Health and Wellbeing Board 10 March 2015	Tower Hamlets Health and Wellbeing Board
Report of: NHS Tower Hamlets Clinical Commissioning Group	**Classification:** Unrestricted
Integrated Care Programme Update	

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Executive Summary

The Integrated Care Programme is a key component of the Waltham Forest and East London (WEL) Care Collaborative and an established Programme in Newham, Tower Hamlets and Waltham Forest and is one of 14 national pioneer sites.

It currently focuses on patients who have been identified as between very high risk and medium risk according to risk stratification and is based upon the Integrated Care Case for Change which was approved by the Governing Bodies of Newham, Tower Hamlets in Jan 2013. The Integrated Care work is a key component of the Better Care Fund plans.

Objectives

The Programme has three high level objectives:

1. Shaping the local health economy around the patient
2. Changing behaviours across the system
3. Developing the provider landscape

Key partners include acute, primary care (GPs), mental health and the local authority.

Integrated Care is underpinned by four principles':

- Care co-ordination
- Rapid Respond
- Discharge Support
- RAID and mental health liaison
- Self-Care and Self-Management

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the report.

1. DETAILS OF REPORT

The following is an update of activity in Integrated during February 2015.

1.1 Care Co-ordination

Expand identification and enrolment of the eligible population from to cover 6% of the population during 2015/16. Enrolment involves people consenting to share information with the four statutory providers and join the integrated care programme.

People are able to select which provider organisation they are prepared to share with.

Lists are shared with providers to flag onto their local systems.

1.2 Care Planning

A workshop in February brought together a selection of patients with a range of health professionals working across WELC who are involved in developing care plans and the care planning process. The workshop was intended to

- use the emerging findings from the audit currently being undertaken and other evidence base (national and international) to stocktake where we are as a pioneer site with care planning and the development of care plans e.g., who develops them, how are they developed, who is using them, where, what for and what do they look like?
- use the various patient and professional groups to determine “what is the problem that a care plan is trying to address”?
- develop and agree a common set of principles to inform and drive forward the local approaches to developing care plans and care planning processes within in each borough

A Task and Finish Group is being establish to take forward the recommendations from the workshop to agree a standardised care planning approach and the resulting IT requirements. Terms of reference, membership and timeframes for this group are still to be agreed.

1.3 Discharge Support

A task and finish group is established to map the discharge process from hospital into the community and interface between the community, social care and mental health.

1.4 Information Technology

The ability to share relevant information is a key enabler for delivering integrated care. The Tower Hamlets Integrated Care Record is being deployed to deliver a shared system.

The portal has the ability to extract information from multiple provider systems and present a single view of the patient records. Interfaces are currently in place with

- Primary Care
- Acute
- GP OOH

Work is underway to interface with Mental Health and the Local Authority systems. This work is aiming to complete by March 2015. Only patients who have consented to share will be viewed in the portal and access is limited to those organisations that have been selected.

1.5 Self Care and self-management

Patient Activation Measure

Tower Hamlets CCG is a national pilot site for the implementation of the Patient Activation Measure (PAM) in England. The CCG has secured 60,000 licenses for the tool through NHSE, with view to using these in the next two years. A Learning Set has been established to support pilot sites and discuss approach to the national evaluation..

Self Management Workstream

A workstream is established to oversee the delivery of the following initiatives:

- CCG self management pilots
- PAM pilot
- HENCEL funded Self-Management UK pilot
- Social prescribing pilot
- Any Innovation Bursary projects that have a self-management component
- Links with primary are innovations projects commissioned by the Excellence in General Practice programme.

This workstream will report to the Integrated Care Board for strategic oversight. The delivery of the workstream will be undertaken by a Working Group with the following membership:

- Clinical Lead (to be identified)
- Transformation Manager for Integrated Care
- Transformation Manager for Long Term Conditions (LTC)
- Presentation from LBTH Public Health

- Representation from CCG Mental Health
- Representation from TH Primary Care Networks

This approach will enable alignment of work undertaken within the Long Term Conditions and Integrated Care programmes around self-management and reduce duplication of effort.

NEXT STEPS

- Launch IC NIS 1st April . Develop resources and provide guidelines for practices
- Focussed discussion at WELC Ops group to agree content of single plan
- Workshop co-design the evaluation and provide PAM training to the pilots.
- Organise social prescribing workshop mid-March
- Negotiate with Orion developers to procure additional functions and agree new working arrangements

2. FINANCE COMMENTS

2.1. Funding for delivering this programme is incorporated in the Better Care Fund.

Appendices

- None.