Forward View into Action

Registering interest to join the new models of care programme

Q1. Who is making the application?

Islington and Haringey Health and Care

Submitted by:

Islington CCG, Haringey CCG, and Whittington NHS Trust, Camden and Islington Foundation Trust, Islington Council and Haringey Council.

Wider Partnership:

University College London Hospital, North Middlesex NHS Trust, Voluntary and Community Groups, Local Healthwatch organisations, Age UK, Barnet, Enfield and Haringey Mental Health Trust, Patient and Public groups

Contact for communication:

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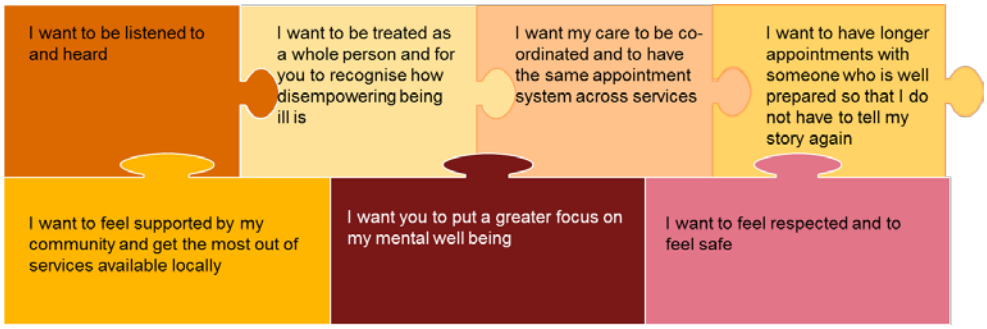
(See Appendix 1: Partner organisations and commitment sign up)

Q2. What are you trying to do?

Our patients have asked for a coordinated health and care support system that meets their individual physical, emotional and care needs and we have delivered a wide range of initiatives against our system strategy to do just that. Our service users tell us:



Islington and Haringey have strong partnerships across the CCGs and local authorities. Islington and Haringey have had shared budgets across health and care services in place for at least 10 years. Working in collaboration with public health, we have engaged with the whole population to deliver targeted prevention programmes to actively close the prevalence gap, and have delivered a 33% and 21% reduction in premature CVD mortality in Islington and Haringey respectively. In 2011 Whittington Hospital merged with the community provider arms of Haringey and Islington to form an integrated care organisation (ICO).This provided the backdrop to enable the introduction of wide-spread supported self-care, GP-led MDT teleconferences and an infrastructure that supported people to stay in their normal care environment. Further enabling work in IT and risk stratification has begun to help target resources more efficiently. The development of a workforce plan has embraced a more generalist approach to support in primary and community care across the system to enhance early intervention for those at highest risk. With these foundations in place we have expanded our initiatives and broadened our approach to include mental health and social care, with cross-fertilisation of learning between the Haringey and Islington teams. We now have a comprehensive programme of initiatives in place to support delivery of our aims. Our system plan is based around our patients, and how we support them as individuals, wrapping our combined expertise around their needs. It is also about building system resilience and affordability in the face of growing demand. The combined effect of the initiatives is resulting in improved demand management into emergency care at the Whittington. We are now looking to scale up our local successes to the whole system, continue to strengthen our provider relationships and create a commissioning and contract structure to build system resilience.

As part of our mission to improve our population health with proactive, coordinated and accessible health and care, we aim to deliver a fully integrated health and care system.

Q3. Which model(s) are you pursuing?

We are aiming for a population based model that links Whittington Health, our ICO, with our patients, voluntary and community organisations, mental health services, social care and primary care services, in one seamless system. The model will be driven by our local communities and primary care, with a strong focus on prevention aligned to population based outcomes. The PACS model most closely aligns in scale to our ambition. We intend to achieve all the operational impact of a PACS through means other than a single organisational model.

Q4. Where have you got to?

Across our local health and social care economy there is a history of strong working relationships and partnerships. As part of our journey so far, we have implemented many innovative new initiatives and built up evidence-based experience of the most effective ways to integrate services to meet the needs of our local community, and remain sustainable. In support of this we have:

- A **local shared vision** with a Transformation Board to provide collaborative system leadership.

- An **Integrated Care Organisation,** Whittington Health, at the heart of our community.
- Been awarded **Integration Pioneer** status in Islington,
- **Better Care Fund** agreed in Islington and Haringey CCGs and Local Authorities, who are working in collaboration to jointly commission services.
- Examples of **successful enhanced health in care homes** are supported by new Consultant led **multi-disciplinary teams** alongside integrated consultant led community urology, respiratory, cardiac and diabetes services.
- Innovative **rapid response** models in both Haringey and Islington
- Many examples of **integrated care test and learn sites** across organisational and professional boundaries
- Providers, commissioners and patients have designed and are working towards a **value based commissioning** model for people with diabetes, those living with psychosis, and older people with frailty. We have agreed clinical patient reported and patient determined outcomes against which success will be measured.
- All partner **Boards and CEOs** are committed to pursue the new models of care

A sample of our achievements are outlined below, painting a picture of the progress we have made:

Working together

We have multidisciplinary teams working across Haringey and Islington led by GP practices, in partnership with social care, mental health, community services, and voluntary sector. Personal outcomes are identified with people, enabling a proactive approach to care, through the process of care and support planning. We have extensively tested and evaluated the best ways to deliver care through MDTs. For example, early indication of improvement following an MDT support in N19 showed a reduction in A&E activity of 27%, reduction in non-elective inpatient activity of 25% and reduction in GP activity of 19% across MDT patients in a year.

We are starting to introduce patients into our MDT teleconferences, and to scale up our learning to system level.

Normal care environment – care homes

Our aim is to deliver person-centred, integrated care to residents of care homes. Part of this is to advocate for this vulnerable group and enable equality of access to existing community services. By doing this we increase their time spent at home by avoiding un-necessary hospital admissions.

We work in MDTs across hospital community and care homes. This integration with GPs and community allied health professionals enables timely information sharing and advanced care planning. We use care home in-reach, virtual wards, ambulatory care pathways, and care home visits as part of our approach.

Through this work emergency admissions have reduced by 10%.

Success in integrating mental and physical health

The introduction of our Integrated Liaison Assessment Team has generated a significant improvement.

By increasing mental health professional input on acute hospital wards has resulted in early identification of a range of mental health conditions. This has enabled early appropriate intervention and delivered a reduced length of stay of 50%, and reduction in readmissions of 60%. This has emphasised the ongoing need to recognise the interdependency of physical and mental health in our system. We also offer physical health care for older people in mental health wards

Supporting this we empower patients through a 'Recovery College' to provide education courses to support healthy lifestyles and independent living.

Ambulatory Care

We have developed a population based innovative model of ambulatory care in the hospital setting.

This model of care enables patients to be seen promptly, diagnosed and treated and maintained in their own homes. This reduces the need to attend A&E or be admitted to hospital.

The model has been in place for the last 10 months, referrals are from GPs, A&E, and the ward, as well as community services. There are new community pathways supporting the model. Patient feedback has been excellent and is changing the way clinicians work.

Over 50% of GP direct referrals to A&E are being seen in Ambulatory Care Centre. 4% convert to admissions.

Our success in General Practice

Aligned to the London primary care strategic framework our GPs are delivering a proactive, coordinated and accessible general practice. To become more proactive the population is risk stratified to identify those most at risk and interventions put in place accordingly. Care planning is now commissioned to enhance discussions around personal goals. In line with this approach the Year of Care was introduced for diabetes, including sharing results and information before consultations. This is now being rolled out to all long term conditions. Age UK support this by providing health navigators to support primary care in accessing voluntary and community organisations that offer a more than medicine approach to the management of people with LTCs. There is absolute GP engagement with the adult and children's MDTs, and also with the concept of co-commissioning going forward.

GPs have come together in localities to define ways to offer improved access. A named lead professional coordinates individual care, linking directly into the MDTs, further supporting integrated working and personalised care. A Federation of 8 GP practices (WISH) from across Islington and Haringey now successfully run the urgent care centre located at the hospital, and look further into hospital in-reach opportunities as well as providing GP input into the hospital at home service. A business case is in development, by local GP providers to establish an Islington wide GP federation.

Technology
We are currently tendering an interoperability solution that will enable real time, bi-directional data flows across all local health and care providers. This data will populate a Person Held Record so empowering people to take an active role in their own care. Currently we have achieved a bi-lateral medical interoperable gateway (hospital-GP-hospital read only capability) as an interim solution.

Workforce planning
The Community Provider Educational Network (CEPN) is looking at building capacity and capability through workforce development and future planning to support new models of care. This is being developed through collaborative stakeholder engagement at all levels and delivered with a focus on multi-disciplinary educational initiatives across health and social care including nursing homes. We are developing new blended roles skilled to work across organisational interfaces with a strong focus on achieving sustainability in primary care, development of local apprenticeships with opportunities for career progression. To do this we are piloting innovations including the care certificate, a multi-disciplinary simulation hub, and a community hub to facilitate collective local training opportunities for GPs and nurses. All of this is being done in collaboration with Health Education England. The CEPN has been operating for over a year Islington, and started in Haringey.

Evaluation
We have developed a system logic model that outlines our short, medium and long term outcomes, with clear evaluation overarching and detailed measures in place against each, baselined in 12/13 – 13/14
We recognise and hope that the work we are doing will be part of a growing evidence base.

We link with UCLP on their wider evaluation model and are very keen to share the learning and outcomes we have evidenced with others, as we use it ourselves to progress to system wide goals.

Q5. Where do you think you could get to by April 2016?

Against this strategic trajectory, we believe that by 2016 we will deliver

- Primary Care Networks in place in Islington and Haringey extended access to general practice
- Reduced A&E admissions in our local hospitals in line with the local Better Care Fund agenda
- Extended health and care teams aligned to general practices undertaking continuous improvement cycles to refine systems and performance
- Locality offer covers proactive care, and for those who need it co-ordinated care, supported from rapid response and care navigator
- New models of care including for frail elders, diabetes and psychosis running, aligning care across primary, community, mental health, social care and hospital services
- A clear prevention offer using community assets in place across health and care services
- Interoperability across health and care services achieved through procurement of Person Held Record and Integrated Digital Care Record
- Integrated workforce strategy in place with blended training and roles as part of this
- One offer of personalisation across health and care
- We will have 20 patient champions in place across the system as part of our community engagement
- Extend nursing home care model across both boroughs
- Extend co-creating health model and patient activation across the system
- The refinement and measurement of metrics developed for our integrated care programme utilising a logic model including whole system impact and balance

Q6. What do you want from a structured national programme?

We have experienced how hard it is to build the momentum and pace required to embed large scale change, and we know how much more there is to do to achieve our system plan. Consequently it would help to have national support to share and learn with other systems experiencing change, particularly in respect of **workforce development** to address the big challenges.

To achieve our local PAC model we would also appreciate help in navigating incentives and levers:

- Governance and regulatory legal advice
- Contractual procurement and contract form to support delivery of a sustainable health and care system that meets local needs.
- Capacity to transform at an appropriate rate, and freedom to try new ways of working that fit with local needs and narrative.