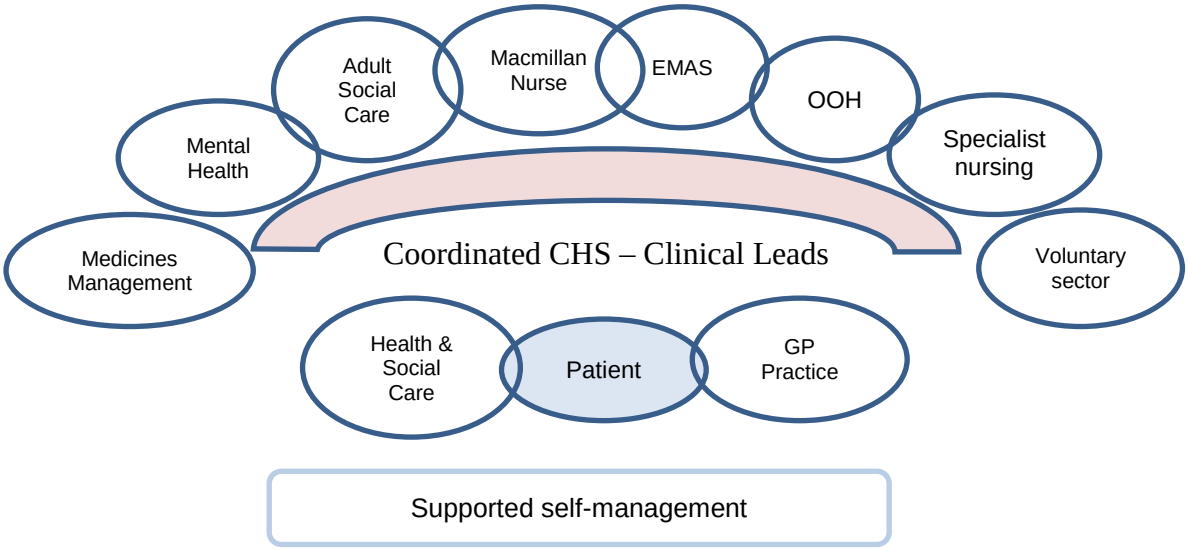
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
IUR2
Scheme name
Integrated Hub (Joint working between CHS and RCC)
What is the strategic objective of this scheme?
A whole system response is required to ensure a fully co-ordinated and integrated service offer is developed, to truly prevent adults and older people from experiencing unnecessarily protracted admissions and for them to have the greatest opportunity for recovery so as to be able to return to their own homes. By bringing our resources together to have an integrated pathway of home based support which can support people more effectively within their own homes.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A Practice Population based Model The overarching philosophy around the development of an Integrated Coordinated Health and Social Care is: • A practice population approach clustered around GP practices • Admission to secondary care should be the last resort for any patient where it is clinically appropriate • Discharge home from acute care should be achieved as quickly and efficiently as possible • Health Services should be delivered at, or close, to a person's home wherever possible. • Development of joint funded or co-located health and social care posts, to reduce duplication and provide more seamless services. • To ensure an integrated, seamless pathway exists for people who are at risk of falls, or who have experienced one or more falls. The 'integrated hub' will ensure alignment with ELRCCG's plans for transforming primary care services and redesigning community services as out lined in the CCG's 2-year operational plan and the LLR 5 year strategy The diagram below shows how patients are at the heart of the integrated model, supported in the community by a multi-disciplinary team comprising Primary Care, Coordinated Community Health Services (CCHS) and Integrated Care Coordination (Social Care) couple with effective links to a wider range of services, including the Independent Care Sector.

Putting the Patient at the Centre of Services
Integrated Community Health Services, Primary Care and the wider Multi-Disciplinary Team



Core components of the Hub model:

- Locality Hub will have arrangements in place for clinical leadership of nursing (clinical case managers), and professions allied to medicine (occupational therapy and physiotherapy) delivered through multi-disciplinary teams.
- Locality hub will include operational management and administrative support
- Multi-disciplinary teams for delivery of 'planned care', each serving a 'cluster' of General Practices with a registered list size of c.30-35,000. Planned teams will deliver:
    - Planned pathways of health and social care for people with long term conditions, older people, people with Continuing Health Care (CHC) needs and people at the end of their life, to deliver integrated care plans and case management.
    - Support GPs in delivering care plans for patients aged 75 and above (named GP)
    - Work with GPs and Integrated Care Coordinators (social care) to support risk stratification and care planning
    - Support self-care and provision of patient and carer information, including patient-held records which include a care plan detailing the patient's nursing and therapy needs.
    - To proactively identify and prevent falls in susceptible people/situations, also advise and provide training to care homes and health and social care teams in falls prevention and management so that falls awareness and assessments are part of every contact.

- A multi-disciplinary and integrated unscheduled care service comprising:
    - An unscheduled care team containing nursing staff, professions allied to medicine and health care support workers
    - Intensive Community Support (ICS)
    - Integrated Crisis Response Service (ICRS)
    - Reablement

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The integrated hub is a new scheme and the delivery chain is not defined currently. Work will be completed in identifying current pathways into and out of services, the programme will link with some elements of the Better Care Together LLR 5 year strategy – long term conditions and planned and unplanned care work programmes. The delivery will be from existing assessment and provider services, Gp practices, community nursing services and social care organisations. It will also consider the role of the voluntary sector and other council services in an integrated response to identified need.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence from cross-cultural examples indicates that integration is most effective when it is targeted towards people with severe, complex and long-term needs. It is best suited to frail older people, those with long-term chronic conditions and mental health illnesses and those requiring urgent care. It is most effective when it is population based and approaches the holistic needs of a patient, rather than being based on the patient's condition. The Evidence suggests that condition-based approaches to integration can create silos and thus lead to different types of fragmentation.

- **The King Fund – case for Integrated care 2011**
- **Nuffield Trust – preventing hospital readmissions**
- **The King Fund – making our health and care systems fit for the ageing population 2014**
- **Safe and Compassionate care for frail older people – using an integrated pathway practical guidance for commissioners, providers and nursing, medical and allied health professional leaders NHS England**

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Anticipated outcomes are:
- To facilitate early secondary care discharge (reduction in LOS)

- To reduce impairments attributable to long term conditions
- To rehabilitate patients to their optimum level of functioning
- To promote social inclusion where appropriate
- To enable the development of patient capability in self directing their care and self-manage their conditions
- To enable patients to end their lives in the place of their choice

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key Performance Indicators outlined under the following broad headings:
<u>Waiting times & Access times</u>

- Urgent – visit within 2 hours of referral to SPA
- Non–urgent – Assess within 48 hours
- Routine – Assess within 5 working days of receipt of referral
- Waiting times compliance of 95% within target

<u>Intensive Community Support (ICS)</u>

- Overall Occupancy of 95%
- Average length of Stay – 26/27 days (c.640 patients per annum)
- Waiting time compliance meets the above standards (95% compliance)

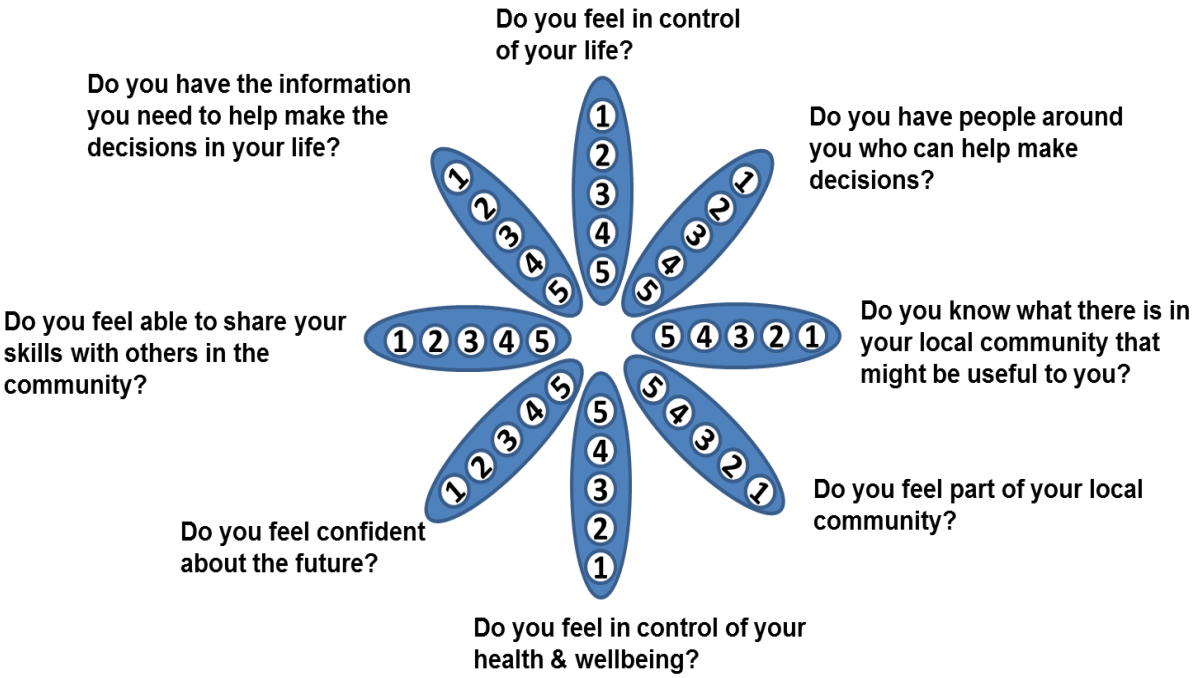
<u>Patient Focused KPIs</u>

- Percentage of patients who feel that they manage their condition better after accessing CCHS – achieve target of 90%
- Percentage of patient dying in their place of choice – achieve target of 95%
- Named key worker on patients record
- Health and social care plans integrated so the person only has to tell their story once.
- Patient experience – improve by 10% on 2013/14 baseline
- Care Plan – identification and use of care plan agreed between GP practice & service
- Reduced number of injuries and hospital admissions due to falls.

<u>Outcomes to be reported Monthly</u>

- Number of avoided GP home visits
- Number of avoided GP appointments
- Number of avoided 999 calls

- Number of avoided A&E Attendances
- Number of avoided unplanned Hospital Admissions
- Number of avoided emergency medical readmissions for over 75s



Have Health agreed to use this within their planned and unscheduled services that this Annex relates to ????? If not suggest delete - Pt focused KPI requires some way of measuring which needs to be clarified

What are the key success factors for implementation of this scheme?

Factor	Explanation
Partner engagement	The success of the scheme is dependent on appropriately communicating with partners, and the creation of multi-disciplinary and multi-agency representatives who work in an integrated way to identify and meet need.

Assessment criteria and tools	The success of the scheme depends upon the ability to identify and support the vulnerable individuals in the community (i.e. those who are likely to enter the care system over the next 3- 5+ years). The return on the investment will be helping individuals *who would otherwise have needed acute and secondary care.* Therefore it depends upon successfully identifying these through suitable assessment criteria. A triage approach will be necessary to ensure that those who reach the more intensive levels of support are eligible for service and those who need prevention services are signposted appropriately.
Monitoring & KPI tools	In order to evaluate the progress of the individual and the success of the project, there must be realistic, measureable and agreed KPIs. The service must improve outcomes for users, deliver efficiencies for providers and contribute to the identified need to reduce hospital admissions. The scheme will link with the Better Care Together unplanned and planned care service models.
Governance & escalation	Governance is a challenge in any partnership programme. The governance of this programme should enable clear and transparent assessment and escalation of risks. This can be achieved through: Agreement on the KPIs of the programme; Clear routes for issues escalation and resolution; Clear and transparent progress reports; Senior sponsorship from relevant partners; Consistent governance across districts/ areas
Support System & tools	In order for the scheme to be as successful as possible, there must be appropriate supporting systems and processes in place. An important element is the ability to have access to the right information and advice and signposting of available community assets. The available tools to access these services will be a key enabler to this aspect of the role. These tools will include the community agents service and the information and advice service – which are also better care fund schemes as well as access to the Reablement and crisis service.