Harrow Integrated Care Development Programme
Overview and Update

Health and Wellbeing Board – 3rd November 2018
Joanna Paul – Programme Director
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 next day – capability to insert short duration care package during period of acute illness.

**Hospital team** work with Hub to expedite discharge back into community when appropriate.
Phase 1: Prototype testing GP surgeries who applied and pilot model in Nov from 1 practice

October 2018

Phase 2: Spread test model of care to ‘GP locality’ and wider Local Authority

December 2018

Phase 3: Spread model of care to entire over 65 population in Harrow

April 2019

Overview of Testing 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

Signed off March 2018
1. Population cohort
2. Use of the WSIC dashboard
3. Approval of funding for resource post March 2018

Outcomes Framework – final draft to programme and sovereign boards June 2018

Population Segmentation
March 2018
Outcomes
May 2018
Development of Models of Care
September 2018
Formal Collaborative Agreement – MoU sign-off
November 2018
Business Case Sign-off
December 2018
CCG Contract Generation and Contract Sign off
February 2019
Early Wins and Mobilisation Provider Network

Models of care designed, signed off and ready for testing - September 2018

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Outcomes

Framework – final draft to programme and sovereign boards June 2018
## 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