INTEGRATED CARE PARTNERSHIP UPDATE

Board Member	Dr Ian Goodman
Organisation	Hillingdon CCG / Hillingdon Health and Care Partners (HHCP)
Officer Contact(s)	Keith Spencer, Hillingdon Health and Care Partners (HHCP) Joe Nguyen, Hillingdon CCG
Papers with report	None

1. HEADLINES

Summary	This reports provides the Board with the latest update on the Integrated Care Partnership (ICP) achievements, progress for 2019/20 and our emerging plans for 20/21.
Contribution to our strategies	This contributes to the Health & Wellbeing Strategy, Hillingdon CCG Operating Plan and individual organisational strategies for Hillingdon Health and Care Partners (HHCP). The Integrated Care Partnership is also our local vehicle to deliver on the commitments of the NHS Long Term Plan.
Financial Cost	There are no financial costs – however the programme will be impacting on financial positions of all partners.
Relevant Ward(s)	All Hillingdon Borough Wards

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1) **reviews and provides feedback on the progress update on Hillingdon ICP development – February 2020 update.**
2) **notes the proposed the direction of travel for our Hillingdon ICP development for 2020/21 focused on the 6 'High Impact' Change areas.**

3. SUPPORTING INFORMATION

Context

The NHS 10 Year Plan, published earlier this year, put into print the much needed recognition that health, social care providers and commissioners having been waiting to see, this included:

- A commitment to boost 'out-of-hospital' care, ending communication issues and system gaps between primary and community health care providers
- Support to redesign emergency hospital services that reduces pressure on staff
- A move towards personalised healthcare that gives patients and their carers more control to

manage or live with their health condition(s) so they stay healthy, at home and part of their communities
- Mainstreaming access to digital services and information relevant to primary and out-patient care services.

In readiness to deliver these system changes health and care organisations; CNWL, The Hillingdon Hospital, The Hillingdon Primary Care Confederation, Hillingdon for All (a consortium of voluntary sector providers) and The Hillingdon Clinical Commissioning Group have formed an alliance known as **The Hillingdon Health and Care Partners (HHCP).** This alliance will enable frontline staff from across the different organisations to work together to provide joined up care.

What is an Integrated Care Partnership (ICP)?

ICPs are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved. Some ICPs are taking on quasi commissioning functions that previously have lodged in CCGs with some aspects being delegated (but not fully). The ICP forms the local and borough component of the NWL CCGs case for change for developing a single-CCG footprint.

What is our focus for 19/20?

- Empower our residents and patients to keep themselves well and take charge of their own health.
- Provides access, where required, to high quality, sophisticated care at the right time.
- Quicker access to specialist or inpatient care, where required, but;
    - where an admission is unavoidable, patients will return home quickly and;
    - with a personalised care package that continues to support their needs either from home or in the community.
- An improved “End of Life” care that better supports people to die in their preferred place.
- Identifies and intensively supports high risk patients to better manage their health and wellbeing in the community.

Summarised Update

1. **<u>The overall programme</u>** focus has now moved from implementation (mobilisation) to operationalising the new models and driving benefits realisation.

2. **<u>The HHCP Escalation Plan</u>** was implemented from the 20 January 2020 following the triggering of the Financial Early Warning System in December 2019. Data analysis showed that the deterioration in the year to date position in A&E is principally driven by a relatively marginal shift in Urgent Treatment Centre (UTC) performance against contractual plan.

   The Escalation Plan put in place additional Primary Care Capacity (80 appointments per week) from the 20 January 2020 particularly in the 3 Southern Neighbourhood Teams to enable diversion away from the UTC and A&E and to support the UTC to deliver to their contractual targets.

   Greenbrook (Urgent Treatment Centre Provider) have reported that that performance

against these KPI's for the first 10 days of February is as follows:

KPI	Target	Year to Date	February
Patients streamed away from A&E	85%	79.1%	80.6%
Patients streamed to A&E from UTC	5%	6.78	6%
Redirected to alternative Pathways	6%	4.6%	8.5%

These represent a progressive improvement since the implementation of the Escalation Plan. In fact, since the implementation of the plan on the 20 January, type 1 A&E attendances have reduced by 8% overall (as at 9 February). However, it is early days and we will continue to work with both the UTC to maintain these improvements and with THH colleagues to understand the drivers behind the shift between Category 1 and 3 attendances.

In response to bed related system pressures in the post-Christmas period, HHCP set up **a short term Pop-Up HHCP Co-ordination Centre on site at THH for 4 weeks** from Monday 13 January 2020. The purpose of the centre was to better co-ordinate and leverage out of hospital health and social care capacity in order **to expedite increased and accelerated hospital discharges.** Our principal target was to work together intensively as a system to free up hospital beds by reducing the number of stranded patients from 238 to 150 as set out in the Winter Plan.

The Centre was staffed 9-5 Monday to Friday on a rota basis by Senior Operational Staff from HHCP Partners together with Senior Operational Colleagues from Adult Social Care. **The operation of the Pop-Up Co-ordination Centre was associated with a statistically significant step change reduction in the number of stranded patients from 238 to 161.** One of the benefits of the co-ordination centre was that the seniority of its system staff enabled it to shorten decision making time by constructively challenging people, systems and processes.

We are continuing to embed this change, we will be delivering the following actions by end of March 2020.

- Ward and IDT staff jointly develop and implement a simple Standard Operating Procedure for discharges and inter ward transfers (including the process of escalating internal delays) with clear KPI's, accountabilities and performance reporting arrangements
- HHCP Partners and LBH collectively appoint a Senior Manager with delegated authority for operational management of an integrated health and social care IDT. Timeline to Delivery: 6 week.
- Urgent solution is developed that enables a single view of systems for IDT staff. This would provide the necessary transparency for the system and more efficient working practices.
- Consideration be given to bringing therapy staff together into a single Hillingdon wide Therapy service underpinned by a robust rotation scheme across hospital/community/primary care to establish consistency in approach and the best use of resources.

- Review of the Rehabilitation Pathway is led by the Clinical Director for Intermediate Tier with appropriate external support.

3. **<u>Transformation and Financial Management</u>**: Significant discussions have taken place between HHCP Partners and NWL CCG regarding the development of a **Medium Term (3 Year) Financial Strategy** for Hillingdon. **Proposals based on these discussions were discussed and approved by the HHCP Delivery Board as follows**:
   - A **System Transformation Plan** will be developed that implements new models of care, addresses rising service demand and progressively reduces the system financial deficit through an agreed joint transformation and efficiency programme. The programme will use shared benefits to reduce the system deficit across the health and care system. The programme will focus on 6 Joint System Wide 'High Impact' workstreams: Each led by an Executive SRO from a Partner Organisation and supported by a system programme management office (PMO):
     - Urgent and Emergency Care (incorporating Intermediate Tier, Long Terms Conditions, Prevention and End of Life Care) with SRO Caroline Morison, HCCG
     - Neighbourhood (PCN) Development with SRO Edmund Jahn, HPCC
     - Planned Care (Elective) with SRO Jason Seez, THH
     - Children & Young People with SRO Joe Nguyen, HCCG
     - Mental Health and Learning Disabilities with SRO Graeme Caul, CNWL
     - Non clinical efficiencies e.g. back office, estates, integrated management with SRO to be confirmed

4. **Outpatient Transformation:** For 2019/20, the HHCP Delivery Board has set up 5 priority area task and finish groups: MSK (T&O, Pain and Rheumatology), Ophthalmology, Dermatology, Gastroenterology and Gynaecology. These account for approximately 50% of all Hillingdon CCG OP activity and spend.

   The output from the Task and Finish Groups will be incorporated within a single integrated business case for Outpatients. The OP IBC will be developed by the HHCP Team with support from Business Development colleagues at THH. The timeline for completion and associated governance approval process is proposed as follows:

   - 20 March 2020: Task and Finish Groups complete their work
   - 23 March 2020: Draft OP IBC presented to Out Patient Transformation Board
   - 26 March 2020: OP IBC System Workshop at Brunel University
   - 2 April 2020: OP IBC presented to Strategic Finance Group
   - 9 April 2020: OP IBC presented to HHCP Delivery Board
   - April/May 2020: OP IBC presented to Partner Governance

Detailed Progress Report

The high-level summary below accompanies the programme-level milestone plan and includes operationalising key initiatives that have been accelerated as part of the Intermediate Tier programme in order to support winter planning and resilience.

Programme	High level summary assessment	Deployment	Benefits Realisation
Neighbourhood development	• **The service is now fully mobilised and operational** • **CCT target caseload set out in the IBC has now been achieved and continues to increase:** Caseloads have increased to 1,391 from 1,269 patients. • A recently completed CCT impact analysis for YTD M8 19/20 referrals shows activity reduction of 975 A&E attendances (saving of £137,568) and 514 NELs (saving of £955,217). • As part of the recent Delivery Board Escalation Plan, we have re-iterated with Primary Care that CCT's must only be used for the purpose for which they were set up; Admission and ED avoidance for the in-scope cohort. In addition, CCT's must follow the agreed case finding algorithm. This is to ensure that the right patients are selected for case management. We are currently also undertaking an audit to compare CCT caseload with those patients admitted non electively from the 6 practices with the highest year to date admission rates • This is based on data allowing for 6 months to have passed in order to monitor impact • All OD sessions have now been delivered to the CCT staff to build relationships and increase understanding of roles, process, governance and the rationale for working as part of an integrated team. This relates to a key programme risk around under-utilisation of H4All WSAs. . • The 3 Transformation Managers have started 3/2/3030, Rachael Broadribb, Helen Steward, Sunoj Jacob and are currently in the process of meeting all stakeholders		
Network development	• NWL, Network and HHCP priorities have been mapped and proposals for alignment developed. • Paper from the CEO of the Confederation on the 16 January Delivery Board Agenda setting out the overall approach was approved • Draft PCN service specifications developed and circulated to clinical leads and relevant senior stakeholders. A new specification has been sent out to PCNs • Head of Business Transformation for the Confederation has developed a template business plan with the mapped priorities and is meeting with all CDs to explain he framework • Linking into population health data to further inform plans Key areas of focus include the following – • Collectively develop and support practice managers working together and identify skills and skills needs • A programme to support Clinical Directors collective effectiveness plus the effectiveness of each PCN team • Improving change management skills and their application across PCNs and Neighbourhoods • Identifying and upskilling 'change agents' across the system	-	-
HIU programme	• **The service is now fully mobilised** • Programme has exceeded the original target for collectively case managing the top 50 HIU patients (i.e. top 50 patients are managed collectively by the CCTs and HIU teams). • Month 8 YTD data shows that, when compared to the 7 months prior to active case management, there has been a reduction of 395 A & E attendances (saving of £31,170) and 155 NEL admissions (saving of £179,172). Total combined saving of £223,642. When this is projected to year end for the full target caseload, this will deliver savings of £560k • Further ongoing PDSA work being undertaken to understand how these patients are being actively case managed in a way that will impact on a reduction in A&E attendances and		

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<tr><th>Programme</th><th>High level summary assessment</th><th>Deployment</th><th>Benefits Realisation</th></tr>
<tr><td></td><td>NEL admissions.</td><td></td><td></td></tr>
<tr><td>Care home & acute visiting service</td><td>

The service is now fully mobilised
All 8 GPs are now in post, and the vacancy for 1 GP on Fridays has now been recruited to. It is anticipated that the additional GP on a Friday will commence at the end of March.
SALT commenced 6th January and is currently undertaking a period of induction and shadowing members of the Care Home team.
Dietician & Mental Health Nurse commenced on the 3rd February.
The Tissue Viability Assistant has been appointed and will commence at the beginning of April in line with the Financial Budget.

Following the Escalation Meeting on 18th December, 3 outlier Care homes with significant over performance were identified as Ashwood Centre, Hayes Cottage Care Centre and Poplars Care Homes. Initial short-term actions were identified for each home and implemented.

As part of operationalising the model and increasing reporting as part of monitoring benefits realisation,
NELs for Care home patients are reported routinely to SOLT alongside the FEWS. More detailed reporting includes drilling down to the top 5 Care Homes with highest cost and volume to determine what is driving high cost including looking at relevant clinical information & LoS for selected patients to determine appropriateness.

The Confederation has been monitoring the LAS call out and transfer data associated with the care homes that are covered under the specification. When comparing 2019/20 against 2018/19 data it is clear to see that there has been a 5% reduction in LAS call outs and a 13% reduction in patients conveyed to hospital. These are fantastic benefits considering the service has been implemented using a phased approach.

<table>
<tr><th>KPI Description</th><th>Target</th><th></th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th></tr>
<tr><td rowspan="4">LAS Call Outs by the Care Home</td><td rowspan="4">Monitor for 2019/20</td><td>2018/19</td><td>136</td><td>126</td><td>112</td><td>119</td><td>145</td></tr>
<tr><td>2019/20</td><td>150</td><td>117</td><td>119</td><td>123</td><td>117</td></tr>
<tr><td>Variation</td><td>14</td><td>(9)</td><td>7</td><td>4</td><td>(28)</td></tr>
<tr><td>Variation</td><td>10%</td><td>(7%)</td><td>6%</td><td>3%</td><td>(19%)</td></tr>
<tr><td rowspan="4">LAS call outs when a patient is conveyed to hospital</td><td rowspan="4">Monitor for 2019/20</td><td>2018/19</td><td>116</td><td>104</td><td>92</td><td>105</td><td>126</td></tr>
<tr><td>2019/20</td><td>115</td><td>86</td><td>92</td><td>102</td><td>97</td></tr>
<tr><td>Variation</td><td>(1)</td><td>(18)</td><td>-</td><td>(3)</td><td>(29)</td></tr>
<tr><td>Variation</td><td>(1%)</td><td>(17%)</td><td>-</td><td>(3%)</td><td>(23%)</td></tr>
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Kingsley Court Nursing Homes transferred to Hillingdon GPs from 2nd January (apart from 15 patients who remain with the original Ealing GP). The Confederation is providing support for these patients and are undertaking initial care planning visits in a schedule way; this however will take some time to get through all patients as Kingsley Court is an 85 bedded unit. Acute visiting support is also being provided. Kingsley Court is a very high user of LAS and therefore the Matron will be working closely with the home to try and reduce this activity.

As of the 3rd February, the service was fully rolled out to cover all Care Homes for Older People and Extra Care Housing for patients registered with a Hillingdon GP and has become BAU.
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Programme	High level summary assessment	Deployment	Benefits Realisation
End of Life care	**Nurse-led End of Life In-reach model** – One internal applicant has been shortlisted and interviews planned for w/c 17th. As it is an internal applicant, if successful, there is confidence that the recruitment checks can be expedited **Information Dashboard:** Agreed metrics to be collected and Social Finance are supporting the programme in developing this data into an information dashboard. It is anticipated that the first draft will be reviewed at February's EoL Programme board **Michael Sobell House** • 6 beds now open and the unit will transition to 10 beds over the coming week. The transition period will allow to safely manage the pressure on the members of staff • There still remain few referrals from THH. MSH are meeting with cardiologists, respiratory and geriatricians to identify people at the end of life and not known to palliative care services. The Admission & Discharge nurse has updated the bed state daily to include MSH. Referrals to hospice at night service are also encouraged		
Intermediate Tier	• **Community point of contact and coordination successfully commenced in December 2019** – Hillingdon points of access to services summary updated to incorporate feedback from H4All, Confed and CNWL contact centre. This is being rolled out in early January to the Contact centre team and is being shared with THH IDT as a useful point of reference; H4All staff, relevant LBH colleagues (which establishes the link to LBH social care and safeguarding triage team) and CNWL MH SPA and Older Adults Duty Team. • **Cellulitis pathway implementation:** the pathway changes are starting to work well in practice in terms of releasing THH capacity. Patient rep sign off and resolving of final queries expected by 14th Feb. The GP and patient comms will complement the clinical decision-making tool and RRT referral process which have also been recently updated • **Integrated Discharge Point of Coordination:** To support Winter Planning, this programme has accelerated and strengthened delivery of an enhanced discharge coordination function that is based at the hospital and managed by the THH Integrated Discharge Team (IDT). **Progress remains on track – PoC went live in early Dec as planned and continues to be closely monitored**: ○ A review of the roles and responsibilities of the IDT has been undertaken to align with the enhanced service. ○ A system-wide escalation process has been implemented to support the Trust when Full Hospital Protocol is instigated. ○ A number of KPIs have been developed to monitor the impact of the expanded IDT - the teams are being inducted and allocated to their respective wards – once this has been completed data will be available to monitor impact ○ The service enhances the already established integrated discharge team by working across health and social care to better manage patient flow. ○ Out of hospital sitrep report developed and implemented which sets out community health and		

Programme	High level summary assessment	Deployment	Benefits Realisation
	social care capacity – this is being used by the IDT at daily bed meetings. In addition, although an effective workaround was developed the THH fire wall issue has been resolved. Next step is to include the key information in the Site Office screen which THH information team are working on. • As part of **reforming same day emergency care** at THH, work is ongoing to: o trial a number of options that will lead to extending Same day emergency care opening hours to improve access (e.g. SDEC team is reviewing impact of opening 7am until 8pm compared with 8am to 10pm) and; o ensure the GP heralded pathway is fully promoted and implemented in a consistent way – GP communications developed and disseminated in December o • **Falls and falls prevention** o Locations for existing falls prevention classes and exercise provision have been mapped o Work underway to simply referral pathways for planned interventions and align to Community point of Contact and Co-ordination and PCN and Neighbourhood developments o PCN DES investment in Advanced Practice Physiotherapist roles in 2020/21 to be taken into account within service development proposals o Identification of falls related outcome measures in draft PCN DES specifications and inclusion in combined PCN/Neighbourhood planning		