



Integrated Care

1. Introduction

Integrated care involves health and social care services working together to ensure individuals receive the most appropriate treatment and care. The Department of Health [Operating Framework for 2011/12](#) outlined an approach to secure quality, value and more responsive and integrated care services.

Integrated care systems include creating new and sustainable ways of working through multidisciplinary teams, in order to streamline the flow of patients across integrated care pathways. This produces a major shift in activity away from hospital admissions and toward community services.

2. The Local Picture

As part of the scoping work for an Integrated Care Pathway in Hounslow, an audit was carried out in December 2010 of 100 frail, elderly people over the age of 65 years in West Middlesex University Hospital. The audit showed that:

- The majority of patients (87%) were aged between 75–95 years;
- The top five reasons for hospital admission were: falls (41%), dementia (29%), heart failure/hypertension (13%), diabetes (5%), and Chronic Obstructive Pulmonary Disease (COPD) (4%);
- Of the 100 patients, 53% had self-referred to A&E, while 12% had been referred from their nursing/residential home;
- 36% of the patients were known to social services and 20% were known to community services; and
- 39% of the patients lived alone.

3. Strategic Leadership and Collaboration

NHS Hounslow and Hounslow Council have made a strong commitment within their 2011/12 joint commissioning intentions to deliver an Integrated Care Pathway for adults and frail elderly people in order to improve both the quality and safety of patient care and, where appropriate, shift care from hospital to community services. An Integrated Care Pathway pilot was launched in June 2011, with a focus on adults aged over 18 years, older people with mental health needs and persons requiring end of life care. The key aims of the pilot are to:

- Provide a range of integrated services to promote recovery from illness;
- Prevent unnecessary hospital admissions via A&E;
- Enable assisted discharge support for timely discharge from hospital;
- Maximise independent living; and
- Prevent premature admission to long-term residential care.

These aims will be achieved through:



- Providing a single point of access for use by patients, carers and health professionals;
- Avoiding admission via a dedicated team set up at West Middlesex University Hospital (WMUH) to rapidly assess patients who are either in A&E, the Acute Assessment Unit, or their homes or care homes (residential or nursing home), so that they can be appropriately referred for acute treatment at the hospital, or diverted to an acute care package in the community; and
- Supporting early discharge such that patients are provided with a seven-day, flexible and intensive care package, which will enable them to be cared for in either their care home or own home ('reablement'), or access to rehabilitation beds (Clayponds) or a day care assessment unit at WMUH. There will also be access to longer stay (typically 6 weeks) rehabilitation beds.

Data from the new service will be used to inform development of the service specification for the Integrated Community Response Service.

4. Priorities

In 2011/12, the emphases in Integrated Care are to:

- Ensure that the integrated care pathway pilot is sustained with good partnership working between all the key stakeholders involved; and
- Evaluate the pilot in order to inform the Integrated Community Response Service.

5. Summary of Need

The table summarising the needs in this area has not been completed as it is not considered applicable to Integrated Care.