Living *longer* and living *well*

Whole Systems Integrated Care

Hammersmith & Fulham Early Adopter

Submitted on behalf of:

h&f hammersmith & fulham

NHS Hammersmith and Fulham Clinical Commissioning Group

Central London Community Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Central and North West London NHS Foundation Trust

West London Mental Health NHS Trust

healthwatch Hammersmith and Fulham

Last updated: 28st May 2014

Version: 1.0

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Executive Summary

As joint commissioners we are committed to delivering radical and innovative change through the Whole Systems Integrated Care programme so that our local residents and patients experience seamless care and support which focuses on their wellness and not their illness. People being in control of their own needs and the care they receive is our primary goal and we recognise that the system needs to change to enable this so that services are commissioned, delivered and paid for differently. For us, the Whole Systems programme offers the opportunity to see real structural and systematic change so that people are at the heart of our health and social care economy.

The North West London Integrated Care Pioneer Programme works towards a shared vision to integrate care across our whole system:

*"We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their communities"*

Each locality (health and care) is now to decide how to take forward our local integration work, within the context of the North West London Whole Systems Integrated Care programme and aligned to our local strategic plans and direction. Following a local co-design process in Hammersmith & Fulham, this Outline Whole Systems Plan captures our local vision, initial planning on critical elements such as the outcomes required of our new model of care and a project plan to prepare full business cases and implementation plans going forwards.

We will address six key delivery workstreams as an early adopter, which together represent our shared commitment to taking an ambitious and truly whole systems approach:

- Delivery of a Virtual Ward model for people with complex needs and high risk as our key admissions avoidance initiative
- Co-design and development of our primary care provider networks and community services
- Developing local hospital services co-designed with our local communities through the Shaping a Healthier Future programme
- Designing streamlined and patient centred acute to community pathways focusing on transitions of care
- Developing effective integrated care at home for older and high risk people who remain in their own home or a care home that is linked to our GP and provider network
- Developing our community assets particularly with a focus on communities and our third sector partners supporting self management, personalisation of care and enabling local responses to people's needs

This document lays out the case for change and describes the vision and emerging thinking on the whole systems model of care for adults and older people with one or more Long Term Conditions in Hammersmith & Fulham.

Tim Spicer
Chair
Hammersmith & Fulham CCG

Liz Bruce
Executive Director of Adult Social Care
Tri-borough

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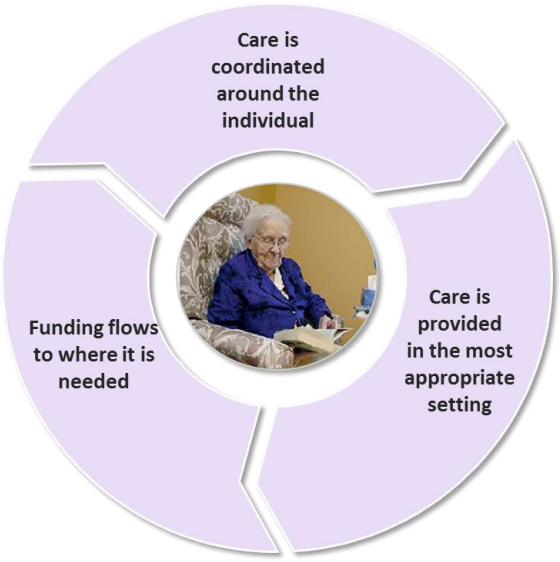
Section One: Whole Systems Vision

- **What is your vision for improving the care people will receive and how the Whole System will change to support this?**

North West London's vision of Whole Systems Integrated Care is underpinned by three principles:

1) People will be empowered to direct their own care and support and to receive the care they need in their homes or local community
2) GPs will be at the centre of organising and coordinating people's care
3) Our systems will enable and not hinder the provision of integrated care



We have a clear vision for whole systems transformational change in health and social care for the population of Hammersmith & Fulham, and significant progress has been made in delivering this through partnership working over a number of years.

The Local Authority and Clinical Commissioning Group have worked in close collaboration, and our Commissioning Intentions, for the first time, contain joint intentions for health and social care in Hammersmith & Fulham. Specifically, these intentions include: establishing joint community teams of health and social care professionals to support people remain in their own homes and keep them out of hospital where possible, and aligning better, community based resources such as community nursing, with general practice.

Our ambition is to:

"Enable individuals to be as healthy and independent as possible maintaining and / or regaining their quality of life and well being"

"Support individuals choice to live in the most appropriate place that they want according to their needs and to have control over their lives"

"Ensure that the individuals experience is a positive one by ensuring the service is personalized and seamless within the system"

"Ensure that the treatment, care and support that is provided is right for the individual's needs, in the right setting and respects their individuality and dignity"

"Increase integration and efficiencies across health and social care to ensure strategic investment of funds and resources to maximise value for money"

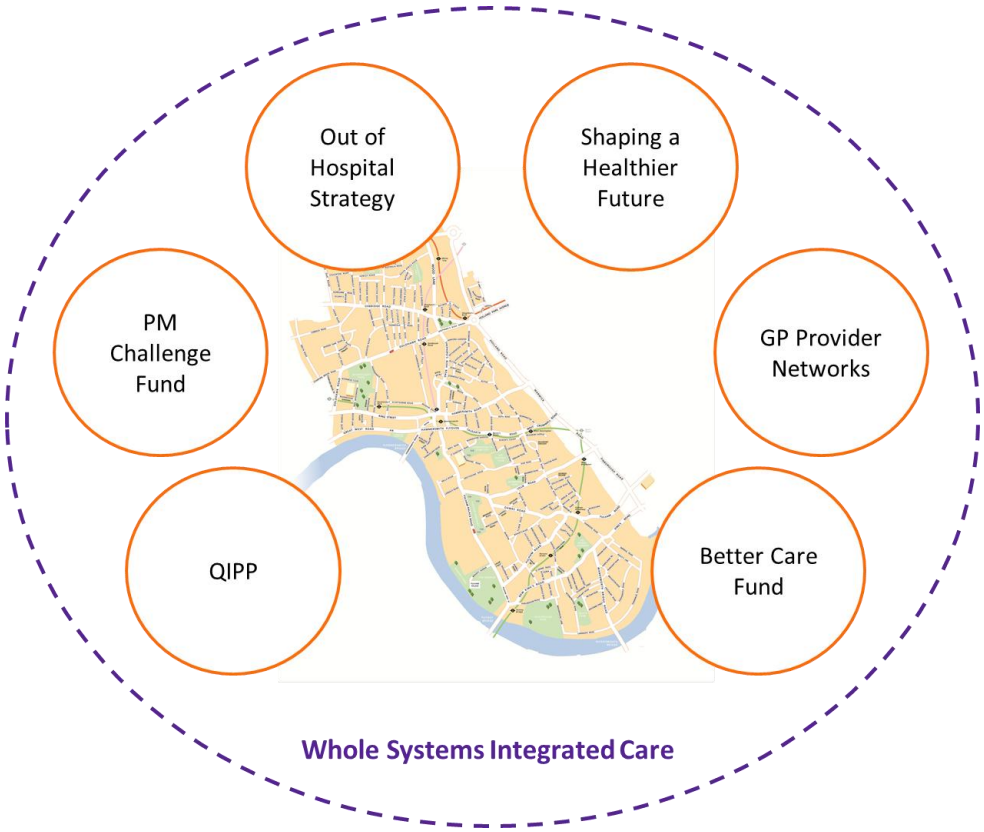
In order to realise our ambition for Whole Systems Integrated Care we have identified six key areas of focus which our Early Adopter work will progress. Put together, these represent our shared commitment to taking an ambitious and truly whole systems approach:

1) Delivery of a Virtual Ward model for people with complex needs and high risk as our key admissions avoidance initiative
2) Co-design and development of our primary care provider networks and community services
3) Developing Local hospital services co-designed with our local communities through SaHF programme
4) Designing streamlined and patient centred acute to community pathways focusing on transitions of care
5) Developing effective integrated care at home provision for older and high risk people who remain in their own home or a care home that is linked to our GP and provider network
6) Developing our community assets particularly with a focus on communities and our third sector partners supporting self management, personalisation of care and enabling local responses to people's needs

■ What will being an Early adopter add above existing strategic initiatives that are already happening in your local area (e.g., Better Care Fund, 7-day working)?

There are a number of existing strategic initiatives already underway within Hammersmith & Fulham:

We are reconfiguring our services to deliver the best care through Shaping a Healthier Future, included in this is our local hospital design work and re-scoping of urgent care. Our Out of Hospital Strategy is building capacity and capability within the community as a vital part of this reconfiguration. Our GP practices are currently exploring mechanisms to drive change through networked provision of care and development of provider networks, and we are improving access to and innovative ways of delivering GP services as part of the Prime Minister's Challenge Fund. The Better Care Fund is enabling us to identify where pooled funding with social care can drive transformation change through, for example, developing integrated services in intermediate care, home care and the commissioning and monitoring of care homes. All of this must be delivered within the financial context of the QIPP gap for Hammersmith & Fulham.



It is vital that health and social care partners work together to integrate at every available opportunity, as integration is necessary to achieving our joint commissioning intentions and to make a step change in service quality. In North West London, health and social care partners are working jointly to progress whole systems integration, and for Hammersmith & Fulham being an early adopter will enable us to test working together differently to manage higher risk cohorts of our population.

For Hammersmith & Fulham being an early adopter will allow us to make the system changes that enable the delivery of our strategic initiatives – without changes to the system we cannot fully realise our ambitions to integrate care and to see the maximum benefit from the existing programmes being delivered in H&F and as part of NWL. These system changes will provide new models for how care is commissioned, delivered and paid for with integration of the supporting infrastructure such as informatics, workforce development and leadership and culture.

Section Two: Involvement of People Who Use Services, Carers and Frontline Staff

- **How have you worked with all the people who will be affected including people who use services, frontline staff, commissioners and providers to co-design our local whole systems plan?**

Hammersmith & Fulham's Whole Systems Expression of Interest was submitted in April 2014 on behalf of:

- NHS Hammersmith & Fulham CCG
- LB Hammersmith & Fulham
- Central London Community Healthcare NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- West London Mental Health NHS Trust
- Central and North West London NHS Foundation Trust
- Healthwatch Hammersmith & Fulham

Hammersmith & Fulham's Out of Hospital Programme Board, jointly chaired by the CCG and Local Authority, has provided oversight of the development of our Whole Systems Integrated Care Expression of Interest, and at our meeting in May 2014 was confirmed as the forum to deliver our Early Adopter proposal, becoming the Out of Hospital and Whole Systems Integrated Care Programme Board going forwards. This Programme Board includes representation from all providers, patients and carers.

Our first Whole Systems Integrated Care workshop in May 2014, focussed on Outcomes and Model of Care was attended by:

Name	Role
Aglaja Dar	Consultant – Imperial College Healthcare NHS Trust
Ann Stuart	Head of Assessment Social Work – LBHF
Anna Letchworth	Integrated Service Manager - ChelWest
Antoinette Eni	Service Manager - Imperial College Healthcare NHS Trust
Aran Porter	Associate Director, ICP – NWL
Aya Ferguson	PPL Better Care Fund
Caroline Allnutt	NWL Strategy and Transformation
Cath Attlee	Whole Systems Lead – Triborough Adult Social Care
Chris Bench	Senior Clinical Lead - WLMHT
Chris Lambourne	Head of Clinical Transformation – CLCH
Clare Graley	GP – H&F CCG

Darren Jones	Interim Senior Manager – CLCH
David Stacey	Director of Strategy - WLMHT
Dominic Conlin	Director of Strategy & Integration - ChelWest
Gillian McTaggart	Community Independence Service Co-ordinator H&F
Ian Garlington	Director of Strategy – Imperial College Healthcare NHS Trust
Jennifer Allan	Divisional Director - CLCH
Jenny Platt	Deputy Out of Hospital Delivery Manager - CCG
Jessica Simpson	Network Coordinator Primary Care Transformation - H&F CCG
Joe Gale	Network Coordinator – H&F CCG
Julie Scrivens	Lead for Planned Care – H&F CCG
Malika Hamiddou	CE - CITAS
Martin Waddington	Director of Commissioning and Contracting, Adult Social Care - Triborough
Matthew Mead	MDG Manager, ICP – H&F CCG
Neil Snee	Service Transformation - CLCH
Noel Morrow	NWL Joint Commissioning Team
Pauline Mason	Adult Social Care – Triborough
Penny Magud	Head of Community Independence Service - LBHF
Philippa Jones	MD – H&F CCG
Rachel Stanfield	Organisational Development – H&F CCG
Ray Boateng	NWL Joint Commissioning Team
Rebecca Vagi	Standing Together Against Domestic Violence
Rob Sainsbury	Deputy MD Out of Hospital Programme Manager – H&F CCG
Samira Ben Omar	Associate Director Equality & Experience - NWL
Samuel Wallace	Borough Manager - Healthwatch
Sena Shah	IT Lead – H&F CCG
Shad Haibatan	Head of Organisational Development - SOBUS
Sophie Ruiz	Senior Network Coordinator – H&F CCG
Stuart Lines	Public Health - Triborough
Susan McGoldrick	GP – H&F CCG
Vincent Law	Consultant Psychiatrist – WLMHT
Will Jones	NWL Strategy and Transformation
Will Tate	PPL (Homecare)

Recognising co-production with service users as an area for development within our local whole systems integrated care plan we engaged with the Co-Production leads for North West London, and have identified members of the lay partners' advisory group for North West London who will support Hammersmith & Fulham to embed the principles of co-production going forwards.

How are people who use services and front line staff part of your decision making and governance arrangements?

To date we have involved people who use services and front line staff in the development and delivery of our Out of Hospital and Local Hospital programmes in a number of ways:

- Developing with the patient reference group the principles for engagement on our Out of Hospital Programme and sharing progress on our projects
- Attending the Older People's Consultative Forum to share and discuss our Out of Hospital programme and Virtual Ward initiative
- Engaging with the Carers Partnership Board and Learning Disabilities Partnership Board
- Engaging people who use services in the design of the local hospital through workshops and visits to service
- Engaging people who use services in the development of our joint commissioning intentions
- Consultation and engagement with people who use home care services by the Local Authority as part of development of the new specification and model of home care across Tri-borough
- Front line staff – nurses, therapists, consultants, social workers, OTs, GPs – have been actively part of developing our Virtual Ward model of care through workshops and weekly operational group meetings

Hammersmith & Fulham Patient Reference Group meets on a bi-monthly basis, reporting into our Quality Committee. The Patient Reference Group comment on our strategies and plans, feeding into their development.

Hammersmith & Fulham's Stakeholder Engagement Working Group – made up of a GP, Head of OD and Governance, Communication and Engagement Lead, a Practice Manager and the two lay people on the board. Discuss how we engage with our stakeholders and how this can be improved upon (e.g. engagement with our voluntary and community sector).

Hammersmith & Fulham's Out of Hospital/Whole Systems Integrated Care Programme Board, which has two lay representatives, meets on a monthly basis to oversee the co-design and specification of the health & social care system.

From July 2014 a regular paper to the Hammersmith & Fulham CCG Governing Body will be presented on patient engagement, equalities and patient experience. This will include feedback from community group reports, to ensure that we are fully aware of developments across Hammersmith & Fulham.

- **How will you support and train partners to support their participation in co-design?**

Co-design is an inclusive and collaborative process with a breadth of stakeholders who can represent the varied interests of service users, their families, their carers and their communities. Hammersmith & Fulham will use the next phase of the programme to engage lay partners, health and care professionals and voluntary services from across the system to contribute to the future of integrated care for adults and older people with one or more long term conditions.

We will work with lay partners from the North West London Lay Partners Advisory Group to develop co-production locally. We will engage with members of our Programme Board to both agree local principles of co-production and begin to model these behaviours at a strategic level. We will also host shared learning events, selecting one of our integrated care initiatives to co-design in practice, as an opportunity to train partners across Hammersmith & Fulham.

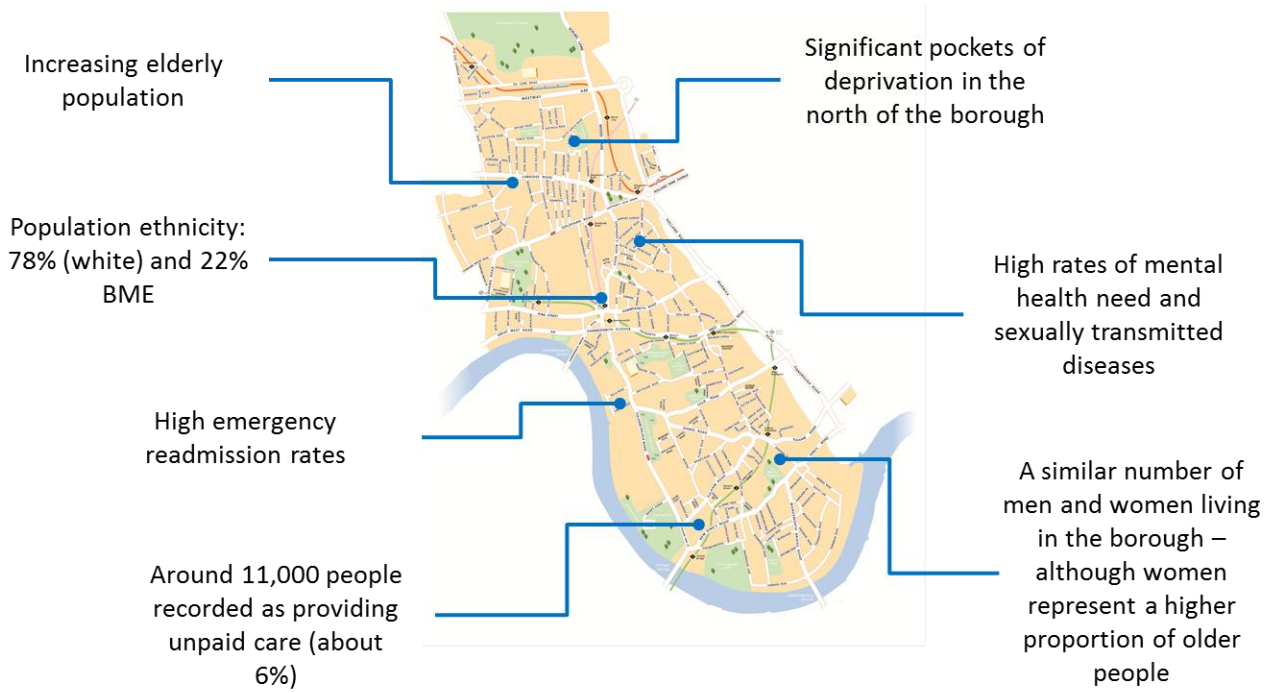
We intend to use the process of co-producing this initiative as a learning exercise in itself, building commitment to co-production and learning lessons in co-production. We would also like to develop a buddying system to provide support to all partners in embedding co-production locally.

At our initial discussion with lay partners we began to talk through our six key delivery workstreams, and it quickly became clear that we need to revisit these to understand the service users affected by these specific initiatives. We will then map out existing community and voluntary groups who would be well placed to represent the varied interests of adults and older people with one or more long term conditions, and will work with these groups to identify opportunities to engage service users, their families and carers in the development of integrated care.

Section Three: Population Grouping

- **Which population group(s) described in the toolkit will you prioritise and what are the local needs?**

Hammersmith & Fulham have a population of approximately 202,202, with a projected increase of to 212,490 over the next five years. The needs of our local population are the starting point for our work, and these are taken from our joint strategic needs assessment (JSNA). The JSNA includes information on the health and wellbeing of our local population which has been analysed to give us an understanding of what people's current and future needs might be, so that this can inform decision making.

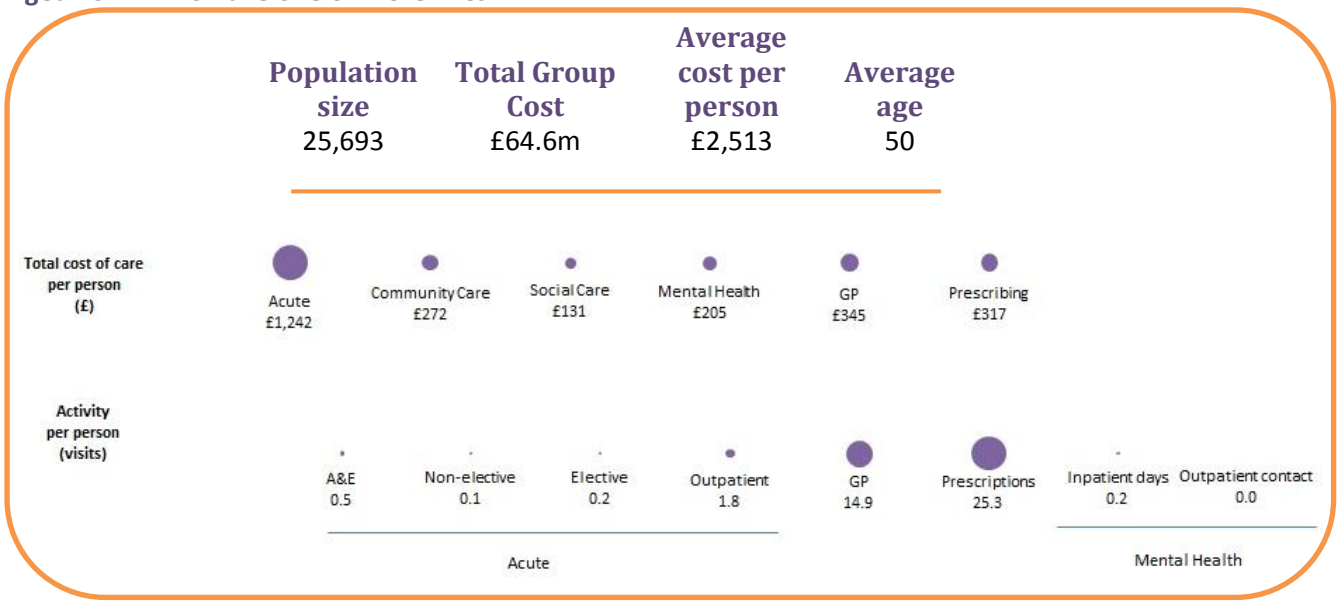


We have chosen to focus our Whole Systems Integrated Care early adopter work on adults and older people with one or more long term conditions, of whom there are approximately 29,802 currently living within Hammersmith & Fulham. These groups are in receipt of a range of services across the health and social care economy, and can often be our most complex in terms of health and social care need. Focussing on these groups will give us an opportunity to build on initiatives, expanding and extending these to provide end to end care for these groups.

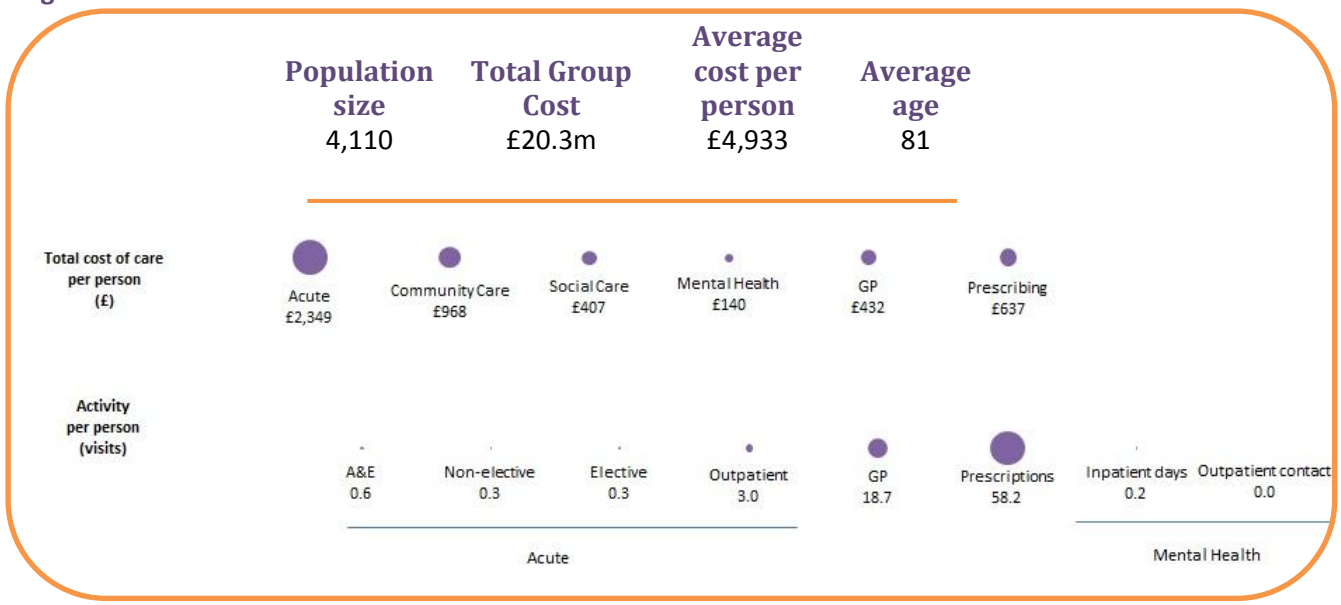
Hammersmith & Fulham CCG and the London Borough of Hammersmith & Fulham have worked closely together to support the development of Whole Systems thinking through enabling a joint data set for Hammersmith and Fulham that has been the basis for developing the population groupings in the North West London Whole System Integrated Care programme.

The population groupings developed from our joint data set identify the holistic needs of individuals who fall into those groupings. The needs of adults and older people with one or more long term conditions in Hammersmith & Fulham can be categorized as follows.

Aged 16-74 who have one or more LTCs:



Aged >74 who have one or more LTCs:



- **What initiatives are planned over the coming year to improve care for this group (e..g, BCF) and how will your plans align with them?**

For our population groups of adults with one of more Long Term Conditions our Whole Systems plan brings together a range of initiatives over the coming year to improve care for these groups and will enable us to deliver this care through an integrated infrastructure to move away from the silo based provision and funding of care that people currently experience:

- Virtual Ward: our Virtual Ward model will be further developed across 2014/15 to offer a multi-disciplinary care response for our most high risk people and extending the groups supported by this model in line with our QIPP plans. We will ensure the resource within the multi-disciplinary team can respond to people's needs and will increase our mental health input and medical cover within the model as well as bringing in third sector and voluntary providers
- Working with acute partners to further develop the rapid access clinics for older people to offer comprehensive diagnostics and assessment within a short timeframe and to link these services to our Virtual Ward
- We are developing care pathways into our Improving Access to Psychological Therapies (IAPT) programme for people with long term conditions and to address anxiety and depression which we recognise are highly prevalent in our population groups
- Developing pathways for smoother and more timely transitions from hospital to community services through our transitions of care and delayed transfers of care projects working with acute, community and social care providers
- Increasing the proportion of planned care that is delivered in community settings by developing new pathways and services for dermatology, respiratory, MSK, diabetes and ophthalmology
- Commissioning an integrated home care service that includes health tasks to reduce duplication and inefficiency caused by people having a number of different health and social care professionals visiting them in their home
- Improving the access and range of primary care services as part of the PM challenge fund with a high number of our practices signed up to deliver this
- Supporting more people with mental illness to be cared for by their GP rather than hospital teams by continuing to increase our enhanced primary care mental health service
- Developing a joint team for commissioning and purchasing of residential and nursing care so that quality of care is monitored and reviewed across the CCG and Local Authority
- Providing proactive enhanced care in care homes to reduce LAS call outs and emergency attendances as well as reducing falls in the home and improving medicines management

Section Four: Outcomes

■ What are the priority outcomes to be achieved by the targeted population group for each of the areas given in the outcomes framework in the Toolkit?

At our first Whole Systems Integrated Care workshop we explored outcomes for adults and older people with one or more long term conditions. Working through each of the five domains of the outcomes framework, as set out in the NWL Integrated Care toolkit, we discussed existing outcomes and explored potential outcomes for development.

A summary of our discussions is below:

	Outcomes and metrics	
	Existing	**Innovative**
Quality of life	• Currently, we have gather patient views on their care in a variety of formats, a have developed some patient reported outcome measures related to quality of life. • Future, we need to give patients the opportunity to shape their care and the goals important to them • Future, we need greater emphasis on psychosocial wellbeing	• An outcome around how people's basic needs are being met and what health conditions make it difficult to fulfil these needs. For example needs such as wellness, having friends and networks, having a suitable house, having enough money • Don't have an outcome that suggests treating the cause of a medical or social problem is the answer to people's needs – look at the person not the condition How do we know that quality of life is improving? a) Is there a care plan b) Has there been a recorded discussion about peoples own goals within that care plan c) At some point an appropriate review, including to what extent those goals have been achieved

Quality of care

Outcomes and metrics

Existing	Innovative
• Currently, there are a lot of outcomes collected on quality of care across the system but in isolation for each service/organisation. • Future, we need to have a patient view of quality of care that is across the system not just from each part of it • Future, we need to have a common definition of what good care looks like – that is based on what people tell us	• Communication – how people are communicated with about their care and supported to understand it • Relationships between organisations – how well is this working? With GPs, Social Care, hospitals, voluntary sector • Quality of visits – asking people what they think about the visit they had in their home? People say it's about the quality of the visit – the time spent with them • Qualitative feedback on care – understanding it's impact for patients and outcomes achieved • How empowered do people feel about their own care needs and the care they receive? • A suggestion that we shouldn't talk about 'quality of care' but 'quality of experience' or focus on people's wellness. As care can have a negative focus.

Financial sustainability

Outcomes and metrics

Existing	Innovative
• Currently, we rely mainly on activity based finances. • Future, should be focused on measuring outcomes for people against investment made, the focus shouldn't be on inputs delivered against budgets but on health and care outcomes achieved against budgets.	• How shared financial responsibility is being achieved across new provider organisations/networks and how incentives are being used to reward providers for keeping people well • Longer term financial planning –to show sustainability over time • How we are investing in prevention and wellness and what the return on this investment is expected to be • Monitoring the shifts in the financial bubble sizes over time (as per the patient diagrams) – for example seeing that the acute bubble reduces and the OOH bubbles increase • Use of the voluntary sector and community assets – how are statutory providers using these services as part of care plans (not as an 'add on') and what savings we think this delivers • Financial sustainability across organisations – of the whole system and not working against each other

	Outcomes and metrics	
	Existing	**Innovative**
Professional experience	• Currently, individual providers measure their employee's professional experience through staff surveys • Future, we need identify factors that improve professional experience, learning lessons from other healthcare systems, and identify areas where we could improve professional experience	• An outcome measure that ensures focus on professionals receiving feedback on their input to a patient's care e.g. feedback on referrals

Operational performance	• Currently, individual providers measure a number performance factors including:
	  • Sickness rate
	  • Vacancy & turnover
	  • Professional development
	  • Patient facing time
	• Future, we need to move away from individual performance to system wide performance – aligning incentives with delivery across providers
		• An outcome around reducing duplication and how we measure this
		• Measuring access to services and people's understanding of how to access appropriate services could be used to show that settings of care are shifting away from acute

We will continue to develop outcomes for adults and older people with one or more long term conditions across the five domains in the next phase of development, focussing on translating qualitative outcomes to quantitative metrics.

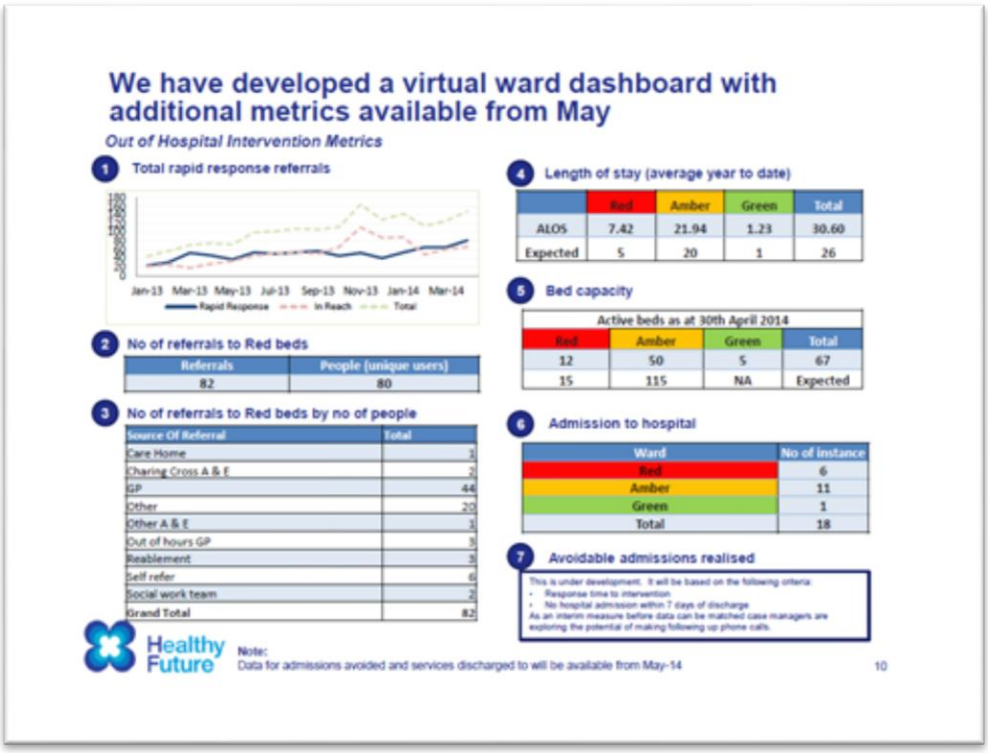
What performance management measures will you adopt?

Once we have established outcomes and metrics, we will build a mechanism for practically measuring and then tracking outcomes. A baseline will be established during the planning phase to enable us to understand the impact of whole systems integrated care on adults and older people with one or more LTC in Hammersmith & Fulham. We will then need to decide how partners will be held to account across the various levels of the system.

We are beginning to develop integrated performance management measures for our integrated intermediate care services and models such as the Virtual Ward. We have identified a range of outcomes and metrics for reporting on the activity and impact of an integrated care model which acknowledge not just the impact on acute services but on social and community services such as:

- A&E attendance avoided
- Non-elective admissions and re-admissions avoided
- Permanent admissions to nursing and residential homes
- People not requiring on-going social or community care
- People remaining in their own home 91 days after discharge
- Impact on community and social care packages following intermediate care intervention
- Number of bed days saved from intermediate care intervention

During 2014/15 we will develop and test our outcomes and metrics for the Virtual Ward using a dashboard like the one below and this will inform how we measure the impact of integrated care in a whole systems model.



We have developed a virtual ward dashboard with additional metrics available from May

Out of Hospital Intervention Metrics

1 Total rapid response referrals

2 No of referrals to Red beds

Referrals	People (unique users)
82	80

3 No of referrals to Red beds by no of people

Source Of Referral	Total
Care Home	1
Charing Cross A & E	2
GP	44
Other	20
Other A & E	1
Out of hours GP	3
Reablement	3
Self refer	6
Social work team	2
Grand Total	82

4 Length of stay (average year to date)

	Red	Amber	Green	Total
ALOS	7.42	21.94	1.23	30.60
Expected	5	20	1	26

5 Bed capacity

Active beds as at 30th April 2014			
Red	Amber	Green	Total
12	50	5	67
15	115	NA	Expected

6 Admission to hospital

Ward	No of instance
Red	6
Amber	11
Green	1
Total	18

7 Avoidable admissions realised

This is under development. It will be based on the following criteria:
- Response time to intervention
- No hospital admission within 7 days of discharge

As an interim measure before data can be matched case managers are exploring the potential of making following up phone calls.

Healthy Future

Note:
Data for admissions avoided and services discharged to will be available from May-14

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Section Five: Integrated Commissioning

Which organisations want to form integrated commissioning arrangements?

The main commissioners of the proposed Whole Systems Integrated Care model of care are:

- Hammersmith & Fulham Clinical Commissioning Group
- London Borough of Hammersmith & Fulham Adult Social Care

As commissioners, we will also engage with the commissioner of general practice and other family health services, NHS England. Commissioners in Hammersmith & Fulham, covering the same population, residents and patients in the services they purchase, share a case for change around care and also a financial imperative for improving the efficiency and quality of services.

Which budgets do you intend, at this point, to pool to support integrated care? Which contracts will be affected by the pooling of budgets?

As we develop our Whole Systems Integrated Care model of care, we need to undertake detailed work to understand the implications for finance and activity within our current commissioning budgets. We are not at the stage where either commissioner can commit to funding a capitated budget, albeit we are already funding work that will support the development of Whole Systems Integrated Care. We want to get to the stage where we can fully understand what is required, the implications for commissioners and make a formal recommendation to pool a budget to support integrated care.

We expect this work will need the focus of a dedicated working group, which will oversee the work outlined below. This work will also require resource, both within each commissioning organisation and shared.

We expect this work will help us to:

- Undertake a baseline of the areas of spend (within the two identified population groups) helping us to further identify where there is potentially unnecessary spend.
- Agree what to pool / capitate and what not to – working on the premise that the multidisciplinary team will manage the resource regardless of whether a service line is inside or outside of capitation
- Explore the nature of incentives (to include savings and risk apportion)
- Ensure that budgets which are in and out of scope also allow organisations to meet their statutory obligations

Commissioners within Hammersmith & Fulham will work to understand the budgets impacted by the proposed Whole Systems Integrated Care model of care, a potential capitated budget taking into account the population cared for and budgets being pooled and also the contracts that will be affected by the pooling of budgets.

We can make change happen already based on our track-record of integrated working and on current ways of working. In other words, we can and we have worked more collaboratively as commissioners and with our providers. We have made some changes to the contractual arrangements this year to help us deliver the Whole Systems Integrated Care model.

To go further to achieve our ambition for truly whole systems integrated care, we will now work together as commissioners to gain a better understanding of the contracts/budgets to adopt a more collaborative approach and to ensure a better alignment of commissioning and contracting intentions. We know this will require just as much, if not more, organisational development as the proposed model of care.

Section Six: Capitation

What is the estimated capitated budget envelope, taking into account the population cared for and the budgets being pooled?

We have chosen to focus our Whole Systems Integrated Care early adopter work on adults and older people with one or more long term conditions, of whom there are approximately 29,802 currently living within Hammersmith & Fulham.

The North West London Programme Team undertook analysis of a joint data set from Hammersmith & Fulham, attributing total costs and average per capita costs of care across health and social care. Their estimate of the total costs associated with adults and older people with one or more long term conditions is £84.9m, which can be broken down by provider setting as:

Adults with one or more long term conditions:

64.6m – Total cost (includes GP and Prescribing)

31.9m – Acute

5.3m – Mental Health

3.4m – Social Care

7m – Community Care

Elderly with one or more long term conditions:

20.3m – Total cost (includes GP and Prescribing)

9.7m – Acute

0.6m – Mental Health

1.7m – Social Care

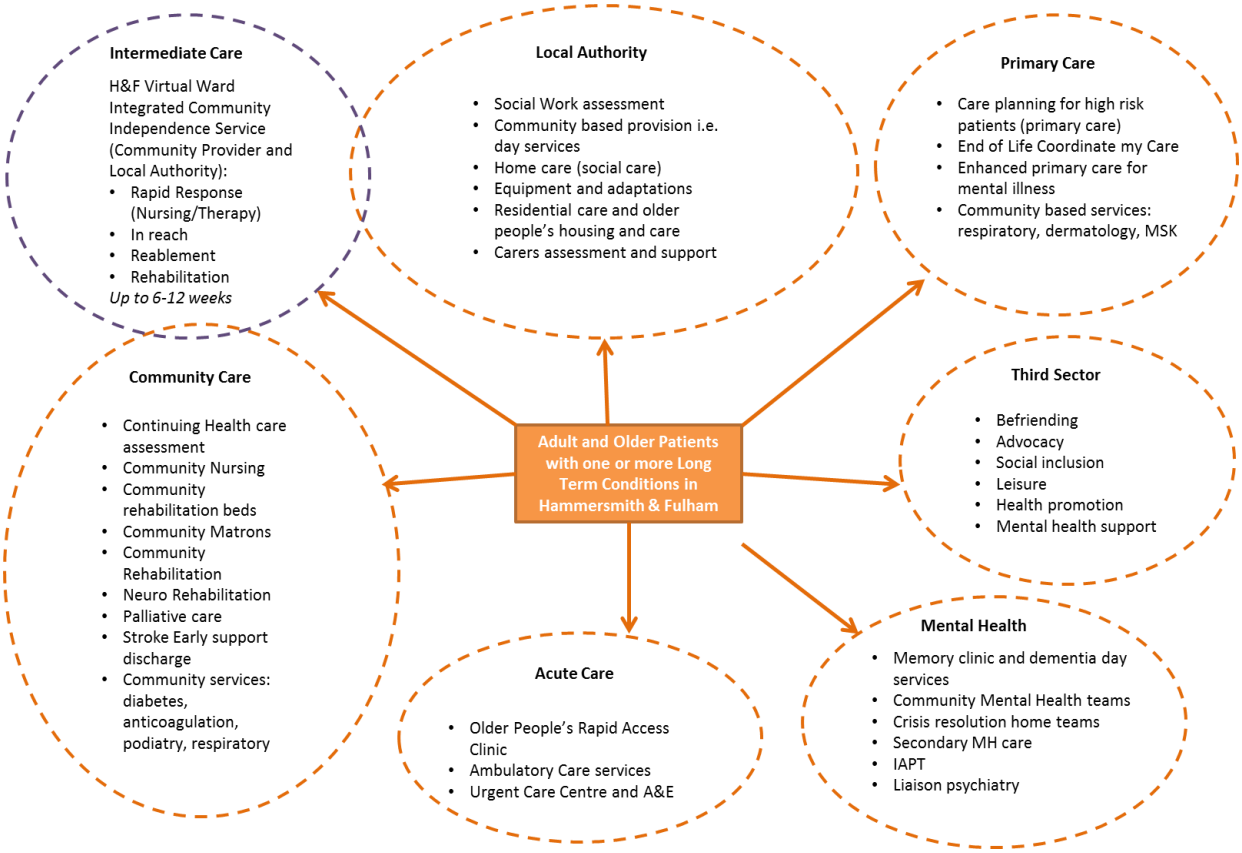
4m – Community Care

We now need to undertake further detailed analysis of the costs attributed to this population, and understand where these are reflected within existing budgets. This will enable us to estimate a capitated budget envelope for adults and older people with one or more long term conditions.

Section Seven: New Models of Care

What is the current model of care for your population group, including the frequency, setting and length of interventions?

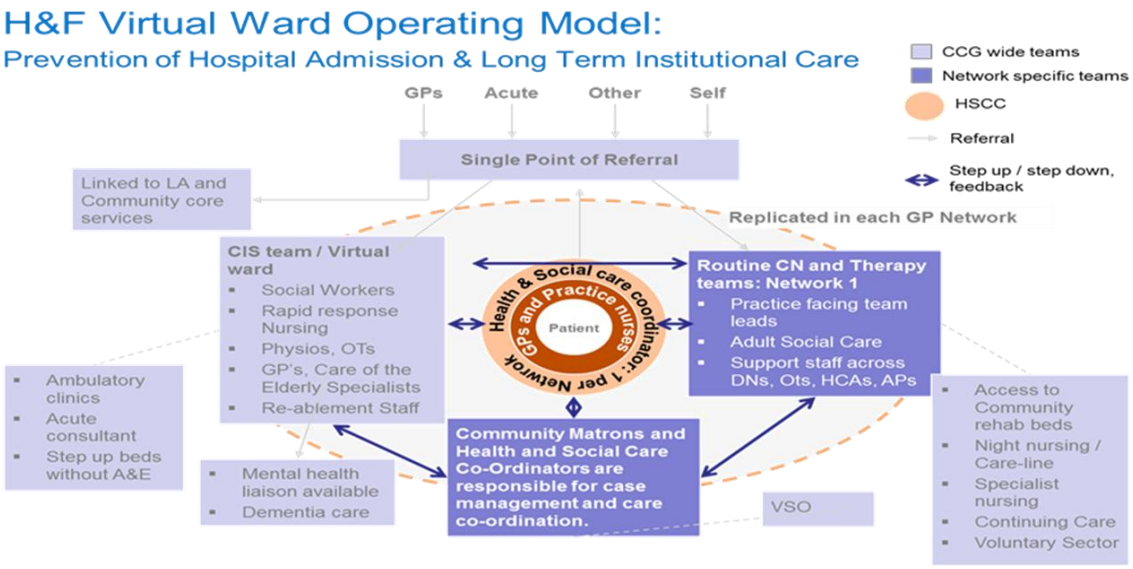
Adults and older people with one or more long term conditions currently access a range of services across Hammersmith & Fulham.



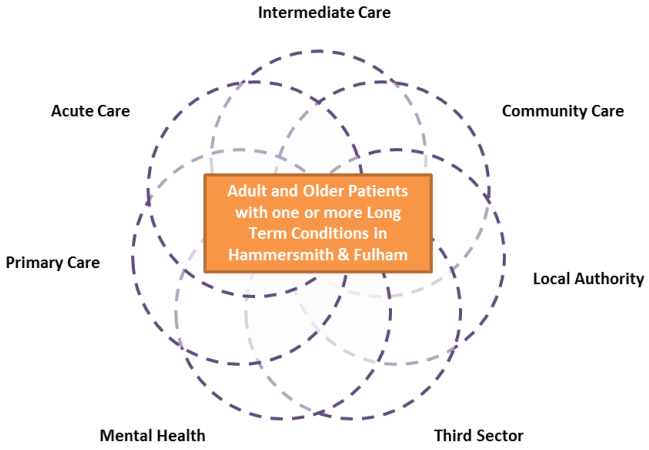
Hammersmith and Fulham have been developing integrated care services for a number of years and launched an integrated Community Independence Service (CIS) in 2012 bringing together the health funded hospital at home and rehabilitation teams with social care reablement. The CIS supports discharge from hospital and aims to prevent unnecessary admissions by providing rapid response nursing and therapy, reablement and rehabilitation and in-reach to acute as part of a multi-disciplinary team. Support from the team continues for up to 12 weeks with a focus on a personalised programme of recovery including reablement and rehabilitation interventions.

The Virtual Ward model builds on this service by providing a wider multi-disciplinary response to people at risk of going into hospital and offering a Red, Amber, Green bed model reflecting people's level of need. The Community Independence Service team is enhanced with dedicated Case Managers and Health & Social Care Coordinators to offer a single point of contact for the patient and their family to coordinate care between the professionals within the team. The team

also includes Community Matrons and Social Workers and medical cover is provided by a consultant geriatrician.



However, outside of these services our core services remain fragmented and can often undo the benefits seen from integrated intermediate care. We have more work ahead to integrate services for adults and older people with one or more long term conditions, and to ensure a holistic response to a person's physical, mental and social needs, rather than an approach focusing on specific diagnoses, services or clinical pathways.

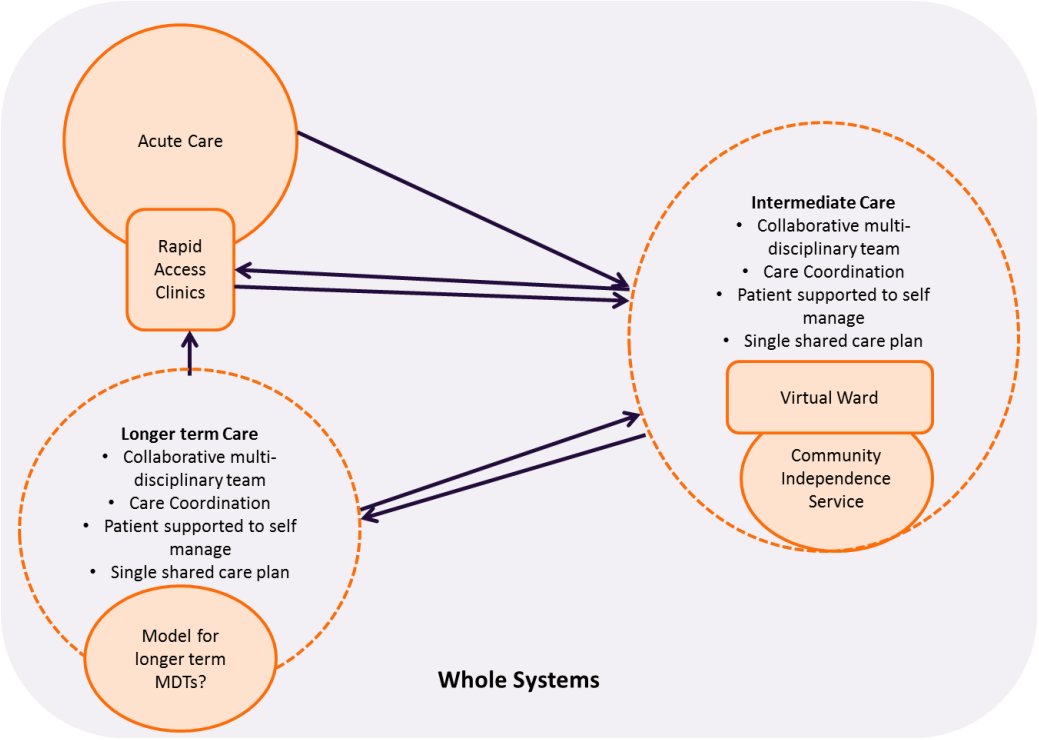


For Hammersmith & Fulham, the Whole Systems programme offers the opportunity to see real structural and systematic change. People being in control of their own needs and the care they receive is our primary goal and we recognise that the system needs to change to enable this so that services are commissioned, delivered and paid for differently.

What is the hypothesis for your model of care, including the frequency, setting and length of interventions?

Our vision for the future model of care is that a network of integrated services will be delivered by a multi-disciplinary team who will work in an integrated way to ensure the patient pathway is seamless, reduces duplication of assessment and ensures the correct outcomes are achieved. The service will utilise the resources of traditional sets of professionals in a more integrated way to create multi-disciplinary teams to enable them to deliver seamless pathways for people. The network will operate as one service, from both a clinical and a patient/service user perspective. Services will maximise patient independence, by supporting and treating individuals in their own home or community thereby preventing and / or delaying admissions into hospital and institutional care placements. We will consider how to maximise support within communities and people themselves, in order to promote social inclusion, prevention and wellbeing – working with other aspects of local provision and community and voluntary groups. Services will deliver tailored packages of support, flexing to people's needs and enabling people to remain at home.

We used our first Whole Systems Integrated Care workshop to explore the four principles of integrated care delivery: One, collaborative multidisciplinary team; Care co-ordination across the MDT; Patient supported to self-manage; and a single shared care plan. To achieve a truly whole systems approach, the new model of care based on these principles should organise care and support around an individual on an continuous basis by establishing a single integrated team that contains the skills/capabilities needed most frequently for the model of care. We set out to understand this in the context of Hammersmith & Fulham, in order to build on and align to existing and planned initiatives across the borough, as in the diagram below:



How do you intend to make full use of social care, self-care, and community capital in your model of care?

We have identified two core principles that will underpin our approach to self-care and empowerment – supporting people to self-manage; and supporting professionals to work in partnership with patients and carers.

"Supporting people to self-manage – using **assets** such as expert patients, community champions to enable people to understand better their condition, and manage it"

"Providing some of the practical tools such as assistive technologies"

"Equally important is that professionals working with patients understand how to work with patients as equals and to work in **partnership** with patients and carers"

"This is a workforce development issue for all professionals about how to work in a way that **empowers** the patients that they are working with. And indeed, working within teams in a more equal way, so for example in teams consisting of qualified and unqualified staff"

"A lot of these things are already happening in Hammersmith & Fulham, but not necessarily across the board"

We are working to understand the capacity of community capital within Hammersmith & Fulham, firstly mapping assets across the borough before moving on to develop mechanisms which harness the potential of community capital to support the delivery of our model of care.

How does your model of care make use of multi-disciplinary teams and care coordination?

We have identified existing multi-disciplinary teams within Hammersmith & Fulham and reflected on the next steps in developing these teams. We identified the need to develop a flexible team membership – designed around people's needs - and began to explore options for provision.

"The members of the team should be based upon the initial assessment and care plan developed – this will determine who is in the team to meet people's needs"

"The team should be based upon how will we meet the outcomes for that person and **design** the team around this"

"It isn't necessarily one team, one employer, one management structure – it is a **matrix** formation"

"We need to develop a different model for care providers"

"People missing from the team diagram – interpreters, housing, wider voluntary sector i.e. leisure, police and community safety, financial support/ benefits"

"Staff should to be **multiskilled**, and we need focus on developing hybrid care providers"

"We need to firstly determine where existing roles overlap, and where there are gaps – so that we can identify the baseline"

We have explored the role of care coordination, the required attributes of these individuals and their core responsibilities.

"A care coordinator should be the person in the team who is **best equipped** to take on that role for that person and their needs"

"Attributes of a care coordinator include: Articulate/Caring/Passionate/Sensible"

"The **ethos** of care coordination as part of professionals roles needs to be developed and embedded so it isn't seen as an 'add on' or an additional task to people's care delivery"

"Care coordination is **continual** not time fixed, as at the moment that is where people begin falling through gaps"

"IT is a key enabler to ensure people are seeing the same information and to ensure the care coordination role is being used efficiently"

"The care coordinator is **responsible** for written and verbal information across the team and with the patient. They also ask the person about their care and what their experience has been"

■ How does your model of care incorporate individual care plans?

We have explored the use of individual care plans within our model of care, and agreed on a number of key requirements. We will incorporate individual care plans into our model of care which are owned by the patient, held within General Practice, accessible to all providers of care, and updated in real time.

*"We need to have an advanced care plan, a crisis plan, which is **accessible** to a range of teams and providers 24/7"*

*"The care plan has to be **owned** by the patient themselves, and has to be contributed to by all of the people within their team"*

"The care plan should be held within General Practice"

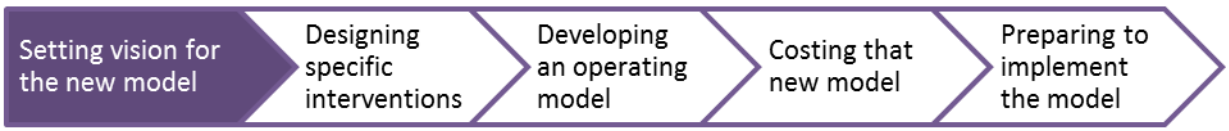
*"Real time access to the care plan is essential, especially as it is **updated** by members of the team"*

"We need to know whether a patient is achieving what was set out in the care plan – we'd monitor and ensure that the plan was delivered by: asking the patients themselves whether their goals were achieved, and monitoring 'failure' of crisis care plans"

*"We don't focus enough on anticipatory planning - understanding based on a patients needs what may lead to exacerbation – we could build the care plan to **divert crisis**"*

Hammersmith & Fulham's partners have articulated their ambition for each of the four principles of integrated care delivery, summarised in the sections above, and we have laid out a vision for the future model of care for adults and older people with one or more long term conditions, moving from separate services for a person's different needs to a single, continuous point of responsibility.

Over the coming months we will convene partners across Hammersmith & Fulham to co-produce the next stages in developing our new model of care:



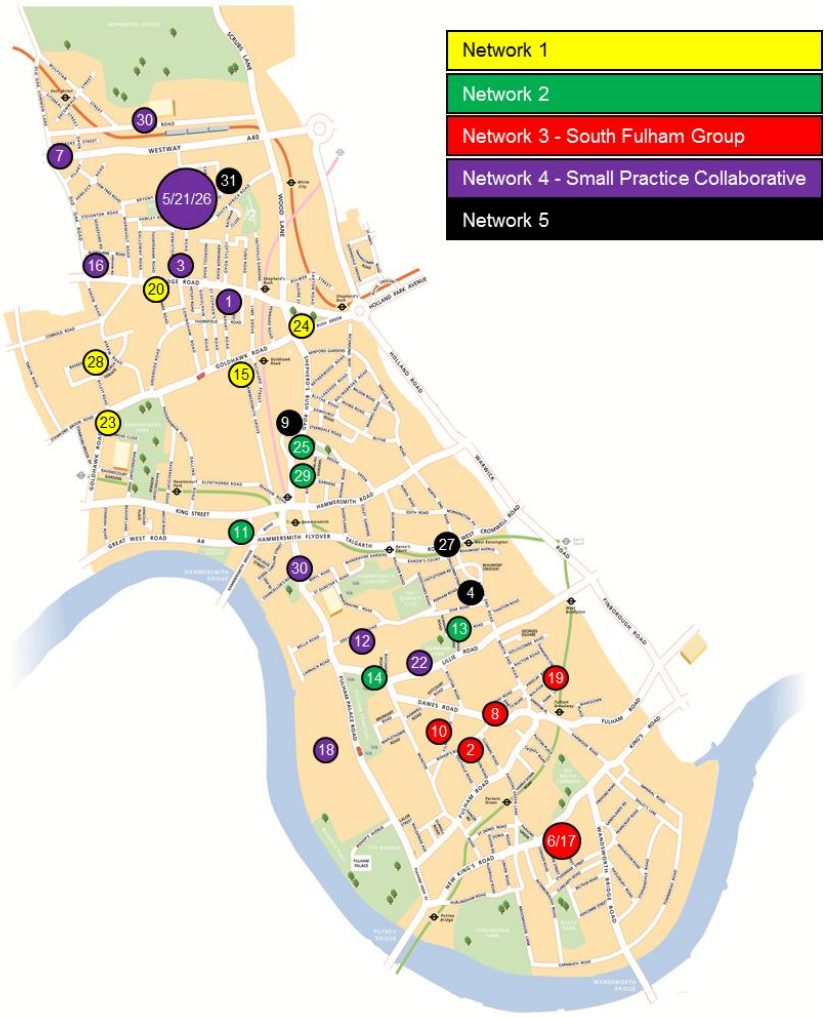
How does your model of care compare in terms of affordability against the capitated budget envelope?

Once we have designed the services, features and specific interventions that will comprise the new model of care, providers and partners across Hammersmith & Fulham will work together to establish the costs of the whole model, establishing the impact on finances that shifting to the new model of care will create.

Section Eight: GP Networks

Which GP Practices will participate in the early adopter partnership?

There are 31 Practices in Hammersmith & Fulham, with a registered population of 190,042. All practices will be participating in the early adopter partnership. GP practices are currently arranged into 5 networks as set out below:



Hammersmith & Fulham CCG are working with member practices to understand preferences for network re-design and reconfiguration. Once a clear vision for networks has been established by the membership, the CCG will support GP Network configurations to successfully form. We anticipate that this network configuration work will be completed by October 2014, and will therefore provide an effective platform for our whole systems integrated approach.

Section Nine: Provider Networks

Which providers will participate in the early adopter partnership?

Hammersmith & Fulham will work with health and social care providers across the borough to deliver our early adopter partnership.

- London Borough Hammersmith & Fulham Adult Social Care
- Central London Community Healthcare NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- West London Mental Health NHS Trust
- Central and North West London NHS Foundation Trust

We will also seek to engage third sector organisations in provision of our model of care.

Section Ten: Information and Informatics

How will you use the data collected in the data warehouse to support more detailed analytics and planning after May?

We recognise that information is critical to the successful development and implementation of Whole Systems Integrated Care in Hammersmith & Fulham. Data and IT capabilities will be essential in:

- Using metrics to determine if outcomes are being delivered for patients and carers;
- Accessing data on activity and performance of existing contracts to calculate capitation costs; and
- Developing, maintaining and sharing care plans across organisations in real time

Our current understanding of the services that adults and older people with one or more long term condition use is based on a joint data set from 2012-13 for Hammersmith & Fulham, which provides a baseline for our early adopter work. However, we now need to review real time data, validated by health and social care providers in order to further develop our model of care.

How do you plan to share data between providers in your network to support cooperation at a day-to-day and strategic level?

Hammersmith & Fulham's strategy will be to continue to extend the principle of one electronic patient record across all settings of care. This is in alignment with existing and anticipated IT strategies published by the Department of Health and its associated bodies as well as the local IT strategy currently under development for the whole systems implementation within the framework of Shaping a Healthier Future.

The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:

Level 1 - There is access to and two way information exchange within a common clinical IT system and a shared record between the GP and the care provider

Level 2 - Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC)

Level 3 - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where people are receiving care out of area.

We will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care community. We will seek to fully implement the recommendations of the Caldicott2 review around the sharing

of patient records to provide integrated and seamless care. Specifically we will ensure that role based access control to electronic patient records in all settings of care is standard. Furthermore, we will facilitate a mechanism and appropriate forum to ensure the management and governance of data controllers is common once common patient records are in place.

Hammersmith & Fulham will continue to have active participation in the NW London IT Forum of commissioning and provider organisations, working collaboratively across the whole health and social care economy to implement an integrated approach to IT systems and information flows across the health and social care community and alignment of commissioning plans with IT solutions and vice versa.

Section Eleven: Planning, Communication and Sharing Learning

- **How have commissioning/provider leadership expressed support for whole system development?**

Hammersmith & Fulham's Out of Hospital/Whole Systems Integrated Care Programme Board provides oversight of the development of our early adopter proposals – and it attended by our commissioning and provider partners:

- Hammersmith & Fulham Clinical Commissioning Group
- Central London Community Healthcare NHS Trust
- London Borough of Hammersmith & Fulham Adult Social Care
- West London Mental Health Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust

The Programme Board is co-chaired by Hammersmith & Fulham's Clinical Commissioning Group Chair, and the London Borough of Hammersmith & Fulham's Director of ASC Commissioning.

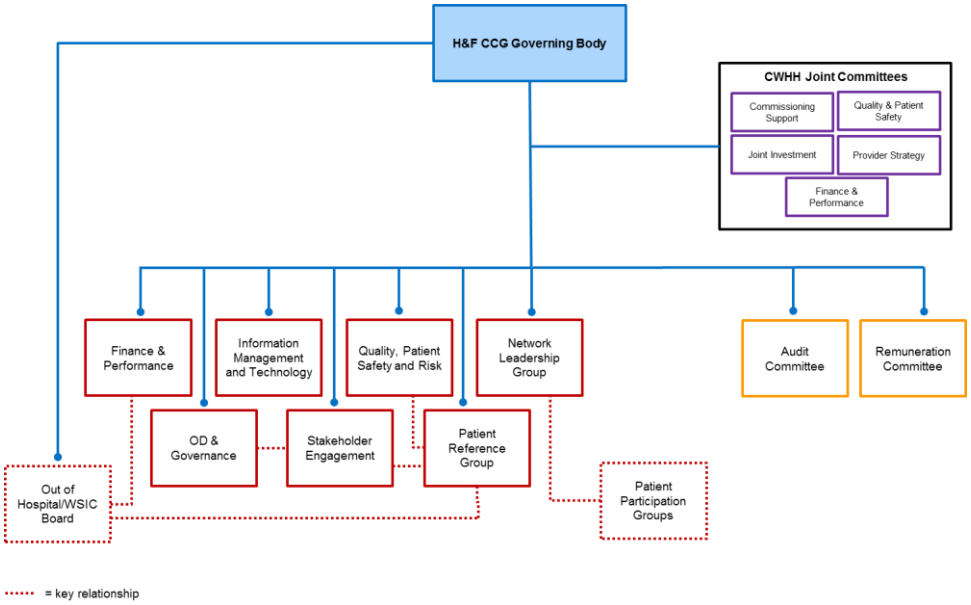
Representatives from across our commissioning and provider partners attended our first Whole Systems Integrated Care workshop to support the development of outcomes and our model of care, a full list of attendees can be found in Section Two of this implementation plan.

Our implementation plan is submitted on behalf of all of our commissioning and provider partners. The implementation plan has received formal sign off from Hammersmith & Fulham Clinical Commissioning Group and the London Borough of Hammersmith & Fulham, with an executive summary reflecting their commitment to whole system development.

- **How will you make decisions together, as commissioners and as providers in the next phase underpinned by your statement of commitment? What are your governance processes? How are people who use services and front-line staff involved?**

Our Out of Hospital/Whole Systems Integrated Care Programme Board, co-chaired by Hammersmith & Fulham's Clinical Commissioning Group Chair and London Borough of Hammersmith & Fulham's Director ofCommissioning, is attended by all of our commissioning and provider partners and in addition by two lay members – and will provide the forum for the delivery of our early adopter proposals.

We will work with our partners to reaffirm how our Programme Board links to the wider governance of our Local Authority Cabinet and H&WB Board, but anticipate that this will continue to take the following form in Hammersmith & Fulham CCG:



We will formalise the Hammersmith & Fulham WSIC working group with core membership from both Hammersmith & Fulham Clinical Commissioning Group and the London Borough of Hammersmith & Fulham. This working group will progress the development of Hammersmith & Fulham's early adopter proposals, reporting to the Out of Hospital/Whole Systems Integrated Care Board.

We will continue to engage all partners through system wide workshops, the content of which is outlined in the programme plan below. We will seek to expand attendance of these workshops to engage service users from across health and social care, voluntary organisations and experts from outside of the health and social care system.

- **What is your Organisational Development plan including: Cultural change, shared leadership, workforce development, estate and resource planning supporting investments?**

We will initiate an organisational development plan for Hammersmith & Fulham during the next phase of this project that will include:

- Cultural change
- Shared leadership
- Workforce development
- Estate and resource planning
- Supporting investments

This will draw from and link in closely to the work on organisational and cultural change which will be taken across NWL as part of the overall Whole Systems programme.

- **What is your programme plan to develop a full Whole Systems Plan after the June checkpoint?**

We will focus on progressing key elements of the full Whole Systems Plan as follows: