Hertfordshire and West Essex Integrated Care System

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An Implementation Guide for Proactive care in Integrated Neighbourhood Teams

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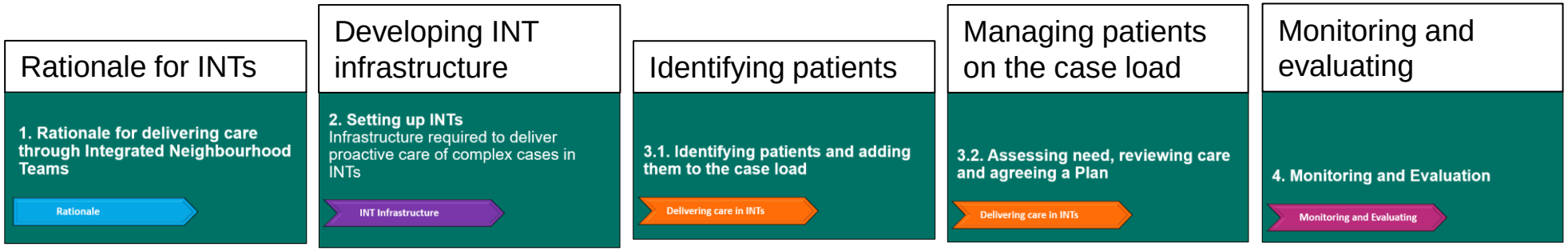
Outline

This toolkit provides Health & Care Partnerships (HCPs) and Integrated Neighbourhood Teams (INTs) with resources and guidance for developing and implementing proactive care for patients at high risk of emergency care through INTs. The agreed priority cohort for this care is people with frailty, advanced disease and on the end of life register.

The toolkit provides INTs with guidance on the operational, clinical and Population Health Management resources that will support the development and implementation of INTs and delivery of proactive care through neighbourhood teams.

Included in this toolkit are:



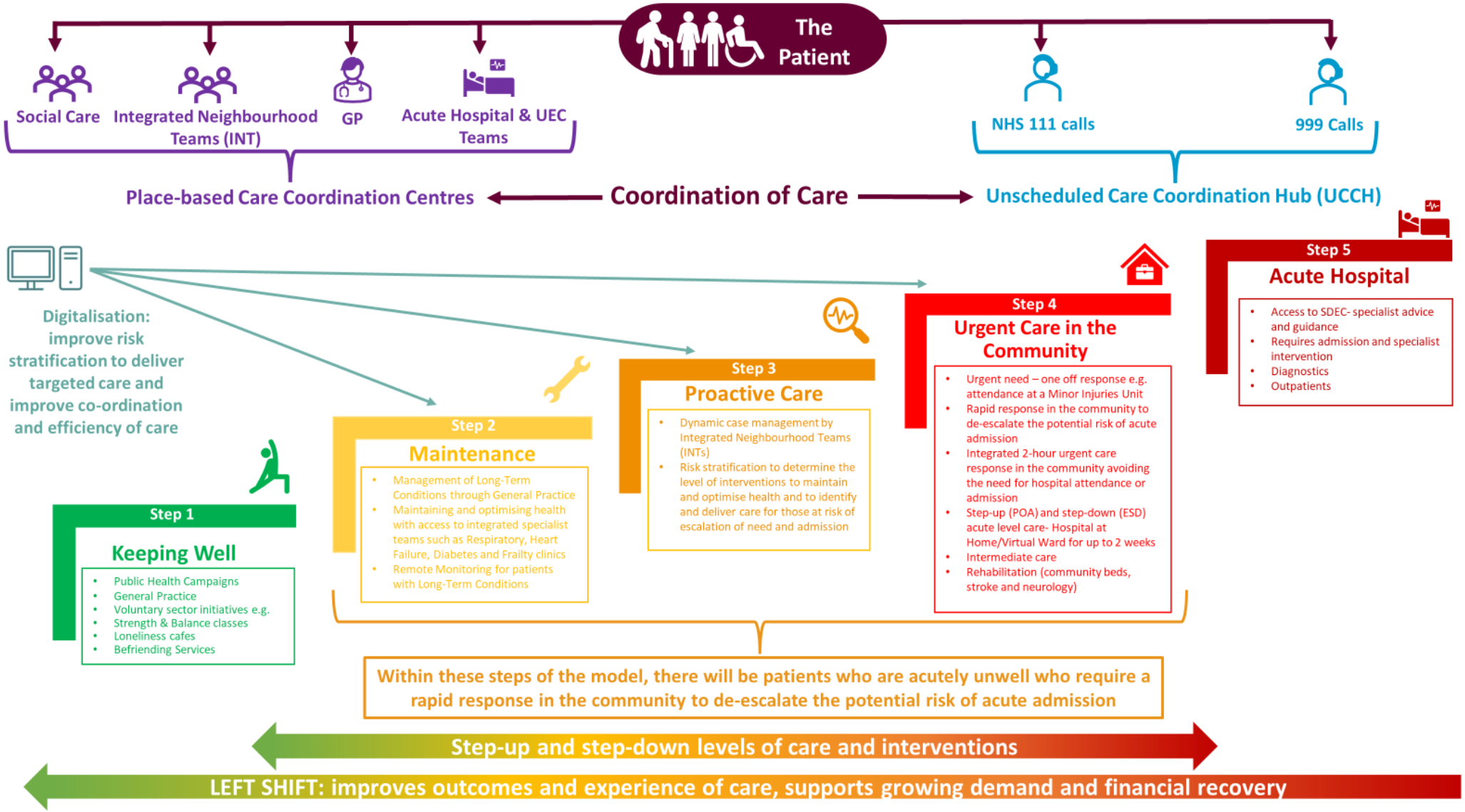
Practical support, for example templates, searches, training and development are incorporated throughout to provide INTs with the tools that will enable effective delivery.

Supporting information is available including: the expected number of people searches identify in each Neighbourhood, SNOMED codes and other practical information.

Integrated Neighbourhood Teams as a key component of local and national strategies

- Delivering integrated care at ‘Neighbourhood’ level is a key component of NHS delivery plans and strategy, from the NHS Long Term Plan (2019), to the Fuller Stocktake, Darzi review and recently published NAPC report on Creating Integrated Neighbourhood Teams.
- Locally, INTs form a core part of the future delivery model in Hertfordshire and West Essex (HWE) ICS, as outlined in the HWE primary Care Strategic Delivery Plan and ‘Care Closer to Home’ strategy.
- One of the ways that neighbourhood teams can support people locally is through delivering coordinated care for complex patients. This multi-agency, case management care meets the needs of the individual, making best use of local assets and services. This care is intensive, community support and so needs to be targeted to people at highest risk of poor outcomes.
- Getting proactive care for complex cases right will support the ICS ambition to reduce avoidable emergency care for people living with frailty or in their last year of life.

HWE Care Closer to Home Model



INT Infrastructure

Integrated Neighbourhood teams will provide a range of different functions to support the health of their local population. A key function is the proactive management of complex high risk cases. This function will support the local ambition to improve outcomes and experience for people living with frailty and in their last year of life through coordinated care and case management.

For INTs to effectively deliver this care the following key infrastructure need to be in place:

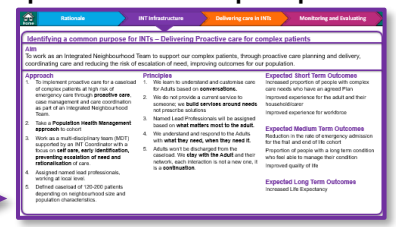
- A clearly defined purpose and function for proactive management of complex cases through INT (and all members of the team) is working towards

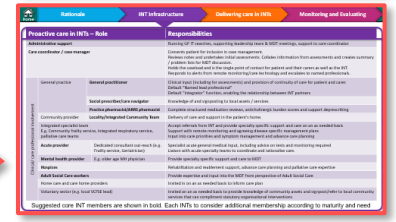
- Dedicated resource from core partners is identified (funding or staffing resource) and aligned to INT delivery
- A core INT delivery team is in place.
- INT leadership team is in place
- Roles & responsibilities of staff and organisations is defined, with work planning dedicated to INT delivery

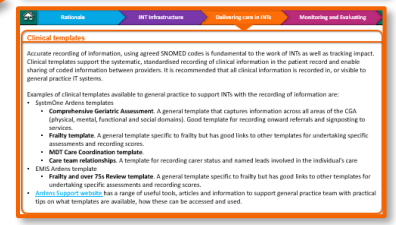
- Data sharing agreements are in place to support INT staff to gather and share information with INT partners

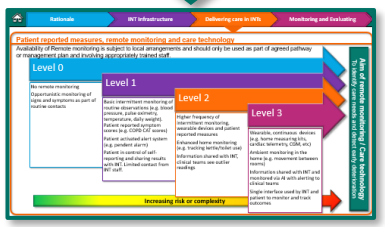
- Tools and resources (e.g. EPR, clinical templates, clinical codes etc) are in place to capture and record clinical information and agreed Plans. See Support tools

- Remote monitoring, if relevant, is available for patients who will benefit.









Identifying a common purpose for INTs – Delivering Proactive care for complex patients

Aim

To work as an Integrated Neighbourhood Team to support our complex patients, through proactive care planning and delivery, coordinating care and reducing the risk of escalation of need, improving outcomes for our population.

Approach

1. To implement proactive care for a caseload of complex patients at high risk of emergency care through **proactive care**, case management and care coordination as part of an Integrated Neighbourhood Team.
2. Take a **Population Health Management approach** to cohort
3. Work as a multi-disciplinary team (MDT) supported by an INT Coordinator with a focus on **self care, early identification, preventing escalation of need and rationalisation** of care.
4. Assigned named lead professionals, working at local level.
5. Defined caseload of 120-200 patients depending on neighbourhood size and population characteristics.

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

Increased proportion of people with complex care needs who have an agreed Plan

Improved experience for the adult and their household/carer

Improved experience for workforce

Expected Medium Term Outcomes

Reduction in the rate of emergency admission for the frail and end of life 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 Life Expectancy

Progressing towards a fully established INT infrastructure

Emerging

- The INT is defined around an agreed population and purpose
- Core partners aligned to INT
- Leadership team identified
- Data sharing arrangements in place
- Roles and responsibilities defined
- Core roles for delivery of proactive care filled and aligned to INT
  - Care coordinator
  - Named lead professional
  - INT 'Integrator'
- Processes agreed across INT for identifying patients, consenting and adding to the caseload
- Processes agreed for assessing and managing patients added to the case load.
- Searches run and patients coded to identify as target cohort

Maturing

(Emerging plus)

- Wider neighbourhood partners identified and aligned
  - Dedicated in-reach clinical support in place from health and care partners
  - Voluntary sector
  - Social prescribing/care navigator
  - Social care
- All INT partners contributing to case management and development of Plans
- Process agreed for identifying and monitoring impact
- Single point of access into INTs in place via care coordinator
- Information shared between providers creating a single assessment and Plan.

Independent

(Maturing plus)

- Fully shared INT resource
- INT access to a single electronic patient record
- Strong relationships within an established team
- Strong connections between proactive case-management care team and other teams (e.g. specialist integrated services)
- Signposting to wide range of health and social care support services as well as voluntary sector and neighbourhood assets
- Capacity increases as partners and resource becomes established, with expansion of INT remit
- Continuous learning and improvement cycles

Proactive care in INTs – Role			Responsibilities
Administrative support			Running GP IT searches, supporting leadership team & MDT meetings, support to care coordinator
Care coordinator / case manager			Consents patient for inclusion in case management. Reviews notes and undertakes initial assessments. Collates information from assessments and creates summary / problem lists for MDT discussion. Holds the caseload and is the single point of contact for patient and their carers as well as the INT. Responds to alerts from remote monitoring/care technology and escalates to named professionals.
Clinical/ care professional involvement	General practice	**General practitioner**	Clinical input (including for assessments) and provision of continuity of care for patient and carer. Default "Named lead professional" Default "Integrator" function, enabling the relationship between INT partners
		Social prescriber/care navigator	Knowledge of and signposting to local assets / services
		Practice pharmacist/ARRS pharmacist	Complete structured medication reviews, anticholinergic burden scores and support deprescribing
	Community provider	**Locality/Integrated Community Team**	Delivery of care and support in the patient's home.
	Integrated specialist team E.g. Community frailty service, Integrated respiratory service, palliative care teams		Accept referrals from INT and provide specialty specific support and care on an as needed basis Support with remote monitoring and agreeing disease specific management plans Input into care priorities and symptom management and advance care planning
	Acute provider	Dedicated consultant out-reach (e.g. Frailty service, Geriatrician)	Specialist acute general medical input, including advice on tests and monitoring required Liaison with acute specialty teams to coordinate and rationalise care.
	Mental health provider	E.g. older age MH physician	Provide specialty specific support and care to MDT
	Hospices		Rehabilitation and reablement support, advance care planning and palliative care expertise
	Adult Social Care workers		Provide expertise and input into the MDT from perspective of Adult Social Care
	Home care and care home providers		Invited in on an as needed basis to inform care plan
	Voluntary sector (e.g. local VCFSE lead)		Invited on an as needed basis to provide knowledge of community assets and signpost/refer to local community services that can compliment statutory organisational interventions

Suggested core INT members are shown in bold. Each INTs to consider additional membership according to maturity and need

Setting up MDT/case management discussions

Delivery of Proactive care through INTs requires administrative resource to arrange and convene case reviews as part of multi-disciplinary working. Not all partners are required in case review meetings, but should have the opportunity to contribute to the development of plans. Wherever possible, the case review and development of the plan should be done with the patient, alongside their carer or family member if appropriate.

The INT should consider:

- Defining membership (core + extended), roles and responsibilities and who is chairing and managing the meeting
- Having an identified 'Integrator' within the neighbourhood team
- Ensuring there is a named person recording information, decisions and actions with good quality, coded data.
- The amount of time that needs to be allocated to each case discussion
- How many new cases and reviews should be discussed in a session
- Sharing documentation prior and accurately documenting and sharing notes from the case review/MDT.
- Whether all partner members need to attend in person, or if hybrid/remote sessions are suitable and increase involvement
- How each partner in the Neighbourhood team can contribute with information on the patient's and carer's needs and developing the Plan.

Flexibility and best ways of working to facilitate membership and engagement of partners. Not all meetings need to be multi-disciplinary, and the focus is on integrated, multi-disciplinary care. Some follow up and review may be completed by a sub-group of the core team.

INTs will need to develop and improve their processes, learning from what works within their local area, adopting a learning culture.

Integrated Neighbourhood Teams - Proactive Care Blueprint

Identify the Cohort

Run 'INT Proactive Care Cohort' search, in GP patient record systems to identify priority cohort using Population Health Segmentation Model and risk stratification

Recording using SNOMED code 'at risk of emergency hospital admission' 788921000000108 or 'eligible for integrated care pathway' 936221000000104

Add to the Caseload

Review needs of prioritised cohort, clinical validation to check will benefit from proactive care in INT.

Agree who and how to make first contact with the adult. Explain and gain consent for the service.

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

Deliver Proactive Care

Named Lead Professional

INT MDT

Care Coordinator

Shared Care Record

Continuous improvement cycle

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

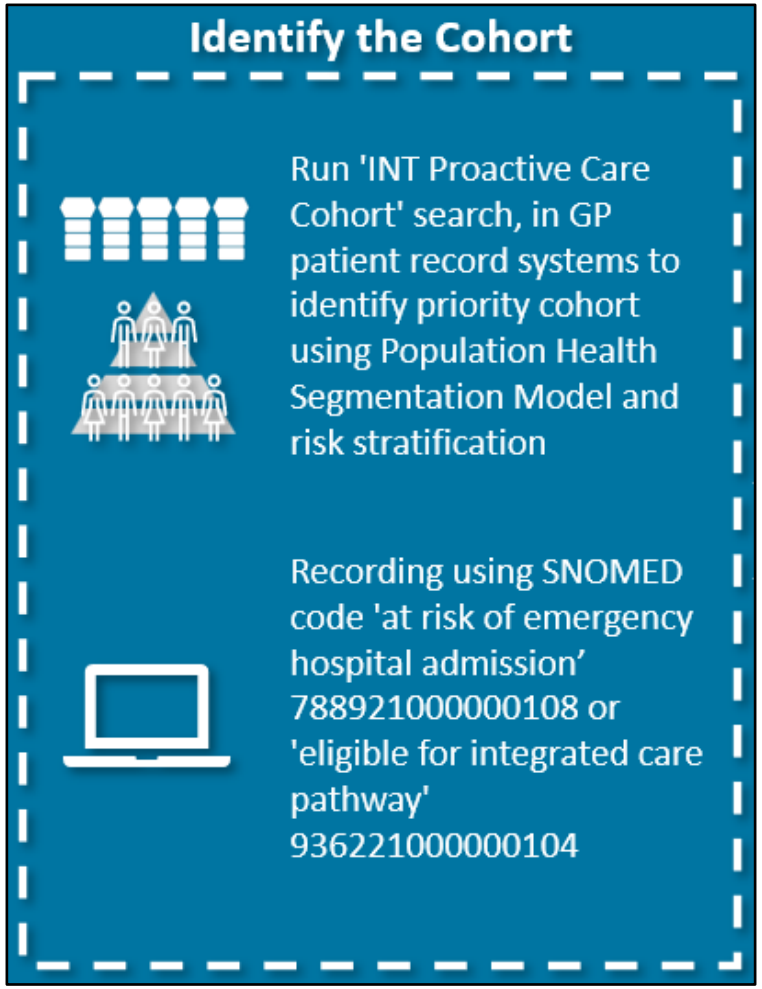
Identifying patients

Practices should identify the group of patients suitable for proactive care by running the following GP IT system search: **INT PROACTIVE CARE COHORT**

Patients identified using this search should have the SNOMED code ‘At Risk of Emergency Admission’ **788921000000108** or ‘Eligible for Integrated Care Pathway’ **936221000000104** added to their clinical record. For EMIS practices, it is particularly important the code is then upgraded to a ‘Problem’ so it displays in the patient's Shared Care Record across providers.

This search has used advanced analytics to identify ~120-200 patients per Neighbourhood with advanced disease and complexity or severe frailty and end of life (equivalent to 3% of over 65 population) who are at increased risk of requiring emergency care within 6-12 months. See Supporting Information for numbers per Neighbourhood.

The patients returned using this search have been identified using a combination of population segmentation and risk stratification. As more advanced tools become available, these will be made accessible to INTs to help them in proactively identifying people at high risk of an emergency admission.



Review, consent & adding to caseload

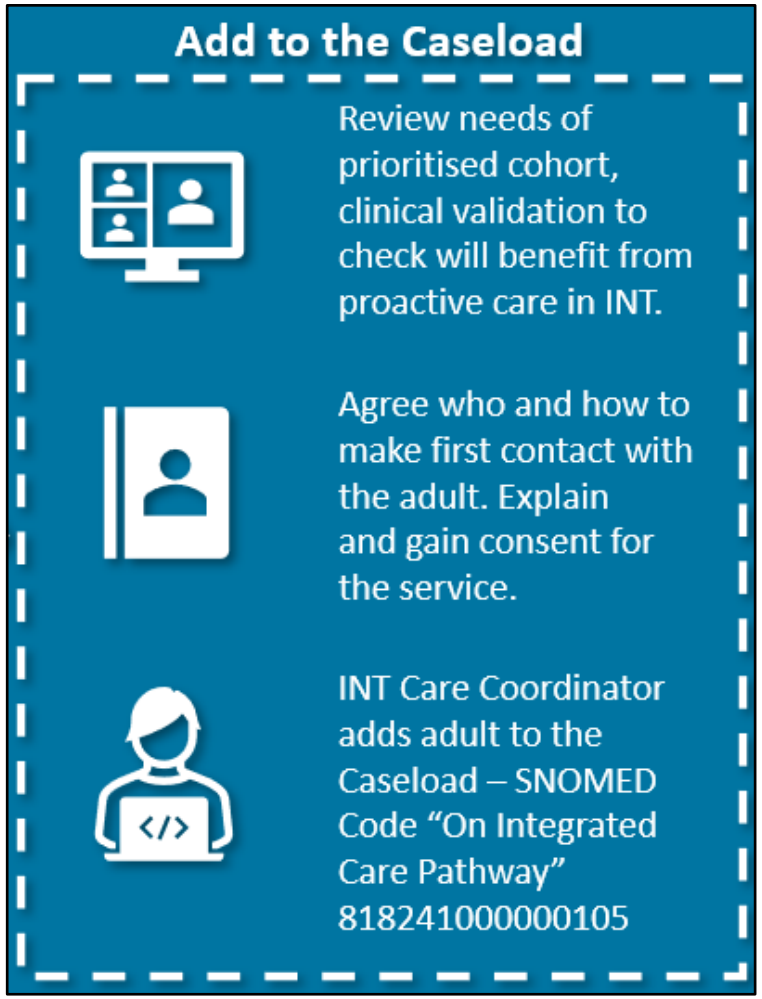
Once the search '**INT Proactive Care Cohort'** has been completed.

1. Undertake a desktop clinical review of each patients' case notes (including service utilisation across the system via theographs on DELPPHI) to identify patients who will benefit from proactive multi-disciplinary care coordination and case management through INTs.

2. If identified as appropriate for the INT caseload proactively contact patients for the caseload to inform them of the service. If not, code as "Proactive care needs assessment not appropriate" **1239441000000103**

3. Explain the service to the patient (or Next of Kin if relevant), gain consent, record in the EPR and share the patient information leaflet.

4. If the patient declines, add SNOMED code 'Integrated care pathway declined' **877011000000107.**
   If the patient consents, add the SNOMED code "On Integrated Care Pathway" **818241000000105**



Case management and care coordination

1. Assessing and monitoring needs

Understand the individual's needs

Assess the patient's holistic (physical, mental, social and functional) needs through information gathering and conversations with the patient, their carers and others. Confirm Next of Kin.

Review current Medication and Anticholinergic burden and any Advanced Care Plan with patient.

Agree patient goals and priorities.

Summarise information for MDT discussion.

2. Multidisciplinary care and Planning

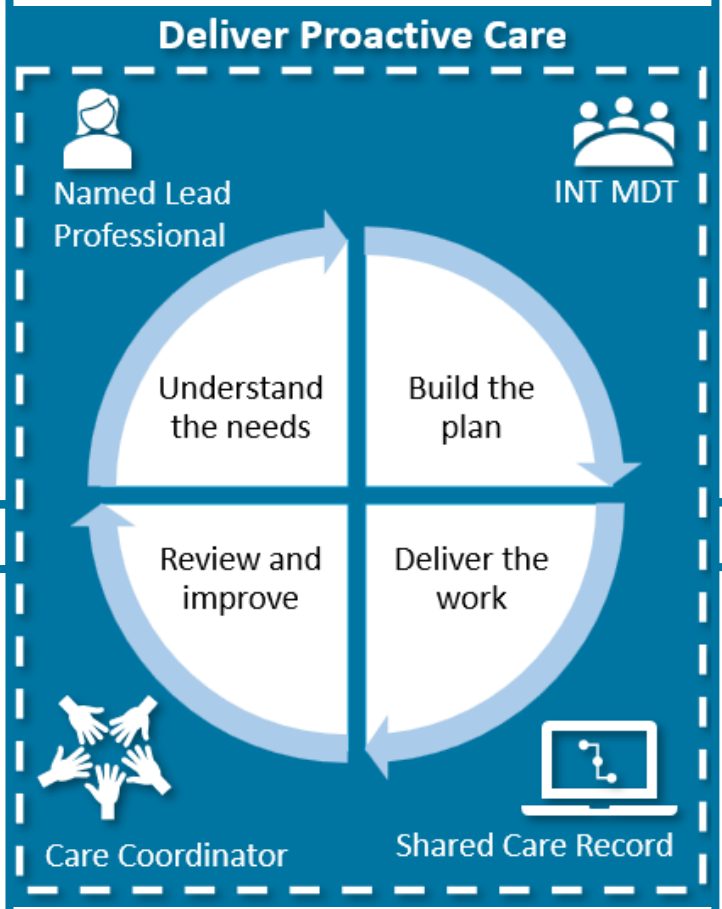
Build the plan

MDT review needs and goals and identify problem list and priorities for action.

Consolidate and rationalise care aligned to patient priorities.

Agree the most appropriate named lead professional.

Develop a joint plan with the patient, including escalation plans and actions in the event of a crisis.



4. Review to improve

Continue to involve and engage the patient in the ongoing monitoring and assessment of needs.

Set a review date according to complexity alongside dynamic review as needs change.

Update individual holistic assessments and plans as they develop, particularly if urgent issues arise.

3. Implement changes and coordinate care

Coordinate and streamline care, including input from specialist teams as required. Take actions to achieve goals and reduce risks.

Communicate and share the plan with relevant teams. Ensure upload to Shared Care Record (in particular ACP) with Named Lead Professional, Care Coordinator & NoK.

Respond to urgent issues as needed. Use remote monitoring where appropriate.

Understand needs – Initial assessments and information gathering

Assessment 'bundle' for frail and end of life cohort

Consider the following as part of the holistic assessment and review of the patient's needs. This is based on the BGS Comprehensive Geriatric Assessment toolkit. Use the SNOMED code **"Subject of Comprehensive Geriatric Assessment" 836131000000104**

- Physical health – disease specific assessment and review (e.g. heart failure, COPD, diabetes review) as part of a holistic physical assessment, vaccination status, osteoporosis/FRAX
- Mental health – mood/depression (PHQ2 or PHQ9), anxiety (GAD-2 or GAD-7), loneliness (UCLA 3-item scale), dementia/memory (6-CIT)
- Social – carer status, safeguarding, housing and home safety, smoking status and behaviour risks
- Functional – frailty status (Rockwood), falls risk assessment (FRAT), hearing, vision, nutrition and dental, gait and balance, activity of daily living
- Medication – structured review of current repeat medications and anticholinergic burden score, including indications and feedback from patient

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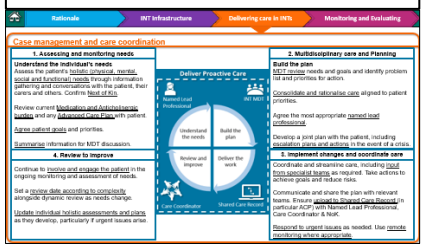

Patient defined goals

As part of the initial and ongoing support, the individual's personal goals should be identified and documented and considered at all stages of decision making, involving carers and relatives.

Identify recent assessments completed across care settings and record results

↓

Meet with the patient (and any relevant carers and family members) to discuss and complete holistic assessments

↓

Collate assessments on health, social and wider needs (including carers)

↓

Record information into the electronic patient record using appropriate clinical templates or codes.

↓

Create a summary of the patient's needs and wishes for discussion at MDT. Include a problem list that has been agreed with the patient
Add the patient to an upcoming review meeting

MDT review and building agreed Plans

Multi-disciplinary review

- Complete a multi-disciplinary review of information on patient needs and medication/treatment regimen, involving the patient (and their carer or family if appropriate).
- Develop a prioritised problem list and management plan, including key risks.
- Agree the most appropriate named professional lead for the individual, based on the needs and problems.
- Complete a structured medication review, consolidating medicines and deprescribing where appropriate.
- Agree a plan for coordinating and consolidating care around the needs and wishes of the individual. Consider avoiding multiple specialist appointment.
- Consider the role of technology to support remote monitoring.
- Identify additional care, services and support the individual requires.
- Agree a plan for responding in a crisis with the individual (and their carer or family if appropriate).

Information sharing

Consent to share the agreed Plan with system partners and services directly involved in care and support.
Ensure the patient and services are aware of key contacts to communicate with, both proactive and in a crisis.

Recording MDT completion

Once the case review and action plan is completed, record using SNOMED code **"Multi-agency case management review" 1026051000000106**

Outputs

1. An agreed Care and Support Plan that includes ReSPECT or PEACE advance care plan documentation, treatment escalation plan and management plan for conditions. The Plan should include a medication regimen, care coordination plan and the services/specialties supporting the individual's care.
2. An agreed set of actions for managing care, linked to Plan, with named leads and timelines for implementation.
3. Agreed timeline for routine reassessments and follow up review by Named lead professional +/- multi-disciplinary team.

Principles

- Patient centred care that considers the individual's holistic goals, wishes and circumstances.
- Managing multiple care touch points and coordinating care and delivering joined up care and support close to home.
- Multidisciplinary care, not always multi-disciplinary meetings.

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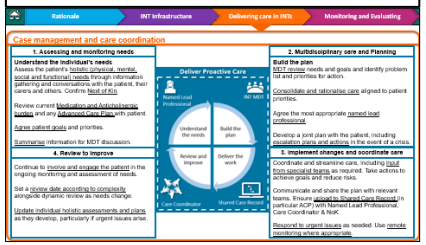

Deliver the work - proactively manage care

Ongoing case management and care coordination

Following case review, the care coordinator collates an action plan and coordinates care.

- Compete assigned actions on action plan
- Arrange any additional tests or investigations (e.g. blood tests)
- Liaise with specialists and named action owners to complete tasks, including structured medication review and changes to medication regimen
- Sign post and refer to services that will support the needs and issues identified in the Plan

Specialty and provider leads complete assigned actions as per the Plan.

Care is consolidated and rationalised, creating coordinated support around the patient. The patient avoids contacts with services that are unnecessary or duplicate care.

Medications are aligned to the Plan, avoiding overprescribing and medication related harm.

Proactive monitoring and response to crisis

Care coordinator

- Acts as the single point of contact for the patient or as per local arrangements (including out of hours).
- Reviews information from remote monitoring and care technology to identify early signs of deterioration.
- Where there is evidence of acute illness or deterioration, links with named lead professional to agree an action plan.
- Responds according to urgent needs, considering escalation options in the community (e.g. Hospital @ Home/Virtual Hospital, SDEC pathways etc).

INT leads from partner organisations

- Provide on the day advice on managing urgent issues, including liaising with Hospital @ Home and Virtual Hospital.
- All providers to prioritise face to face response and consideration of community response to urgent needs in line with the individual's Plan.

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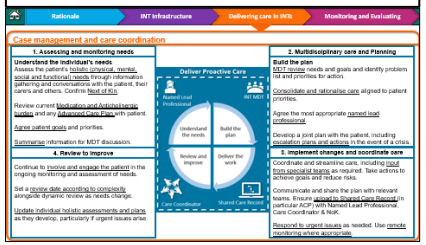

Patient education and advice on self-management

Escalation plans support patient decision making.

Patient provided information on when and how to contact the care coordinator.

Share relevant patient leaflets, information and advice.

Review and improve the Plan

Reason for review by INT

Agreed date for review
The review date should consider the complexity of need and clinical benefit of reviewing and updating the agreed plan

Identified change in status or need, e.g. following an acute illness or urgent episode of care (e.g. a hospital admissions) or evidence of disease progression.

Reassess needs

Update relevant assessments and record patients wishes and goals
Review escalation plan and Advance decisions
Assess what is working well for the patient and what can be improved
Update the Plan and ensure sharing across partners.

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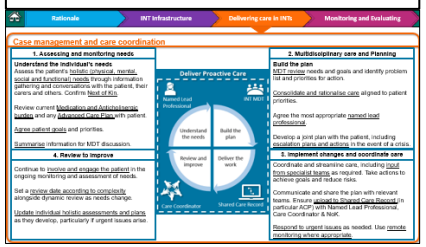

Schedule for MDT discussion / case review

Arrange follow up for completion of reassessments, review in INT case discussion with updated Plan and actions

Consider step-down from the service/MDT.

Is there ongoing benefit to the patient of multi-disciplinary proactive management and care coordination
Consider if the patient has palliative care needs that mean care is better managed through GSF meetings

INT learning cycle

Each INT will be starting from a different point, depending on the maturity of relationships and established integrated working. The aim is for INTs to deliver proactive care for complex cases at the scale that meets current capacity and adopt a culture of improvement that supports a move towards increasing maturity and independence.

- A core initial function of INTs is the implementation of proactive case management through multi-disciplinary working, with an initial focus on the frail and end of life cohort. As the INT matures, this function can then develop and expand to reflect other local issues and needs, increasing capacity as benefits are realised.
- Adopting the principles of integrated working across organisational boundaries will deliver coordinated, joined up care. This will support wider system improvement and positive culture change and integrated approaches to frailty care.
- Mature and independent INTs adopt an active, enquiring approach to development, learning from cases and multi-disciplinary discussions to adapt and improve the quality of proactive care offered.
- Accurate coding of information in the clinical record supports learning and evaluation of the impact proactive care has on this cohort. Clinical templates and coding facilitate the entry of information.
- Alongside INT learning and development, the ICB will undertake an evaluation of proactive care in INTs to assess impact and establish what is working well and can be scaled across the ICS.

INT Development progress monitoring

INTs will self-assess their progress against developing their infrastructure and maturity against Emerging, Maturing and Independent characteristics using the INT Development Dashboard.

Information on INT development will be shown alongside data (extracted automatically) on the number of patients under proactive management within INTs alongside the number of patients in receipt of care processes (e.g. CGAs, record sharing) and MDT reviews. This will allow neighbourhood teams to track the size of the cohort being managed by proactive care and activity levels.

The INT Development Dashboard supports continuous improvement and sets out guidance on the standards around ways of working. The INT Development Dashboard can be used by INTs to learn from others that are further towards 'Independent' status, or managing a larger caseload. It is not intended as a tool for comparing INTs against each other.

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Supporting Information
Proactive care of complex patients in INTs

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Key contacts and links

HCP links and contacts

- South West Herts – ICB primary care locality support managers (hweicbhv.localities@nhs.net), CLCH leads (Leanne Fishwick, Louise Ayers, Kevin Barrett) clcht.herts@nhs.net
- East & North Herts – ICB primary care support managers (hweicbenh.localities1@nhs.net), HCP leads (Sabina Tai and Cathy Galione)
- West Essex – Sara Choudhry (sara.chaudhry2@nhs.net)

Other links

- ICB strategy
- PHM website
- PHM email: hweicbhv.phm@nhs.net

Resources

Neighbourhood teams should utilise the collective resource of all partner members. This includes:

- Primary care multidisciplinary teams, such as
  - Staff employed to deliver care proactive care as part of national (e.g. IIF) or local (e.g. ECF) contacts. Care delivered through neighbourhood teams will support the delivery of this contractual work if information is recorded in the GP IT system using appropriate clinical codes.
  - ARRS funded roles (e.g. care navigator/social prescriber, clinical pharmacists etc).
  - Clinical resource will be released through proactive management and care coordination in this cohort of patients that use a high level of primary care services.
- Community services
  - Teams currently delivering care through community services for this population group (e.g. community frailty services, community falls teams, integrated care teams).
- Secondary care
  - Secondary care providers can use clinical capacity released as a result of the associated reduction in emergency admissions in this cohort to support neighbourhood teams through restructuring job plans.

As they form, **Emerging INTs** should take stock of existing services, resources and pathways that are focused on people with frailty. The INT should develop a plan for aligning these and bringing services and resources around the patient, consolidating and streamlining care.

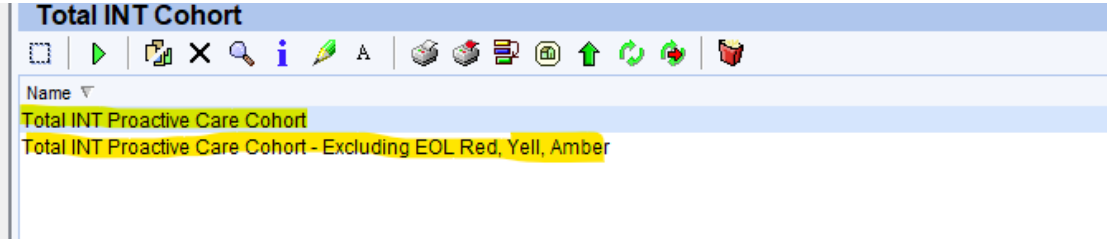
INT Caseloads – Accessing Searches

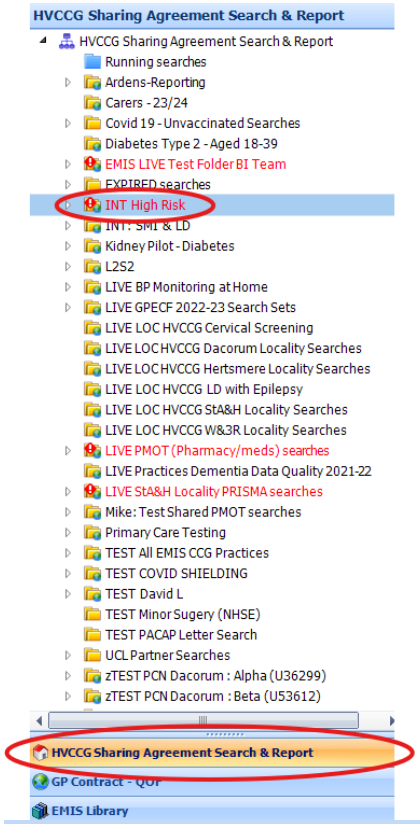
The INT High Risk cohort searches can be found in the following areas of SystmOne (depending on HCP):

- West Essex: West Essex Reporting Unit > West Essex CCG Template Group > INT High Risk
- East and North Herts: Hertfordshire Main Reporting Unit > ENHertsCCG > INT High Risk
- South West Herts: Hertfordshire Main Reporting Unit > Herts Valley CCG > Int High Risk

The final Searches you need to run are contained in a folder titled '**Total INT Cohort**':

- **INT High Risk > Total INT Cohort**

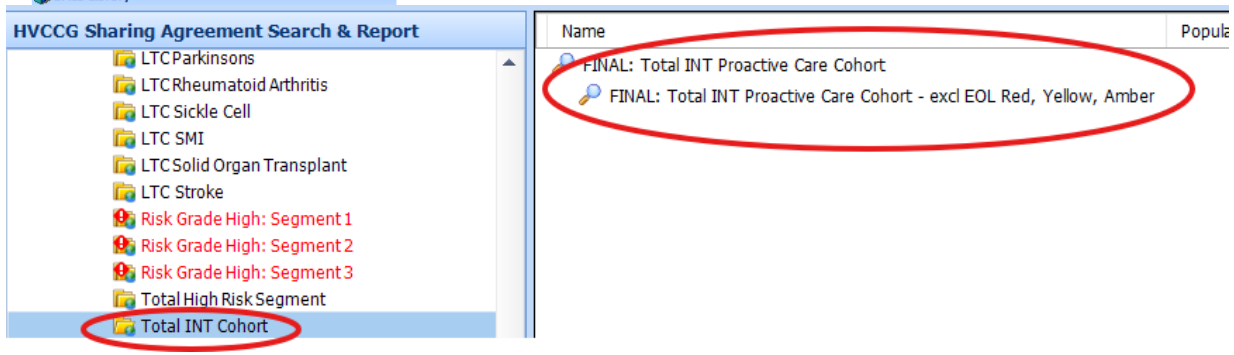




For EMIS, searches can be found in the HVCCG Sharing Agreement Search & Report section of EMIS Web as shown.

This folder contains many searches used in the logic of identifying our high-risk cohort. The final Searches you need to run are contained in a folder titled '**Total INT Cohort**':
HVCCG Sharing Agreement Search & Report > INT High Risk > Total INT Cohort

If your practice is yet to sign the EMIS Enterprise agreement the searches will need to be emailed – contact hweicbhv.phm@nhs.net for the searches.



INT Caseloads - Searches

The table below gives details at INT level of the estimated number of patients returned by the INT Proactive Care Cohort searches. Please note that a separate report is available including people with a current End of Life GSF status of green, yellow or red. INTs can use this search if care for this patient group will be managed through this model of care, rather than through practice GSF meetings.

Practices will be able to select patients based on clinical review and the capacity and maturity of the Neighbourhood Team.

HCP	INT name	Registered population 65+	Prevalence of frailty (all)	Count of people identified by searches	% of population over 65 identified
E&N Herts	BROXBOURNE ALLIANCE	8181	3483	406	5.0%
E&N Herts	HATFIELD*	3959	2168	206	5.2%
E&N Herts	HERTFORD AND RURALS	13932	5418	559	4.0%
E&N Herts	HITCHIN AND WHITWELL	8934	3439	351	3.9%
E&N Herts	HODDESDON & BROXBOURNE	8931	2773	390	4.4%
E&N Herts	ICKNIELD	12175	3752	432	3.5%
E&N Herts	LEA VALLEY HEALTH	5334	2470	254	4.8%
E&N Herts	STEVENAGE NORTH	7499	2938	275	3.7%
E&N Herts	STEVENAGE SOUTH	10724	3352	314	2.9%
E&N Herts	STORT VALLEY & VILLAGES	10292	3059	392	3.8%
E&N Herts	WARE AND RURALS	7386	821	264	3.6%
E&N Herts	WELWYN GARDEN CITY A*	6017	1917	225	3.7%
S&W Herts	Dacorum	33736	16436	804	2.4%
S&W Herts	Hertsmere	18641	9107	754	4.0%
S&W Herts	StAlbans&Harpenden	26501	5317	557	2.1%
S&W Herts	Watford&ThreeRivers	31727	15108	1018	3.2%
West Essex	EPPING FOREST NORTH	14273	4980	572	4.0%
West Essex	HARLOW NORTH	8975	4068	414	4.6%
West Essex	HARLOW SOUTH	6440	3681	371	5.8%
West Essex	LOUGHTON BUCKHURST HILL & CHIGWELL*	8941	2798	297	3.3%
West Essex	NORTH UTTLESFORD*	2558	637	74	2.9%
West Essex	SOUTH UTTLESFORD*	4897	2208	132	2.7%

* Data for practices accessible via S1 reporting unit & EMIS Enterprise, please consider % not count

Improving identification of patients for management

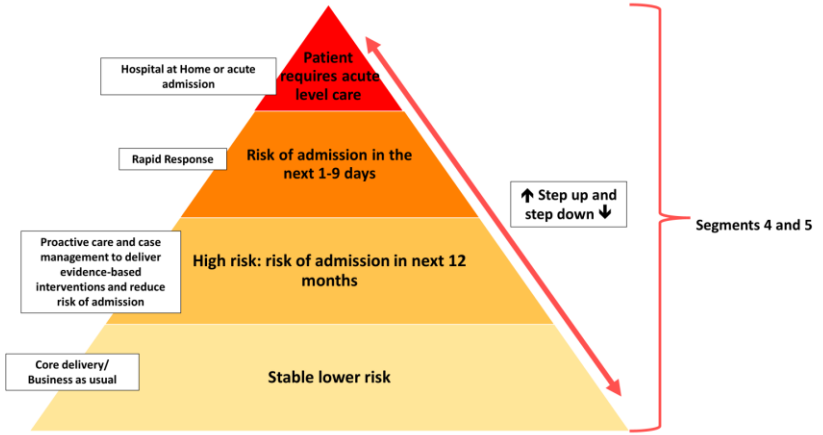
Current tools for proactively identifying cases relies on GP IT system searches. The limitations of this is that it only uses information from a single information source.

The ICB is implementing DELPPHI, the local data platform for Population Health Management. DELPPHI includes a validated risk stratification tool that INTs will be able to use to identify people at high risk of requiring emergency care. DELPPHI combines information from across different health and care settings at the person level alongside wider demographic and social information.

As primary care data flows to DELPPHI INTs will be able to use this to support the identification of people for proactive care in INTS and the risk stratification tool will become increasingly accurate and precise deployed, enabling INTs to target care to individuals most likely to benefit and scale up the service.

The HWE Segmentation tool segments our 1.6 million population into different segments of similar need e.g. Severe frailty and End of Life

The HWE risk stratification tool groups those patients within a segment into cohorts with different risk levels.

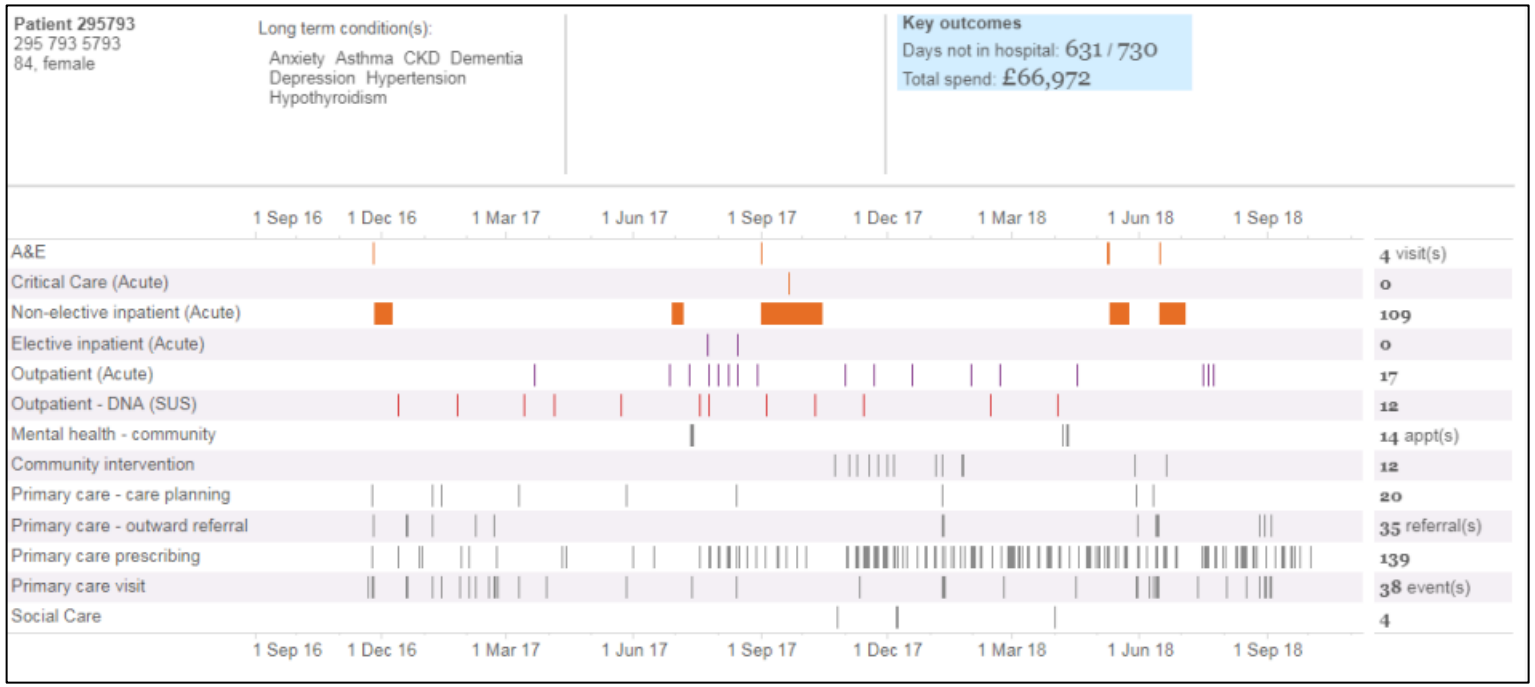


Theographs

‘Theographs’ are a graphical representation of the different contacts an individual has with different services over time.

Theographs will be available at the patient level in DELPPHI, and accessible by INTs. Theographs are a useful tool for INTs to understand the range of different care that an individual is using, how ‘joined up’ that care is and how much urgent and emergency care use the individual requires. This information can support INTs in identifying the right people for inclusion on the Proactive management caseload as the team will be able to identify patients who will benefit from care coordination and proactive management of their conditions.

More information on Theographs is available in this ‘How to’ guide. An example of what a Theograph can look like is shown below



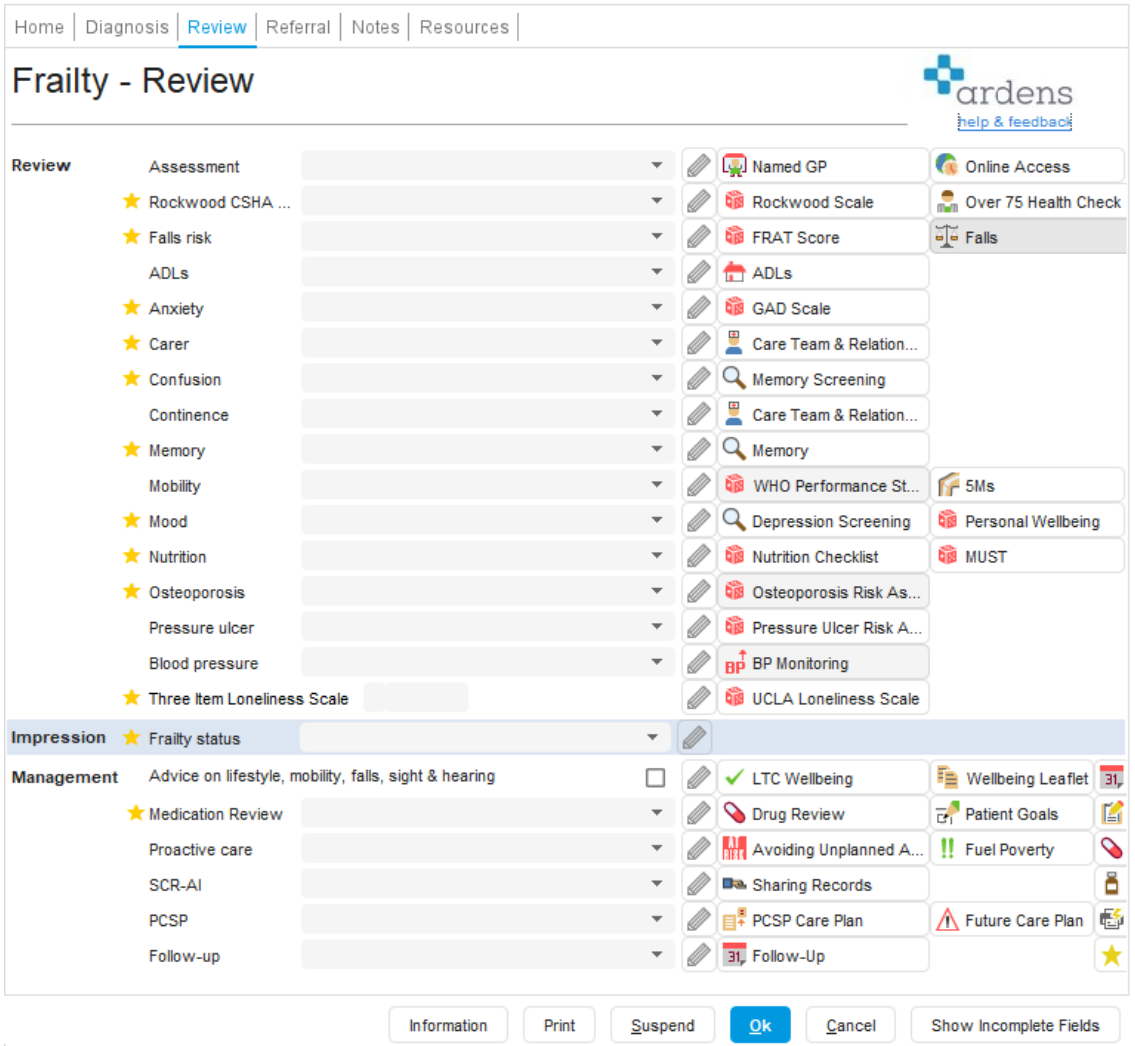
Clinical templates

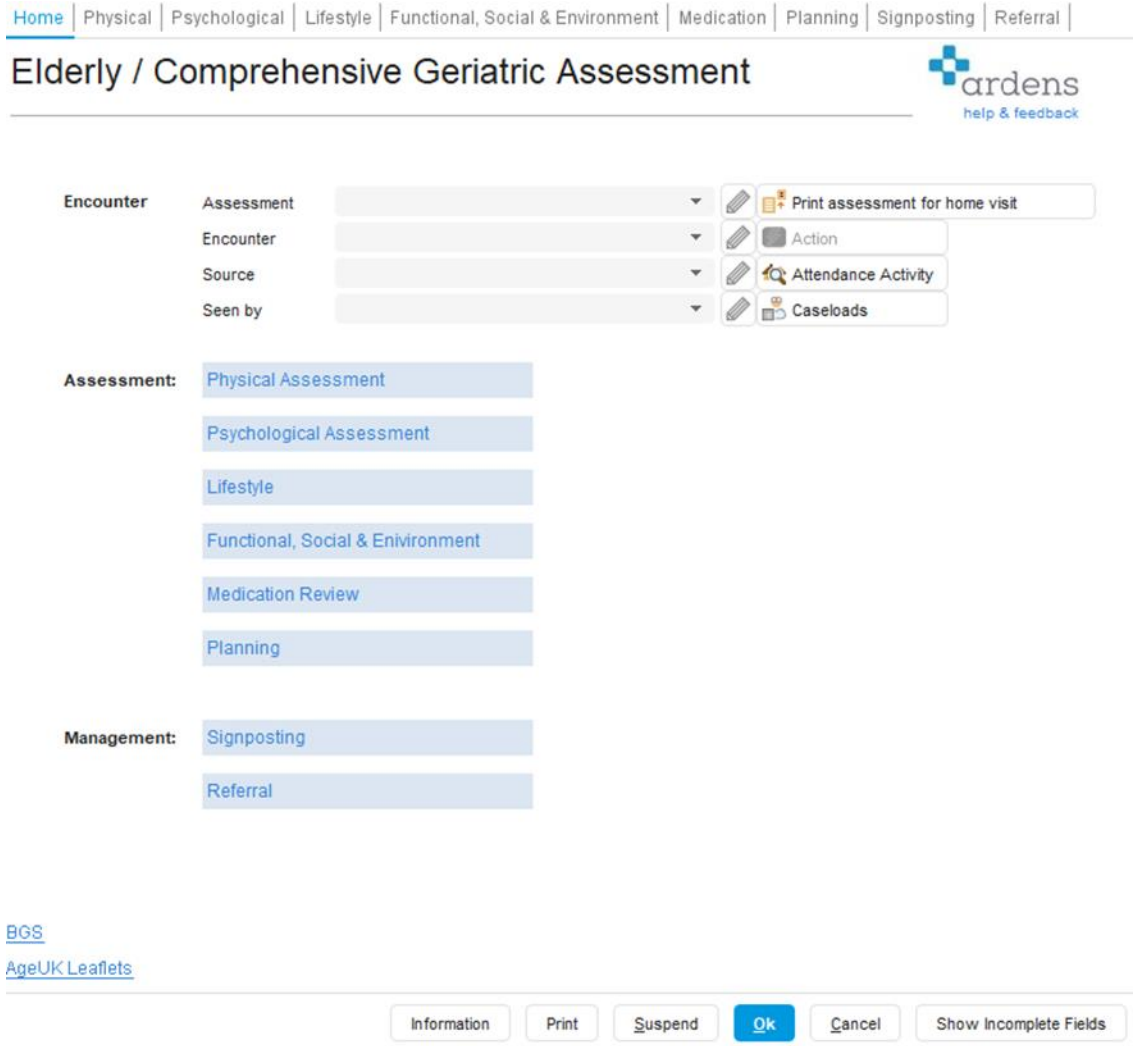
Accurate recording of information, using agreed SNOMED codes is fundamental to the work of INTs as well as tracking impact. Clinical templates support the systematic, standardised recording of clinical information in the patient record and enable sharing of coded information between providers. It is recommended that all clinical information is recorded in, or visible to general practice IT systems.

Examples of clinical templates available to general practice to support INTs with the recording of information are:

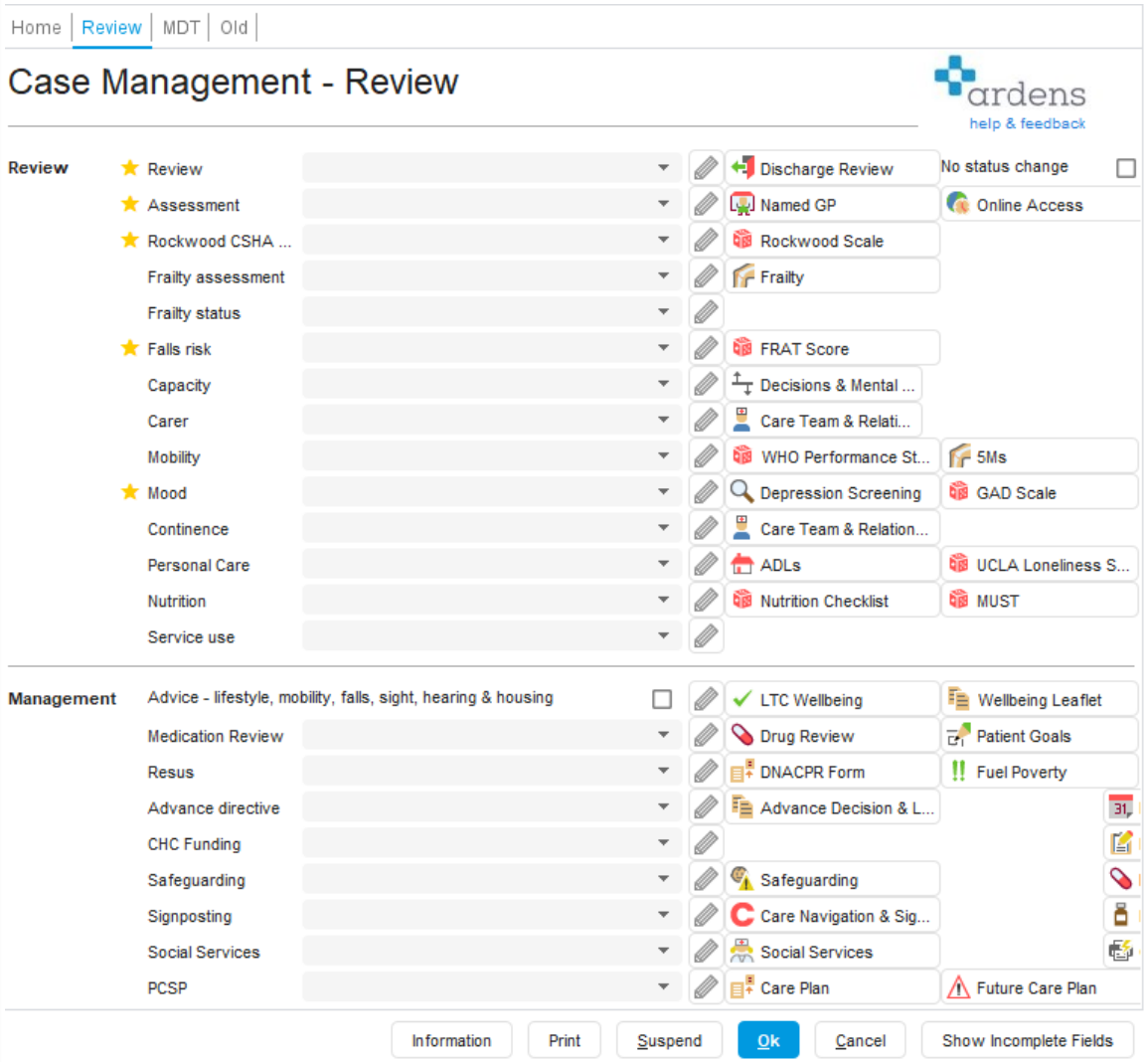
- SystmOne Ardens templates
  - **Comprehensive Geriatric Assessment**. A general template that captures information across all areas of the CGA (physical, mental, functional and social domains). Good template for recording onward referrals and signposting to services.
  - **Frailty template**. A general template specific to frailty but has good links to other templates for undertaking specific assessments and recording scores.
  - **MDT Care Coordination template**.
  - **Care team relationships**. A template for recording carer status and named leads involved in the individual's care
- EMIS Ardens template
  - **Frailty and over 75s Review template**. A general template specific to frailty but has good links to other templates for undertaking specific assessments and recording scores.
- Ardens Support website has a range of useful tools, articles and information to support general practice team with practical tips on what templates are available, how these can be accessed and used.

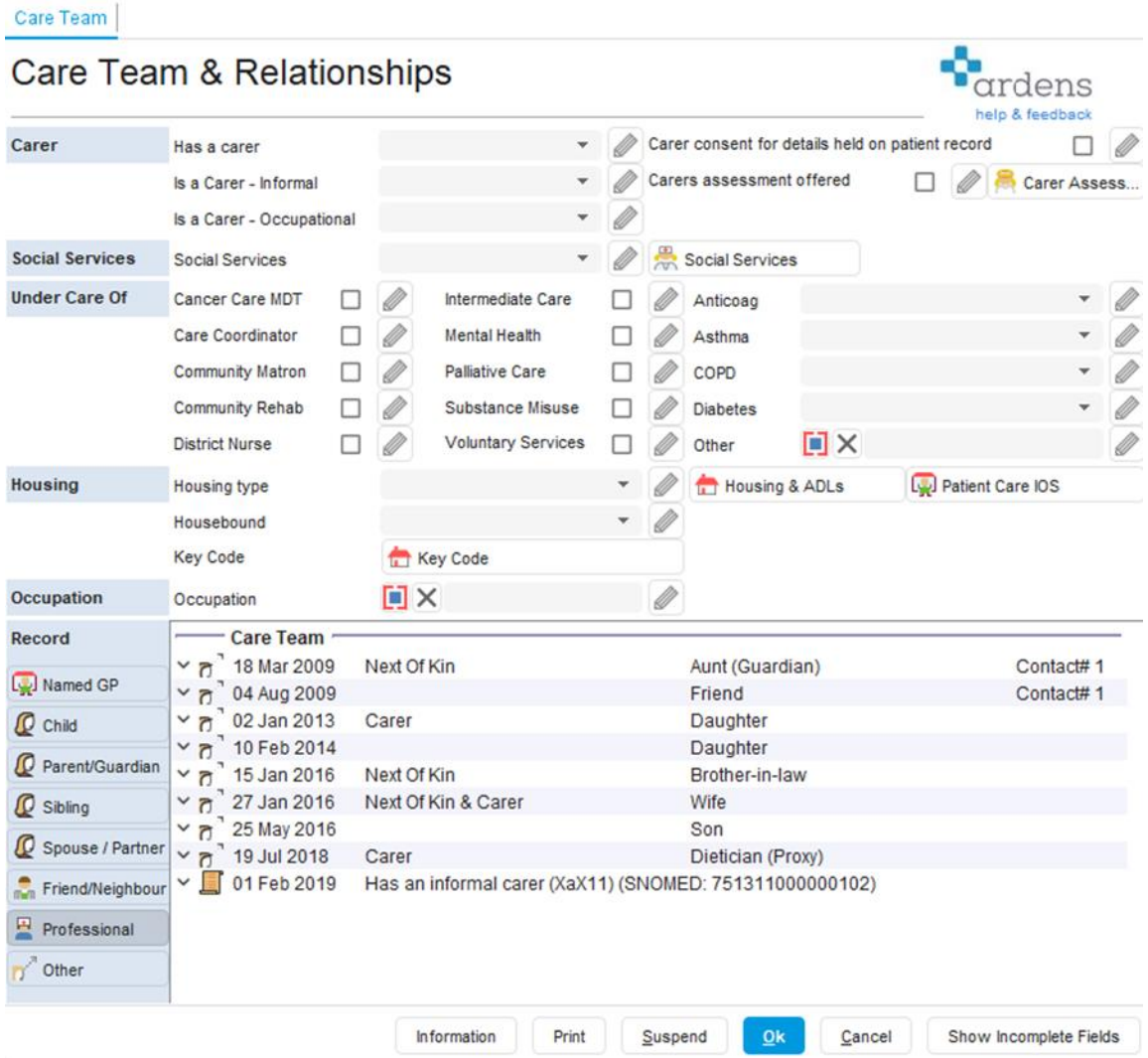
Clinical templates - SystmOne



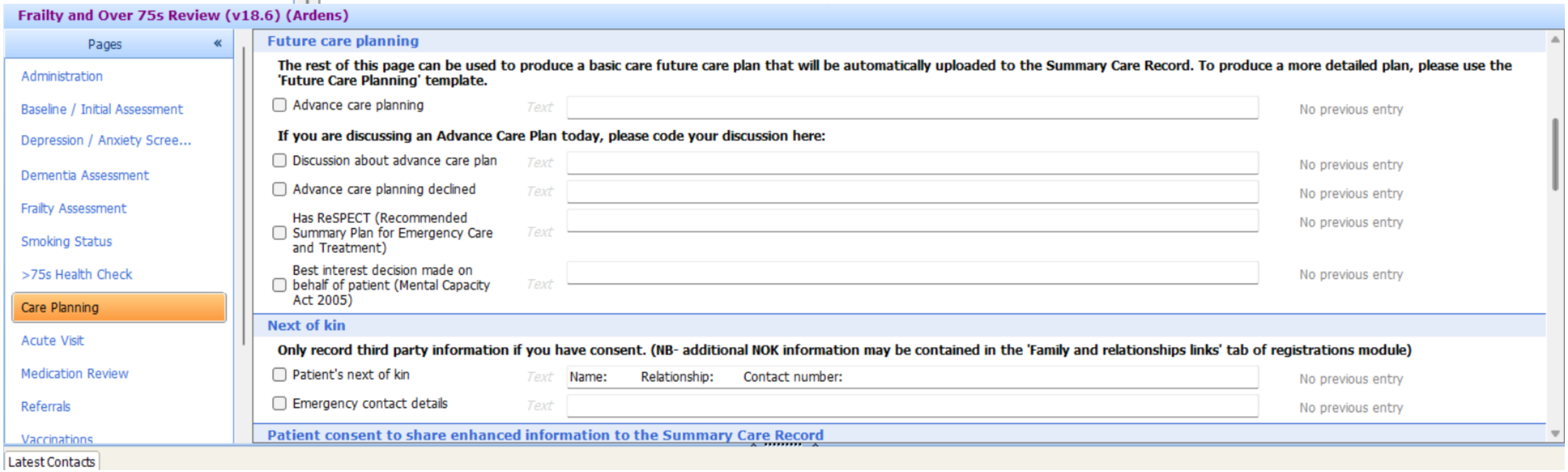


Clinical templates - SystmOne





Clinical templates - EMIS



Role of Self-reported measures, Remote monitoring and Care technology

Remote monitoring and self-reported measures have a role in care coordination to reduce number of face to face visits, improve productivity and identify urgent and emergency issues early. INTs should consider which measurements will support monitoring and care (e.g. clinical observations, in home readings etc), the frequency of taking readings and the level of involvement of the INT. The use of self-reported measures and remote monitoring should consider the complexity of need and potential to benefit, consider the patient's and carers wishes as well as practical considerations.

Monitoring can be patient reported, using existing systems for completing questionnaires and submitting readings. Data is incorporated directly into the patient's electronic record and readings can be reviewed by members of the INT. Patients can be proactively contacted by members of the INT. Patients should be given information and advice on when and how to contact the INT or out of hours service if readings are abnormal, supporting early identification of deterioration.

Monitoring options, depending on local availability. Note that technology is rapidly evolving and new solutions may become available.

- Clinical observations – BP, temperature, pulse, daily weights etc
- Assistive technology in someone's house looking at how often patients mobilise, turn on taps, flush the toilet etc, this can be helpful to reduce needs for a social care package and or reduce the number of calls per day. INTs can establish if these tools are available through discussion with Adult Social Care leads.

Use of complex monitoring should involve the local specialist teams.

Patient reported measures, remote monitoring and care technology

Availability of Remote monitoring is subject to local arrangements and should only be used as part of agreed pathway or management plan and involving appropriately trained staff.

Level 0

No remote monitoring

Opportunistic monitoring of signs and symptoms as part of routine contacts

Level 1

Basic intermittent monitoring of routine observations (e.g. blood pressure, pulse oximetry, temperature, daily weight). Patient reported symptom scores (e.g. COPD CAT scores)

Patient activated alert system (e.g. pendent alarm)

Patient in control of self-reporting and sharing results with INT. Limited contact from INT staff.

Level 2

Higher frequency of intermittent monitoring, wearable devices and patient reported measures

Enhanced home monitoring (e.g. tracking kettle/toilet use)

Information shared with INT, clinical teams see outlier readings

Level 3

Wearable, continuous devices (e.g. home measuring kits, cardiac telemetry, CGM, etc)

Ambient monitoring in the home (e.g. movement between rooms)

Information shared with INT and monitored via AI with alerting to clinical teams

Single interface used by INT and patient to monitor and track outcomes

Increasing risk or complexity

Aim of remote monitoring / Care technology
To identify care needs and detect early deterioration

Data Sharing

Data sharing agreements support partners from different organisations to collaborate and work from a single set of information.

The ICS My Care Record has a range of tools to support INTs and can be used for Proactive Care MDT discussions. An example 'Information Sharing Agreement is available on the My Care Record website in the For Professionals section.

ICS evaluation

The impact of proactive care in INTs will be evaluated across the ICS. This allows for enough scale to meaningfully analyse what is working well and which patient groups are most benefiting from proactive care, allowing further improvements and learning to be shared across all INTs.

Accurate coding of information is needed by neighbourhood teams in order to undertake this analysis.

Population
- People living with frailty or end of life who are at high risk of requiring emergency care

Intervention
- Proactive care in a multidisciplinary neighbourhood team, involving care coordination and case management

Control
- Comparison with the frail population who have not received proactive care from their INT

Outcome
- Improved experience for patient, carer and workforce
- Fewer inappropriate community, A&E attendances & emergency admissions

Continuous improvement cycle
- Iterative development of cohort and intervention
- Evaluating impact and outcomes