Health and Wellbeing Board
Hertfordshire

Agenda Item No.

3

HERTFORDSHIRE COUNTY COUNCIL

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

East and North Hertfordshire Integrated Care Programme Update

Report of

Alison Gilbert
Director of Provider Partnerships , East and North Hertfordshire

1.0 Purpose of report

1.1 To brief the Board on the development and progression of the East and North Hertfordshire Integrating 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”. The programme embraces the principles defined in the strategic shift to prevention endorsed by the Health and Wellbeing Board last year, as well as the strategic priority relating to ‘Integration’.

2.0 Summary

2.1 The East and North Hertfordshire Integrated Care Programme Board (ICPB) was commissioned by East and North Hertfordshire CCG and the County Council in October 2014 to be responsible for the development and implementation of a whole-system partnership approach to integrating care for the population of East and North Hertfordshire. Tom Cahill - Chief Executive of Hertfordshire Partnership University NHS Foundation Trust (HPFT), is designated as the provider system-lead for integrated care and therefore chairs the East and North Hertfordshire Integrated Care Programme Board (ICPB). For a description of the ICPB Membership, please see Appendix A.

2.2 Engagement with the public, patients, users and staff is critical to the successful delivery of care together and this will be a priority as the programme develops.

3.0 Recommendation

3.1 The Health and Wellbeing Board is asked to endorse and support the direction of travel outlined in this paper and specifically to commit to the 'Integrating Care Principles and Commitments' which are seen to be key enablers for success.

4.0 The Integrating Care Proposition

4.1 A proposition has been developed by the Integrated Care Programme Board.

4.2 The Aim

4.2.1 The aim is to improve the care, independence and health of over 65 year olds with multiple complex needs and patients with long term chronic physical and mental health conditions.This will be achieved by:

- Improving person-centred and coordinated care
- Giving people more control over the health and care they receive
- Rebalancing our collective resources towards proactive and planned care, whilst contributing to a reduction in the demand for urgent care across the health and social care system.

4.3 The Approach

4.3.1 A collaborative partnership approach by providers and commissioners will be required which recognises and brings together the innovative developments already underway across the system. An approach that ensure services are configured in a way that recongises the distint needs of populations' in each locality of the CCG has also been agreed.

4.4 The Outcome

4.4.1 Success will be described by our patients and service users as:

"My care is planned with people who work together to understand me and my carers, put me in control, coordinate and deliver services to achieve my best outcome''

3.4.2 Success will be described by our workforce as:

"Everyone working as a coordinated team to achieve joined-up care through a shared single person-centred care plan. We will do this by preparing, discussing , documenting and reviewing together in partnership with the person and carers rather than planning for several specific disease or care needs in isolation"

4.4.2 The delivery of the integrating care proposition will ensure that;

- more people live independently in their own homes;
- health and care teams and services will be co-ordinated and joined-up;
- there will be a greater focus on proactive community care;
- there is a move away from single disease and care management to holistic care approaches;
- there is a sustainable reduction in the urgent care demand on primary care, community services, hospitals and social care services

4.4.3 All of the above are clearly aligned to the Health and Wellbeing Board's own aspirations as outlined in its strategy.

4.5 The Principles

4.5.1 **Five** delivery principles have been proposed which will be embedded into current and future developments during the co-design and co-production of the 'integrating care' delivery models.

4.5.2 **One** – Proactive care management by health and social care staff together will keep people as healthy as possible in the community for as long as possible

4.5.3 **Two** – Crisis and urgent care management in the community must be appropriately available to support the maintenance of more community proactive care management

4.5.4 **Three** – Coordinated and joined-up care (wherever that care is provided) will make services more efficient and easier to understand and use

4.5.5 **Four** – Promoting more independence, choice and personalisation of the care delivered around the needs of individuals and their carers rather than around the service needs

4.5.6 **Five** – Promotion of health and wellbeing to help people keep well and to participate in the enjoyment of life

4.6 The Commitments

4.6.1 Alongside the principles, the following commitments to the workforce and to the service developments required have been agreed.

4.6.2 **Our Workforce Commitment**

- We will assess comprehensively together
- We will share records and share goals
- We will proactively case find and risk stratify together
- We will value, respect and trust each other

- Together we involve and place carers and the person at the centre of care
- We will peer review together
- We will always make time for our professional supervision and support through inter professional networking
- We will network our care together

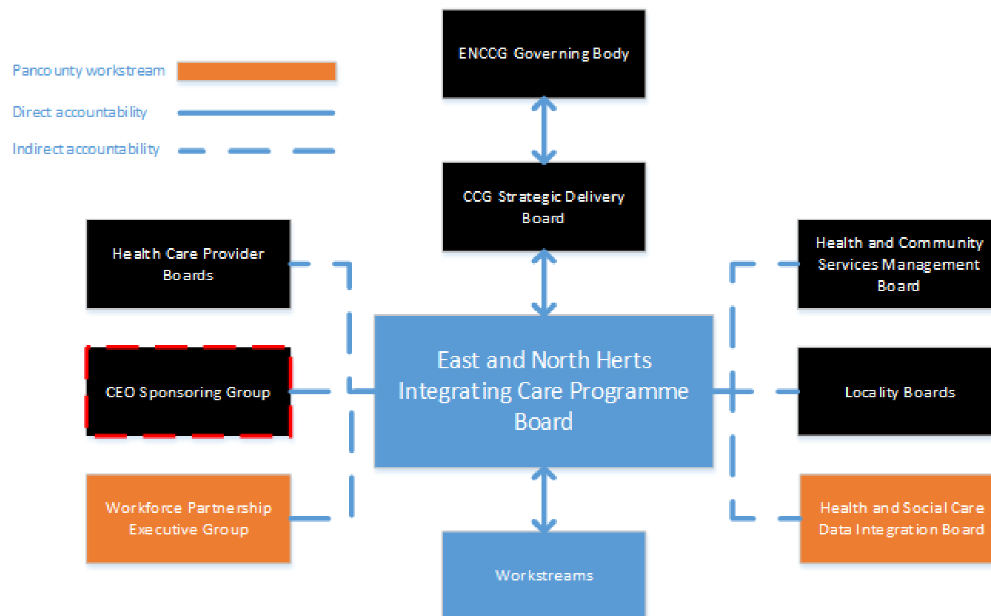
4.6.3 **Our Service Development Commitment**

- We will coordinate proactive care together as an integrated team
- We will case manage and provide ongoing care together
- We will have a centralised referral, intake and staff deployment point
- We will share accountability for care
- We will appropriately co locate our services
- We will have one integrated directory of services
- We will develop person centred transfer agreements
- We will develop shared performance accountability and outcomes
- We will develop our integrated multi professional team approach
- We will organisationally develop together through shared values and goals

4.6.4 For a summary of the connection between the integrating care vision, principles and commitments, please see Appendix B

4.7 Programme Governance

4.7.1 Integrated Governance is an essential component to enable and strengthen sustainable partnership working and decision making of the integrated care programme board. Currently the health and care system governance infrastructure for the ‘Integrated Programme’ is proposed as described above, with accountability to the health and



wellbeing board through the health and care commissioner boards.

4.7.2 The implementation of the ‘Integrating Care ‘ proposition and application of the principles will be delivered through four main work streams which have been proposed and agreed by the ICPB. These include:

4.7.3 Work stream 1 – Improving access – to simplify how services are delivered through an improvement in the coordination and quality of access and assessment leading to the delivery of the appropriate care. Identified projects for prioritisation and implementation in 2015, include;

- the development of directory of available health and social care services for staff
- identification and removal of some key barriers preventing professionals access services from other organisations

4.7.4 Work stream 2 - Ensuring seamless transitions of care – to improve the quality and minimise the numbers of care transfers between organisatons Identified projects for prioritisation and implementation in 2015, include;

- the development of an integrated frailty rapid access service at East and North Hertfordshire Hospital Trust

- a review and improvements to the integrated discharge planning services at the East and North Hertfordshire Hospital Trust

4.7.5 Work stream 3 - Integrating care in the community - to improve the number of people having care closer to home through a focus on transforming the approach to proactive care planning in integrated teams alongside a streamlining of the number and complexity of care pathways available to our communities and workforce. Identified projects for prioritisation and implementation in 2015, include:

- the further development and roll out of an integrated cared delivery model (Homefirst-type model) to two more localities, which will encompass virtual wards, rapid response ans early supported discharge models of care, and will align with the care home Vanguard work (see below)
- implementation of the integrated respiratory service across all localities

4.7.6 Work stream 4 - Integrating care in care homes (Vanguard) - to improve the model of care for residents in care homes by an enhanced approach to proactive care and rapid response services by community health and social care providers, primary care and the voluntary sector.This work is part of the national New Care Models 'Vanguard' programme. Work in year 1 will include:

- implementation of the Complex Care Premium, enhacing the skills of care home staff (this is being delivered Countywide)
- development of alternatives to ambulances for rapid response to urgent issues facing residents, e.g. falls etc.
- development on Interface Geriatrician support to homes caring for the most complex patients

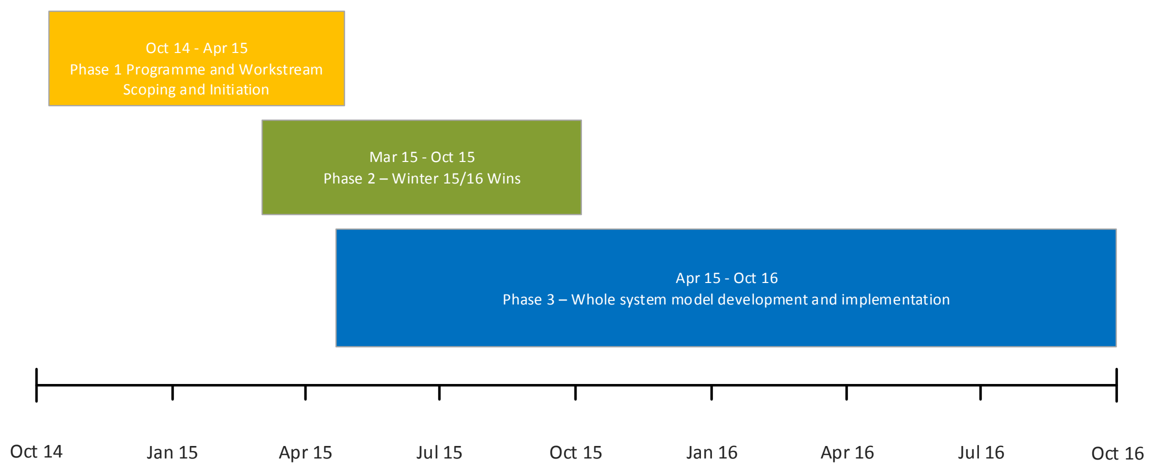
4.7.7 Each work stream has an assigned provider executive director (Senior Responsible Officer) working as a system lead. All current relevant projects / services (80 plus) delivered by the providers will be reviewed within these work streams in line with the proposition principles and regrouped alongside the need for consideration of new projects and services. This will be done in conjunction with commissioners and will provide an integrated delivery foundation for the Health and Well-being Board's commitment to the Better Care Fund.

4.7.8 The balance of provider and commissioner leadership and contributions in these work streams is essential. The work streams will work in partnership with local health and social care leaders to ensure that services are appropriately tailored and reflect the needs of the local population.

4.7.9 Additionally there are aligned pan county work-streams, with associated working groups, which will support the delivery and these include;

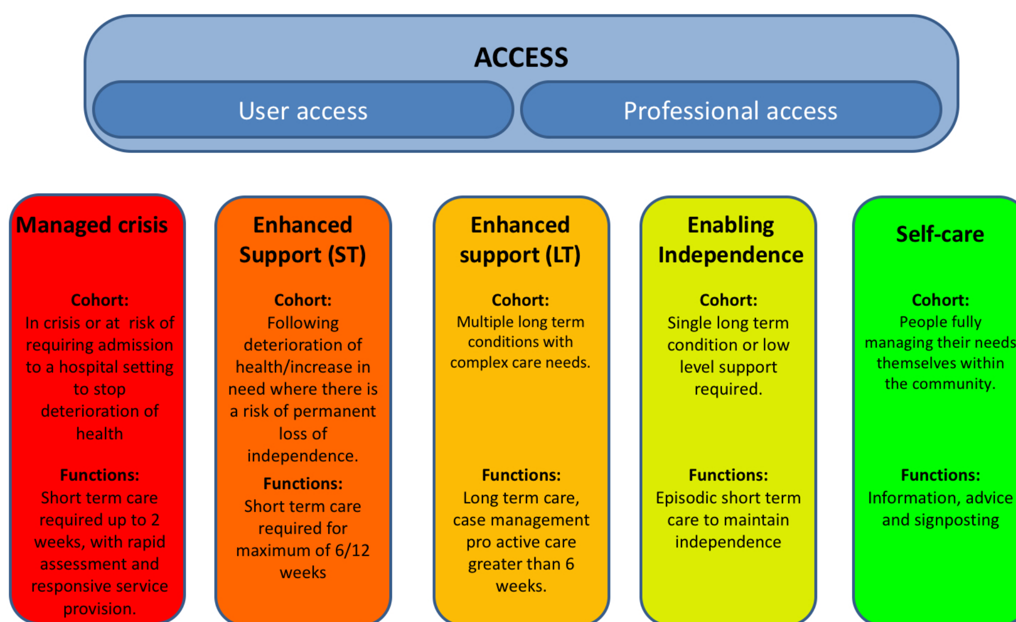
- workforce issues
- health and social care data integration and technology

4.8 Delivery timeline



4.8.1 The Programme is now moving at pace into the second delivery phase with the establishment of the work streams, continued scoping and implementation planning already underway.There is additionally a focus on the delivery of identified 'integrated quick wins' to support the system in its urgent care demand management during winter 2015/16, as outlined for each workstream above.

4.8.2 The service model is being developed to support the delivery of the following functions, appreciating that citizens will move at different rates, with varying requirements, through this continuum of care as outlined below.



4.8.3 The programme recognises during this next phase the need to;

- Work closer with the developments in phase 2 of the Care Act
- Support the delivery, where relevant, of the the public health prevention strategies and self management programmes, as indicated above which will link clearly to the new Health and Well-beiong Board's strategy
- Progress work with patietns and service-users to desing services that meet their needs
- Enhance clinical leadership involvement and locality engagement

4.8.4 This paper has provided an overview of the approach being taken by ENCCG, in conjunction with HCS and the four main health and social care providers to developing a new integrated delivery of care across E&N Hertfordshire.

4.8.5 In order to deliver the benefits and outcomes outlined in this paper, commitment, ambition and partnership is required from all health and care providers and commissioners to enable the scaling up and translation of this system proposition into sustainable service delivery changes. The overall proposition and principles have been considered and endorsed by the four provider Boards (HCT, HPFT, ENHT, HCS) and two Commissioning bodies (HCS and CCG).

Appendix A

Chair (System Integrated Care Lead/HPFT Chief Executive Officer)	Tom Cahill
ENHT Executive Lead	John Watson
ENHCCG / GP Lead	Dr Nicky Williams
Commissioner Integration Lead (ENCCG and HCS)	Chris Badger
Provider Partnership Programme Director	Alison Gilbert
HCT Executive Lead (Deputy Chair)	Julie Hoare
HPFT Executive Lead	Karen Taylor
HUC Chief Executive	David Archur
Healthwatch	Michael Downing
HCS Director lead	Earl Dutton
Ambulance Trust (EEAT)	Dave Fountain
ENHCCG Executive Lead	Sharn Elton

Appendix B- Summary of the connection between the integrating care vision, principles and commitments