Integrated Care in Barnet

Introduction

Barnet Clinical Commissioning Group and the London Borough of Barnet have been working together to give greater numbers of people in Barnet, of all ages, the opportunity to live healthy, active lives; to help prevent avoidable illnesses, and to manage long term conditions more effectively. Barnet is initially looking at elderly population which is set to rise by 21% over the next 10 years and assuming there are no changes in the existing care pathway and this group continues to access services at the current rates there will be significant pressure on both the health and social care system so changes in how care is delivered are essential to improve patient care and alleviate future pressures.

Many people with long term conditions are often at risk of deteriorating health, reduced wellbeing and lack of independence. This can lead to an increase in hospital admissions, more extensive involvement of health/social care and reduction in control of their own lives. From an individual point of view people want to manage their own lives and remain independent, retaining contact with family, friends and support networks. Barnet CCG and the London Borough of Barnet aim to support people to have the best possible quality of life in a setting at or close to home for as long as possible. From a systems perspective, providing Hospital and Residential care for this group represent significant financial cost to both health and social care budgets. The challenges faced in Barnet in relation to meeting these needs are mirrored in other London Boroughs and across England.

To support these patients, we will continue to redesign and integrate services to meet the population's health and social care needs and to meet people's changing aspirations. Care pathways will be designed to deliver opportunities to prevent a decline in well-being and independence, to offer patients and their family and carers control and choice in the way those needs are met, and to offer a range of early intervention and support services linked to the individual. We will do this by designing integrated Health and Social Care systems and teams working at a local level to support people both in a crisis and with long term conditions. The Health teams will include primary, community and secondary care and we will commission community services which support primary care in delivering this new system.

NHS Barnet CCG working with the London Borough of Barnet is committed to developing a range of long term conditions and rapid response services building on existing progress and expects to see considerable progress in implementation during 2013 to 2016 reflecting a significant reduction in hospital activity as set out in the CCG's strategic commissioning plan.

The London Borough of Barnet and Barnet CCG are committed to the vision of the Barnet Health and Social Care Concordat:

Health & Social Care Concordat

We will work together tirelessly to deliver the Barnet vision of integrated care so that Mr. Colin Dale and others like him enjoy better and easier access to services.

Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money.

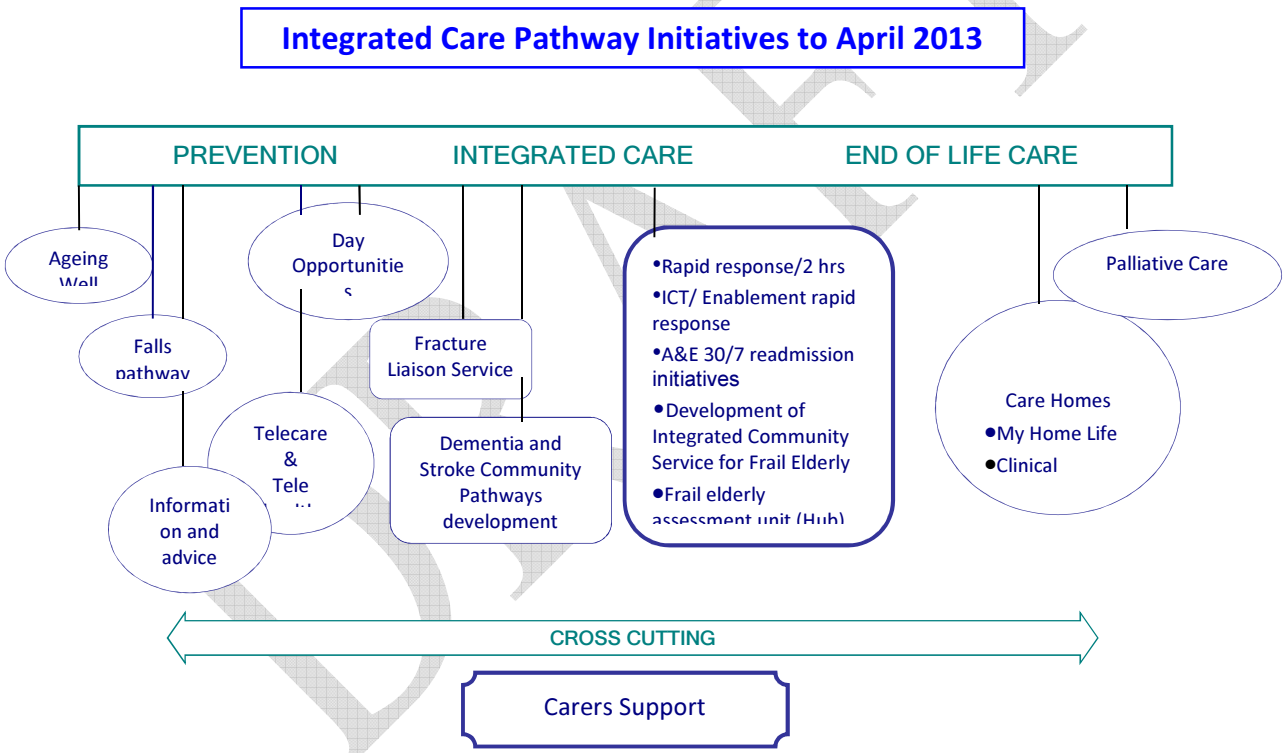
Mr. Dale deserves the best care, at the right time and the right place. When Mr. Dale needs treatment, support or care, he will cross organisational boundaries effortlessly, supported by professionals who take responsibility for his whole care and treatment journey, regardless of who they work for

For Mr Colin Dale this will mean:

1. He has enough information and support to allow him to look after himself as much as possible without having to rely on others
2. His care is planned so that when he becomes ill he knows that he can get help quickly to manage his illness and to keep him out of hospital where possible
3. He knows who to call when he needs help and they know all about him
4. If he has to go to hospital he knows that care and support will be put in place to allow him to come home as soon as possible
5. If he needs a care home in the future he knows that it will give him the best possible quality of life
6. Care towards the end of his life will be co-ordinated and will allow him to die in the place that he chooses
7. He knows that everyone providing his care is well supported and the system helps them to learn from each other and develop better care for others

Current Picture

In 12/13 there were a number of engagement events to ensure that general practice, secondary care and social care professionals had the opportunity to consider the options for redesign of the care pathways for frail and elderly people. As a result a number of initiatives have commenced or are currently being implemented. The diagram below illustrates the current programme for the Integrated Care Pathway to date for older adults, with flows to projects.



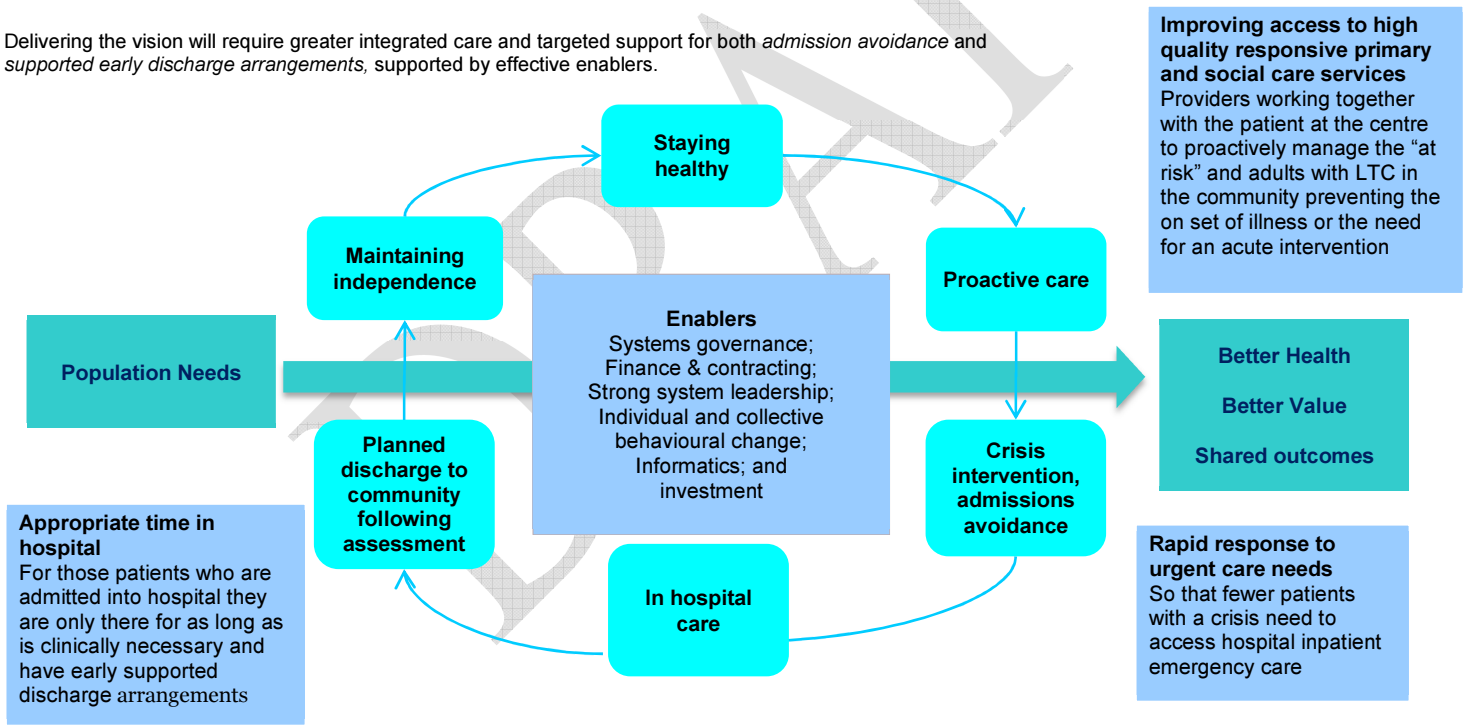
Key achievements to date include:

- Intermediate Care Team 2 hour Rapid Response service operational initiating early intervention in the community with primary care
- Procurement of Risk stratification tool identifying those at risk in the community and where intervention may be required
- Care Navigators being recruited to proactively support general practice to review and assess their frail and elderly population. Intervention, to implement a preventative plan and ensure that individuals are appropriately sign posted to services and facilitated to access support where required
- Multi-Disciplinary Team arrangements agreed to allow for higher risk individuals, identified through risk stratification and managed by care navigators, to be referred for detailed review and active management of a care plan
- Palliative Care Service in place (PCSS)
- TREAT service at A&E at Royal Free Hospital to prevent admission, and geriatrician input at Barnet A&E
- Redesign of Falls Pathway and Fracture Liaison Service
- Redesign and improved integrated service specification for Dementia care including early diagnosis via memory clinic
- Improvements agreed and planned for the care of Patient who have had a stroke including, identification and treatment of those at risk, improved early support discharge capacity and improved follow up reviews
- Advance care planning pilot for Barnet GPs completed in Care Homes
- Care Homes pilot (building on themes of My Home Life) commenced. Pilot aims to establish strategies and appropriate support to reduce hospital admissions and support the development of better care standards in managing patient care in Care Homes

Integrated Care Delivery Model for 2013-14 Onwards

Evidence from similar projects across the country illustrates that there are many differing ways to integrate care. However, a consistent factor is that successful integration is best achieved through whole-system working focussing on a specified set of agreed objectives and outcomes as outlined in the diagram below. Inherent in all models is maintaining independence and self care management , managing complex care in the community, rapid response to urgent care needs and coherent discharge from acute hospital admissions to the community with support.

Integrated Pathway



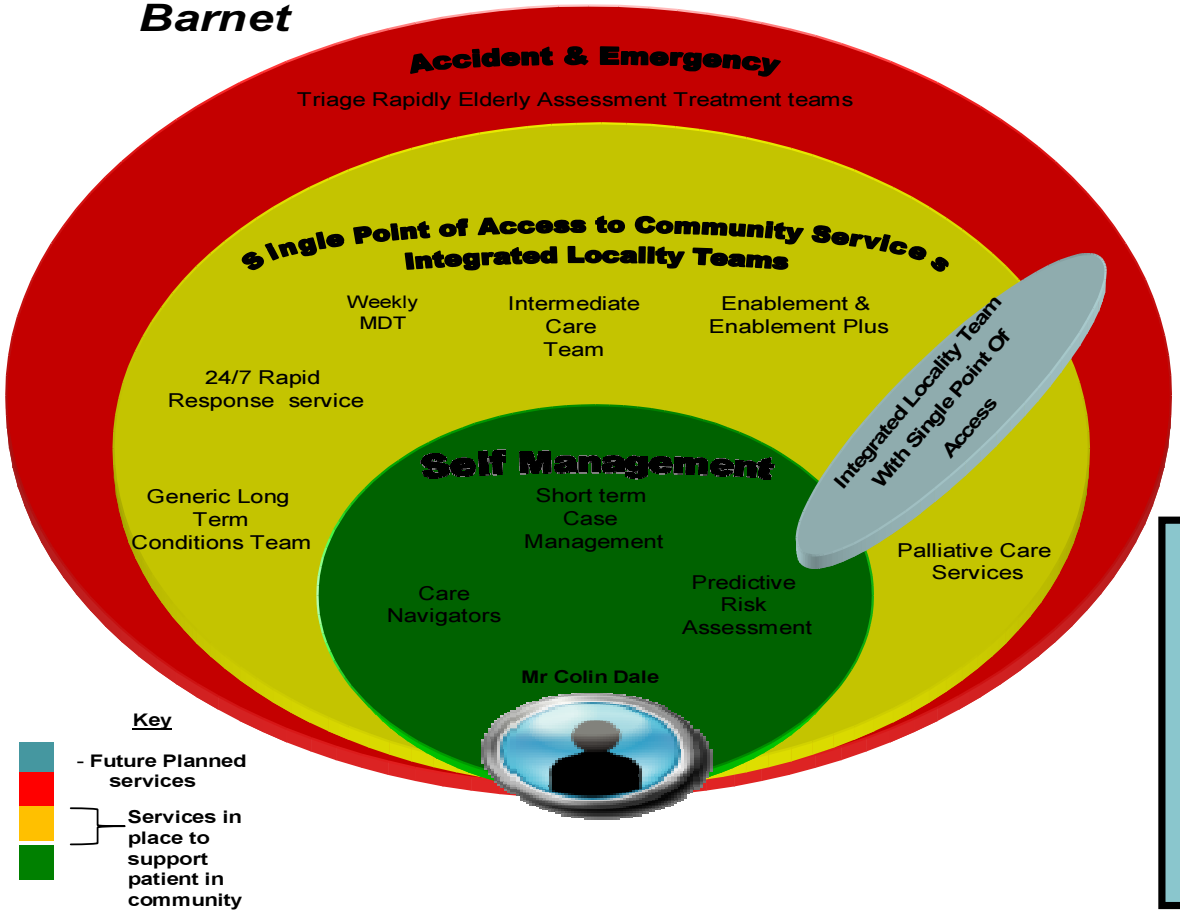
Barnet Model

Central to the future delivery model in Barnet is the development of a fully integrated care team based in each locality. The teams will incorporate health and social care and will address patient need through a single point of access. The locality based teams will be designed to support and manage care from self-management through periods of crisis, and into end of life pathways where necessary. A raft of services (existing and new) will be aligned to link with the locality based teams providing a seamless flow for patients. Integrated teams will include primary, community and secondary care services and the CCG will commission a range of services to support primary /community services in delivering these plans.

This will also involve working closely with and integrating with LA social care services. This framework will help to ensure that patients avoid hospital admission where possible, and are able to return home following a hospital episode as soon as possible with appropriate support to maintain independence. The models will, as stated previously, support in managing Barnet's increasing ageing population and increases in the number of people with multiple long-term conditions.

The Barnet model is represented below and tables indicate where Barnet is in terms of current development going into place and the planned Actions to take forward to 2013/14:

Integrated Care In Barnet



- Generic Long Term Conditions Team
- Advanced Care Planning
- Older Adults Assessments Clinic
- Expand Rapid Response to 24/7
- Robust Assessment at A&E Barnet Hospital
- Review Discharge Arrangements From Secondary Care
- Fracture Liaison Service
- Falls Service
- Stroke Service
- Dementia Hub With Memory Service
- Care Homes Pilot
- Telehealth / Telecare
- Care Home Support

Service Development

Building on the work of the Kings Fund and linking it to the Barnet delivery model we have highlighted below some of the key areas of focus for commissioning of integrated care in Barnet through to 2015. This prioritisation draws out the areas where greatest impact is needed to create an environment that will support the development of integrated care; and outlines how the work is supported by rationale, evidence, impact assessment and examples of good practice from elsewhere.

Progress in Barnet has been framed in line with these priorities highlighting current and planned projects, and programme focus for 2013-14 and beyond. This section is outlined in **bold** at the end of each section

Care coordination through integrated health and social care teams	
What is it?	Creating patient-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health care systems. Providing the appropriate, timely and co-ordinated crisis care to prevent admissions and to support end of life care pathways
Why is it Important?	• Co-ordination of care for people with complex chronic illness is a global challenge. Driven by broad shifts in demographics and disease status, long-term conditions absorb by far the largest, and growing, share of health care budgets • Co-ordination of care for patients with complex needs and long-term illness is currently poor, and those with long-term conditions have a lower quality of life • Patients are frequently admitted to hospital when it is not clinically justified because of a lack of alternative options • A&E attendances continue to grow with a 30% increase between 2003/4 and 2011/12 • Two thirds of people would prefer to die at home, but in practice only one-third actually do • Costs of caring for people at the end of their lives is estimated to run into billions of pounds (National Audit Office 2008)
What is the Impact?	• Robust evidence on health outcomes is limited, but improved care co-ordination can have a significant effect on the quality of life of older frail people and people with multiple long-term conditions and hospital

	admissions. • Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience. • Impact on costs and cost-effectiveness is less easy to predict and is likely to be low in the short term given the upfront investments required. However, health systems that employ models of chronic care management tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction
How to do it	There is no one model of care co-ordination, but evidence suggests that joint commissioning between health and social care that results in a multi-component approach is likely to achieve better results than those that rely on a single or limited set of strategies and include : • a move to community-based multi-professional teams based around general practices that include generalists working alongside specialists • a focus on intermediate care, case management and support to home-based care • joint care planning and co-ordinated assessments of care needs • personalised health care plans and programmes • named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey • Clinical records that are shared across the multi-professional team. • Clearly defined signposting routes Care for Older People in Torbay provides a good example of the kind of change required. Torbay established five integrated health and social care teams organised in localities aligned with general practices. Care co-ordinators support older people following an emergency hospitalisation, helping them to receive the intensive support required to enable them to live at home. Northamptonshire Integrated Care Partnership focused on helping patients remain independent for longer and creating personalised care plans for high-risk individuals that aimed to reduce admissions to hospital. It developed a new community-based service for patients at the end of life and a multidisciplinary care service for older people to support independent living in the community
Currently implemented	• ***Rapid response service established. Operating over 7 days from 8am to 10pm. Referrals accepted Monday – Friday only***

in Barnet	• ***Risk stratification tool being rolled out to GP practices*** • ***Palliative Care Service in place*** • ***Advance care planning pilot completed in Care Homes*** • ***Care Home pilot underway building on 'My Home Life'***
What we plan to do in Barnet	• ***Extend the rapid response service to 8am-10pm 7 days per week 2013-14*** • ***Introduce care navigators to proactively manage patients in the community with transparent management plans back to GP and linking to signposted services Q1 2013-14*** • ***Establish weekly multidisciplinary team reviews for complex patients Q1 2013*** • ***Establish shared patient /client care records to ensure a robust and integrated approach to care management*** • ***Set up Fragility clinic at FMH to include with input and co-location of Geriatricians, psyhogeratrics ,OT, Physio, Memory Clinic, Parkinson's and Diabetic clinic so patient can have coordinated approach during one visit . Q3 2013-14*** • ***Develop Integrated locality care teams supporting Long Term Conditions and Rapid Response including COPD, Heart Failure, Stroke, Dementia and End of Life Care Q3 2013-14*** • ***Establish single point of access to locality based integrated care team 2014-15*** • ***Comprehensive Falls Service roll out Q2 13-14*** • ***Stroke pathway re-design implemented Q2-3 2013-14*** • ***Dementia hub planned Q2-3 2013-14*** • ***Assess and support the use of integrated care services by Care Homes (eg Rapid Response) Q3 2013-14*** • ***Link IAPT with delivering service to those with long term condition*** • ***Establish robust Older People's assessment at Barnet A&E 13-14*** • ***Review discharge process to ensure smooth transition between hospital and home 14-15*** • ***Review current process/pathway for community palliative care and link with enablement and expand services Q2 2013-14*** • ***Implement advance care planning across all care agencies, including primary care 13-14***

Self-Management & Primary Care (including prevention)			
	Self-Management	**Prevention**	**Managing ambulatory Care – sensitive conditions**
What is it?	Self-management support can be seen in two ways - as a range of techniques and tools to help patients choose healthy behaviours; and a fundamental transformation of the Patient–caregiver relationship into a collaborative partnership	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.	Ambulatory care-sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include heart failure, diabetes, asthma, epilepsy and hypertension.
Why is it Important?	•Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years • People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days.	•More systematic primary prevention is critical in order to reduce the overall burden of disease in the population and maintain the financial sustainability of the NHS. • It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated. • Addressing this clustering, and its socioeconomic determinants, is likely to reduce inequalities and improve	•Despite admission being largely preventable, a significant proportion of all acute hospital activity is related to ACS conditions. In England ACS conditions accounted for 15.9 per cent of all emergency hospital admissions in 2009/10 • There is significant variation in how effectively ACS conditions are managed – emergency admissions per head vary more than two-fold between local authority areas after adjusting for the differences in age, gender and deprivation

	• Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England • Around 70–80 per cent of people with long-term conditions can be supported to manage their own condition	overall population health.	•These admissions are costly. The total cost to the NHS in 2009/10 was estimated at £1.42 billion for a core set of 19 ACS conditions
What is the Impact?	• Self-management has potential to improve health outcomes in some cases, with patients reporting increases in physical functioning • Self-management can improve patient experience, with patients reporting benefits in terms of greater confidence and reduced anxiety. • Self-management has been shown to reduce unplanned hospital admissions for chronic obstructive pulmonary disease and asthma and to improve adherence to treatment and medication and further evidence that this also translates into cost savings.	•Primary prevention is an excellent use of resources compared with many treatments. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80 per cent cost less than the £30,000 threshold used by the National Institute for Health and Clinical Excellence for cost effectiveness • Community-level campaigns to improve health behaviours, such as No Smoking Days, have been found to be very cost-effective (£82 per life year gained)	•Maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes. • Emergency admissions to hospital are distressing, so better management that keeps people well and out of hospital should lead to a better patient experience. • According to The King's Fund estimates, emergency admissions for ACS conditions could be reduced by between 8 and 18 per cent simply by tackling variations in care and spreading existing good practice. This would result in savings of between £96 million and £238 million. This calculation may significantly underestimate potential

			savings as admission rates in all areas are significantly above what should be achievable.
How to do it	There are a number of well-established self-management programmes that aim to empower patients to improve their health and the evidence indicates the importance of ensuring the intervention is tailored to the condition e.g • Structured patient education can be beneficial for people with diabetes • people with depression may benefit more from cognitive and behavioural interventions. • Other plans with patients could include the opportunity to co-create a personalised self-management plan which could include patient and carer education programmes, use of	Evidence-based interventions include: supporting individuals to change behaviours, for example, through brief advice during a consultation; systematic community interventions in schools to reduce childhood obesity; and regulatory actions, such as controlling the density of alcohol outlets . In many areas, a strategic approach using a combination of interventions at the individual and societal level is likely to be most effective. NHS England, acting in its new role as the single purchaser of NHS primary care, has an important opportunity to ensure that primary prevention is implemented systematically and at scale.	Early identification of ACS patients is crucial if their management is to be successful. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices. Some progress can be made through relatively simple measures such as expanding vaccination, where available, to prevent the onset of a condition. For other ACS conditions (chronic and acute aggravated conditions), commissioners will need to encourage active disease management. A review of evidence (Purdy 2010) suggests that many evidence-based self-management interventions should be implemented and evaluated locally eg• support for self-management for those with long-term conditions. In addition, it also suggested that improvements in the quality of primary care are needed,

	telecare, medicines management advice (as examples		to manage people without the need for secondary care intervention
Currently implemented in Barnet	• ***Provide limited patient expert diabetic education programme*** • ***Joint working with LBB on Advice and Information Strategy programme to develop trusted information centres for patients and web portals***	• ***Public Health Barnet leads an effective Smoking Cessation Service has established*** • ***Flu and Pneumococcal vaccination programme***	• ***Good established management of COPD in Community including pulmonary rehab and case management*** • ***Increasing dietetics support*** • ***Falls Pathway redesigned and agreed by Stakeholders***
What we plan to do in Barnet	• ***Develop self management programmes following on from the implementation of the risk stratification tool eg diabetes*** • ***Identify and introduce additional support to strengthen primary care management of long term conditions*** • ***Multi-disciplinary Inhaler improvement project*** • ***Provide framework***	• ***To develop further prevention programmes in collaboration with partners, particularly public health*** • ***Integrate key primary prevention messages throughout pathways.*** • ***Implementing the use of the GRASP tool in primary care to identify and treat those at risk of stroke*** • ***Implement Fracture Liaison Service*** • ***Increase dietetic support in Community***	• ***Identify and implement ACS pathways*** • ***Improve long term condition management of ACS conditions in Community particularly Heart Failure*** • ***Review discharge process to ensure smooth transition between hospital and home*** • ***LBB Care Homes pilotIntegrated Care in Barnet draft 170613***

	(inclusive of IT support) to link self management plans to local integrated teams in terms of crisis management		