Better Local Care Hampshire Multi Community Partnership Vanguard

Deep Dive Evaluation Report: Extended Primary Care Teams (EPCT)

April 2017

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1 EXECUTIVE SUMMARY

RSM PACEC were appointed to by the Southern Health NHS Foundation Trust on behalf of the Hampshire MCP Vanguard to complete an evaluation of the NHS Vanguard Pilot to implement a new care model with GPs called a multi-specialty Community Provider (MCP), known locally as Better Local Care.

1.1 Overview of Extended Primary Care Teams

Hampshire Better Local Care aims to have Extended Primary Care Teams (EPCTs) across Hampshire. This will be done in the aim of that are intended to improving improve clinical and care outcomes for those complex health and care needs. The EPCT projects involve:

- Risk stratifying the population to identify the people at greatest risk
- Operating as a single team under the leadership of local GPs
- Reducing the paperwork and re-assessments associated with multiple 'hand-offs'
- Proactive care – identifying those at risk and supporting them rather than just responding to need as it arises[1]

More specifically, EPCTs are intended to improve: care and quality outcomes, patient and staff outcomes, and systematic outcomes. The improvements will enable greater support for patients to manage their health conditions, reduce emergency admissions and provide GPs with support to manage patients.

The agreed objectives for the EPCT project are:

- Clinical and care outcomes will be improved for people with complex health and care needs, through extended multi-practitioner care teams providing integrated care at a practice and locality level;
- Improve patient experience by a team based approach to the delivery of care, holistic assessment and joint care planning to achieve their own health and care goals;
- Safety, quality and systems will be safeguarded as shared care records and team working across organisations providing high quality evidence based care to people with complex needs.

1.2 Project activity

The EPCT bid document outlines the key performance indicators (KPIs) for the EPCT which are anticipated to be achieved by 2019. These include:

- 3% sustained improvement in the quality of life for patients with complex needs pre / post intervention;
- Shift of activity and costs in primary care services vis a vis acute hospital care over 3 years
- Reduction in admission rates for people aged >65 years / <75 years
- >50% patients have a named coordinator of care
- 90% of people classified as frail have a care plan in place;
- Reduction in the number of NOF admissions
- Reduction in the number of bed days.

Given that the project has only completed the scoping phase there is no formal data ready at this point in relation to the outputs and outcomes.

[1] Manual for the development of locality MCPs, Better Local Care, Southern Hampshire Vanguard, Oct 2015

1.3 Emerging conclusions

The rationale underpinning the need to provide extend primary care teams and team development support, to deliver improved integrated care, is well evidenced and widely understood.

The project objectives are clear and well aligned to important strategic documentation regarding the impact, both for clinical and care outcomes of extended primary care teams. The project also represents a good fit with objectives within the NHS Business Plan, the Five Year Forward View, the GP Forward View and the local STP.

The programme does have KPIs however it is early in the process to provide any significant data against these. However, the current lack of data monitoring and recording within the project will make measuring impact all the more challenging. A robust framework of monitoring and data collection from staff and patients' needs to put in place. The RSM PACEC team are working together with EPCT leads to finalise and implement a project specific evaluation framework in April 2017. Early evidence suggests that so far, the project has been successful in:

- Supporting the coming together of a group of practices who are working together with the project management on developing BLC models and committing their time to the project development;
- Establishing a good EPCT Project team and identifying one clear goal which has helped to focus the team and those involved in the project;
- Gaining support and commitment from all stakeholders involved in the project and the commitment of time in already time pressured environments;
- Developing wound and catheter clinics as a result of the data analysis completed.

Of course, the project has also faced challenges particularly in relation to maintaining staff buying, sharing data and demonstrating the future financial sustainability of the project.

1.4 Emerging recommendations

Emerging recommendations for the EPCT project include:

- **Recommendation 1: Provide a mechanism for information sharing** – a mechanism should be agreed for the sharing of patient identifiable data between organisations involved, especially when working on managing patients with complex needs.
- **Recommendation 2: Providing clear estimates of expectations for staff involved** – there is a need to be clear with the staff involved about the time commitment to the project so that they understand this from the outset.
- **Recommendation 3: Provide sufficient notice** – give at least 4 weeks' notice to primary care individuals for attendance at events.
- **Recommendation 4: Link to existing infrastructure –** develop better working relationships and links with ICT department and Estates Department to foster better delivery of the project.
- **Recommendation 5: Governance and Contract Arrangements** - special attention must be paid to the governance arrangement and contracts agreed between the parties involved so that everyone is clear of their remit, roles and responsibilities in the implementation and delivery of the project.
- **Recommendation 6**: **Need for Staff Consultation** – going forward there is also need for additional and robust staff consultation particularly when there are changes in roles and the skills mix of the team

2 INTRODUCTION AND BACKGROUND

RSM PACEC were appointed to by the Southern Health NHS Foundation Trust on behalf of the Hampshire MCP Vanguard to complete an evaluation of the NHS Vanguard Pilot to implement a new care model with GPs called a multi-specialty Community Provider (MCP), known locally as Better Local Care.

Better Local Care multispecialty community provider vanguard, will support people in taking a more active role in managing their own care and will offer access to improved care where needed.

The aim of Better Local Care is:

> *To improve the health, well-being and independence of people living in our natural communities of care, making Hampshire an even greater place for all our residents to live.*

Better Local Care has four key themes:

- **Improving access to care:** So it's easier for people to get a same-day or urgent appointment at their GP surgery, and so people with complex health problems get more input from their GP.
- **Joining up the professionals that support the same people:** So doctors, nurses, social and voluntary sector workers and volunteers are part of the same extended team, making care more straightforward (especially for people with complex needs).
- **Bringing specialist care nearer to you:** So patients can see the professional they need, sooner: For example physiotherapists and mental health workers in local GP surgeries.
- **Concentrating on prevention:** to support people earlier, and help them make the right choices about their health and wellbeing, to stay independent and reduce the need to go to hospital.

The Better Local Care vanguard is a partnership of GPs, NHS providers and commissioners, Hampshire County Council, local councils of voluntary services, several local community, voluntary and charity organisations.[2]

2.1 Overview of Extended Primary Care Teams

2.1.1 Overview

Hampshire Better Local Care aims to have Extended Primary Care Teams across Hampshire. This will be done in the aim of that are intended to improving improve clinical and care outcomes for those complex health and care needs. The EPCT projects involve:

- risk stratifying the population to identify the people at greatest risk;
- operating as a single team under the leadership of local GPs;
- reducing the paperwork and re-assessments associated with multiple 'hand-offs'; and
- proactive care – identifying those at risk and supporting them rather than just responding to need as it arises.[3]

More specifically, EPCTs are intended to improve: care and quality outcomes, patient and staff outcomes, and systematic outcomes. The improvements will enable greater support for patients to manage their health conditions, reduce emergency admissions and provide GPs with support to manage patients.

[2] http://www.southernhealth.nhs.uk/inside/better-local-care/

[3] Manual for the development of locality MCPs, Better Local Care, Southern Hampshire Vanguard, Oct 2015

2.1.2 Timescales

- Start Date: June 2016
- **End Date:** October 2017

2.1.3 Objectives

The agreed objectives for the EPCT project are:

- Clinical and care outcomes will be improved for people with complex health and care needs, through extended multi-practitioner care teams providing integrated care at a practice and locality level;
- Improve patient experience by a team based approach to the delivery of care, holistic assessment and joint care planning to achieve their own health and care goals;
- Safety, quality and systems will be safeguarded as shared care records and team working across organisations providing high quality evidence based care to people with complex needs.

2.1.4 Funding

According the EPCT project bid document the budget for the project was £127,610. Further information on the budget and spend can be found in Section 6 of this report.

2.2 Purpose of the Write Up

Discussions with the MCP evaluation team identified the need to build on the early write-ups on the progress and outcomes in respect of a number of MCP projects. This is an interim report as it is acknowledged that the time of writing that some of the strands of the projects have not been completed or have been completed recently and therefore there is limited information on some of the elements.

This interim deep dive evaluation report focuses upon the **Extended Primary Care Team** project. Given the nature of the project and that only the scoping stage of the project has been completed this is a baseline report.

2.3 Methodology

Our methodology used a mixed method approach and the main strands are detailed below:

- **Desk Based Research:** focused upon the data and information collected by the project team. This included but was not limited to financial reports, progress reports, databases on activities e.g. number of participants, attendance at each session etc. and information outputs and outcomes.
- **Survey of staff involved:** our team conducted a survey of staff involved in the one team project as part of the overall programme staff survey. This contained targeted questions on ECPT.
- **In depth interviews with managers:** we conducted in-depth interviews with the managers responsible for the implementation and delivery of the programme; and

2.4 Structure of the Report

The structure of the remainder of the evaluation report is as follows:

- **Section 3:** Context Needs and Project Overview;
- **Section 4:** Model, Project Resources and Implementation;
- **Section 5:** Outputs and Outcomes;
- **Section 6:** Value for Money;
- **Section 7:** Findings from Fieldwork; and
- **Section 8:** Conclusions and Recommendations.

3 CONTEXT, NEEDS AND PROJECT OVERVIEW

3.1 Context of the intervention

The **GP Forward view** (2016)[4] notes that patient demand and GP shortages, as a result there is not enough time to use GP expertise on patient issues that can be safely managed by others. Wider members of the team need to play a key role in the coordination and delivery of care. Greater use of skill mix from advanced nurse practitioners, clinical pharmacists, physicians, physiotherapists and paramedics offer patients a greater range of services whilst aiming to increase the high quality of care. The patient demand can be managed through a large multi-disciplinary team, with the GP acting as a leader and providing continuity of care. The MCP is core to redesigning services and integrating teams. The GPFV reported Sunderland (MCP vanguard) were able to provide an enhanced level of care to patients with complex needs through multi-disciplinary teams working across several practices.

The NHS **Five Year Forward View** outlines key arguments to how the NHS should break down the barriers in how care is provided, as service pressures continue to grow. It backs diverse solutions and local leadership, this includes the delivery of care to be integrated and combining general practice with hospital services, with improved access to specialised care.

The Forward View describes three widening gaps within the NHS:

- The Health and Wellbeing Gap
- The Care and Quality Gap
- The Funding and Efficiency Gap

It notes that GPs find it increasingly difficult to offer timely appointments and often struggle to provide enough time for patients with complex needs. As part of its pledge to support MCPs, the Forward View promises to 'get away from the treadmill of the 'one size fits all' 10 minute consultation followed by outpatient referral or prescription.' The document interprets the MCP's goal as supplying 'more integrated urgent care as part of a reformed urgent and emergency care system'. Extended primary care teams will help tackle the care and quality gap through reshaping care. Pooling the knowledge and care resources of primary care, community and mental health services, social care, pharmacists and voluntary/social enterprise partners, EPCTs will serve a broad range of needs in a more cohesive way, focusing on the 5% of the local population at greatest risk of failure to co-design a care and support plan.

The **NHS business plan 2016/17** plans to strengthen primary care services through enabling general practice to join forces with hospital specialists, community nurses and pharmacists to deliver better integrated care. For Extended Primary Care Teams to be successful in offering clinical leadership, the BLC outlines key enablers which are needed:

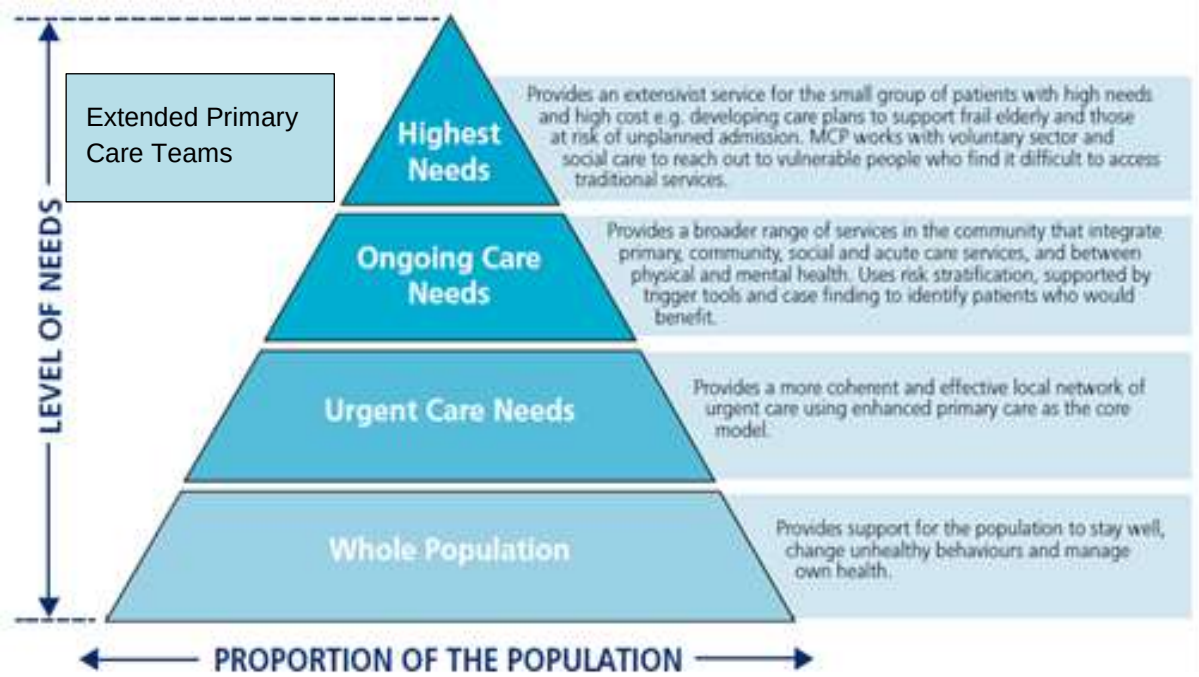
- Team and leadership development – cultural and structural change
- Engagement – clear patient engagement strategy
- Commissioning reform – clear direction from commissioners and clinical and commercial needs
- Patients and partners – a structured link with patients and partners in social care, acute care and the third sector[5]

[4] General Practice Forward View, NHS England, 2016

[5] Value Proposition, Hampshire Better Local Care 2016

HBLC aligns the MCP Vanguard interventions to the MCP Care Model[6] as set out in Figure 1 below.

Figure 3.1: MCP Care Model



Source: NHS MCP emerging care model

3.2 Need for the intervention

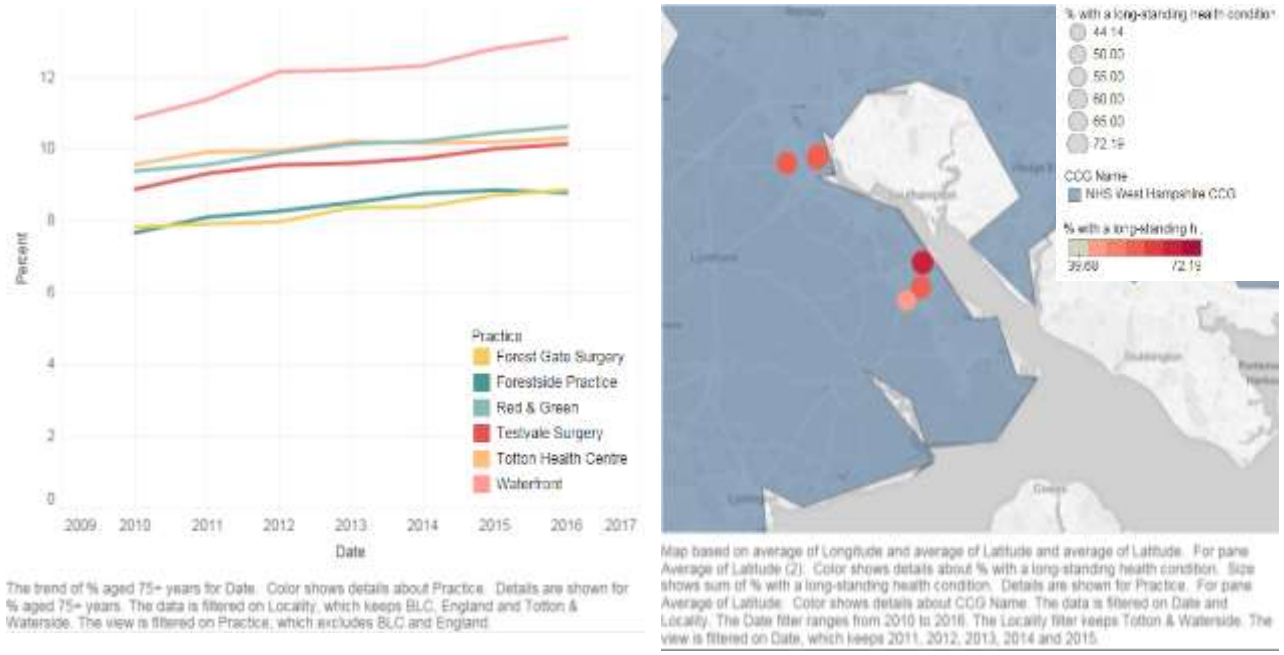
The EPCT bid document outlines the nature and severity of the problem and the case for intervention. It states that the case for change is based upon several reasons:

- The population health needs in Totten and Waterside are changing: People are living longer with multi-morbidity. People over 75 make up 10% of the population and this is forecast to increase by 25% by 2021;
- The services provided are stretched and struggling to keep up with growing demand: Across Wessex there are significant GP recruitment and retention issues, 1 in 6 GPs in Wessex plan to retire in the next 2 years;
- There is financial pressure across all organisations: to achieve financial stability there is a need to move the balance of future health and care expenditure into community delivery and, more importantly, into preventative services;
- Data shows that Totten and Waterside has significantly higher than England average prevalence of diabetes, smoking and the percentage of people with long standing LTCs.

Figures overleaf provide an illustration of the health profile of the Totten and Waterside population at the outset of the EPCT intervention.

[6] https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

Figure 3.2: Profile of Age and Long-Term Conditions in Totten and Waterside, 2015

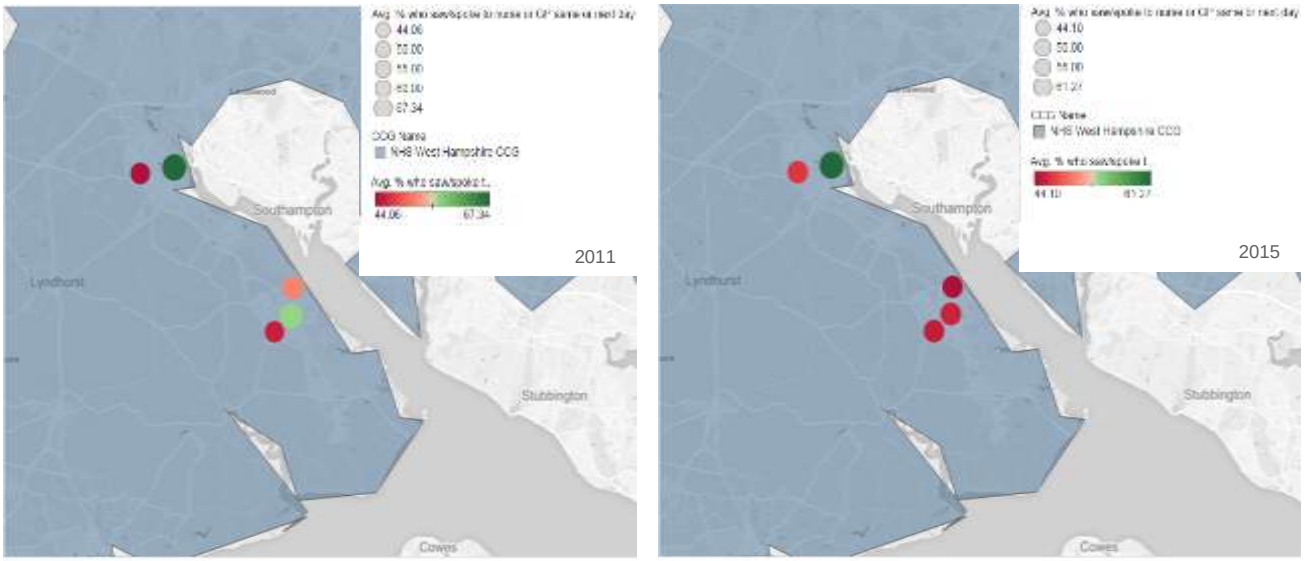


Source: GP Patient Survey, 2015 / 2016, RSM PACEC

The data shows the steadily increasing trend in the 75+ population registered with all practices in the Totten & Waterside locality, the notably higher proportion of 75+ residents registered with the Waterfront Practice, and the high percentage of registered patients living with a long-standing heath condition (above 50% for most practices). Historic data (not presented above) shows that high proportions of the population with long-standing health conditions have been a feature of the population profile in Totten & Waterside since pre-2010.

As a result, general practice in Totton is reported to be under strain due to the growing demand for services, which has impacted the quality of care and service responsiveness, current services are reported to be becoming unsustainable. Figure 3.3 overleaf shows a worsening picture regarding same day access to a nurse or GP between 2011 and 2015.

Figure 3.3: Same Day Access to Nurse / GP: 2011, 2015



Map based on average of Longitude and average of Latitude and average of Latitude. For pane Average of Latitude (2): Color shows average of % who saw/spoke to nurse or GP same or next day. Size shows average of % who saw/spoke to nurse or GP same or next day. Details are shown for Practice. For pane Average of Latitude: Color shows details about CCG Name. The data is filtered on Locality, which keeps Totton & Waterside. The view is filtered on Date, which keeps 2011.

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Source: GP Patient Survey, 2011, 2015 / 2016, RSM PACEC

The Better Local Care partnership identified a priority to support people with complex needs through the Extended Primary Care Team model.

An audit conducted in the summer of 2016, identified that approximately 32.4% of patients seen by a GP for urgent or on-day appointment could have been seen by an alternative healthcare professional.[7] The West Hampshire CCG created an out of hospital strategy to ensure people receive personalised and co-ordinated care through keeping well, supporting recovery and proactive intervention. These aims fit in with the wider CCG operating plan to close the 'care and quality' gap, as well as the STP of improving health and well-being and the quality & care of services. West Hampshire CCG plans on using a holistic model for early intervention. The majority of care should be within the community via urgent care centres, rapid clinics and end of life care, therefore avoiding admitting patients to hospital through an integrated care system.

The rationale for the development of the extended primary care team, aligned to the Buurtzorg model is that:

- **Patient safety / quality / system:** Healthy life expectancy is reducing, indicating increasing years of ill health as people get older, and associated pressure on resources available.
- **Patient experience:** patients with multiple morbidity and high care needs but often receive care that is reactive rather than proactive and fragmented;
- **Clinical Outcomes:** Patients with multiple morbidity and high care needs are high users of health and social care services.

[7] Totton EPCT Strategic Business Case

3.3 Project Overview

3.3.1 Background

Hampshire Better Local Care aims to have Extended Primary Care Teams across Hampshire. This will be done in the aim of that are intended to improve clinical and care outcomes for those complex health and care needs. More specifically, EPCTs are intended to improve: care and quality outcomes, patient and staff outcomes, and systematic outcomes. The improvements will enable greater support for patients to manage their health conditions, reduce emergency admissions and provide GPs with support to manage patients.

3.3.2 Project implementation

The implementation of the project has four phases in total and the diagram below details the key phases. This report is based on the completion of the scoping phase.

Figure 3.4: Implementation phases

3.3.3 Logic Model

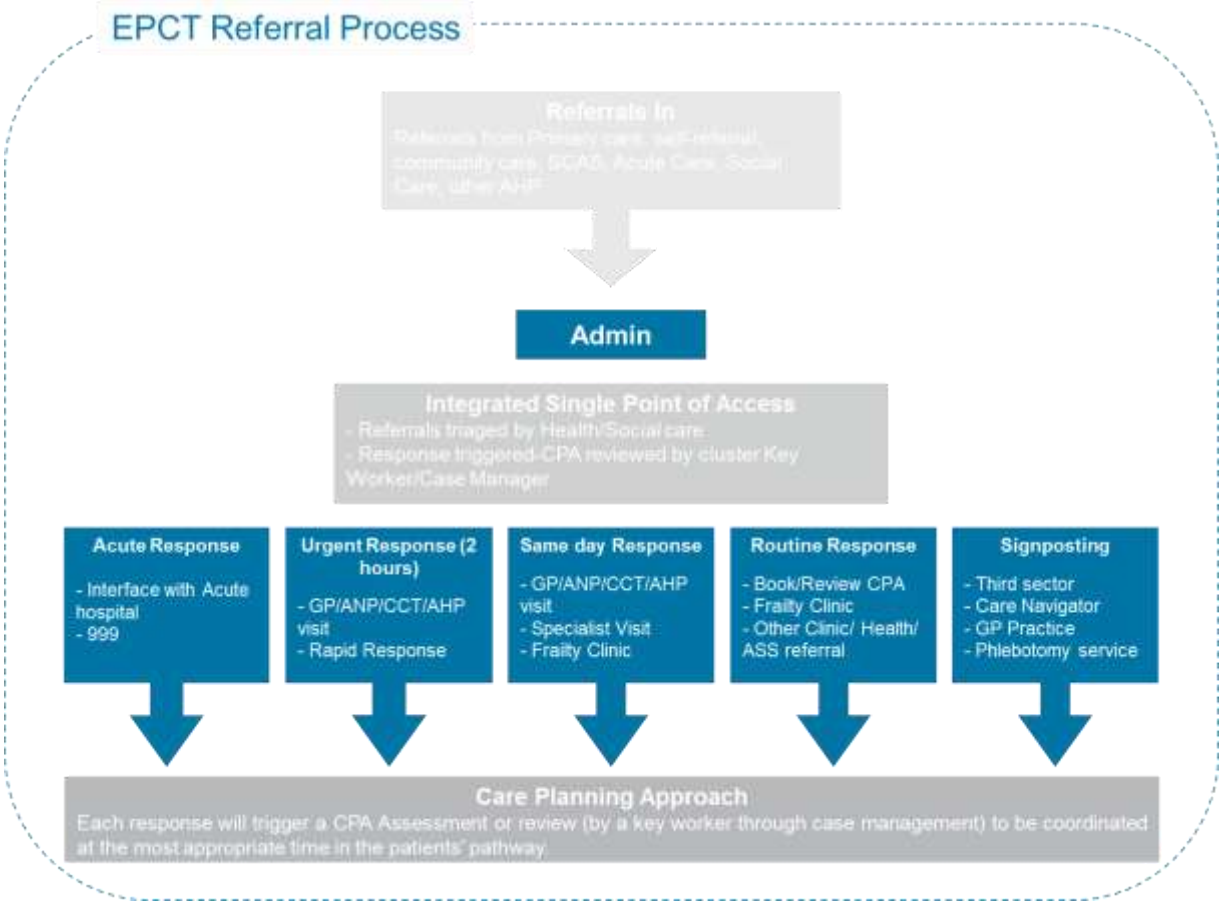
The model below outlines how the EPCT joins up care provided by a variety of professionals who support the same people. The practicalities for each step are outlined below:[8]

- **Referral:** This requires a single telephone number for local patients to use, a shared record system that allows read-access as a minimum.
- **Contact with admin team:** This requires a triage algorithm. Local options for management of triage can be clinical or non-clinical
- **Patient:** is linked with appropriate care (right person, right place, right time)

The transfer points may be to a single specialist lead or GP, if the patient requires long-term/complex management, the handoff is made known to the EPCT case manager. The aim is to make minimal referrals outside of the EPCT team.

[8] EPCT SOP Draft 2016

Figure 3.5: EPCT Referral Process



Source: ECPT Model service description, Better Local Care

In order to make the EPCT model work successfully, a variety of staff will be needed to deliver daily administration, core care provision, specialist medical diagnostic/treatment, professional administrative support and rehabilitation/reablement. EPCT roles are therefore identified by skill rather than professional background.[9] Staff will be required to manage episodes of care with the patient through shared electronic records and ensure that they have all introduced themselves as a single team across previous organisation. Complex case escalation review meetings will take place, support by the patients' case manager via the shared record with specialist input when required. The multidisciplinary team includes:

- GP
- ANP's/practice nurses
- SHFT community nursing and therapy
- SHFT older persons' mental health
- SHFT adult persons' mental health
- HCC social services
- NFHC care navigators
- Voluntary sector

This dedicated team will provide a range of services for participating practices, many of which are being tested as single interventions elsewhere as part of the BLC Vanguard. Clinicians and social care staff from the team will be co-located in the Hub and provide effective triage for people. This will involve mainly remote consultation (telephone/technology). The triage service operates alongside core general practice hours (08.00 – 19.30) from Monday to Friday and face-to-face

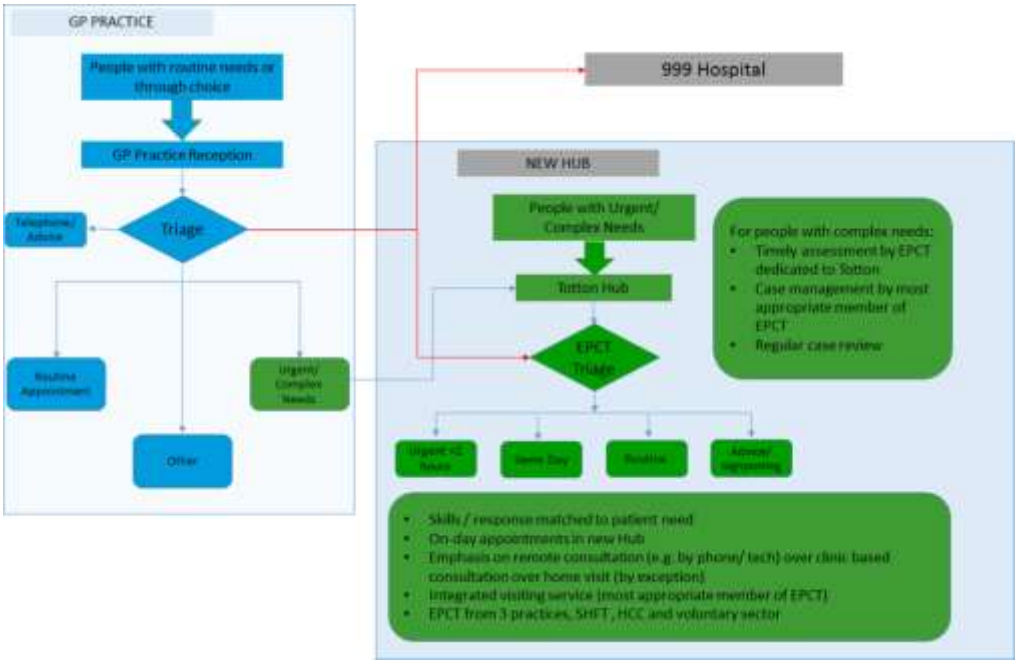
[9] ibid

appointments run from 8am to 8pm. Visits are scheduled for those patients who are housebound, this line of service is often delivered by ANPs.

Patients who require the EPCT are offered a holistic assessment, undertaken using 'My Wellbeing Plan' that is currently utilised across MCP localities. The patient is then allocated a key-worker and reviewed through case management.

The EPCT model includes a specific service to support people living in care/nursing homes. People who live in care will benefit from a case management approach where appropriate.

Figure 3.6: New Model



Source: ECPT Model service description, Better Local Care

3.3.3.1 The Hub – urgent and on-day access

The Hub is a new central accessible element of the triage area of the GP practices involved. The concept behind the Hub is to provide an immediate point of access for those patient presenting at GP practices and requiring immediate triage. It is hoped that this will reduce the number of patients presenting at A&E.

The Hub provides the following services:

- customer services team – the customer service team provide call handling for all urgent / on-day AND patients with complex needs;
- robust MDT triage – this provides an emphasis on remote consultation over clinic based appointment over home visit which is only used if absolutely required;
- on-day access clinic (8-6.30 M-F) for all urgent/on-day primary care;
- base for new Specialist Home visiting Service (SHVS); and
- base for extended primary care team.

3.3.3.2 EPCT for people with complex needs

The Extended Primary Care Team is co-located in the practices involved and is made up of staff from practices, SHFT, HCC, Care Navigators and Voluntary Organisations. The team was established to:

- streamline referrals by removing the referrals between practices and ICT;
- integrating the ICT ISPA within the new locality access / triage Hub;
- the development of individual "My Wellbeing Plan" for patients which is to be shared via MIG;
- the development of a case management approach with MDT review;
- to promote and encourage a shift to proactive case finding approach; and
- development of more clinic based approaches (e.g. wound care) as alternative to domiciliary visits to promote better outcomes.

3.3.3.3 Specialist Home Visiting Service (SHVS)

The overall project also has developed a specialist home visiting service (SHVS) which again is co-located in the practices and is led by staff from the practices and SHFT. The project seeks to pool the resources from Primary Care and the CCTs to provide an on-day access visiting service between 8am and 6:30pm Monday to Friday. The SHVS will be used specifically for all urgent / on day primary care and rapid response presentations. The service will be based in the Totton Health Centre Hub.

3.3.4 Objectives

Hampshire Better Local Care aims to have Extended Primary Care Teams across Hampshire that are intended to improve clinical and care outcomes for those complex health and care needs. The EPCT projects involve:

- Risk stratifying the population to identify the people at greatest risk
- Operating as a single team under the leadership of local GPs
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- Proactive care – identifying those at risk and supporting them rather than just responding to need as it arises[10]

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[10] Manual for the development of locality MCPs, Better Local Care, Southern Hampshire Vanguard, Oct 2015

3.3.5 Key performance indicators

The EPCT bid document outlines the key performance indicators (KPIs) for the EPCT which are anticipated to be achieved by 2019. These include:

- 3% sustained improvement in the quality of life for patients with complex needs pre / post intervention;
- shift of activity and costs in primary care services vis a vis acute hospital care over 3 years;
- reduction in admission rates for people aged >65 years / <75 years;
- >50% patients have a named coordinator of care;
- 90% of people classified as frail have a care plan in place;
- reduction in the number of NOF admissions; and
- reduction in the number of bed days.

Given that the project has only completed the scoping phase there is no formal data ready at this point in relation to the outputs and outcomes.

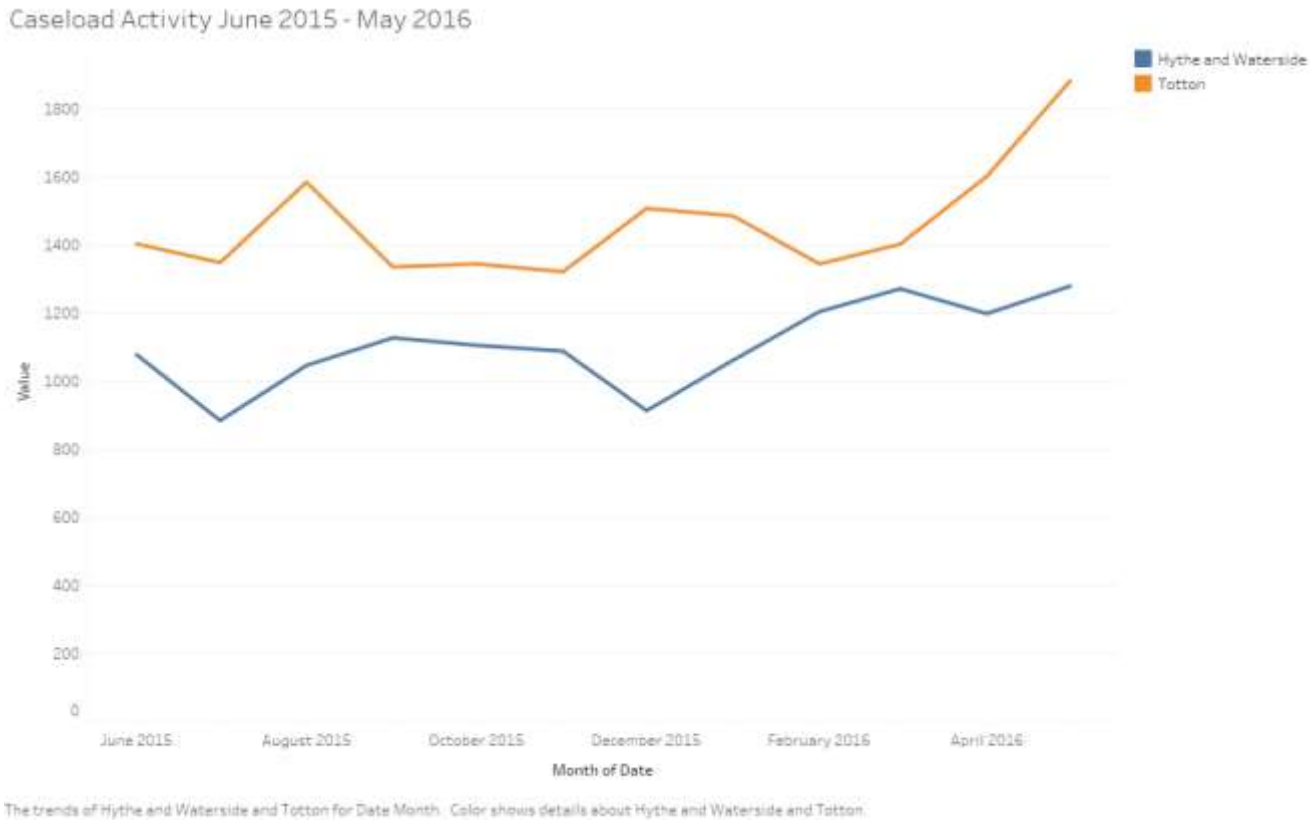
4 BASELINE DATA

4.1 Baseline data on Practice activity

4.1.1 Case load

The case load data has been recorded at the practices involved in the extended primary care team project. This is displayed in Figure 4.1.

Figure 4.1: Case load



Source: Totton and Hythe and Waterside Caseload data (June 2015 – May 2016)

The caseload data above relates to the number of GP appointments in two of the practices involved in the EPCT project and specifically within the Totton practice which forms the base for the new Hub. The caseload data shows that on average 1,400 patients are seen monthly in the Totton. The data shows a distinct increase in caseload towards the end of the data collection period (May 2016) with caseload peaking at over 1,800. Similarly, on average 1,100 patients are seen monthly in the Hythe and Waterside. The data shows a distinct increase in caseload towards the end of the data collection period (May 2016) with caseload peaking at over 1,200.

4.2 Baseline information on the EPCT Projects

4.2.1 Effective triage by the EPCT

Clinicians (and social care staff) from the EPCT have be co-located within the Hub and now provide a timely and effective triage service for all request / referrals for people with urgent or

complex needs. This includes a duty doctor, duty ANP, duty community nurse and duty social worker.

Where possible and safe, remote consultation (e.g. by phone/ tech) is used over clinic based consultation and as a last resort a home visit can be arranged.

Early data suggests that approx. 60% of calls have been converted to a telephone consultation (or skype for care-homes) and 40% of calls have required a face-to-face appointment with a clinician.

4.2.2 Urgent and on the day demand: Baseline data to inform the development of the project

Within the local partnership work has been undertaken to assess the potential for different approaches to meeting on day demand. An audit was conducted in summer 2016 that identified that of all patients seen by a GP for urgent or on-day appointment an average of 32.4% could have been seen by a different healthcare professional.

Totton practice undertook a survey identifying urgent on the day patient caseload that could be seen by another health professional than GP was undertaken during the months of May, June and July 2016. The results are presented below.

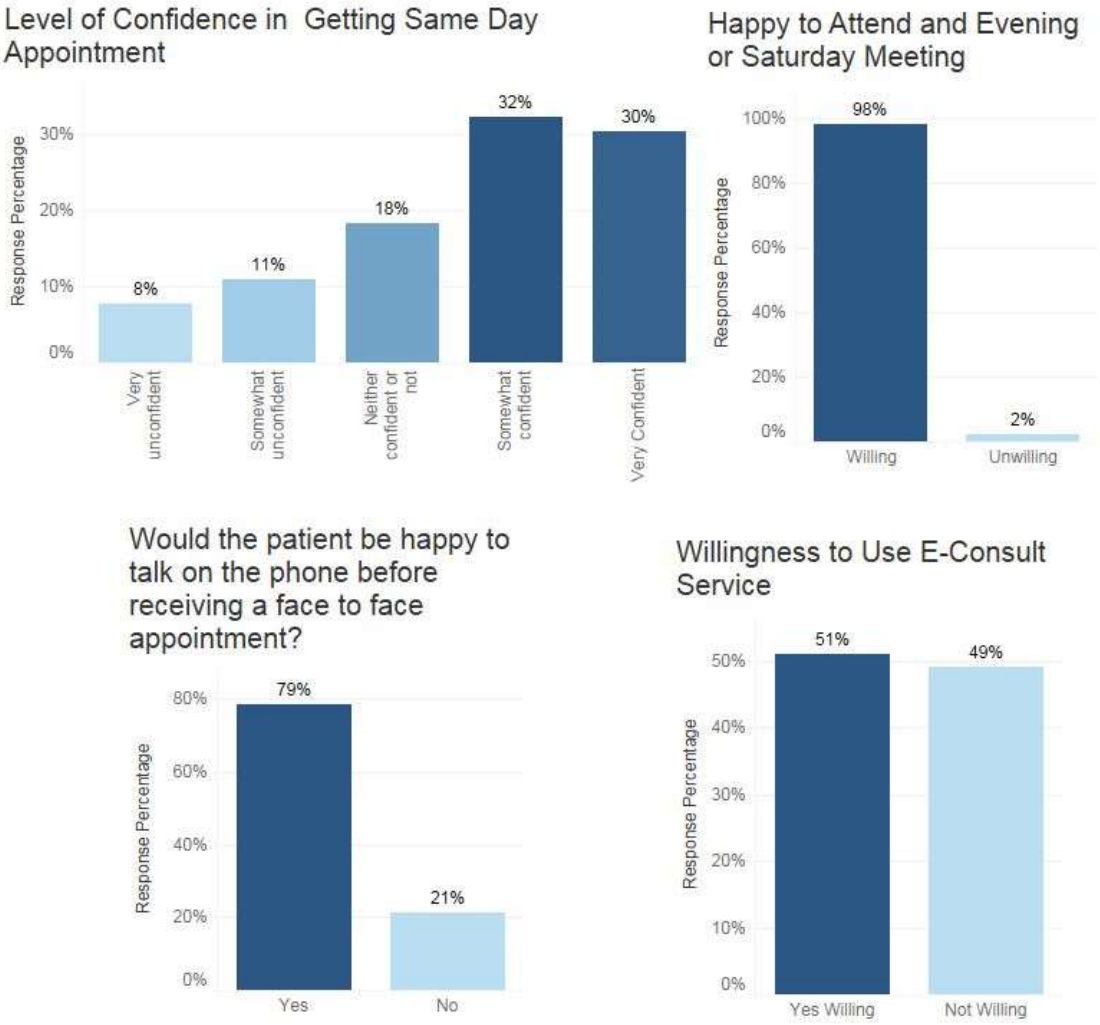
Figure 4.2: Scoping urgent on the day patient caseload

Professional	% of caseload which could be re-directed
Nurse Practitioner	64.73%
Extended scope physio	14.40%
Clinical Pharmacist	5.84%
Practice Nurse	5.67%
Psychiatric Nurse	4.96%

Source: Totton LMC Survey (2016)

A patient survey in summer 2016 also supported alternate approaches to managing on-day demand. The results of the survey are detailed below. A total of 257 responses were collected across the 3 surgeries between May and July 2016 and the results are detailed below. Patients surveyed were asked how confident they were that they could get an urgent on the day appointment at their GP surgery. Figure below displays the results.

Figure 4.3: Initial snapshot questions (base=256)



Source: Totton Patient Survey Results (2016)

Level of confidence in getting same day appointment

As can be seen from the figure above:

- 30% of those surveyed (n=77) stated that they would be 'Very confident' of getting an urgent on the day appointment;
- 32% of those surveyed (n=82) stated that they would be 'Somewhat confident' of getting an urgent on the day appointment;
- 18% of those surveyed (n=46) stated that they would be 'Neither confident or unconfident' of getting an urgent on the day appointment;
- 11% of those surveyed (n=28) stated that they would be 'Somewhat unconfident' of getting an urgent on the day appointment; and
- 8% of those surveyed (n=21) stated that they would be 'Very unconfident' of getting an urgent on the day appointment.

Willingness to have a telephone consultation

Patients were asked if they would be willing to have a telephone consultation before deciding whether a face to face appointment would be required. Figure 8 displays the results.

As can be seen:

- The vast majority of respondents (n=195, 79%) stated that they would be willing to have a telephone consultation before a face to face appointment if required.
- Only 21% (n=52) stated that they would not be willing to have a telephone consultation.

Willingness to have an 'e-consultation'

Patients were asked if they would be willing to have an e-consultation. As can be seen:

- The majority of respondents (n=126, 51%) stated that they would be willing to have an e-consultation.
- However 49% (n=121) stated that they would not be willing to have an e-consultation.

The new model has formed the foundation for potential extended hours services in future if this is viable and supported by local practices and other partners.

4.2.3 Home Visiting Service

Existing GP duty visiting for the participating practices has been replaced with a pooled duty visiting response service operating from the Hub. Visits have been assigned following patient contact with the Hub and subsequent triage. Visits have been by exception for housebound patients only.

The triage process now ascertains the most appropriate clinician to attend. In the detailed design of the visiting service further work will be undertaken to consider the most appropriate skill mix to meet demand. In other MCP localities this has included the deployment of ANPs and/or paramedics.

Current unscheduled / urgent requests for the SHFT community teams are now managed through the same process – with urgent visits for patients on the new EPCT caseload scheduled similarly to visits for patients on the GP list.

4.2.4 Case Management for people with complex needs

All people deemed to have complex care needs have been supported by a new, more integrated and co-located Extended Primary Care Team (EPCT). The team has been formed from named and Totton dedicated staff. During 2016 a range of One Team workshops were help to begin to develop the EPCT model – considering case studies from other areas.

Local registered patients who require the support of the EPCT have been offered a comprehensive holistic assessment involving MDT input from the most appropriate members of the EPCT. Assessment is undertaken using a locally adopted "My Wellbeing Plan" that is currently utilised by HCC and increasingly across MCP localities

During November 2016, local practices and SHFT undertook a pilot of this approach for a single patient with significant and complex care needs who had a history of recurring GP appointments, ambulance conveyances and admissions. Following the application of the EPCT model and development of a "My Wellbeing plan", a more proactive approach to care and support for the individual has been applied – including more regular, scheduled appointments with GPs and other relevant professionals.

4.2.5 Support for People Living in Care Homes

The new EPCT model includes a specific service dedicated to supporting people living in care and nursing homes. It is expected that people supported in nursing and care homes will also benefit from case management approach where appropriate.

Consideration has been given to the deployment of technology within key homes to support remote consultation. This might take the form of Skype arrangements that offer nursing and care home staff the ability to link remotely with clinicians within the Hub who will have immediate access medical records, care plans and a range of other EPCT professionals.

5 OUTPUTS, OUTCOMES AND EXISTING BASELINE DATA

5.1 Introduction

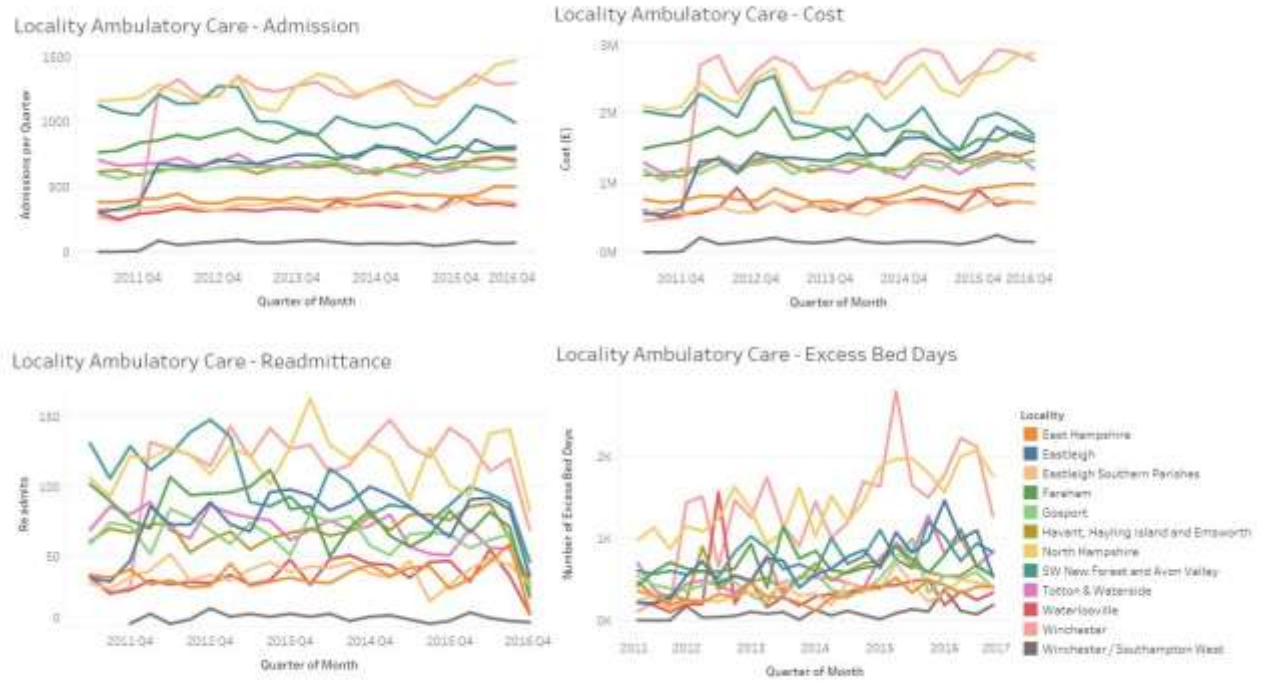
The EPCT bid document outlines the key performance indicators (KPIs) for the EPCT which are anticipated to be achieved by 2019. These include:

- 3% sustained improvement in the quality of life for patients with complex needs pre / post intervention;
- shift of activity and costs in primary care services vis a vis acute hospital care over 3 years;
- reduction in admission rates for people aged >65 years / <75 years;
- >50% patients have a named coordinator of care;
- 90% of people classified as frail have a care plan in place;
- reduction in the number of NOF admissions; and
- reduction in the number of bed days.

5.2 Baseline Ambulatory Care data

Our team have analysed baseline data on ambulatory care for all of the localities. This data is presented in the dashboard below.

Figure 5.1: Dashboard of baseline data on Ambulatory Care



Source: Better Local Care Ambulatory Data Extract (SUS)

Some of the key points include:

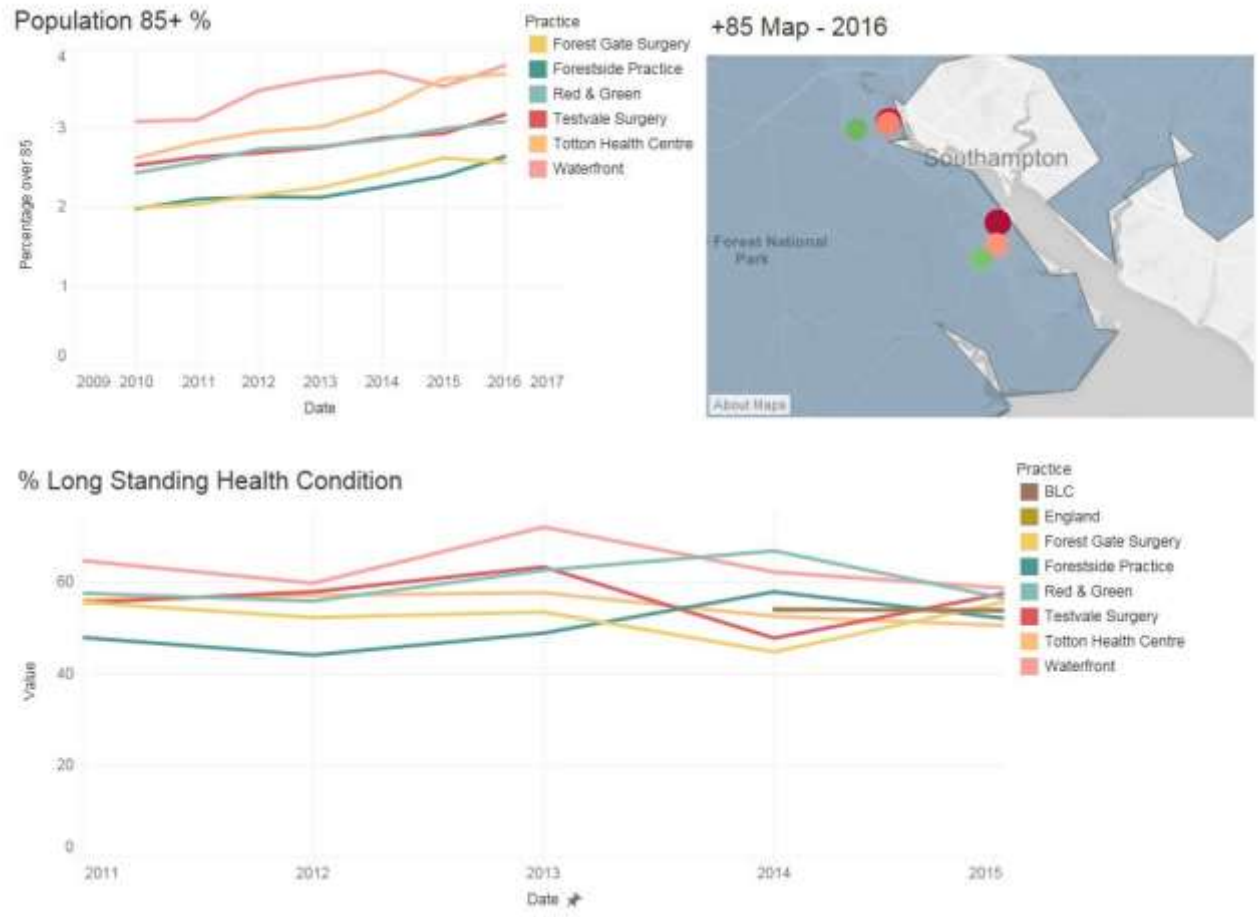
- The level of admission by locality ambulatory care in the Totton and Waterside Locality has remained fairly flat with 706 admissions in Q2 2011 compared with 723 admissions in Q2 2016;

- The cost of ambulatory care services in the Totton and Waterside has increased by approximately 10% between 2011 and 2016. The cost of the service in Q2 2011 were £1.28m compared to £1.41m in Q2 2016.
- The level of re-admittance in the Totton and Waterside locality has decreased since 2011, Q2 2011 saw 69 people re-admitted compared to 56 in Q2 2016.
- In terms of excess bed days this measures the number of bed days used by patients who, having been confirmed as fit for discharge stayed in hospital after this. The number of excess bed days used in Totton and Waterside has increased from 699 days in Q2 2011 to 1,003 in Q2, 2016.

5.3 Frailty

Our team have analysed baseline data on frailty for all of the localities. This data is presented in the dashboard below.

Figure 5.2: Dashboard of baseline data on frailty



Source: Better Local Care Ambulatory Data Extract (SUS)

Some of the key points include:

- There has been a steady increase in the number of people over the age of 85 in the Totton Health Centre. This was 2.6% of all patients in 2011 rising the 3.8% in 2016.
- The number of people with a long standing health condition has steadily decreased in the Totton Health Centre moving from 57% in 2011 to close to 50% in 2015.

6 VALUE FOR MONEY

6.1 Budget and projected spend

The table below sets out the budget for the EPCT project.

Table 6.1: EPCT budget

Phase	Aspect	Source of Funding	Amount of Funding (£)
Set Up	Project management 0.6WTE	The Health Foundation	£22,658.00
	Admin support		£18,444.00
	Backfill costs -Leadership		£6,042.00
	Travel costs to attend up to three events in central London		£480.00
Total			**£ 47,624.00**
Set up	Honoraria for any patient/carers/service users' involvement	Vanguard	£250.00
	Leadership/external facilitator -One Team Programme		£20,000.00
	Data collection, analysis and other technical support related to measurement		£16,000.00
	Attendance at meetings/event in relation to the project including room hire, catering, etc. if appropriate.		£1,000.00
Total			**£37,250.00**
Total phase set up			**£84,874**
Implementation	Project management 0.6WTE	The Health Foundation	£9,063.00
	Admin support		£7,378.00
Total			**£16,441.00**
Implementation	Data collection, analysis and other technical support related to measurement	Vanguard	£6,295.00
Total			**£6,295.00**
Total implementation phase			**£22,736**
GRAND TOTAL			£127,610.00

Source: EPCT Bid Document

6.2 Actual spend

The following sets out the spend data in relation to the EPCT project for May – December 2016.

Table 6.2: EPCT budget spending (May 2016 – Dec 2016, Q1 to Q3)

Aspect	Source of funding	Amount of funding (£)	Actual
Set up phase			
PM and GM time	The Vanguard	£TBC	£61,669.20
Admin support		£7,378.00	£8,442.87
Backfill costs -Leadership		£45,167.00	£40,702.00
Honoraria for any patient/carers/service users' involvement		£250.00	£0
Leadership/external facilitator -One Team Programme		£20,000.00	£24,101.00
Data collection, analysis and other technical support related to measurement		£16,000.00	£0
Attendance at meetings/event in relation to the project including room hire, catering, etc. if appropriate.		£1,000.00	£1,702.00
Total set up phase		£89,545	£136,617.07

Source: EPCT Bid Document and information provided by the EPCT Team (April 2017)

The table below sets out the budget for the EPCT project for January – March 2017.

Table 6.3: EPCT budget spending (January 2017 – March 2017, Q4)

Aspect	Source of Funding	Amount of Funding (£)	Actual
Set Up Phase			
Project management 0.6WTE	The Health Foundation	£9,063.00	£9,048.50
Admin support		£7,378.00	£1,160.79
Backfill costs -Leadership		£0.00	£5500
Total		£ 16,441.00	£15,843.29
Honoraria for any patient/carers/service users' involvement	Vanguard	£250.00	£400.00
Leadership/external facilitator – One Team Programme		£20,000.00	£3,025.00
Data collection, analysis and other technical support related to measurement		£16,000.00	£0
Attendance at meetings/event in relation to the project including room hire, catering, etc. if appropriate.		£0.00	£1702
Bids and additional funds: Health Coaching and PAM EMIS RC Nurse Practitioner X-Ray Find MIG cost – ENTVS, ESP, T&W		 £25.100 £7,195.00 £500.00 TBC	 £17,243.55 £2,100.00 £500.00 TBC

Source: EPCT Bid Document and information provided by the EPCT Team (April 2017)

6.3 Analysis and conclusions

Any value for money analysis must be treated with a considerable caution as there are gaps in the finance data available. The objectives of EPCT project are very firmly culture change and therefore it is challenging to apply monetary values to the outputs and outcomes.

Initial financial analysis is limited given that the EPCT project is still largely at the scoping phase however it is clear from the evidence that the initial set up costs, particularly for May – December 2016 exceed what was expected.

7 FINDINGS FROM THE FIELDWORK

7.1 Introduction

The following sections sets out the findings from the fieldwork elements of this evaluation.

7.2 Methodology

Our methodology used a mixed method approach and the main strands are detailed below:

- **Survey of staff involved:** our team conducted a survey of staff involved in the one team project as part of the overall programme staff survey. This contained targeted questions on ECPT; and
- **In depth interviews with managers:** we conducted in-depth interviews with the managers responsible for the implementation and delivery of the programme.

The findings from the survey and the interviews are detailed in the sections below. These have been grouped around the main objectives of the EPCT project. It should be stressed however that given these early findings reflect that only the scoping phase of the project has been completed.

7.3 Findings from the staff survey

RSM PACEC undertook a programme wide staff survey of all those involved in Better Local Care. In total 104 responses were received. Of those, 25 were involved in the EPCT. Some of the key findings are detailed below. These have been grouped under the main objectives of the EPCT Programme.[11]

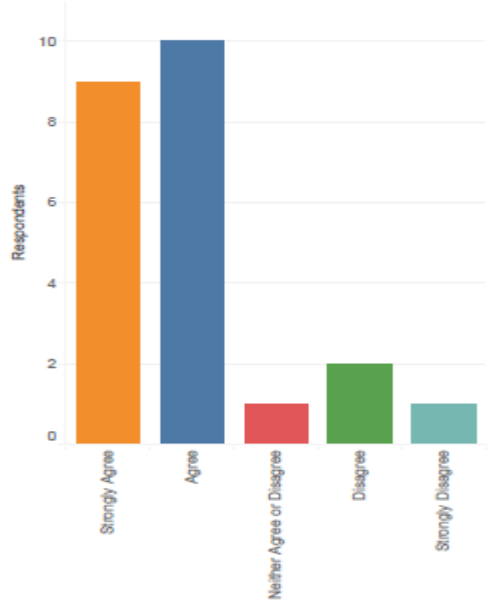
7.3.1 Safety, quality and systems will be safeguarded as shared care records and team working across organisations

Those who had participated in the EPCT project were asked a number of questions related to the development of the team and team working across organisations. Some of their responses are displayed below.

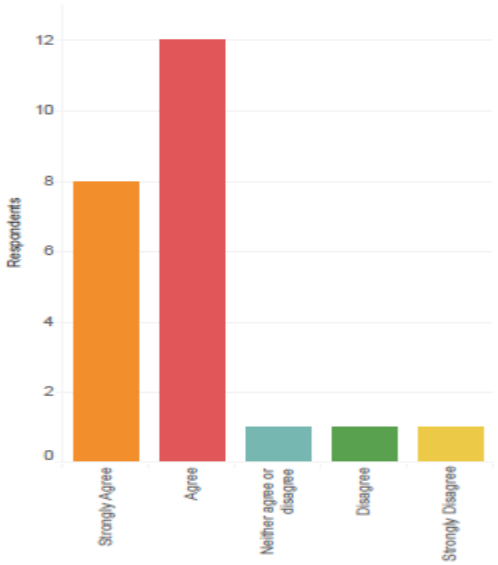
[11] Note: Not all of the objectives have been used – only those appropriate to the questions asked in the survey.

Figure 7.1: Staff Team Working and Relationships

When there is a conflict the people involved usually talk it out and resolve the problem.



The staff have constructive working relationships



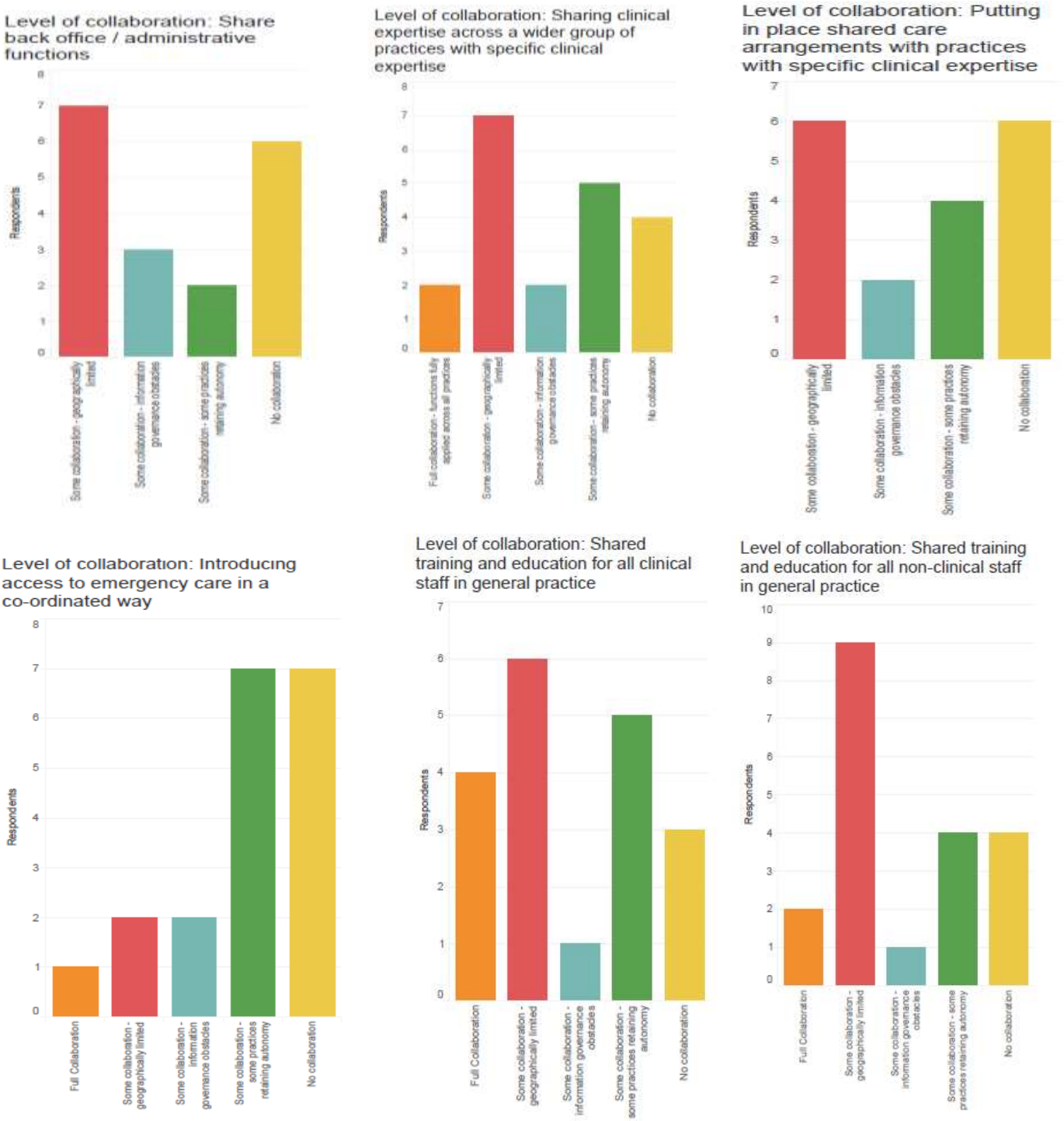
Source: RSM PACEC Staff Survey (March 2017)

Those involved in EPCT were asked if conflict could be resolved through the team talking to one another. Nine of the respondents '**Strongly Agreed'** and 10 respondents **'Agreed'** that this was achievable.

Respondents were asked if constructive working relationships existing between team members. Eight respondents **'Strongly Agreed'** and 12 respondents **'Agreed'** that constructive relationships existed.

Those responding to the survey were also asked about the levels of sharing with regard to data, information, support services etc. The dashboard of their responses are detailed below.

Figure 7.2: Sharing Care Records and Services



Source: RSM PACEC Staff Survey (March 2017)

Those respondents involved in EPCT had varying opinions on the levels of sharing across a number of different areas.

When asked about the level of sharing of back office and administrative functions there was a divide in opinion with seven respondents stating that there was '**Some Collaboration – Geographically Limited'** whereas six respondents stated that there was **'No Collaboration'**.

When respondents were asked about the level of sharing of expertise and across a wider group of practices the results were more encouraging with two respondents stating that there was **'Full Collaboration'** and 14 respondents stating that there was **'Some Collaboration'** whether that be because of geographic limitations, governance limitations or individual practices wishing to maintain autonomy.

When asked about putting in place shared care arrangements with practices with specific clinical expertise respondents were again divided with six stating that there was **Some Collaboration – Geographically Limited'** whereas six respondents stated that there was **'No Collaboration'**.

Respondents were agreed that there was limited collaboration when it came to introducing access to emergency care in a co-ordinated way with seven respondents stating that there was **Some Collaboration – Limited by practices seeking to maintain autonomy'** and seven respondents stating that there was **'No Collaboration'**.

In relation to sharing training and education for clinical and non-clinical staff there was a mix of opinion. 10 respondents (four stating **'Full Collaboration'** and six stating **'Some Collaboration'**) stated that there was shared education and training for clinical staff. Only three respondents stated that there was **'No Collaboration'** on this issue. In relation to non-clinical staff 11 respondents (two stating **'Full Collaboration'** and 9 stating **'Some Collaboration'**) stated that there was shared education and training for non-clinical staff. Only four respondents stated that there was **'No Collaboration'** on this issue.

7.4 Findings from the in-depth interviews

Initial interviews were carried out with the manager and some of the staff involved in the EPCT project. Some of the key findings have been presented below based around the main objectives of the EPCT project. Full details of the interviews conducted to date can be found in Appendix 1.

7.4.1 Clinical and care outcomes improved through Extended Multi Practitioner Care Teams

Consultees were in agreement that it was too early to provide any meaningful insight into whether clinical and care outcomes had been improved, however there was consensus that this was a realistic and achievable goal for the EPCT project.

In completing the scoping phase of the project, the consultees agree that the project had been successful in enabling teams to come together which has provided a greater level of understanding of roles across all stakeholders.

"The coming together of the team has provided a greater level of understanding of roles across all stakeholders"

In addition, staff interviewed indicated that the new team approach had worked well in enabling the sharing of data, development of new care models, pathways and processes.

"The whole team approach (including Primary, Community and Social Care) has worked very well together to provide data and work on model developments with pathways, processes, shared documentation"

The development of the MDTs however was not without challenge and those interviewed highlighted a number of challenges faced in the scoping phase of the evaluation. One of the greatest challenges was not being able to share patient identifiable data between organisations involved, especially when working on managing patients with complex needs. The team could only estimate 'demand' based on Southern Health data.

In addition, developing those relations early in the process seemed to pose challenges as well as getting time commitment from those involved. Also, it was noted that once established, getting teams to agree common goals was challenging.

"Influencing stakeholders to agree the common goal was challenging we had to work hard to engage and influence"

7.4.2 Improving patient experience by team based approach to the delivery of care

Like with the previous objective, it is too early in the EPCT project's life to see any real improvement in patient experience, however there is anecdotal evidence that the project is making a positive difference.

Those interviewed indicated that the projects supported through the EPCT had significant potential to not only improve patient experience but the clinical outcomes achieved as well. Some of the initial successes in relation to the improvement of patient experience include the development of a wound and catheter clinic which should free up capacity within the health care system.

"Outcomes of our data case finding and analysis: The ICT data analysis led to a development of wound and catheter clinics (currently being developed). It is anticipated that these will free up capacity within our ICTs."

The conversations and discusses that EPCT has enabled has provided a forum for clinical and non-clinical professionals to discuss the needs in each locality and develop tailor solutions which will have positive impacts on patient experience. These include the development of the virtual ward process.

"The conversations with colleagues identified issues that needed to be addressed in the locality e.g. the virtual wards process."

7.4.3 Safety, quality and systems will be safeguarded as shared care records and team working across organisations

Consultees indicated that the setup of the EPCT and the sharing of care records had posed and continues to pose significant challenges for the implementation of the project.

One of the greatest challenges was not being able to share patient identifiable data between organisations involved, especially when working on managing patients with complex needs. The team could only estimate 'demand' based on Southern Health data.

In addition, the team had to do a manual room use review to identify space for the EPCT Hub at the Totton Health Centre. More support from the Estates Team would have made the implementation of the project smoother.

Stakeholders interviewed indicated that the project, as a Fast Follower, did not have the impetus and focus which have been given to the three main Vanguard sites and as a result the project was a slow burner with a slower progress of development. However, the stakeholders did stress that despite this Totton had made significant progress toward the goals established. The stakeholders felt that more focus could have led to the achievement of more. In addition more structured support would have improved the communication channels between the project team and the PMO.

In addition, the implementation was hampered by the lack of discussion and agreement around the infrastructure needs of the project. Going forward more communication is needed with the key enabling departments e.g. IT, Telephony and Estates.

8 EMERGING CONCLUSIONS AND RECOMMENDATIONS

8.1 Emerging conclusions

The rationale underpinning the need to provide extend primary care teams and team development support, to deliver improved integrated care, is well evidenced and widely understood.

The project's objectives are clear and well aligned to important strategic documentation regarding the impact, both for clinical and care outcomes of extended primary care teams. The project also represents a good fit with objectives within the NHS Business Plan, the Five Year Forward View, the GP Forward View and the local STP.

The programme does have KPIs however it is early in the process to provide any significant data against these. However, the current lack of data monitoring and recording within the project will make measuring impact all the more challenging. A robust framework of monitoring and data collection from staff and patients' needs to put in place. The RSM PACEC team will be working together with EPCT leads to finalise and implement a project specific evaluation framework in April 2017.

Early evidence suggests that so far, the project has been successful in:

- Supporting the coming together of a group of practices who are working together with the project management on developing BLC models and committing their time to the project development;
- Establishing a good EPCT Project team and identifying one clear goal which has helped to focus the team and those involved in the project;
- Gaining support and commitment from all stakeholders involved in the project and the commitment of time in already time pressured environments;
- Developing wound and catheter clinics as a result of the data analysis completed.

Of course, the project has also faced challenges particularly in relation to maintaining staff buying, sharing data and demonstrating the future financial sustainability of the project.

8.2 Emerging recommendations

Emerging recommendations for the EPCT project include:

- **Recommendation 1: Provide a mechanism for information sharing** – a mechanism should be agreed for the sharing of patient identifiable data between organisations involved, especially when working on managing patients with complex needs.
- **Recommendation 2: Providing clear estimates of expectations for staff involved** – there is a need to be clear with the staff involved about the time commitment to the project so that they understand this from the outset.
- **Recommendation 3: Provide sufficient notice** – give at least 4 weeks' notice to primary care individuals for attendance at events.
- **Recommendation 4: Link to existing infrastructure –** develop better working relationships and links with ICT department and Estates Department to foster better delivery of the project.
- **Recommendation 5: Governance and Contract Arrangements** - special attention must be paid to the governance arrangement and contracts agreed between the parties involved so that

everyone is clear of their remit, roles and responsibilities in the implementation and delivery of the project.

- **Recommendation 6**: **Need for Staff Consultation** – going forward there is also need for additional and robust staff consultation particularly when there are changes in roles and the skills mix of the team

APPENDIX 1: STAKEHOLDER CONSULTATION FEEDBACK TO DATE

Successes

Some of the main successes of the EPCT to date have included:

- Development of sustainable models working in partnership with the CCG to ensure the model becomes commissionable going forward;
- The coming together of the team has provided a greater level of understanding of roles across all stakeholders;

Challenges

Some of the main challenges highlighted include:

- Influencing stakeholders to agree the common goal – GP's in the locality currently sustained and not on a burning platform and so we have had to work hard to engage and influence;
- Hampshire county council going through major consultation has delayed integration discussions.

Future Changes / Recommendations

Stakeholders interviewed indicated that the project, as a Fast Follower, did not have the impetus and focus which have been given to the three main Vanguard sites and as a result the project was a slow burner with a slower progress of development. However, the stakeholders did stress that despite this Totton had made significant progress toward the goals established. The stakeholders felt that more focus could have led to the achievement of more. In addition more structured support would have improved the communication channels between the project team and the PMO.

In addition, the implementation was hampered by the lack of discussion and agreement around the infrastructure needs of the project. Going forward more communication is needed with the key enabling departments e.g. IT, Telephony and Estates.

Findings from the In-Depth Interviews with Staff

In depth interviews were carried out with some of the staff involved in the project. The key points from the discussions are detailed in the following section.

Successes

Some of the main successes of EPCT to date have included:

- The coming together of a group of practices who are working together with the project management on developing BLC models and committing their time to the project development;
- Establishing a good EPCT Project team and identifying one clear goal which has helped to focus the team and those involved in the project;
- Gaining support and commitment from all stakeholders involved in the project and the commitment of time in already time pressured environments;
- The whole team approach (including Primary, Community and Social Care) has worked very well together to provide data and work on model developments with pathways, processes, shared documentation;
- Outcomes of our data case finding and analysis: The ICT data analysis led to a development of wound and catheter clinics (currently being developed). It is anticipated that these will free up capacity within our ICTs.
- Infrastructure: identifying physical space (noting that estates availability is always an issue especially in primary care establishments) and interoperability solutions; and

- The conversations with colleagues identified issues that needed to be addressed in the locality e.g. the virtual wards process.

Challenges

The implementation of the project and its delivery have not been without challenges. Some of the key challenges faced included:

- **Inability to share patient record information**: One of the greatest challenges was not being able to share patient identifiable data between organisations involved, especially when working on managing patients with complex needs. The team could only estimate 'demand' based on Southern Health data. Going forward it would be more efficient if lists could be compared as this would better inform the workforce models.
- **Time Commitment**: both primary and community care are facing workload and workforce challenges and in some instances were not able to fully commit to all meetings;
- **Financial**: The set up costs for the project require Vanguard funding, if this is not approved there will be significant resistance from primary care;
- **Estates**: The team had to do a manual room use review to identify space for the EPCT Hib at the Totton Health Centre. More support from the Estates Team would have made the implementation of the project smoother.

Future Changes / Recommendations

Some of the key changes / recommendations included:

- **Governance and Contract Arrangements** – going forward special attention must be paid to the governance arrangement and contracts agreed between the parties involved so that everyone is clear of their remit, roles and responsibilities in the implementation and delivery of the project;
- **Need for Staff Consultation** – going forward there is also need for additional and robust staff consultation particularly when there are changes in roles and the skills mix of the team; and
- **Providing sufficient lead in time** – learning that primary colleagues need to give our primary 4-6 weeks' notice so that they could commit to attending events.