Mobilisation of a New Risk Tool

Executive Summary

Integrated Care is a strategic change programme deliverable for both Barnet CCG and Barnet Council. The purpose of the programme is to focus on adults who are at higher risk of hospital admission and/or have complex needs, with the aim of delivering improved outcomes; access to more integrated care outside of hospital; a reduction in unnecessary hospital admissions; and enable effective working of professionals across provider boundaries.

Phase One of the programme saw the introduction of case navigators, a Barnet wider multi-disciplinary team meeting (run once a week) and a risk stratification tool; in addition to a number of prevention programmes e.g. Dementia Cafes and the revised falls service. The aim being to provide care coordination with proactive case management, care planning, navigation and sign-posting of people at very high risk and high risk of admission (who have 3 or more long-term conditions (LTCs)).

Phase Two involved piloting a co-located integrated locality team in the West of the Borough.

Phase Three of the programme of work aims to bring together the services established in phase one and two under one umbrella, providing a holistic care model covering care requirements for the agreed cohort spanning primary care, community care and entry points into unscheduled acute care and acting as an enabler for the work currently being mobilised as part of the Finchley Memorial Hospital initiatives as well as the Care Homes and End of Life strategies.

Being able to identify patients who will benefit the most from accessing the services and track the effectiveness of the interventions offered will form a core part of the integrated programme moving forward in order to deliver this objective, Barnet CCG requires a dynamic risk stratification solution to help gain a greater understanding of the changing needs of the local population and to support intelligent commissioning of services.

1 Background Information and Management Summary

There are a number of drivers influencing the approach adopted, key ones are highlighted below:

1.1 National Policy

The Integrated Care agenda is a powerful model for transformational change and service re-design in the way we deliver and manage care for the frail elderly and individuals who are at risk of hospital admission and frequently have one or more long term condition.

1.2 Better Care Fund (BCF)

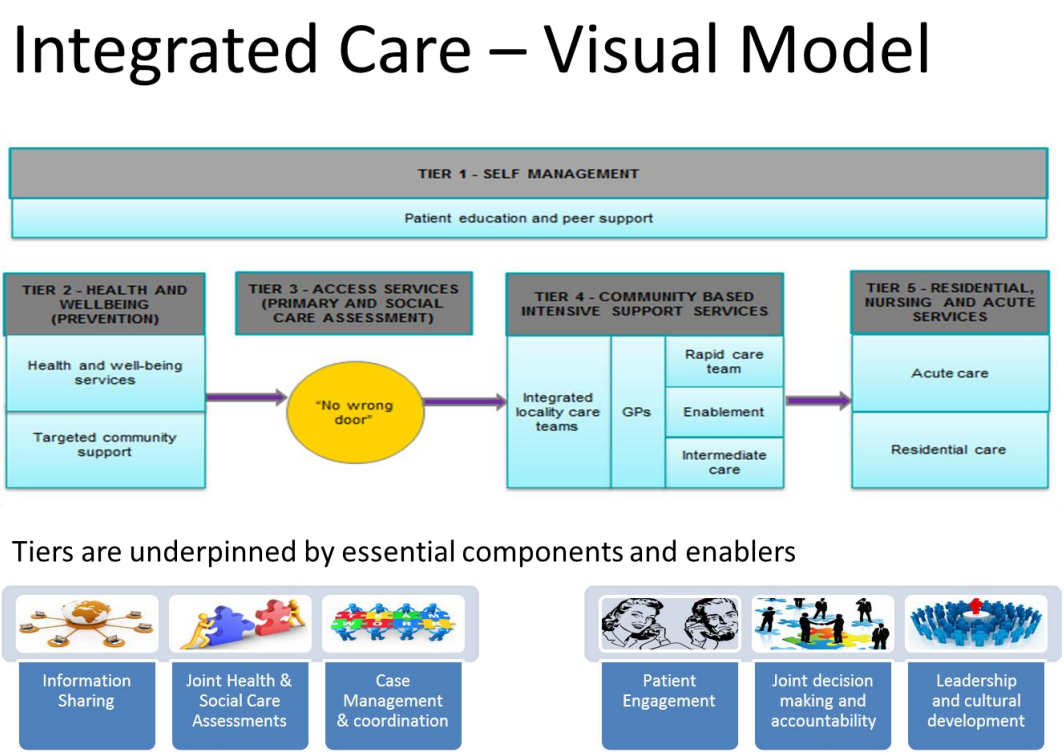
In June 2013 the Government announced the 'Integration Transformation Fund' (ITF) now re-named the BCF. The BCF will be implemented in the form of a single pooled budget of £3.8 billion to enable closer working between health and social care in local areas when delivering services to adults. Additional guidance has subsequently been released[1], detailing the monitoring requirements that CCGs must fulfil. Noteworthy is the section on having robust evidence base and risk stratification to support the implementations that have been identified.

1.3 Admission Avoidance Direct Enhanced Service (DES)

The Admissions Avoidance DES payment incentive scheme for GPs was put in place 2014/15. Under this arrangement GPs signed up to undertaking risk stratification and identification of patients at risk. The DES served as a key enabler for GPs and provided the initial support for our local Integrated Care delivery processes. In 2015/16 NHS England offered a similar scheme under the *Enhance Service* scheme –Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/09/making-it-better-v4.pdf

2 Local Context



Our local model for managing care in Barnet is depicted in the 5-Tier model above; and outlined in the draft Health and Wellbeing strategy 2016-2020. A brief synopsis of the key enablers is outlined below:

- Rapid Care**:** Provides intensive, home-based packages of care to support people in periods of exacerbation or ill-health.

- Weekly Multi –Disciplinary Team Meeting (MDT): The Barnet MDT (Multi-disciplinary Team) continues to bring together all services who work with Frail and Elderly Barnet residents to provide expertise and care planning for those people who have the most complex needs. This service

- Community Point of Access: Receives and manages referrals for adult community health services, ensuring urgent and non-urgent referrals and requests are pro-actively managed to enable rapid co-ordinated care and effective planned care.

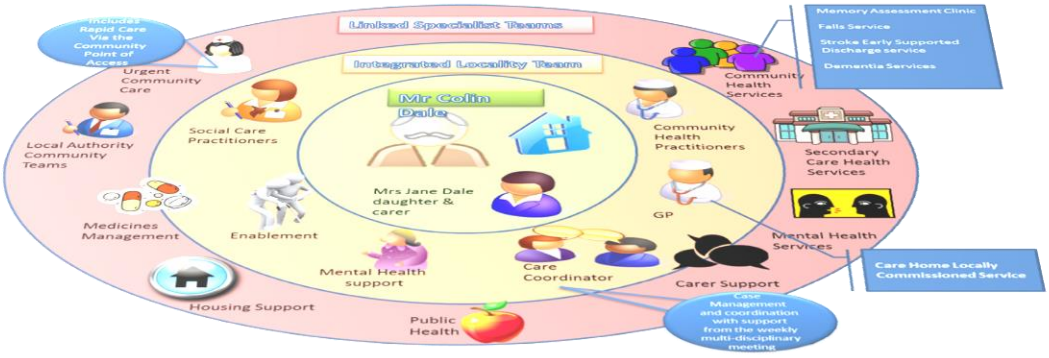
- Case Navigation Service: enables access to local services including community care assessments, and advice on use of personal budgets.

- Integrated Locality Team**:** The pilot of the integrated locality teams, which has been testing models of integration, in the West of the Borough has demonstrated the effectiveness of providing community based care in collaboration with practices. The service is now being mobilised across the North and South localities from August 2016 onwards.

- Older Peoples Assessment Service: Provision of Assessment clinics, Responsive frailty clinics at Finchley Memorial Hospital (procurement commencing in Q2 of 2016).

3 What is being proposed

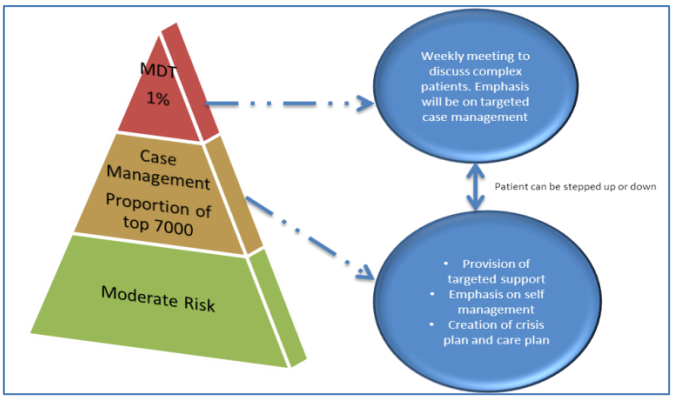
The model outlined below is still focused around patient-centred care delivering early interventions, diagnosis and the management of long term conditions by enabling more alternatives to hospital admission, and providing care closer to home through a pathway of care using a systematic approach.



4 Patient Identification

It is essential that a best practice approach is adopted for identifying patients that would benefit most from accessing the integrated locality team and the older people's assessment service. Van guard sites including Redbridge, Greenwich and WELC have all utilised a risk stratification tool to manage and track patients through the system in conjunction with their existing clinical systems.

Do note that **the resources required for administering the risk profiling tool used to identify and track patients have already been included in the integrated locality team** setup. It is anticipated that this approach will facilitate the process of managing patients within the care triangle (see diagram below).



5 The New Risk Tool

Risk stratification remains one of the central components in the delivery of Integrated Care model in both enhancing quality of care for people with more complex needs and reducing avoidable unplanned hospital admissions.

The new risk stratification tool which will be rolled out across Barnet is provided by Arden and GEM Commissioning Support Unit.

The tool is delivered through Arden and GEM CSUs in-house developed information system, GEMIMA. This is underpinned by the Johns Hopkins University Adjusted Clinical Groups (ACG) algorithm. This well established risk stratification tool has been effectively used by Arden and GEM CSU in Leicestershire (3 CCGs) and Northamptonshire (2 CCGs) since 2013. It is also used in other CCGs nationally as well as having working applications internationally.

Uses and benefits of the ACG Risk Stratification Tool include:

- Case finding – supporting practices to understand that risk is not all about the risk of Emergency Admission. The ACG Risk Stratification tool can identify risk in 6 different domains. A key measure within this is the re-scaled cost index.
- Supporting GP practices to use the tool and reporting output to identify patients with emerging need rather than patients with an already established high need.
- Population profiling – Looking at the distribution of clinical risk in
    a. Care home population
    b. Learning disabilities population, allowing for the identification of several areas of skill and knowledge opportunities in healthcare delivery.
- Helping CCGs understand the fundamental impact of multi morbidity as a driver for emergency admissions.
- Enriching the understanding of elements of primary care quality and performance, using case mix adjustment.
- Uncovering of undercoding of key long term conditions in certain practices.

From a whole system perspective this will enable the local health economy to have access to information that will enable it to:

- Identify patients at risk of future A&E attendances, unplanned admissions and at increased risk of being placed into a nursing or residential home
- Identify the most important conditions, including but not limited to, long term conditions effecting frail and elderly.
- Understanding the variation of risk of future unplanned attendances, hospital admissions and placements in residential or nursing care homes across the local population.
- Allow case finders to identify patients for review for case management intervention and multi-disciplinary team case conference.

6 What Is Involved in Mobilising the New Tool

This section provides a high level view of the actions and steps that will take place over the coming months. It is anticipated that the tool will be accessible to users from October 2016 onwards.

- **Information Governance**[2] – There are a number of information governance steps that will need to be completed by each practice before patient data can be shared with the risk tool provider and before users can access the tool

    - Practices will be asked to sign a new Information Sharing Agreement (ISA) before electronic consent is provided on their EMIS Web clinical system. A draft version of the ISA is attached to this document.

    - Comply[3] with the Fair Processing Notice[4]: Practices will be provided with notices and electronic leaflets which must be available to patients. *An example notice has been provided to show what could be included, the CCG is in the process of drafting generic version that practices can use.*

    - All users of the ACG risk stratification tool will require a GEMIMA user account. Arden and GEM CSU will create accounts for all users rather than ask them to follow the self-registration process. Practices will be asked to provide details on the staff and login details will be sent out.

- **Training** - Users will be invited to training sessions where they will have the opportunity to see the tool first hand and learn how they can effectively use it in their roles. Arden and GEM CSU will take a varied approach to training. Initial training will be for key groups including the integrated locality Team staff; a staggered approach will then be taken for GPs and practice staff.

- **Engagement Activities -** The CCG will initially contact the practices to let them know about the new ACG risk stratification tool and apprise them of the new information governance requirements, what will be required from them and timescales for delivery.

    - Arden and GEM CSUs dedicated team for risk stratification will be able to assist practices with any queries they may have.
    - Existing forums such as locality and practice meetings will be used to keep practices updated. This will allow users to ask any questions, as well as allowing the CCG and the CSU to clearly demonstrate the uses and benefits of the tool.

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[2] https://www.england.nhs.uk/wp-content/uploads/2016/07/risk-stratification-ass-statement.pdf
[3] https://www.england.nhs.uk/ourwork/tsd/ig/ig-fair-process/fair-process-gps/
[4] https://www.england.nhs.uk/ourwork/tsd/ig/ig-fair-process/checklist/