Harrow Integrated Care Development Programme

Working Together For Your Care

Newsletter | 11 January 2019 | Get in touch: collaborating.harrow@nhs.net

Headlines

Welcome to the new Integrated Care Newsletter

I am delighted to share the first newsletter from the Integrated Care Programme team in Harrow. As we continue to work together to develop and test new models of care and services, I want to share news about the progress we are making, the challenges we are facing and the lessons we are learning as we aim to develop integrated care across the borough. This newsletter will be published regularly and will provide important updates and news to all those interested in the day-to-day running and implementation of the programme. To share news, experiences or thoughts with the wider team as part of this newsletter, or to give us your comments and feedback, please contact us at collaborating.harrow@nhs.net.

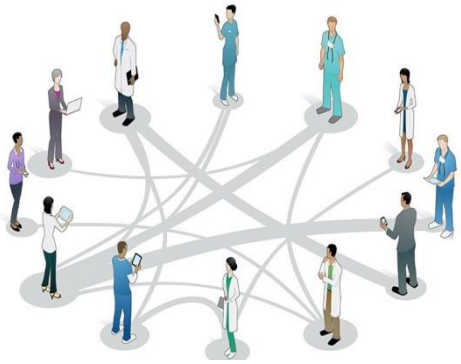
We have made great strides over the last year to bring commissioners and providers of health and care services closer together within Harrow, and we must continue to endeavor to work better together, deliver more care at home, reduce wasted resources, and base commissioning on a shared responsibility to make more impact on people's health and care.

I want to take this opportunity to thank you for your hard work throughout 2018 and to wish you a very Happy New Year.

Joanna Paul, Programme Director

Harrow's new frailty tool

Over the past few weeks, staff across health and care services (including GPs, social workers, community nurses and occupational therapists) have developed and tested a new frailty trigger tool. This tool will allow health and care professionals working in a number of different disciplines to identify people aged over 65 who are moderately or severely frail, and refer them for more intensive support. We have used an iterative, continuous improvement process to develop the tool, and have learnt how important it is to build in reflection and consider different perspectives when prototyping. Now that the tool has been developed, we will be asking staff working in one locality to use it within their day to day work from the 21 January, and in future we will be asking them to refer any patient who is identified to the new Harrow Integrated Care resource, and providing feedback on the use of the tool to collaborating.harrow@nhs.net.



Prototyping a new integrated approach

Having secured funding from the Urgent and Emergency Care Workforce Collaboration (£96k) and with support from our sponsors, we are bringing together resources from current services to prototype and test a new approach to integrated care, which will provide proactive and reactive care and support to patients who are over 65 with moderate and severe frailty, and patients who are in the last phase of their lives.

The team will consist of a GP with a special interest in care of the elderly, a community or enhanced practice nurse, a physiotherapist, a social worker, an improvement facilitator, a specialist palliative care nurse and a care navigator. The team will start working in a skeleton form on 21 January, by looking at referrals currently handled by the virtual ward and rapid response teams in Locality One (out of Honeypot Lane 907), and in future we will be asking staff who identify patients with moderate and severe frailty using the frailty trigger tool to refer those patients to this team. From April this will be rolled out to the rest of Harrow.

Developing one single point of access – 'One call no more'

Harrow CCG currently commissions multiple different single points of access for different health and care services across Harrow. Our ambition is to have **one single** point of access for all services, which can navigate patients and professionals seamlessly through an integrated system and ensure they access the right care in the right place at the right time.

We are starting to develop this through looking at the need for a point of access for the new Harrow Integrated Care system and wider services for people aged over 65, and looking at how we can create a single point of access for our Harrow population that interfaces with urgent care.

Training and education in care homes

We are working together to improve the care received by our residents in care homes through better collaborative staff training, improvements and standardisation of good practice. By April 2019 we are aiming to support care homes in implementing toolkits to keep residents out of hospital, to develop and test a training and resource pack, prototype intensive facilitation in one care home, develop an information sharing platform and build up the membership and role of the Care home Managers' forum.

Improving dementia services

A 'Living with a diagnosis of dementia' workshop took place on 29 November at Milmans Resource Centre, and we are continuing to work together to finalise the plans in late January to improve and develop services including post diagnosis support and education.

Social prescribing

Harrow CCG and Harrow Council have agreed to fund the current social prescribing service until 31 March 2019, and are currently working together to develop a new model and specification which will be commissioned from 1 April 2019.

Coming up

Future editions of this newsletter will include:

- Case studies from staff working in an integrated way;
- Information on future events where you can hear more about the Integrated Care Programme and get involved;
- Plans for education, development and training in Harrow.