



Changing the Landscape Through Integrated Care

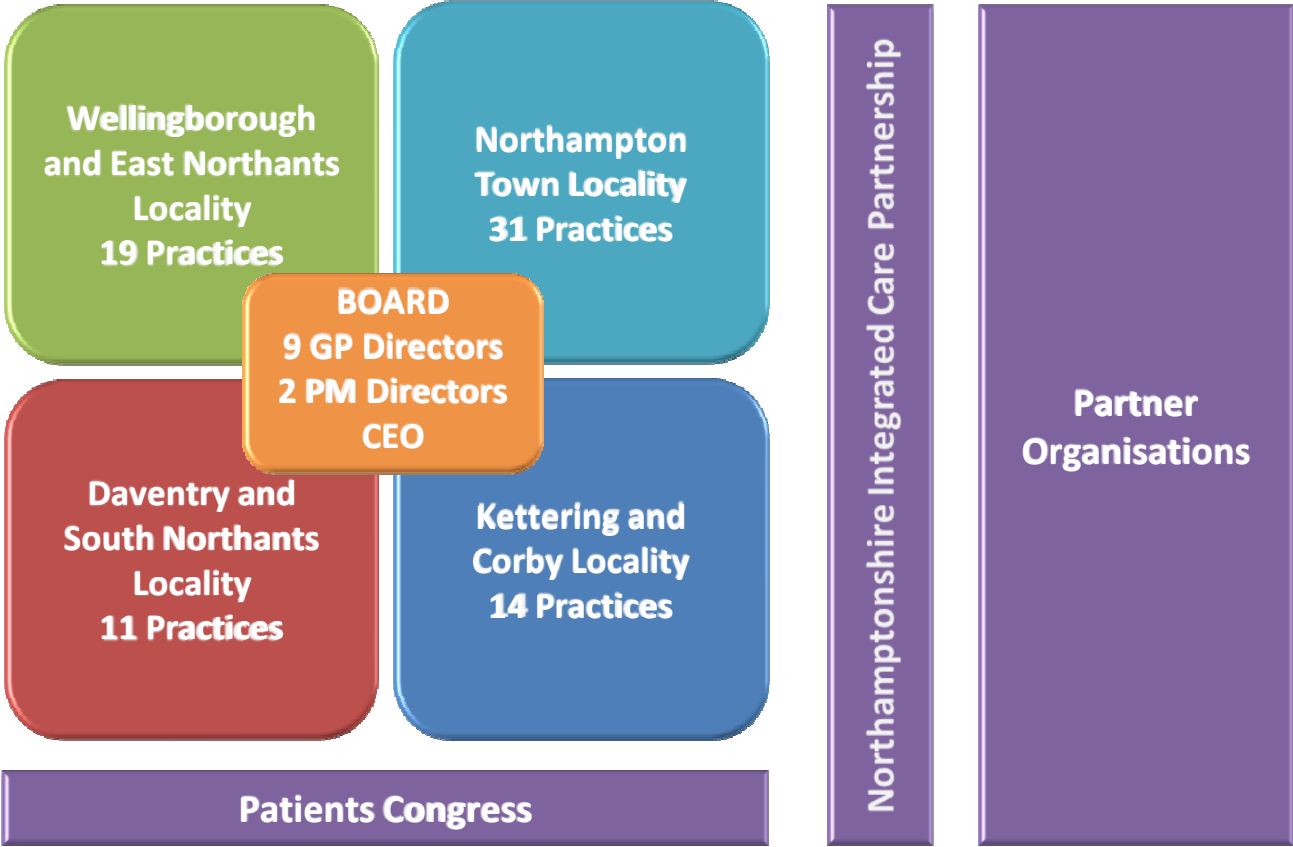
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Nene Commissioning

6 Key Fundamental Requirements for Successful Integration

- Clinical engagement and leadership
- User involvement in shaping services
- Partnership “no blame” culture
- Identify the buttons
- Delivery of product
- Robust approach to business case production

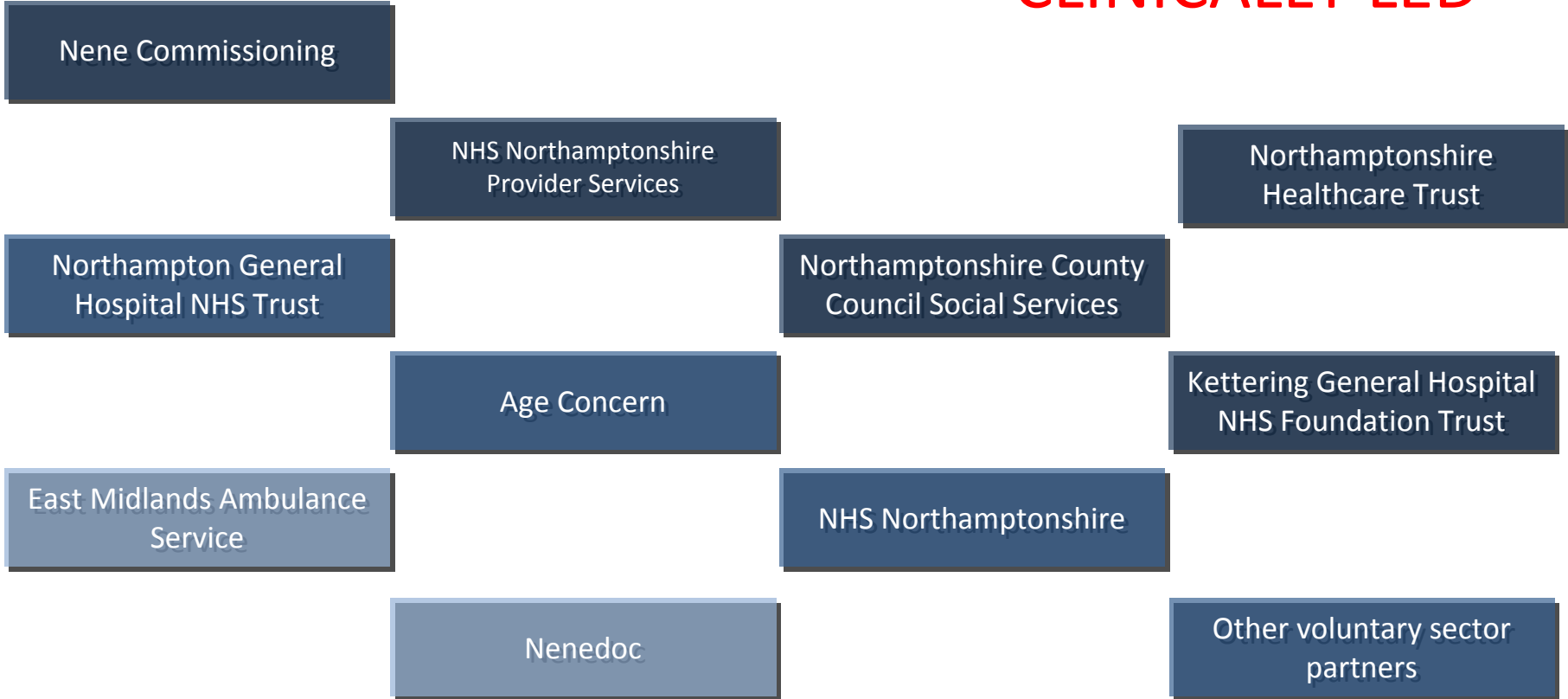
National Nene Commissioning PBC

How We Work



Northamptonshire Integrated Care Partnership – Who We Are

CLINICALLY LED



Critical Success Factors to Achieving Top 5 Outcomes

NICP Workstreams

Roll out of Pro Active Care/ Extended Case Management

To date 65 GP Practices participating
PAC team = GP, DN and trader
Weekly PAC Team meetings
Robust case finding
Strong clinical leadership
CN backfill deployed – additional 24WTE



Development of business case to commission telehealth services



Identification of appropriate patients for deployment of equipment

Work with NCC to develop processes to install equipment in patient homes

Telephone support for patients at risk score level 2



End of Life

Commission end of life community services to include:

- Rapid response Service
- Care co-ordination centre
- Additional night and day sitters
- Link nurse in NGH
- Extension of current hospice provision



Urgent Care

1) GP in KGH hospital to work in A&E and wards to identify patients who either could be prevented from admission or discharged quickly and safely due to primary care expertise



2) BMAS Primary Care protocol
Ambulance staff contacts GP Practice where transit to hospital is not deemed appropriate



3) Care homes
Strengthening of contract management arrangements



4) Community Geriatrics Service
Thoughts on the model include a community based MDT to include geriatric consultants, physio, tissue viability nurses, community matrons (linked with our Pro Active Care practices), pharmacy, social services case management and mental health specialists.



Medicines Management

Initially small pilot to test logistics.



Pharmacist to visit PAC patients on discharge from emergency admission.

Pharmacist to undertake medication review to include compliance and waste management

Potential to roll out beyond PAC patients

Potential to utilise skills of community based pharmacist

Depression Management

Develop pilot in Corby to improve depression management for patients with COPD



Identify all COPD patients with one or more emergency admission

DN to undertake mental health assessment tool with each patient

Where applicable signpost to wellbeing teams
Follow up assessment in 6 weeks

Improve concordance with antidepressants based on the evidence provided by the STAR*D study



Personal Health Budgets

Targeted at BME community and to be rolled out in 3 phases:

- Mental Health
- Stroke
- Carers – through the Carers Demonstrator site work

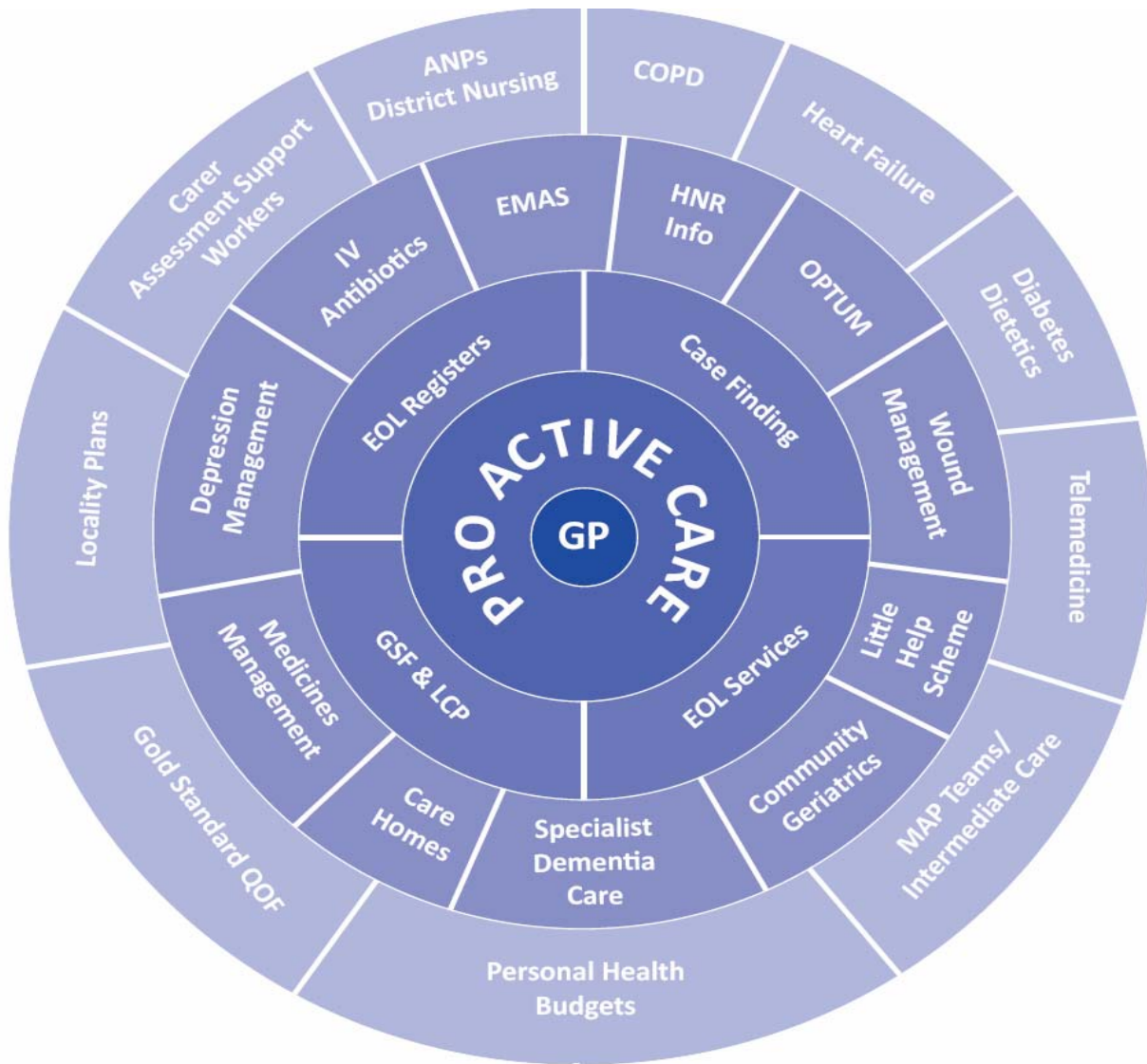
Aim for the first year will be for 50-100 people receiving personal health budgets. Gateway reviews will be held every six months to evaluate progress and make any changes to the programme.



Top Five Outcomes

A	Reduction in emergency admissions
B	Reduction in readmissions
C	Reduction in care homes LOS
D	Reduction in hospital LOS
E	Increase in the number of patients who wish to die at home

Pro Active Care: Platform for Integration



Pro Active Care

- Face to face case management approach
- GP, Advanced Nurse Practitioner, District Nurse, Tracker, Age Concern working in partnership
- Focus on top 1% of population at highest risk of hospital admission – target 6,000 pop
- Started July 2008 with 12 practices, 62 practices now engaged
- 26.5 WTE community nurses now recruited
- Daily “live” A&E data from both hospitals sent to practices weekly to assist with case finding
- Hospital discharge teams refer directly into PAC

Pro Active Care (Results)

- 1963 individual patients since starting in July 08 - 13,597 reviews in 24 months
- Jan 09 to Dec 09 393 individual patients supported
- 45% reduction in emergency admissions for these patients (679 down to 374)
- Developing whole system support through NICP – links with hospitals, social services, voluntary service, Eol and CECS

End of Life Community Services (Commence Nov 10)

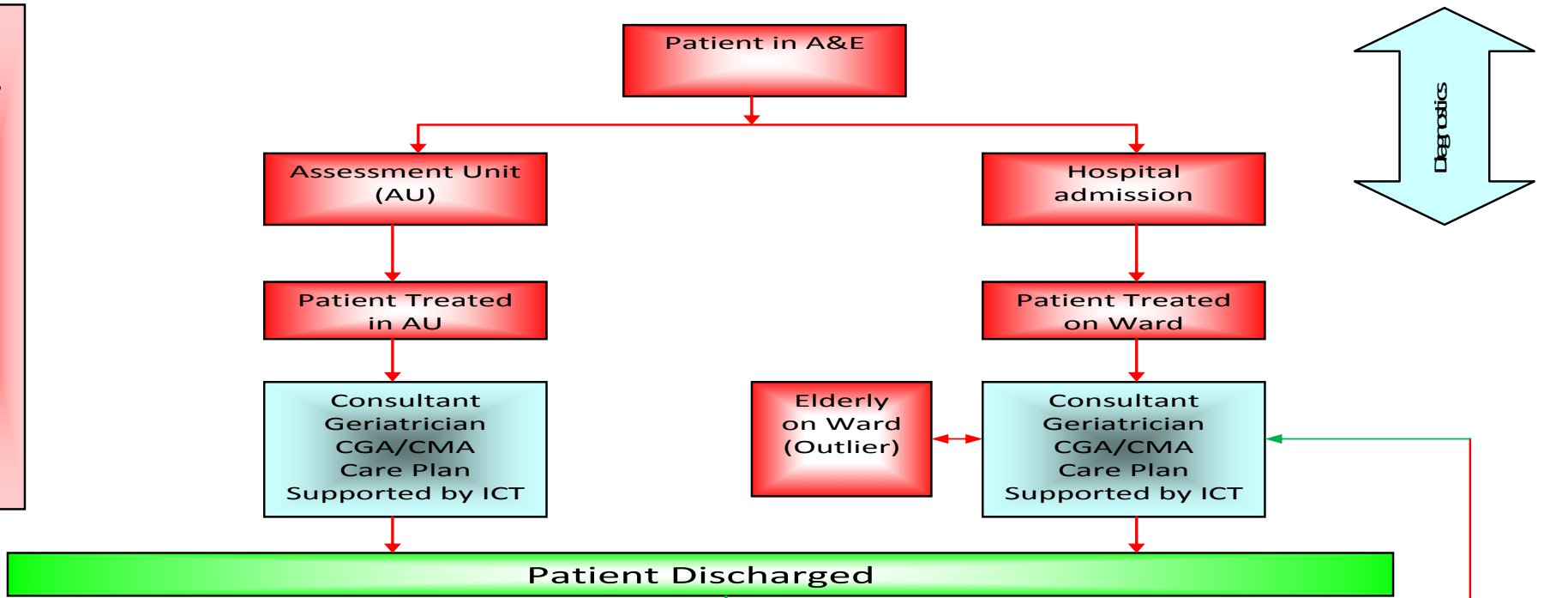
- Care Coordination service 24/7
- Rapid response service
- Primary care link nurse in acute hospitals
- Increase the proportion of deaths that occur at home from 20% to 29.34% - top decile

Community Elderly Care Service (Commence Dec 10)

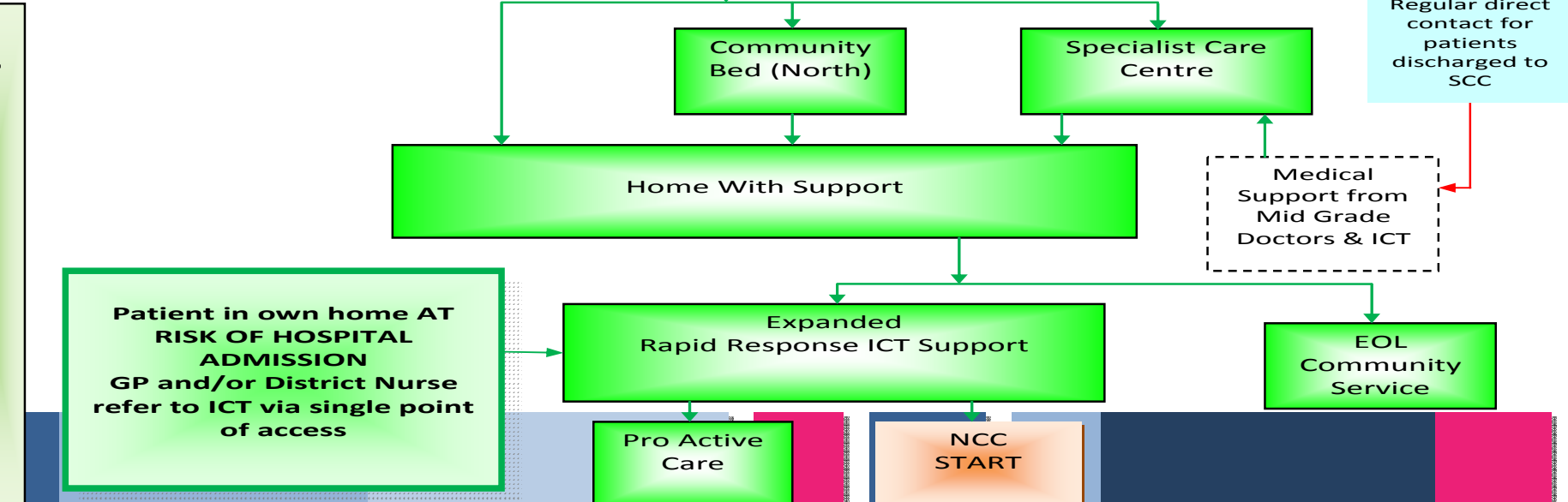
- Consultant led with multi disciplinary support
- Comprehensive Geriatric Assessment
- Links to Care Homes & Specialist Care Centres – additional START & Case Managers
- Provision of ICT countywide – increase of 40%
- Primary/secondary care audit results – initial findings 30% of patients could be supported in the community
- Prevention of 2,100 emergency admissions for elderly, frail patients

Community Elderly Care Service

HOSPITAL BASED 1000am to 600pm



PRIMARY CARE BASED 800am to 900pm



Thank You

Questions/discussion