Integrated Commissioning: Unplanned Care Workstream Update

Health in Hackney Scrutiny Commission, 4th February 2019

1. Purpose

The purpose of this report is to update members of the Health in Hackney Scrutiny Commission on the work Unplanned Care work-stream. The workstream last reported to the commission on February 2018; this report gives an update on progress against the transformation objectives since that point and provides some background to the workstream for new members.

2. Who is part of the workstream and what are we trying to achieve

The workstream is a collaboration of health and social care providers and commissioners across City and Hackney. Membership of the board includes senior representation from the following organisations:

- Homerton University Hospital
- East London Foundation Trust
- City and Hackney GP Confederation
- City of London Corporation
- London Borough of Hackney
- Hackney Council for Voluntary Services
- Two patient representatives, recruited jointly with Healthwatch in both City and Hackney
- City and Hackney CCG
- City and Hackney Urgent Health Social Enterprise (CHUHSE)
- London Ambulance Services

We have spent some time in the workstream defining what we want to achieve for unplanned care in City and Hackney. The following describes our vision and strategic priorities. These have been informed by the Integrated commissioning board over-arching vision for the wider integrated commissioning structure.

Vision and strategic priorities for unplanned care

The unplanned care workstream is part of the wider integrated care system in City and Hackney.

Our vision is to bring together partners to create services that meet people's urgent needs and support them to stay well.

In order to achieve this -

- We will develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- We will provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information
- We will develop urgent care services that provide holistic, consistent, care and support people until they are settled
- We will work together to prevent avoidable emergency attendances and admissions to hospital
- We will provide timely access to urgent care services when needed, including at discharge
- We will deliver models of care that support sustainability for the City and Hackney health and care system.

The workstream is heavily clinically led, with both senior managerial and clinical representation from the Homerton, East London Foundation Trust, City and Hackney GP Confederation and City and Hackney CCG. We have three clinical/practitioner leads who lead on each of the main areas of transformation.

User representatives are represented at board level, and on each of the reference/steering groups directly below the board. We have also run a number of co-production events and taken our plans to various patient groups including the Older Peoples' Reference Group, the CCG Patient and Public Involvement Forum and the CCG Patient User Experience Group. Given the breadth of transformation required to deliver the neighbourhood model we have convened a patient panel to help us to communicate what we are doing with patients and to hold us to account to involving patients as the work progresses.

3. Plans and priorities

In order to deliver on our vision and strategic priorities, we have developed three main areas of transformation. These are: neighbourhoods, urgent care and discharge.

The following provides further detail on the ambitions and current position in relation to each of the transformation areas:

Neighbourhoods

Neighbourhoods is an ambitious programme to fundamentally change how we deliver community health and care services and how we engage with our residents in the planning and delivery of services. Eight neighbourhood areas have been created in City and Hackney with each serving a population of 30,000 to 50,000 residents. This population is small enough to provide personal care, but large enough to provide a broad range of resilient services.

At the core of a neighbourhood will be a community-centred, integrated team, working across healthcare, social care, public services, community groups and voluntary agencies. By working together, staff across different disciplines can deliver care that is joined up, community based, proactive and focused on the whole needs of a person. Neighbourhoods have sustainability as a core aim. A key principle of the programme is to deliver improved outcomes from supporting existing teams to work better together rather than to bring in significant additional resource.

The neighbourhood structure is fundamental to delivering our ambitions as an integrated care system in City and Hackney and the programme is much broader than just unplanned care. Whilst the governance and project team sit within the unplanned care workstream, the programme incorporates work from across all of the care workstream.

Summary of work to date and planned activities

The programme launched at start of April 2018. We have agreed our overall neighbourhoods strategic framework with all borough partners. This outlines where the neighbourhoods are, the core of what a neighbourhood will look like, who is involved and what we need to do to get there. We have appointed primary care leads for each neighbourhood who are leading on developing the neighbourhood identity.

We undertook a large-scale resident engagement exercise in the South-West of the borough. This was intended to understand what neighbourhoods means to resident, but also to provide a test case for effective resident engagement at a neighbourhood level. We received over 200 responses through a range of mediums which demonstrated that people are supportive of our aims to support local communities to improve their health and well being with a localised and responsive service offer.

Each of the key partners from health and social care that are central to the neighbourhood delivery model have set up a project to test new ways of working at neighbourhood level. These include a model of care for adult community nursing, adult social care and mental health. We are also developing a model of care for residents with complex and diverse needs, and a model of navigation at neighbourhood level to support residents to access the services that they need. We are also working with voluntary sector partners to develop a model for engaging with voluntary sector providers at a neighbourhood level.

We have developed detailed neighbourhood level information packs which show the demographic and public health outcomes across each neighbourhood. These are being used to develop local bottom up quality improvement projects in each neighbourhood.

In year two of neighbourhoods, from April 2019, we will focus on really delivering change on the ground by testing and rolling out the new ways of working. Alongside this, we will develop a five year plan for neighbourhoods which demonstrates how they will move from transformation to sustainable delivery and lays out the expected outcomes on a multi-year basis.

Integrated Urgent Care

The overarching objective of this programme is the development of a new model of integrated urgent care services for City and Hackney and which aims to:

- Provide clear and easy pathways for patients to navigate
- Avoid fragmentation / duplication
- Manage demand away from A&E where possible

Summary of work to date and planned activities

We have been working closely with North East London colleagues to oversee the implementation of the new 111 service. There are some access issues within the clinical assessment service (CAS – the clinical telephone triage element of 111) though these are being closely monitored through the contractual levers.

We are implementing a new GP out of hours which will start in April 2019 and be delivered by the Homerton, delivering face to face GP appointments overnight at the Homerton site. GP home visiting services overnight will be provided by the Tower Hamlets GP Care Group from 1st April. The very small number of home visits each night coupled with the additional infrastructure required for home visits (drivers and vehicles) made a single borough model costly.

We are also developing specific pathways for falls, dementia and end of life that prevent crisis and support our residents better at times of crisis:

Falls: We have reviewed and enhanced our range of falls prevention and response services in the borough. We have commissioned a home based falls prevention exercise service which has been proven to prevent falls and targets those residents that cannot attend exercise classes in community venues. We have also expanded the Paradoc service to provide a falls response service, which is run by a therapist and a paramedic.

End of life: We are implementing a new Urgent End of Life Care Service which will provide a 24 hour rapid response to people in their last weeks of life. This will be run by palliative care nurses from St Joseph's hospice and will provide specialist support to patients and their carers/families with the aim of supporting people to die at home if that is their wish.

Dementia: We are implementing a new City and Hackney Dementia service which rapidly enhances the level of navigation and support that people diagnosed with dementia receive. Patients will be assigned a key/worker navigator who will support them to manage their condition and should reduce instances of dementia crisis.

Discharge

Delays to discharges can lead to adverse outcomes to patients who can lose mobility and the ability to do everyday tasks, it is also important that patients that require any rehabilitation following their hospital stay can access it as quickly as possible. The workstream is working with health and social care services to improve how we discharge people from hospital by ensuring that they have the right services in place at the point of discharge, and that that they do not sit in acute or mental health trusts for longer than is medically required.

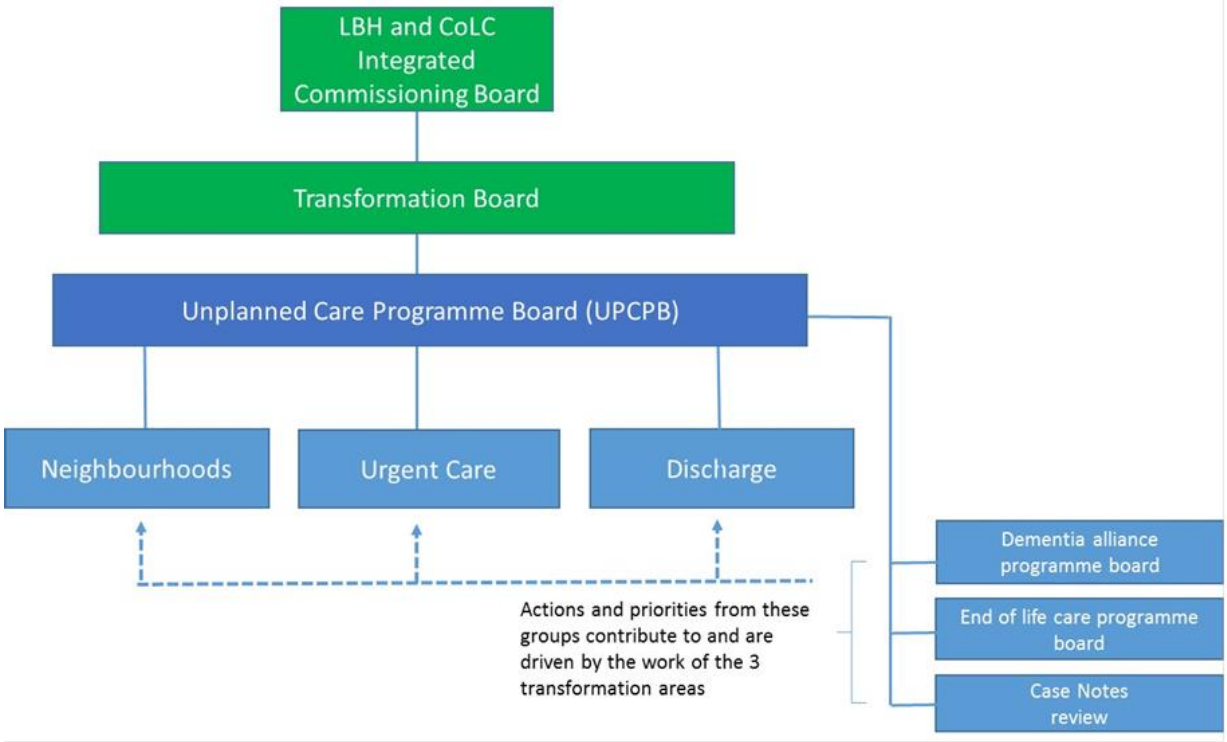
Summary of work to date and planned activities

We are piloting a new model of care known as discharge to assess, where patients receive assessments for their ongoing health and social care needs post-discharge rather than from a hospital bed. This has been running since summer 2018, and anecdotal evidence is that it has reduced length of hospital stay and improved access to step down and intermediate care. We are commissioning an external evaluation to review the success of the new service and make recommendations for the service going forward.

We undertook a multi-disciplinary case notes review of 50 delayed transfers of care. This was undertaken by colleagues working across all elements of the discharge pathway and the learning has been combined into an action plan. Actions include improved communication with patients and families earlier in the pathway about likely discharge pathways and improved communication with a range of agencies such as housing and home equipment services.

We scoped the potential for providing intermediate care beds in the borough. It was established that demand for bed based rehabilitation services was much lower than previously thought, mainly owing to the successful delivery of home based rehabilitation services by the Integrated Independence Team. This is in line with national trends of supporting people in the home where possible. The review identified a need for only 2 - 4 beds at any one time. It has therefore been challenging to identify a suitable and cost effective space for such a small service. However, we are still facing capacity challenges for interim and nursing home beds in borough, and so we are reviewing the feasibility of commissioning a larger mixed use facility including a small number of intermediate care, beds alongside interim care and nursing home beds. Any likely options will require capital investment and a considerable lead in time so this is a longer term strategic plan.

The following shows our workstream structure that is driving our work:



Integrated systems

The City and Hackney IT enabler group have overseen a programme of work to integrate patient records from a range of different systems into our 'Health Information Exchange'. This means that clinicians in primary care, secondary care and community services, who all use different systems, can access patient records from each different system. This is vital to being able to deliver integrated care. The IT enabler group sits outside of and supports all four workstreams, however, many of the improvements that unplanned care want to deliver will be reliant on the Health Information Exchange and further IT developments.

4. Finance

The workstream has a responsibility to both deliver in year financial balance, and to support long term system financial sustainability. The latter will be delivered through the transformation areas that have been described. Short term financial balance is delivered through a combination of delivery of small steps towards the larger transformation and some 'business as usual' (ie non-transformational) work to improve efficiencies in the system.

In 2018/19 we have a budget of £136m and a target to deliver £1.6m of savings to the system. We are currently projecting a £2m adverse position against this. This is driven by an increase in A&E attendances in the first half of the year at both Homerton and Barts Health and an increase in emergency admissions at Barts and an increase in ambulance conveyances. We have also seen an increase in spend of non-elective admissions at the Homerton, so whilst the activity is under plan there were a number of complex cases which drove overall commissioner spend up.

We have undertaken the following actions to mitigate the position:

- Working with London Ambulance Service and local telecare providers to utilise our local Paradoc service where appropriate instead of deploying an ambulance. Paradoc offers a GP and paramedic rapid response service that can stay with a patient for, on average, two hours and potentially therefore provide an alternative to an A&E attendance.
- Publicity to patients to use their Duty Doctor service in hours and 111 out of hours instead of going to A&E for non-critical issues.

- Increasing links between our GP practices with both Barts ED and Homerton ED. This includes introducing a re-direction service so that patients that are better served by their GP are booked into their local practices.

In 2019/20 there is a significant shift in how acute trusts get paid for all emergency activity in hospital (A&E attendances and emergency admissions, excluding maternity). A new 'blended tariff' has been mandated by NHSE to replace Payment by Results (PbR). This new arrangement comprises an agreed contract value (block contract) with a variable rate payment for activity over or under the agreed value. If activity goes over the agreed value the acute trust will only get paid 20% of the PbR tariff for that activity. If activity is lower than the agreed value then the acute trust keeps 80% of the amount by which it is lower.

This is intended to have the following benefits, which should in themselves support the overall aims of the workstream:

- An improved activity planning process between the commissioner and the trust so that both parties agree to a realistic activity plan as this forms the basis for the value of the block contract
- Incentivises the acute trust to try to reduce demand on emergency care services where they can
- Provides the system with a much better assurance that commissioner costs for emergency care will be contained

We are currently working with the Homerton and the CCG to set the agreed contract value. This should be set at a level that supports the CCG's overall affordability without de-stabilising the Homerton.

5. Performance and winter pressures

The workstream also has a responsibility to deliver on a range of performance indicators. As a workstream we have now agreed a broad range of performance and outcome indicators which we will use to track the progress of our work. However, there is national scrutiny on two main national standards within the programme. These are the four hour wait in A&E (95% of patients must be seen and treated and have left the department within four hours) and delayed transfers of care from acute and mental health settings (we must deliver the reduction in delayed transfers of care that was agreed when we submitted out Better Care Fund plans). These measures are also used as an indicator of how well the system is coping with the increased acuity and demand often seen over winter.

The Homerton are the only A&E in the borough. They have delivered excellent performance against the target. They are currently delivering 94.7% performance year to date against a North East London average of 85.93% and an England average of 88.9%. They are consistently within the top 3 performing trusts in London. The workstream oversaw a detailed winter planning exercise, and continued good performance against this indicator through winter to date demonstrates that the system is delivering well despite winter pressures.

Delayed Transfer of Care performance was within target in each month of the current year up until October. Performance from October to December deteriorated. This was due to a reduction in interim and long-term nursing home placements following a care home not meeting required quality standards. Whilst this is disappointing, system partners have responded quickly to the pressure by commissioning additional intensive home care packages where appropriate, including overnight care. Positively, the position in January is currently much better.

6. Management of risk

The table below sets outs the main risks across the workstream and the mitigation in place. The risk rating is the current risk rating

Risk	Likelihood	Impact	Score	Mitigation
Unable to deliver the required system savings to support overall sustainability of services	4	5	20	Continued work through the workstream programme board to identify the strategic direction that will deliver more long term financial sustainability Horizon scanning of evidence from other systems for interventions that have effectively delivered savings Close working between providers and commissioners to ensure current contracts deliver value for money and new contracts are developed to support overall financial sustainability.
Unable to effectively engage patients, therefore we deliver services that do not meet their needs	2	5	10	Working with healthwatch and existing patient groups to develop a model of meaningful engagement Workstream team and user representatives attended co-production training together All proposals to the workstream board must detail what level of patient engagement has happened Workstream are collating a checklist of different ways of engaging patients
Unable to deliver the large-scale transformation required within the neighbourhoods programme, which cuts across all of the workstreams	2	4	12	Programme provides resources for partner organisations to release staff to support neighbourhood design and implementation Neighbourhood governance model in place and robust and includes workstream director representation at the steering group.
Improved DToC levels are not sustained	4	3	12	Continued focus on DToCs via the discharge workstream Implementation of discharge to assess Increased provision of continuing healthcare assessments Delivery of 7 day discharge services (including social care) from the Homerton.

7. Conclusion

The unplanned care workstream has an ambitious but exciting agenda to deliver real transformation across City and Hackney. This will be delivered through strong clinical/practitioner and operational leadership, patient involvement and close collaboration between a wide range of partners.

January 2019