Hillingdon Health and Care Partners (HHCP)

Integrated Care System Update

23rd November 2018

Hillingdon Health and Care Partners

NHS 70 YEARS OF THE NHS 1948 - 2018
Hillingdon Clinical Commissioning Group

What our residents and professionals have told us that they want from an Integrated Care system:

Theme	Residents	Professionals
1. Connected	• A system that sees **multiple dimension** of need (physical, psychological, emotional, social) - concurrently, through multi-skilled individuals or teams • **Fewer** handovers, journeys and appointments • Professionals are connected and **'know my story'** • **Streamlining transitions:** from hospital to community; from children's to adult services	• **System interoperability** (shared care records and plans) • **Space, time and resource** to connect professionals and organisations • Quick access to **experts and expertise** • Knowledge about **local community options** • Simplified and smarter IT systems that **reduce workload rather than add to it**
2. Collaborative	• Treating people as **sources of value and support**; more listening, respect and compassion • Fostering **partnerships** and reciprocal relationships • Patients and carers seen as **partners,** affording them greater control and means to be effective • Investing in building **volunteer capacity** and activating community assets and resources	• Better collaboration with **commissioners** and **service users** to make improvements • Encouraging the **involvement of staff from all levels** in service improvement and redesign • **Inverting hierarchies** and celebrating **team-work** • **Collaborative relationships** between GPs and acute; and in neighbourhoods - with voluntary sector organisations and across professionals in NHS and LA
3. Open	• Better and **quick access to advice**, support and information across medical, social and wellbeing • **Transparency** and access to records and data • **Diversity of available options** aligned to needs and preferences of population, rather than single option with long waiting list (or available 'while you wait') • Early intervention for **MH and behavioural issues** in schools and community organisations	• A **learning system** • **Less rigid** and **more adaptable** to local needs and assets • Encourages colleagues from across the system to **learn together,** shadow and innovate together • Fosters '**can do' culture -** permission to improve and offer care and compassion to patients

**Based on initial co-research work between August and October 2018 – to be further developed as part of ICS co-production approach.*

How are we addressing these requirements? **Where are we now?**

1. Developing an overarching 'Hillingdon Whole System Plan' that defines what an integrated care system would look like including a 5-year system financial plan – *focusing on Children's and Young People (CYP), Mental Health & Learning Disabilities, Urgent Care and Planned Care*
2. Widened the focus of the HHCP integrated service model to the **18+ age cohort** in order to improve urgent care performance across the system
3. Currently focused on **five key priorities** that will improve urgent care performance and as a corollary potentially deliver savings of up to £10m to the system
4. Developing a new **Neighbourhood based model of integrated care** that embeds multi-disciplinary working based on an integrated workforce spanning primary, secondary, mental health, community care, social care and the voluntary sector
5. Strengthened the current **HHCP Governance Structure** to enable HHCP to move more rapidly from ideas to benefits realisation
6. Developed a **draft integrated business case** based on the 5 HHCP key priorities (due for approval in December 2018) including a robust Implementation plan with clear timelines and accountabilities that is implemented at pace
7. Seeking to move to **a single Integrated Care Contract** incrementally over the next 3 years

We are **focusing on 5 priority areas for 18/19**…building on the partnership work to date:

1. **Extending active case management to the 15% of the adult population most at risk of a non-elective episode and admission to long term care** by implementing the following key interventions:
   - **I. Extension of Care Connection Teams 's to a broader age group cohort (18+)**
   - **II. Implementing a High Intensity User Service** to better manage the top 50 'Frequent ED Attenders'
   - **III. Revised End of Life Care Pathway** to reduce the number of people spending the last year of their life in an acute hospital bed
   - **IV. Revised Falls Service and Frailty Pathway** to reduce the number of non-elective episodes
   - **V. Better Support to Care Homes** (to prevent Non-Elective presentations)
2. **Transforming the MSK Pathway** to reduce the number unnecessary secondary care interventions
3. **Optimizing the Hospital Interface** (Front Door) through Effective Same Day Emergency Care for ambulatory care sensitive conditions.
4. **Optimising Intermediate Care**, Rapid Response/GP Visiting including Discharge arrangements
5. **Developing integrated multi-disciplinary 'Locality Neighbourhood' Team** working built from and led by general practice as the basic delivery unit of integrated care

What is the data telling us about our population?

- **There are 230,000 people in the 18+ Hillingdon Population**
- **Approximately 34,000 (15%) 18+ have a life limiting illness (LLTI)**
- **Approx 5,500 are identified as high-risk of emergency admission**
- **6,417 people (3% of Adult population) account for 50% of all Hillingdon emergency hospital admissions (equates to £26m)**
- **Approx 1350 Hillingdon residents died of predictable causes liable to require palliative care in the last year of their life; 54% of whom died in a hospital bed (compared to England average of 47%)**

Based on the data currently available, we plan to address the needs (stratify) of the local population based on the following assumptions:

➢	**Tier 1:**	Mostly healthy people with low needs (195,500)
➢	**Tier 2:**	People with 1 or more well-managed long term conditions (29,000)
➢	**Tier 3:**	People with 1 or more complex or unstable long term conditions (4,133)
➢	**Tier 4:**	People with Advanced or incurable illness (1,350)

Moving towards a **needs based and active case management** model…

Focus of the Integrated Business Case

TIER 1: Mostly Healthy (Low Needs)

These people are in relatively good health; there are no serious on-going health or social care concerns. They would benefit from support to 'stay well'.

195,500 People (85% of over 18s)

TIER 2: 1 or more well-managed LTCs (Substantial)

These people are stable - coping with one or more long-term conditions and would benefit from support to plan care and manage their condition.

29,000 People (13% of over 18)

TIER 3: 1 or more complex or unstable LTCs (Critical Needs)

These people have complex needs and require significant multi-disciplinary support. In addition to unstable LTCs, they may have mental health or social care needs.

TIER 4: Advanced & incurable illness (People at the end of their life)

These people have advanced, progressive, incurable illness. The key aim of support is to help them to live as well as possible until they die and support them to die at home

High-risk 5,500 People (3% of over 18)

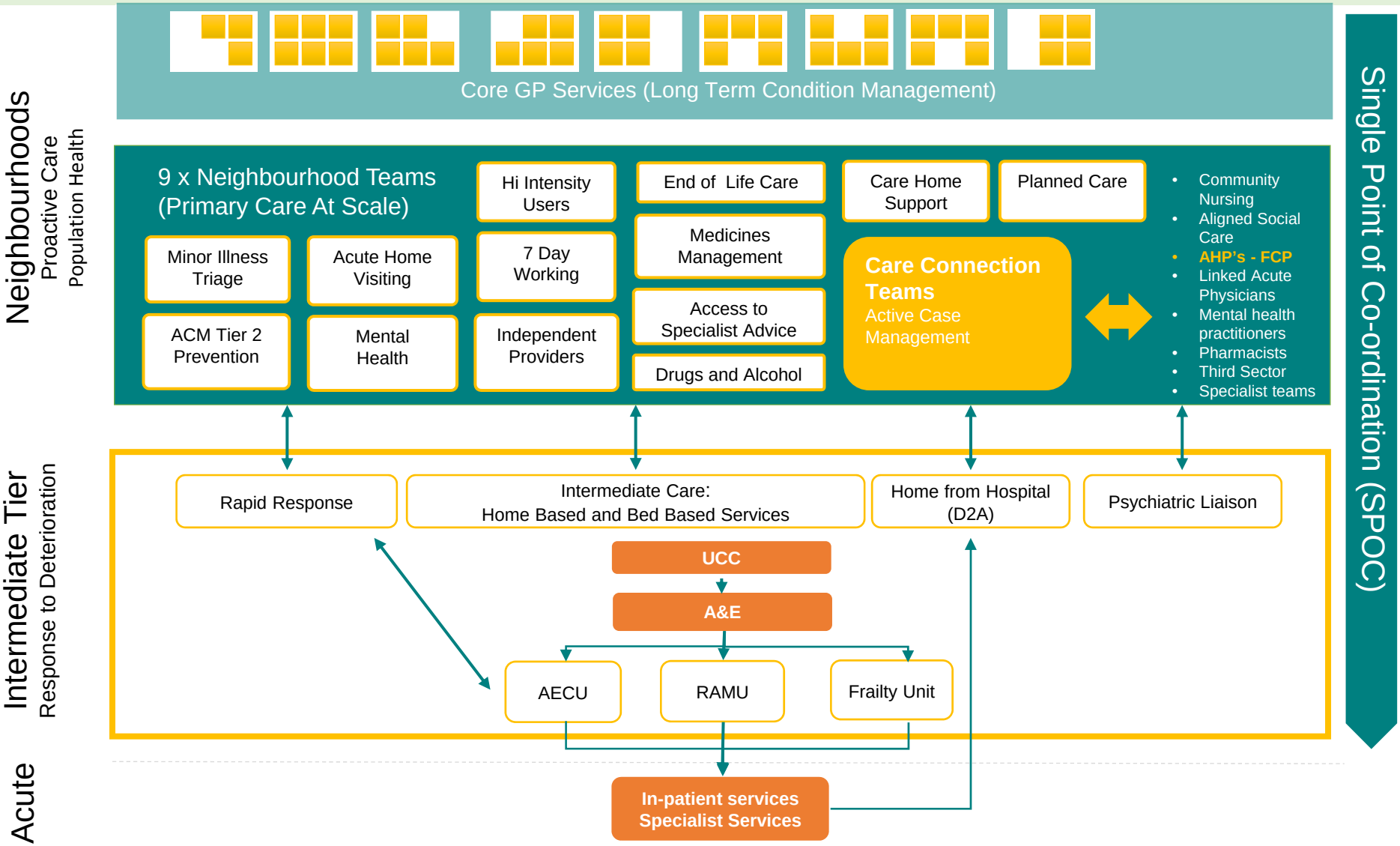
4,150 People (2% of over 18)

1,350 People (1% of over 18)

The Hillingdon model of care and 5 HHCP priorities is underpinned by active case management.

Active Case Management (ACM) is an integral part of the Integrated Neighbourhood Team and wider health care system. The aim of ACM is to identify (stratify) and then care for patients with complex needs at high risk of hospital admission, through intensive co-ordination, at a complex health and social care multi-disciplinary team level.

The emerging model of care



Toward a new model of care…the **key benefits:**

Benefits for residents and patients will be:

- People will only have to tell their story once
- Reduced hand-offs between services by creating neighbourhood teams who work together with primary care and the third-sector to deliver care and support to meet patients' and carers needs.
- Patients with have a named case manager who will organise and co-ordinate their care.
- Breaking-down demarcation lines between professionals and multi-skilling of staff to improve care.
- Services will be available over extended hours
- More care will be provided closer to home
- There will fewer confusing transfers between organisations and services
- Increased breadth of provision in local GP practices

Benefits for wider health and care system will be:

- Keeping people independent at home for longer
- Ensuring safe and sustainable General Practice and out of hospital services
- Reducing avoidable hospital admissions for those most at risk
- Substantially reducing avoidable visits to accident and emergency departments
- Reducing avoidable admissions to care and residential homes
- Reducing the average length of time people stay in hospital