BHR Integrated Care Partnership

Better care, better lives, together

Barking and Dagenham Locality Development

23 January 2017






Locality development leadership – Dr John

Barking and Dagenham has a well established partnership group which is driving and overseeing development of the locality model; the Integrated Care Health and Wellbeing Board Sub Group.

This group has well established links with the B&D Health and Wellbeing Board and provides regular updates on progress.

Membership of the group includes:

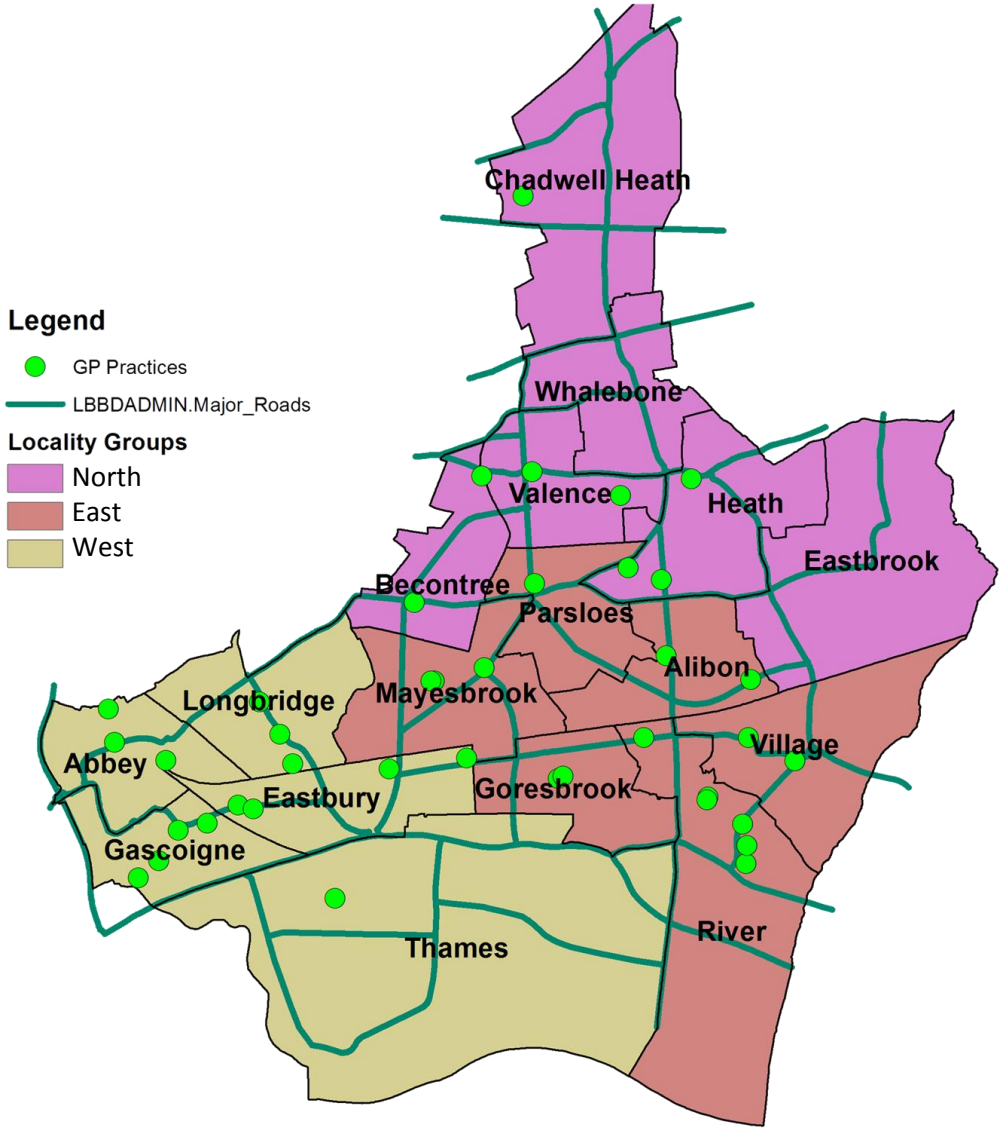
- Dr Jay John, B&D CCG
- Dr Kalkat, B&D CCG
- Melody Williams, NELFT
- Tudur Williams, LBBD Adult Social Care
- Ann Graham, LBBD Childrens Social Care
- Susan Lloyd, LBBD Public Health
- Sharon Morrow, B&D CCG
- Sarah See, BHR CCGs

Basirat Sadique from BHRUT is also involved in locality development in B&D and joined the workshop held on 12/12

The CCGs have identified a project manager (0.5 WTE) to support locality development in B&D

Barking and Dagenham localities – Dr John

The below map shows the Barking and Dagenham localities which partners are re-aligning to. These have also taken into account future population growth. It is anticipated that a fourth locality the support the Barking Riverside development will emerge in around 2021.



Network Population	Network (post Jan 17 Inf CDs)
West	77,101
East	75,239
North	61,469
Not Applicable	340
Total	**214,149**

Agreement has been reached to refer to the localities as north, east and west

Progress to date – Dr John

At the Integrated Care Health and Wellbeing Board Sub Group meeting on 28th November the group agreed to extend the next meeting of the group, planned for Monday 12th November to take place in workshop style to enable in depth discussion around;

- ✓ Setting the scene
- ✓ Vision
- ✓ Reality
- ✓ Commitment to developing the new model and resource requirements
- ✓ Next steps

Key messages from the workshop:

- ✓ Big dreams
- ✓ High level of trust
- ✓ Collective leadership
- ✓ Consensus re: localities, focus on community asset and the benefits of coterminous working
- ✓ Borough Manifesto as the route to further develop and share the locality vision
- ✓ Localities agreed / good progress on plan
- ✓ Willingness to resolve IG issues and test joined up information/IT systems
- ✓ Clear confidence between partners that this model is the right direction of travel and is deliverable
- ✓ Next steps to take forward locality development together agreed

What are our priorities?

We have identified some key priority areas through which we are proposing to test the locality model. These are based on the evidence available in the commissioning for value packs as well as clinical experience including input from Public Health;

- Diabetes
- Social prescribing
- Crisis management
- Core locality team
- Childrens services; Childrens Social Care is currently working to realign their services to the locality model and are under consultation. This is not quite in as advanced a stage as adults services but further work will take place to see how Childrens services can work with the locality model in the future

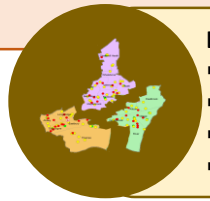
Each of these areas has its own challenges within Barking and Dagenham and improvements to these areas will contribute towards closing the key health and wellbeing, care and quality and finance and productivity gaps at both a borough, and Barking and Dagenham, Havering and Redbridge system level.

The group have considered some of the benefits of locality working which include; better risk and crisis management born of improved joint working which will result in visibility and accessibility between services and embedding prevention; As confidence in the locality model grows and joint working embeds, it is possible that more services in the future could be delivered at locality level.

Where we are now; Jacqui Van Rossum - NELFT

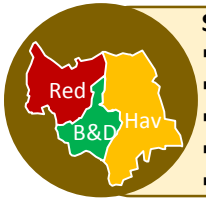
Jacqui Van Rossum; NELFT

- Clinical leads, operational staff and managers within NELFT have come together to undertake a review of the service provision in B&D including which services could be provided at a **locality (x3)**, **borough (whole)** and **system (BHR)** level to ensure economies of scale. Scoping how this could operationally and managerially work within the current contractual framework has begun
- NELFT will require access to dedicated resource to support any reconfiguration and will have to undertake a staff consultation due to the subsequent changes to working locations, managerial changes (with the move from 6 clusters to 3 localities) and caseload reallocation. Any changes would have to be phased rather than big bang
- NELFT's preference is an 'all age' coterminous approach which will ensure the delivery of more seamless care
- Through these discussions NELFT have identified a number of key benefits of the new way of working including: increased clinical time with patients, better use of resources and providers working together to address the needs of a defined population. Trusted assessment developing through relationships born of co-location and positive impact to recruitment and retention
- The next step will be confirming 'need' by locality through the locality profiles and subsequently weighting service capacity in each locality and then actively consulting with staff to embed the new model
- The below diagram shows *current thinking* (subject to consultation) around which services could be provided at each level:



Locality level services (current thinking);
- Community Health and Social Care Service (CHSCS)
- Universal children's' functions (school nursing / health visiting)
- Talking therapies (IAPT)
- Community recovery services (mental health - CRT)

Borough level services (current thinking);
- BDAABIT (Access and brief intervention team -mental health
- Older Adult Mental Health and memory services
- Childrens Targeted services (CAMHS, Paediatricians , Therapy Services)
- Long Term Condition Services

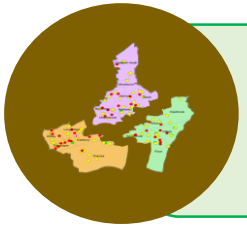


System level services (current thinking);
- Walk in Centre
- Community Treatment Team/Intensive Rehab Service
- Perinatal infant mental health
- Eating disorder services
- Clinical Health Psychology Services

Where we are now; Tudur Williams - LBBD

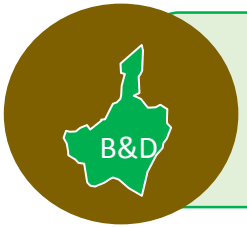
Tudur Williams; LBBD

- LBBD are in the process of reconfiguring their social care services and have just completed a staff consultation and are in the process of responding to the comments received through this process
- This will include a degree of centralisation of some services e.g. central business unit/ information to ensure greatest efficiency
- Focus on ensuring that social workers on the ground have a greater proportion of clinical/face to face time with service users. It has become apparent that social workers have been picking up a lot of work that does not necessarily need to be undertaken by a qualified social worker; to ensure that best use is made of qualified social workers' time, Care Navigator roles are being created, this will strengthen the role of social workers to focus on longer term, complex case management
- The OT service needs some reorganisation as not currently as efficient as it could be
- The below diagram shows *current thinking* (which may be subject to change) around which services could be provided at each level:



Locality level services (current thinking);

- 4 social workers
- Locality manager
- Consultant social worker role



Borough level services (current thinking);

- Central business unit
- Assessment team

Where we are now; Dr John – GP Networks

Dr John; GP Networks

- GPs are now part of developing networks of practices, aligned to the locality model (three networks geographically aligned to the localities)
- As well as Dr John, Drs Kalkat, Hara and Goriparthi there are GP Network leads for the 3 networks in B&D
- An extraordinary PTI meeting took place in December to explore the development of networks and localities in greater detail
- There are two GP Federations in B&D which are essentially provider networks design to enable the delivery of primary care at scale
- GPs on the ground are aware of the developments around localities and networks but not necessarily how this will work in practice e.g. the impact on ICM but this will be explored through engagement around locality development

BHRUT

- Clinicians aware of developments in the community but not of the detail at this stage
- Key need to communicate information at the right time in the right way

Where are we now; summary

- **Localities and supporting information:** Locality boundaries have been agreed and partners are working to develop a key suite of supporting information to enable key decisions around workforce requirements in line with need to be made alongside informing the operational model. This information will include a map of the services currently provided across the system and 'locality profiles' being developed by Public Health.

- **Progress to date:** A lot of work has already taken place in B&D to begin to realign services from the 6 ICM clusters to the three localities model (with a fourth locality coming online in 2021 to support the Barking Riverside development). LBBD are in the process of reconfiguring their social care services and have just completed a staff consultation which will include a degree of centralisation of some services e.g. central business unit/ information to ensure greatest efficiency and will have a focus on ensuring that social workers on the ground have a greater proportion of clinical/face to face time with service users. NELFT are in the process of scoping a similar approach to realign their services to the three localities.

- **Leadership to take this forward**: The existing Integrated Care Health and Wellbeing Sub Group (ICSG) is overseeing locality development. This group includes leads from; B&D Local Authority, B&D Clinical Commissioning Group, NELFT, B&D Public Health and BHRUT.

- **Current thinking around locality development**: Thought has already been given to the different services that could be provided at locality, borough and system level to ensure economies of scale and improve service delivery.

- **Strong partnership working to ensure delivery:** The ICSG, at their workshop in December discussed their commitment to develop the locality model and feel that by April 2017 based on the work already underway, Primary Care, NELFT and LBBD will be reconfigured into a model that will support the delivery of health and care in the three localities in B&D.

B&D locality develop next steps

Key next steps:

- ✓ Public Health to develop locality profiles (in progress)
- ✓ Once locality profiles are completed, NELFT will review the level of need within each locality and weight service provision/the 'core' service offer in each locality accordingly
- ✓ Tudur Williams (LBBD) and Melody Williams (NELFT) to meet to discuss how to align the NELFT and Social Care reconfiguration processes; there are clear plans for each organisation/partner at the moment in terms of re-aligning to the three localities; we are in the process of bringing these plans together
- ✓ ICSG meetings will continue to further develop locality proposals and oversee establishment of the model
- ✓ NELFT, LBBD, primary care and other partners to work on development of the locality operational model
- ✓ ICSG to consider how to engage with the community and voluntary sector in the development of the locality model at a B&D level

Use of £8k support funding

The £8,000 supporting funding for locality development will be used towards:

- **GP backfill** to enable non clinical directors to lead on development of the locality model
- Resources to access **data** / CSU support
- Support **engagement** as required as the programme progresses

Requirements of the ICP

- Dedicated project support to develop the plans/project documentation and develop the prevention strategy
- Support to enable backfill for staff including NELFT and independent GPs to develop the locality model
- Business intelligence support that will regularly provide borough and locality information so that we can be responsive to the needs within the system and weight services according to need in each locality (from a core service offer)
- Connected data/information sharing which will greatly improve outcomes for our population and improve the effectiveness of interventions

Summary

Strong, well established relationships

Shared vision

Joined up planning

A commitment to make this happen