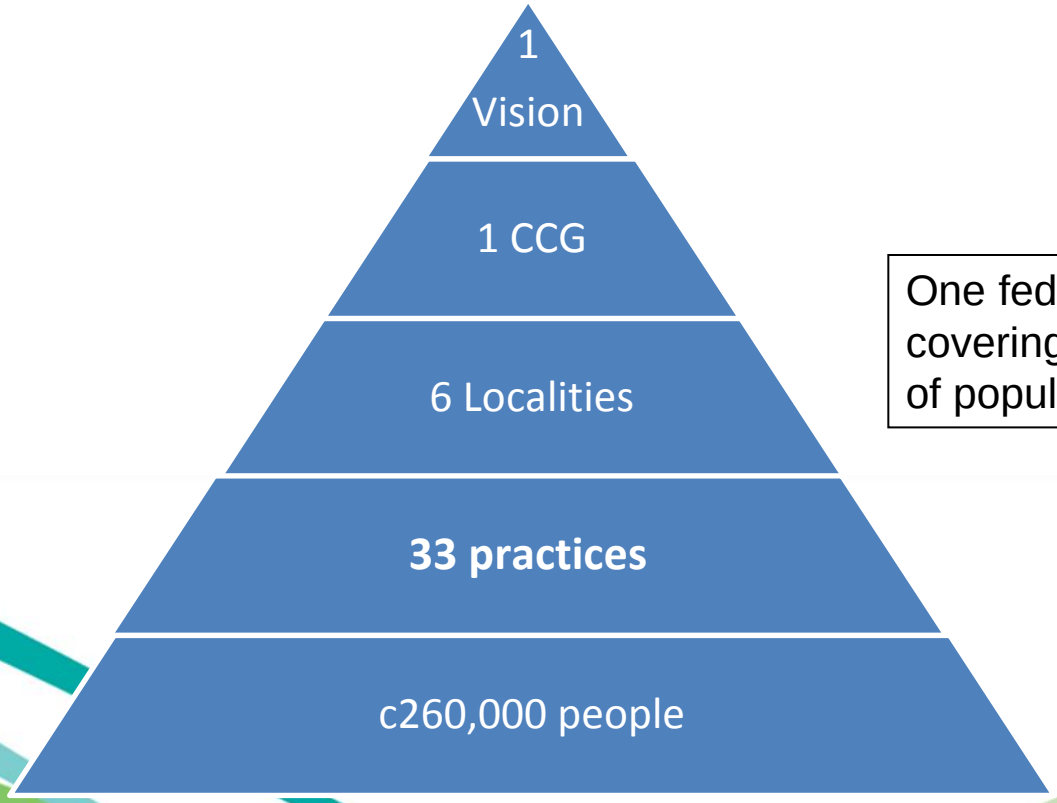
Integrated care

Development of Integrated Care Models for Barnsley Patients

Welcome, are we ready to engage?

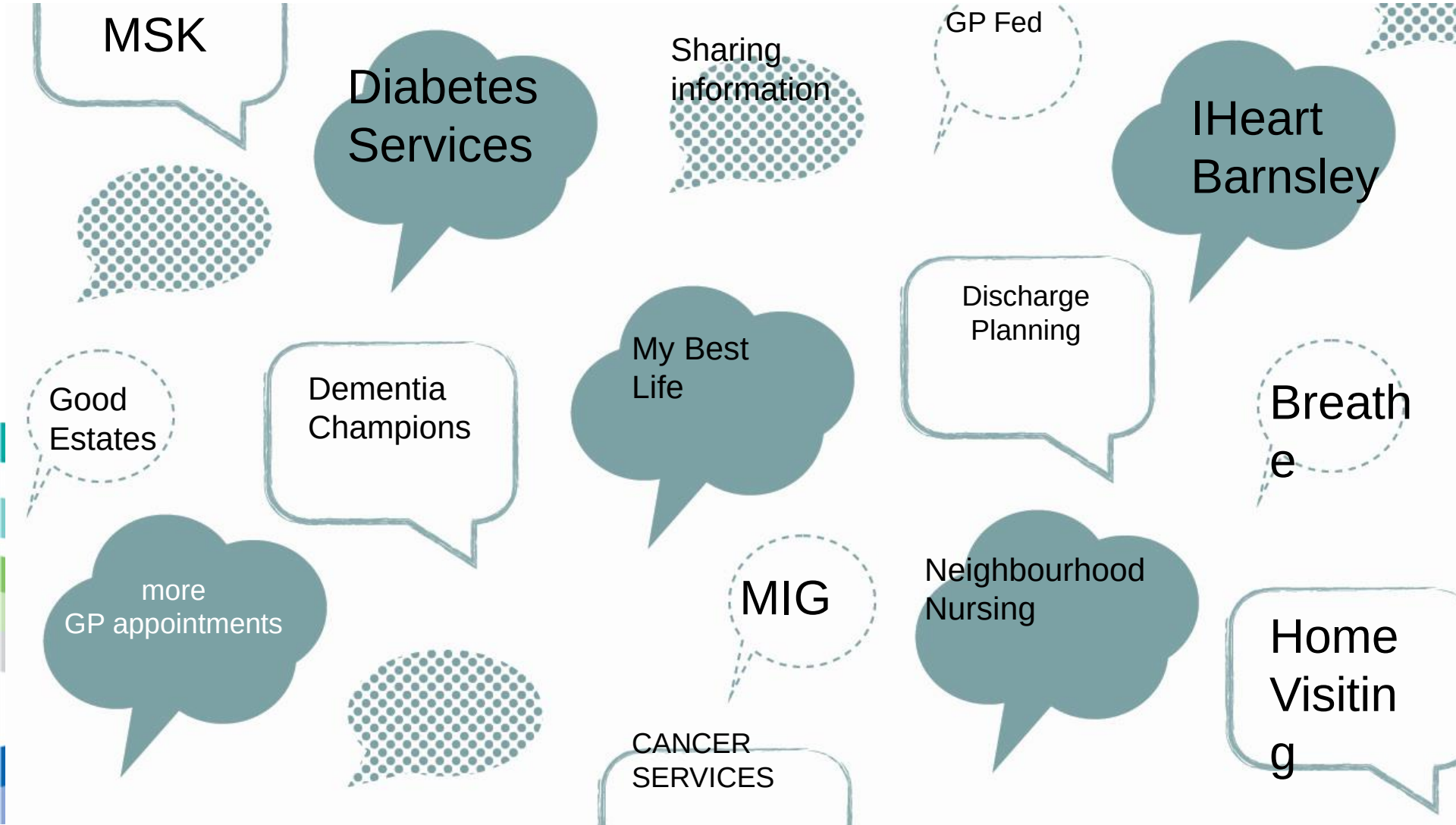
“I want my care to be coordinated and not to feel afraid”

Local Care Networks
2018



One federation covering 100% of population

We are committed to co-design and have already listened



Why are changes needed?

Barnsley has:

- An aging population
- A rise in long term conditions
- Less money due to reduction in funding for Councils and increasing costs for providing care
- Demand for longer term care
- Increased demands on all services

What's our aims?

- Reduce the gaps in life expectancy in Barnsley
- Ensure all children have the best possible start in life
- More emphasis on prevention- help people stay well
- Reduce the need for A&E attendance and emergency admissions
- More local management of health & social care problems
- Better working life

What people have said so far

- Tell my story once
- Keep me at home
- Care & support closer to my home
- Treat all of me at one time
- Getting to see my GP can be difficult

Integration, a new idea?

- The idea is not new- lack of integration dates back to before the NHS Started

- Concerns are about “ fractures” in the systems and delivery, people fall through the gaps

E.g. Primary to secondary care, health and social care, mental and physical health

Integration and integrated care

- ***Integration*** is the combination of process, methods and tools which facilitate integrated care
- ***Integrated care*** results when the culmination of these processes directly benefits communities, patients or services
- ***Integrated care*** is successful if it contributes to better care experiences; improves care outcomes more cost effective delivery

Core components of a successful integrated care

- Effective & Accountable leadership at all levels
- A collaborative culture
- Team working
- Patient and carer engagement
- Defined populations
- Aligned financial incentives- make the money work
- Shared accountability for resources
- Information technology that supports
- The use of guidelines to reduce unwarranted variation

The foundations to building successful neighbourhood models

- **Empowering and engaging with the public** on how to access and use services
- **Developing IT** to support collaborative working, self-care and providing services closer to home
- **Developing a workforce in the community** that is fit for purpose
- **Developing governance systems** which support collaborative working- led by the workforce

NHS
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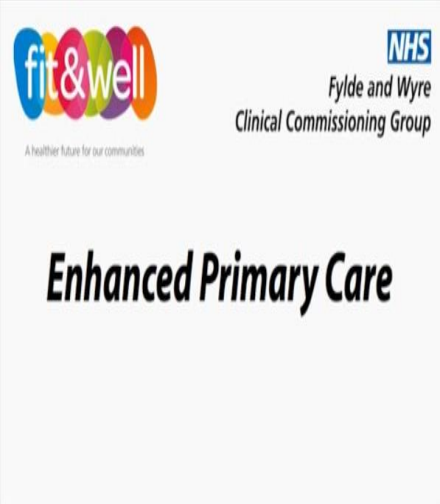
NAPC | National Association of Primary Care

Primary Care Home: population health-based workforce redesign

Primary Care Home (Practices working together in population groups developing new services)	Teams around the patients (Wrapping community based services around practices)
• Developing services to populations of at least 50K	• Wrap around of community services to populations of 50K • Focus on frail elderly and LTCs
• Acute and community spend • Prescribing • Demand Management • Can pool budgets if wish to	• Pooled community and virtual social care budgets to support integration • Local coordination
• GP practice at the centre of co-ordination • Encourage work with secondary care	• Integrated workforce • Strong focus on partnerships • Primary, community and social care • Voluntary Sector



- Coordinated & integrated support for patients with complex conditions
- Increased level of clinical & social support in community
- Designed to enable Health & and Care professionals to operate in a more cohesive manner
- Teams vary ,skills reflect local need
- Enhanced local services
- Better communication between service providers
- Reduced A&E & NEL Admis

Foundations of Enhanced Primary Care

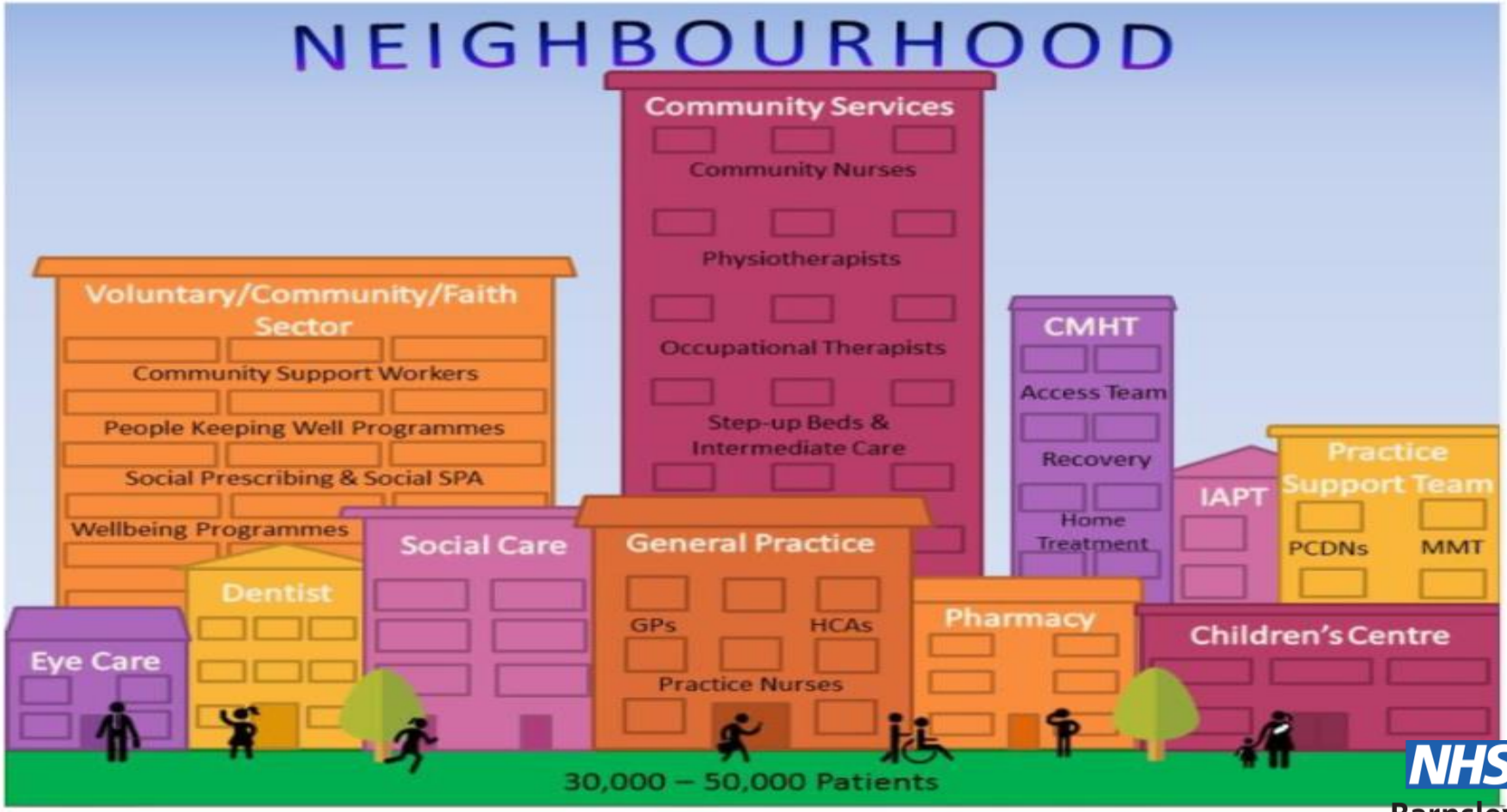
CORE

- GP
- Therapists
- Nurse
- Co-ordinators
- Wellbeing support workers
- Social care
- Mental Health
- Neighbourhood assistants & Administrators

2 YEARS ON

- Drug & alcohol services aligned
- Mental Health specialist
- Social care link worker
- Empowering communities
- Other services linked, police, fire
- Year 3 – aligning all community health services to neighbourhoods

What is the end state?



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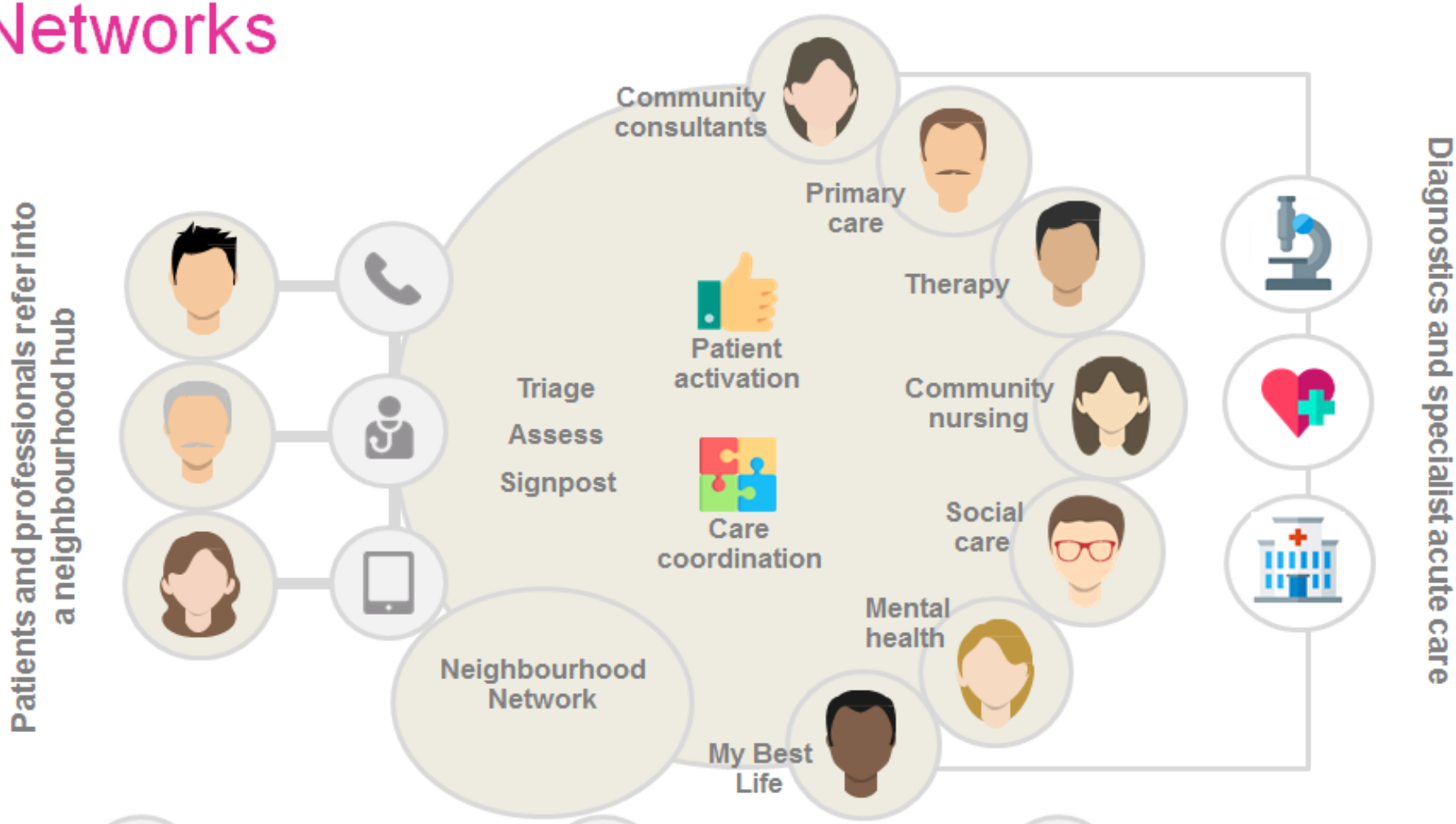
A different future? - Integrated Care Networks



1. Improved outcomes and experiences of care for patients
2. Better Utilisation of the local health and care workforce
3. Improved utilisation and sustainability of local services

Break the ‘rules’, be creative and have the difficult conversations

- Distributive leadership
- A collaborative culture
- Patient and carer engagement- conversations
- Information technology that supports
- Shared accountability
- Aligned financial incentives
- Defined populations

Next Steps

The world hates change, yet it is the only thing that has brought progress – Charles Kettering