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Focus on the impact of Population Health Management on Integrated Neighbourhood Teams

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Integrated Neighbourhood Teams

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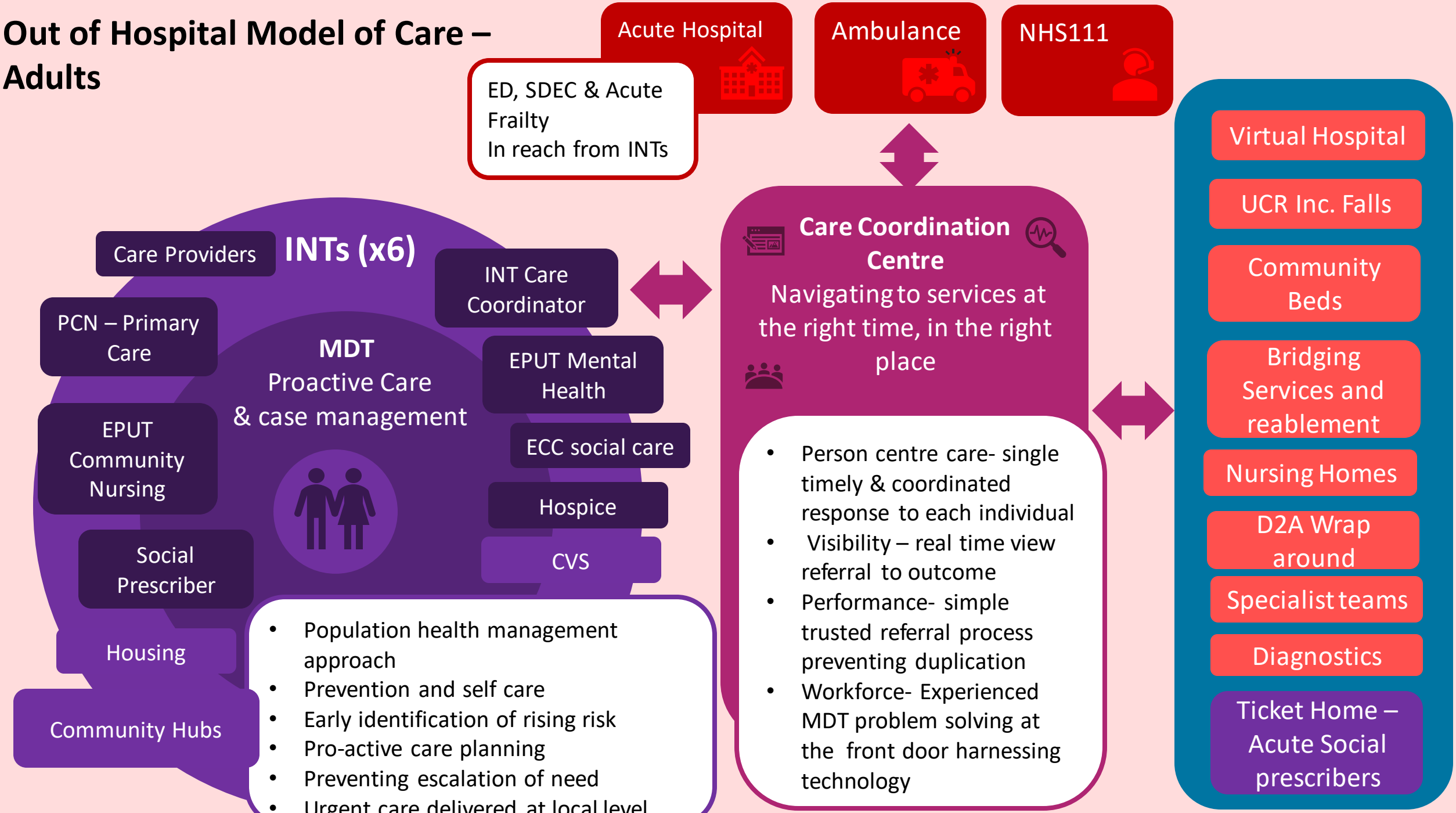
Out of Hospital Model of Care – Adults



Integrated Neighbourhood Teams - Vision and Success Criteria

Integrated Neighbourhood Teams Vision Statement:

"Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population"

01.

Person Centred Care

Each Integrated Neighbourhood Team will ensure individuals have person centered care plans coordinated by a named lead professional

02.

Pro-active

Each Integrated Neighbourhood Team will respond to information shared to pro-actively identify the needs of individuals and the local population

03.

Performance

Each Integrated Neighbourhood Team will enable collaborative, flexible working with simple care pathways that prevent duplication and develop trust across the team

04.

Workforce

Each Integrated Neighbourhood Team will bring together a skilled workforce of professionals across health and social care, supported by a single leadership team, to promote multi-disciplinary problem solving and utilise all available community assets

West Essex Health and Care Partnership

Developing INT Function 3. Pro-active care planning , care delivery and management of complex patients

Aim

To work as an Integrated Neighbourhood Team to support our complex patients, through pro-active care planning and delivery, enabling earlier intervention and prevention, and reduction in escalation of need, improving outcomes for our population.

Approach

1. To design, test and implement our Integrated Neighbourhood Team model for Pro-active care planning, care delivery and management of complex patients.
2. Taking a Population Health Management approach to cohort identification including risk stratification
3. Working as a multi-disciplinary team (MDT) supported by an INT Coordinator
4. Assigned named lead professionals
5. Caseload of between 30-50 patients.

Principles

1.We learn to understand and customise care for Adults based on **conversations.**
2.We do not provide a current service to someone; we **build services around needs** not prescribe solutions
3. Named Lead Professionals will be assigned based on **what matters most to the adult.**
4.We understand and respond to the Adults with **what they need, when they need it.**
5. Adults won't be discharged from the caseload. We **stay with the Adult** and their network, each interaction is not a new one, it is a **continuation**.

Expected Short Term Outcomes

Improved experience for the adult and their household/carer
Improved experience for workforce

Expected Medium Term Outcomes

Reduction in escalation of need, avoiding unnecessary hospital admissions for cohort
Proportion of people with a long term condition who feel able to manage their condition
Improved quality of life

Expected Long Term Outcomes

Increased Healthy Life Expectancy
Increased Life Expectancy

Building the bridge from ICB Outcomes to HCP Ambitions and Priorities

WE HCP Aim	Indicators (source: indicator library)	Quality Measures	Linked HCP Priorities	Linked HCP Ambitions	Tier 1/2 ICB Outcomes
To work as an Integrated Neighbourhood Team to support our complex patients, through pro-active care planning and delivery, enabling earlier intervention and prevention, and reduction in escalation of need, improving outcomes for our population.	Quality of life of people living with a LTC Rate of hospital admission within our frail population Proportion of people living with frailty who have an improvement in their clinical frailty score post an event Rate of unplanned hospital admissions for ambulatory care sensitive conditions Proportion of people with 4 or more non elective admissions in the preceding 12 months Proportion of people who are still at home 91 days after discharge from hospital Rate of emergency admissions within 30 days of discharge from hospital	✓ Improved staff experience - MDT Survey ✓ Improved service user experience – National GP Survey using question: *"In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition (or conditions)?"*	(8) Increase in the proportion people having their needs met in a community based setting avoiding the need to attend hospital. (4) Increase in the proportion of people living independently with long term conditions and with a perception of wellbeing.	Age Well – People live safely and independently as they age.	Increased life expectancy Increased healthy life expectancy Proportion of people with a long term condition who feel able to manage their condition Quality of life (indicator to be agreed) Reduce the rate of ambulatory care sensitive emergency hospital admissions Reduce the overall spend on emergency hospital admissions

Integrated Neighbourhood Teams - Proactive Care Blueprint

Identify the Cohort

Identify cohort using Population Health Segmentation Model.

Apply risk stratification to prioritise cohort based on the needs of your neighbourhood (PCN Data Pack).

EMIS/S1 Reports written, supported by ICB PHM Team and run in PCN patient record systems.

Support developing an effective intervention for the cohort using logic models

Add to the Caseload

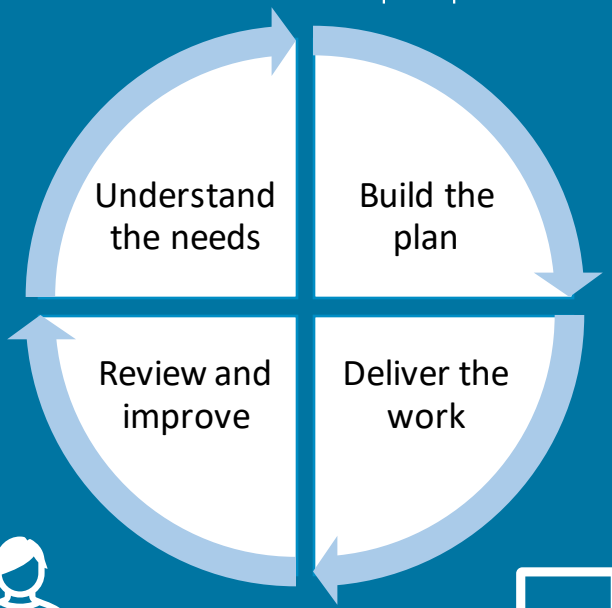
Review prioritised cohort with INT.

Agree who and how to make first contact with the adult.

INT Care Coordinator adds adult to the Caseload – SNOMED Code "On Integrated Care Pathway" 818241000000105.

Delivering Proactive Care

Named Lead Professional



INT Coordinator

Shared Care Record

Continuous improvement cycle

- Iterative development of cohort and intervention
- Evaluating impact and outcomes

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How has Population Heath Management added value at each stage?

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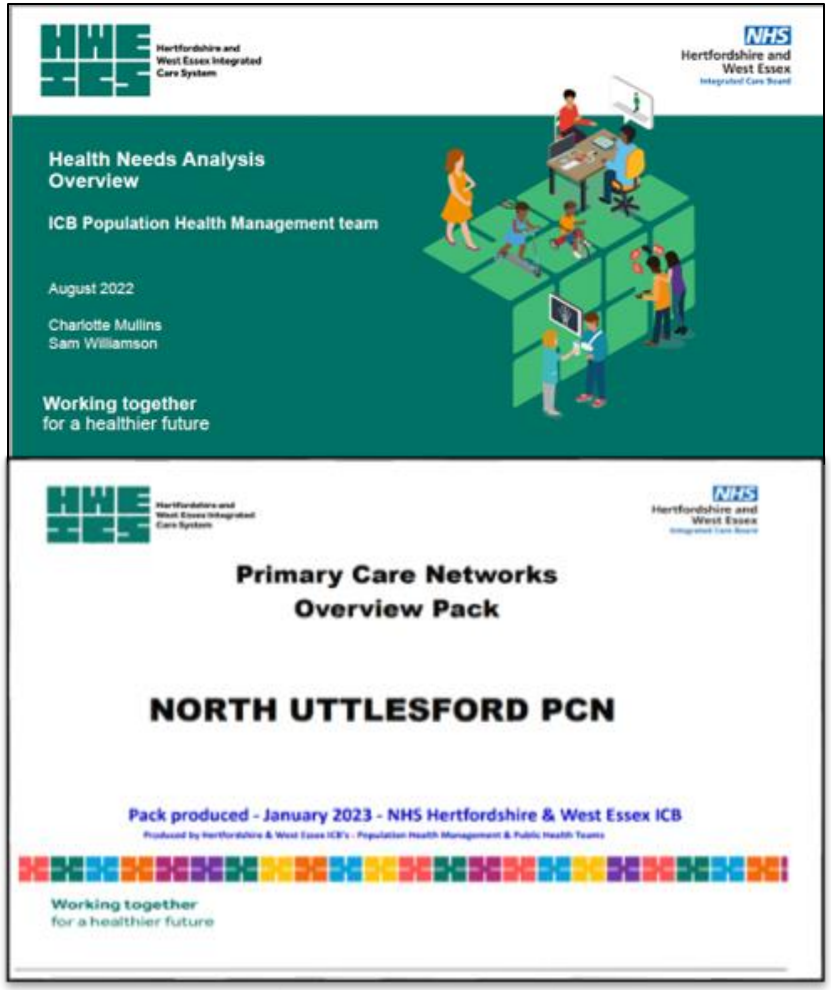
Preparatory work – Understand the needs of the population and identify an opportunity

Work with the PHM team, local clinicians and other key stakeholders. Review local data and identify PCN priorities.
Example resources:

1. High Level Needs Analysis (2022)
2. PCN Packs (2023)
3. Urgent and Emergency Care Needs Analysis (2022)
4. Consideration of ICB Clinical Priorities (2023)

Area	Clinical Priority
CYP	• Improved Readiness for school in children eligible for FSM • Reduce rates of Childhood obesity • Reduced unnecessary A&E attendances and admissions
Prevention and Health Inequalities	• Reduced premature mortality rate for CVD
LTC & Frailty	• Reduce attendance and admissions for falls, people with frailty and people in last year of life • Development of more proactive, preventative care models for management of LTC and Frailty
Mental Health	• Reducing suicide rates and attendances/ admission rates for self-harm • Reducing rates of A&E attendances involving substance misuse and violence
Maternity	• National recommendations to be implemented and linked quality issues with local providers requiring ICB clinical transformation support. • Neonatal urgent care pathways



Step 1 – Identifying the cohort

Identify the Cohort

Identify cohort using Population Health Segmentation Model.

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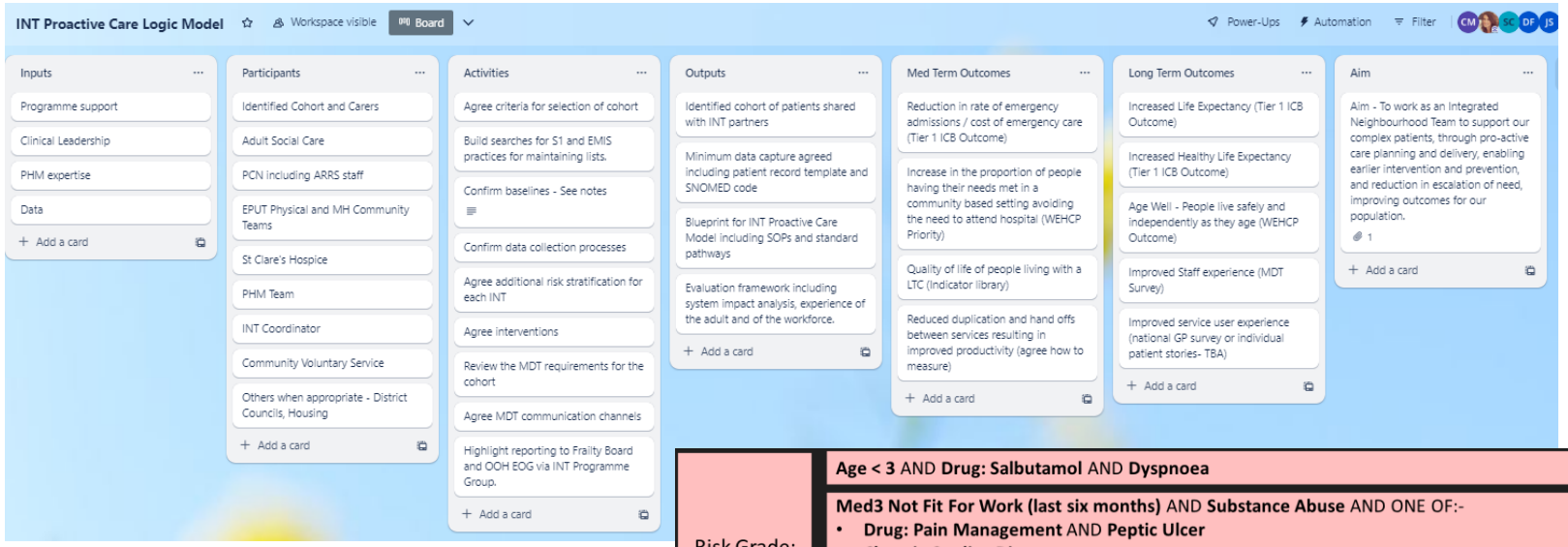

Herts and West Essex Segmentation model V

Generally Healthy	Living with Illness	Lower Complexity	Advanced Disease & Complexity
Acute Episodic	Living With only MH	Mild frailty	End stage disease
Child & Maternity	Living With Illness	Multi-morbidity	Complex Mental Health
Low Risk	At-Risk	Moderate social complexity	Severe LD, ADHD & Autism
			High social complexity
			High Complexity

Risk Grade: High	**Age < 3** AND **Drug: Salbutamol** AND **Dyspnoea**
	Med3 Not Fit For Work (last six months) AND **Substance Abuse** AND ONE OF:- • **Drug: Pain Management** AND **Peptic Ulcer** • **Chronic Cardiac Disease**
	Drug: Pain Management AND **Falls** AND ONE OF:- • **Stroke** AND **Memory and Cognitive Problems** • **Stroke** AND **Substance Abuse** • **End Stage Disease**
Risk Grade: Medium	**Age < 3** AND ONE OF:- • **Drug: Salbutamol** AND NO **Dyspnoea** • **On any waiting list**
	Med3 Not Fit For Work (last six months) AND **Substance Abuse** AND NO **Chronic Cardiac Disease**
	Age < 45 AND **Med3 Not Fit For Work (last six months)** AND **Drug: Pain Management**
	Drug: Pain Management AND **Substance Abuse** AND **ONE OF:** • **Drug: Opioids** • **eFI: Falls** AND NO **Stroke** AND NO **End Stage Disease**
Risk Grade: Low	All others

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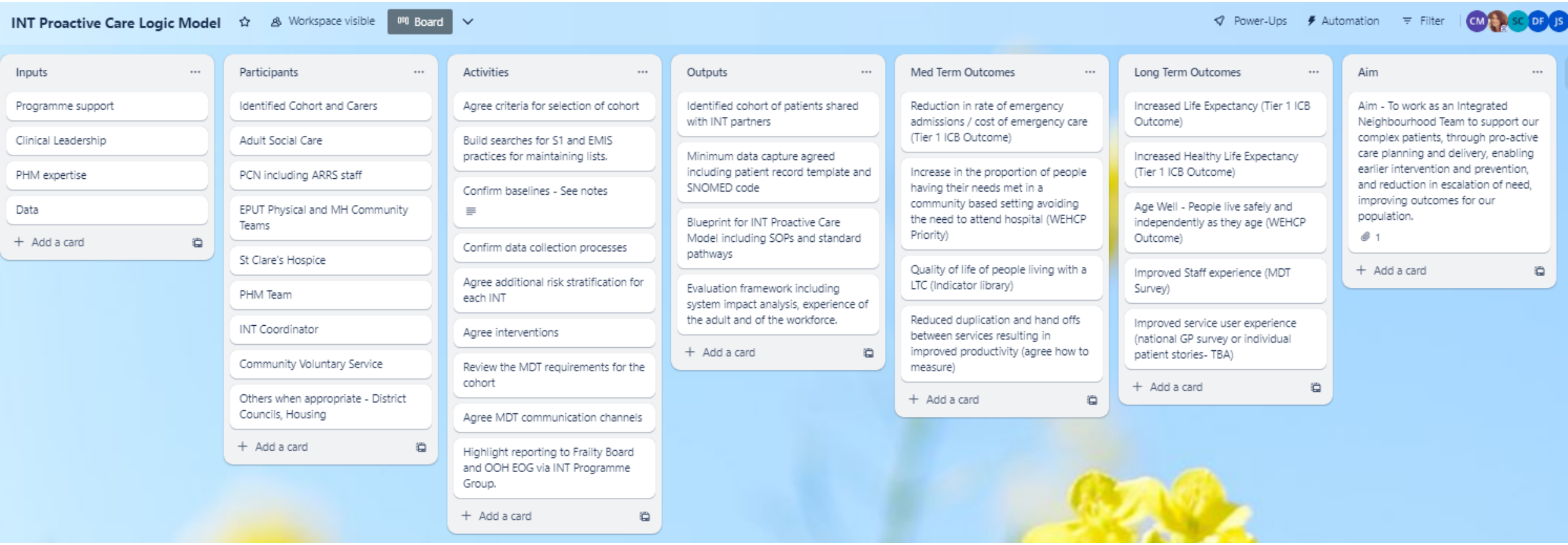
Step 1 – using Logic Models to developing the care model



[INT Proactive Care Logic Model | Trello]

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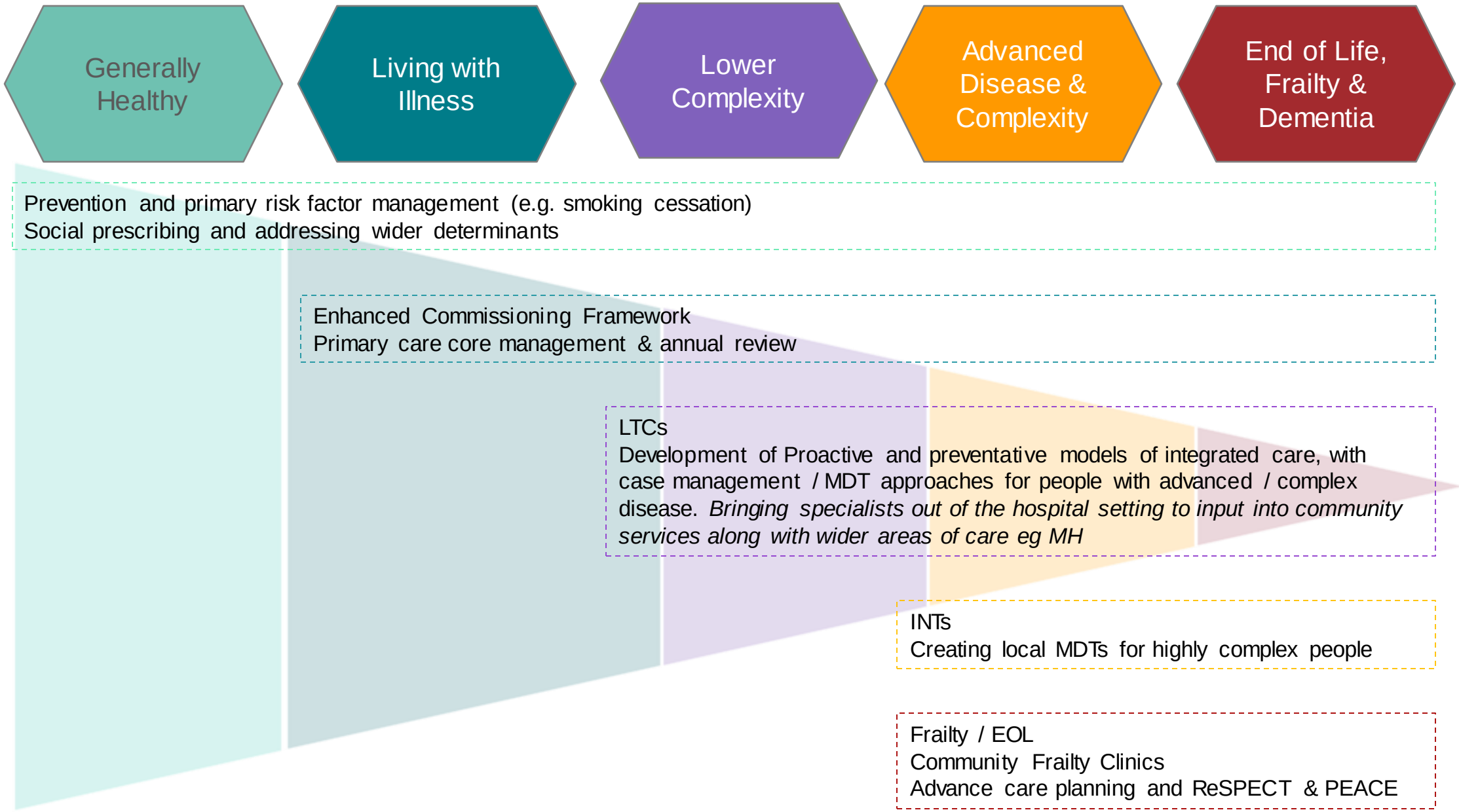
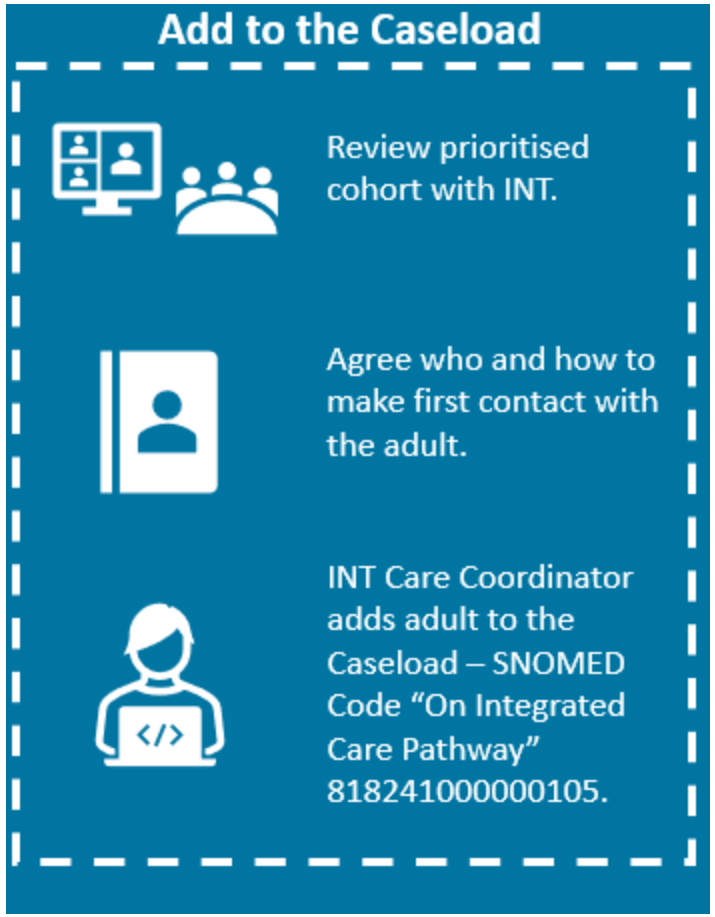
Delivering proactive care across different segments of our population



Step 2 – Add to the caseload



Include what to do if not deemed appropriate – what might be a reason

Include review of case notes by all partners – What do we know, what don't we know, what are we assuming?

Assign Named Lead Professional - if unclear who should be named lead at this stage, this can be allocated following first contact with adult.

Recommend approach for first contact and whether contact should be made by Care Coordinator or if Named Lead Professional would be more appropriate.

Patient to be added to the caseload using SNOMED Code – "On Integrated Care Pathway" 818241000000105

Step 3 – Deliver proactive care within the INT for individuals

Understand the needs
We learn to understand and customise care for Adults based on conversations.

Named Lead Professionals will be assigned based on what matters most to the adult.

Build the plan
We do not provide a current service to someone; we build services around needs not prescribe solutions.

Review to improve
Adults won't be discharged from the caseload. We stay with the Adult and their network, each interaction is not a new one, it is a continuation.

PROM - Developing in partnership with NHS England.

Deliver the work
We understand and respond to the Adults with what they need, when they need it.

Step 4 – Measure impact and evaluate – Designing the evaluation

- Is there a clearly defined intervention that is recorded?
  - INT Care Coordinator adds adult to the Caseload – SNOMED Code "On Integrated Care Pathway" 818241000000105
- Is there a clearly defined cohort who are eligible for the service/intervention?
  - Searches created from the segmentation model outputs
- Are there clearly defined outcomes?
  - see Step 3

Cohort identified by the presence of the SNOMED code

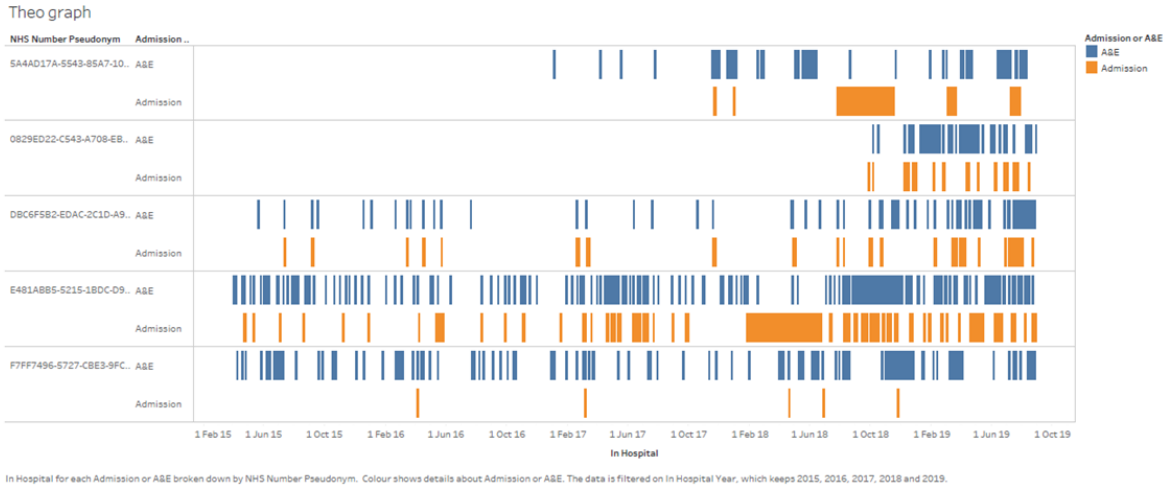
Consider control group for comparison

Confirm baseline of utilisation of services for each individual

Analysis will look at utilisation of services pre and post the intervention by the INT

- Part of the Test and Learn will also be testing the evaluation approach
- Through the nature of pro-active care pre and post analysis will not capture the full impact
- INT Care Coordinator adds adult to the Caseload – SNOMED Code "On Integrated Care Pathway" 818241000000105
- Identifying control groups will be tested during the process.

As the cohort identified is for proactive care not all people receiving an intervention will have pre utilisation. Therefore capturing case studies for impact will also form part of the evaluation.



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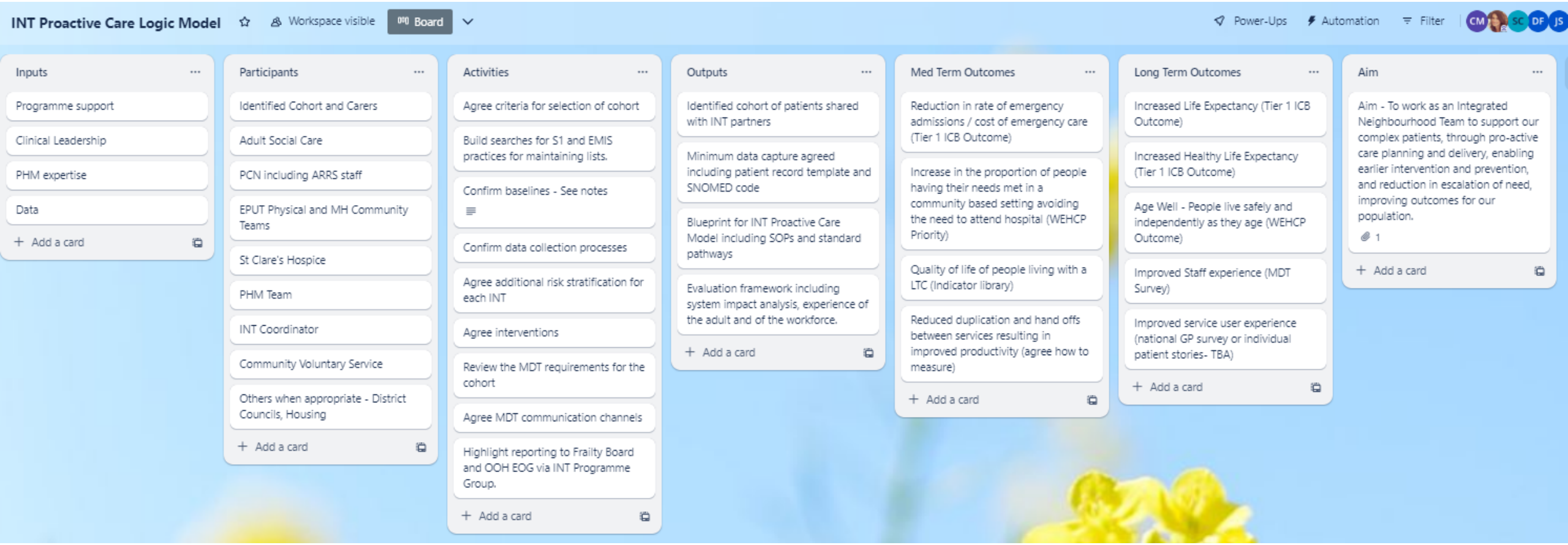
Step 4 – Measure impact and evaluate – Logic Model



[INT Proactive Care Logic Model | Trello]

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Step 4 – Measure impact and evaluate - Creating a cycle of improvement

The West Essex Proactive Care Approach will embed a cycle of improvement working in partnership with the adult to improve their outcomes.

The ICB will also create a cycle of improvement around the model to:

- Review the patients being identified from the analysis and consider if any refinements are needed based on what is working well.
- Review the intervention, including the membership of MDTs to ensure that individual needs are being met.
- Make any adjustments to searches and intervention in an iterative way.
- Undertake a more formal evaluation of the service, measuring outcomes as defined in the logic model.
- Enable scale and spread based on robust learning.

Step 4 – Measure impact and evaluate - Patient Story

"Mr and Mrs C are 88 and 84.
April. *Mr C had been identified and referred to social prescribing towards the end of last financial year as part of the frailty work undertaken at practice level for the ECF. Mr C had fallen and there were some concerns over his memory. Interventions and referrals were refused at the time as 'We're doing fine'. Attendance allowance forms were completed though for extra funding for the couple and Mrs C completed an episode of physiotherapy and was in receipt of 6 weeks of extra care as part of a reablement process following a covid illness for herself. A summary of them at this stage would be that Mr C was physically fit, but cognitively struggling and the reverse could be said for Mrs C. They were hanging on by a thread, but any change would make them vulnerable.*

May. *Mrs C was identified as a patient eligible for the proactive care cohort through our searches and had complex medical conditions as above, specifically mobility issues and poorly controlled diabetes, but in conjunction with her husband it was felt the proactive care coordination team would reassess the circumstances despite previous refusals. Assessment was undertaken. It was identified the reablement coming to an end for her husband was causing a lot of anxiety for Mrs C, and the undiagnosed memory problems were progressing. AS a result of considering the couple as a unit, further referrals were able to be coordinated for diagnosis. Importantly, the holistic assessment brought in feedback from their daughter, who was struggling (at the end of her tether!) to manage and was even more anxious about their care than Mrs C, and the potential for this to fall apart at the end of reablement. She was stressed as her own son as additional needs and she didn't feel her parents were listening to her concerns for them. She needed agencies such as the INT to support her assessment that they needed ongoing care when reablement came to an end.*

June. *Mr and Mrs C are still waiting on the attendance allowance, but have committed to ongoing privately funded care, taking the pressure off Mrs C, and certainly the daughter. The plan now is to return over the coming months and be more prescriptive/encouraging about falls assessment and visual aids for MR C who is suffering with visual impairment. The relationship between professionals and the family is growing. The family have begun to understand the advantage of engaging with an INT rather than believing all roads for help and support leading to our surgery.*

Feedback from workforce:

- *'We got it wrong by imagining the social prescribing referral was the end of our responsibility, the opportunity to review this couple again with the resource to actually make a positive difference and engage with the social circumstances - particularly to recognise the strain on the daughter has been very rewarding.'*
- *For myself I have known this couple for a long time and dealt with various of their crises (because they are difficult to continually engage - I wish it were different and I could drop in on my rounds like we used to!) it is great to know that they will now have a different, possibly more responsive set of professionals dedicated to their care reduces my anxiety and I am interested to see how their care will change / evolve as a result of this intervention. My hope is that the regular contact and trust building allows for more voluntary sector help (low visual aids, decluttering of the house) will reduce the risk of falls for Mr C as far as we can."*

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What value has PHM added to the process?

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How might this have looked without PHM tools?

- No shared understanding of need.
- Identification of a target group or intervention based on anecdote and instinct rather than data.
- Personalised searches based on the INT needs identified a cohort of patients (and their families) flying just beneath the radar. Identifying the people most likely to benefit from care.
- Developing a model of care that reflects the needs of the people being proactively identified.
- Patients may have experienced a crisis and required an acute admission.
- An evaluation that provides limited insight into how these local efforts will contribute to improved high level ICB outcomes.

Learning so far

- Complements and goes above universal offers
- INTs have welcomed the structure that the PHM approach brings and the ability to personalise the cohort to their population using the risk stratification e.g. Harlow North having a focus on respiratory and North Uttlesford having a focus on frailty.
- They are no longer looking at only the individual but looking at the household and any carer.

> *"We got it wrong by imagining the social prescribing referral was the end of our responsibility, the opportunity to review this couple again with the resource to actually make a positive difference and engage with the social circumstances - particularly to recognise the strain on the daughter has been very rewarding."*

- Continuous improvement through engaging with clinicians able to personalise searches identifying key risk factors for the local population.

> "You could feel the excitement in the room when the INT started reviewing the cohort, we could see the potential impact we could make straight away"
> "Adults known by all organisations at one point in time but no one <u>really knew</u> the adult"
> "Instantly recognised the need to look at the household, not just the identified adult"

- We need to invest in our INT Care Coordinators to ensure they have the support, skills and knowledge to undertake this new role.

> "The PHM team will support you through this process identifying the right segment and right size for your INT."

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Any questions?

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