Strong IT set up
	12. Good working relationships with ambulance crews
	13. Good working relationships with care homes
	14. Good working relationships with community staff (e.g. ERS@H)
	15. Good working relationships with GPs

Rapid Home Visiting service - Themes

Higher order theme	Themes
Patient impacts	1. High satisfaction with care
	2. Improved access to rapid home visiting
	3. Saving time and work for patients
	4. Made appropriate decision to convey to hospital when needed
	5. Encouraged patient to accept support
	6. Reducing anxiety/stress by reducing their perception of the need to call 999
	7. Patient kept safe at home
	8. Increased access to 'Making Connections' support
System impacts	9. Admission avoidance
	10. Reduction in 999 calls
	11. Improved access to medication
	12. Avoiding GP appointments
	13. Saving GP time
	14. Supporting other localities to develop the Paramedic Practitioner role

Rapid Home Visiting service - Challenges

Challenges	1. Early attitudes were sceptical from ICT, district nurses and care homes
	2. IT systems needed before service is set up
	3. Demand for paramedic practitioner work increasing
	4. Patients not accepting support or going to hospital
	5. Referral patterns affect paramedic productivity
	6. GP engagement

Summary

- RHV well received and positively discussed
- Active ingredients included having time, good working relationships with other parts of the system, and prevention ethos
- Patient impacts included increased access to services (e.g. medications, Making Connections)
- System impacts included avoiding admissions, GP appointments and 999 calls

Why do we need a Home Visiting Service? What's Changed…?

The Community Paramedic
Home Visiting Service

fics
farnham integrated care services

Farnham Rapid Home Visiting Service

Patient requests a home visit

- ✓ Housebound
- ✓ Acutely unwell
- ✓ Complex
- ✓ Frail
- ✓ Over 18 years

The Community Paramedic Home Visiting Service

fics
farnham integrated care services

comprehensive

Assessment

ageUK Love later life

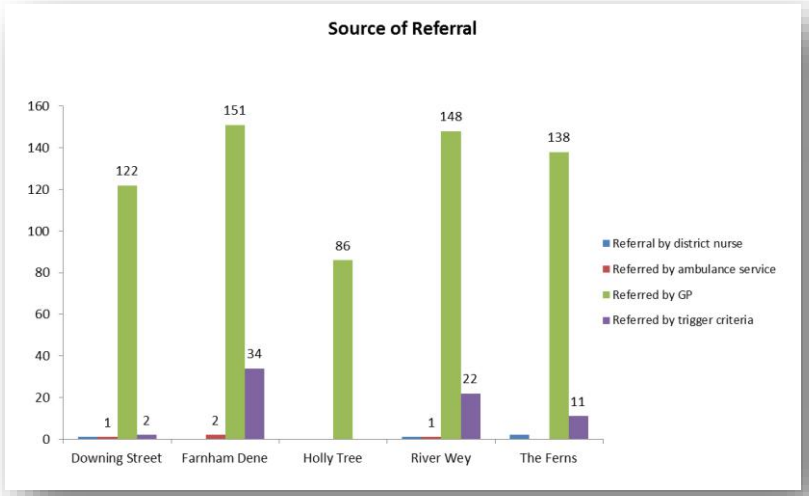
IBIS

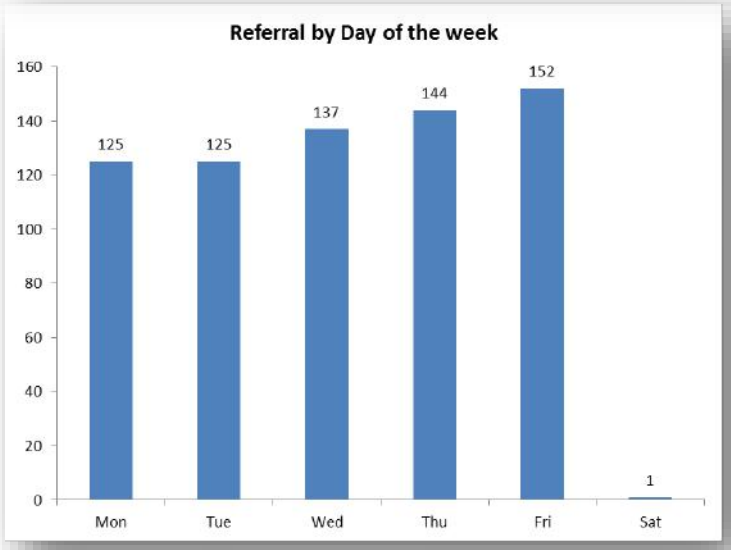
emisWeb

SURREY COUNTY COUNCIL

NHS Surrey and Borders Partnership NHS Foundation Trust

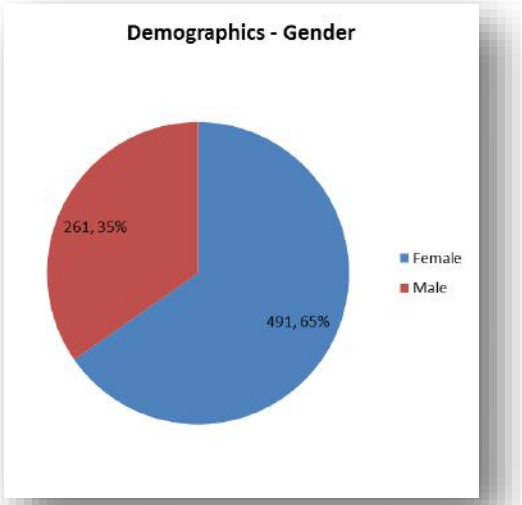
How do patients come to us?

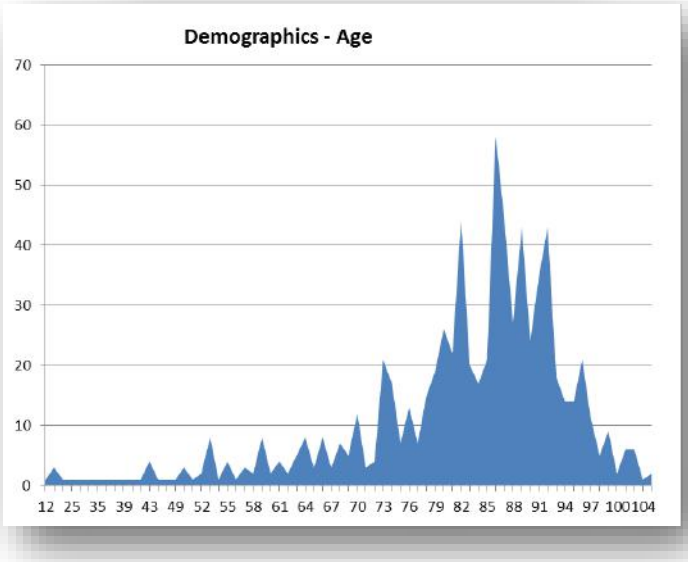




- Most referrals come from GPs, but increasing numbers from proactive case finding
- Referrals peak towards the end of the week

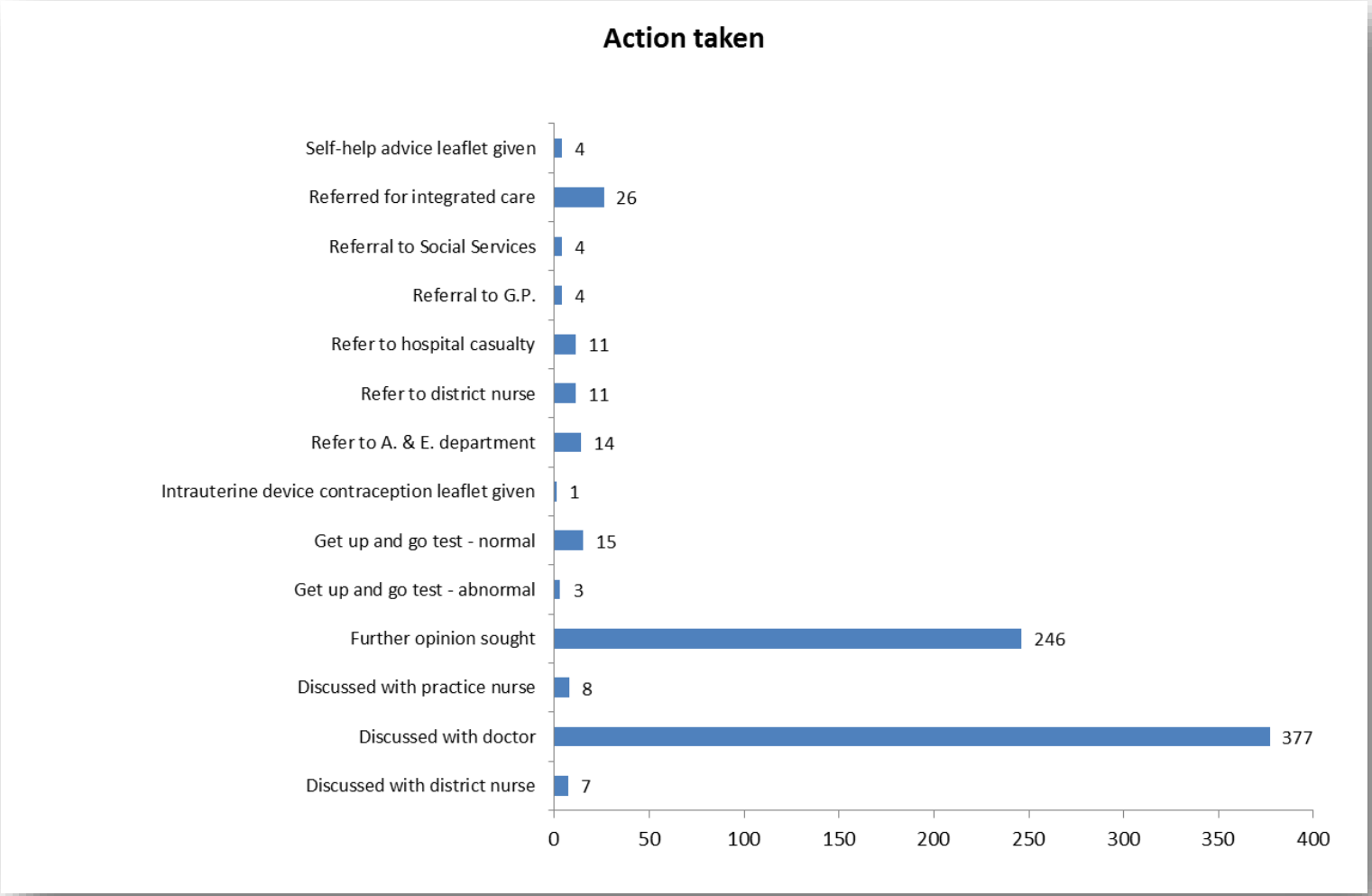
Who are we seeing?



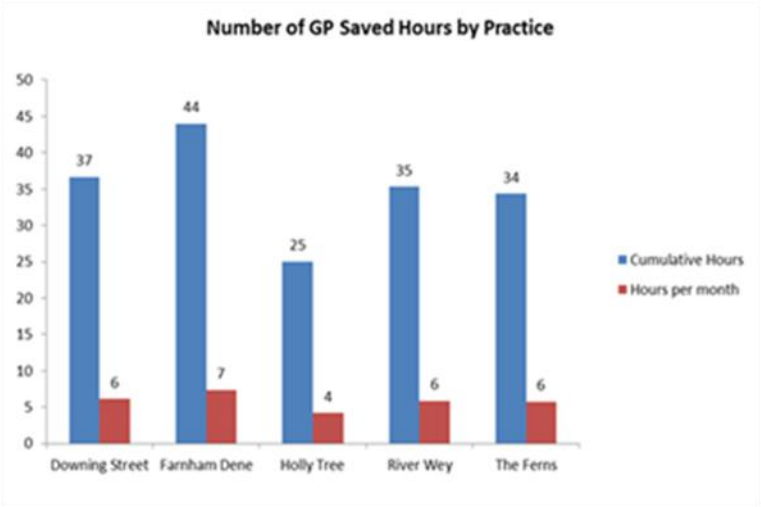


- 402 patients seen (April – Nov 2017)
- Most are 70yrs+ and have complex health issues
- On average patients are seen 1.8 times each by the service

What action do we take?



The difference we're making



A&E attendance avoided: 19 @ £3,219
Emergency admission avoided: 73 @£ 209,475
TOTAL avoided acute cost: £212,693

This avoided cost is based on the average cost for a Farnham ICT patients (post referral) per A&E attendance or Emergency Admission. Source: 120 day +/- Report M06
This is £169 per A&E attendance and £2869 per emergency admission

175 hours of GP time saved to date
29 hours of GP time saved per month
Average of 5.8 hours saved a week per practice

This is the amont of saved GP time where RHVS have undetaken home visits which otherwise would have been done by a GP.
*Based on the number of home vists * (20 min visit + 20min travel time).*

Rapid Home Visiting service – Staff Survey

71 surveys (37 were GPs) completed across Farnham, Yateley, Farnborough, Aldershot and Fleet

Headline findings:

- 96% thought patients received home visits quicker
- 94% stated they now work in a more positive working environment due to RHV
- 94% stated RHV was an efficient use of staff skills
- 89% saw improvements in patients ability to access urgent primary care
- 83% thought the service had avoided hospital admissions
- 65% thought the service had avoided A&E attendances
- 44% thought GPs were able to offer patients with complex health issues longer appointments

Please be back in your seats for 13:15

LUNCH

Out of hospital integrated care

How do we look after our most vulnerable patients?

Harriet Luximon, Head of Commissioning (Integrated Care and Community Services)

NHS North East Hampshire & Farnham Clinical Commissioning Group

Integrated Care

People benefit from **care** that is person-centred and co-ordinated within **healthcare** settings, across mental and physical **health** and across **health** and social **care**. For **care** to be **integrated**, organisations and **care** professionals need to bring together all of the different elements of **care** that a person needs.

The Mrs Smith Test

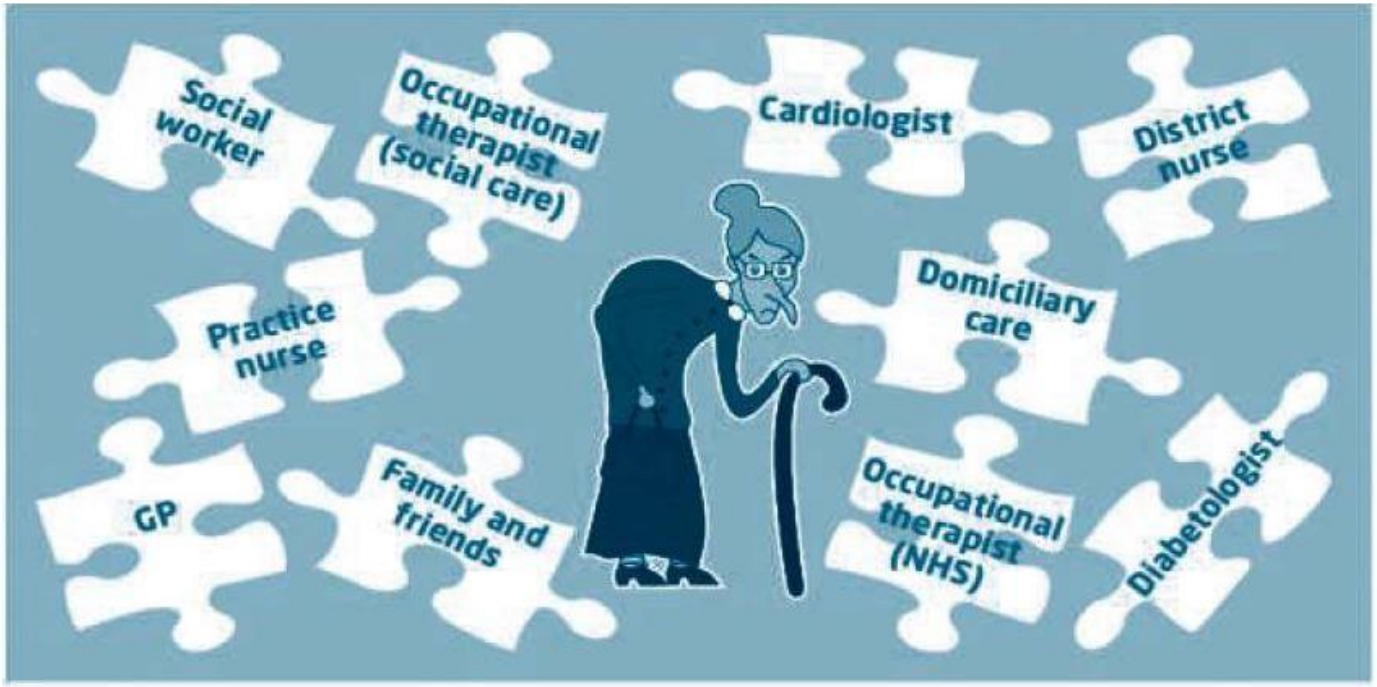
Many people with mental, physical and/or medical conditions are at risk of long hospital stays and/or commitment to long-term care in a nursing home.

Mrs Smith is a fictitious women in her 80s with a range of long-term health and social care problems for which she needs care and support.

Mrs Smith encounters daily difficulties and frustrations in navigating the health and social care system.

Problems include her many separate assessments, having to repeat her story to many people, delays in care due to the poor transmission of information, and bewilderment at the sheer complexity of the system.

From a fragmented set of health and social care services…



...to a co-ordinated service that meets her needs

Fran Campbell, Operational Manager – Community Services, FHFT
Lisa Beadle, Team Manager Enhanced Recovery & Support at Home
Dr Catherine Matheson, Senior Research Fellow, Centre for Implementation Science
Joe Sladen & Philippa Darnton, Programme Managers Wessex AHSN

ENHANCED RECOVERY & SUPPORT AT HOME

OUTLINE

A. **Background on ERS@H** [team]

B. **Mixed methods evaluation** [evaluation team + team]

C. **Future of ERS@H** [team]

A. BACKGROUND ON ERS@H

For the ERS@H team:
Fran Campbell

Our goals

'To support people and promote independence so that they can stay in their own homes'

Admission avoidance

Early supported discharge – reduced length of stay

Improved outcomes for patients

Happy, healthy, at home:
North East Hampshire and Farnham Vanguard

ENHANCED RECOVERY LOGIC MODEL

A In this CONTEXT

The Health and Wellbeing of the local population is generally better than the England average. However despite the overall picture of general good health, there are areas of deprivation and child poverty concentrated in parts of Rushmoor, where over 40,000 people live in the most deprived quintile nationally for health deprivation and disability. People living within deprived areas tend to have poorer health and be high users of healthcare services. Life expectancy in North East Hampshire and Farnham is higher than the average for England, at 81 years for men and 85 years for women. However, people in the most affluent parts of Hart can expect to live for at least 10 years longer than those living in the most deprived area of Rushmoor. Addressing Health inequalities is a key strategic priority. The key strategic issue relevant to our long term planning is the ageing population and its impact on health needs, including that the prevalence of long term conditions will increase over the next five years.

Through a new model of integrated primary and community care, GPs with other care professionals will identify those individuals at risk, develop a holistic care plan with each of these individuals, and proactively manage the health and social care of the population. Our model is based on the findings of successive reviews of the successful national and international integrated care systems. The current model of care being delivered is unsustainable, this method aims to create a more sustainable and person-centred approach to care.

B with these INPUTS

Enhanced Team comprising of :

Registered Nurses

Occupational therapy

Rehab Support Workers

Physiotherapy

Associate Practitioner

Advice and support from the mental health team, the integrated care teams and the social care teams.

C we will carry out the following ACTIVITIES

Intensive multi-disciplinary community support

Education and support

Anxiety management

Education of carers/ patient

Rehabilitation – adapting support packages to patients needs

Initial trouble shooting

Home environment reviews

Equipment provision

Falls assessment

Settling at home/ reassurance

Use of telecare – just checking system

D Creating the following OUTPUTS

Enhanced capacity – number of visits conducted

Increased Number of patients added to caseload

Decreased Number of patients declined due to capacity limitations

Decreased Number of readmissions to hospital of patients receiving ERS@H service

Decreased Number of avoidable admissions to hospital

E to deliver the following OUTCOMES

Reduced unscheduled hospital admissions
Reduced hospital readmissions.

Reduction in number of patients requiring long term packages of care

Reduction in unplanned use of care

Increase in number of bed days saved in relation to the increased capacity

Improved patient reported outcome measures

Improved patient experience

Empowering patients to self manage and manage their own conditions

Cultural shift in organisational integration

Engagement of voluntary sector in developing the environment

Upskilling people in generic roles

F with these long term IMPACTS

Happy
Patients are happy with the care they receive and feel confident to look after their condition in the home

Healthy
Patients are confident to manage their condition and are empowered to do so in the home

At home
Patients are facilitated to return home so that they no longer have to stay in hospital for longer than they need to.

Value For Money
Reduction in length of stay and avoidable admissions.

North East Hampshire and Farnham Clinical Commissioning Group NHS
Frimley Health NHS Foundation Trust
Salus Medical Services
Southern Health NHS Foundation Trust
virgincare
Surrey and Borders Partnership NHS Foundation Trust
North Hampshire Urgent Care
Wessex Academic Health Science Network
Hampshire County Council
Surrey

Who are the team members?

Evolving skill mix

- Team Lead
- Physiotherapists (4/5 WTE)
- Occupational Therapists (3/5 WTE)
- Registered nurses (3/4 WTE)
- Associate Practitioners (2/2 WTE)
- Rehab support workers (27/27 WTE)
- Admin (0/2 WTE)
- ICT

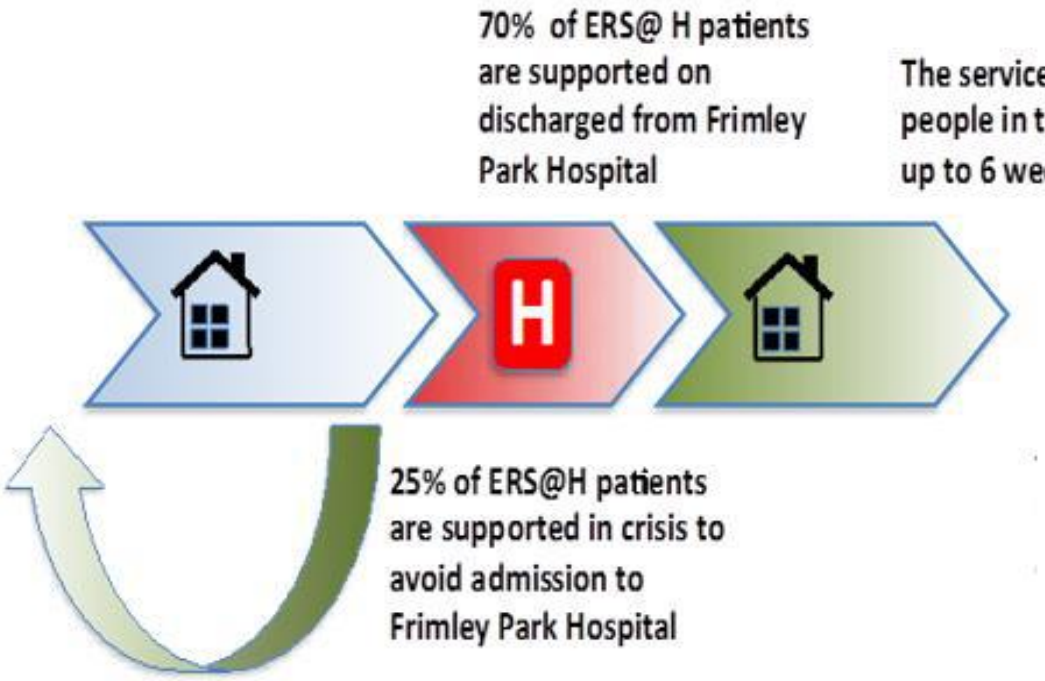
Extended team

- As required: GPs, Community Geriatrician, Specialist Nurses, Pharmacists
- On-site clinician at FPH at front door and on the wards to identify suitable patients

Evolving skill mix

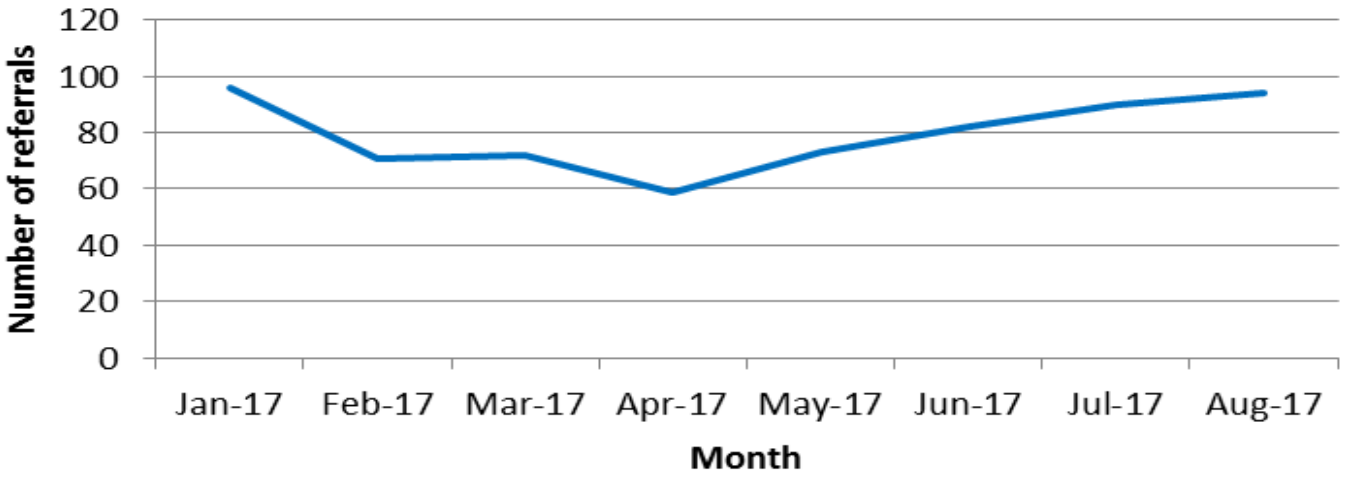
To include Associate Practitioners and OT rotational posts

How does ERS@H contributes to looking after vulnerable patients – integrating the pathway of care?



Our activity figures

New referrals



- Referral numbers have been **steadily rising** since April 2017
- Average number of referrals is **79 per month** and average number on the caseload in **56**.

B. MIXED METHODS EVALUATION

For the evaluation team:
Philippa Darnton and Dr Catherine Matheson-Monnet

For the ERS@H team:
Fran Campbell and Lisa Beadle

A mixed methods evaluation

Activity and system benefit

1. Activity impact
2. System benefit

The Team

3. Staff reported outcomes (R-Outcomes)
4. Manager interviews
5. Team evaluation

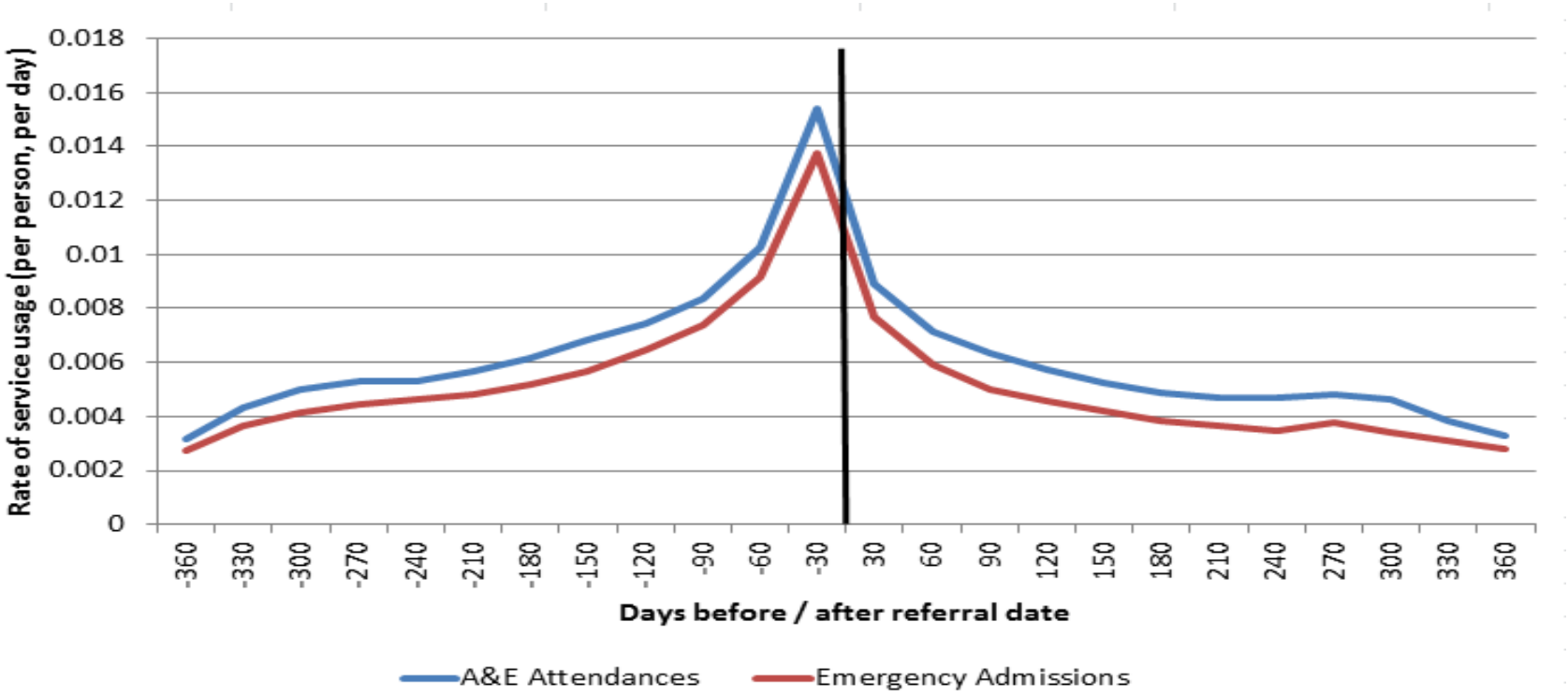
Quality of Care

6. Patient reported outcomes (R-Outcomes)
7. Patient interviews and case studies – single synthesis

Conclusion

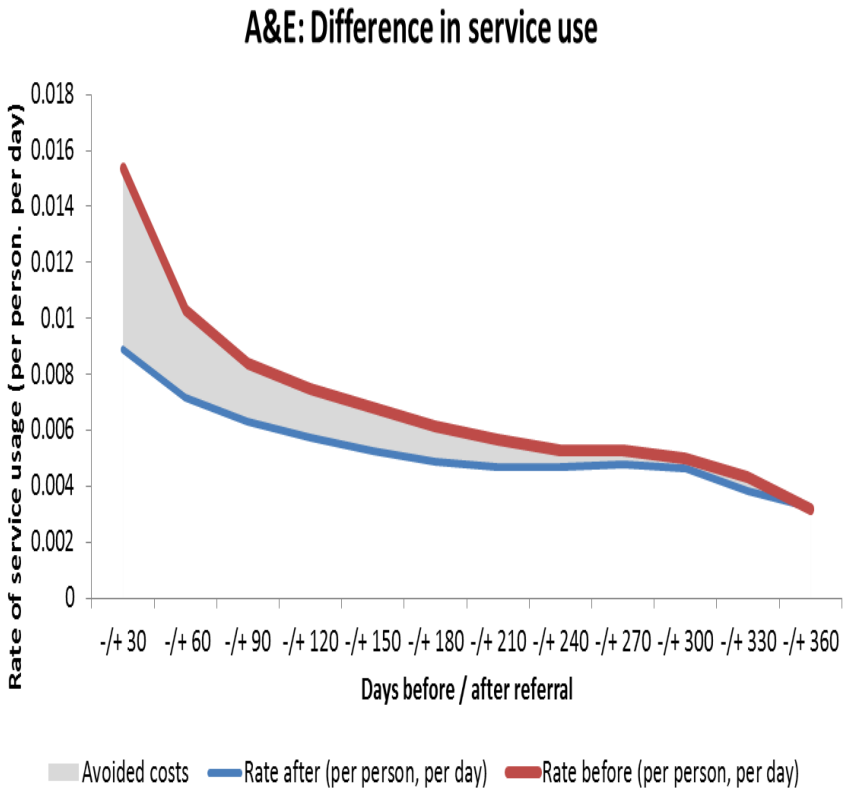
1. Activity impact

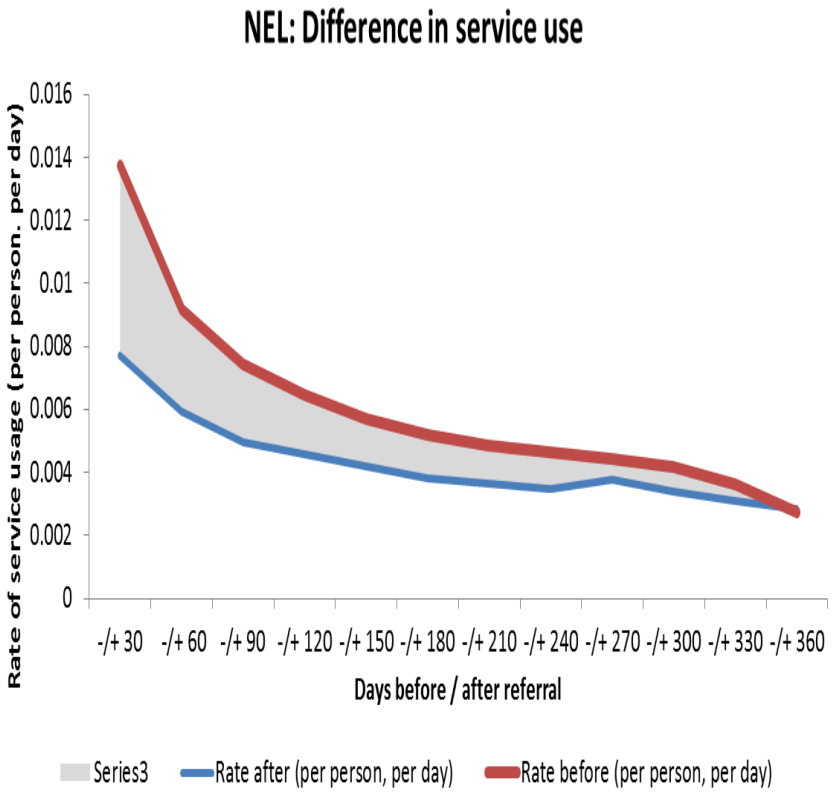
Rates of A&E attendance and emergency admission 12 months before and after referral to ERS@H



2. System benefit

Potential to avoid costs (commissioning value) based on activity level of 668 patients per annum





Cost benefit analysis

668 patients per year	Cost before (1 year)	Cost after (1 year)	Potential commissioning value over 1 year
A&E	£220,213	£169,711	**£50,503**
Emergency admissions	£3,202,716	£2,280,890	**£921,826**
Total	£3,422,930	£2,450,601	**£972,329**

814 patients per year	Cost before (1 year)	Cost after 1 year, with service at 100% capacity)	Potential commissioning value over 1 (future) year
A&E	£268,209	£206,699	£55,359
Emergency admissions	£3,900,744	£2,778,007	£1,010,463
Gross Total	£4,168,953	£2,984,706	£1,065,822
Net total, including discounting			**£1,029,780**
Total staff costs for 45 WTEs			**£1,282,457**

Limitations of the analysis

- Other interventions in the pathway may be contributing to cost avoidance and perceptions of impact

AND:

- We have not been able to quantify other potential benefits of this service to the health and care system

A mixed methods evaluation

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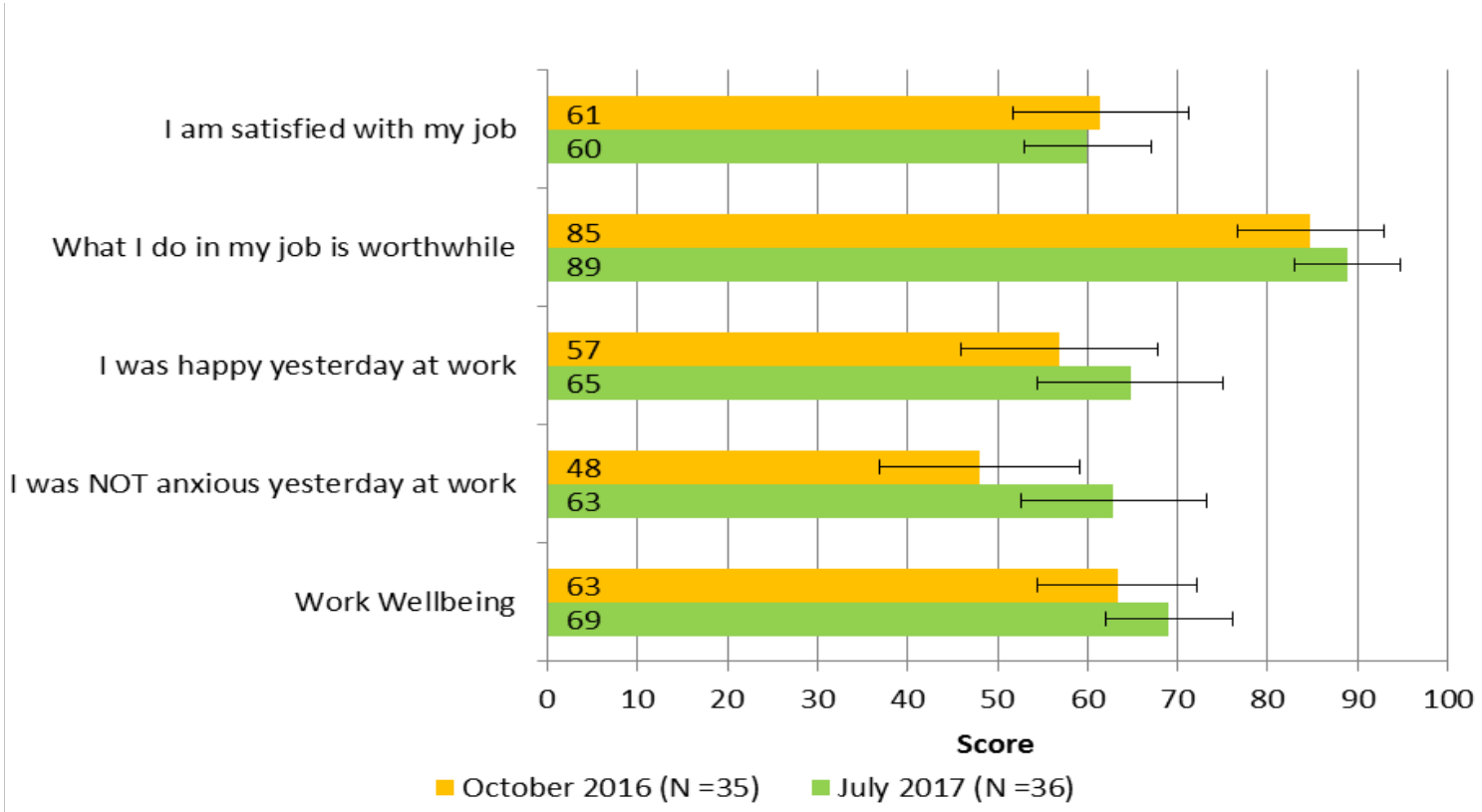
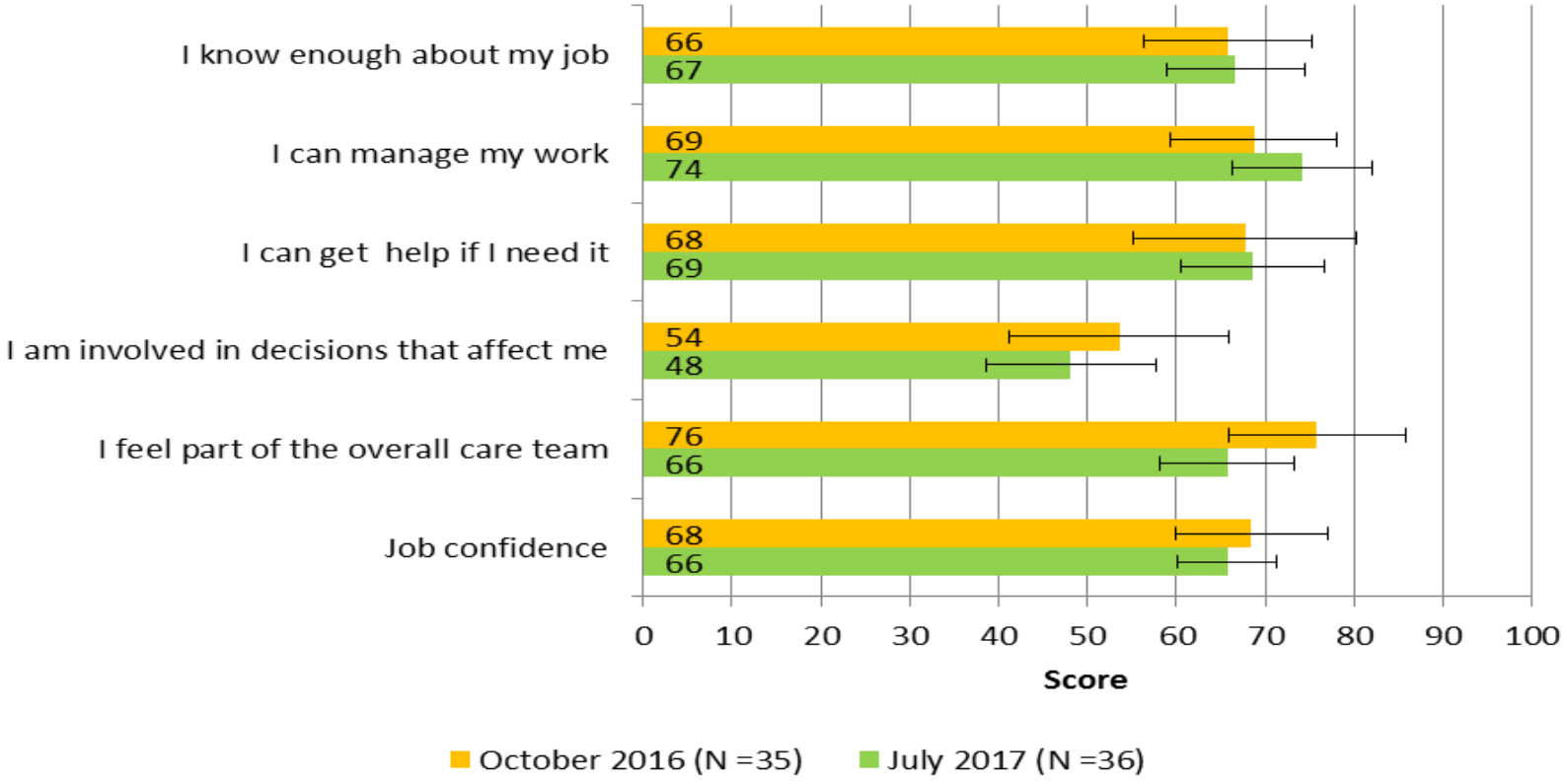
3. Staff reported outcomes

Work wellbeing



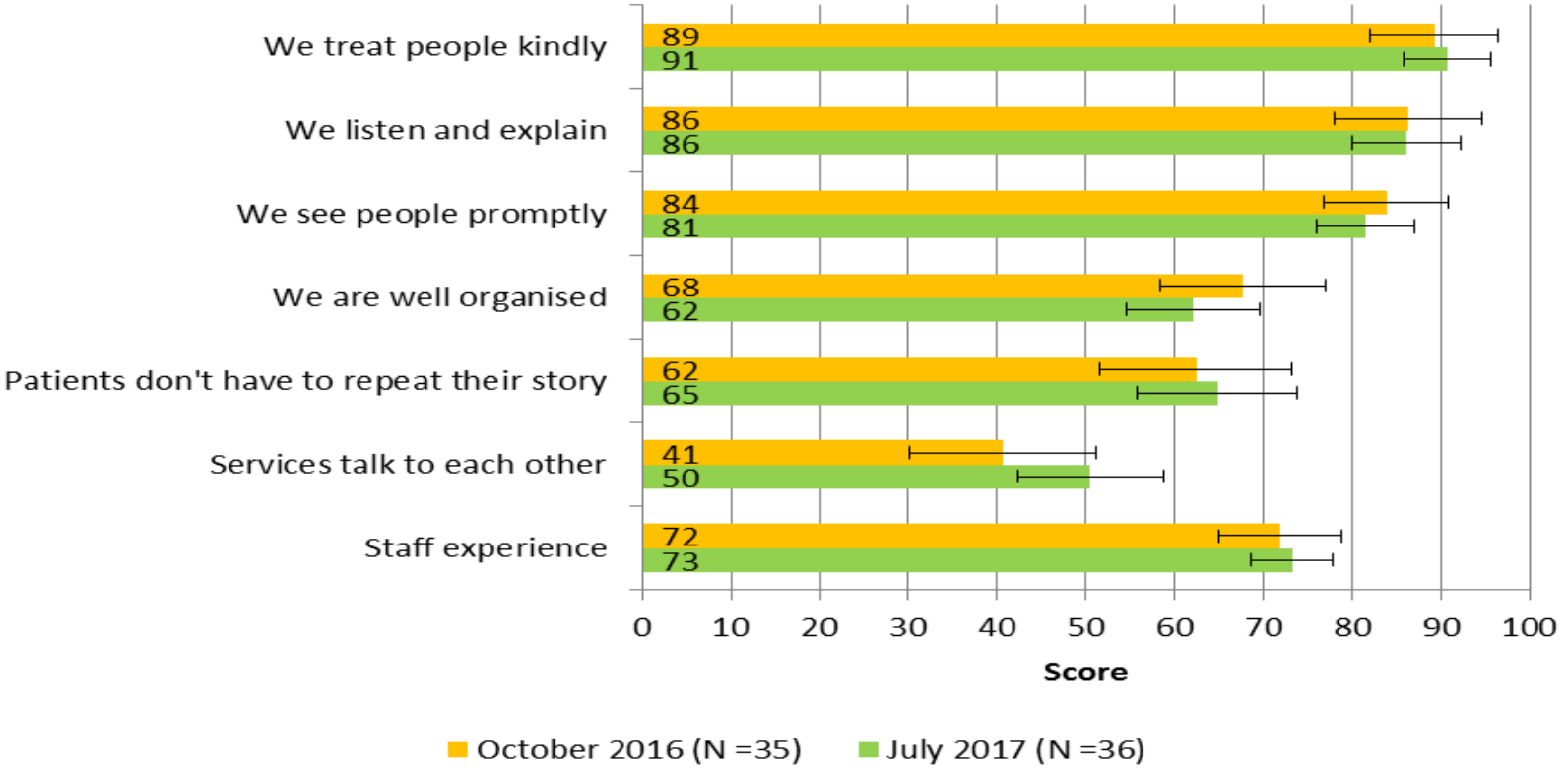
3. Staff reported outcomes

Job Confidence

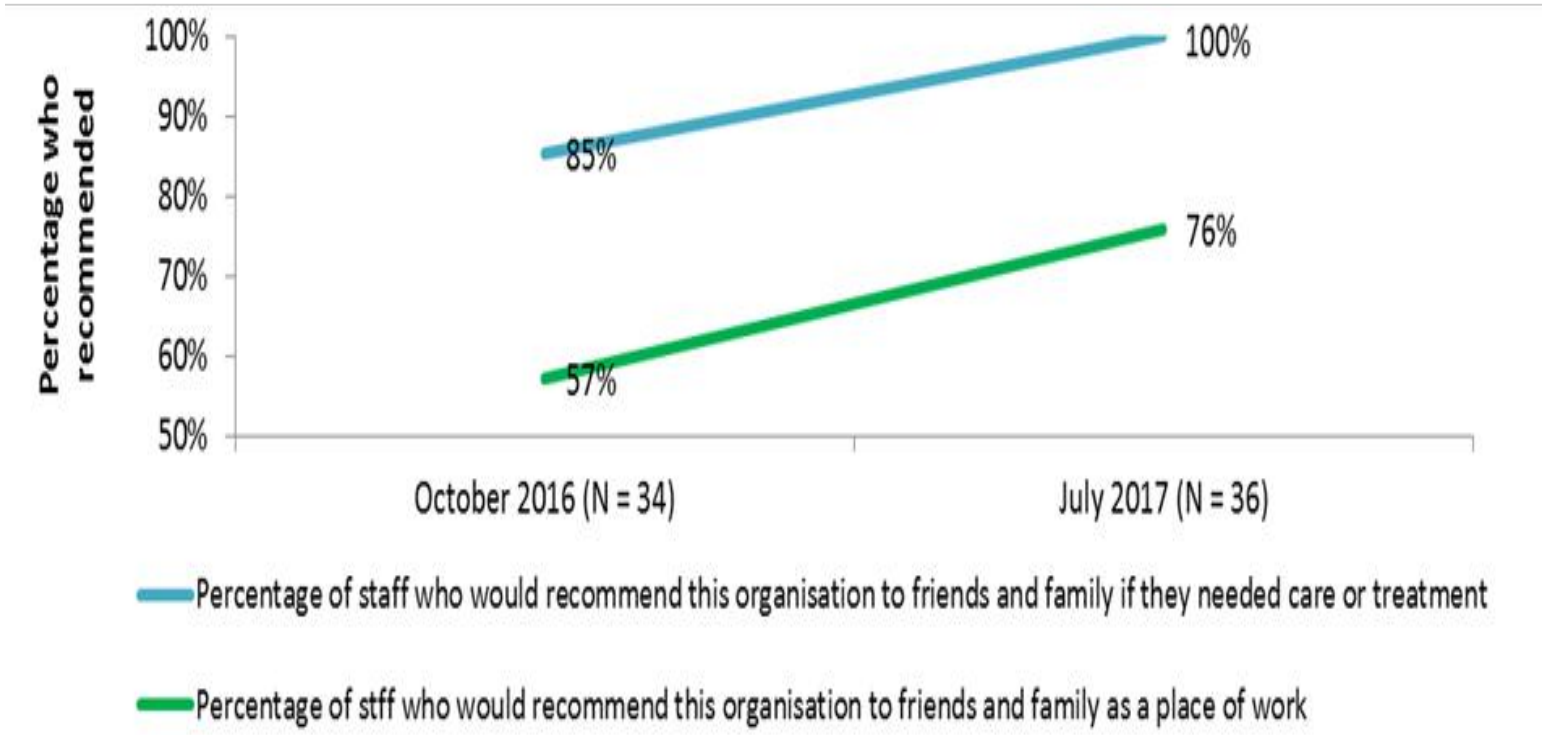


3. Staff reported outcomes

Staff experience – how are we doing



ERS@H staff: friends and family test



4. Manager interviews

Higher order theme	Theme
Integrating two culturally different teams was challenging **"Bringing them [two teams] together was vital as the success of the team depends on the multi-disciplinary approach we offer." (Manager 1)** **"Once we became one organisation, the dynamic of the team significantly changed for the better." (Manager 2)**	Confusion about leadership
	Need clarity about financial risk sharing across two organisations
	Must be one organisation with one governance structure
	Internal team struggles
	Attitudinal challenges
	Vital need to engage in the minutiae of working practices
	Earlier project management needed
	Witnessing evidence of success

5. Team evaluation

Context: data collected on 6 Sept 2017

Conceptual framework:

NPT (May and Finch, 2009)

- **Making sense** [Coherence]
- **Buy in** [Cognitive participation]
- **Collective action**
- **Reflecting** [Reflexive monitoring]

Method:

1. Non-participation of an MDT (n=25)
2. Focus group (n=23)
3. Survey (n=23)

Sample:

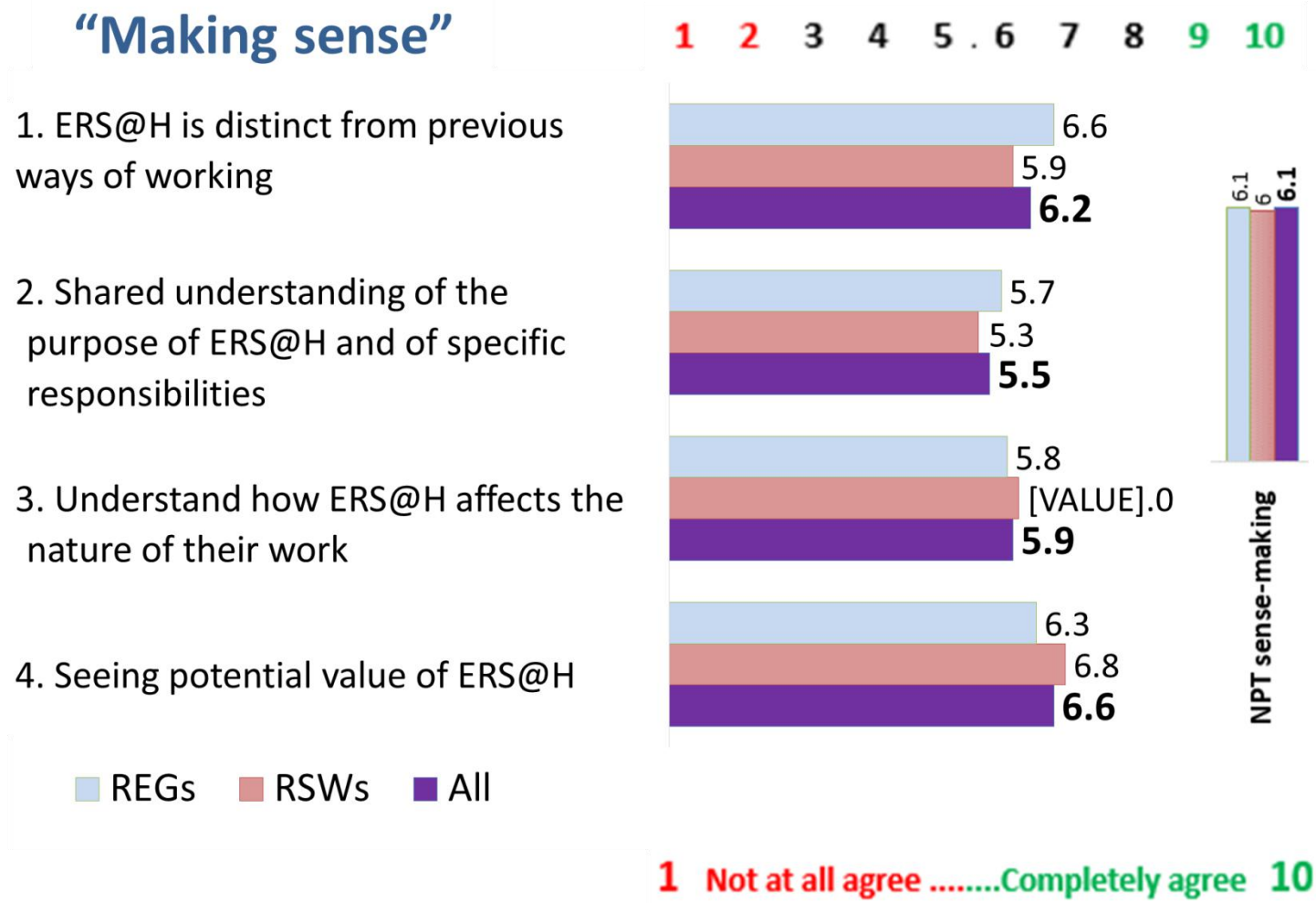
14 RSWs + 9-11 REGs

See Matheson-Monnet, CB (2017) *Independent Evaluation of NEHF : Using the Normalisation Process Theory [NPT] framework to evaluate a NCM: ERS@H.* Southampton, UK: University of Southampton e-Prints

Happy Healthy atHome

Wessex Academic Health Science Network

"Making sense"



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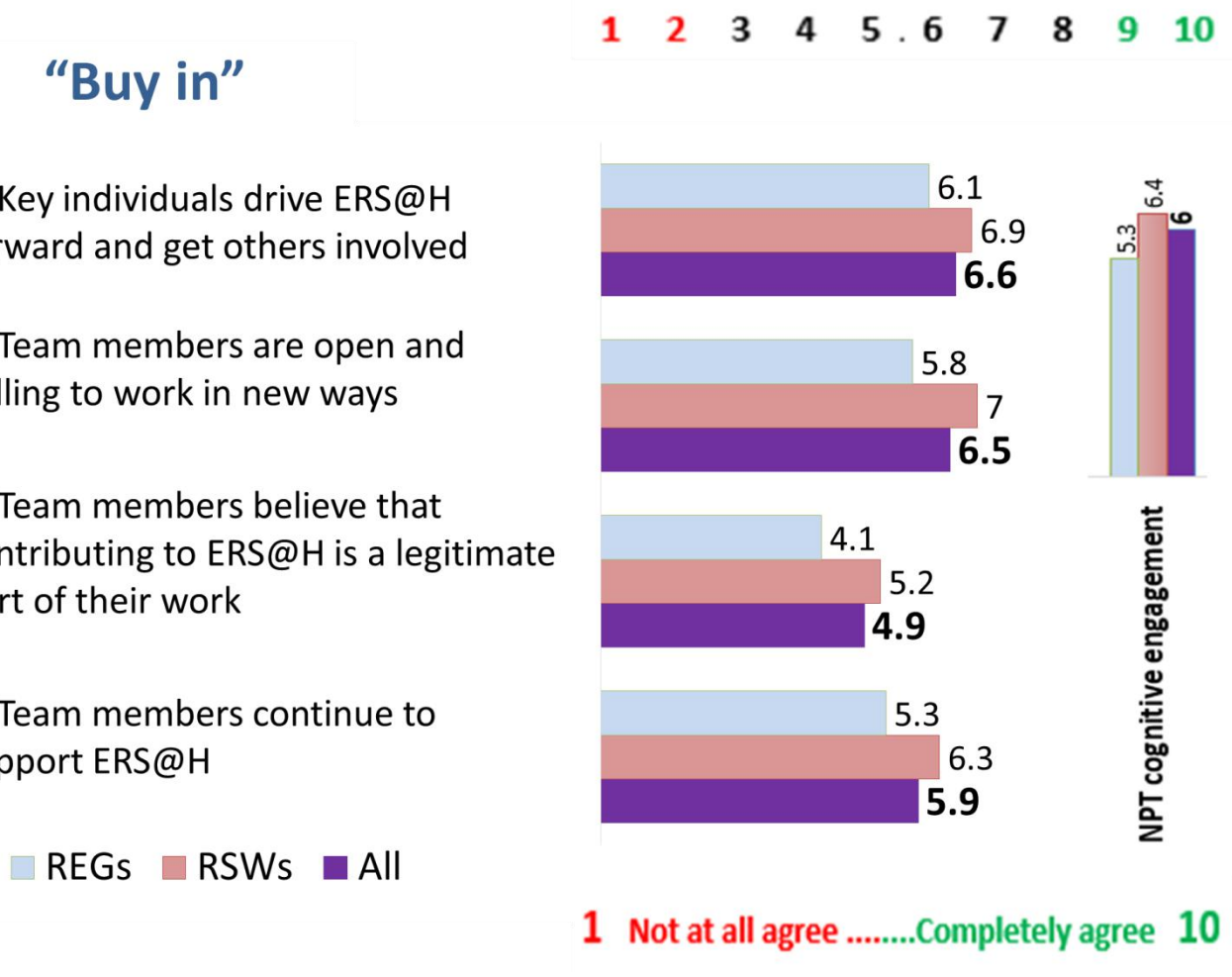
"Buy in"

5. Key individuals drive ERS@H forward and get others involved

6. Team members are open and willing to work in new ways

7. Team members believe that contributing to ERS@H is a legitimate part of their work

8. Team members continue to support ERS@H



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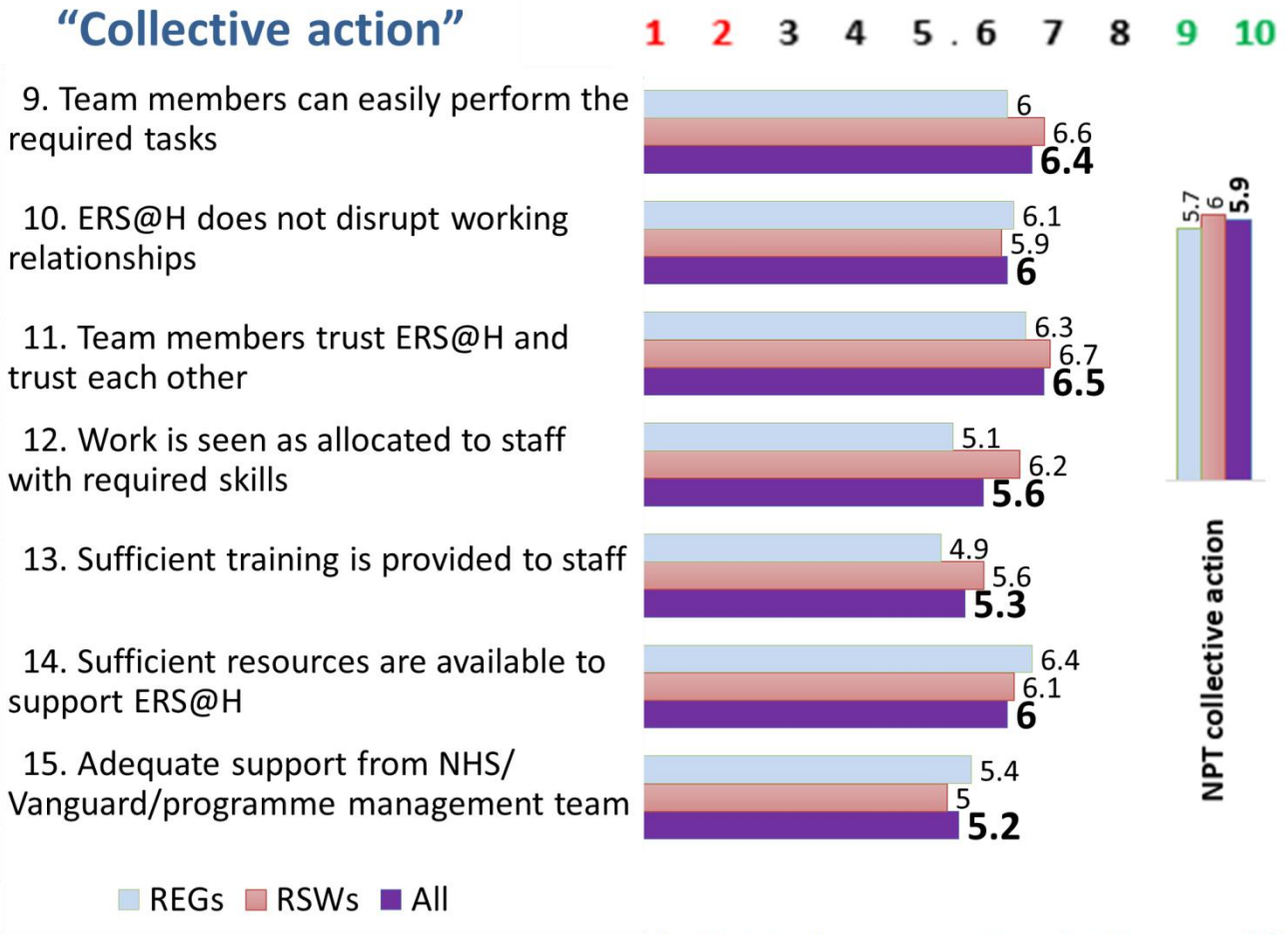
Wessex Academic Health Science Network

"Collective action"



1 Not at all agree .....Completely agree 10

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Wessex Academic Health Science Network

Ranking exercise

Centre for Implementation Science

UNIVERSITY OF Southampton

Focus group [brainstorming exercise]

Enabling factors

- ❑ Starting to have cohesive team
- ❑ Opportunity to learn new skills from other members of MDT
- ❑ Group feedback
- ❑ Huge amount of expertise in the combination of team members **TEAM**

- ❑ Far more care in community available to patients
- ❑ Patients benefit due to having a larger team
- ❑ Patient benefit positively from the service and its flexibility **PATIENT OUTCOMES**

Restricting factors

- ❑ Not enough time for too many **CHANGES** to become embedded before next change start

- ❑ Team too big and one team had to morph into the other
- ❑ Existing staff stretched more and more
- ❑ Difficulties seeing importance of own role within the team
- ❑ Not enough opportunities for upskilling **TEAM**

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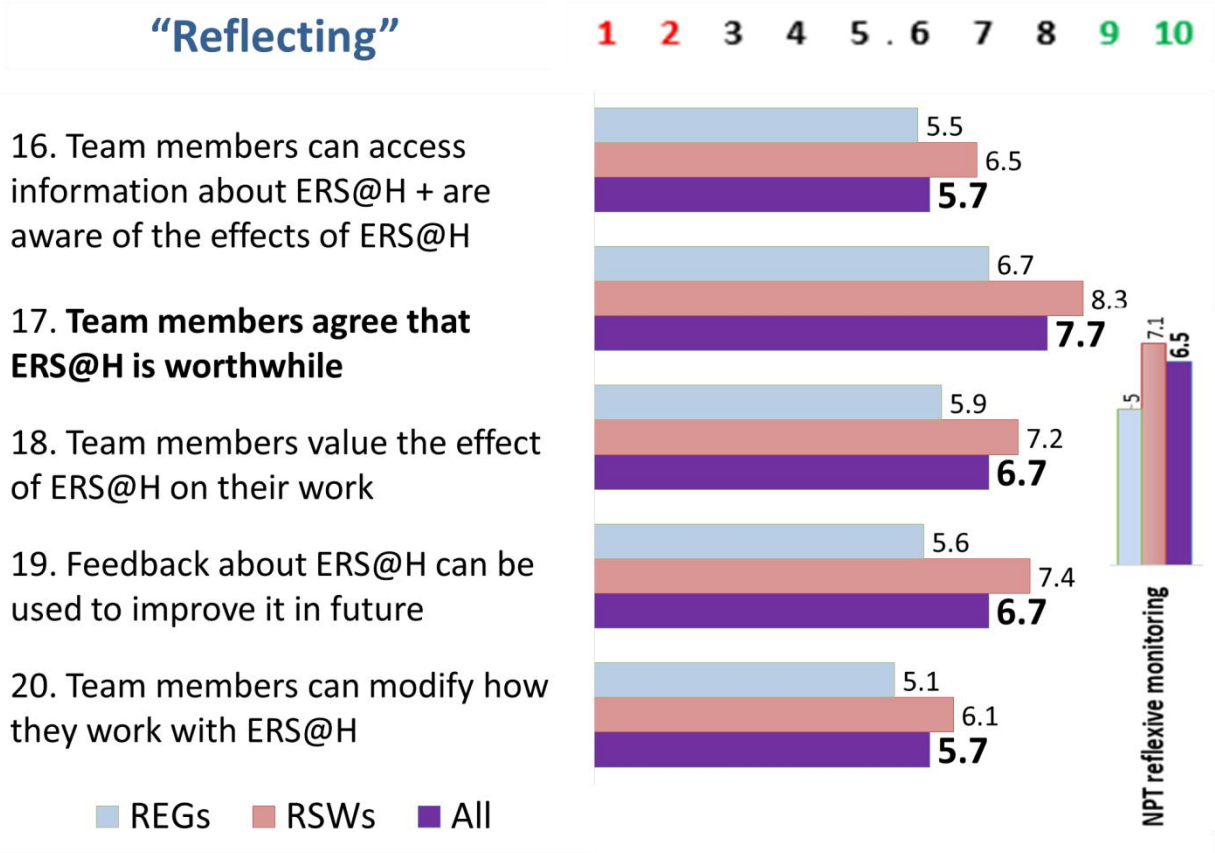
"Reflecting"



http://www.normalizationprocess.org/npt-toolkit/

1 Not at all agree .....Completely agree 10

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A mixed methods evaluation

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Conclusion

Case Study - Mrs Jones

Situation

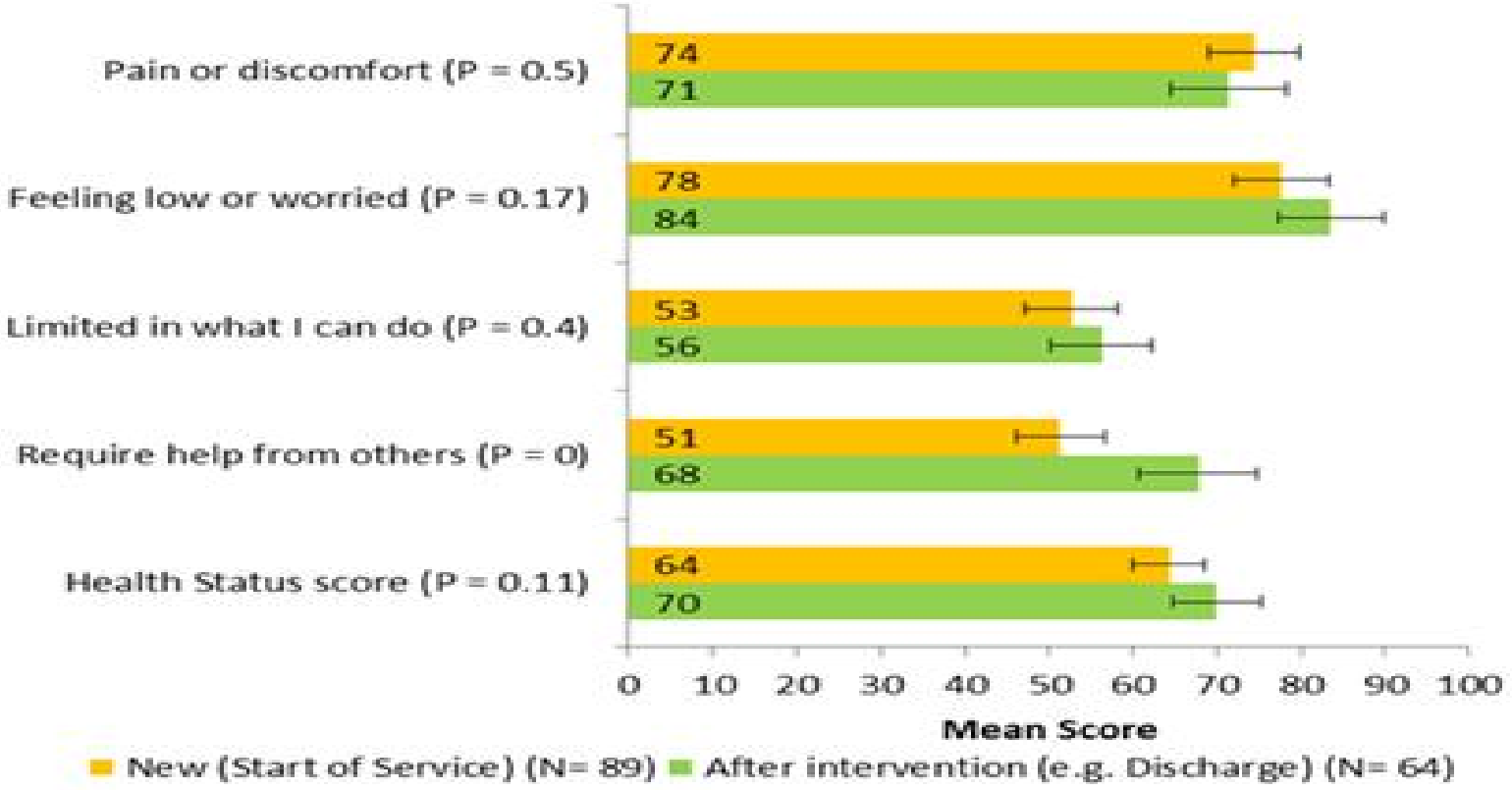
Fall - #NOF
Discharged FPH with TDS rehab from ERS@H
To a new micro-environment

Goals

To be independent with personal care, including showering
To be independent with meal prep
To be independent on the stairs

6. Patient reported outcomes

Health Status

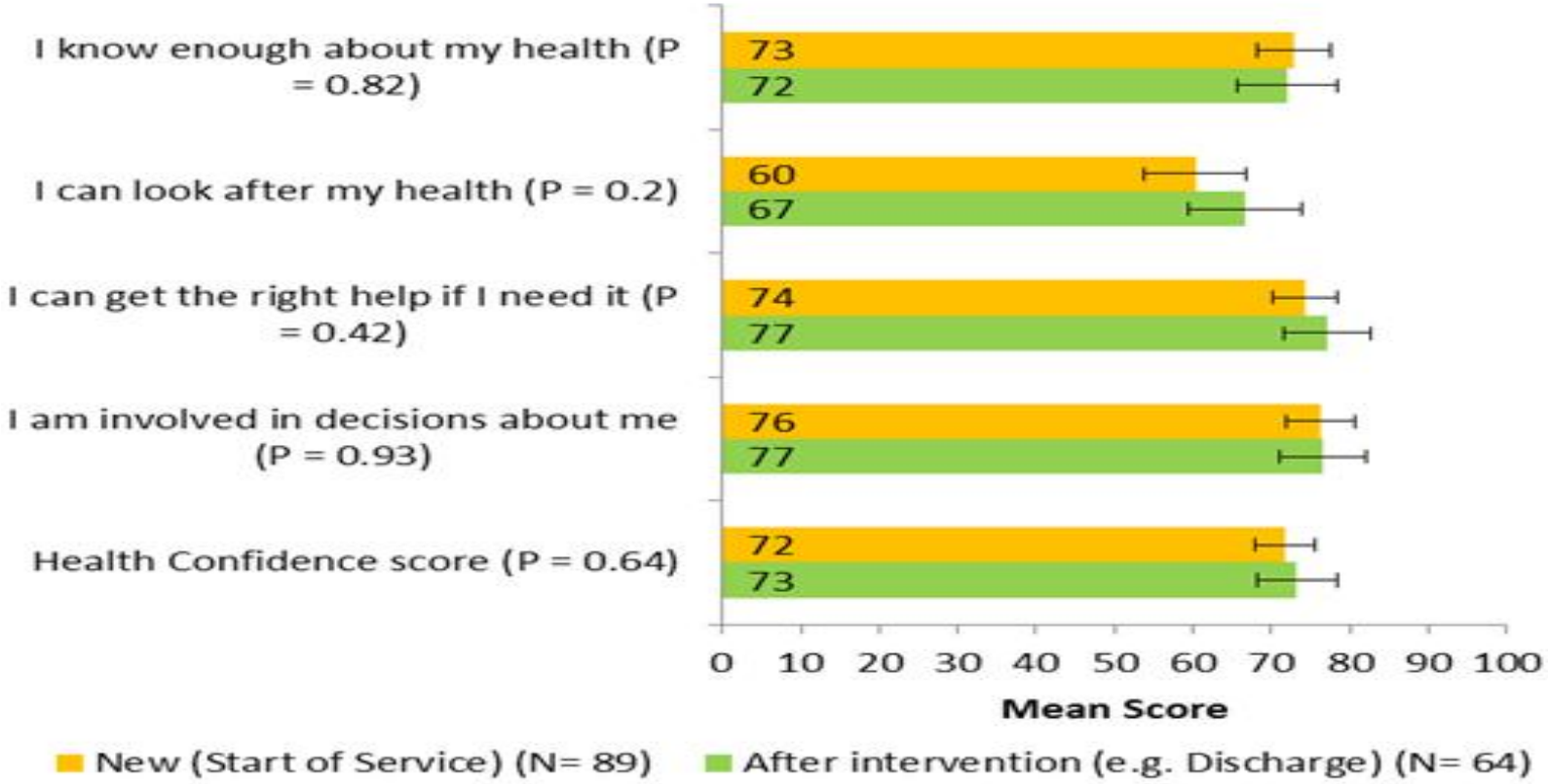


ERS@H patient experience

I really didn't want to go home, I didn't think I was ready. She [ERS@H staff member] helped me see that I was and I could cope and would be happier there. I have a lot to thank her for.

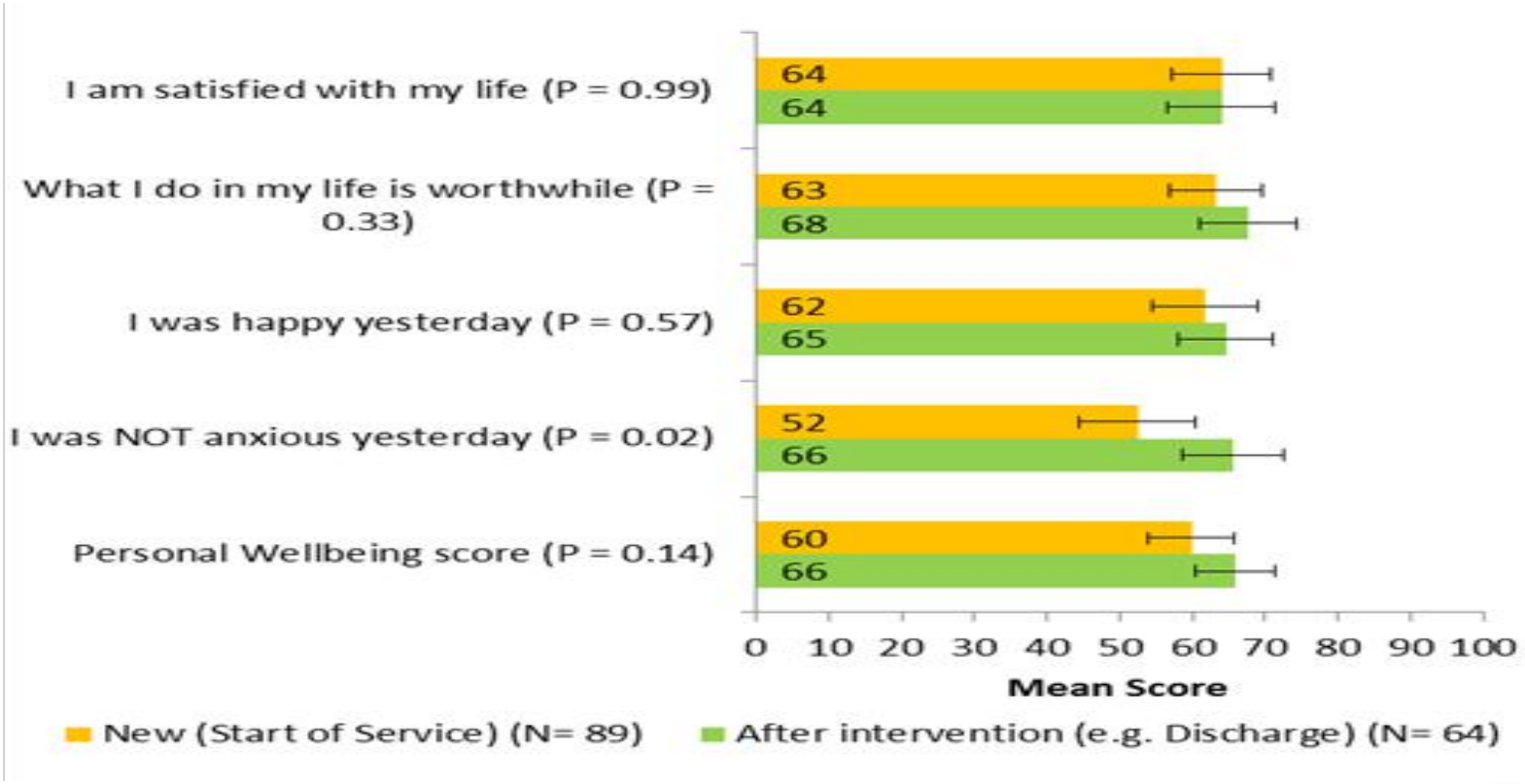
7. Patient reported outcomes

Health Confidence



7. Patient reported outcomes

Personal wellbeing

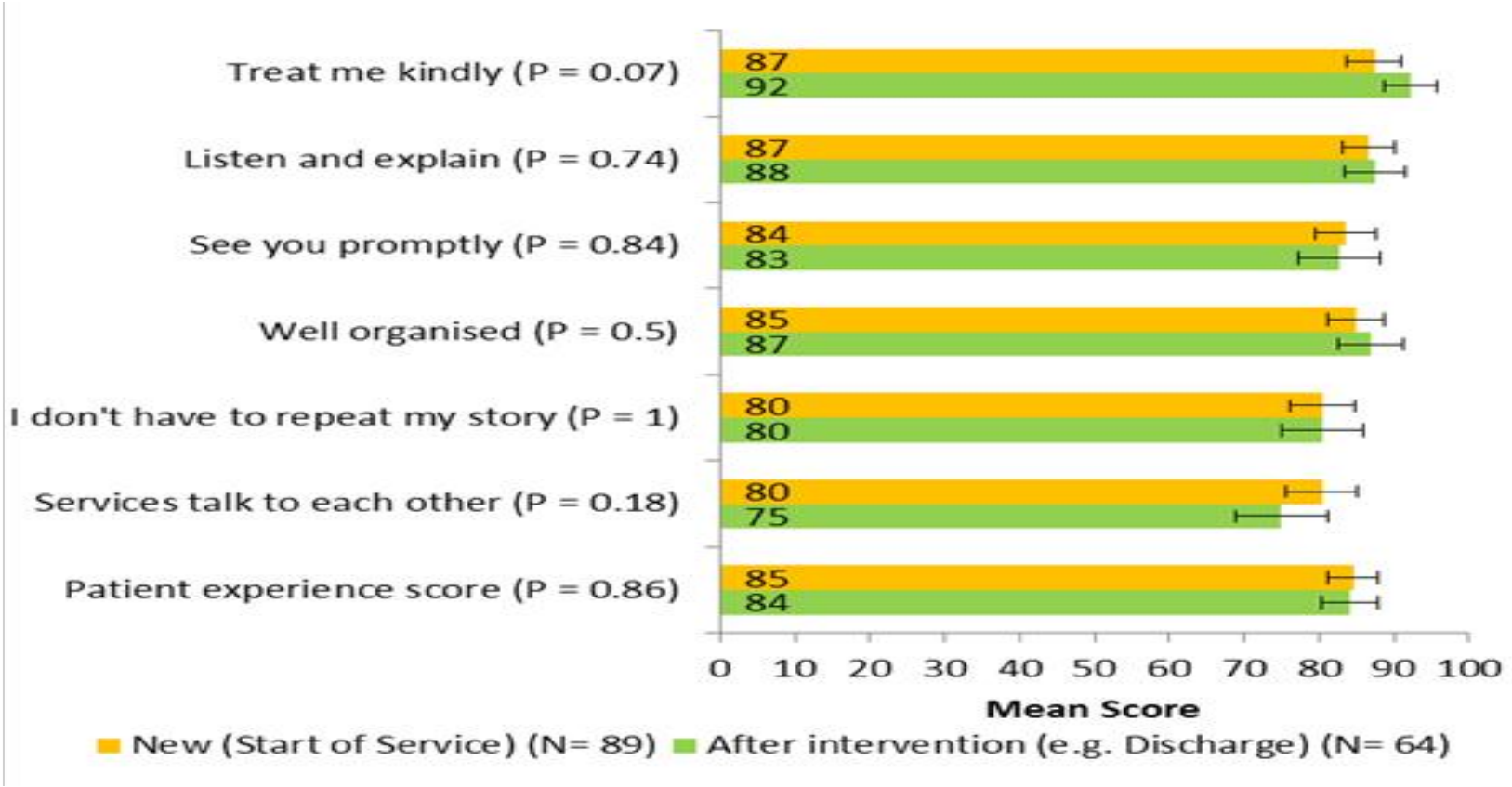


ERS@H patient experience

As each day went by, I could do a little more. They helped me to see that I could do it. In the end, I only needed 3 weeks instead of 6 weeks that I was told it might take. I was determined to get better and [ERS@H staff member] helped me do it.

6. Patient reported outcomes

Patient Experience



ERS@H patient experience

There is nowhere like home, I'd rather be there than a hospital bed. I'm very glad they [ERS@H team member] were there to help me get home.

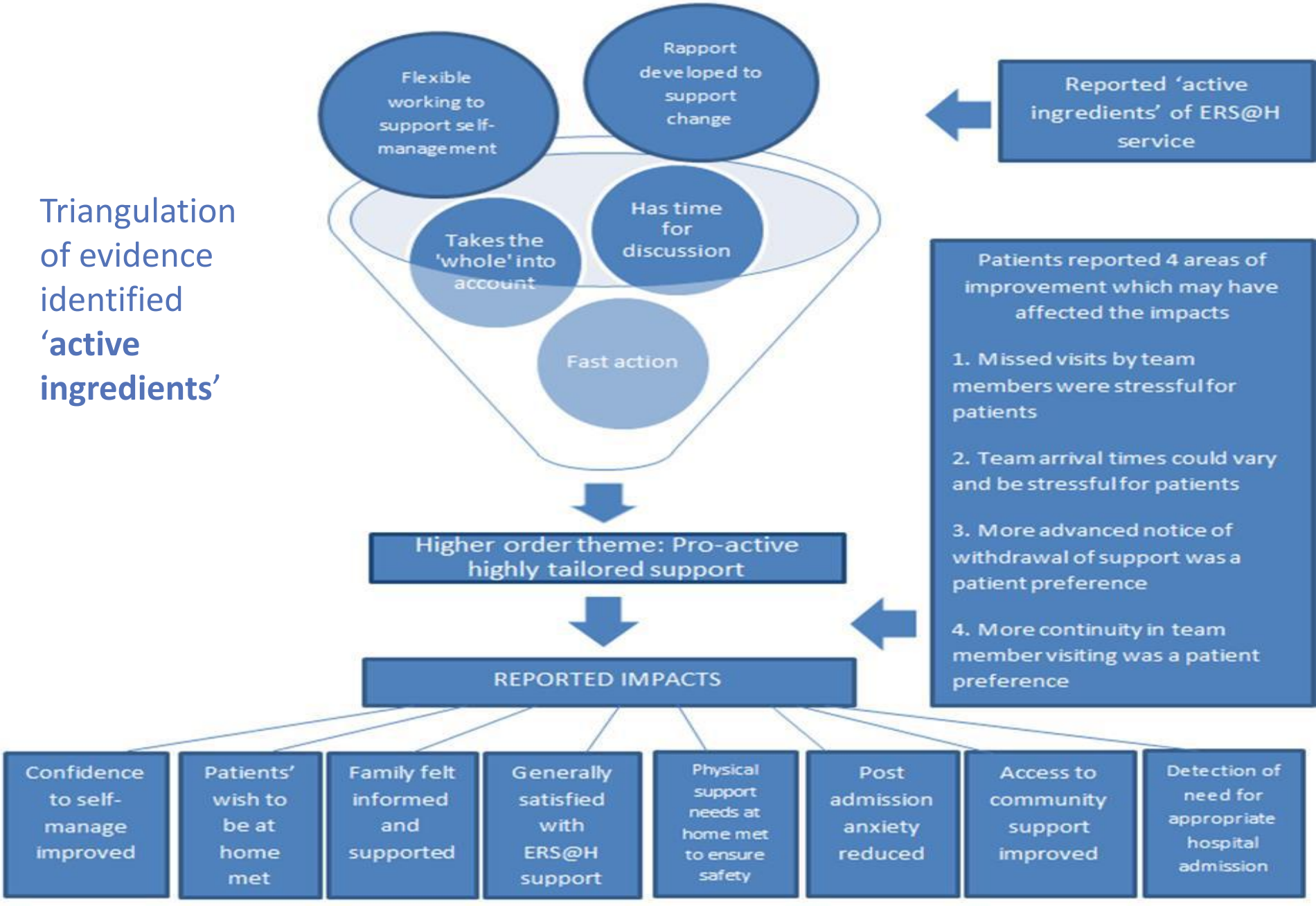
They were very concerned about my husband, they knew all this would affect him too. He's got arthritis and is slow now. They spoke to him and asked if he's ok with all this and if he can manage. He said yes and would call them if he needed help.

7. Patient interviews and case studies: single synthesis

- **10** Patient/carer interviews
- **32** Case studies provided by staff
- The work of the team was **well received and positively discussed**.
- A range of patient and carer impacts were identified from the case studies and interviews
- Triangulation of the evidence identified factors that were considered to be '**active ingredients**' of ERS@H

ERS@H: active ingredients, barriers, and reported impacts

Triangulation of evidence identified '**active ingredients**'



A mixed methods evaluation

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Conclusion

Conclusion

Activity and system benefits

- Reduction in emergency activity by 40% in 1st month and 12% reduction at month 11
- Potential commissioning value of £972,329 over a year for a caseload of 668 patients (increased to £1,029,780 if caseload 814 patients)
- Reduction in emergency activity is likely to have led to reduction in length of stay and avoidable admissions

Quality of Care

- Patients are facilitated to return home so that they no longer have to stay in hospital for longer than they need to
- Patients are happy with the good quality of care they receive and confident in managing their condition at home

Team

- Interviews with service managers evidenced challenges associated with the **integration of 2 culturally different teams** into one organisation.
- Lack of shared understanding of team roles, BUT team members believed ERS@H to be **worthwhile** and **valued its effect on their working practice**
- Flexibility, responsiveness and autonomy were valued as strengths, but could also pose significant operational challenges
- Significant progress made towards a cultural shift in ways of working
- On track to become embedded in daily routine practice in a long term sustainable way

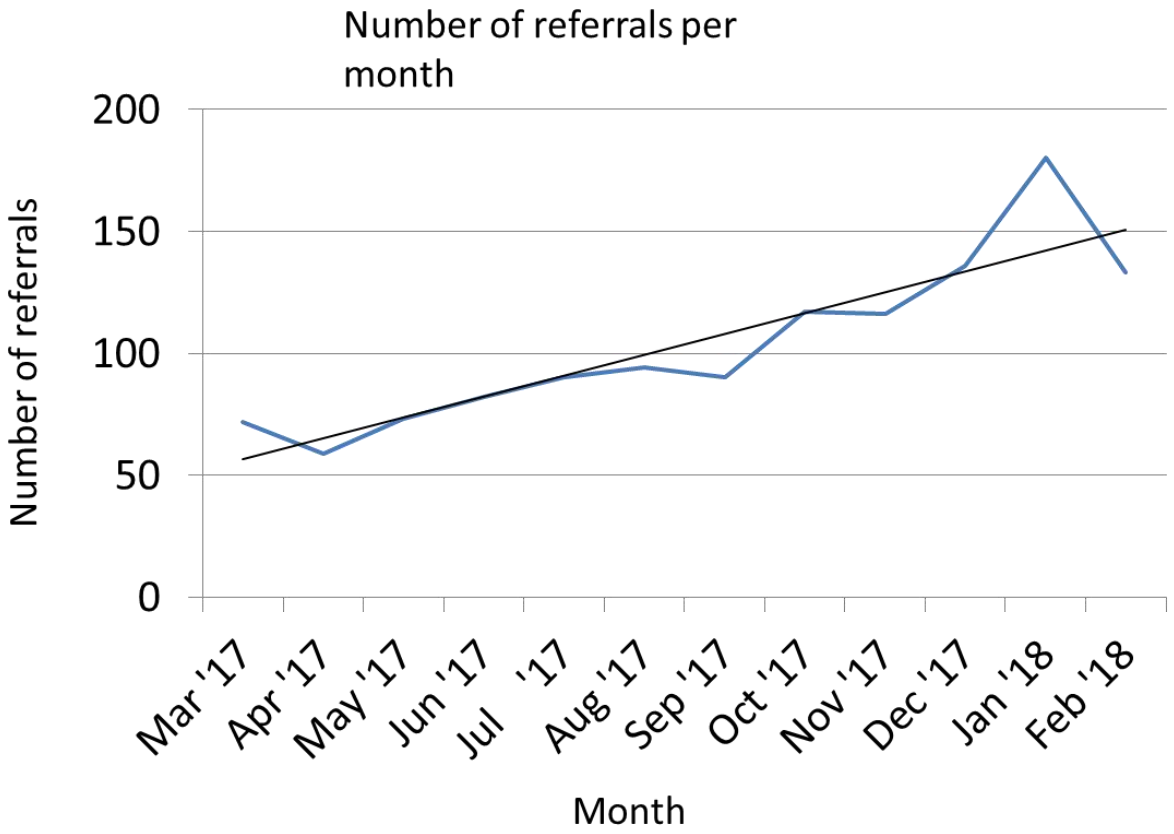
C. FUTURE OF ERS@H

For the ERS@H team:
Lisa Beadle

Learning points

- Context of constant change, job confidence, involvement in decision-making process and feeling part of the overall care team
- Some tensions between the need to follow care plans and flexibility and responsiveness during home visits
- Further development of team working is required to fully realise the benefits of ERS@H

Where we are now: referrals and caseload



Where we are now: staff feedback

- Team noticed a big difference and now feel like one big team.
- There is a significant difference from November 2016.
- There is more understanding of roles and respect for each other, and staff know who to contact.
- Being in one place helps with communication.
- Staff like being in the same uniform.
- There is no barrier between clinicians and RSWs.
- There is a clearer management structure.
- Staff reported that the turnover of staff was hard. The team are feeling more valued.
- There is still room for improvement.

- We have a Fantastic reputation and the team want to be the best they possibly can be. Staff are confident to say how they are feeling and feel like their opinions are valued.

Where we are now: patient feedback

1. Missed visits by team members were stressful for patients.
2. Team arrival times could vary and be stressful for patients.
3. More advanced notice of withdrawal of support was a patient preference.
4. More continuity in team member visiting was a patient preference.

The Future

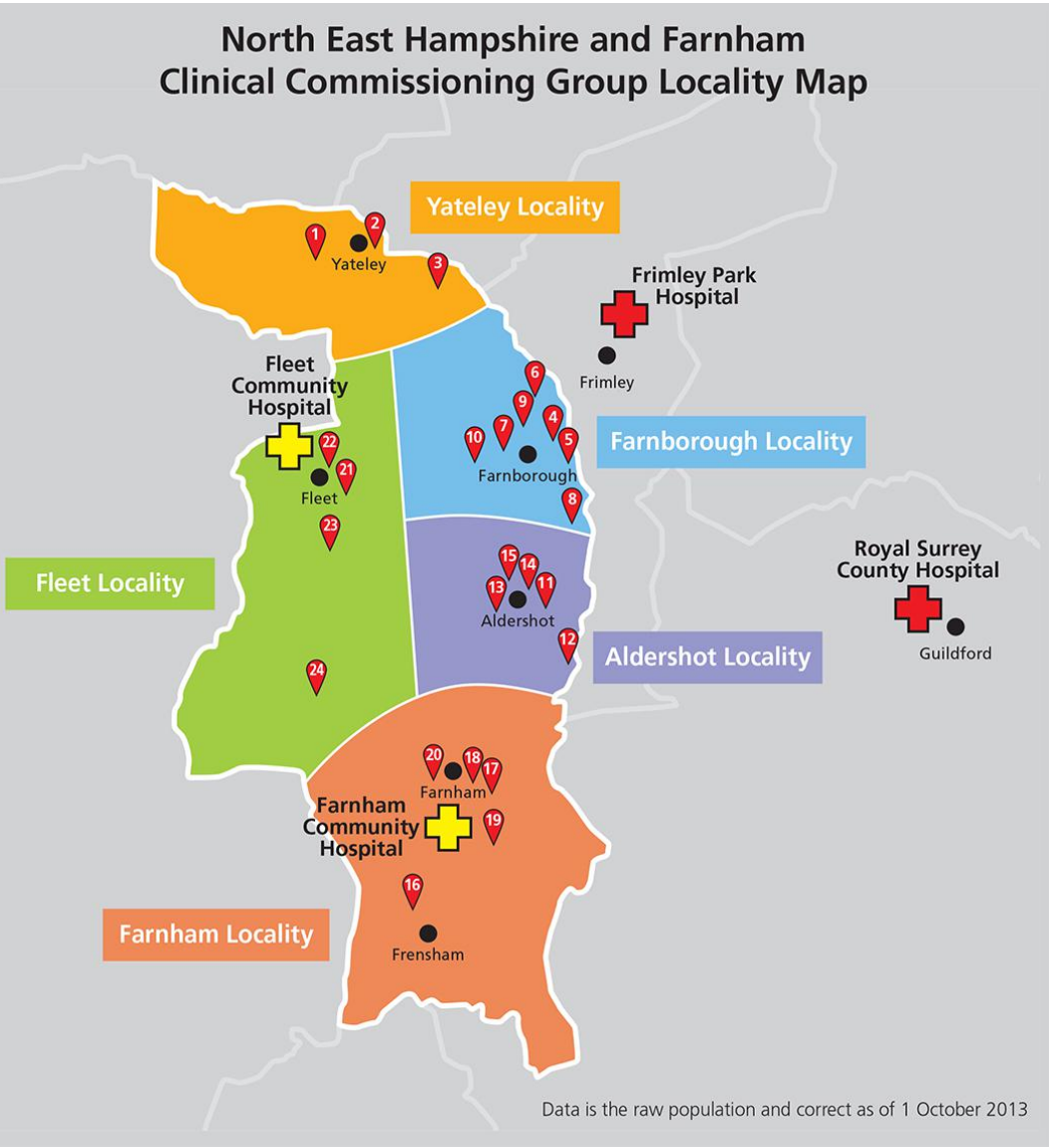
- Professional Development
- Recruitment
- D2A
- Therapy Merge
- Replicate System-Wide

Dr Gareth Robinson, Yateley Clinical Lead
Sharon Boylett, ICT Lead (Farnborough, Aldershot, Fleet)
Andrew Liles, Consultant Wessex AHSN
Sarah Harraway, Vanguard Project Manager

INTEGRATED CARE TEAMS

Yateley ICT

Locality		GP Practice	Total Population
Yateley Locality	1	Monteagle Surgery	5976
	2	The Oaklands Practice	10632
	3	Hartley Corner Surgery	11561
Yateley Total			28169
Farnborough Locality	4	Alexander House Surgery	9410
	5	Milestone Surgery	11128
	6	Mayfield Medical Centre	9179
	7	Jenner House Surgery	10298
	8	North Camp Surgery	4567
	9	Giffard Drive Surgery	8338
	10	Southwood Practice	6260
Farnborough Total			59180
Aldershot Locality	11	Southlea Group Practice	14228
	12	The Border Practice	8614
	13	Princes Gardens Surgery	7821
	14	Victoria Practice	8172
	15	The Wellington Practice	3130
Aldershot Total			41965
Farnham Locality	16	Holly Tree Surgery	5645
	17	River Wey Medical Practice	6534
	18	The Ferns Medical Practice	10642
	19	Farnham Dene Medical Practice	11602
	20	Downing Street Group Practice	12492
Farnham Total			46915
Fleet Locality	21	Branksomewood Healthcare Centre	12592
	22	Fleet Medical Centre	14767
	23	Richmond Surgery	12403
	24	Crondall New Surgery	4259
Fleet Total			44021
North East Hampshire and Farnham Total			220250

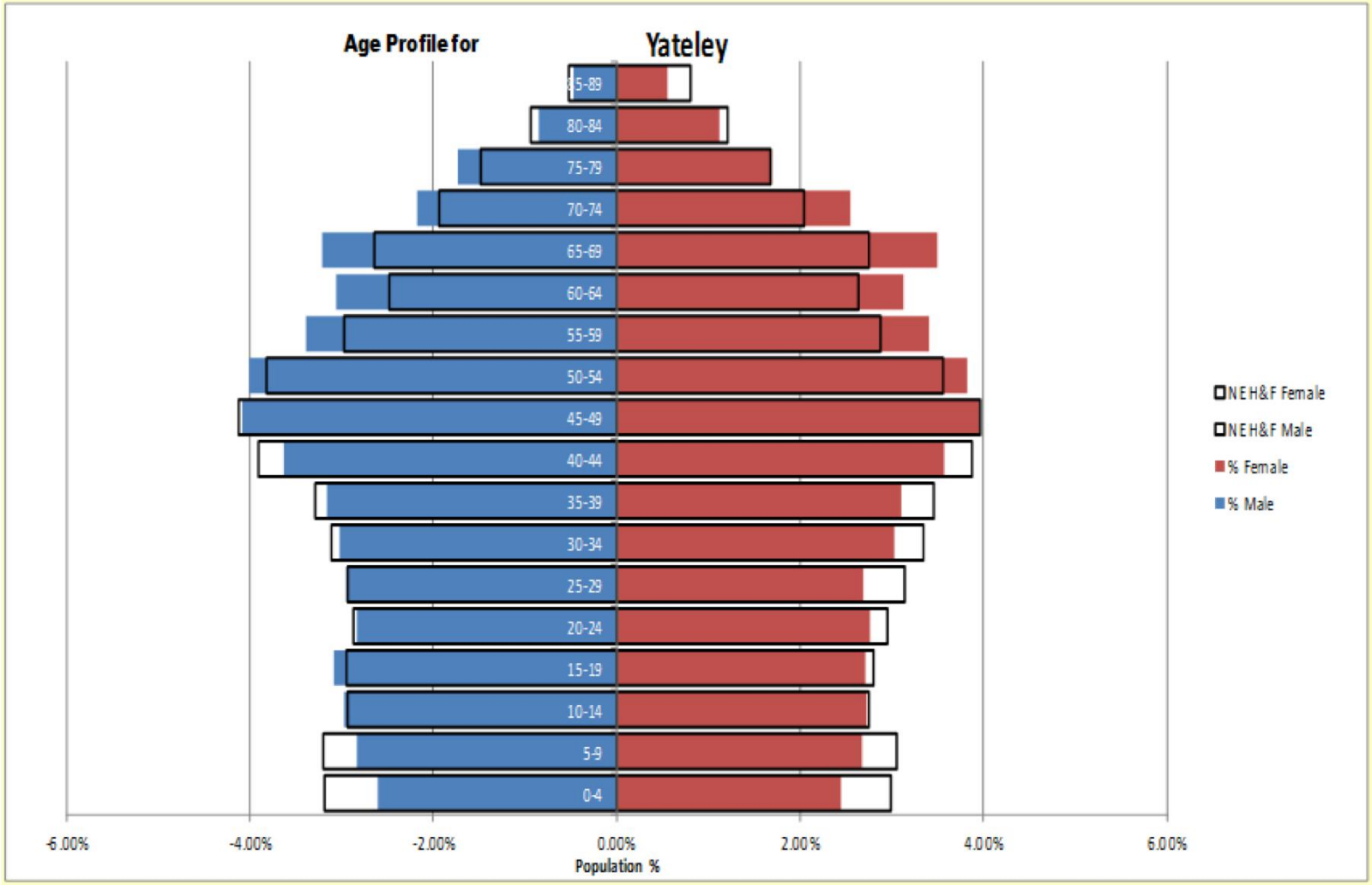


Happy Healthy atHome

ICT

Wessex Academic Health Science Network

Practice: Yateley



Yateley Locality (Oakley Health Group)
Happy and Healthy at Home

PHASE ONE

16/17 17/18

Urgent Care Centre
All patients guaranteed same day appointment if patient believes it clinically urgent they are seen. Not "walk-in"

"Never full"

Help Hub
Booking & signposting. Calls for all sites taken in call centre located at Yateley Medical Centre working with Urgent Care and ICT

Prevention & Self Care
Strategy plan

Integrated Nursing Team
Not achieved

Integrated Care Team
Based at Yateley Medical Centre, GP led
Paramedic Practitioners x 2
Practice Community Matron, Nurses
Community Matron
Mental Health Practitioner
Clinical Pharmacist
Making Connections
Care Coordinator, Management Support
Palliative Care Specialist Nurse
Orthopaedic Practitioners
Link to Adult Services (not co-located)

Associated Care Team
Midwives, Health Visitors, Talk Plus, Learning Disabilities

Each patient allocated **"Named GP"** who oversees care

Practice **Administration** Team **operating at scale** with increased specialisation – Accounts/HR/IT

Enhanced Access
Open 8 a.m. – 8 p.m. Mon – Fri
08:30 – 11:30 Saturdays
E-Consultations, Online Services

Specialist Community Clinics
Heart Failure Nurse
Parkinsons Nurse
Dietician
COPD

PHASE TWO

18/19

Urgent Care Centre
- Minor Injuries
- Point of Care Testing
- DVT Pathway

Help Hub
Review role of SPA "One number to access whole team".

Integrated Nursing Team
- GP supervision
- Community team matching practice hours 8 x 8
- EMIS as only clinical record
- Practice admin support to remove this function from clinicians
- Utilisation of Practice Nurse chronic disease management in community
- Clinics for catheter care, IV
- Leg Club
- Recognition that ICT is currently providing significant extra resource to Community Nurses

Integrated Care Team
Continue **ICT** as above

Additional resources:
- Occupational Therapist – co-located, working with team on falls assessments, re-ablement
- Advanced care planning – increasing deaths at home were this is preferred place of death.

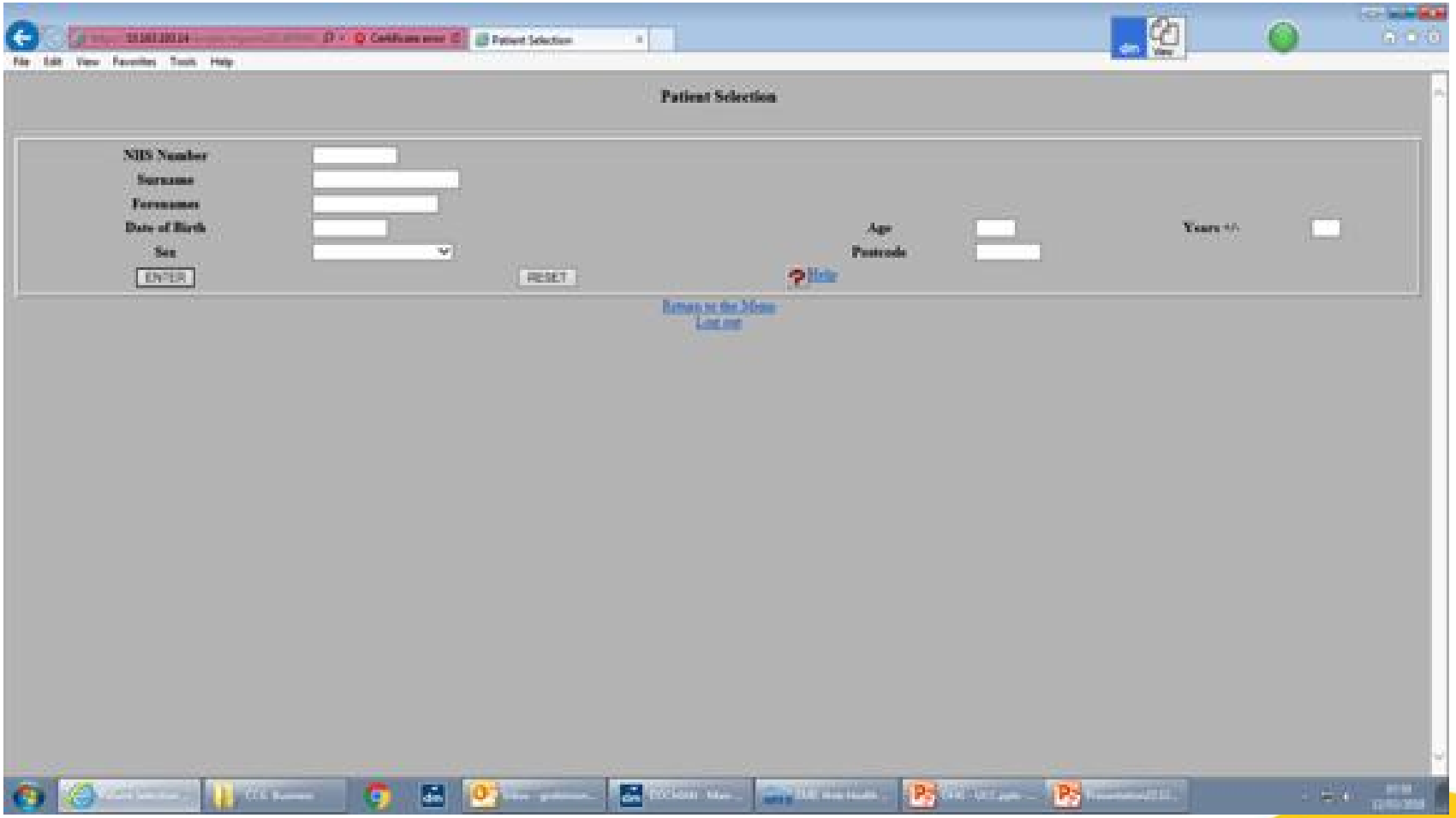
Prevention & Self Care
Continue to develop strategy, in particular:
- Xpert Patient Programme
- Leg Club
- Care Calls

Continue **Named GP**, **Operating at Scale**, **Enhanced Access**

Specialist Community Clinics
Continue to develop existing clinics. What other clinics could be cost effective and bring care closer to home?
Paediatrics (planned)
Rheumatology?
Dermatology

What other projects would CCG wish to commission – Referral Management, increased blood pressure screening???

ICT


Patient Selection
NHS Number
Surname
Forenames
Date of Birth
Sex
Age
Postcode
Years +/-
ENTER
RESET
Help

ICT - MDT

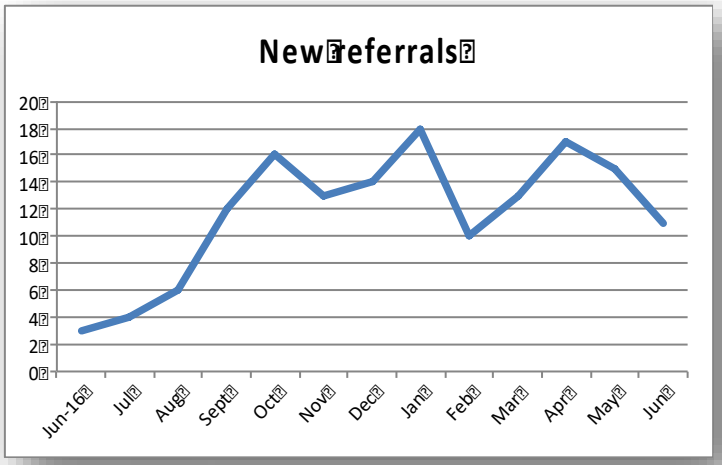
Happy Healthy atHome

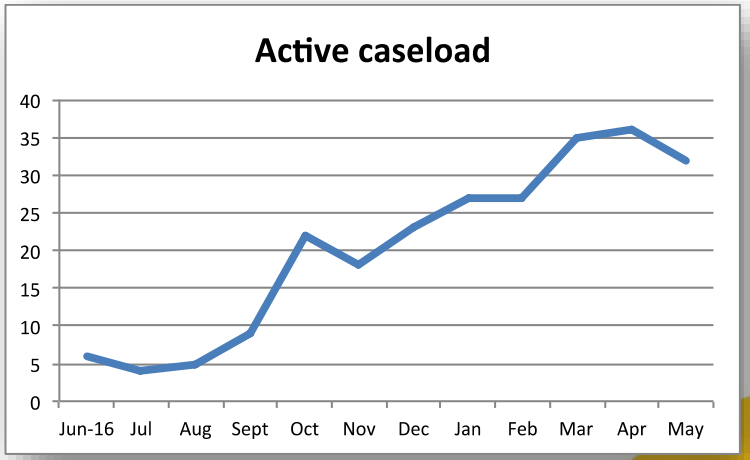
Wessex Academic Health Science Network

ICT Co-location

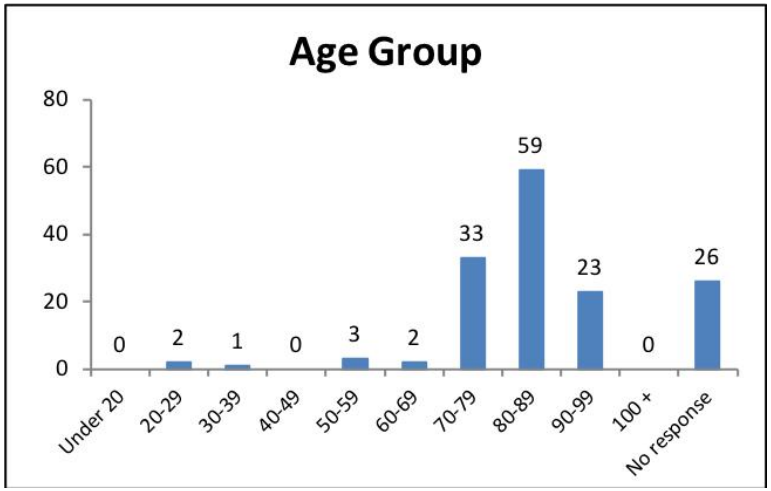
ICT Activity

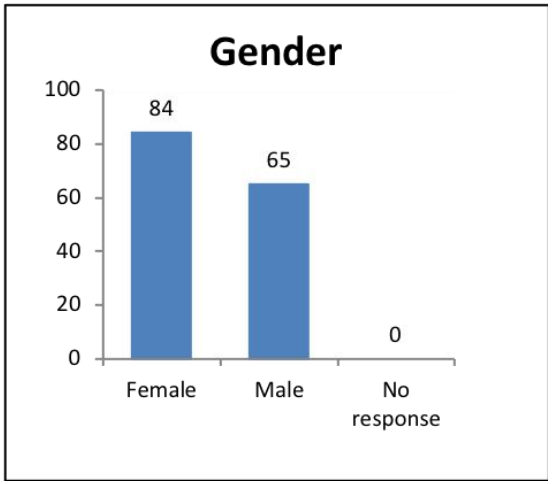
	Jun 16	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May 17
Number of new referrals	3	4	6	12	16	13	14	18	10	13	17	15
Cumulative new referrals	5	9	15	27	43	56	70	88	98	111	128	143
New patients discussed	7	5	6	13	19	15	17	19	19	17	15	14
Active caseload	6	4	5	9	22	18	23	27	27	35	36	32
IBIS avoided conveyances*				0	0	6	3	1	1	2	0	0
A&E/ emergency admits avoided**		0	0	1	0	7	3	2	2	0	0	0

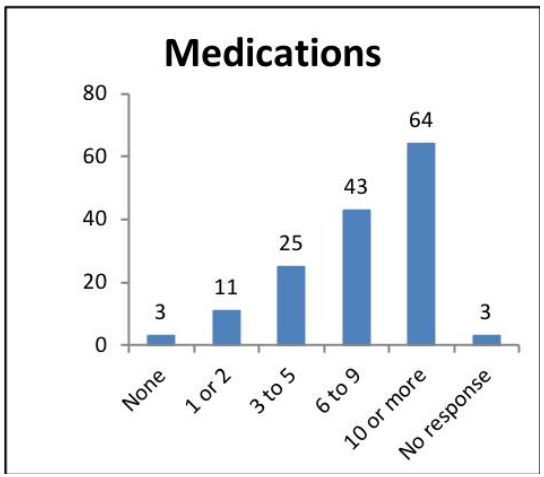




Patient reported outcomes



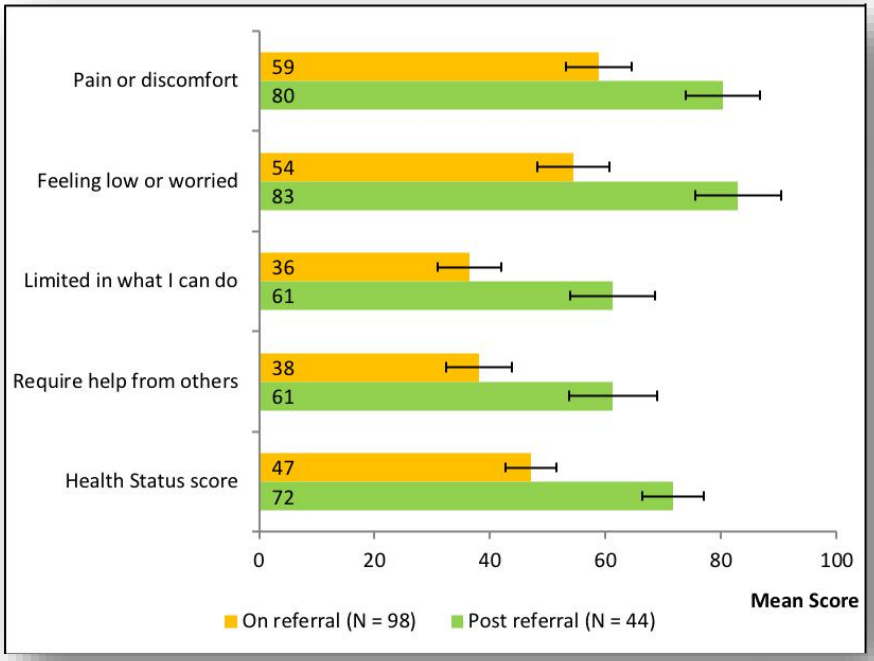




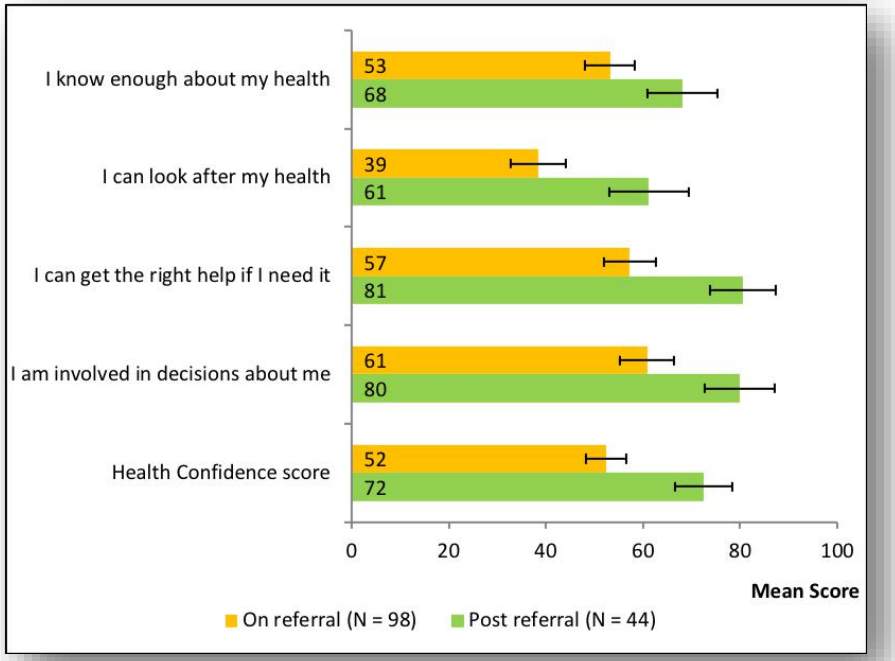
142 responses

Patient reported outcomes

Health status



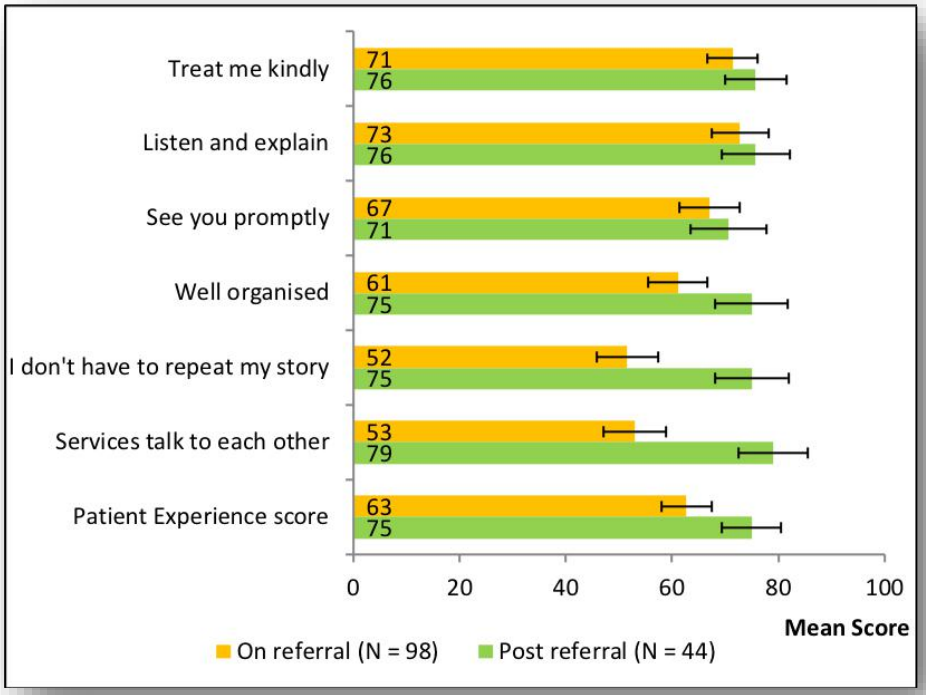
Health confidence



Patient reported outcomes

Personal wellbeing

Patient experience



Qualitative findings

Qualitative evaluation included thematic review **of 5 case studies** and **4 patient/ carer interviews**.

1. Evidence of **good quality care** for patients and carers (albeit from low numbers)
2. Interviews confirmed the late stage and '**point of despair**' that people come into contact with the team, **positive relationships** and the importance of the **practical support** they provide
3. Concerns about **continuity of care** at the weekends and what will happen when they are no longer on the active caseload
4. Five case studies provided examples of ICT members **overcoming obstacles** in their path to ensure patients received a better experience and tailored support

Team evaluation

Conceptual framework:

Normalisation Process Theory [NPT] (May and Finch, 2009)

1. **Making sense** [Coherence]
2. **Buy in** [Cognitive participation]
3. **Collective action**
4. **Reflecting** [Reflexive monitoring]

Methods:

a) Non-participation observation of MDT (n=11)
b) Focus group (n=9)
c) Survey (n=9)

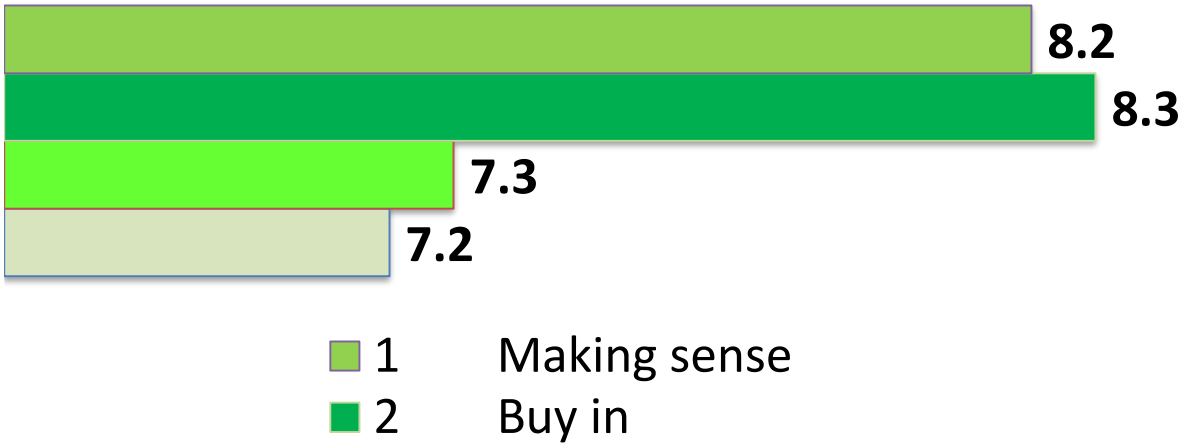
Highest and lowest average score

1 Not at all agree .....Completely agree 10

Key individuals drive ICT forward and get others involved [2]	8.8
Sufficient resources are available to support ICT [3]	6.1

On occasion, some of it has felt painful because of external forces, battling against IT and Wi-Fi, but it has all been worth it because there has been an improvement of our working lives and an improvement in the care of patients. [GP lead].

Overall scores for 4 NPT domains [20 questions]



Team evaluation

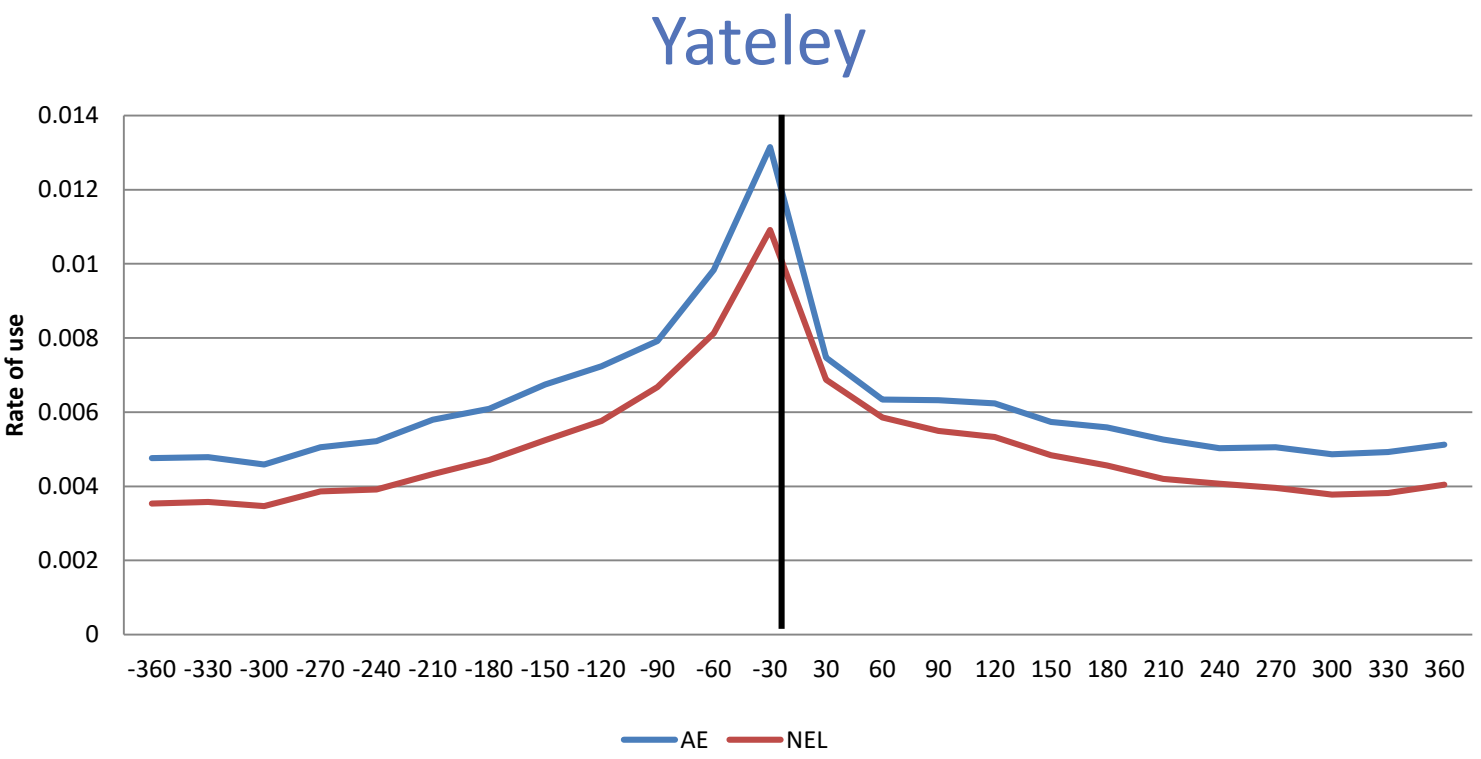
Lack of access to systems eg Hand Direct and IRIS
Battling against IT and Wifi
Shared role/commitment to other agencies
Difficulty with information from Frimley Park Hospital
Day of MDT meeting in the week not suitable so cannot always attend

Visual information (Dashboards, EMIS etc. projected on wall)
Great documents/notes to scroll through
Interaction with colleagues
MDT allows all to speak as required (length varies according to needs)
Happiness to persevere
Want more integration

Barrier categories	Votes	% of votes	Driver categories	Votes	% of votes
IT issues and lack of access to systems	**6**	**33.3**	**Access to patient records (visual info and dashboards)**	**6**	**33.3**
Lack of understanding of others' roles and clarity of directives	**4**	**22.2**	**Good team of trusted people in flexible MDT**	**5**	**33.3**
Time pressures/other commitments	3	16.6	Ability to refer patients to other agencies	3	16.6
Communications with other agencies i.e. Frimley Park	3	16.6	Shared learning from other agencies	3	16.6
Less than full integration	2	11.1	Vanguard funding	1	5.6
Total (n=9)	18	100	Total (n=9)	18	100

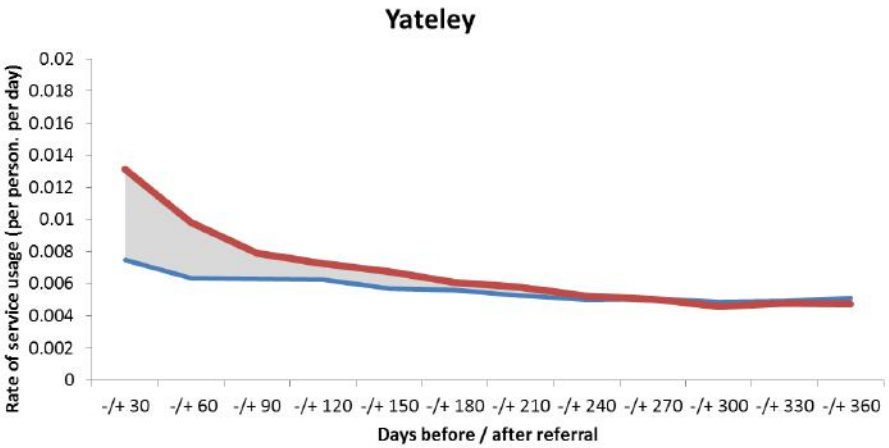
Economic evaluation

A&E and NEL - rates of use for:

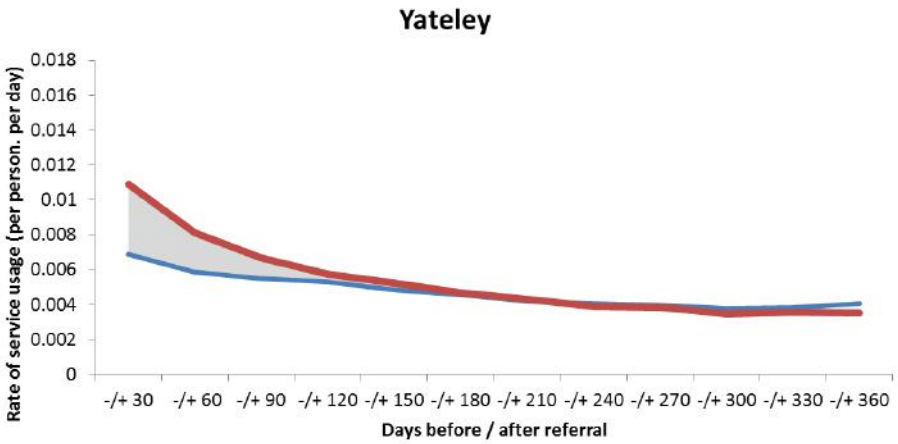


Economic evaluation

A&E attendances



Emergency admissions



Economic evaluation

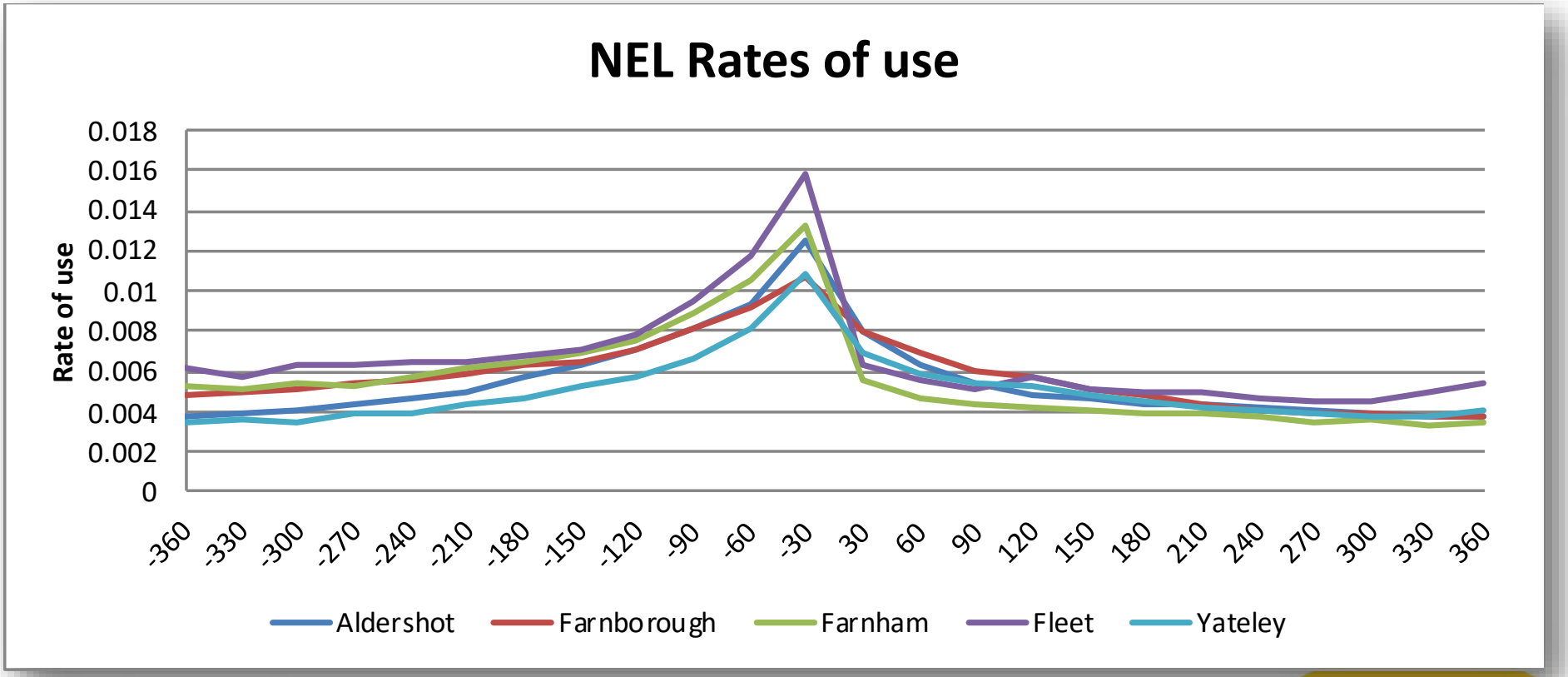
Assuming 26 new patients referred per month, the **commissioning value** of the lower level of A&E and emergency admissions would be **£167K**.

2017/18 additional investment:

- GP clinical lead sessions }
- ICT coordinator }
- 2 paramedic practitioners } full year cost **£238K**
- 1 community matron }
- 1 prevention manager }
- 1 community nurse }

Economic evaluation

Understanding the difference across localities



Next steps

Currently completing the evaluation reports for Farnborough, Aldershot and Fleet ICTs

Work to compare and understand the difference in outcomes across the 5 ICTs planned for spring.

A brief introduction to the structure of the Integrated Care Teams and how we work together in Aldershot, Farnborough and Fleet

Sharon Boylett

Salus Medical Services

- Salus Medical Services is the GP Federation in North East Hampshire and Farnham, representing the interest of all 23 GP surgeries under the CCG
- Salus is responsible for the Aldershot, Farnborough, Fleet and Yateley Integrated Care Teams
- Salus employs a number of clinical and non-clinical staff including Paramedic Practitioners.

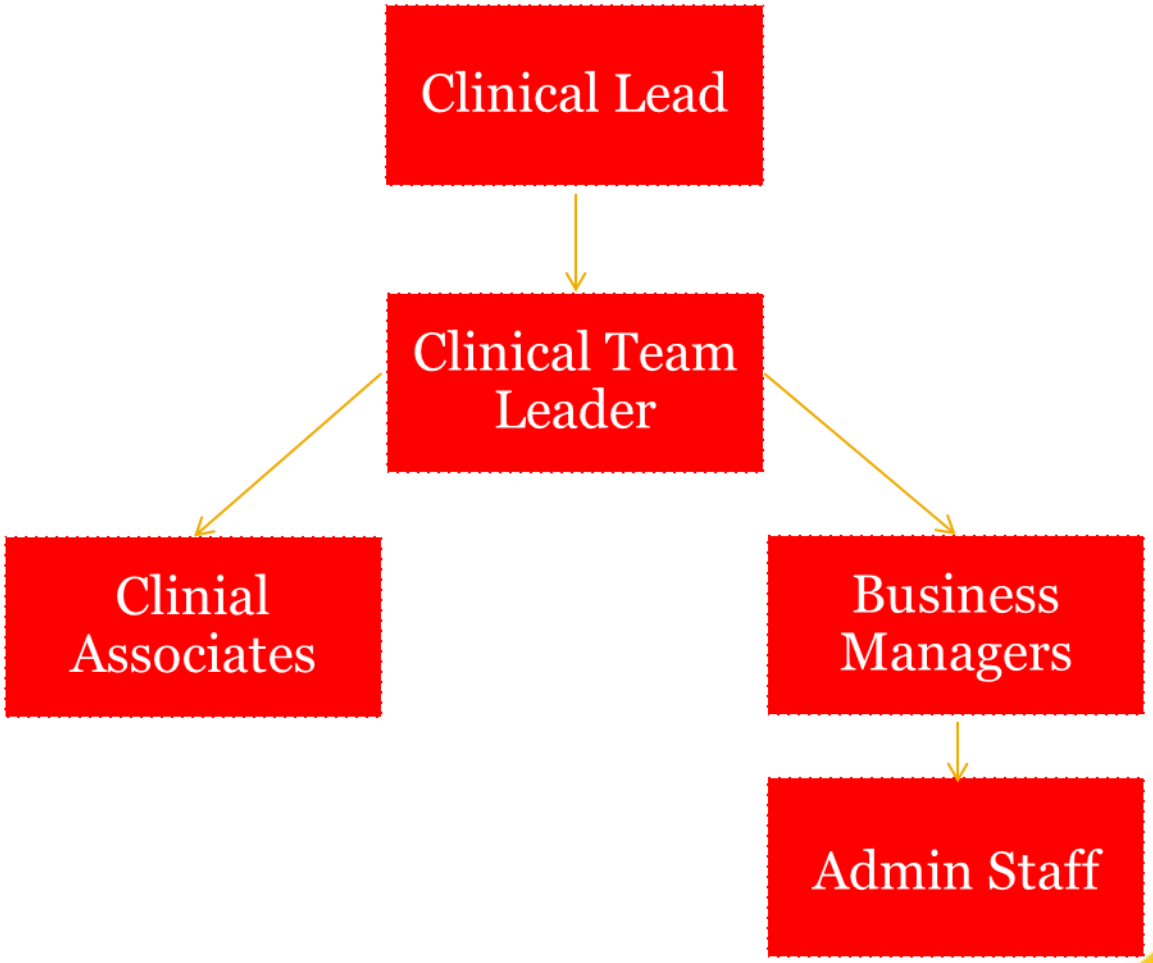
Integrated Care Team :

- The Integrated Care Team (ICT) is comprised of representatives from different health and social care and voluntary organisations
- The Multidisciplinary Team (MDT) meet weekly to discuss identified cases, combining the team's experience to facilitate holistic and person-centred care. This is to prevent hospital admissions, promote discharge and provide care at home keeping patients in their preferred place of care
- ICT members communicate throughout the working week to ensure actions are completed in a timely manner with further actions continually being identified and allocated

Meet the organisational team

- Sharon Boylett, Associate Director of Nursing
- Caroline Cuthbertson, ICT Clinical Team Leader
- Andrew Smith, Business Manager Aldershot and Farnborough
- Mahmuda Ullah, Business Manager Fleet
- Grant Stillwell, ICT Clinical Associate Aldershot
- Julie Burrows, ICT Clinical Associate Farnborough
- Maddie Rayment, ICT Administrator Aldershot and Fleet
- Beth Batchelor, ICT Administrator Farnborough

Team Structure

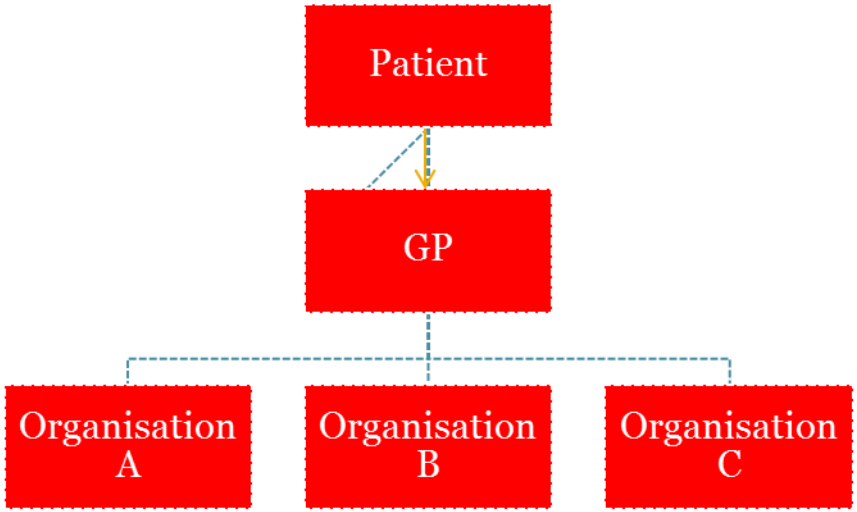


How we work together

- The ICT works on a case by case basis, assessing identified patients and working with partner organisations to facilitate appropriate care and support
- Anyone can refer into the ICT with ICT staff also proactively identifying individuals who require support
- The ICT does not directly provide care, instead focusing on assessing individuals with multiple or complex needs and arranging with appropriate organisations to establish support packages

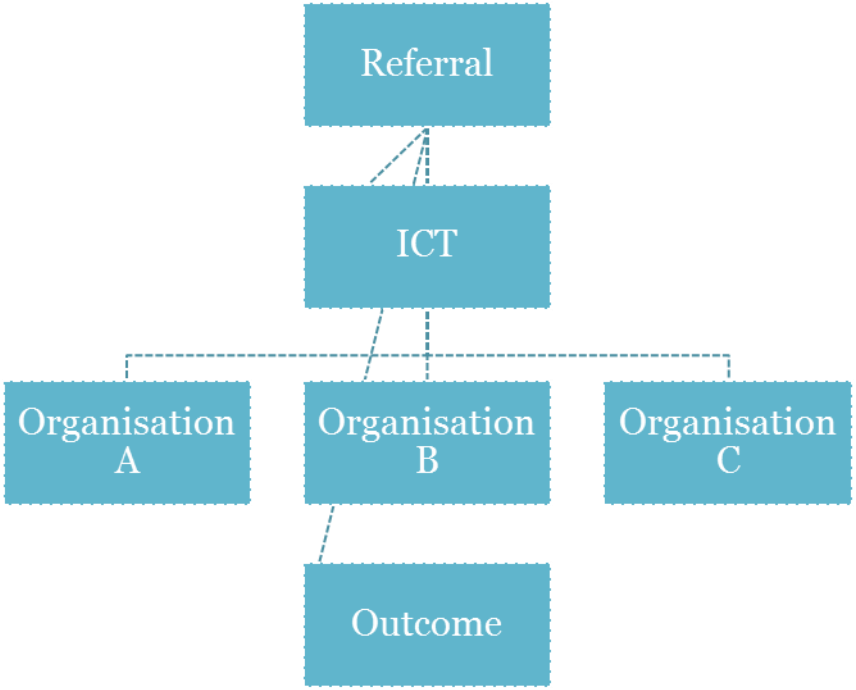
The past process

- In the past; a healthcare professional could encounter a complex individual and the onus would be on them to arrange support through the different support organisations
- This would typically be a time consuming exercise and the HCP would need to follow up with each individual organisation for updates



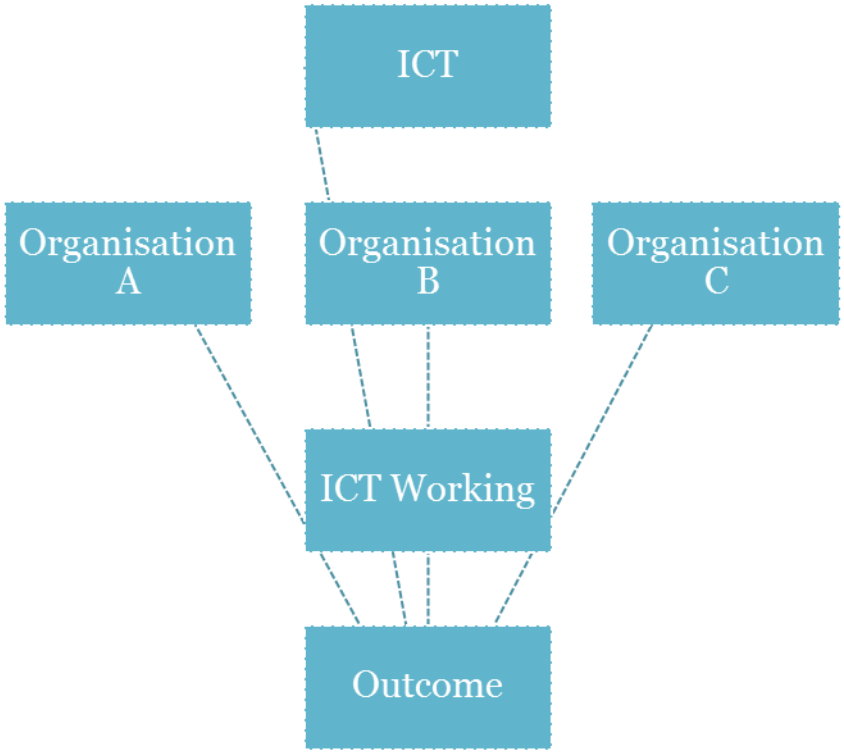
The present process

- Referrals into ICT are triaged by clinical members of Salus staff
- Actions are allocated as appropriate including completion of ICT-specific assessments
- Referrals into additional organisations are made appropriately
- ICT will monitor and review cases



The present process

- Salus ICT staff liaise directly with different organisations to identify appropriate individuals
- ICT will facilitate care and support of identified individuals and monitor cases



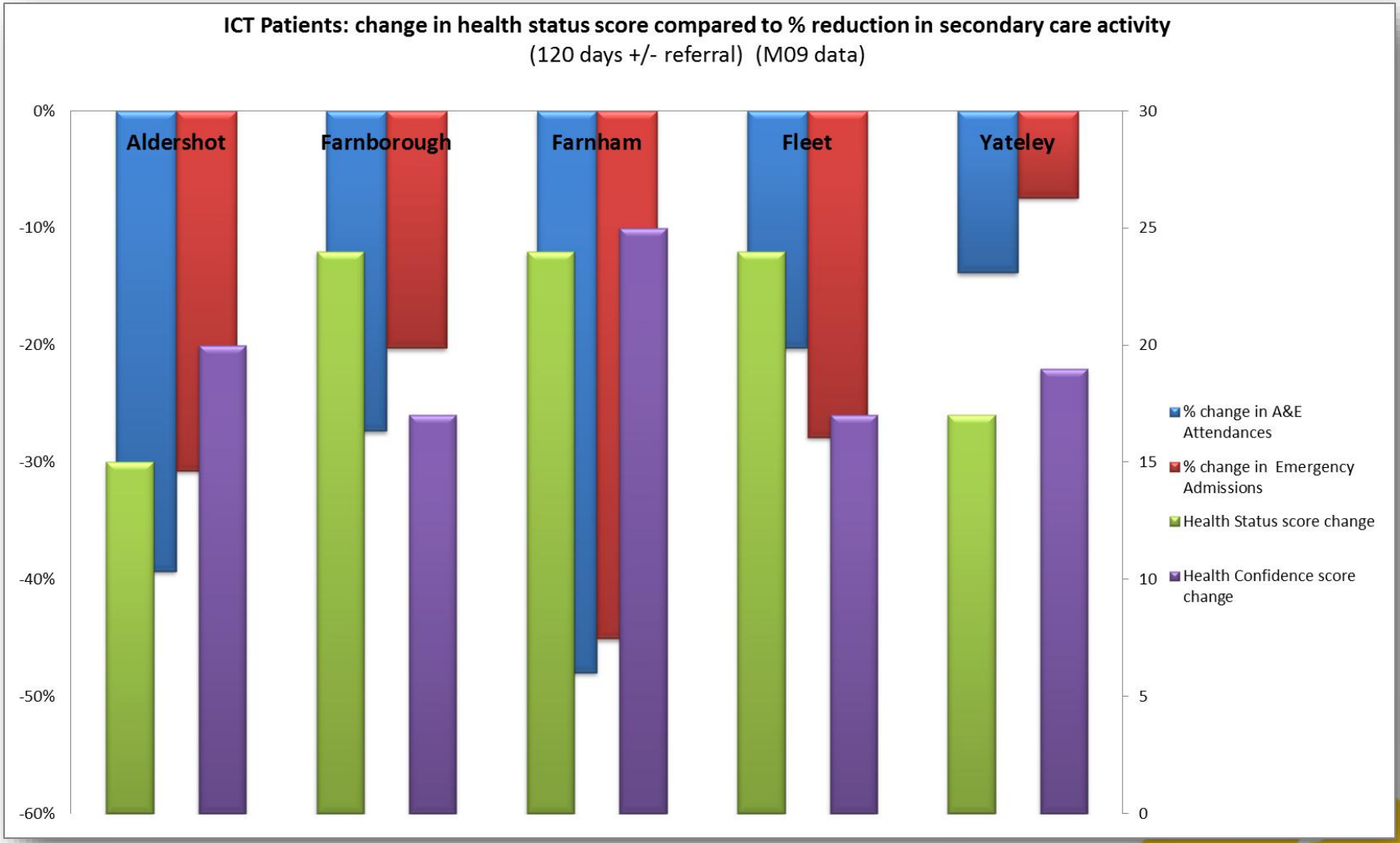
Summary

- The ICT works between different organisations to facilitate care and can take the lead on case management
- The team is constantly evolving and developing and we want to continue to develop to support people with complex needs and work proactively to limit people entering crisis

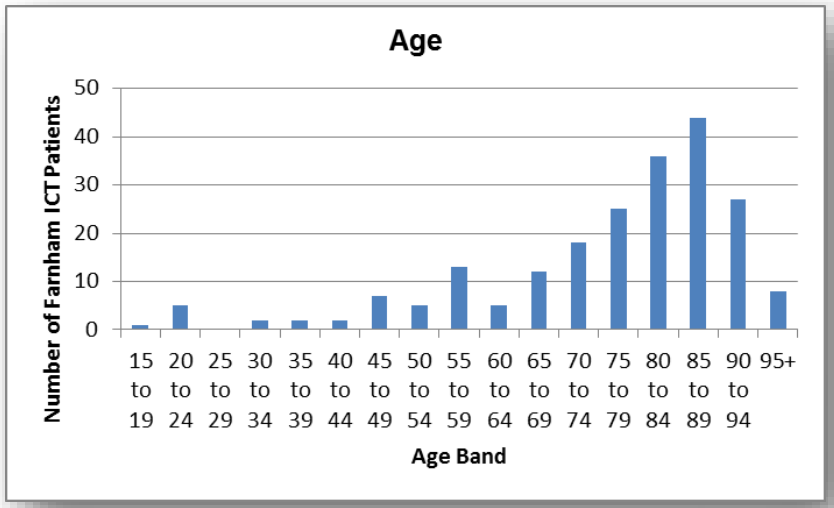
5 different localities

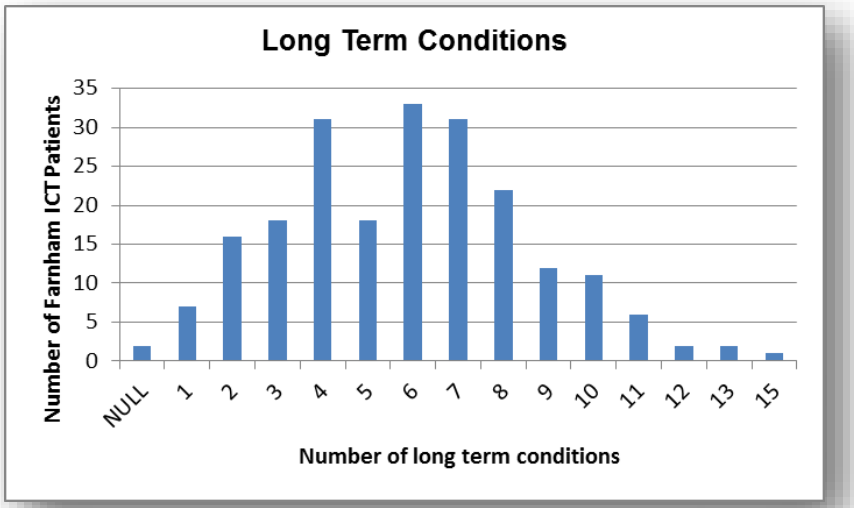
	Aldershot	Farnborough	Farnham	Fleet	Yateley
Changes in secondary care activity: (M09: 120 days +/-)					
A&E Attendances	-39%	-27%	-48%	-20%	-14%
Emergency Admissions	-31%	-20%	-45%	-28%	-7%
Caseload	278	467	346	203	243
Patient Reported Outcomes:					
Health Status	+20	+17	+25	+17	+19
Health Confidence	+15	+24	+24	+24	+17
Personal Wellbeing	+19	+22	+19	+19	+7
Patient Experience	+19	+26	+11	+22	+5
Avg. length of ICT intervention	TBC	TBC	59 days	TBC	43 days
% of ICT patients attending Mental Health related outpatient appointments	34.7%	34.5%	47.7%	29.0%	37.7%
Predominant type of mental health disorder causing admissions	44.8% Mental & Behavioural disorders – substance	37.4% Mental & Behavioural disorders – substance	39.6% Organic Mental disorders	43.8% Organic Mental disorders	47.5% Organic Mental disorders

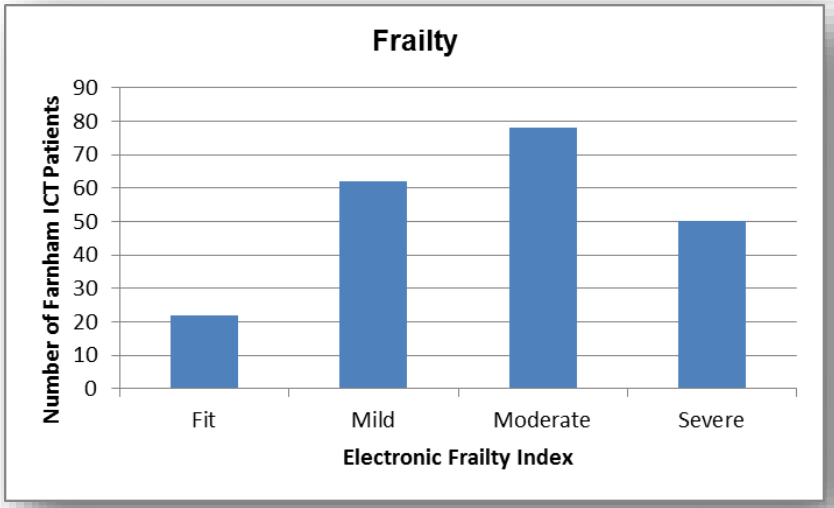
5 different localities

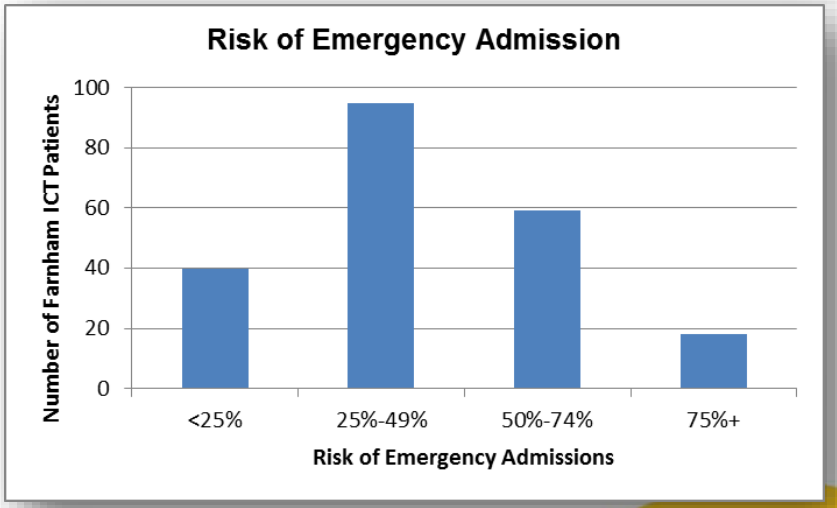


Farnham ICT Patients









Based on 212 read coded Farnham ICT Patients out of a total of 346 as at end Jan-18

Refreshments available

WORKSHOPS – DATA SYNTHESIS

Synthesis Approach

Why do it?

- Confirmation of findings
- Contribution analysis

Do the findings/data demonstrate the MDT work affected its intended outcomes?

What's the story of this collection of findings/data?

What conclusions can be drawn about this complex intervention in real-world practice settings?

Your task

- Using the data provided (7 datasets)
- Undertake a synthesis of all the data (quantitative and qualitative)

- **Output 1:** data synthesis table (blank template provided)
- **Output 2**: 5 headline findings

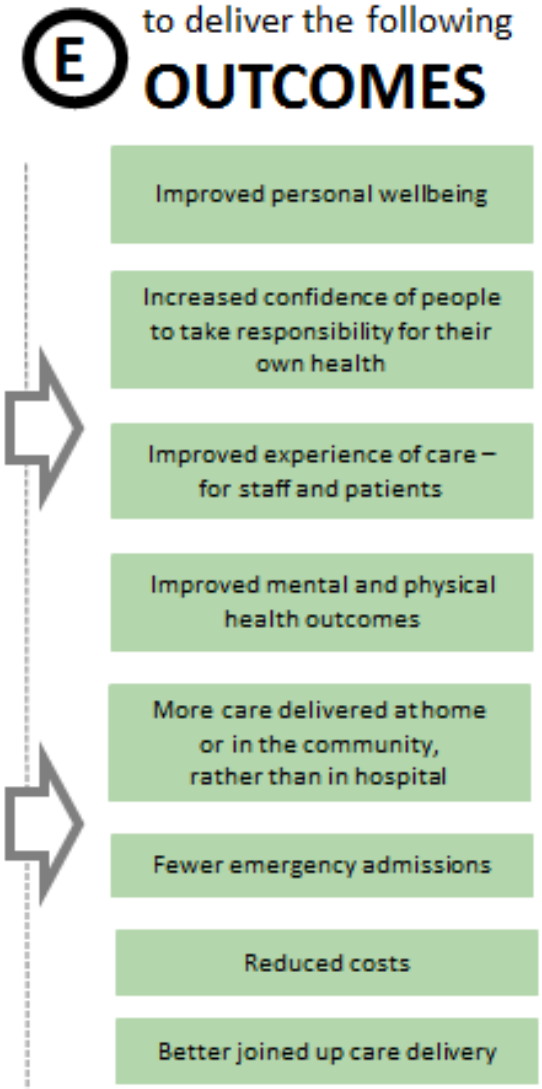
- 30 minutes
- 1 facilitator per group

Service Description

- The Bigtown MDT
- A community based MDT
- Formulated 1 year ago, by bringing together:
  - Team co-ordinator
  - Clinical lead
  - Nurse
  - Community Matron
  - Allied Health Professional – Physiotherapist/Occupational Therapist/Speech and Language Therapist
  - Social worker
  - Mental Health practitioner
  - Making Connections (Social Prescribing support)
  - Paramedic practitioner
- Working in a local area which has both urban and rural settings
- Covering a population of c.47,000 people

Service Outcomes

- Evaluation Questions (Evaluation purpose):
  - ***Has the service achieved its outcomes?***
  - ***What impact does the service have on patients and staff?***
  - ***How does the service impact the health and care system?***



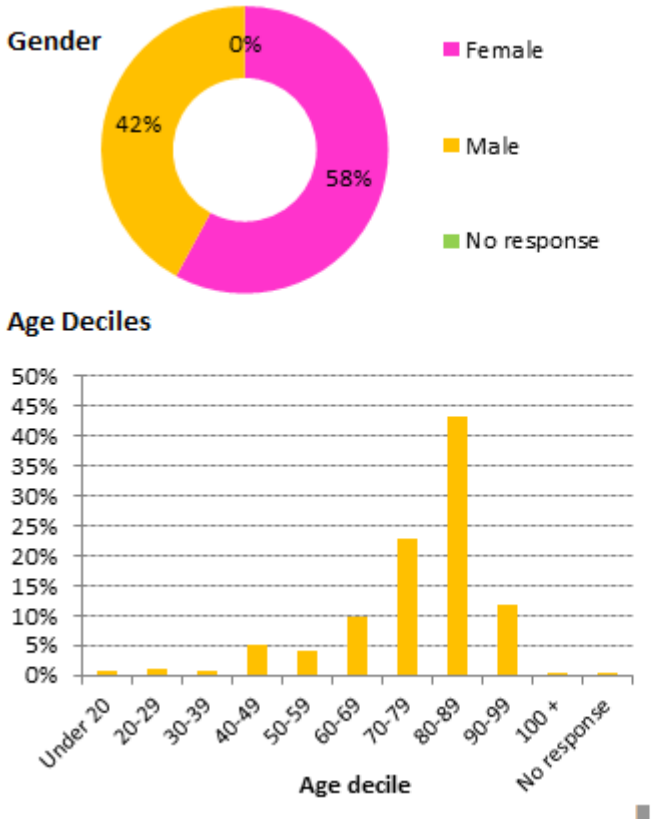
Activity Data

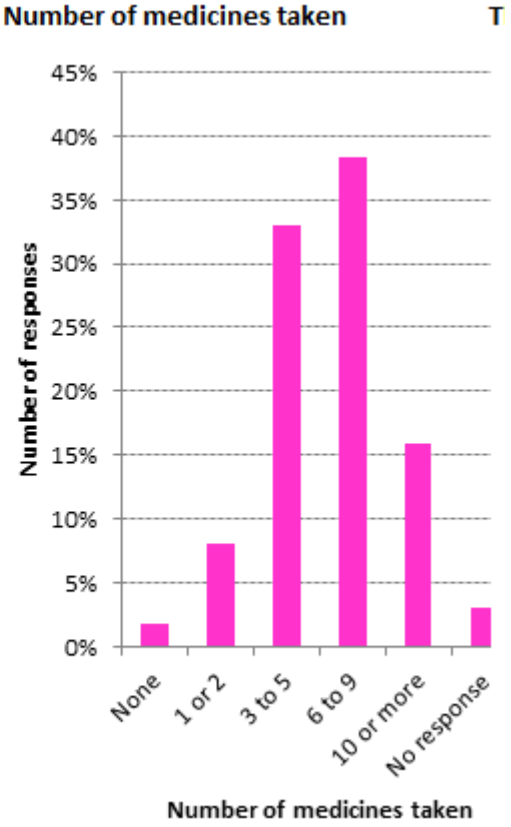
- **Data shows**: Activity data for the team, across 10 months

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Number of MDT meetings held	5	5	4	3	3	3	5	4	3	4
New patients referred	25	37	26	23	43	21	39	36	44	39
Referrals to non-acute services	3	4	3	4	4	3	1	1	3	5
Cumulative new referral	25	62	88	111	154	175	214	250	294	333
Individual patients discussed	89	84	95	71	89	72	93	87	79	95
Patients discharged	14	7	10	14	8	7	13	15	9	10
Caseload (active)	29	27	20	28	28	24	30	22	21	23

R-Outcomes - Patients

- **Data shows**: Demographics of PROMS
- N = 384

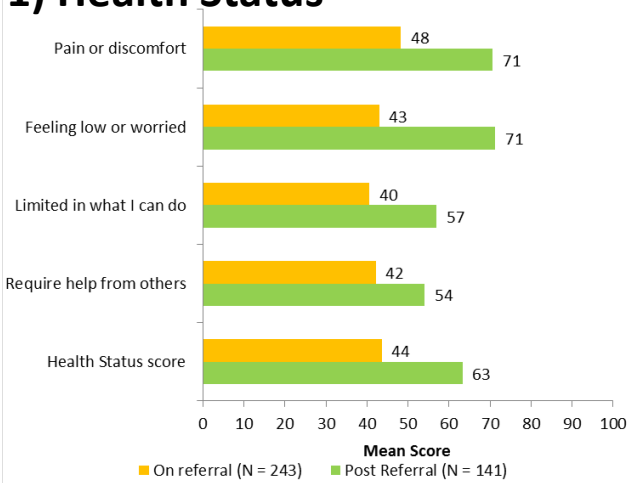




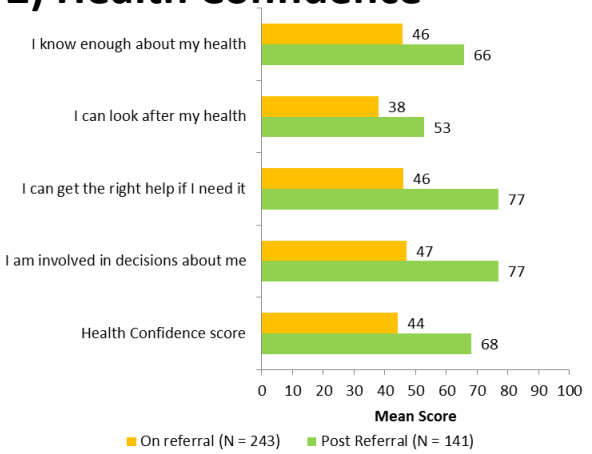
R-Outcomes - Patients

- **Data shows**: PROMS on referral, and then 8 weeks after referral
- N = 382 patients

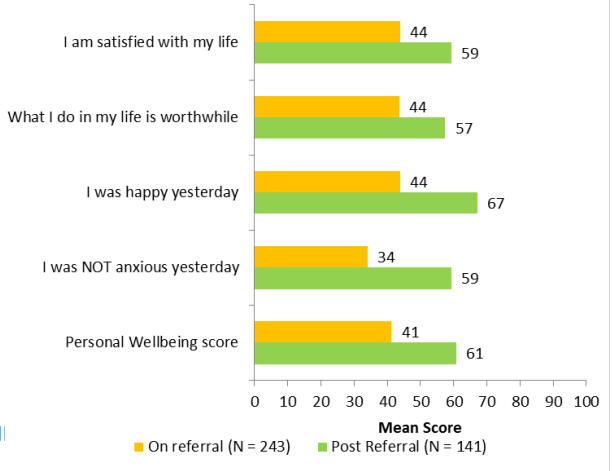
1) Health Status



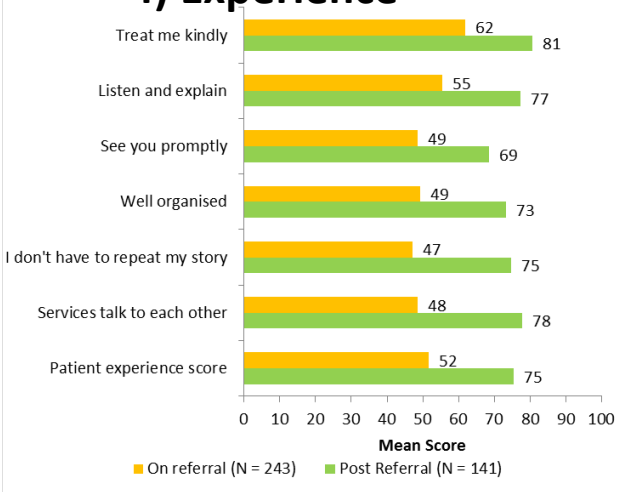
2) Health Confidence



3) Personal Wellbeing



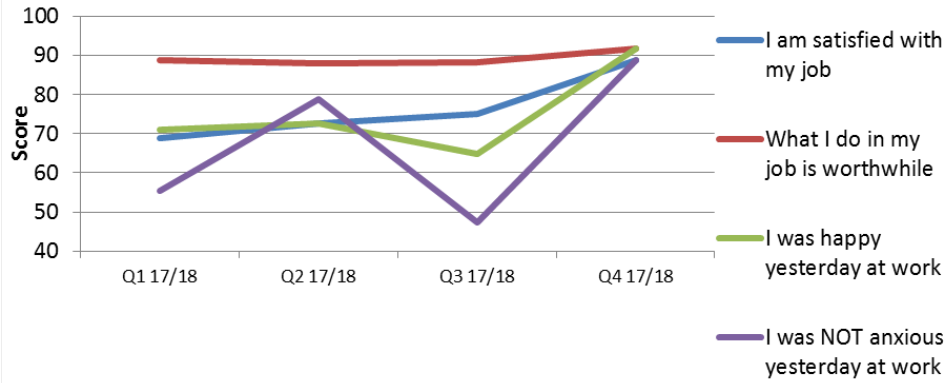
4) Experience



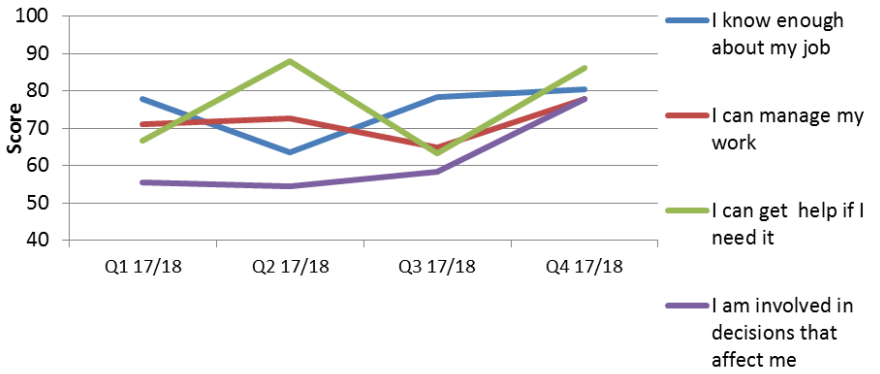
R-Outcomes - Staff

- **Data shows**: Staff PROMS over 4 quarter
- Response rates (N= 91)

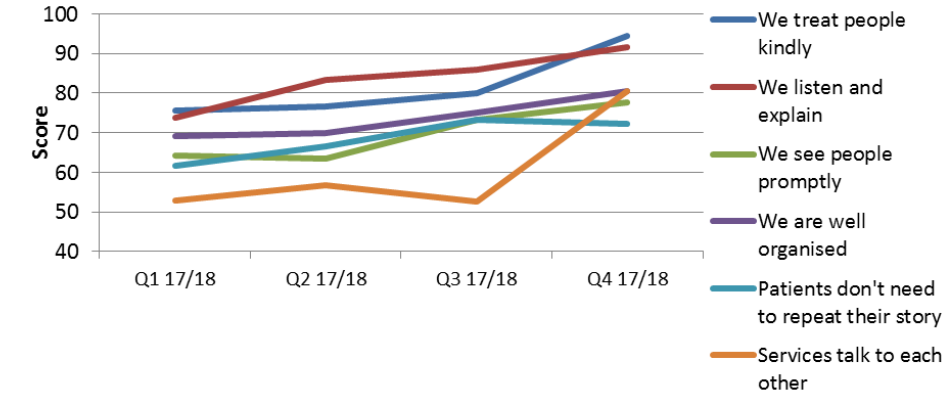
1) Job satisfaction



2) Job confidence



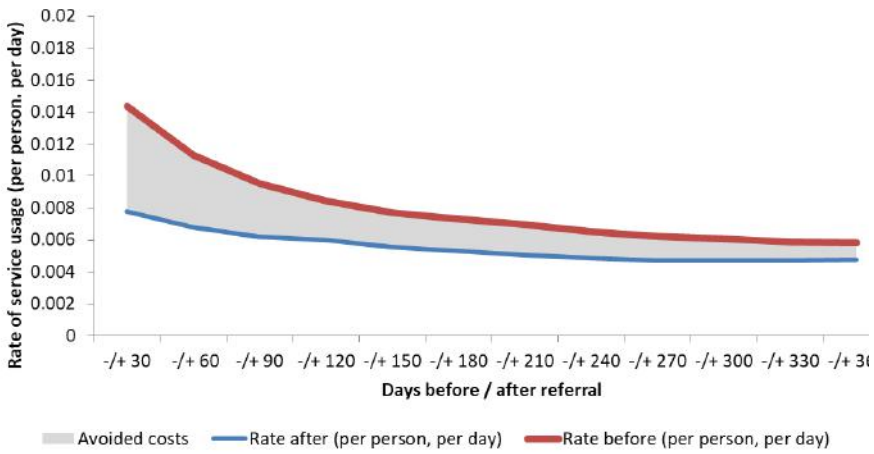
3) Staff experience



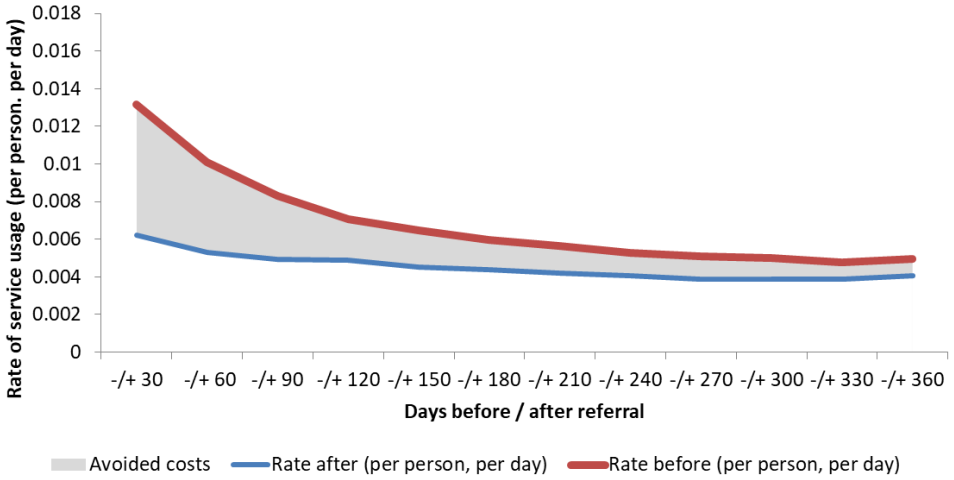
Before and After Cohort Analysis

- **Data shows**: Reduction in service usage (grey shading) for A&E and emergency admissions, over 1 year before, &1 year after referral to the MDT
- **Units**: rate of use per person, per day

1) A&E



2) Non Elective Admissions



- Cost of service = £560,000
- Total avoided costs (grey area for A&E and non-elective admissions) = £889,575
- ROI = 59%

Staff interviews

"We helped a patient with 3 long term conditions, they lived alone, had no family support, was depressed and lonely. We organised for a community matron to do an assessment of the medical needs, social care to assess what sort of package of care was needed and a mental health practitioner to assess whether psychological therapies would be appropriate and talk to the GP about possible medications."

"There can be a wait for some secondary care referrals to happen so at the MDT we use that gap to ask the Making Connections service to meet the patient and see if they can support the patient. They help to tackle loneliness which can be part of the reason they come up at the MDT in the first place."

"An action from the MDT was for a local paramedic practitioner to visit a patient who was identified as at risk of being admitted to hospital. So I went to the patient's home and realised he had a chest infection, was deteriorating, and on the border of going into hospital. I thought if the patient didn't get antibiotics that day the likelihood was they would get worse in the next day or two, be too ill to take oral medication or for it to work, and end up in hospital. The patient couldn't leave the house and didn't have family or neighbours to help. I knew it would take a day or two to organise antibiotics the usual way and get them delivered by the pharmacy. So I spoke to the GP immediately, explained my plan, got the medication agreed, went to the pharmacy and delivered it to the patient. I also booked the patient in for a follow-up visit with me in a couple of days to check on their situation."

"As a GP, I believe we've seen fewer hospital admissions of patients I know are complex cases, and also generally with the elderly and vulnerable patient populations. I know our paramedic practitioner is seeing a lot of people on the verge of being admitted and we've managed to organise the right support to prevent an admission or ambulance conveyance by using our colleagues in the MDT."

Patient interviews

"I know that lots of professionals have spoken to each other and made a plan for my wife and I. From my point of view, it all happened very quickly, my wife was discharged and we were told a nurse would be with us that afternoon to talk about our needs at home. Well, I'd hardly got back to the house and they were there. Later a carer arrived and asked what we required and took it from there. It seemed quite organised, I was very impressed."

"After the professionals met to discuss my situation they sent a paramedic practitioner to my house to speak to me. I really appreciated the 45mins with the paramedic, I knew I would definitely get my medication when I needed it and he helped me get a referral to physiotherapy for my bad knees. We also talked about me getting more exercise and maybe joining some local community groups. He passed on some information about a service called Making Connections which I'll have a think about. I thought I got a lot out of the visit and definitely wouldn't mind being visited by them again."

"I think they saw the whole situation, including my home situation, and not just my health problems. That helped a lot. I also really appreciated having support organised for me at home. That's where I want to be. I've been a lot happier in recent months and haven't had to go to hospital for anything, everything seems to be under control."

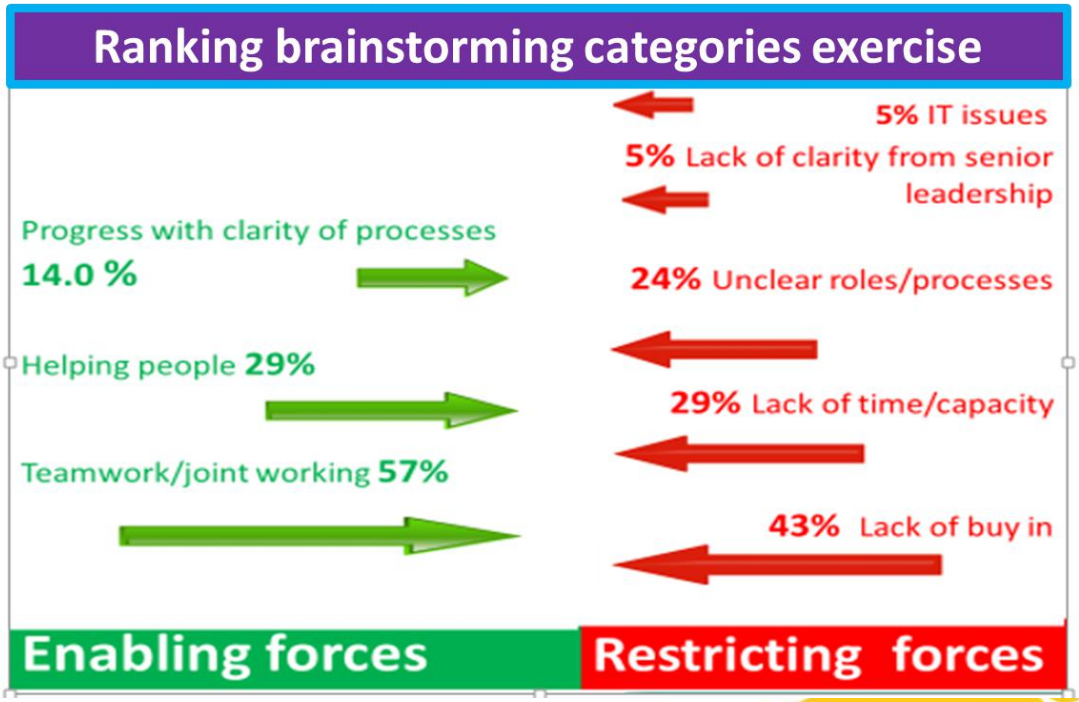
"I had a lot of difficulties managing my health but the different professionals all did their bit. In particular the community matron and mental health practitioner, they both helped to improve my confidence to manage at home on my own."

Team Observation

Illustrative brainstorming items

- Lack of buy in from other organisations eg police or MH
- Can only attend 1 MDT every 3 weeks
- Lack of clarity about consent and referral process
- Confusion of process MDT A and MDT B and MDT C running alongside each other
- Senior leadership not guided us and they have no idea of what we do and what we have achieved

- Putting faces to names and building good working relationships with other agencies
- Team's resilience to amount of 'buy in'
- Achieved some great outcomes for patients
- More structured processes in place



Synthesis table

Data source -> Outcome	Activity (Local data)	R-Outcomes – Patients	R-Outcomes – Staff	Before and after cohort analysis	Staff interviews	Patient interviews	Team Observation
Improved personal wellbeing							
Increased confidence of people to take responsibility for their own health							
Improved mental and physical outcomes							
More care delivered at home							
Fewer emergency admissions							
Reduced costs							
Better joined up care							

Copies of this table are printed and on your tables

Happy Healthy atHome

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PLENARY

Keith Douglas, Vanguard Programme Director

CLOSE