THE KING’S FUND INTEGRATED CARE SUMMIT 2018

The King’s Fund – Thursday 20th September 2018

Dr John Ribchester MBE
GP
Chair and Clinical Lead for Encompass MCP Vanguard
Senior & Executive Partner at Whitstable Medical Practice
The Journey of Encompass Multi-Speciality Community Provider (one of the NHS Vanguards) in the development and spread of a new model of care.

Leadership challenges of rolling out a new model of care;

*Rabindranath Tagore*

“You Can’t Cross The Sea Merely By Standing And Staring At The Water.”
Encompass Multi-Speciality Community Provider (MCP)

14 GP practices across Ash, Canterbury, Faversham, Sandwich and Whitstable, in partnership with Health and Social Care.

We are part of the NHS “vanguard programme”, which means we made a bid to NHS England for special funding to improve the health of local people by testing new models of care.
Local Care Hubs

Five Local care Hubs – 180,784 patients

- Whitstable
  - 2 practices – 38,574
- Faversham
  - 2 practices - 30,743
- Canterbury N
  - 4 practices – 47,391
- Canterbury S
  - 3 practices – 46,632
- Sandwich & Ash
  - 3 practices – 17,444
Encompass MCP – Health, Social Care, Voluntary and Community involvement working together at scale – The Local Care Hub model

**Number of People**

**Admission Avoidance**

- **Routine, Prevention and Proactive Care** – Integrated Case Management (ICM patient centred approach for admission avoidance, anticipatory care planning.
- **Emergency and Reactive Care** – ICM approach for admission avoidance, rapid/emergency response to avoid hospital admission to keep people well at home.
- **Acute Care** - When intervention is essential. Working with IDT for repatriation at the earliest opportunity.
- **Tertiary Care** - For highly specialist intervention. Repatriation at the earliest opportunity.

**GP Practice at scale built around Person/Population Health needs**

**Integrated Systems of Care**

**Local Care Hubs**
Total Population 180,784
Each Hub – 30 to 50,000

**Level of Acuity**
New Models of Care: different approaches are needed to manage our population

Patient Cohorts

- Most vulnerable/frail/elderly/multiple co-morbidities (5.9% Population)
- Relatively fit and coping Health complaint (16% population)
- Generally well (78% population)

Our Approach

- Integrated Case Management* £19.6m
- Health Condition Management* £3.6m
- Supported Self-care and PREVENTION* £1.3m

* Acute expenditure on emergency admissions
Multi-Disciplinary Team

**CHOC core team includes:**

- Mental Health worker
- GP
- Health and social care coordinator
- Pharmacist
- Community nurse / LTC Nurse
- Geriatrician
- Allied Health Professional
- Nurse Specialist
- Social Prescribing
- Social Care representative / social worker
- Mental Health worker
- Social Prescribing
- Administrator

**Our Integrated Case Management (ICM) Approach**

- Care plan
- Agreed with patient/carer

**Additional members** which vary locally:

- Integrated Discharge Team
- Police
- Fire and rescue
- Acute specialists
Supporting and empowering people who have long term physical and mental health conditions is important. The aim is to keep people well and avoid hospital admission.

Some of this involves moving some services, historically provided within a hospital setting, into the community, extending the roles of GPs and other health care professionals.

Ensuring that mental health is given the same level of importance as physical health, means provision of services to support people with long term mental health problems.

Patients identified through population modelling, down to GP caseload.

Fast access to services within the community to avoid attendance at A&E such as the community catheter clinics.
Supported self care

Supporting people to make healthier lifestyle choices to avoid prevent able diseases. The aim;
• Building strong social networks
• Exercising more
• Eating more healthily
• Feeling more supported and in control of lives
• Reduction in healthcare interventions for patients identified with a social prescribing need

Giving people information to make informed decisions about their own health:

WaitLess, the APP which provides real time data on MIUs and A&E departments in east Kent; linked to Health Help Now - providing people with symptom advice and guidance on treatment
Catheter service: 4th centre opened June 17

CHOC MDTs: all 5 in place

Community Geriatricians: integrated in CHOC MDTs

Dementia Support worker in place

Rapid home visiting service supporting GP Home Visits

GPwSI: Training underway (Linked to Tiers of Care)

Health and Social Care co-ordinators: organise the MDTs

Health Trainers: rolled out across all CHOCs

Community Pharmacists: supporting CHOC MDTs and Home First

Social Prescribing: gaining real momentum in year 3

WaitLess: providing positive benefits for the urgent care system

Group Psycho-education showing positive results

Directory of Services

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Activity deflections

- 33.1% Short stay Admissions
- 6.4% A&E minor attendance
- 8.2% Emergency Admissions
- 22.6% Catheter related Admissions

£3.4m Planned model forecast 2017/18 net savings

Patient experience

First time in years I feel confident enough to go outside and hang my washing on the line.

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

I have gained a lot of insight about a condition I have had for 17 years.

Now more confident and independent. Changed my life.

So good. I broke my leg and needed it checked immediately and with this app it told me what hospital had quicker service and how long it will be to wait - excellent.
Encompass Has Helped Define The Model For Local Care Across Kent and Medway

- Local care is a new model of delivery of **integrated health and care** services **close to where people live**.
- It is a **collective commitment** of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well.
Lessons Learnt:

**Workforce** (recruitment, retention, realignment, new roles) – working together strategically on workforce design, education and rotation across acute and community

**Governance** (data sharing of patient information, IT and confidentiality) – ensuring due diligence is undertaken prior to implementation

**Organisational Development and Engagement** - the importance of this must not be underestimated; it’s all about the relationships, building trust and having a shared vision, “THE WHY”

**Meaningful communications** (internal and external) - it is worth investing time in a stakeholder engagement plan

**Timing and release of central funding** in order to be able to implement - for the vanguard delays in release of funds to invest to save had an impact on ability to deliver

Above all- Ability to “hold your nerve”
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