NHS
North Central London

Integrated Care in North Central London

5th July 2012

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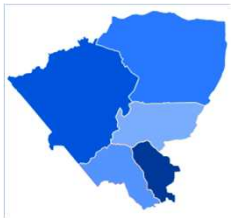
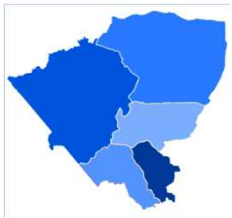
AD Strategy & Planning



Strategic context

Many of our frailest and sickest groups receive care in a fragmented and disorganised way – both planned care - for long Term Conditions or mental illness - and unplanned – 40% of people using our accident and emergency departments need primary not emergency care. We need to develop new ways of commissioning and delivering healthcare so that peoples' care is planned and managed close to their home with the resources to enable this.

This is our **Integrated Care Programme**. By 2015 we will be commissioning for our older people and those with long term conditions on a year of care/population basis from providers who deliver to pathways, care will be managed not chaotic and urgent care will be transformed.



Strategic context

Primary Care Strategy

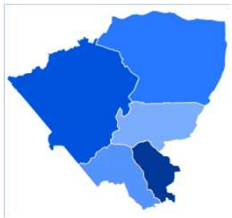
•Significant investment in primary care

•Primary care fundamental to all integrated care systems in UK

•Developments of networks for integrated primary care commenced in NCL – needs synergy between networks for primary care and networks for integrated care

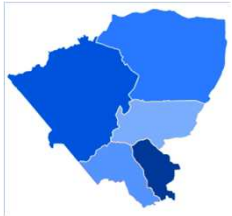
•Improving quality and reducing inconsistencies in primary care across NCL

•Development of web based systems to enable integrated working across practices



What is Integrated Care?

Integrated care enables delivery of joined up health and social care for specific populations of patients. Providers work together in partnership to deliver both uni-disciplinary and multi-disciplinary care as well as multi-disciplinary case management. As a consequence planned care replaces unscheduled care, leading to better clinical outcomes, patient experience and value for money in terms of health and social care investment.

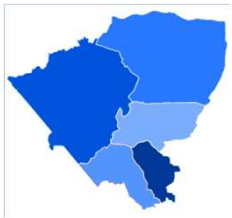


What is an Integrated Care System?

Integrated care needs to have a system which supports the new way of delivering care by a range of providers. The systems in North Central London will include primary care, one or more acute trust and community providers, a mental health provider and social care providers. The IC System is the partnership and infrastructure that enables delivery to take place.

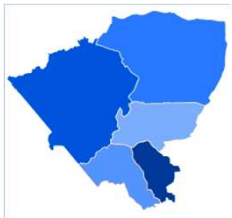
An Integrated Care Organisation has an advantage but is not a pre-requisite.

Leadership and commitment to integrated care across the system is essential for successful delivery.



Integrated Care: 7 pillars

- Patient Registry
- Risk Stratification
- Clinical Protocols
- Single Care Plan
- Planned Care Focus
- MDT Case Conferences
- Performance Reviews of MDTs



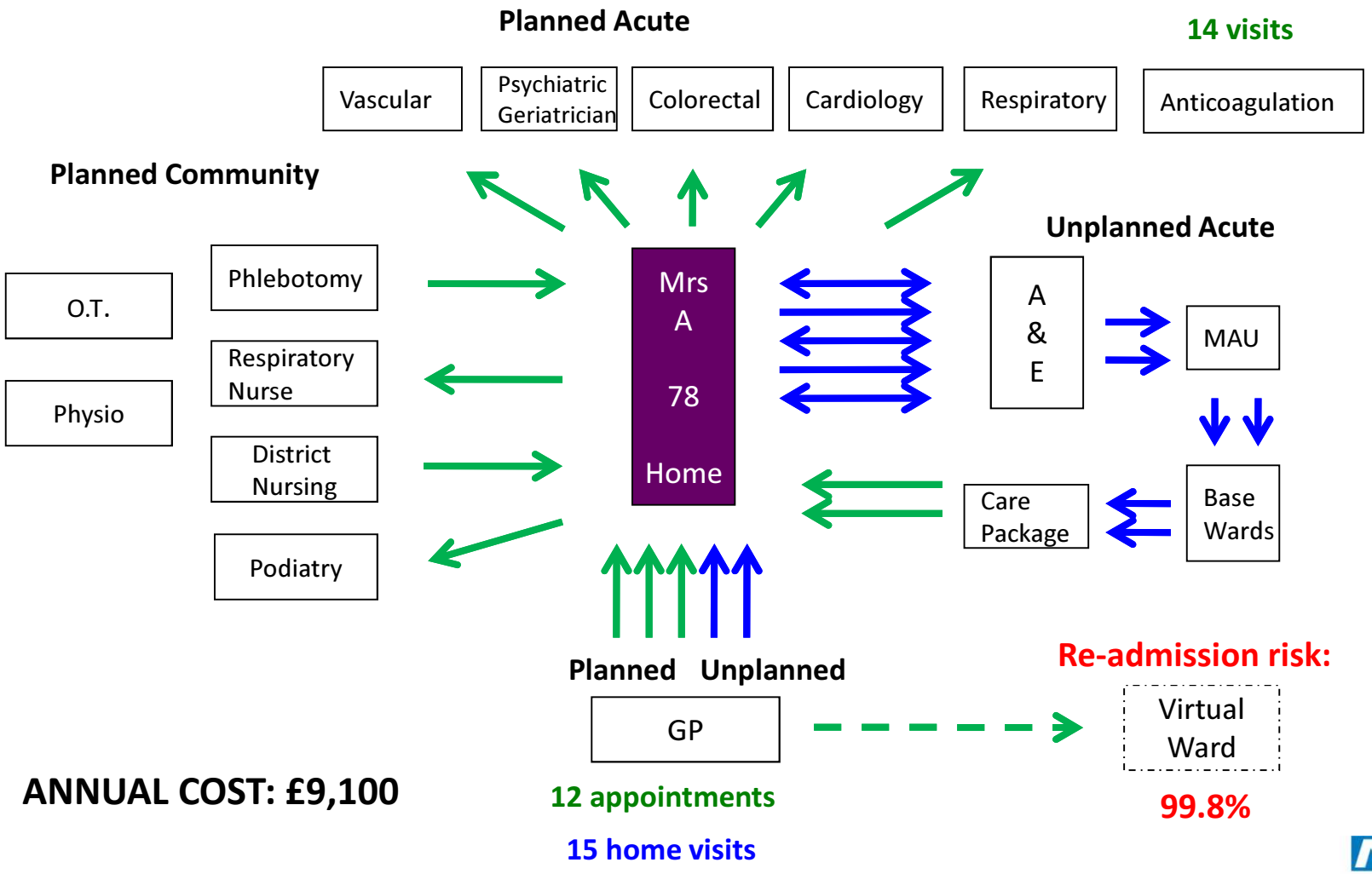
Why Integrated Care

- Only 19% of patients with COPD have just COPD
- Only 14% of patients with Diabetes have just Diabetes
- Only 5% of patient with Dementia have just Dementia
- Non-elective admissions have risen by 36% in NHS since 2000 and by 1.6% over same period in Sweden with more than a decade of integrated care

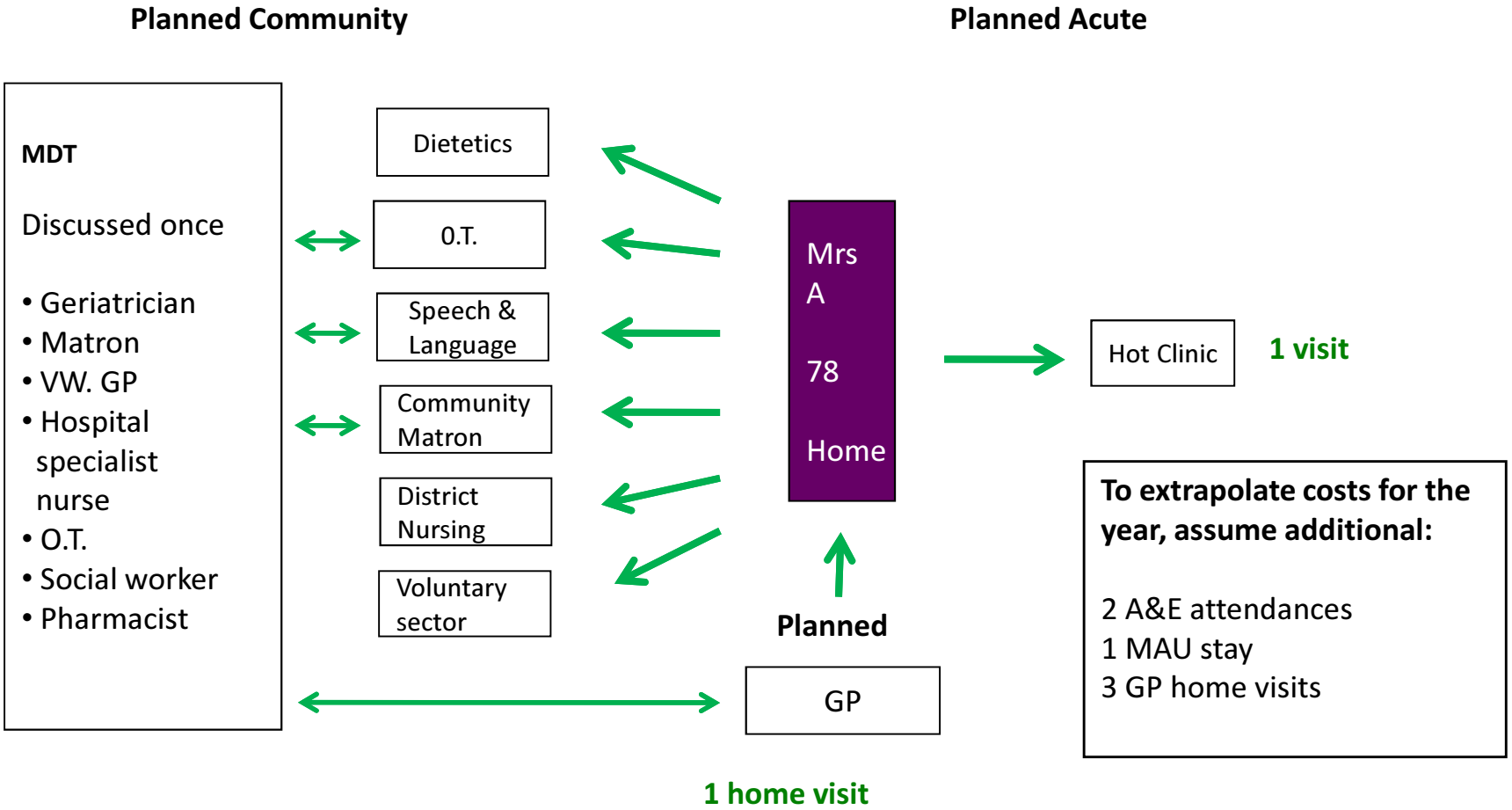
John Oldham, 2012

- In NCL, more than four fifths of all admissions for those aged 75 years and above are non-elective, at a cost of nearly £87m

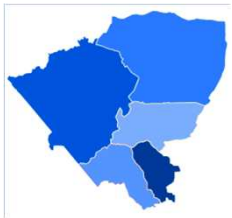
A patient journey before care planning: Camden



A patient journey in the 6 months following care planning

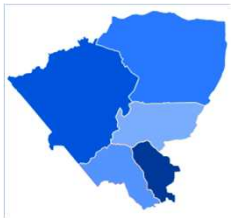


ANNUAL COST: £3,600



Impact on Patients and Service Users

- Most patients and service users expect their data will be shared amongst professionals in order to facilitate the delivery of care however explicit consent to share will be obtained
- Individuals will not need to give the same information over and over to different professionals
- Individuals will see a reduction of duplicate diagnostics or interventions due to information being available to all necessary professionals
- Individuals will have discussions with professionals that can bring in other aspects of their care which are important to that discussion by accessing a shared view of care
- Individual's experience of care will be improved



Impact on Professionals

- Professionals will have access to real time information about patients and service users across range of providers
- Professionals working as part of multi-disciplinary teams, virtual or real, will all have access to shared care view to enable case conferences to take place and shared agreements on next steps in care provision
- Professionals will reduce the time and effort required to find out pieces of information for them to undertake assessments and appropriate interventions due to the shared view of the care record
- Both the individual professional experience and the inter-professional experience should be improved
- Professionals will be able to monitor patient and service user outcomes much more effectively, provide clear comparison of norm, and agree and plan any necessary interventions

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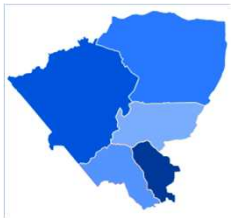
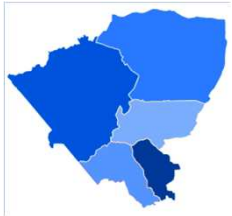


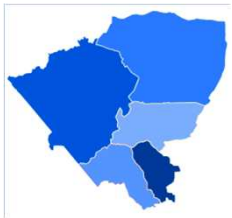
Impact on Commissioners

- Commissioners can have greater confidence in terms of the individual's outcomes they commission
- Commissioners will have access to aggregated data from all providers within the local health and social care system for the first time
- Local commissioners will have access to network and borough level information
- Commissioner reporting to CCGs will be enhanced
- The provision of information to CCGs for strategic planning will be enhanced
- Commissioners can support agreed research projects with datasets e.g. UCLP tariff Project



Progress to Date in North Central London Collective

- Senior leadership stakeholder event across health and social care with strong engagement and agreement on areas to undertake on NCL wide basis as well as those areas at borough /CCG basis
- Discussions with King's Fund about their involvement in NCL integrated care programme
- NHS London approved £500k from Regional Innovation Fund to support integrated care across Whittington Health and North Middlesex Hospital with particular focus on Haringey
- Initial draft of business case prepared for an IT solution to meet the information requirements of integrated care
- Evaluation brief developed in consultation with UCLP, NHS London and King's Fund to evaluate integrated across North Central London
- North Central London part of NHS London "Community of Practice" which is a network of integrated care leads across London



Progress to Date in North Central London Barnet

•Developed integrated health and social care teams for rapid response frail elderly as part of system wide redesign of frail elderly services

• Implemented enhanced GP support to care homes as pilot

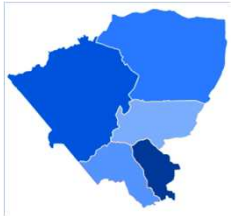
•Service specification and pathway developed for frail elderly

•Integration summit with health and social care providers planned for July

•Integrated commissioning plan developed for approval at HWBB

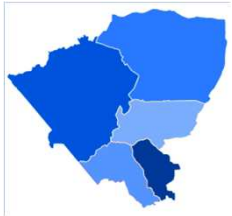
•Further development of integrated approach with children's services particularly SALT and CAMHs Tier 3

•Initiated redesign of dementia and stroke integrated community pathways



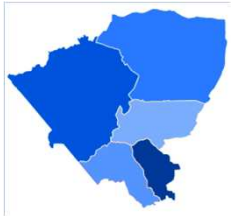
Progress to Date in North Central London
Camden

- Significant work with stakeholders in developing approach to integrated care
- Launched 2 year pilot for integrated working
- Practice networks being established
- Central hub established for integrated teams: diabetes/CKD, dermatology and shortly COPD, heart failure, memory service,
- Retinal screening to be available at diabetes/CKD hub
- Practices developing frailty registers and weekly MDT for complex frail patients
- Patients with 3 or more long term conditions referred to MDT for assessment
- Psychological support being embedded into integrated teams
- Patient experience evaluation to commence shortly
- Restructuring of therapies underway
- Progressing with information sharing protocols and procurement of IT solution



Progress to Date in North Central London
Enfield

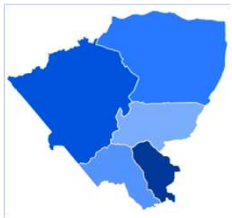
- Integrated care team established for northern care homes with positive outcomes including 50% reduction in emergency admissions and shortly roll out to southern care homes
- Stakeholder event with key providers , some agreed areas for action, programme being developed including governance and work streams
- Developing A&E based rapid response and early supported discharge in collaboration with acute trusts
- Practice networks being established
- Joint work with London Borough of Enfield on developing risk stratification
- Strong focus on implementing Primary Care Strategy as key enabler



Progress to Date in North Central London

Haringey

- Partnership Board established across health and social care
- North East Haringey Collaborative of GP practices piloting integrated care approach including running case conferences for complex patients 65 years or older
- Roll out to 3 more collaboratives over next 4 months
- Mapping and modelling of community services to align with integrated care model
- Joint London Borough of Haringey and NHS Haringey business plan for integrated care developed
- GP practices to be incentivised for care planning



Progress to Date in North Central London
Islington

- Programme Board established
- Emerging model of integrated care aligned to sub-localities (GP Networks) and localities
- Stakeholder work completed to define outcomes for COPD and diabetes models and review and implementation of recommendations underway
- Launch of COPD and Diabetes pathways planned for September
- Developing operational guide for implementation of MDTs and case conferences
- Realignment of community service to develop integrated care teams in sub-localities
- Developing clinical commissioning enhanced service to develop care planning for those risk stratified as Tier 3