Harrow Integrated Care Development Programme
Overview and Update

Health and Wellbeing Board – 3rd November 2018
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Harrow Council LONDON

NHS Harrow Clinical Commissioning Group

HARROW COMMUNITY ACTION

NHS London North West Healthcare NHS Trust

St Luke's HOSPICE

HarrowHealth CIC

NHS Central London Community Healthcare NHS Trust

NHS Central and North West London NHS Foundation Trust

We've identified key reasons for the poor outcomes in Frail / Last Phase of Life people's care in Harrow

Poor identification of people at risk:

- Resulting in A&E attendances and non-elective admissions – 98% admissions resulting in death in Harrow were unplanned and via A & E
- % of frail patients identified by GP practices is hugely variable between neighbouring practices – from 3.5% - 20% of practice adult population

Fragmented services to people :

- Resulting in failed implementation of care plans
- Poor patient and carer experience – patient and staff survey 's
- A&E attendances and non-elective admissions - 8 % growth in admissions via A & E 2017/8 with 3% growth in admissions for older people in Harrow overall in 2017/8. 12 % of elderly admissions are readmitted.

Workforce need greater training/capacity to meet patients' needs

- PIE /PACT feedback / data
- Vacancies in key workforce – DN's, GP's
- Key workforce have significant numbers of Junior Staff with little experience

Financially unsustainable models and services

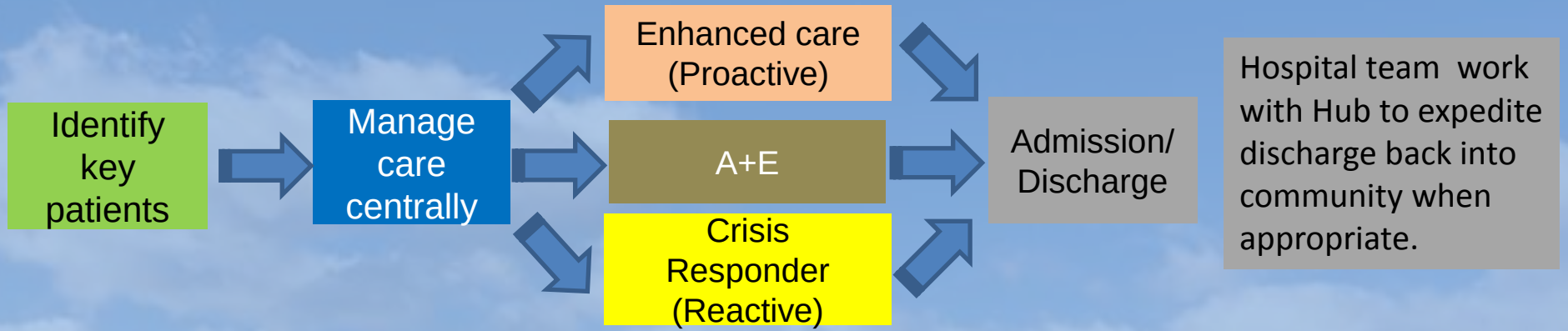
- Failure demand – duplication, repeat visits/tests/assessments
- Non-alignment of resources or outcome

Harrow New Model, based on the evidence..

Toolkit to identify potentially frail individuals & EoLC patients

A+E: Access to dedicated telephone line. Work with A&E team to reduce admissions/ increase flow of information.

Enhanced Care:
1. Vulnerable individual flagged by anyone in the IC system.
2. Triaged by MDT Hub in GP locality footprint. MDT includes disciplines across health, social and community sectors
3. Ongoing assessment (CGA, ACP, DNAR) to identify future needs



Managed Care
1. Assessed by GP locality EPN or GP : shortened/modified CGA.
2. Signposting to services co-located or known to by Hubs (inc voluntary)
3. Referred to appropriate services in Hub e.g. locality social worker,
4. Advance care planning where appropriate
5. Health & resilience coaching

Crisis Management : fluid and rapid
- Health: 8am – 11pm, clinician manned telephone line to offer advice to OOHs teams, paramedics & district nursing teams expanding intervention capabilities of Rapid Response & district nurses e.g. intravenous treatment, catheter complications, faecal impaction,
- Social: Hospice@home overnight Adult social services nex day – capability to insert short duration care package during period of acute illness

Overview of Testing Phase

October 2018

Phase 1:

Prototype testing GP surgeries who applied and pilot model in Nov from 1 practice

December 2018

Phase 2:

Spread test model of care to 'GP locality' and wider Local Authority

- Introduce healthy adults over 65 into model of care
- Lateral work around developing resilient communities
- Introduce dementia cohort into model of care

April 2019

Phase 3:

Spread model of care to entire over 65 population in Harrow

Testing/Actions by Phase

Phase 1: Now till December 2018

- **Prototype testing across 7 practices that expressed an interest and applied. Testing :-**
- **Identification tool, risk stratification, triage and assessment – applicable irrespective of point of in the system**
- **Test levels of managed care at practice level - EPN and GP care planning / advanced care planning**
- **Identification and pilot of the Harrow Integrated Care team (HIC) to assess, manage crises and prevent admissions (PDSA review cases daily to build skills / capacity required).**
- **Test need and use of SPA telephone with clinicians, test triggers**
- **Testing delivery CGA within team**
- **Understanding of training / roles required for model**
- **Pilot Model of Care in Nov from 1 of the practices**

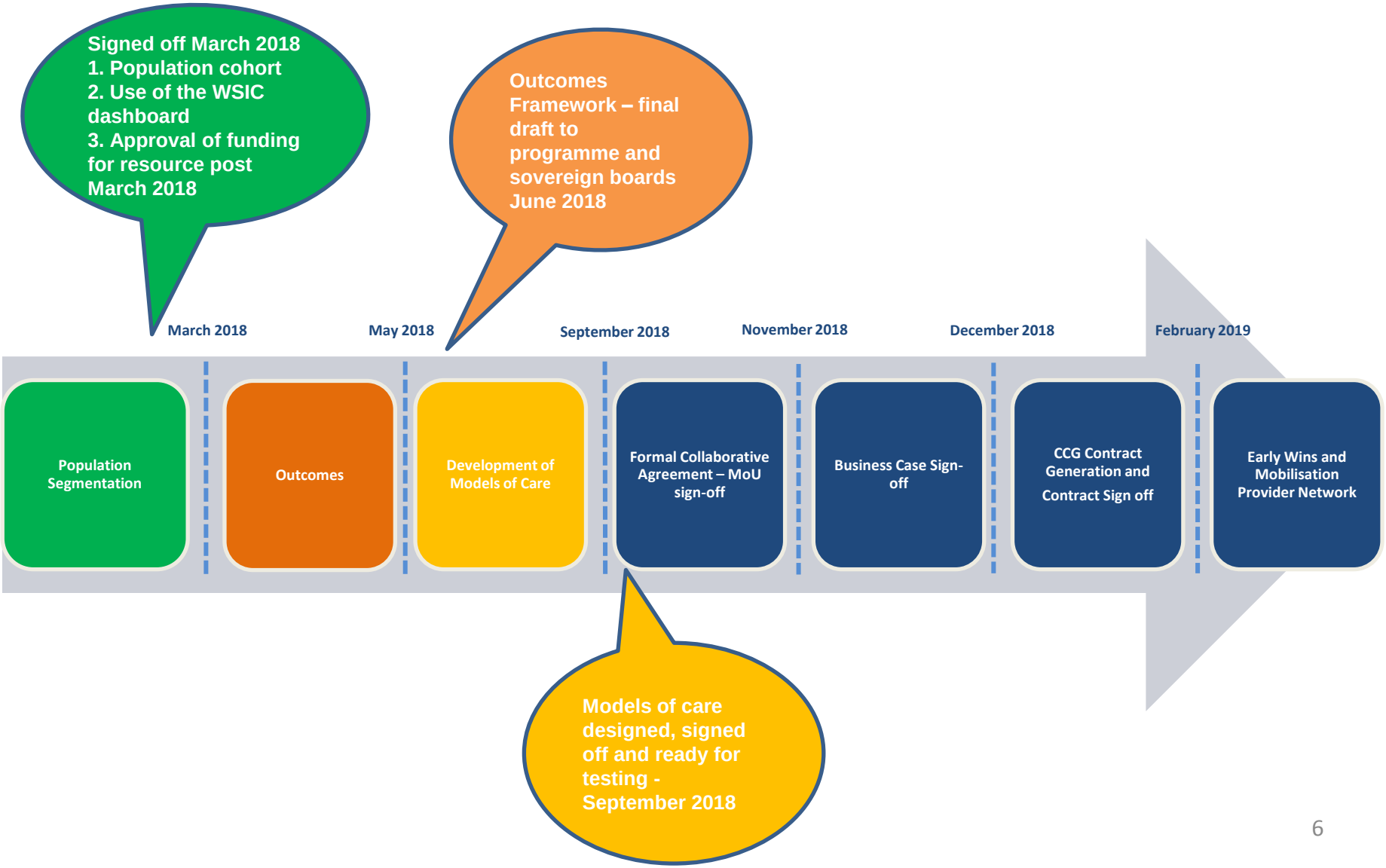
Care Homes specific :

- Develop a Care Homes Charter/Strategy – workshop on 16th Nov 2018
- Set up a Joint Intelligence Group (JIG) – **funding agreed by CCG**
- Use of Quarterly Care Home Managers' Forum to improve integration between health and social care, reduce duplication, standardise care. Team presented on 20th Sept 2018
- Increase use of voluntary sector services and community assets by care homes staff and residents (e.g. IAPT). Presented at Care Homes Managers Forum 20th Sept 2018
- Structured Education/workforce development – St. Luke's and LA currently providing some
- Facilitate the creation of a Relatives & Residents forum to ensure collaborative change – Engagement event to be planned

Phase 2: From January – March 2019

- **Testing Model with a GP Locality (80,000 population)**
- **Scaling up model based on PCH hub including:**
  - SPA
  - Identification, Assessment and Triage
  - Managed Care – GP / EPN
  - Care Planning / Advanced Care Planning
  - HIC team – admission prevention / crisis management
- **Bringing on line – Mostly Healthy (Social Prescribing (Loneliness) / Support for Carers and Dementia MOC recommendations**
- **Additional Care Home recommendations:**
  - 'Virtual' pooled budget for small pilot population (2-3 care homes)
  - Standalone/dedicated team for primary care delivery in care homes (GPs, community team)
  - Care homes commissioning – Joint CCG/LA; collective responsibility for outcomes
  - Support care homes with IC Toolkit roll-out to facilitate appropriate sharing of data across organisations; data protection within care homes

Gateways for the Harrow ICP Development



Progress to Date and Next Steps

Progress to Date

- Integrated Care Development Programme team appointed and programme governance set up (Sponsoring Group, Programme Board, SRO, Core Team)
- Seven partner organisations from health, social and voluntary sectors actively involved in developing a Harrow Integrated Care Partnership (ICP). MoU signed in 2017
- Population segmentation completed for testing and scaling the new models of care to be delivered by the ICP. 5 cohorts of 65+ population selected for 18/19
- Outcomes Framework for ICP – first draft completed for testing in 18/19
- New models of care designed and signed off. Prototyping commences in October 2018
- Workstreams to enable delivery are in progress:
  - IM&T, Workforce, Training and Education, Communications and Engagement, Outcomes Development, Contracts and Procurement, Finance, Provider Network Development

Next Steps

October – November 2018:

- Test model of care for frailty in 1 or 2 GP surgeries based in 1 GP locality
- Implement change projects for 65+ in care homes
- Progress key enabler workstreams

December 2018 – March 2019:

- Spread test model of care to GP locality incl. local authority footprint
- Introduce 65+ Mostly Healthy cohort into model of care
- Introduce 65+ with Dementia cohort into model of care
- Continue to progress key enabler workstreams
- Harrow Integrated Care Partnership formalised

April 2019 onwards:

- Harrow Integrated Care Partnership commissioned to deliver care to five 65+ cohorts – test partnership
- Spread model of care to entire over 65 population in Harrow