Integrated Care - Where are we going?

1. **GP Practices Working Independently**  
   *GP practices working independently to provide core primary care services to their registered patients only.*

   - Prior to 2015 the CCG provided Local enhanced services for the provision of services in individual practices. Practices were able to provide serves such as phlebotomy for their own patients at activity levels determined by the practice.

   - Long term condition management for conditions such as Diabetes incentivised individual practice via the Quality and Outcomes Framework (QOF)

   - No active transfer of patients from secondary services for management in primary care.

   - Individual discussions between GPs and community staff about working together to build on existing relationships. No strategic approach to address challenges, good work and experience not always shared across practices.

2. **GP Practices Working Together Informally**  
   *GP practices collaborating to extend the primary care services they can provide to patients. Exploration of opportunities to share clinical expertise, patient referrals and resources.*

   - From 2011 Hounslow Clinical Commissioning Group (HCCG) has worked with its members to establish geographically aligned networks. Through locality based schemes, sharing of data and working closer together, it was hoped that relationships and trust between practices would build and underpin future working
• Supported through the Integrated Care Programme (ICP) to risk stratify and care plan for Over 65s and patients with Diabetes. Multidisciplinary Group working developed between social care, community, mental health and acute services.

• Relationships between GPs as providers as well as surrounding organisations developed without a formal network put in place.

• Anti-coagulation monitoring and initiation provided in locality hubs for whole populations

3. **GP practices working together as locality teams covering a defined population**

*Practices working together to coordinate primary care across a geographical locality. Coordination requires oversight of a lead GP supported by a locality leadership team.*

• From 2015 formal legal entities established to reflect the locality model and deliver the Out of Hospital Services.

• Practices linked via performance targets at network level which produced significantly improvement in diabetes care

• Some inter practices referrals being undertaken for services such as insulin initiation, near patient testing, ECG. Case management retained within individual practices for services such as diabetes, care planning and mental health.

• Sharing of contracts, finances and performance data across networks with some increased scale addressing variation.

• Discharge from secondary care for management in general practice increasing but not proactive from the GP side.

• Increase flow of patients and improved pathway between GP and community for services such as wound care.

• These formalised networks have had varying degrees of success such as; increased performance of diabetes management, locality based extended hubs and further improvement as locality based delivery units. However, the localities were still seen by the practice members as a means to hold contracts rather than a development opportunity for general practice. This saw a significant amount of duplication from an operational perspective across the five individual networks which highlighted the need for an inclusive Hounslow wide consortium.

• Hounslow & Richmond Community Healthcare trust redeveloped there services along a locality model providing:
  - MDTs to provide seamless primary care within five Localities in Hounslow
  - Clinical Triumvirate providing personalised support to complex patients
- Coordinators acting more holistically to support case management, active signposting and self-management
- Data-driven focus on most complex and highest risk to deliver step change in unwanted variation
- Coordination with wider locality network for example pharmacy and voluntary sector

4. **GP practices working together to provide borough-wide services integrated with community services**

*Effective locality working acts as a foundation for planning and coordinating the delivery of services at a greater scale i.e. across the whole Hounslow population.*

- In February 2018, the Hounslow consortium was formed with the vision that General Practice is at the heart of delivering comprehensive patient care and reduce variation. The collaboration of the five localities and the Hounslow Consortium aims to give timely access to high quality primary care and facilitates appropriate access to secondary care.

- Joint working is supported through the delivery of the Enhance Primary Care Contract which includes network based performance targets as well as a gain share around a reduction of Non-Elective Activity

- Directors in post representing all localities with an MOU for joint working in place across the five

- Consortium Operations team in place with premises within the borough

- Formal agreement in place with community trust for the delivery of staff included Allied Health Professionals such as pharmacists, physicians associates, physiotherapists and paramedics

**Actions Required**

1. CQC registration to be put in place for the employing of clinical staff
2. Working processes with practices, collaborative working further developed
3. Credible business plan showing a sustainable future without CCG development funding
4. Shared training approach with community trust included taking on the CEPN programme
5. Development of shared delivery and service redesign of Primary Care Coordinators Service (PCPC) with community trust for April 2019.
6. Confirm extension on PCPC contract for 1 year.
7. Embed joint working with GP Consortium through programme board
8. Further development of the locality model required to deliver integrated working
5. **GP practices working with a full range of health, care and local authority partners providing integrated care for the full Hounslow population**

*Acute, community mental health, Local Authority and voluntary sector services integrated into the integrated model of care.*

- GP Consortium is represented on the STP Implementation Group alongside all key providers in the area.
- Programme board with community trust in place, working arrangement supported by robust governance to enable joint projects with joint responsibilities.
- Early development of locality working with community trust focusing on the following
  - Specialists being involved in a more community focussed service
  - Multi-disciplinary clinical and social care team service delivery
  - Strong affinity between participating practices and community services
  - Reducing historical organisational boundaries and working collectively through networked arrangements with access to diagnostics and IT systems.

**Actions Required**

1. Improving use of data to target unwanted variation and maximise impact, embedded use of WSIC and risk stratification on a locality level.
2. Single holistic care plan for health and care professionals, moving to integrated care records
3. New technology and digital services: e.g. tools, information and training to increase self-management
4. Shared workforce solutions to aid recruitment and retention
5. Joint outcomes to be included in community and GP contract from April 2019
6. Development of PCPC Coordinators acting holistically to support case management, active sign-posting and self-management