Health and Wellbeing Board
Hertfordshire

Agenda Item No.

4

HERTFORDSHIRE COUNTY COUNCIL

HEALTH AND WELLBEING BOARD
THURSDAY, 4 JUNE 2015 AT 10.00 a.m.

Herts Valleys Integrated Care Programme Update

Report of: Carole Gillespie, Programme Director, Herts Valleys Integrated Care Programme

1.0 Purpose of report

1.1 To brief the board on the development and progress of Herts Valleys Integrated Care Programme, a key element of supporting the delivery of the Health and Wellbeing Board vision - *"with all partners working together, we aim to reduce health inequalities and improve the health and wellbeing of the people in Hertfordshire".*

1.2 The report outlines expected outcomes for service users and carers, objectives of the programme and progress to date.

2.0 Summary

2.1 The Herts Valleys Integrated Care Programme (HVICP) Board was established in March 2014 following agreement by Herts Valleys CCG for the provider partnership (HCT, HPFT, HCC) to be responsible for the development and implementation of a whole system partnership approach to integrating care for the population of west Hertfordshire.

2.2 To date, priority has been *'integrating care in the community'* and the key driver has been the '**Living Well Programme**' that is founded upon the three main provider organisations, in partnership, establishing a proof of concept model, initially within Watford Locality, focusing on older people, over 65, with complex needs.

2.4 The intention of the Living Well Programme is to improve the co-ordination of care for people with a broad range of health, social and psychological needs, to improve their health and wellbeing and reduce reliance on institutional care. The approach taken has been to work on a small scale to understand what is required to support effective joint working. As the programme extends it will broaden its focus to supported self-management and preventive strategies with a wider population. The work will support the future models of care that are being developed and are to emerge from Herts Valleys strategic review, 'Your Care, Your Future'.

3.0 Recommendation

3.1 The Health and Wellbeing Board is asked to endorse and support the direction of travel outlined in this paper.

4.0 Herts Valleys Integrated Care Programme Update

The Herts Valleys Integrated Care Programme (HVICP) Board was established in March 2014 following agreement by Herts Valleys CCG for the provider partnership to be responsible for the development and implementation of a whole system partnership approach to integrating care for the population of west Hertfordshire.

4.1 Aim

The overarching aim of HVICP agreed in March 2014 was:

"To deliver the best in class community services for older people in West Hertfordshire through the alignment of health and social care services including third sector provision."

To date, priority has been given to 'integrating care in the community,' working through the three main provider organisations (HCT, HPFT and HCC), in partnership, aligned around general practices, establishing a proof of concept model, initially within Watford Locality, focusing on older people, over 65 with complex needs.

The small scale approach was consciously agreed to enable crucial testing of alignment between health & social care teams, enabling blocks and barriers to be understood and addressed. Key learning from the 'proof of concept' in Watford & Three Rivers, other local pilots e.g. Hertsmere HomeFirst and National integrated care pioneers has led to review of HVICP aims and objectives.

The overarching aim of HVICP has been refreshed and is now:

"To deliver the best in class community services for adults, over 18, with multiple long term conditions and complex needs in West Hertfordshire through the alignment of health and social care services including third sector provision."

4.2 Objectives

The objectives of Herts Valleys Integrated Care Programme are:

- To provide services that are:
  - personal – care plans for individuals and carers and trusted assessment arrangements
  - well-co-ordinated – a single team and management, organised around general practices
  - responsive – a single point of access and responding rapidly to need
- To enhance the level of community provision, meeting the health, social and psychological needs of individuals, carers and families
- To enhance self-management for older people
- To work with voluntary and community organisations to make best use of all available resources
- To achieve best in class outcomes
- To deliver a shift in the cost of care, particularly for people with complex needs and reduce reliance on the acute sector
- To develop the workforce to meet needs effectively and efficiently

4.3 Benefits

The expected benefits to individuals, users, carers, GP and care professionals and the system are:

Individuals, Users and Carers

- Supports shared decision-making
- Improves sharing of information and understanding between care professionals and the individual – less repetition & awareness of services available
- Empowers the individual and their carer to highlight what is important to them and take control
- Improves experience for the person and their carer
- Provides confidence to support self management and promote prevention
- Improves health and wellbeing outcomes
- Supports as far as possible to live independently at home or usual place of residence
- Prevents illness and tackles risk factors to help people remain in good health
- Appropriate care provided on a timely basis, reducing delays

GP and care professionals

- Offers partnership working, services wrapped around GP, no duplication of workload, uses the best of professional skills and capacity
- Enables professionals to have more holistic view reflecting pathway and not episodic care with clearer access and improves decision making
- Provides clear care planning that is communicated and owned by everybody, delivering quality outcomes to users

System

- Reduced risk of decompensation, helping to manage flow effectively in acute hospitals
- Reduced reliance on acute care allowing specialists to provide expertise to those with higher acuity needs
- Effective use of commissioning resources care improving health and wellbeing and not just focus on treatment of poor health
- Contributing to CCG strategy and to a sustainable health economy

4.4 Progress to date

4.4.1 Phases

A summary of the key phases are:

- **Phase 1** - '**aligning**' existing team members to a Multi-Speciality Team (MST), not actually creating a new team but rather **introducing a new approach to working**. Testing proof of concept with existing patients/ services users known to 2 or more providers.
- **Phase 2** – Established fixed core members of MST and extended testing proof of concept with referrals from 4 GP Practices in Watford & Three Rivers Locality.
- **Phase 3 (Current)** – design of this phase will be at a workshop on 11th May 2015, followed by a workshop on 30th June 2015 to finalise the proposed model. A number of considerations at this stage:- to improve care planning, expand referrals from wider GP Practice cohort, and extend the members of the MST to grow the model into other parts of the system.
- **Phase 4 (Sept 2015)** – aim to have designed an approach to working that supports an integrated model of care for adults with multiple long term conditions and complex needs in west Hertfordshire and informs Herts Valleys commissioning plans 2016/17.

4.4.2 Key Learning

The **Key Learning** from Watford & Three Rivers Locality 'proof of concept' (Phases 1 & 2), Watford Rapid Response Service, Hertsmere Homefirst and National integrated care pioneers is that:

- **Care is still fragmented** - *Most individuals selected for case management need services or input from multiple providers, but no one person takes oversight or overall accountability for whole care process, including all the various services that come in contact with the patient.*
- **Service Users and GPs still struggle to navigate all the different services involved in a persons care** - *no single point of access for individuals to address any queries or concerns.*
- **Partnership/ collaborative working with GPs needs development** - no current process in place for sharing coordinated summary of interventions with GPs.
- **Still very much a reactive approach to addressing complex needs** - *no capacity within existing resources to do targeted proactive and preventative holistic care planning and promote self management (key to preventing future admissions).*
- **Blurring of boundaries between care coordination and care delivery.**
- **Lack of continuity of care** - *current services designed to be intervention specific.*
- ***Lack of Integrated Service Management*** to support operationalisation of aligned health & social care teams.

4.4.3 Proposed Approach

The **proposed approach** and key features of the integrated community care model for adults with multiple long term conditions and complex needs for west Hertfordshire is:

- Improved Care Navigation and Coordination for patients
- Assigned Accountability: named case manager to act as a fixed point of contact for the patient during the course of their care.
- Alignment of case managers to GP Practices: to act as a link between primary, secondary and social care for case managed patients.
- Case manager/team to maintain oversight of the whole care pathway
- Development of shared care plan approach
- Proactive targeting of risk stratified patients- with focus on prevention and self-management

4.4.4 Expected Outcomes

The **expected outcomes** are in line with the government's definition of integrated health and social care, expressed from the perspective of the individual:

'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'

- Patient centred, joined up services around the needs of individuals with multiple long-term conditions.
- Targeted, community-based, pro-active approach to care that involves case-finding, assessment, care planning, and care co-ordination.
- Shared care plans that are 'live' and accessible
- Improved experiences of users and carers

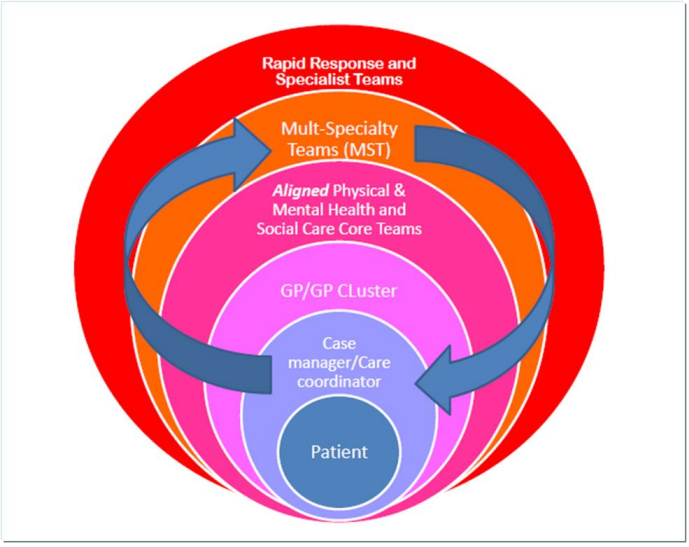
4.4.5 Proposed Model Structure

The **proposed structure** (*see: Figure 1*) for integrated model for adults with multiple long term conditions and complex needs for west Hertfordshire supports Herts Valleys Clinical Strategy and Operating Plan and, in particular, it supports Herts Valleys ***Primary care plus*** vision of delivering care at population level:

- Supporting primary care so that they continue to deliver high quality primary medical care services
- Transforming the management of Long Term Conditions as well as the proactive management of frail older people with multiple morbidity through provision of right care and treatment at the right time and place

- Empowering patients to take an active part in their own care through care planning and self-management
- Ensuring services are joined up and better coordinated around the patient

Figure 1: *Proposed structure for integrated model for adults with multiple long term conditions and complex needs for west Hertfordshire*



4.4.6 Benefits Realisation

The **benefits** realised for **individuals, users and carers** during the 'proof of concept' are starting to deliver the government's definition of integrated health and social care, expressed from the perspective of the individual:

'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'

The **Multi-Specialty team (MST)** established in Watford & Three Rivers, which has a core member from each of the three provider organisations, is agreeing shared care plans with individuals, users and carers that describe personalised 'I' goals and actions in an integrated health & social care plan (*See: Figure 2*).

Figure 2: *Example Shared Care Plan Summary*

Shared Care Plan: DW

Issues	Agreed Goals	Plan	Person Responsible	Timescale
"I have not been attending my hospital appointments"	• To have support with arranging transport	• Community Navigator to arrange transport	Community Navigator	1 Week
"I have no local family support and my relationship with my neighbour has broken down"	• To have help with future correspondence • To maintain independence at home and reduce isolation	• Community Navigator to arrange for an advocate • To engage 'Herts Help' to review voluntary support groups	Community Navigator	1 Month
"I have no local family support and my relationship with my neighbour has broken down"	• To review care provision following surgery	• Refer to EIT for assessment following enablement team involvement	Social Worker	1 Month
"I am on too many medications and do not understand what I should be taking and when"	• To empower him to manage medications more effectively	• GP review medications • Arrange Dossette Box • Engage local pharmacy support for repeat scripts • To provide 'easy read' information on medications	Case Manager	1 Month
"I find it hard to get around my flat as I get too breathless"	• To reduce the risk of falls • To help mobilise around the flat	• To review medication with GP • To monitor heart failure symptoms over a period of time to establish base-line • To establish a Clinical Management Plan for use with the ICT	Case Manager	3 Months
"I find it hard to get around my flat as I get too breathless"	• To reduce the risk of falls • To help mobilise around the flat	• To assess for rails and adaptations around the flat	Case Manager	1 Month

4.4.7 Case Study

The shared care plan summary above *(Figure 2)* underpins the case study presented in ***Figure 3: Derek's story.***

Figure 3: Case Study: 'Derek's story'

Case Study: Watford & Three Rivers 'Living Well Multi-Specialty Team'

Co-ordinated Care – A Patient's Story:

Derek is a 73 year old man who lives in Warden Controlled accommodation. He has been living with Chronic Heart Failure, Type 2 Diabetes, chronic kidney disease, peripheral vascular disease and has been identified as having learning difficulties. Derek was self-caring with his personal care and medication and has been managing to administer his own insulin twice a day.

Derek has a long-term urinary catheter that he manages with support from the Community Nurses who visit every 10-12 weeks to change the catheter. He has also previously been known to the Cardiac Rehabilitation Team, Specialist Diabetic Nurse and the Podiatrist; however this care has never been co-ordinated before.

He has no family that live locally that he can rely on for support; however he has in the past relied on a neighbour for some help with shopping and correspondence. Sadly this relationship has broken down in the past few months which has led to Derek feeling isolated at home and he is now struggling to cope on his own. He is becoming more breathless when mobilising around his flat due to his heart failure and is awaiting planned surgery at Harefield Hospital that will help with this.

Derek was referred to the Living Well Team by his GP as Harefield Hospital were about to defer the surgery as he had not been attending his previous hospital appointments.

Derek was discussed at the Multi-Specialist Team (MST) meeting and it was felt that he had a mixture of long and short term needs. The MST worked with Derek to develop the following statements:

I would like……

- help to arrange transport so that I can attend my appointment
- to manage my correspondence
- to get around my flat
- manage my medication

The MST Case Manager initially arranged for the Community Navigator to support Derek with arranging transport for his planned operation as this was felt to be the primary need. Derek finally attended his appointment and his progress was tracked by the MST Co-ordinator. Post-surgery Derek returned home with an enablement care package for twice a day for help with personal care. The Community Nurses increased their input to help with his surgical wound and he was referred to the Integrated Community Team for therapy support and assessment following the surgery.

The MST Case Manager then worked with Derek on his longer term needs developed from his 'I' statements. The action plan included:

- arranging for an advocate to help with correspondence and future out-patient appointments
- engaging 'Herts Help' to support Derek at home
- referred to the Extended Involvement Team for longer-term assessment of care needs following the enablement team input after surgery
- reviewing his medication with the GP and arranging support with the local pharmacy on dispensing and repeat prescriptions
- developing easy read information
- Derek's long-term conditions would be reviewed via a Clinical Management Plan with support from the Case Manager and the Community Nursing Team
- help with adaptations in the home to help him mobilise around his flat

The action plan resulted in a number of time-limited goals that also included planning for transfer of care to the Core Services once the goals had been achieved. Derek is still being supported through the MST and it is envisaged that this co-ordinated approach will lead to the following outcomes:

- his long-term conditions will be better managed
- he will have a greater understanding of his medications
- his correspondence will be managed and he will be supported in attending future appointments
- he will be less isolated with help from local voluntary groups
- he will know where to go to access future support

5.0 Summary & Next Steps

The Living Well Programme is creating foundations from a number of current integrated care/ primary care initiatives in Herts Valleys and a proof of concept model in Watford, upon which to build the strategic intentions and support the future models of care that are being developed and are to emerge from Herts Valleys strategic review, 'Your Care, Your Future'.

5.1 Phase 3 and 4

Progression with phases 3 and 4 will continue to further refine the proposed model. The next key milestone is Living Well Workshop on 30th June 2015 to finalise the model for integrated community care for Watford & Three Rivers Locality.

5.2 Outcome Measures

The Department of Health (DH) commissioned the Policy Innovation Research Unit (PIRU) to provide advice on indicators of integrated care for individual and collective progress monitoring using routine data. The result is advice on a generic set of indicators, measurable from existing data sources that address the elements of integrated care, for monitoring, assessing and improving care coordination and other dimensions of local integration.

HVICP Design Team will use PIRU indicators for integrated care as a basis to set the performance and outcome measures to monitor impact of the Living Well Programme.

5.3 Service User Focus Group

A focus group is being convened in June 2015 to further test the model and approach with service users and carers.

5.4 Refresh of Governance Structure

It has also become increasingly evident that HVICP now needs to connect and create an overarching strategic direction that supports all the parallel integrated care work programmes and harnesses the resources, skills and experience, assets and technology required to successfully deliver Herts Valleys' vision to improve the health and wellbeing of West Herts population. In view of this a revised governance structure is being developed in collaboration with commissioners to ensure robust integrated governance is achieved.

5.5 Pan County Workstreams

HVICP Programme Director and East & North Hertfordshire Director of Provider Partnerships will work closely on aligned pan county work streams, which will support the delivery and these currently include;

- The workforce partnership executive group
- The health and social care data integration board

Report signed off by	David Law, CEO Hertfordshire Community Trust, Chair HVCIP Board
Sponsoring HWB Member/s	David Law, CEO Hertfordshire Community Trust
Hertfordshire HWB Strategy priorities supported by this report	Supports aspects of all nine priorities, in particular: •Enhancing quality of life for people with long term conditions •Living well with dementia •Supporting carers to care •Improving mental health and emotional wellbeing •Promoting healthy eating & maintaining a healthy weight
Needs assessment N/A	
Consultation/public involvement Engagement with the public, patients, users and staff are critical to the successful delivery of care together and this will be a priority as the programme develops.	
Acronyms or terms used. eg:	
HVICP	Herts Valleys Integrated Care Programme
MST	Multi-Specialty Team
MDT	Multi-Disciplinary Team
HCT	Hertfordshire Community Trust
HPFT	Hertfordshire Partnership Foundation Trust
HCC	Hertfordshire County Council
PIRU	Policy Innovation Research Unit
DH	Department of Health