**Integrated Commissioning**: Unplanned Care Workstream

**Update to Health in Hackney Overview and Scrutiny Committee**
**29th January 2019**

## 1. Introduction

The Unplanned Care workstream has been in place since December 2016. It is a collaboration between commissioners and providers of health and care services within City and Hackney, as well as public representatives.

The workstream is now well established, and has agreed and is working towards its overarching objective, and strategic priorities, as follows:

The overarching objective of the workstream is to bring together partners to create services that meet people's urgent needs and support them to stay well

This is delivered through the workstream's strategic priorities:

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

We continue to drive this through three transformation areas; Neighbourhoods, Integrated urgent care and discharge

## 2. Transformation

The following provides updates on what we have achieved in year and what we are planning for the coming year against each of these transformation areas:

### Neighbourhoods

We continue to progress our system-wide neighbourhoods programme. The neighbourhoods are working to deliver locally integrated services that respond to local population need. The eight neighbourhoods are now well established and we have an agreed operating model for neighbourhoods that all system partners are committed to implementing.

We have detailed population health data for each neighbourhood, and this is being used to determine each neighbourhood's priorities and to address inequalities in health outcomes.

Primary care networks (PCNs) have been established since July and provide the primary care foundation for each neighbourhood. Homerton, East London Foundation Trust and the GP Confederation are now working much more closely together as part of the Neighbourhoods Health and Care services alliance, and this provides the vehicle for the transformation of community services to deliver neighbourhood working.

The following phase 1 re-design projects are progressing well:

- Following a pilot project in one neighbourhood we are working to roll out the new neighbourhood model of community nursing across the borough from April.
- Community Mental health services have secured national transformation funds and are implementing a new model of neighbourhood based mental health community services from April.
- Adult social care have tested a new model of closer working with primary care in two neighbourhoods, which they will roll out across the borough in the coming year.
- We are developing a new model of community navigation. This includes recommissioning of social prescribing services to make them more joined up and the introduction of new posts, *well-being practitioners,* that launch in January 2020 and will to provide more focused support to people with complex needs.

We have also launched the following phase 2 re-design projects:

- Community pharmacy; we have identified eight neighbourhood community pharmacy leads. They are working with system partners in each neighbourhood maximise the benefits that community pharmacies can provide to support improved population health, this could include health promotion, immunisations and provision of services.
- Community therapies have started work to deliver a neighbourhood model for the Integrated Independence Team, Adult Community Rehabilitation Team and the Surgical Rehabilitation Team.

HCVS are leading the work to develop and strengthen links between statutory services and voluntary sector organisations and community groups, which is being tested in the Well Street Common neighbourhood. This work is crucial to ensuring that neighbourhoods can address the wider determinants of health.

We are progressing work with wider local authority colleagues in housing, regeneration, welfare and debt advice, and employment services to establish how these services work with neighbourhoods to support improved access and support to vulnerable people.

We are also working with Healthwatch and the communications and engagement enabler to establish the best mechanism to engage with and involve local communities within each neighbourhood to ensure that local residents can be involved in the planning and design of their services.

**Integrated Urgent Care**

We continue to progress our work to develop an urgent care system that:

- Triages and navigates people to the most appropriate place at every entry point into the system,
- Develops strong and effective community based services as an alternative to hospital wherever possible.

Key achievements over the last 12 months include delivery of a new GP out of hours (GP OOH) service at the Homerton (replacing CHUHSE) since April 2019. The service is working well and has successfully managed to recruit sufficient numbers of GPs, which had been the main risk. It has also been able to support A&E by seeing primary care suitable patients at times when the department is particularly busy.

The new 111 service has been in place since August 2018. The service has had some access issues, although overall performance is improving and we are seeing lower levels of ambulance dispatches than the London average for 111 calls.

A new *High Intensity User Service* started 1st April 2019 to support frequent attenders to A&E and frequent callers to 111 and 999. The service is provided in partnership between ELFT, the Homerton, Family Action and the Hackney Volunteer Centre and addresses patients' physical, psychological, and social issues. A six month interim evaluation of the service showed that it is effectively supporting people and reducing inappropriate use of urgent care services.

We continue to drive the use of effective care planning to reduce the likelihood of crises, and to ensure that patients receive the care that they want should a crisis arise. We utilise an electronic care planning tool called Co-ordinate my care (CMC) which all partners can view. We have done a lot of work to improve care plans (most of which are developed in primary care) and to ensure that all partners do review and update these plans. Positively, we have seen a huge increase in LAS usage of care plans in the last six months.

In partnership with Newham CCG, we have just launched a pilot Urgent end of life care service, which provides rapid access to palliative care in the home for people that are in the last few weeks of life and want to die at home. The service is provided by Marie Curie and runs overnight, which is when there is a gap in current services. We will work with Newham to evaluate its effectiveness over the next 12 months.

We are working with North East London partners and LAS in an exciting project that could provide significantly reduce the number of inappropriate ambulance conveyances by realising the benefit of LAS providing both 111 and 999 services. The proposed model is that all low acuity 999 calls will be triaged by the 111 clinical assessment service and patients could be referred into GP extended access, GP OOH, MH crisis line, Paradoc, IIT or Duty doctor without the need to convey an ambulance. Where an ambulance was needed they could send a more appropriate clinician (such as a mental health practitioner) to treat the patient on site.

This was piloted for one day in September. The outcomes from the day were positive, and we are working with LAS to take this forward. One of the lasting impacts from the day is that we have now established a referral route from LAS into duty doctor.

**Discharge**

We continue to see the benefit from bringing together hospital, local authority and voluntary sector partners to support improved discharge for our residents.

Following a pilot period we completed a full evaluation of our Discharge to Assess service. This showed that the service provided quality and financial benefits. A surprising benefit was that it has also enabled more people to be successfully supported from A&E, therefore avoiding an admission. We have agreed to continue to fund it recurrently going forward and are exploring options to further improve the service.

We have launched a project to review and improve hospital and discharge pathways for homeless people, working with St Mungo's Hostel and Pathways (a national charity that supports hospitals to implement better services for homeless people). Pathways are currently undertaking a needs assessment of homeless admissions and attendances at the Homerton Hospital. We are looking to develop a hospital based team that will better support people who are homeless both whilst they are in hospital and supporting a safe discharge.

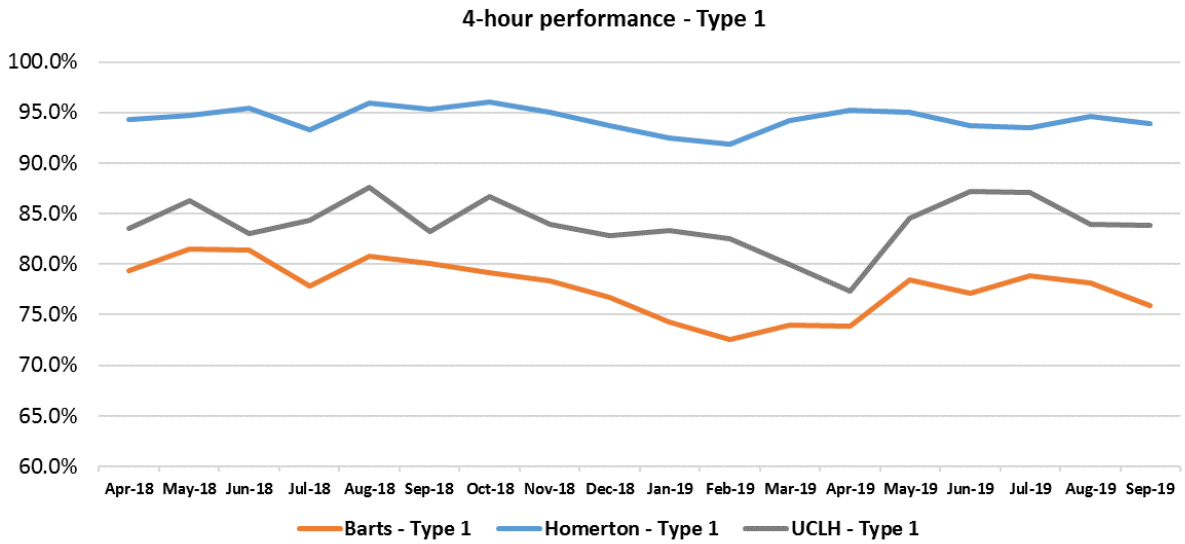
We have increased support to local care homes from local health partners including reviewing our primary care service to care home residents and providing more training on areas such as supporting deterioration and dementia to care home staff.

We are seeing poor performance for delayed transfers of care (DToC) so there has been considerable focus on delivering a recovery plan. This is detailed below.

**Outcomes and Performance**

The two key performance metrics that the workstream oversees are the A&E four hour wait, and delayed transfers of care (DToC).

Performance against the four hour standard continues to be excellent at the Homerton. In 2018/19 they were the second best performer of all London acute trusts, and performance is considerably better than nearby trusts:



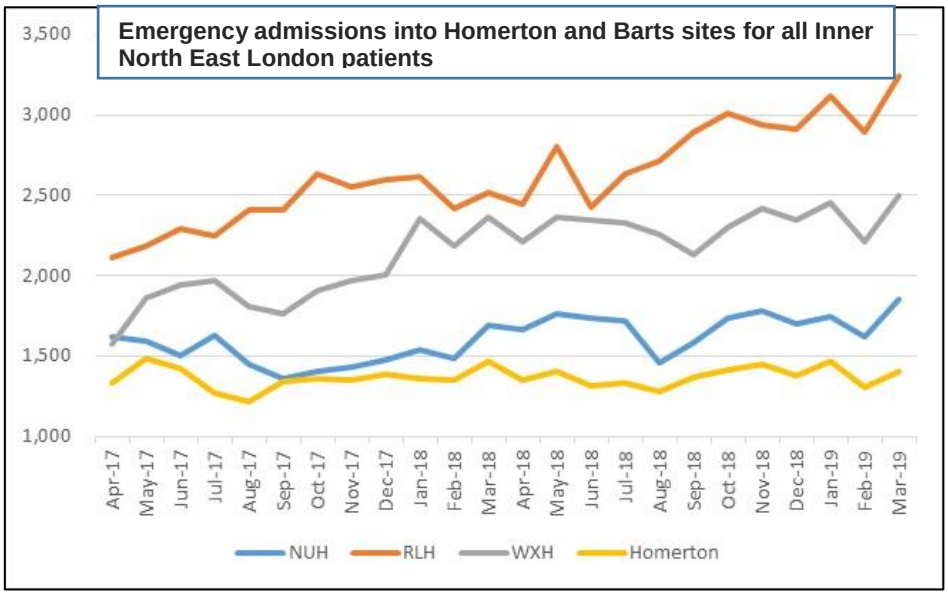

*Nb: type 1 activity is any activity within hospital emergency departments*

Unfortunately we did not achieve our DToC target in 18/19, and are currently not achieving in 19/20. Whilst this is in line with a national and London trend, local partners are focused on recovering performance through the integrated discharge meeting. Actions include:

- Establishment of a control centre at the Homerton site that brings together key local authority and trust colleagues to support complex discharges
- Procurement of additional interim and nursing home beds
- Closer working with home care providers
- Increased use of enhanced packages of care for people who would otherwise require a bed based placement
- Increased access to cleaning services where people's home environment is a limiting factor
- Work with NEL colleagues to ensure that patients in hospital in other boroughs can access step down services quickly
- Work with ELFT to focus on mental health delays (where there are small numbers of patients but some large delays)
- Improved discharge pathways for homeless people

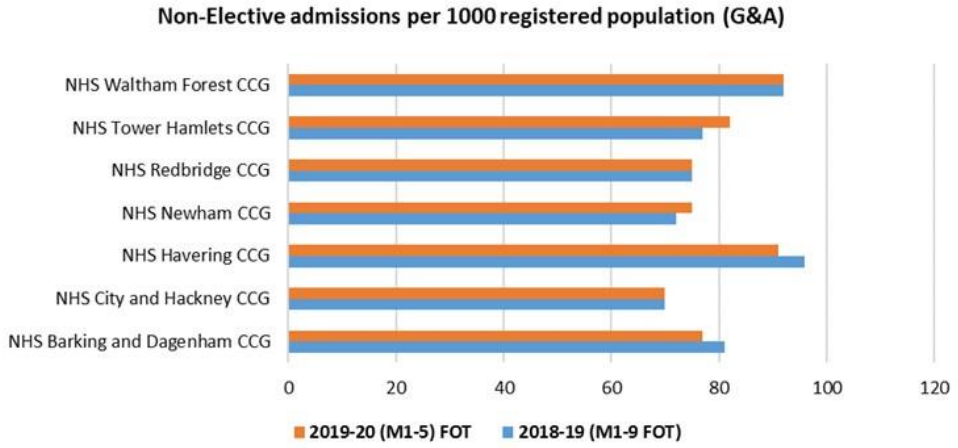
We have seen some improvement in the last few weeks; this continues to be monitored closely including a weekly director level review.

The workstream regularly reviews emergency activity as preventing emergencies and reducing inappropriate use of emergencv services is a key measure of success for us. Recent data shows that we have seen a much smaller increase in emergency activity since 2017 for local patients at the Homerton, in comparison with increases in activity for local patients at Barts. This is also much lower than national increases in emergency activity, which are reported at 4-8% in the same period*




*(this number varies according to different reports, Kings Fund reported 4%. NHSE reported 10%)*

Linked to this, we are reporting lower rates of emergency admissions for City and Hackney patients, relative to the rest of NEL:




| | 2018-19 (M1-9 FOT) | 2019-20 (M1-5 FOT) | difference |
|---|---|---|---|
| **NHS Barking and Dagenham CCG** | 81 | 77 | -4.9% |
| **NHS City and Hackney CCG** | 70 | 70 | 0.0% |
| **NHS Havering CCG** | 96 | 91 | -5.2% |
| **NHS Newham CCG** | 72 | 75 | 4.2% |
| **NHS Redbridge CCG** | 75 | 75 | 0.0% |
| **NHS Tower Hamlets CCG** | 77 | 82 | 6.5% |
| **NHS Waltham Forest CCG** | 92 | 92 | 0.0% |

We are looking at how we demonstrate impact more tangibly through our workstream Outcomes Framework, Logic Model and ongoing evaluation with Cordis Bright partners. The outcomes framework for neighbourhoods has previously been shared with this committee, and we now have established outcomes for our other transformation areas.

**Financial Performance**

The workstream manages a budget of £137m. This is made up of £131m of CCG spend, £400k of City of London Corporation and £5.5m of London Borough of Hackney spend. In 2018/19 we successfully delivered an underspend of £1.1m. This was mainly driven by a reduction in spend on emergency admissions at the Homerton.

**Risks and Challenges**

Key risks are managed through workstream governance structures, with high level risks reporting through to the Integrated Commissioning Board. The following are our highest rated risks:

| Issues, risks and challenges: | Progress/ Actions being taken to address: |
|---|---|
| Failure to deliver the workstream financial objectives for 2019/20 | • Plans in place to deliver system financial objectives agreed with all providers<br>• Monthly monitoring and reporting in place<br>• Criteria that all service developments must support system sustainability |
| If Primary care and Community Services are not sufficiently developed and are not established as a first point of call for patients this could lead to an increase in the number of inappropriate attendances at A&E and unplanned admissions to hospital. | • Continued work to develop community services through the neighbourhoods programme.<br>• Work with London Ambulance Service to increase referral to community services as an alternative to hospital<br>• Evaluation of the primary care proactive care service showed that it does result in lower hospital activity for patients within it.<br>• Work with telecare to ensure that they utilise our local falls response service (provided by Paradoc) as an alternative to 999.<br>• Evaluation of proactive Care Home Visiting Committee. The service is being evaluated. |
| Discharge and Hospital Flow processes are not effective, resulting in increased DToCs and Length of Stay | Delivery of DToC reduction plan as described above |
| Risk that we cannot get sufficient engagement from front line staff across all of our partner organisations in order to deliver the scale and pace of change required. | • The programme group continues to work with existing members to broaden engagement through their organisations.<br>• We are working with the Engagement and Communications enabler develop some key communications materials.<br>• The Neighbourhoods structure has embedded clinical leaders and project managers across all partners which has improved engagement with an ongoing responsibility to continue to raise awareness and champion Neighbourhoods within their own providers. |

## Co-production & Engagement

We continue to involve local residents in our work and have seen a real benefit from their input into our plans.

We have at least one resident representative on the workstream board and on each of its sub-committees, we also have a neighbourhoods resident involvement group. These groups/individuals hold us to account for taking a co-production approach to all of our work.

Some of the key areas that residents have supported are:

-In discharge, a group of residents have supported a piece of work to review and improve how hospital and local authority services communicate more effectively and empathetically with patients and their families/carers about their discharge and ongoing care.

-As part of the re-design of community nursing, the team used a model of Experience Based Co-design, which meant filming current patients and staff talking about the service, and then using the footage to

-Healthwatch supported the workstream to hold an all-day event in Ridley Road market to talk to residents about how they accessed and used urgent care services. It was attended by over 80 people, 50 of whom completed our survey. The findings were used to inform our winter communications as well as service planning.