



Care Closer to Home

Deep Dive for Health and Wellbeing Board

FOR DISCUSSION

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31st October 2018

Overview

The Care Closer to Home Programme (CCTH) within Barnet has made significant and tangible progress to date during the 2018/19 operating year. We are very close to achieving our population coverage target and we are moving into the mobilisation phase of a number of new innovative projects.

Our ultimate aim for the remainder of this operating year is to have achieved our population coverage target and have all Care and Health Integrated Networks (CHINs) either in service delivery or business case development by March 2019.

A snapshot of our achievements and challenges are shown below:

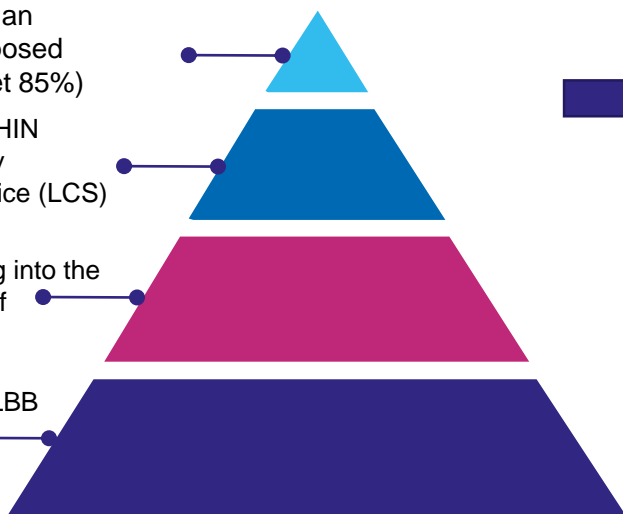
Achievements since April

46 practices within an established or proposed CHIN (88% - Target 85%)

Development of a CHIN Infrastructure Locally Commissioned Service (LCS) and CHIN FAQ

Three CHINs moving into the mobilisation phase of their initial ideas

Development of an LBB offer to the CHINs



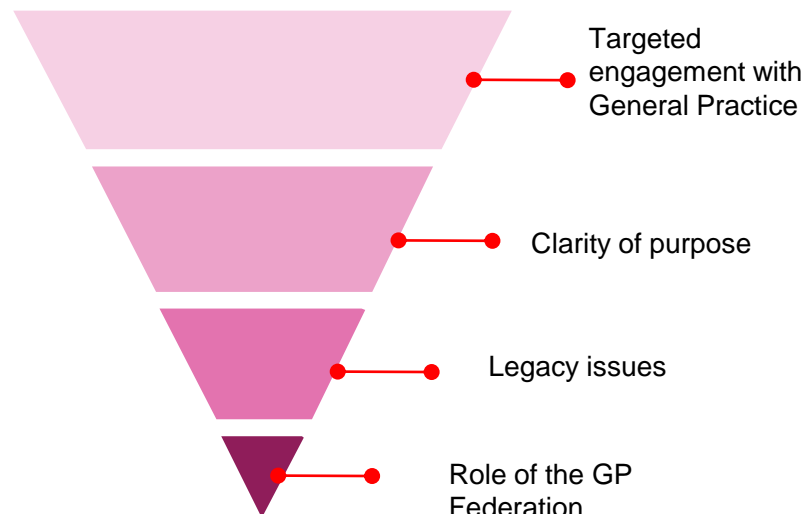
Challenges since April

Targeted engagement with General Practice

Clarity of purpose

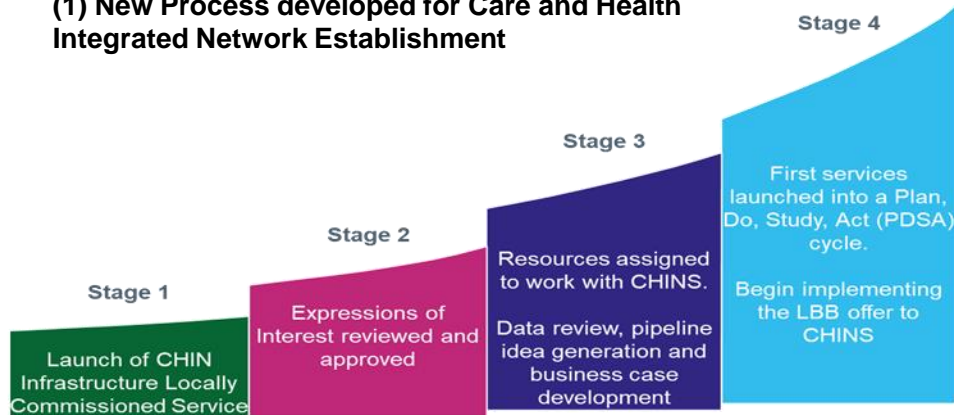
Legacy issues

Role of the GP Federation

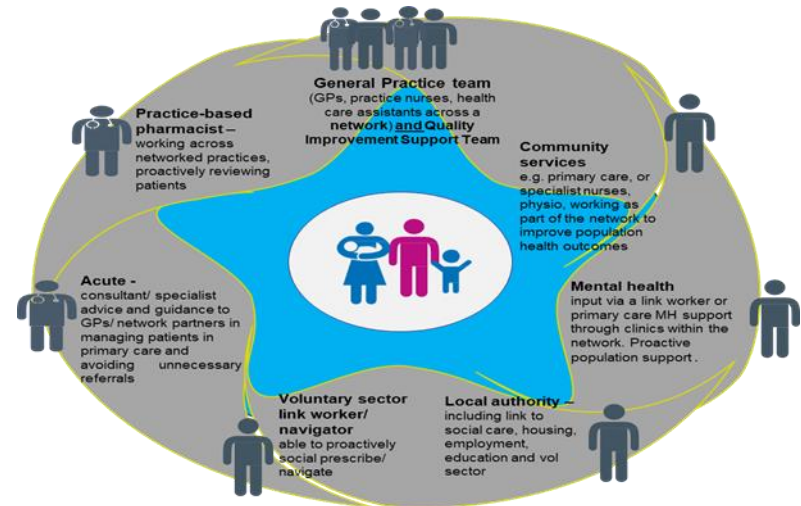


Current Position in Barnet

(1) New Process developed for Care and Health Integrated Network Establishment



(2) Typical Care and Health Integrated Network structure



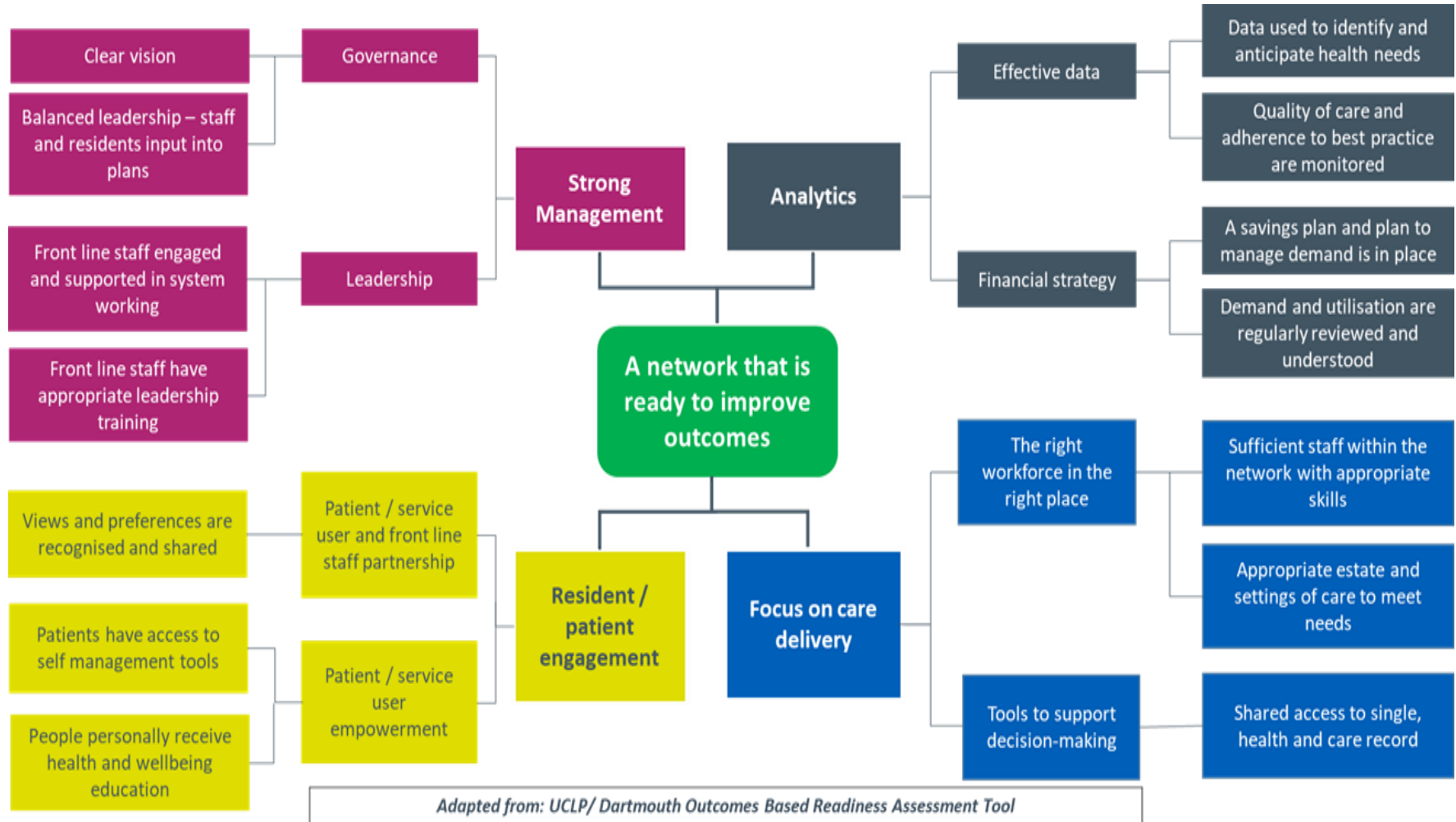
(3) Current Position within Barnet

Integration networks in place – infrastructure in place			Integration networks in plan			QIST
No. of CHINs	Population size (k)	Clinical focus	No. of CHINs	Population size (k)	Clinical focus	
3	CHIN 1: 48,473 CHIN 2: 50,575 CHIN 3: 86,146	CHIN 1: Paediatric Hot Clinics CHIN 2: Frailty MDT CHIN 3: Diagnostics and Near Patient Testing	3	CHIN 4: 44,618 CHIN 5: 39,154 CHIN 6: 41,324	CHIN 4: Digital and MyMHealth CHIN 5: Dementia CHIN 6: TBC	Diabetes

Care and Health Integrated Networks (CHINs)

CHIN development model to deliver improved outcomes for their populations

Source: North Central London (NCL) Primary Care Strategy



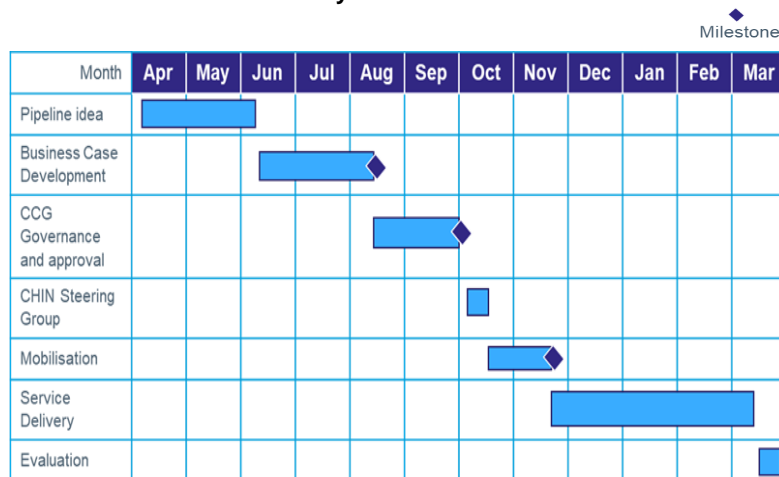
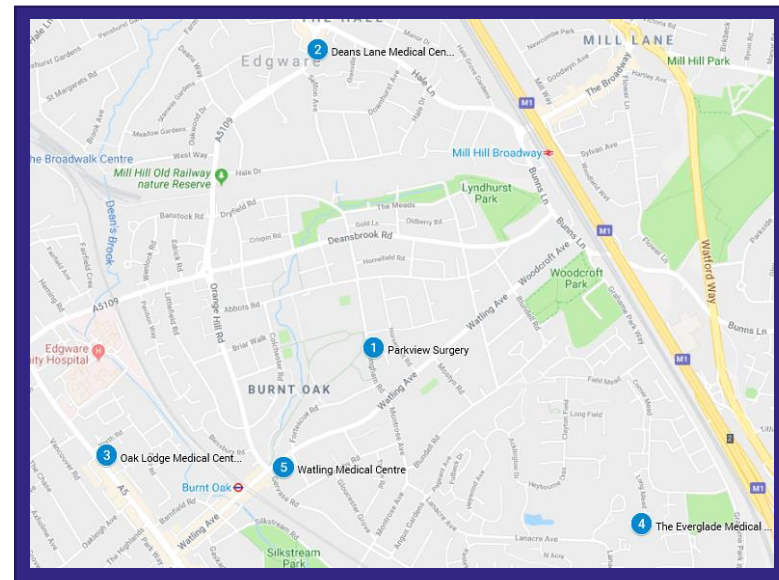
Deep Dive into Care and Health Integrated Networks (CHINs) in Barnet

CHIN One

Current Project: *Paediatric Hot Clinics*

- To reduce the current number of patients within the 0-9 patient cohort attending the Emergency Department and resulting in a HRG Code of VB09Z and VB11Z
- To evaluate the PDSA cycle and inform commissioning intentions for 2019/20 in terms of “scaling up” this model or resulting in a new model of care

Resources	Activities	Outputs	Outcomes
Advanced Nurse Practitioner / Prescriber (ANP)	Hold 3-5 sessions / clinics per week depending on level of demand	Patients will be seen within a primary care setting where waiting times are far shorter than the Emergency Department	Improved patient experience
General Practitioner			Fewer A&E attendances to improve overall waiting times
EMIS community platform	Develop and implement communications plan. Including for practices to undertake assertive outreach using text messaging from the EMIS platform, informing the 0-9 patient cohort, of the hot clinics that are available and how to access them		



CHIN Two

Clinical Lead: Dr Anita Patel

Focus: *Frailty*

Population: 50,575

Involving: 8 *practices*

Road map: *All system partners by April 19*

Current Project: *Frailty MDT*

The objectives of this proposal are:

To enable patients to benefit from a range of integrated services and new pathways delivered through a CHIN that works across health and social care boundaries, specifically:

To introduce models of care that will reduce avoidable non-elective admissions for the frail and elderly population of Barnet, focused on pneumonia and UTIs

To promote the use of end of life care plans to enable a greater number of Barnet residents to die in their place of choice.

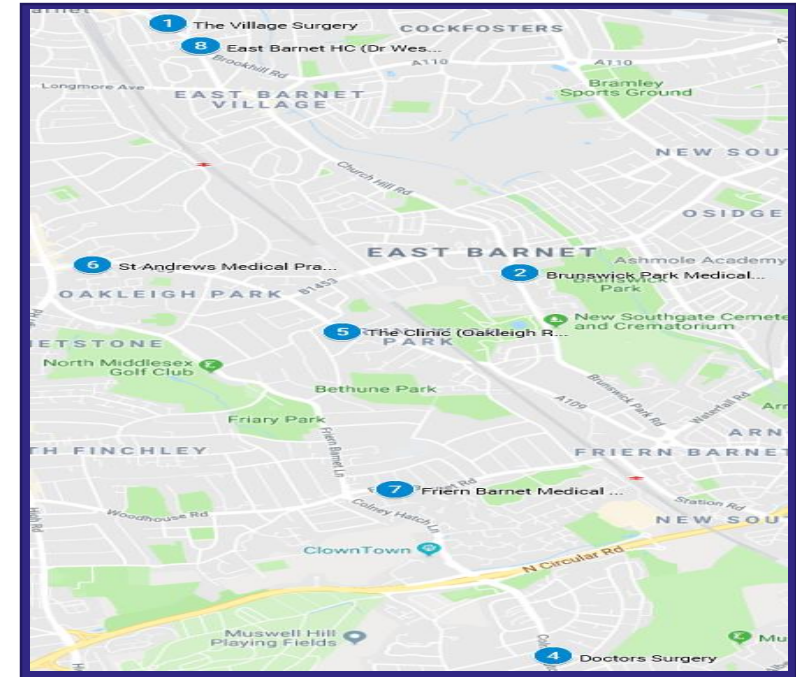
To support GP Practices to work together effectively and successfully deliver a specific Care Closer to Home initiative during 2018/19

To support Barnet CCG to deliver the ambition set out in the North Central London (NCL) STP Local Care Strategy

The proposal would be to adopt a PDSA approach to implementing a Frailty and Palliative MDT-model with CHIN Two practices over a 6-month period. This approach will provide an opportunity to review and refine the model and enable anticipated outcomes and savings to be identified. Following a PDSA evaluation, a Full Business Case (FBC) will be developed outlining the cost and impact of full rollout across all CHINs via a Locally Commissioned Service (LCS). This approach would help CHIN Two to form and provide an initial function.

There is a wider programme of work across Barnet on frailty which is a key area of focus for the CCG and will be linked in to the Royal Free CPG programme's frailty workstream.

GP Practices and Location of CHIN



Frailty Multi Disciplinary Team (MDT) Delivery Timetable

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CHIN Three

Current Project: *Diagnostics*

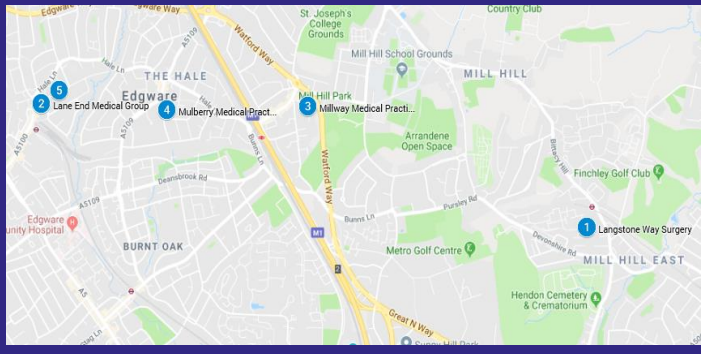
The diagnostics service that will be provided would enable patients to have their test in a setting where they receive other aspects of their care at the same time. The test result would be recorded in the practices and would be directly imported into EMIS. They would then be interpreted by clinicians within the practice who will have access to the patient records so that the results will be contextualised and reported directly into the notes.

A map of Barnet and East Barnet, London, showing 11 numbered locations for medical services. The map includes major roads like A109, A110, and A111, and landmarks such as the South Herts Golf Club and Alexandra Palace. The numbered locations are:

1. Longrove Surgery
2. Longrove Surgery
3. Longrove Surgery
4. Torrington Park Group ...
5. Wentworth Medical Prac...
6. Woodlands Medical Prac...
7. Addington Medical Cent...
8. Lichfield Grove Surgery
9. Cornwall House Surgery
10. Cornwall House Surgery
11. Derwent Medical Centre

[illegible]

CHINs Four, Five and Six



CHIN Four

Clinical Lead: Dr Daniela Amasanti-DeBono

Focus: *Digital*

Population: 44,168

Involving: 5 practices

Road map: *All system partners by Jun 19*



CHIN Five

Clinical Lead: *TBC*

Focus: *Dementia*

Population: 39,154

Involving: 6 practices

Road map: *All system partners by Jun 19*



CHIN Six

Clinical Lead: *TBC*

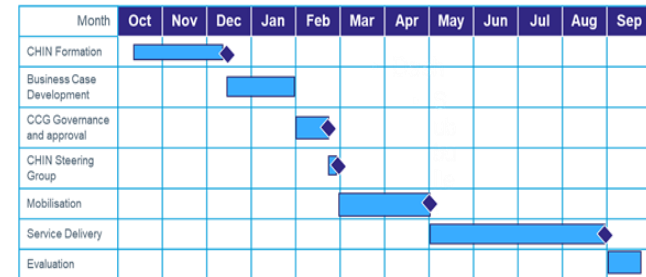
Focus: *TBC*

Population: 34,134

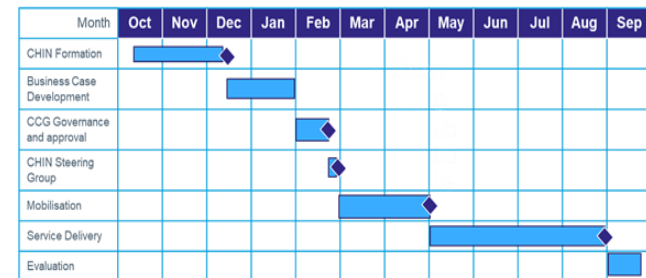
Involving: 6 *practices*

Road map: *All system partners by Jun 19*

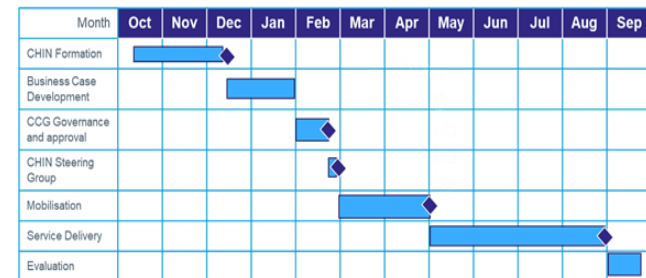
CHIN Four Delivery Timetable



CHIN Five Delivery Timetable



CHIN Six Delivery Timetable



CHINs Next Steps for LBB and CCG

Key Areas of Focus for 2019/20

	Workforce	Primary Care at Scale	CHIN Development	Accelerators / Enablers
Funding Streams	To be determined. Potential national funding or programmes to support this.	£10m top sliced from Extended Access Funding across London Barnet Allocation is £435k	CCG Primary Care Headroom	CCG Primary Care Headroom NHS England central transformation funding Estates and Technology Transformation Funding (ETTF)
Delivery Partners	Primary Care providers Acute and Community Care providers Community Education Provider Network (CEPN)	Barnet Federated GPs Care and Health Integrated Networks (CHINs)	CCG LBB Barnet Federated GPs CHINs CLCH and Royal Free VCSE	CCG LBB Barnet Federated GPs Care and Health Integrated Networks (CHINs) NHS Digital
Overview	New workforce models: MDT workforce with acute and community provider staff working within the Care and Health Integrated Networks (CHINs)	Infrastructure Resources for CHINs Systems and Efficiency QI Capability and Analytical skills 10 High Impact Actions	Pipeline idea generation Develop New Models of Care Operationalising New Models 10 High Impact Actions	Digital Enablers Social Prescribing / Self Care 10 High Impact Actions Transformative Estate
Objectives	Improved Access to Primary Care ED Redirection Direct booking from NHS 111 Paediatric Hot Clinics	Embedded Resources in CHINs QIST function established CHIN Level Functions	Assess QI Findings Engage wider CHIN partners Build into Business Cases Plan, Do, Study, Act (PDSA) and then scale up	Embed digital into all projects (i.e. Apps for prevention, support, etc.) Work-streams mapped to 10 High Impact Actions Implement social prescribing model

Discussion