One Hackney

1. Introduction

One Hackney is an innovative way of working across health and social care based at GP practice level. The new model of working will initially support priority groups of patients, focusing mainly on over 75s with complex needs who need a special type of rapid response when their condition deteriorates to enable them to remain supported in the community, including people at the end of life. It will also provide support to other adults with complex needs.

A partnership of Hackney providers developed the One Hackney approach in response to the specification produced by City and Hackney CCG. Partners include:

- Out of hours GP social enterprise
- East London Foundation Trust
- The GP Federation
- Hackney CVS
- Healthwatch
- Homerton University Hospital Foundation Trust
- Adult Social Care
- St Joseph's Hospice
- The Tavistock and Portman Foundation Trust

One Hackney will:

- give patients/users and their carers more choice and control over their care and improve their outcomes
- improve the impact and effectiveness of practitioners through integrated working.
- reduce unnecessary hospital admissions or delayed discharge from hospital.

One Hackney is funded by NHS City and Hackney CCG as part of the pooled Better Care Fund, initially for an 18 month period.

2. The aims of One Hackney

Evidence has shown that older, vulnerable people are often admitted to hospital or residential care because there is not appropriate or flexible community based support to enable them to remain safely at home. Other avoidable admissions to hospital are made because family members, paid carers or other professionals who do not understand individual's conditions or are aware of their care plans react inappropriately.

In addition, patients are frequently not discharged from hospitals when they are medically fit because their home environment cannot be made safe quickly or because new care arrangements cannot be put in place in a timely way.

The key aims of One Hackney are therefore to:

- Reduce inappropriate hospital admissions
- Support people to be discharged from hospital in a timely way
- Increase the numbers of people dying out of hospital where that is their choice
- Decrease use of emergency bed days
- Decrease number of readmissions

One Hackney will achieve this by:

1. Increasing capacity in the systems by putting in place additional social work and community nurse support, additional CPN and psychiatric support, more geriatricians, practical support at home and befriending services that can be put in place at very short notice
2. Changing the way in which professionals work together and share information.
3. Providing a forum for all professionals to learn together and adapt their pactice
4. Improved co-ordination of care through shared care plans developed by the patient with professionals and multi-disciplinary meetings
5. Providing patients and carers with a clear point of contact for their care.
6. Increased communication via available telephone numbers, meetings at various levels, learning and adapting.
7. Quadrant teams to support, trouble shoot and unblock problems and signpost to community resources.
8. Borough wide learning and coordination via the 'one hackney' programme board.

One Hackney is a new approach adopted by providers from across the statutory and voluntary sections drawing on user feedback and experience. There is no lead or prime provider and all partners work at an equal level. It has been agreed by the Provider Programme Board that the performance fund that will be awarded if One Hackney meets the agreed targets, will be reinvested in the new ways of working, rather than taken as a payment by individual organisations. It offers a truly collaborative way of working, which if successful can be rolled out more widely as an integration methodology.

How the One Hackney model will work

i At practice level

GPs, supported by community nurses and other multi-disciplinary team members develop and review care plans for their most vulnerable patients

Multi-disciplinary (MDT) meetings will be held monthly at all practices involving GPs and other practitioners to work through the needs of individual patients.

GPs and practices will be able to draw on a range of services available through the provider network for individual's care plans including:

- The RICS (Reablement and Integrated Care) and community nursing services
- Social care support through 4 new social worker posts, one located with each quadrant team
- Mental health services provided by East London Foundation Trust
- Mental health services provides by the Tavistock and Portman Trust to provide skilled psychological support/family therapy when there are difficulties for patients and their families
- Community support workers located with each quadrant team with full community and VCS knowledge to ensure patients/carers are able to access the full range of local, neighbourhood, volunteering and befriending support
- LYOL services provided by St Joseph's Hospice supporting more people to remain at home and improve access to care/ palliative care rapid response
- Night nursing and sitting and additional care provided by Marie Curie Cancer Care and others: provided both for end of life and other patients
- Flexible support commissioned on a spot purchase basis from the voluntary and community sector through City and Hackney Together (a special purpose vehicle for the voluntary sector in Hackney) including:
    - Practical care to enable to patients to remain at home or return after a period of hospitalisation;
    - Mental health support
    - Financial and legal support for individuals
    - Exercise and social interaction in the home to enable older people to continue to regain their abilities and build their confidence after initial hospital/ rehabilitative support
    - Practical support in the home including de-cluttering.

Practices will also be able to draw on additional services including:

- Elderly home visiting service via the GP Federation to fund practices to develop the care plans, participate in MDTs and undertake home visits
- A duty doctor in each practice to respond to requests from other services if a patient is in crisis and needs an urgent response from primary care
- Night time care coordinator and on call doctor in CHUHSE
- Take Home & Settle service.

ii. At the quadrant

GP practices in Hackney and the City have been divided into four geographically based quadrants. There will be monthly leadership meetings for quadrant teams to review performance and resolve problems

The Quadrant Leadership Team will be supported by a Quadrant Manager, Quadrant Co-ordinator and Quadrant Administrator who will support practices in co-ordinating MDT meetings, facilitating the delivery of care plans and troubleshooting any problems.

There will be also being quarterly clinical meetings of practitioners/clinicians from across each quadrant to review clinical cases, identify where gaps are not being addressed and identify learning and improvement.

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