

Integrated Care Value Case

Northamptonshire, England



November 2013

This Value Case has been commissioned by the Local Government Association with support from the national partners on the integrated care and support collaborative

Guiding principles for the value case:

The overall goal of this work is to develop value cases which are:

- Aimed at Health & Wellbeing Boards

And incorporate:

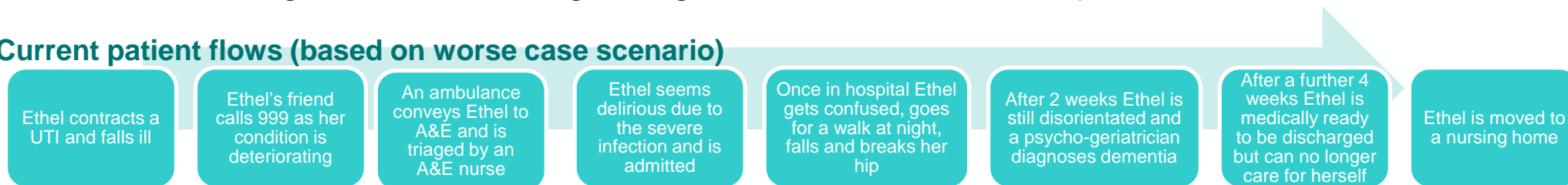
- Service user stories, capturing changes to the service user's journey
- Features of the model, including enablers (e.g. technology initiatives to support the model)
- Costs of the model
- Evidence of benefit, including activity, spend and outcomes

We recognise that the information contained in the value case may prompt further questions, in which case we recommend you use the contact details at the end of the value case to follow up with a direct contact.

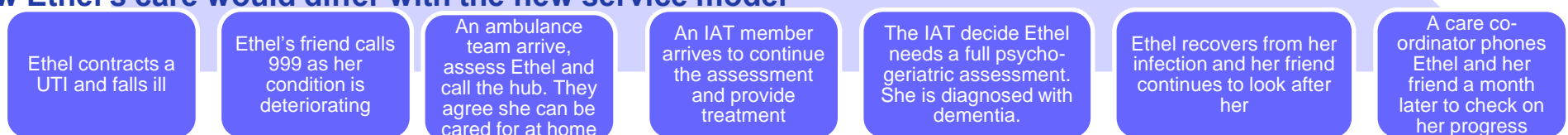
About Northamptonshire Frail Elderly programme

- Northamptonshire has a growing and aging population. Previous investments have been made in reablement services, however patients continue to remain in hospitals longer than necessary, with the 2nd lowest rate of independence after an admission to hospital when compared to similar counties.
- The Northamptonshire Integrated Care Partnership (NICP) started the Frail and Elderly Programme in July 2012, aimed at patients aged 75+. Five interventions were implemented:
 - Multi Disciplinary Teams (MDTs)
 - Crisis intervention by community geriatrician led 'Crisis Response Teams' (CRTs)
 - Admission avoidance at A&E by managing the crisis through a co-ordination hub
 - In reach service by the acute hospital geriatrician to work with the integrated area teams
 - Discharge to assess through integrated teams into the 'hospital at home' environment

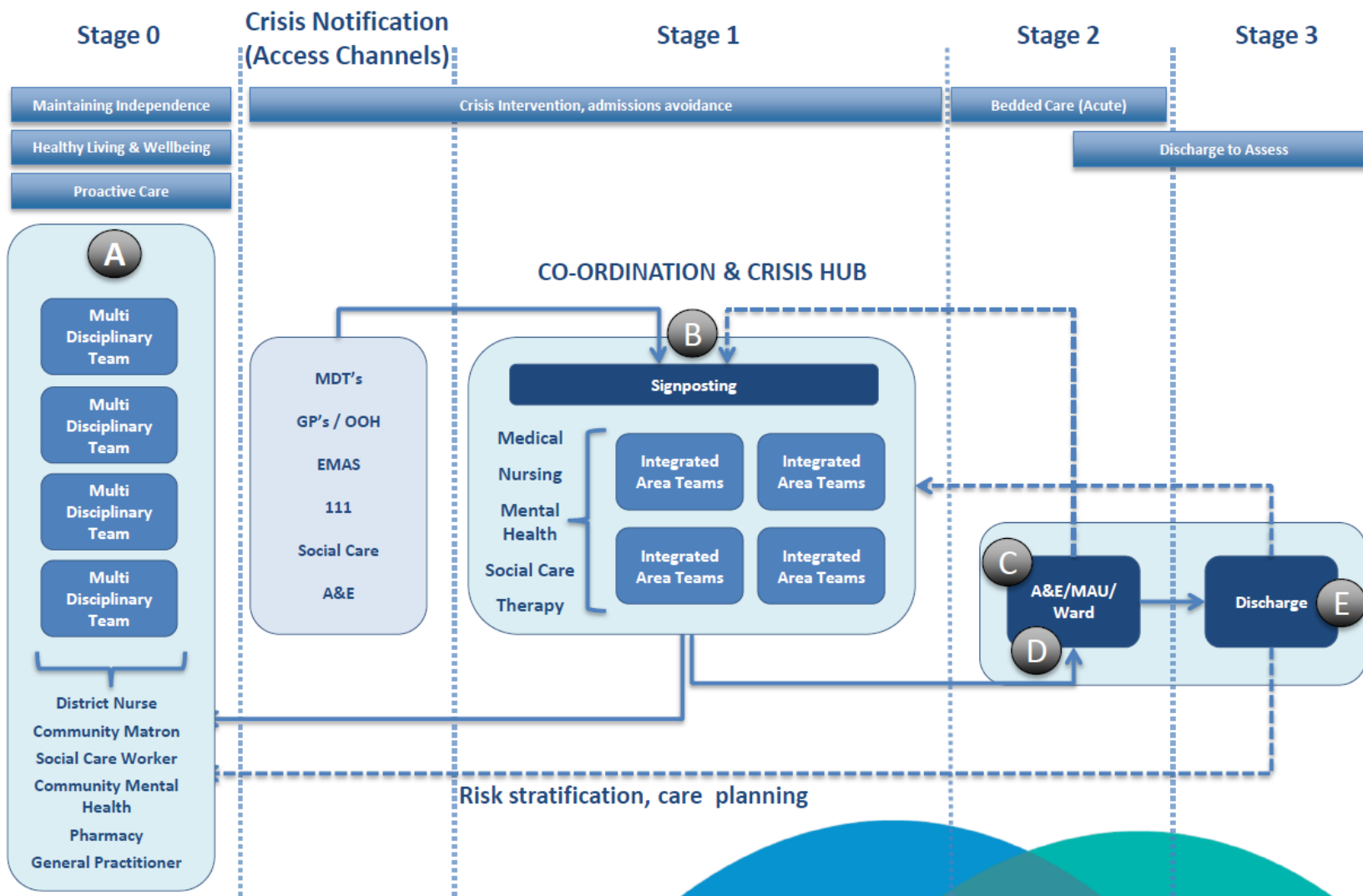
Current patient flows (based on worse case scenario)



How Ethel's care would differ with the new service model



Northamptonshire Frail Elderly visual model



Frail Elderly programme stakeholders

- Nene CCG
- Northamptonshire County Council
- Corby CCG
- Kettering General Hospital
- Northampton General Hospital
- Northamptonshire Healthcare NHS Foundation Trust
- Age UK
- Northamptonshire Carers
- Northamptonshire Volunteer Centre

Outcomes evidenced by Northamptonshire Frail Elderly programme: What difference does it make?

User experience

- 87% of CRT service users felt that the team had enabled them to have maximum choice, control and independence
- 98% reported that the support that they had received made a difference to them

Frontline staff experience

- 100% of staff who undertook the service bespoke education evaluated that they were fully aware of current issues in practice
- 100% felt they were prepared through bespoke education to effectively undertake their role

Health & wellbeing outcomes

- In FY12/13 1,095 patients were assessed in accordance with Evidence Based Clinical Guidelines (NICE) for Falls
- 80% were referred for a medication review

Impact on institutional care

- In FY11/12 an additional 1,893 patients were treated in the community by ICT/CECS
- Prevented emergency inpatient admissions targets have been exceeded by 14%
- Prevented excess bed days exceeded target by 21%
- Case load per annum targets exceeded by 4%

Impact on cost

- CECS made a net saving of £1.5m in FY11/12
- Savings of £3.5m for prevented admissions, £800K from excess bed days, £900K for prevented readmissions from SCCs and £22k for community treatment of class 2 cellulitis

Productivity

- Over 40% of CRT referrals originated from the falls ambulances. Almost 50% of these were made for the purpose of avoiding hospital admissions and 43% sought to aid falls discharge from A&E departments.



“This is an excellent service – gave me a sense of being cared for”

“They treated me with a lot of care and support”

How we did it: key enablers

Governance

- Commissioners Management Board – governance across Nene CCG, Corby CCG and the Local Authority
- County Leaders Group (CLG) assumes overall accountability for strategic vision and the outcomes delivered by the programme
- Supported by the Frail & Elderly Board who are responsible for managing the contract with the service provider

Integrated team working

- CECS (the Community Elderly Care Service) delivers a responsive appropriate alternative to hospital admission
- Uses an extended Integrated Care Team and works flexibly with consultant geriatricians and psycho-geriatricians to enable the delivery of care at home and in the community

Information management and technology

- Analysis of patient information across organisations to identify those most at risk and enable proactive care services to be put in place
- Access to reliable, up-to-date patient information across all of the organisations involved to help in the event of a crisis

Legal and contracting models

- Ideal Model of Care (IMOC) developed with a system wide alliance contractual model

Financial enablers

- The total spend on Frail and Elderly Services is divided by Ideal Model of Care into different proportions contributing to: Healthy Living & Wellbeing, Proactive Care, Crisis Intervention & Admissions Avoidance, Bedded Care (acute), Discharge to Assess, and Maintaining Independence. Funded disproportionately by NCC, KGH, NGH, NHFT, and EMAS
- NCC has reinvested funding to provide additional Care Managers and a dedicated START team in each Specialist Care Centre (SCC)



“The support team made me feel useful again in life. I felt as though life was worth something”

What we did: integrated care design

Crisis Intervention Hub

- Rapid co-ordination of the appropriate multi-agency frailty crisis response following a call from an initial assessor of crisis (GP, ambulance A&E etc.)
- Single operational budget from both health and social care

Joint assessment

- Each professional interaction is designed to identify health and/or social care risk and minimise or reduce risk through person-centred care and interventions
- Clinical risk is minimised through the use of paramedics and the utilisation of both NICE Guidelines for falls and elements of the Comprehensive Geriatric Assessment
- The service has flexibility to deliver both social and health related care to those who used the service

Multi Disciplinary Teams (MDTs)

- Function to provide co-ordination of health and social care package to maintain independence
- Visible care plan with carer involvement

Information Technology

- Two access portals: one for patients, one for health and social care professionals
- A GP-Acute integrated system that acts as the master medical record
- Joint health / social care portal – providing information to Acutes, the co-ordination Hub & integrated area teams
- Reporting / risk stratification system which includes data from all health and social care systems

Equipment

- CECS commissioned 18 Specialist Care Centre (SCC) beds with enhanced medical and nursing support to offer an appropriate alternative to hospital admission for elderly patients with “sub-acute” medical needs



“The team made me feel more confident after a fall. They advised me of items and ‘classes’ that they felt would help me to retain my independence. This is very important to me.”

Who we did it for and why

Users and carers

- Restore confidence to patients after falls
- Provide respite for carers and provide support and advice
- Support patients to be discharged effectively and look after themselves
- Reduce occurrence of isolation and associated depression
- Provide a rapid response in an emergency
- Allow people to feel at ease by remaining in their own homes

Workforce

- Development of 'value based care' across social care roles to improve outcomes
- Widen participation of learners across care roles
- Facilitate access to higher education (HE) for social care staff
- Promote and foster continuing professional development

Organisational boundaries

- Flexible delivery model which was able to provide an immediate paramedic, social care or intermediate (health) care response
- Development of trust across emergency, health and social care organisations
- Development of information sharing across organisations
- Commitment to the development of all staff on all IT systems across health and social care (Care First and System One)

General public

- Valuing older age in Northamptonshire
- Promoting an independent, healthier and socially engaged older population in Northamptonshire
- Helping older people to live how they want live



“The team gave me confidence, while at my lowest point”

“It was a great help for my wife (my fulltime carer), it gave her some respite and gave her strength to continue to care for me”

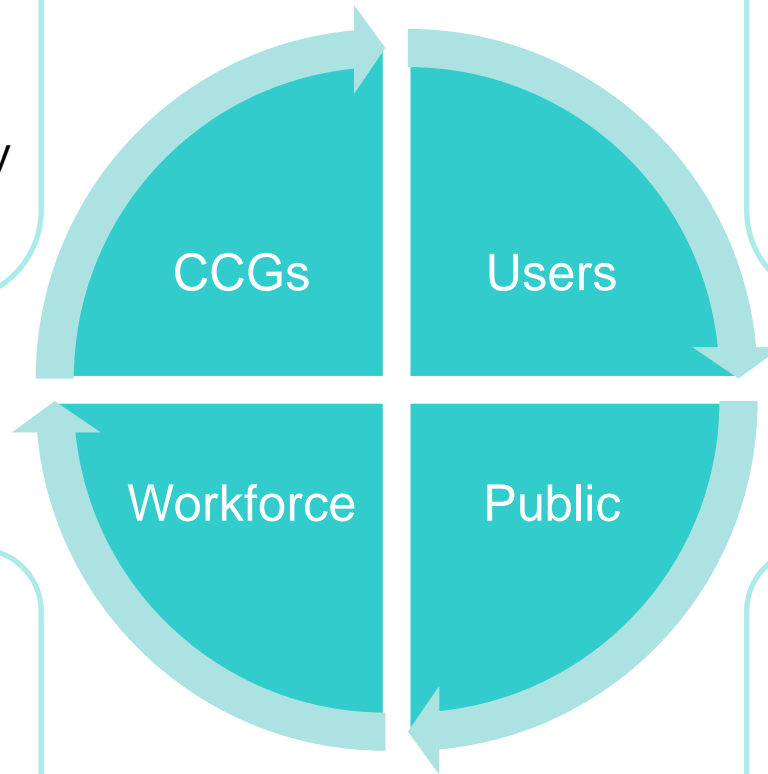
Benefits

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- Optimised management of LTCs
- Rapid discharge from acute care
- Reduced spend
- Showcase frail and elderly best practice to the national health economy

Benefits

- Visible care plan with carer involvement
- Co-ordinated health and social care package with maintains independence
- Increased patient satisfaction



Benefits

- Value based care
- Improved knowledge, skills and attitudes
- Continued development
- Outcome focused

Benefits

- Maintenance of independence in the elderly population

Lessons learned

Users and carers

- Some patients have no access to transportation in order to allow them to access services
- Some patients require ongoing encouragement to continue attending exercise programmes, self-help groups etc.
- Provide better communication methods with patients and their carers about the service

Marketing

- There is a lack of awareness among health and social care professionals of the various services that exist within the healthcare system which are provided by the community or the healthcare sector
- There is a lack of referrals to CECS from home by GPs for admissions avoidance in relation to treatment of cellulitis
- Since CECS established new money has been invested into elderly health and care services which has created confusion about what is provided by CECS. At the same time demand has increased, straining capacity - this has created the perception that CECS is not effective

Workforce & relationships

- There is a reluctance/unwillingness to share risk between commissioners and providers
- Historical approaches to health and care provision (and tasks) can be difficult to challenge

Leadership

- Be new, creative and innovative with commissioning of services
- Be prepared to challenge historical practices and boundaries
- Use investment funding to create a better tomorrow



“We wish all support and care provided was to this high standard. The best we have received to date”

Contact details

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