Transforming Community Services
Locality Working and Implementing
the Primary Care Home Model Approach

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The future of health and social care is locality working

CURRENT STATE

TRANSFORMED STATE

Working together for better care in Richmond
What do we mean by Locality Team Working?

The locality working approach draws from the national Primary Care Home (PCH) Model in developing an integrated multi-professional workforce that enables primary care, community health and social care professionals to work in partnership with acute specialists.

The key elements of locality working are built around the PCH approach with a focus on:

- Specialists being involved in a more community focused service
- Multi-disciplinary clinical and social care team service delivery
- Strong affinity between participating practices and community services
- Reducing historical organisational boundaries and working collectively through networked arrangements with access to diagnostics and IT systems.
NHS SW London SPG: Draft KPIs – Locality Teams

- Number, source and type of referrals to locality teams
- % of patients identified as high risk of admission through risk stratification and admissions avoided
- % of high risk patients with an anticipatory care plan
- Days/weeks and frequency locality teams
- Patient Experience (PREMs) and Patient Outcomes (PROMs)
- Reduction in unplanned care need – GP appointments, A&E attendances and Non-Elective admissions
- % of patients receiving active care coordination
What is RCHiP?

- Richmond Community Healthcare in Partnership—a joint venture between HRCH and Richmond GP Alliance (RGPA)
- 2-year transition period (to March 2018) to move to a full outcomes based contract
- The transition plan describes the approach to optimising and standardising services and transforming and integrating pathways, where necessary, to improve quality and deliver system-wide savings
- Transformation partners (Kingston Hospital NHSFT, Chelsea & Westminster Hospital NHSFT and the London Borough of Richmond upon Thames) are committed to delivering transformational change
What is outcomes based commissioning?

- 2 year transition period
- Redesigning patient pathways and services
- Hosted by RCHiP

Transition period

Way of thinking

- Outcomes not outputs
- Whole system working
- Transformation Partners

Richmond Adults Contract

- A population based/capitated payment mechanism
- Commissioned from a provider organisation that assumes responsibility for health and care outcomes
What are the local challenges?

• Moving from outputs from outcomes
• Increasing health needs e.g. 57% of over 75s in Richmond have 3 or more long term conditions
• Delivering change at scale and pace whilst not compromising quality of care
• System-wide behavioural change
• Affordability - CCG £16m deficit for 2016/17
• CCG Financial recovery plan (FRP) additional savings of c£9.4m by 2017/18
Richmond Localities

4 localities based on approximately 50,000 population per locality.
HOW ARE WE DEVELOPING THE MODEL TO SUPPORT LOCALITY TEAM WORKING?

**Enablers**
- Care co-ordination
- Single care record
- Comms & engagement
- Workforce
- IT systems and data
- Single budget

**December 2017**
Locality teams operational

**Implementation**
Scale up and roll out proof of concept across Richmond. Additional integrated/coordinated care development for the rest of the patient population, and to meet requirements of locality team working.

**Proof of concept**
Co-design and test key components of locality team model in Teddington & Hampton

**Build common vision and shared purpose between commissioners, RCHiP and OBC transformation partners**

**Develop OBC Clinical Pathways e.g. diabetes, respiratory, frail elderly, cardiology**

**Workshops Development of Locality Teams**

**PCH pilot Signposting**

**Implementation**
Scale up and roll out proof of concept across Richmond. Additional integrated/coordinated care development for the rest of the patient population, and to meet requirements of locality team working.

**June 2017**

**March 2017**

**July 2016**

**August 2015**
Engagement with Key Stakeholders

Local Community
Involvement
Communication
Access & quality of services

Building trust and confidence is crucial

Primary Care
Participate
Activate

Frontline Staff
Support
Inspire
Empower

Transformation
Partners
Collaborate
Commit
Share

Working together for better care in Richmond
Solutions to gaps/problems

- System Interoperability or IT sharing agreements
- New services at TMH e.g. short stay inpatient ward
- Increasing awareness of the community services available
- Further integration of social care and voluntary sector with healthcare
- More joint working between RGPA and HRCH
- Improving links with acutes e.g. Omni-Join/virtual ward meetings
- DXS to improve referral process

80 members of staff from HRCH Community and Richmond primary care attended RCHiP ‘Planning how our new model localities will work’ workshop (11th Oct 2016)
Proof of concept in Teddington & Hampton

1. Small co-design group focused on developing a model for locality team working as next steps from the 1st March Locality Team Development workshop.

2. Co-design group members: GP, Community Matron, RRRT, Social Care, CILS

3. 1st March workshop next steps:
   - Agree mechanism for identifying patients in top 2% at-risk cohort by practice for integrated MDT case management
   - Nominal budget in shadow form based on secondary care activity – A&E attendances, non-electives, outpatients
   - Testing of patient involvement in weekly frail elderly virtual MDTs
   - Testing small amount of new ideas put forward by co-design group

4. Identifying KPIs and outcome indicators to be tracked during proof of concept

5. Capturing patient views and experiences to be aware of what patients think

6. Testing the roles and responsibilities of an integrated MDT locality team

7. Share learning and what achieved so far to enable planning for scale up and roll out across the Localities
### Key Components of T & H Locality Model

Co-developed by stakeholders during the 1st March workshop

<table>
<thead>
<tr>
<th>Referrals/SPA</th>
<th>MDT members</th>
<th>Sharing the load</th>
<th>Proactive, reactive and enduring care</th>
<th>Improved communication</th>
</tr>
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</table>
| • Simplified referral pathways  
• SPA to hold info on vulnerable patients and have a clinician on team | • Specialist services, RRRT, AHP, community pharmacist, CILLS voluntary care, matrons, district nurses, GP, social services, clinical care co-ordinator, admin  
• Virtual team  
• Inclusive of patient | • Joint/MDT meetings  
• Social meetings  
• Awareness of local services available to patients | • Prioritising  
• Case finding  
• Prevent hospital admission  
• Facilitate early discharge | • Holding continual conversations - between acute, primary and secondary care services  
• Joint working between acute and community nurses  
• Feedback loop to GP/referrer |

<table>
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<tr>
<th>Co-location / reconfiguration</th>
<th>MDT care plans</th>
<th>Utilisation of data</th>
<th>Self-management</th>
<th>Care coordinator</th>
</tr>
</thead>
</table>
| • Community nurses able to work in GP surgeries with RRRT and in acute settings  
• Working with care homes and residential homes | • Care plans agreed as MDT  
• Accessible and universal  
• Clear baseline data  
• Advanced care planning prior to deterioration | • More done in community to prevent further admission by weekly review of admission data and A&E discharge summaries | • MDT services to help patients self-manage e.g. community pharmacy, RRRT, district nursing | • Role of clinician / professional most involved with the patient |

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<tr>
<th>Utilisation of apps</th>
<th>COPD rescue packs</th>
<th>Early visits</th>
<th>Carer skills</th>
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</table>
| • Help patients self manage e.g. coordinate my care | • All COPD patients to have a rescue pack including antibiotics and steroids | • Patients visited early in day to facilitate care package arrangements  
• GP duty triage  
• Re-instate flying RAT | • Train care staff and carers to extend skills |
Desired Outcomes for T & H Locality Model
Co-developed by stakeholders during the 1st March workshop

- Services keep patients in the community by working to their localities
- Improved communication between services to provide a more seamless transition for a person moving through the system
- Simplified referral pathways
- Joint working between acute and community services to support hospital admission avoidance and advanced hospital discharge
- Accessible and universal care plans to enable services to collaboratively manage a patient’s care and allow patients to move through different services at ease and pace to prevent avoidable deterioration
- Using secondary care data to pull patients back into the community by their locality
- Help patients to self-manage
- Patients visited earlier in the day to facilitate arrangement of care packages
- Reducing duplication of effort
Outline process for integrated MDT case management

The diagram below describes a best practice outline process for Integrated Case Management to be developed in more detail with co-design members and virtual MDT/SHC MDT participants.
Risk Stratified Population

Population divided into four levels of risk (Kaiser Triangle) based on their level of non-elective admissions, A&E attendances and outpatient appointments. This is then used to determine which care intervention is most appropriate for different segments of the population.

**Level 1: Very High Relative Risk (top 0.5% of population)**
People with chronic diseases and complex needs who frequently use hospitals.

**Level 2: High Relative Risk (0.5 – 5% of population)**
People with chronic diseases and complex needs who use hospital or are at risk of hospitalisation.

**Level 3: Moderate Relative Risk**
People with chronic disease and/or complex needs who can be managed in the community.

**Level 4: Low Relative Risk**
People with chronic health conditions who can self manage with support.

**New Initiatives**
- OBC Pathways
  - Frail Elderly e.g. Virtual MDT, Senior Health Clinic, Hospital Transfer (Red Bag Scheme)
  - End of Life Care

**OBC Pathways**
- Cardiology
- Diabetes
- Respiratory

**PCH Initiatives**
- Signposting training for:
  - GP receptionists
  - Community Pharmacy counter staff

**Other Initiatives**
- Social prescribing pilot

**Population Wide Prevention & Wellness Promotion**
- Targeted care co-ordination and navigation for most at-risk
  - Inform and support the build of community resilience.
Richmond OBC – Red Bag Initiative

• Focuses on elderly residents from care homes in Richmond who are transferred to A&E at Kingston Hospital and West Middlesex University Hospital by London Ambulance Services.

• Designed to meet the requirements of the NICE guidance on transition between inpatient hospital settings and care homes.

• Contains personal effects such as dentures, glasses, hearing aid and toiletries, as well as a change of clothes and pair of slippers so the individual can function, get out of bed and be ready to go home as soon as they are able.

Also contains:
• Standardised information about the resident's general health
• Any existing medical conditions they have
• Medication they are taking
• Current health concerns and important personal details about the individual.
Senior Health & Virtual MDT Clinic

Senior Health Clinic

- For “Subacute” older people.
- Consultant, Therapist, Pharmacist & Nurse assessment.
- To improve their functional status and build resilience as much as possible.
- To manage their long term conditions/multimorbidity, polypharmacy.
- Offering a MDT functional assessment with diagnosis, onward referral to voluntary & acute sectors & co-ordination of a care plan.

Virtual MDT Clinic

- For complex, urgent, high risk & vulnerable Frail Elderly patients.
- GP, Consultant, AHP, Nurses, Social Care, Patient & Carer review without physical assessment.
- Weekly videoconference set up through a booking system on Vision 360, GPs or clinicians can book direct or via administrator.
Diabetes - From clinic holding to supporting and educating

The focus of the new model is about changing the role of level 3 specialist community diabetes services from being primarily focused on holding clinics to becoming a source of specialist support to allow more care to be delivered in general practice.

**Level 3 Specialist community services**

By upskilling practice nurses, GPs and other primary care staff the specialist community team will be able to discharge more routine patients to closer and more holistic care from their practice. Their advanced skill set will be able to support more people and focus more on those who need more specialist care.
Diabetes ‘To be’ pathway

Flow down care levels
Key to the new pathway is a focus on providing care at the right level and an expectation that, where possible, patient care flows back down the care levels. This is enabled by increased education both of general practice and patients.
Respiratory proposed model

• Increase case identification for patients with COPD, for which Richmond CCG is currently an outlier

• Ongoing support for patients with severe or very severe COPD &

• Low risk mild to moderate COPD to be managed in Primary Care by their GP
  – Access to expert advice through Kinesis system

• Community Respiratory team to support primary care to manage complex patients

• BREATH education sessions to be offered to all newly diagnosed COPD patients to promote positive self-management
Remodelling of pathway of care for IP beds at TMH

**Before**
- 50 beds across two wards
- Length of stay 44 days and above national average
- Inappropriate admissions: few from the community with the majority coming from the acute Trusts.
- Poor internal process

**After**
- 29 beds across one ward
- Length of stay approx. 17 days
- Piloting revised referral form to access referrals from RRRT
- Strict adherence to admission criteria (agreed with CCG) from July 2016 coupled with,
  - Active management of admissions and discharges against a transformed rehabilitation pathway – with return to 2015-16 admission levels.
- Senior nurse from unit seconded into RRRT
Remodelling of pathway of care for IP beds at TMH

Number of Admissions Per Month

- Number of Admissions 15/16
- Number of Admissions 16/17

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Primary Care Home - Locality working Twickenham and Whitton

Signposting training for reception staff and pharmacy counter assistant staff, as well as social care staff and a patient participation group member.

**Delivery:**
- 2 and half hour training programme
- Delivered at primary care venues across Richmond PCH
- Consultation indicated training needed to be offered on different dates to maximise number of participants
- Support also given to share knowledge and skills with colleagues in their practice or community pharmacy
- Training supports delivery of NHSE 10 High Impact Actions to help release capacity in Primary Care

**Goals:**
- Key Primary Care non clinical staff attended training resulting in skilled workforce able to signpost whilst responding compassionately and helping facilitate access to appropriate services
- Primary Care non clinical staff aware of existing, relevant and appropriate services and are able to advise those in need appropriately and recognising the significance of carers within a health and social care setting
- Primary Care non clinical staff able to navigate and effectively utilise Health Help Now website and application and opportunistically engage with patients to promote technology
- Management team in practice support and value enhanced role.
Next steps for locality team development

Proof of concept
1. Track patients through virtual MDT to identify gaps/opportunities for improving integrated locality working.
2. How to simplify referral pathways into other services, including fast track where required.
3. Engage with acute services on how to enable advanced discharge for case managed patients.
4. Options appraisal for single locality team structure.
5. Implement mechanism for identifying patients who could benefit from an MDT integrated approach to their care and support so that interventions can be offered to prevent or delay decline.
6. Determine volume of target patients likely to be on each locality ‘caseload’.

Comms & Engagement
7. Continue to organise engagement sessions e.g. with GP practices and patient networks to share what is happening.
8. Work jointly with other relevant transformation programmes e.g. community nursing and community matron optimisation.

Enablers
9. Scope feasibility of Coordinate My Care as the IT system for sharing single integrated MDT care plan across health and social care.
Summary

- A great deal of work has been undertaken over the last 6-9 months on service transformation in Richmond
- Locality team working is a key component of integrated care in a community setting
- The majority of the components required in a locality model are in place and work over the coming month will refine this to maximise impact in one locality initially
- The aim is for the locality working model to be fully operational by December 2017 across Richmond.
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