Health and Wellbeing Board 9 September 2014	Tower Hamlets Health and Wellbeing Board
Report of: Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group.	**Classification:** [Unrestricted or Exempt]
Tower Hamlets Integrated Care Programme	

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Executive Summary

Waltham Forest, East London and the City face an unprecedented challenge over the coming years in their health and social care system. The boroughs of Newham, Tower Hamlets and Waltham Forest have come together to address these challenges over the next 3 to 5 years

- Demand for health and social care is rising, driven by deprivation, population change and disease prevalence
- We already face challenges in outcomes and the system is currently not meeting patients' expectations of integrated care – coordination, transparency and a focus on experience and relationships
- Clinicians also find the current system challenging in how they provide care to their patients and work with their colleagues

It is recognised that 21% of patients drive 80% of costs acorss health and social care. Integrated care can help address these challenges, by empowering patients and service users, by improving outcomes and by providing the best quality of care at the minimum possible cost

Commissioners, providers and Local Authority came together to develop a localised vision for Integrated Care in Tower Hamlets. This vision focuses on **patient centred care,** with primary care, network resources and activities (e.g. MDT case conferences), Integrated Community Health Teams and borough-level specialist support **wrapping around patients**. Primary care, being closest to the patient, holds the final accountability for the patient's care, but is supported by network and CHS resources to coordinate and provide care as required.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the progress outlined in this report and endorse the approach

2. To note that the model described in this report underpins our submission for the Better Care Fund (with certain slight amendments for local factors).

1. DETAILS OF REPORT

The Waltham Forest, East London and City (WELC) Integrated Care Programme has the opportunity to revolutionise care for a population of almost one million people in an area facing significant health and social challenges. The footprint of the UK's largest trust, Barts Health NHS Trust, provides us with the unique ability to leverage the existing local examples of excellence in integrated care and deliver them at scale and pace across east London.

Local patients and carers have told us that it needs to be clearer who they should speak to and when, with a single point of contact and consistent information. They don't want to have to repeatedly provide their details and they expect that we will share that information with others who need it to provide their care. They want all the professionals they come into contact with to act as a team.

Staff have told us that there are many things they could do differently with the right enablers in place, knowledge about who else is involved in the care of a person, and access to a joint care plan at the right time.
How we deliver integrated care in each of the boroughs is evolving but the programme partners have agreed a common set of principles:

- Systematic, regular risk stratification of the whole population to support case finding for those most at risk of hospitalisation.
- Care that is centred on an individual's needs to enable individuals to live independently and remain socially active.
- Care that is evidence based and cost-effective.
- Preventing admission to hospital wherever possible by supporting care at home or in the community.
- Avoiding duplicated effort in situations where a patient has many people involved in their care.
- Actively developing local providers and supporting collaboration in the way we contract.
- Evaluating what we do as we do it and revising our approach as we learn about what we are achieving.
- Learning from each other, learning from national and international integration programmes and sharing our learning outside the programme.

- Health and local government partners in east London have come together to build a model of integrated care that looks at the whole person – their physical health, mental health and social care needs.

Tower Hamlets is amongst some of the most deprived in London, with significant health needs and inequalities. There is a rising need for care across the country as society gets older and we see more people with chronic illnesses. Care needs to be personalised so people stay healthy for longer and can live independently reducing reliance on hospital services.

We recognise we need to address these needs while tackling significant financial pressures on health and local government budgets. We know we need to create whole system change at scale and pace and build an integrated care system across health and social care to have a chance at meeting the needs of patients and staff and addressing these pressures. By joining up health and social services to provide more care in the community, we hope to reduce non-elective spend by 24-40%[1] over the next five years.

Empower people and their carers

- Enable people to live independently and remain socially active.
- Establish education and self-care programmes for people
- Personalise care to people's needs and preferences

Provide more responsive, coordinated and proactive care

- Proactively manage people's health and improve their outcomes
- Enable high-quality care that can respond to people's needs rapidly in crisis situations
- Provide more care in the community or at home
- Prevent avoidable admissions and minimise residential care
- Leverage tools and technology to deliver timely and better quality of care

Ensure consistency and efficiency of care

- Deliver the best possible care at minimum necessary costs
- Avoid duplication of effort in situations where people are seen by multiple health and social care providers
- Ensure most effective possible use of clinical time and resources

Headline health indicators show significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is lower than national averages (male - 75.3 years, female - 80.4 years). Tower Hamlets has the highest or second highest mortality in London for the three major killers: cardiovascular disease, cancer and chronic respiratory disease (COPD). There are an increasing number of patients with co-morbidities, particularly in the 65 years and over age group, and the distribution of these patients varies across the borough. The highest numbers of patients with multiple co-morbidities are found in LAPs 1, 6 and 7. Within this there are variances in prevalence of long term conditions across different ethnicities, age groups and genders in Tower Hamlets. Hypertension, depression and asthma are the most common conditions affecting the white

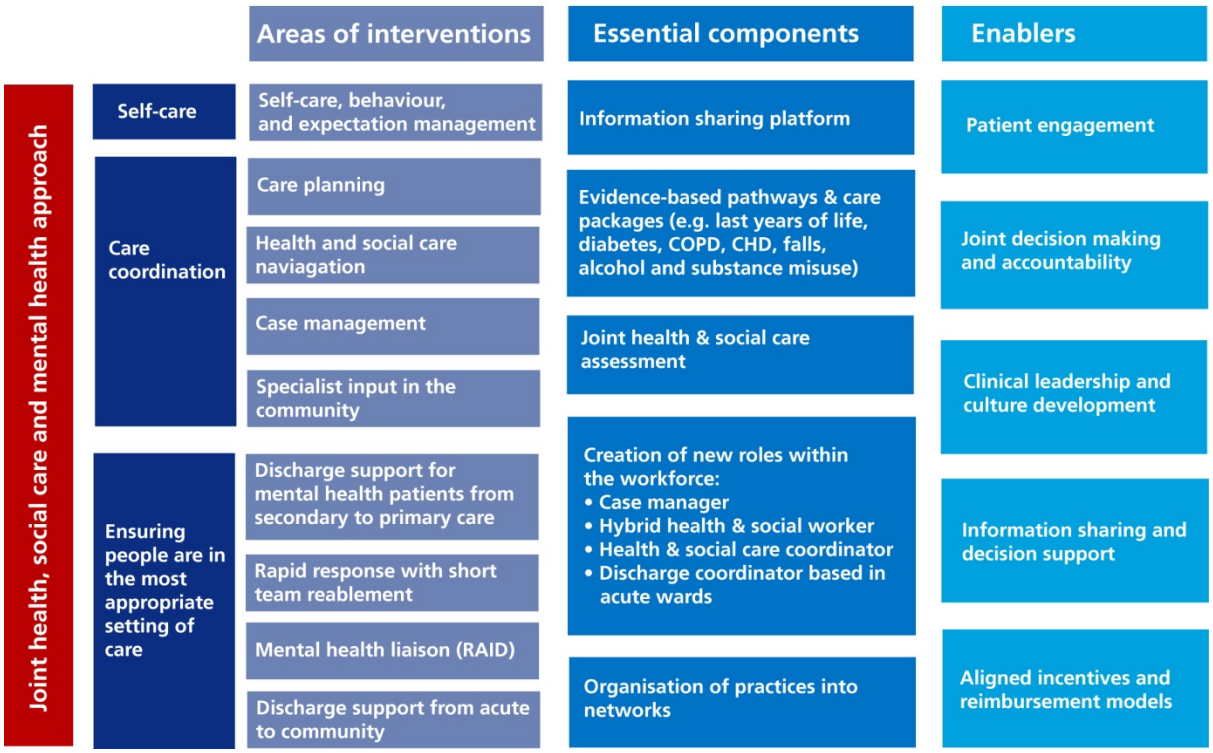
[1] This range reflects an estimate of variability between practices across the boroughs, a comparison of WELC performance against ONS top performers and a review of the international evidence base for integrated care.

population, whereas asthma, diabetes and hypertension are most commonly seen in the Bangladeshi population.

Around 1,140 Tower Hamlets residents will die per year of which around 870 will need some form of last-years-of-life care. The majority of these people will be aged over 65. Tower Hamlets has a higher hospital death rate at 68% than the national average and a significantly lower home death rate at 17%.

Our model of care has been adapted from international best practice and evidence[3-34]. The result is a suite of standard interventions that broadly cover supported discharge, care planning and coordination, and mental health liaison and Rapid, Assessment, Interface and Discharge (RAID). These interventions will be supported by system changes like routine information sharing and primary care networks, and enablers like patient systematic engagement, clinical leadership.

WELC will provide nine key interventions for its population underpinned by five components and enablers



Care Planning and Case Management

The case managers are an essential link between acute and community settings and with social care services. They work as part of the locality community health teams and focus on

- case managing patients at high risk of admission (previously community virtual ward patients)
- reducing non-essential use of A&E, to prevent hospital admissions and attendance at emergency services
- reducing inappropriate use of services (acute and primary care) by ensuring that the care planning and case management are effective

- complementing existing services by bridging service gaps
- promoting multiagency working, assisting in preventing the breakdown of service provision
- linking closely with local social workers and social care providers
- case finding frequent attenders at hospital and working with them to reduce hospital use
- care navigator role

Rapid Response
The rapid response team will be responsible for providing community based urgent assistance predominantly in patient's own homes in response to acute episodes. The rapid response service will be available for patients, clinicians and care navigators to call on during extended working hours to provide advice and attend the patient as necessary to wherever possible remove the need to call on other emergency care provision, and work with primary and social care.

Discharge management
The function aims to reduce the number of beds days used for each patient, ensure a smooth transition for the patient from hospital to home and improve the communication. They act as the interface between acute and community care.

The function includes:
- Attendance of acute MDT discharge planning meetings and liaising with the Locality Community Health Teams to facilitate discharge in a timely manner;
- Ensuring the appropriate equipment is ordered and provided for specific patients prior to discharge;
- Advising and supporting services to carry out CHC assessments to facilitate discharge;
- Working closely with the Locality Community Health Teams and continuing health care team to facilitate continuing care reviews;
- Continuing to develop discharge pathways to facilitate discharges from in-patient facilities
- Proactive case finding to facilitate discharge

Mental Health Liaison
The mental health liaison function operates in the acute setting in A&E and on the wards. The function is designed to attend patients with mental health issues swiftly on attendance in A&E to avoid admission where possible, and to provide support to

patients with physical and mental health needs that have been admitted to reduce their length of stay.

2. FINANCE COMMENTS

2.1. N/A

3. LEGAL COMMENTS

3.1. N/A

4. IMPLICATIONS TO CONSIDER

4.1 N/A

Appendices

Appendices

- None.