A Shared Vision for Whole Systems Care

Expression of interest by
Hammersmith and Fulham Joint Commissioners (CCG/LA)
and provider partners

Whole Systems Integrated Care Programme

Living ***longer***
and living ***well***

Hammersmith and Fulham Joint Commissioners (CCG/LA) and Provider partners

1. Please specify who the expression of interest is submitted on behalf of:

Following our initial submission, the joint commissioners of H&F CCG and LBHF along with our partner providers are resubmitting our EOI to recognise the alignment with other partners across H&F who are also expressing an interest to be an early adopter of Whole Systems Integrated Care (WSIC). H&F CCG and LBHF as joint commissioners and the providers listed in this bid will work collaboratively with all early adopter proposals across H&F to deliver whole systems integrated care to our identified population groups.

We have considered the process for developing our WSIC model of care and governance to ensure all partners are involved in this. This will be led through our Out of Hospital programme which has been operational since 2012. The Out of Hospital and WSIC Programme Board will address six key delivery work streams to implement our Whole Systems model of integrated care and will provide the necessary co-design forum and joint governance function to progress our early adopter proposals:

- Delivery of a Virtual Ward model for high risk, complex needs persons 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 SaHF programme
- Designing streamlined and patient centered acute to community pathways focusing on transitions of care
- Developing effective integrated care at home provision for older and high risk persons who remain in their own home or a care home that is linked to our GP and provider network function
- 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 peoples' needs

This proposal has been developed with all local partners who are supportive of the bid and are represented on our OOH and WS Integrated Care Programme Board including:

- All GP Networks
- Central London Community Healthcare (CLCH)
- LBHF Adult Social Care
- West London Mental Health Trust (WLMHT) and Central North West London Foundation Trust (CNWL)
- Imperial College Healthcare
- Chelsea and Westminster Hospital Foundation Trust
- Public Health
- Third sector organisations

We are developing our plans in partnership with people who use our services and their families and carers. We have written our principles of engagement for our Out of Hospital and WSIC Programme and have representation of patients and carers on our Programme Board. As joint partners we will commit to using co-production to develop our plans. This will include supporting the work being led by the Local Authority to embed personalisation within health and social care.

CONTINUED:

1. Please specify who the expression of interest is submitted on behalf of:

We submit this bid having been at the forefront of integration activity over the last few years which places us in a unique position to take forward WSIC. We are already delivering initiatives built around the key criteria of WSIC and seeing real change as a result of them. As Commissioners we have worked closely together to support the development of Whole Systems thinking through enabling a joint data set for H&F that has been the basis for developing the population groupings in the WSIC programme. Examples of our integrated care progression include;

- Across H&F we had full take up of the Integrated Care Pilot (ICP) from all our GP providers and alignment to multi-disciplinary groups.
- We have tested a number of WSIC features through pilots such as health and social care coordinators and hybrid workers and through the development of our integrated Community Independence Service which has seen almost a three-fold increase in referrals during 2013 from 45 to 130 per month.
- We have supported our GP practices to use the Coordinate My Care tool for End of Life Care and we currently have the highest take up across the CWHHE collaborative with 419 records as of March 2014.
- Presently H&F also have the highest number of patients transferred from our CMHT teams to an enhanced primary care services across the CCGs who work with WLMHT.
- All of our GP practices and our Community Nursing teams are now using our single IT solution, SystmOne.

We are uniquely positioned to work with our acute providers to develop our Local Hospital and Out of Hospital model of WSIC. In working with Imperial to develop the Local Hospital specification and their bid for Foundation Trust status we are able to accelerate the adoption of WSIC thinking. We are already piloting new pathways of care across acute, primary and community by the pilot of our multi provider step-down ward (Ravenscourt), the Older Peoples' Rapid Access Clinic at Imperial, our Virtual Wards, our Community Independence Service and our restructured community nursing teams. The relationships between these services and the ability for them to provide a pathway of high quality out of hospital care that avoids unscheduled admissions is the basis of developing our WSIC model. Furthermore our current initiatives focus on the reduction of unscheduled emergency care for Ambulatory Care Sensitive conditions particularly for people over 75. We are leading the trial of the MCAP system with ICHT to support admission avoidance and improve the number of people being cared for in the most appropriate setting. Linked to this is our joint working between the CCG and the Local Authority to commission placements and packages of care in Nursing and Residential care homes.

As joint leads for this bid, the CCG and Local Authority will seek to involve wider partners in the development of our WSIC model who we see as critical to improving health and wellbeing for our residents. This includes Local Authority Housing and Environment partners and Housing Associations/Providers as we know that providing high quality, accessible and suitable housing for our older and frail populations is a key determinant of improving health outcomes.

We anticipate this scheme will be considered for the Tri-Borough remit to ensure full potential and equity in service delivery.

2. Who you would want to engage with over the next phase to 31st May business case

- **Engagement with our GPs**: We have recently met with all our GP providers through their Network meetings to continue their engagement in our OOH programme with positive feedback. We've held an initial planning event with our GP members in February focused on our Network, Hub and Local Hospital development. Following this we have commissioned support for a network development programme which will bring together our objectives around network configuration for WSIC, PM Challenge fund and network provider delivery based on an inclusive engagement process with all our practices and clinical leadership at the heart of planning and delivery. Working with our GP membership is critical as primary care will be a key enabler of our vision and delivery for WSIC in the future. We would also be very interested to consider with our GP members how we can work with NHSE to jointly commission primary care.

- **Aligning proposals with our partners**: Since our initial proposal we have understood the other early adopter proposals submitted across H&F and our EOI will be taken forward in alignment with all proposals across the borough. All our providers are represented on our Out of Hospital and WSIC Programme Board.

- **Establishing governance for our WSIC development**: We will deliver our early adopter proposals through our jointly chaired Out of Hospital and WSIC Programme Board which has representation from all providers and including patients and carers. We will work with our partners to reaffirm how our Programme Board links to the wider governance of our CCG Governing Body, Local Authority Cabinet and H&WB Board

- **As commissioners**: We have now agreed that the forum in which the CCG and LA will translate the criteria for WSIC into an outline business case and use the co-designed toolkit to put our ideas into implementation proposals will be our Out of Hospital and WSIC Programme Board. This will link to our planning for, and deployment of, the Better Care Fund.

- **With people, patients, carers and families:** We have developed our principles of engagement and co-design for our Out of Hospital programme in conjunction with our Patient Reference Group and will use these to underpin our engagement particularly around the expectations for integrated care

- **With the third sector -** We are engaged in the Community Assets programme being led by the Local Authority and identified in the Better Care Fund and are part of the White City Community Budget initiative

- **With our housing partners, housing providers**

3. Please make a collective statement of commitment to developing plans to implement the features of a fully integrated system (as per slide 4 above)

We believe that our Out of Hospital programme offers the basis from which to develop our WSIC model and will enable us to test and implement the features of a fully integrated system. Our proposed model of care supports the three key principles of WSIC:

People and their families and carers are at the centre of our OOH model of care: Our work on the Local Hospital development is considering what activities should be delivered in a patient's home, at a GP practice and Network level as well as in Hubs so that activity enables improved outcomes through offering improved access to settings that are local to peoples' homes. A key consideration is how the Virtual Ward/Network and Local Hospital are aligned to deliver high quality integrated care and how together they can operate in an Out of Hospital Whole System model, including consideration of the workforce needs to deliver this.

GPs will lead our proactive care planning and delivery: The future development of our GP Networks and Hubs is critical to support this role. Our Governing Body has committed to exploring options for access to primary care services across 7 days involving all elements of primary care delivery to H&F residents which is a key enabler for us to build our Whole Systems proposals on. Our Cassidy Road practice is already trialling a 7 day working model for a 14 week period over the Winter period. GP s will be at the centre of our Virtual Ward model supporting patients with complex high care needs and at high risk of Hospital admission.

The Out of Hospital and WSIC programme is built upon the principles of enabling high quality integrated care through our development of multi disciplinary teams that share common outcomes for people's health and social care and are supporting by shared systems and joint assessments, and a model of care delivery that drives efficiencies and whole system change. Our vision for the Local Hospital will consider how this provision can be a multi provider and multi function to meet the future health and social care needs of our population.

CONTINUED ON NEXT SLIDE

CONTINUED

3. Please make a collective statement of commitment to developing plans to implement the features of a fully integrated system (as per slide 4 above)

Working jointly as commissioners and with our providers we believe being an early adopter site will give us the opportunity to develop and expand our Out of Hospital programme to implement the criteria of Whole Systems:

Embedding Partnerships: Developing a systemic approach to co-production to ensure that people and their carers/families are partners both in the design of services and in the way their individual care packages are designed and delivered. We will continue to support the personalisation of both health and social care services building on the work of the Local Authority and also in considering community assets in our commissioning of services and the use of community capital. The Parkview Centre for Health and Wellbeing will provide a co-located base for health and social care services and are considering how this will include voluntary and third sector organisations.

Population and Outcomes: The Out of Hospital and WSIC model of care provides us with the vehicle for delivering integrated care to a number of the population groupings, in particular groups 3, 4 and older people in groups 5,6 and 8. For a number of our integration initiatives we have identified shared and common objectives relating to improving people's health and wellbeing. Our challenge in WSIC will be to align these to population segments but also to our commissioning and provider framework including pooled and capitated budgets. As an example we are already working with our ICP partners to develop the multi disciplinary groups and function to align with Virtual Wards and provide a key forum for developing pathways for identified population groups

Commissioning Governance & Finance: Our Out of Hospital and WSIC model of care gives us the opportunity to consider how we achieve savings to the system and improved outcomes through pooled budgets as commissioners and to test this in shadow form across a number of settings and within identified population groups. Agreeing our shared outcomes and a shared performance management approach will be critical to this and is enabled by our work already in place developing pathways to reduce unscheduled care for ambulatory conditions with acute, primary and community providers.

Provider Networks: Our Out of Hospital model of care will allow us to test a number of different provider network options incorporating our acute, community, mental health and primary care providers within a number of settings but based around a GP registered population and funding across a care pathway. For example we plan to develop an expanded model of Community Independence Service provision across the Tri-borough CCGs and LAs. We can explore how through commissioning this service we are able to support the governance of different types of provider networks to provide fully integrated care delivery linked to shared outcomes and performance management.

Information: Our roll out of SystemOne across our GPs and Community Services has allowed the flow of information to support care delivery and is the base from which to explore the potential for a common system and information governance across all our providers.

4. Please describe any initial thoughts on which populations you wish to serve and the integrated model of care that could deliver it

The CCG and LA wish to use the existing foundations of our Out of Hospital integration programme as the starting point for Whole Systems working. Through our Out of Hospital and WSIC model we will provide care and support for people who are at risk of admission to hospital or requiring high packages of social care particularly groups 3, 4 and people over 75 within groups 5,6, and 8. In addition we also wish to work with providers for people in group 5 in providing better integrated and quality care for adults and elderly people with cancer. We will also develop our offer for people within the 'Mostly Healthy' population groups to support them to maintain their health and independence for as long as possible through self care and through accessing support services often provided by third sector organisations and building our community assets. In developing our business case a key task will be to understand how we can develop pathways within our Out of Hospital and WSIC model for these different population groups and how this shapes our proposals for pooled and capitated budgets, shared outcomes and provider networks.

Within our Out of Hospital programme there are a range of initiatives which focus on population groups 3,4,5,6 and 8. The Virtual Ward model of care will be our starting point for implementing out of hospital and WSIC care in community provision which we believe will primarily support people in **groups 3, 4 and older people within groups 5,6, and 8**. This will be developed to fully interface with future Local Hospital provision. Our programme enables us to align a number of complementary initiatives under the six key workstreams (reference slide 1) that focus on similar population groups to develop an overall Out of Hospital WSIC model of care:

- We will redesign our multi disciplinary groups to support the Virtual Wards through providing a forum in which primary, community, secondary and social care professionals offer expert advice on our Virtual Ward populations and shape our pathway development for these groups **(groups 3, 4 and older people within groups 5,6, and 8)**
- We will use the learning from our ICP Innovation Pilots to implement the features of Whole Systems care particular around new types of provider networks and how funding flows to where it is needed through new financial models:
  - Proactive Support for Nursing, EMI and Extra Care Homes **(groups 4, and older people in groups 6 and 8**)
  - Supported Self Care through Long Term Condition Information **(groups 3 and 4)**
  - Transitions of Care Project (developed from MDG led audit of electronic discharge summaries)
  - Dementia Recognition and Post Diagnosis Support **(groups 8, and people within other groups who have dementia diagnosis)**
  - Addition of Mental Health Support to the Community Independence Service (Awaiting Recruitment) **(groups 3,4, and 6)**
  - Care Navigation and Support for High Risk Patients (Awaiting Recruitment) **(groups 3,4 and high risk patients within groups 5-9)**

CONTINUED ON NEXT SLIDE

CONTINUED

4. Please describe any initial thoughts on which populations you wish to serve and the integrated model of care that could deliver it

- We will work with our partners at Imperial and Macmillan on pathway development for Cancer with a focus on early diagnosis, care planning and supporting self management, including for cancer survivors, as part of our Out of Hospital model with an aim to improve patient experience and provide better coordinated care for this group. **(Group 5)**
- We will ensure the learning from the best practice in COPD being led by our Academic Health Science Network (Imperial College Health Partners) is embedded into our initiatives to reduce unscheduled care for ambulatory sensitive condition (**Groups 3 and 4**)
- We will develop the pathway for providing rapid response between secondary, primary and community care through initiatives such as the Older Person's Rapid Access Clinic at Imperial and the proposed Rapid Access clinic at Chelsea Westminster Hospital **(Groups 4 and older people in groups 5-9)**
- Working jointly as commissioners we will design and deliver a model of home care that works across our health and social care system in supporting both health and social care outcomes through an enabling model and embedding this within our multi disciplinary teams and as part of the Virtual Ward **(Groups 3, 4 and eligible adults within groups 5-9)**
- We will align our model of care with our Mental Health providers' proposals around WSIC for older adults with SEMI. We believe there is an interdependency between these proposal as to the population groups we will be targeting and therefore we need to ensure Mental Health provision is fully incorporated into our Out of Hospital and WSIC model of care. **(Group 6)**

H and F template

5. Please describe what support you feel is needed between Jan and April to work the expression of interest up into an outline business case?

- Support to use the co-designed toolkit so that we can move from ideas to implementation and understand how our current initiatives can be supported to transition into a WSIC model and to reflect and embed the criteria of WSIC
- Support to develop shared outcomes and SMART measures that can demonstrate change and track progress. We feel the Health and Wellbeing Board have a key role in supporting this
- Support to engage with our GP membership to deliver a programme of Network development and clarify how this development is aligned with WSIC, what the vision is for WSIC Networks and how we can develop Networks which operate with more than one acute provider
- Support for our GP members and wider partners to consider how the strategic initiatives are aligned under our Out of Hospital and WSIC programme such as the development of the Local Hospital , Network development, 7 day access, Better Care Fund and how we develop a shared vision and outcomes for these strategic developments
- Support for commissioners to work jointly between the CCG and LA to consider the appropriate organisational forms and how decisions to adopt these will be taken
- Support to develop our offer to the 'mostly healthy' populations in drawing upon our community capital and resource (family, carers, community groups, third sector including assets)
- Support to ensure people have choice and control in our Out of Hospital WSIC model of care and we are supporting the direction of travel towards personal health budgets within a model of co-production
- Support with obtaining Network level information and analysis in order to develop our proposals
- Support with the writing of the business case and the legal considerations of our proposals
- Alignment of our H&F proposals with wider Tri-borough and North West London vision and direction of travel