**Report for: Haringey and Islington Health and Wellbeing Boards Joint Sub-Committee**

**Title: Wellbeing Partnership Update**

**Report Authorised by:**

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## 1. Purpose

1.1 Our work to progress integration within Haringey and Islington is at an important stage. We are making several transitions. We are making a transition towards greater integration of care and services around localities. We are approaching a point where we may want to make the transition from a programme structure that sits outside our existing governance towards shaping our decision-making structures to reflect our inter-dependence and joint working.

1.2 The aims and the vision of what we want to achieve are the same and remain rooted in work carried out by councils, CCGs and Trusts over many years to develop greater integration. These are: to ensure that a healthier choice is an easier choice; to support strong communities where residents are healthier and live independent and fulfilling lives; to provide early support for those who have difficulty maintaining their health and wellbeing and to ensure that those who need care receive high quality, connected and responsive services.

1.3 As we move into the next phase of work, there is both an opportunity and a need for co-production with staff and with residents so that any changes are rooted in and shaped by the people who best understand the local needs and opportunities.

1.4 These transitions are explored in the further papers for this meeting and will be the substance of further meetings. This paper considers some of the outputs of our work so far and the learning that we can take from it. It then sets out the high level next steps.

## 2. Recommendations

2.1 The Joint Health and Wellbeing Board is asked to note the continued progress we are making on integrating pathways of care with a focus on people with diabetes; frailty; musculo-skeletal conditions (MSK) and people needing intermediate care (step-up and step-down care from hospital).

2.2 The Board is asked to recognise ongoing work on our enablers particularly integrated digital care records; estates and community services.

2.3 The Board is asked to consider some of the learning and to note plans for the next phase of work.

## 3 Describe the issue under consideration

**Background**

3.1 The Wellbeing Partnership is an alliance between organisations and a commitment to a way of working that enables efficiency and integration. There are therefore numerous 'business as usual' activities between organisations that are contributing towards the aims of the partnership but do not specifically sit within the structure of the Wellbeing Partnership. There are also significant transformation programmes which are led at North Central London or London level and are critical to the Wellbeing Partnership. These include, for example, the work to develop general practice at scale and development, within North Central London, of the shared care record.

3.2 However, there are a range of workstreams are specifically being taken forward as partnership programmes. Some particular achievements from these programmes are noted below.

**Examples of achievements**

3.3 **For people with diabetes**

- **Connecting information to improve care:** the specialist nursing team who support people with diabetes can now access the primary care record, providing them with a much fuller set of information about the patients that they are seeing.
- **Helping people to navigate the system:** in East Haringey, where there is a particularly high incidence of diabetes, care navigators are now helping to coordinate the tests that need to be carried out when someone is first diagnosed. They are pro-actively identifying people whose condition is not controlled. They are supporting people to take up education sessions, which makes a significant impact on people's outcomes.
- **Working across boundaries:** clinicians leading on care for people with diabetes, through a great deal of joint work, are working as an integrated network. They are streamlining processes to minimise the number of appointments people need to attend. The specialist nursing team at Whittington Health is running as a single service

rather than borough based services to become more efficient. Waiting times for specialist care are being reduced through more rigorous processes.

3.4 **For people who need intermediate care (rapid response, rehabilitation and step-down)**

- **Re-design led by operational teams:** Since July, multi-organisational operational leads have participated in five half-day sessions, leading to the development of a new delivery model for intermediate care, a common aim and vision which is shared by the teams working across both councils and Trusts.
- **Taking forward a new model of care:** A mandate is now being sought from organisations to take this work to the next stage. This will involve developing operational leadership to take forward the new model of care; assessing resource implications; further testing with frontline staff and a programme of communication and engagement.
- **Immediate practical steps alongside planning:** From the joint work, a proposal has been developed to treat intermediate care beds across the boroughs as a shared resource so that there is a smoother process in place to access beds in the other borough during winter.

3.5 **For people who are suffering from muscular pain**

- **Quicker access to treatment:** we have trialled a system in which all referrals to hospital for people with pain, rheumatology and trauma and orthopaedics are first reviewed by an experienced physiotherapist. If appropriate they receive physiotherapy which is provided within six weeks, rather than being referred for an outpatient appointment in hospital, where the wait is up to eighteen weeks and capacity.
- **Reducing unnecessary visits to hospital:** reduced the numbers of people needing to go to hospital by 18% and is now being rolled out and evaluated further.
- **Moving resource from acute to the community:** this project has been a test of our ability to co-design a programme to improve efficiency and to put resource into community services through a transparent plan to reduce spend on acute care. The impact of this will be evaluated as it is rolled out.

**<u>Developments underway to support integration</u>**

3.6 **Making best use of our estates**

- We have recognised that there are opportunities to make better use of our public estate across health and social care. We have now mapped out our public estate for Islington and are undertaking this process for Haringey. This is helping us to identify opportunities to make best use of assets.

- We are developing a process by which we can try to resolve cross-charging issues between our organisations
- We are developing bids to One Public Estate that would allow us to develop schemes which have potential both to make efficient use of public estate and to release space for housing.

3.7 **Shared access to digital care records**

- The focus for the Wellbeing Partnership is particularly on short-term, practical solutions to enable community health, social care and mental health practitioners to share information that is relevant to direct care for particular services that are already integrated or planning to further integrate.
- There is an active group involving GPs who have particular IT expertise and interest and the digital leads from each organisation. This drawing on the learning from Federations that are already hosting multi-professional teams and exploring how this approach can be expanded to other services that looking for further integration.

3.8 **Strong core community services**

- Strong community services are fundamentally important in enabling a shift from acute and reactive care to pro-active care closer to people's homes. A service improvement process has been put in place within Whittington Health to improve access for all community health services.
- Steering Groups for Children and Young People's Services and for Adult Community Services have been established. These are co-chaired by the Whittington Health Director of Operations and the Director of the Wellbeing Partnership and meetings are open to governing body members. Each service within scope has set a 'project charter' with a trajectory for improvement. This structure enables review with a shared focus on supporting improvement. Membership is open and involves commissioners reporting together with operational management leads on actions taken and impact.
- Performance has been significantly improved in several key services, particularly in nutrition and dietetics, podiatry, lymphedema and recently in diabetes and respiratory.

3.9 **Addressing workforce challenges**

- At the heart of this approach is the need to overcome significant shortages in key staff groups. There is a Steering Group in place with a specific focus on workforce which brings together a range of management and clinical leads from all the organisations represented within the Wellbeing Partnership.
- This group, the Community Education Provider Network (CEPN), oversees a wide range of initiatives designed to respond to some of the key workforce challenges that we are

facing. It is co-chaired by Dr Jo Sauvage (Chair of Islington CCG) and Dr Dai Tan (GP Governing Body Member for Haringey CCG).

- The majority of projects that are being taken forward are funded by Health Education England. Examples of the projects being carried out under this group include:
    - Rapid up-skilling for social care and primary care staff on mental health conditions and mental health first aid and suicide prevention
    - The development of a Quality Improvement Network to increase advanced level quality improvement capability and capacity locally
    - Development of training for staff (community services and GP practices) in running group consultations
    - The development of a network for newly qualified professionals (including social workers, pharmacists, physiotherapists, psychologists and nurses)
    - Development of an online toolkit for key frontline staff to improve their understanding of how apprenticeships work
    - Training sessions on admission avoidance for paramedics and advanced paramedic practitioners (APPs)
    - Development of apprenticeships (e.g. developing learn and earn apprenticeships for care staff and clinical skills training programme for GP based Health Care Assistants).

**Some lessons learned for our next steps with integration**

3.10 The power of shared leadership and ownership: The very real gains that we have seen in joint working have all been a result of shared leadership from professionals, clinicians and management across different parts of the system. Building trust and moving out of entrenched positions has taken time. As we move into the next phase we will be bringing a far wider range of people and services into this approach. Ensuring that staff have the space and mandate to work in this way will be critical.

3.11 The balance between borough and bi-borough working: Much of our work has highlighted the need for a common framework and standards set across boroughs (or at North Central London level) with local application. This is the approach that we are taking, for example, in our work on frailty. A bi-borough team is working to develop a common frailty offer or pathway, based on best-practice. Borough teams are then evaluating their position in relation to this offer and identifying priority areas for local focus.

3.12 Both a population / pathway focus and a geographic focus have value. A focus on a particular patient group and population ensures consistency and an evidence-based approach, so it guides local delivery. But it does not allow a focus on the wider determinants of health. It does not allow for a holistic offer within a place or allow us to provide early help to those who are rising risk.

**Next steps**

3.13 Work on enablers and pathways of care continues and work on the enablers are becoming increasingly important.

3.14 We have identified areas which will be prototypes for a place-based approach, as outlined in subsequent papers. The next stages of work to take forward this approach are:

- November / December: Launch of locality work for North Tottenham and North Islington. These events will be an opportunity to discuss what is working already; to generate ideas; start to shape a shared vision and identify priorities for immediate and longer term action.
- Early 2019: A phase of 'groundwork' with frontline teams to develop particular projects and plans with frontline teams.
- Early 2019: Work in practice on any quick wins
- Feb/March: Review of proposals and priorities arising from prototype work

## 4 Contribution to strategic outcomes

4.1 This work has the potential to contribute to London Borough of Haringey's Borough Plan, Islington Council's Corporate Plan outcomes and the joint Health and Wellbeing Strategy.

## 5 Statutory Officer Comments (Legal and Finance)

Legal

5.1 The issue under consideration and the recommendation falls within the terms of reference of the Board to encourage joint consideration and co-ordination of health and care issues that are of common interest to both Haringey and Islington.

Chief finance officer (ref: CAPH18-31)

5.2 There are no immediate financial implications arising from this paper, which at this stage sets out proposals and next steps.

## 6 Environmental Implications

6.1 Environmental implications for the planned work identified in this report includes that associated with office usage (energy and water use, waste generation) and publicity (use of resources for leaflets, if used).

## 7 Resident and Equalities Implications

7.1 Local authorities have a Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

7.2 The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

7.3 Place based care will aim to tackle health inequalities; including the 17-year gap in healthy life expectancy for woman and 15-year gap for men between least and most deprived parts of Haringey (Public Health England data).

## 8 Appendices

None

## 9 Background papers

None