NHS
East Lancashire
Clinical Commissioning Group

Agenda Item No: 6.3

REPORT TO:	**PRIMARY CARE COMMITTEE**	
MEETING DATE:	**18th July 2016**	
REPORT TITLE:	**East Lancashire Integrated Neighbourhood Team Evaluation 2015/2016**	
SUMMARY OF REPORT:	The report provides an evaluation of the INT Service which commenced during 2015/16.	
REPORT RECOMMENDATIONS:	The Primary Care Committee are asked to: • Consider the contents of the East Lancashire INT Evaluation Report • Agree to the submission of an East Lancashire INT Service Proposal in November 2016 with full costings and outcome measures.	
FINANCIAL IMPLICATIONS:	£500,000	
REPORT CATEGORY:		**Tick**
	Formally Receipt	X
	Action the recommendations outlined in the report.	X
	Debate the content of the report	
	Receive the report for information	
AUTHOR:	**Kirsty Hamer**	
	Report supported & approved by your Senior Lead	**Y**
PRESENTED BY:	**Kirsty Hamer / Rebecca Demaine**	
OTHER COMMITTEES/ GROUPS CONSULTED:	None	
EQUALITY ANALYSIS (EA) :	Has an EA been completed in respect of this report?	**N**
RISKS:		**N**
CONFLICT OF INTEREST:		**N**
PATIENT ENGAGEMENT:		**Y**
PRIVACY STATUS OF THE REPORT:	Can the document be shared?	**Y**

Which Strategic Objective does the report relate to		**Tick**
1	Commission the right services for patients to be seen at the right time, in the right place, by the right professional.	**X**
2	Optimise appropriate use of resources and remove inefficiencies.	**X**
3	Improve access, quality and choice of service provision within Primary Care	
4	Work with colleagues from Secondary Care and Local Authorities to develop seamless care pathways	**X**

East Lancashire Integrated Neighbourhood Teams Evaluation 2015/16

Kirsty Hamer

On behalf of Locality Managers

NHS East Lancashire

July 2016

Contents

1. Introduction

In 2014, East Lancashire CCG proposed the development of Integrated Neighbourhood Teams (INT) to bring together primary care health services, community services and social care to provide integrated out of hospital care, with the aim of shifting appropriate outpatient and ambulatory care to out of hospital settings. The main driver for this was to improve communication and coordination of services of services thereby improving patient experience, providing care closer to home and reducing avoidable admissions to hospital and attendance at A&E.

An INT brings Providers of services together to work in a more coordinated and integrated way. The INT acts as a support service for patients with complex needs who may benefit from a multi-agency approach. The service seeks to identify a case manager for the patient to act as a single point of access for all their care needs, and combine assessments and care plans to avoid duplication and provide a consistent approach to meet the patient's needs. Because the needs of family members are also important care plans may also include support that is being given to family and carers.

Following national guidance, East Lancashire CCG identified that delivery of the INT model was best delivered on a 30,000-50,000 population footprint. Following discussion with Primary Care and other stakeholders, 9 INT's were formed based around Practice populations, these are:

- Burnley Central
- Burnley East
- Burnley West
- Hyndburn Central
- Hyndburn Rural
- Pendle East
- Pendle West
- Ribblesdale
- Rossendale

The Neighbourhoods worked to develop the INT model which is made up of a core team, the INT Hub and additional services. The INT core team includes a Clinical Coordinator, INT Administrator and Case Managers (including mental health worker), these people are managing, coordinating and planning the whole INT process. The INT hub consists of services that have a specific role within the INT process, they may often be case managers,

and they are regular attenders within the INT Multidisciplinary Team meetings (MDT's); District Nursing, Community Matron, GP Pratices, Integrated Therapy Teams, Lancashire Wellbeing Service, Medicines Support Team, Mental Health, Macmillan, Age UK, Hospices and other Voluntary Sector Organisations who work with patients who are supported by an INT. Additional Service providers may be invited to MDT's if they are part of the care being provided to the patient, they provide input into assessments and development of care plans. Additional Services includes Audiology, Continence Services, Dietetics, Falls Team, Learning Disability Services, Heart Failure Team etc.

Criteria for acceptance of a referral to the INT was developed and agreed and includes:

- Patients requiring input from several services
- Patients who have been referred by the Complex Case Team/IDS at the Hospital.
- Patients who have frequent unplanned hospital admissions.
- Patients with a limited life expectancy.
- Those within the 2% of patients identified via risk stratification by Primary Care
- The INT administrator and clinical co-ordinator will use Aristotle to identify patients who need to be included in the INT caseload.
- Patients who are frail and complex
- Those deemed appropriate at professional's/service discretion

The Neighbourhoods developed their referral processes, assessment processes, care plans, MDT meetings, to meet the needs of their registered patients and maintain a consistency across East Lancashire.

2. Funding Arrangements

The Neighbourhoods were allocated £500,000 to fund a Core Team in each Locality, further details below:

2.1 Burnley

Burnley INT Service supporting 3 INT's Burnley Central, Burnley East and Burnley West.

Service Provision	**Provider**
2 x Clinical Coordinators (B7)	Green Dreams Project
2 x INT Administrators (B4) part time	Green Dreams Project
Total Cost 2016/17	**£164,674**

2.2 Hyndburn

Hyndburn INT Service supporting 2 INT's Hyndburn Central and Hyndburn Rural

Service Provision	**Provider**
1 x Clinical Coordinator (B7) Part time	ELHT
1.5 x Administrators (B3)	Clayton Medical Practice
Total Cost 2016/17	**£81,374**

2.3 Pendle

Pendle INT Service supporting 2 INT's, Pendle East and Pendle West

Service Provision	**Provider**
1 x Clinical Coordinator (B7) Part time	ELHT
1 x Administrator (B3)	ELHT
Total Cost 2016/17	**£71,102**

2.4 Ribblesdale

Ribblesdale INT Service supporting 1 INT

Service Provision	**Provider**
1 x Clinical Coordinator (B7)	ELHT
1 x Administrator (B3)	ELHT
Total Cost 2016/17	**£84,582**

2.5 Rossendale

Rossendale INT Service supporting 1 INT

Service Provision	Provider
1 x Clinical Coordinator (B7) Part time	Rossendale Hospice
1 x Administrator (B3)	Rossendale Hospice
Total Cost 2016/17	**£82,337**

2.6 Mental Health Pilot

As the Neighbourhoods were developing the INT model and reviewing the potential patients who would benefit from an INT approach, it became apparent that many of those patients are affected by poor mental health as a result of their long term conditions / complex needs. As a result of this review, it was determined that a mental health worker could be part of the core team to provide:

- Clinical advice and guidance to Professionals within the INT.
- Provision of assessment of patients mental health needs within the INT
- Triage and navigation of mental health services, ensuring that the patient gets to the right place at the right time.
- Manage a caseload of patients where appropriate.
- Development of safety nets and care plans for patients with mental health problems in the INT, enabling other staff involved in the patients care to manage their mental health conditions more confidently thereby reducing further input from mental health services.
- Provide a needs analysis of patients in the INT and develop recommendations for mental health provision within the INTs across East Lancashire

Lancashire Care Foundation Trust were funded to provide the additional service in the Ribblesdale INT as a pilot for 12 months. A worker was allocated for 2 days per week at a cost of £25,000. The worker commenced in May 2015 and this pilot was extended to cover Pendle for an additional 6 months from May 2016 to November 2016 at a cost of £32,800.

3. Evaluation

Timescales for the commencement of the INT model has varied dependent on Locality agreement, recruitment processes etc. The First INT commenced in Hyndburn in September 2015, with Pendle, Rossendale and Ribblesdale INT's in place by January 2016. Burnley are currently in the recruitment phase of their INT, the commencement of the Burnley INT is due in October 2016.

Since the commencement of the INT Service the following has been achieved:

- Development of a Standard Operating Procedure for the INT Service across the Neighbourhoods
- Establishment of regular MDT meetings in each of the Neighbourhoods. Regular attenders of those MDT's includes; District Nursing, Age UK, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy, GP, Practice Nurse, Lancashire Wellbeing Service, Mental Health, Community Pharmacists.
- Utilisation of the EMIS IT system to develop a single care plan approach and improve communication between INT Hub members.
- Development of a stepped care approach to supporting patients with long term conditions / complex needs. (See Appendix A).
- Improving the links between mental health and physical health ensuring that the person is supported in a holistic way and not treating physical condition and mental health condition separately.

The following information provides an overview of the impact of the Integrated Neighbourhood Teams from September 2015 – April 2016.

NB: Although Burnley are still awaiting INT Coordinators in post, the MDT process has been picked up by the Over 75's Specialist Nurse Practitioners.

- 287 patients have been referred to MDT.
- 681 discussions have taken place.
- Average age of patients referred to the INT is 68. The youngest was 21 and the oldest was 101.
- 66% of patients within the INT are over the age of 65.
- 66% of patients are female, 34% male.
- Main diagnosis of patients are respiratory, heart disease, CVD, Stroke, and urological conditions.

- Referrals have come from GP's, District Nursing, Therapy Services, Over 75's Nurses, Age UK.
- Case Managers in the main are District Nursing, followed by Therapy Services, Mental Health, GP, Over 75's Nurses.
- Feedback from patients, carers and staff has been 100% positive (for case study data please see Appendix B,C,D, E and F)
- Improved communication between Services as highlighted in appendix E and F.
- The Mental Health input into the INT has been invaluable providing advice and guidance to other health professionals on managing a patients anxiety and depression as part of a holistic approach to care. Signposting to relevant mental health services if appropriate. Supporting patients and their carers to manage their ongoing mental health problems related to their condition. Feedback from INT members and patients and carers has been 100% positive. An example of support provided is included in Appendix G.

The following provides data on secondary care services and the potential impact the INT is having. The data is focussed on patients over the age of 65 as this is the main cohort of patients under the INT:

- Emergency Admissions (Medical Specialties) for patients over the age of 65 has reduced by 8%. Average admission rate for Over 65's in 2014/15 was 1125.50, this has reduced to 1039 in 2015/16. (See Appendix G) (SUS Data)
- Readmission rates have also reduced. The average readmission rate in 2014/15 was 17.46%, this has reduced to 16.94% in 2015/16. (See Appendix H) (SUS Data)
- A&E Attendances have stayed the same in 2015/16, however, this is significant due to the increase in numbers of Over 65's across East Lancashire. A&E attendance stayed at similar levels across the year, the CCG didn't see a peak in Winter 2015/16 (See Appendix I). (SUS data)
- The above has been achieved despite an increase in complex patients (See Appendix J) (Aristotle Risk Stratification Data)

NB: Caution needs to be taken with the above figures. There may be a number of reasons that the above has been achieved:

- *Additional service developments to support this cohort of patients may have also impacted admissions and attendances i.e., Over 75's Schemes, Intensive Home Support Service etc.*
- *Query around winter pressures and whether we had a particularly mild winter which may mean that expected levels weren't realised.*

4. Areas for Improvement

From discussions with the INT Core Teams and Neighbourhoods, there are a number of areas for improvement:

- Not every service has access to the EMIS IT System therefore the INT is also having to use paper copies to ensure that information is shared appropriately. Having all members of the INT Hubs having access to EMIS will improve electronic information sharing and communication between professionals.
- Data collection isn't consistent across the Neighbourhoods, this is because of the issues with access to the EMIS system and other clinical systems. Concerns have also been raised about what is currently being gathered and how relevant that is.
- Some teams have the added benefit of being co-located which has improved communication further. Other Neighbourhoods haven't had the opportunity due to accommodation issues.
- There is inconsistency in attendees to the MDT's in INT Neighbourhoods i.e., Practices attending MDT's in some Neighbourhoods and not others.
- Inconsistency in Providers of the INTs in Neighbourhoods which causes difficulties in cross-cover, access to Clinical Systems, information sharing.
- Current contracting of the Core Team is currently fixed term due to the INT's status as a pilot, most staff within the INT's are on secondment or fixed-term contracts which can lead to uncertainty and turnover of staff.
- As the INT Service has developed, gaps in core team needs have been identified i.e., data analysis.
- The mental health pilot is only running in 3 Neighbourhoods, feedback from those Neighbourhoods has highlighted the invaluable support from the pilot but this leaves a gap in the additional 6 Neighbourhoods.
- Further work needs to be carried out to raise awareness of the INT Service to ensure that all professionals whose patients may benefit from INT support are aware of the service and referral processes.
- A workforce development plan is required to provide clear guidance around the roles and responsibilities for the wider INT.

5. Conclusion

The following can be concluded from the evaluation:

- The INT model is providing a care coordination approach to patients with Long Term Conditions / Complex Needs who would benefit from this type of support.
- The main cohort of patients are over 65 with respiratory and / or heart disease.
- Feedback from patients and carers has been excellent and highlights the work the INT Hubs are delivering.
- The model has improved communication between professionals in the management of patients with long term conditions / complex needs.
- The mental health pilot is having a significant impact on the 3 neighbourhoods it is providing a service too.
- Secondary care data shows that there has been a reduction in admissions to hospital, readmissions to hospital against an increasing population. A&E attendances have stayed the same despite an increasing population.
- Further work needs to be carried out to ensure a consistent service model across the Neighbourhoods.
- Additional consideration of IT, Estates, and a Communication and Engagement Plan via the East Lancashire INT Board is required.
- Further review of best practice guidance and feedback from patients and carers to influence the model needs to take place.

6. Recommendations

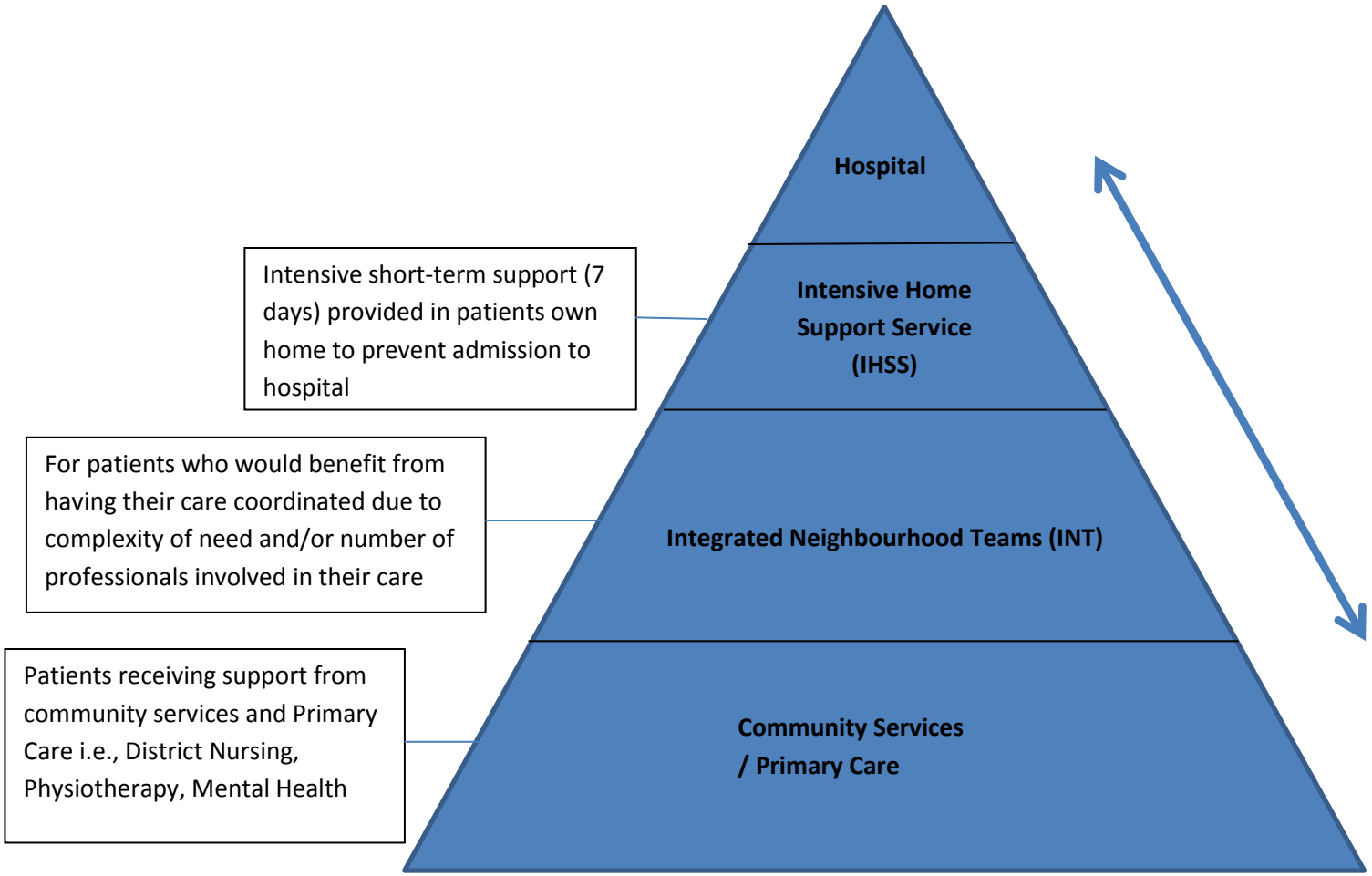
Considering the evaluation and conclusion the following is recommended:

- Development of a consistent service model across the East Lancashire; including core team members, INT Hub, data collection and consideration of Provider options.
- Continuation of funding for roles as per the INT Service model.
- Consideration of Estates and the opportunity of co-location across all Neighbourhoods. Build Estates plans into the East Lancashire Estates Strategy.
- Development of an IT plan for the INT's to improve communication for all stakeholders.
- Development of a communication and engagement plan for the Integrated Neighbourhood Teams including patient and staff feedback process.

The Primary Care Committee are asked to:

- Consider the contents of the East Lancashire INT Evaluation Report
- Agree to the submission of an East Lancashire INT Service Proposal in November 2016 with full costings and outcome measures.

Appendix A – Stepped Care Approach to Integrated Care



The arrows indicate the step up /step down options for patients.

Hospital – may step-down to IHSS, INT or Community / Primary Care dependent on need.

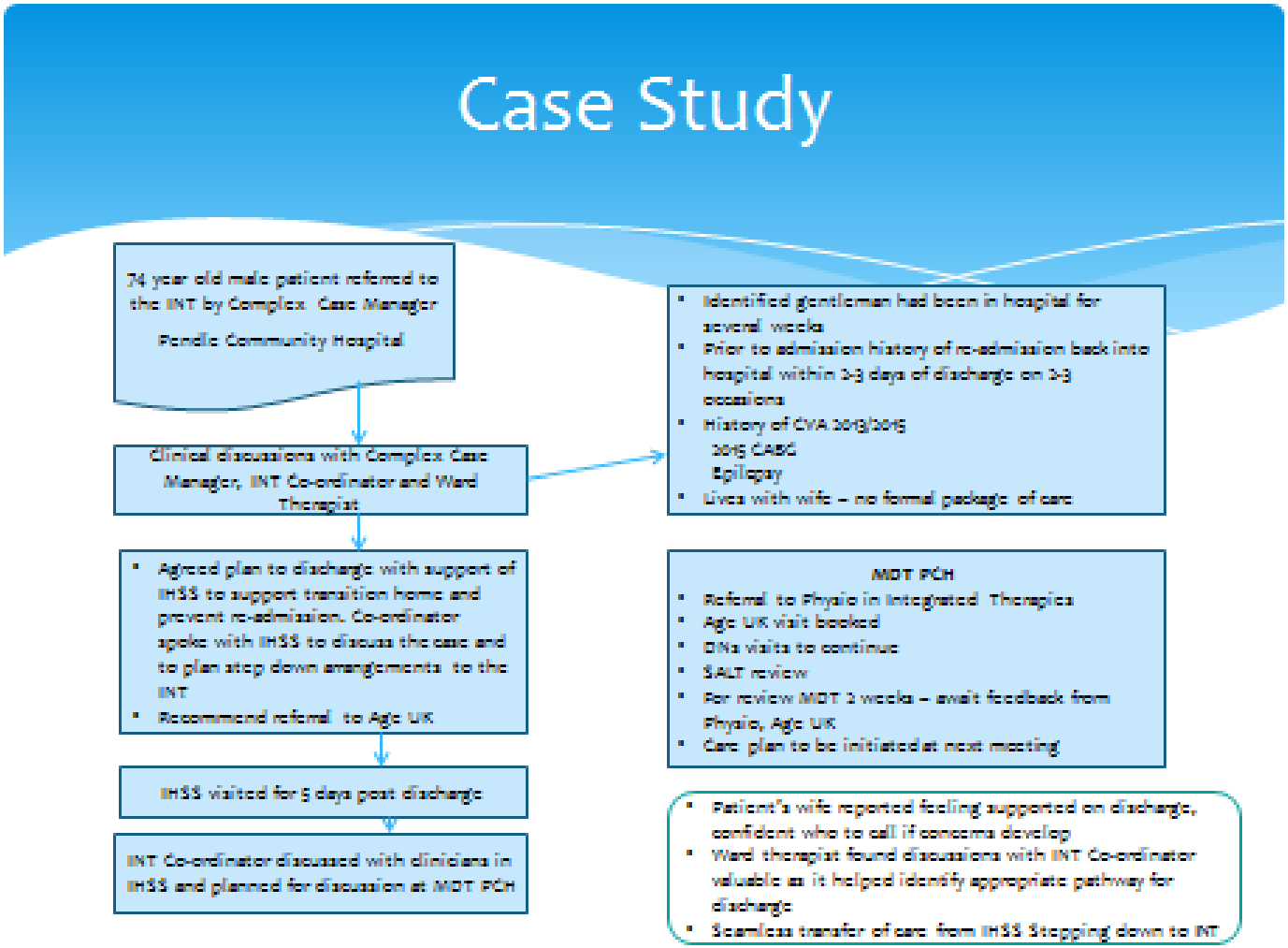
IHSS – may step-up to hospital, or step-down to INT or Community/ Primary Care, dependent on need.

INT – may step-up to IHSS or hospital or step-down to Community and Primary Care dependent on need.

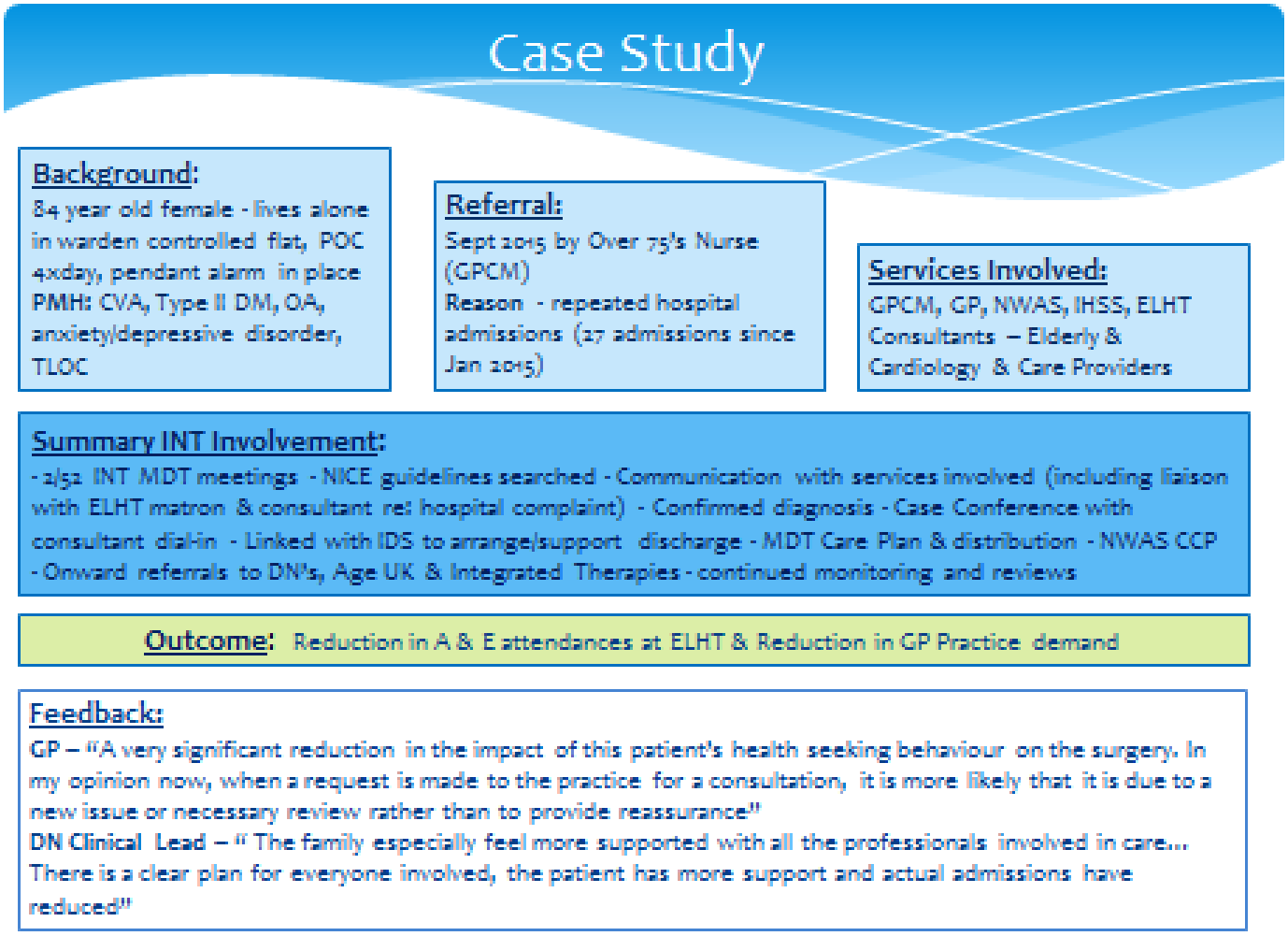
Community Services / Primary Care – may step up to INT, IHSS or hospital dependent on need.

Entry point for the patient shouldn't matter as they will be redirected to the most appropriate service via the MDT approach.

Appendix B - Case Study



Appendix C - Case Study



Appendix D – Case Study

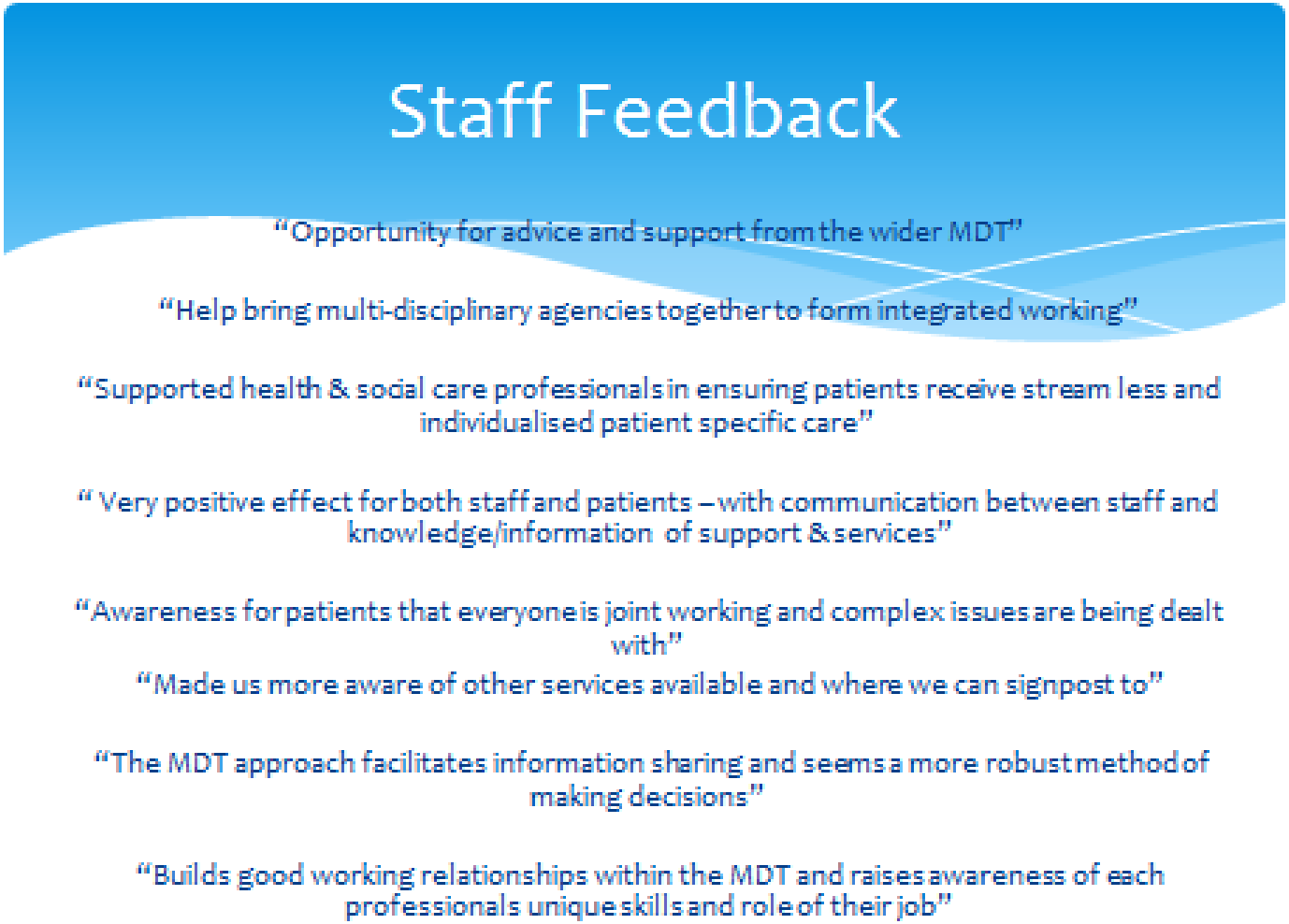
Case Study: Female, Age 54

Patient Background	Referred to the INT 23.12.15 Triaged	Professionals already involved within this 12 month period
✣ On the Gold Standard Palliative Framework ✣ End stage severe chronic obstructive pulmonary disease ✣ Epilepsy ✣ Heart failure ✣ Lives alone, sheltered flat ✣ Cares 6 x per day ✣ Current smoker ✣ Housebound ✣ Retired Rapid Response paramedic	• Admissions: ED attendances = 10 in last 12 months up to this referral Hospital Admissions = 11 in the last 12 months • Aristotle: Ranked Number 1 for the GP Practice** Set-up in the community: Home nebulizer & steroid treatment as required.	• IHSS supported discharge x4 times • Pulmonary rehab service • OHH service • Integrated therapists in the hospital and community • Dietetics • Consultant involvement Respiratory clinic & cardiology • Medicines review • Practice GP

Highlight: Admissions often to different wards in the hospital. Not assessed by the same team and issues not addressed.

INT Input	Difficulties	INT Outcome
✣ Assessed by the Advanced Nurse specialist (care homes) ✣ Clinical Co-ordinator support ✣ New Professional Input: Falls assessment Vision assessment Dental assessment District nurse Smoking cessation	Patient still attending the hospital after INT started input. (6 times) Patient not answering the telephone INT calls. Building rapport	Admission avoidance Plan (EMIS) Advanced care plan discussion & plan (DNAR) Complex COPD Care plan shared with ICAT / IHSS / OHH / Patient • Provision of home oxygen • Introduction of long term antibiotic treatment • IV Antibiotic pathway Patient has had another exacerbation of COPD but was not admitted to hospital and was managed in her own home. The patient has not been admitted into hospital for 6 weeks.

Appendix E – Staff Feedback



Appendix F – Staff Feedback

Staff Feedback

* A referral was made to Catherine Ashworth of the Integrated Neighbourhood Team and she recommended we refer to Intensive Home Support. Mrs X immediately felt supported simply in the knowledge she would be supported once her husband was home.
* The team gave me the confidence to encourage Mrs X to have husband home although with his history we had all believed residential care may well be inevitable.
* Mrs x felt immediately supported and although I have invited her to contact me if she had any concerns or worries I have heard nothing. (she needed to speak with me daily during his admission).
* I have been very impressed and grateful for the team's intervention. I do not believe Mr X would still be at home today without it.

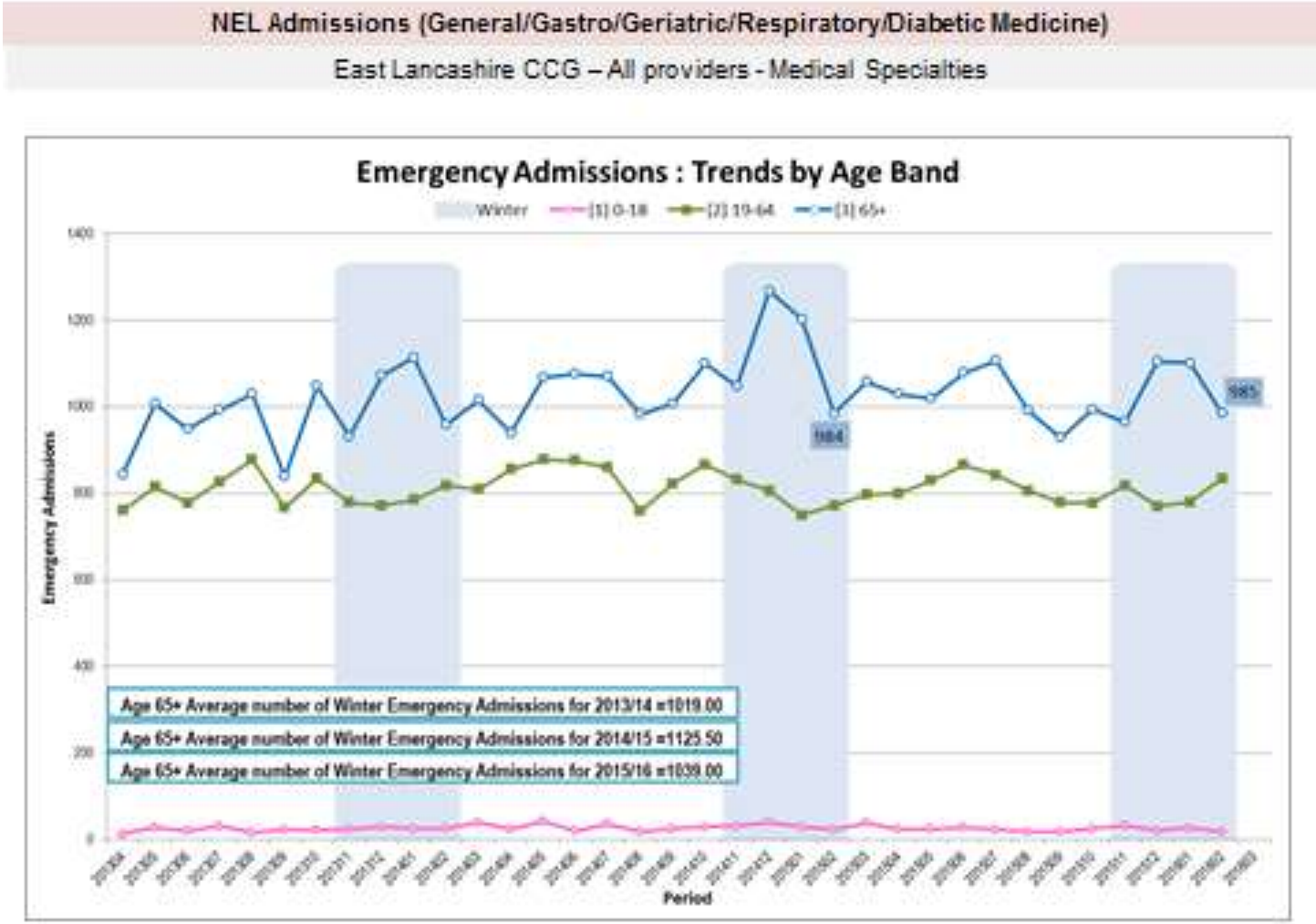
Lynette Orford
OT
May 2016

Appendix G – Mental Health Case Study

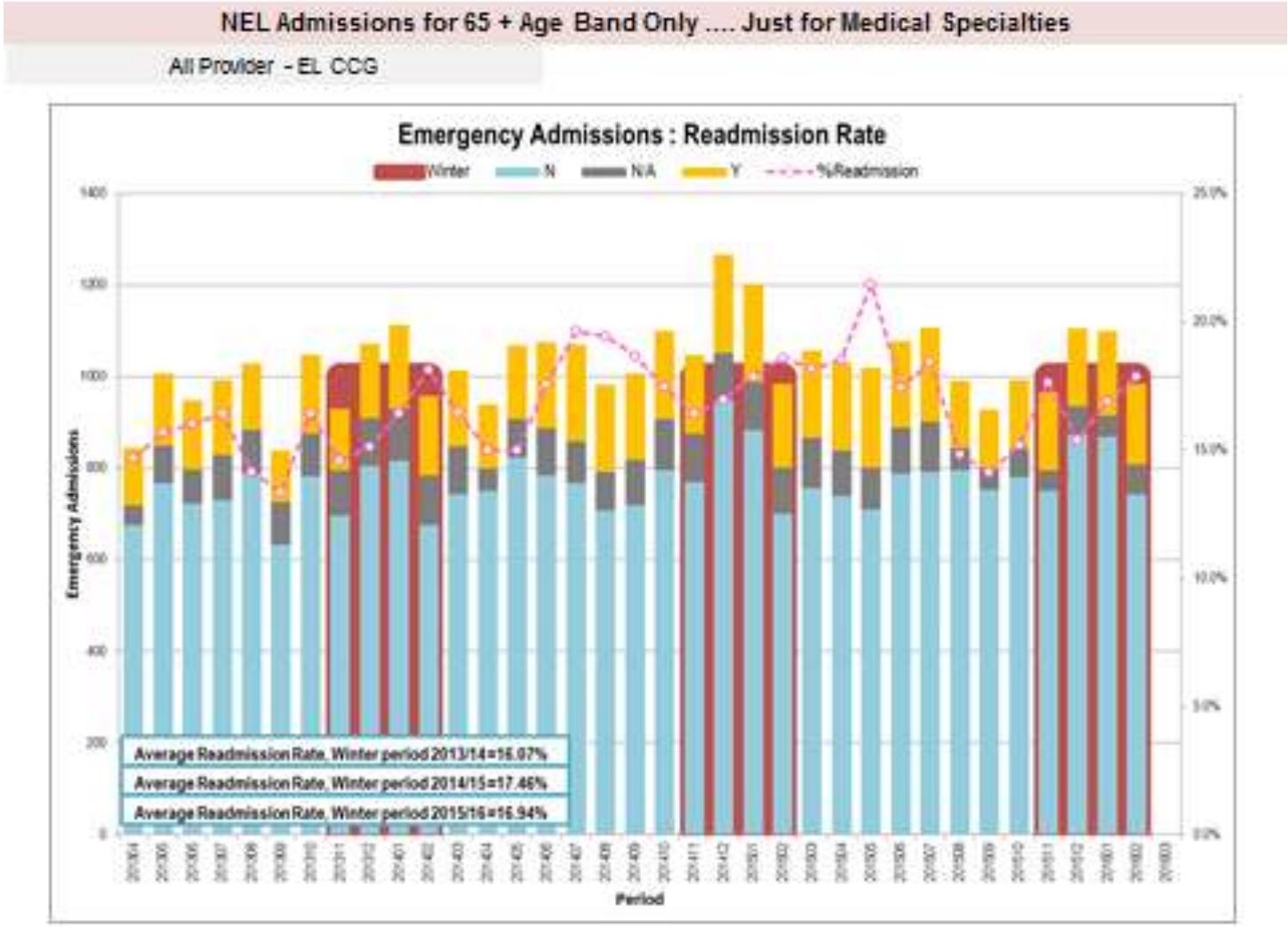
Mental Health Practitioner Case Study

- 63 yr old Patient with COPD, under the care of GP, Physio and Occupational Therapy, limited engagement with goals and exercises. Cited Panic attacks, anxiety and at times low mood as significant barriers, frequent panic attacks resulting in patient at times spending the day or days in bed to recover, quite isolated feels unable to leave to house due to panic and breathing difficulties. Patient agreed to some input from the Mental Health Practitioner after giving consent and after initial joint visit with therapist, patient worked with Mental Health Practitioner over a period of 6-8 weeks.
- Regular visits and contact helped patient speak about thoughts and feelings.
- Discussion to understand symptoms of anxiety, panic and COPD and differentiate these enabling better and good understanding of her situation was able to rationalise triggers and situations that could create panic, feels as though she is on control of her symptoms.
- Patient said that she feels as though she knows that she wants to be able to start looking at going out and accessing appointments when she is ready to.
- Build up of therapeutic relationship helped and supported patient in being able to agree to start anti-depressant medication and also advice given around possible side effects and efficacy of medication when therapeutic dose is reached.
- Patient still has good and bad days but feels more accepting of the bad days associated with her long term condition enabling her to cope better.
- Patient felt that she had a little more confidence and was able to understand good and bad days and try to not to think that on a bad day 'she was back to square one'.
- Starting to feel more confident to eventually work with physiotherapy and occupational therapy teams again and general improvement was noted.

Appendix H – East Lancashire Emergency Admission (Medical Specialties) 2013-2016



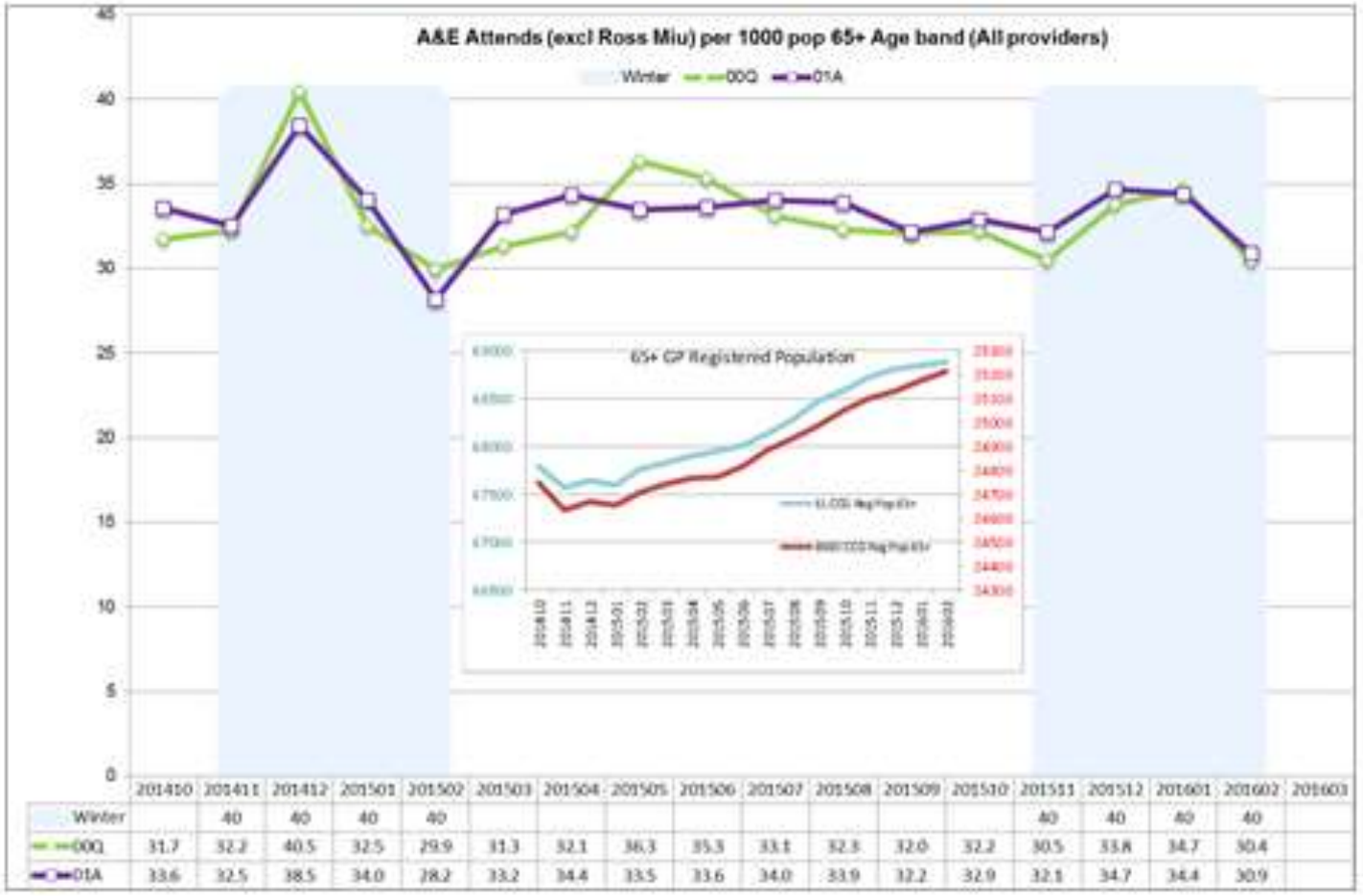
Appendix I – East Lancashire Readmissions (Medical Specialties) 2013-2016



Appendix J – East Lancashire A&E Attendances 2014-2016

A&E Attendances

A&E attends per 1000 population for aged 65+, for all providers for Pennine Lancashire.

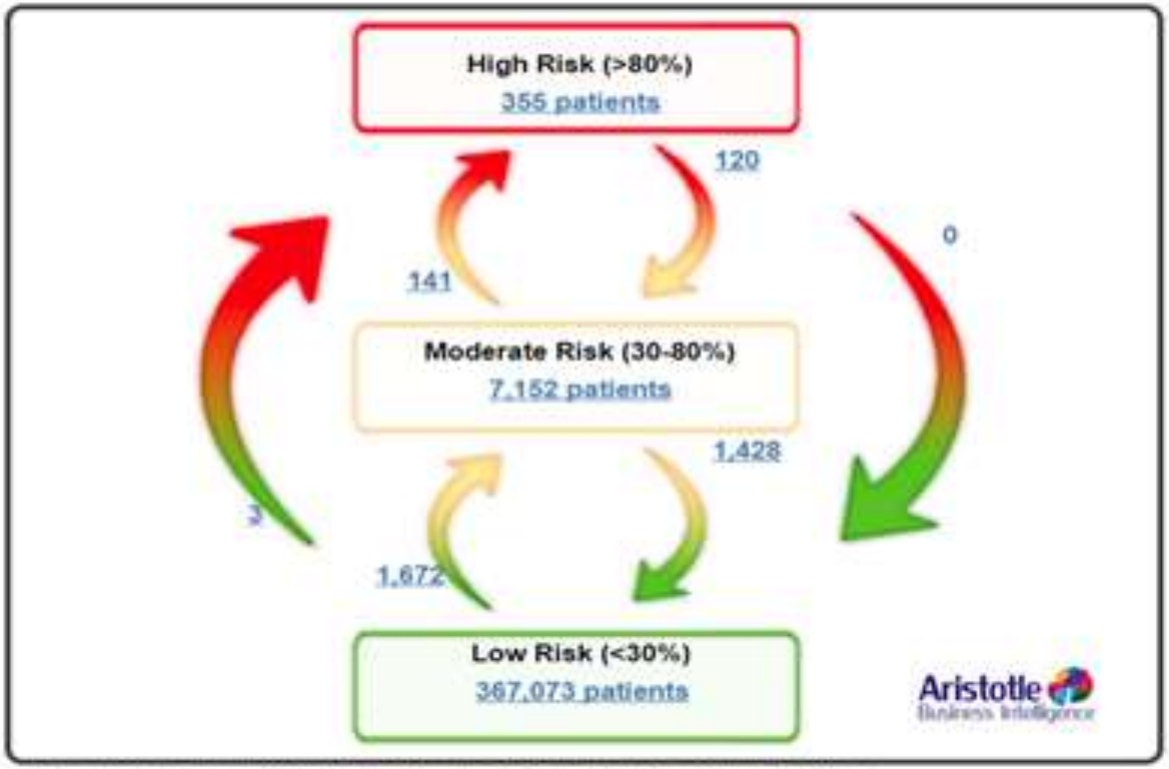


	201410	201411	201412	201501	201502	201503	201504	201505	201506	201507	201508	201509	201510	201511	201512	201601	201602	201603
Winter		40	40	40	40									40	40	40	40	
00Q	31.7	32.2	40.5	32.5	29.9	31.3	32.1	36.3	35.3	33.1	32.3	32.0	32.2	30.5	33.8	34.7	30.4	
01A	33.6	32.5	38.5	34.0	28.2	33.2	34.4	33.5	33.6	34.0	33.9	32.2	32.9	32.1	34.7	34.4	30.9	

Appendix K – East Lancashire Complex Patients (Aristotle Risk Stratification)

Risk Stratification Score Movement – East Lancashire

As patients move through the risk stratification bands, the associated costs for admissions fluctuate accordingly. It is important for services to be available to support patients to ensure that they do not jump through the bandings too quickly and deteriorate.



NB: This shows the number of patients that have moved between Risk Groups in the last month.
All patients for the selected practice(s) are included, i.e. not just patients in the selected cohort.