BHR Integrated Care Partnership

Better care, better lives, together

Barking and Dagenham Locality Development Workshop

SUMMARY OF DISCUSSION

12 December 2016






Background and attendees

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

Invitations to the group were extended to Jacqui Van Rossum (NELFT), Bas Sadiq (BHRUT), Anne Bristow and Mark Tyson (LBBD), Drs Hara, Goriparthi and Kalkat.

The workshop was facilitated by Rita Symons, NELFT.

Workshop attendees (12/12/2016) included:

- Sarah D'Souza (B&D CCG)
- Mark Tyson (LBBD)
- Tudur Williams (LBBD)
- Melody Williams (NELFT)
- Jane Gateley (BHR CCGs)
- Bas Sadiq (BHRUT)
- Ann Graham (LBBD)
- Dr J John (B&D CCG)
- Dr Goriparthi (B&D CCG)
- Sharon Morrow (B&D CCG)
- Sue Lloyd (Public Health)
- Sandeep Prashar (Public Health)
- Monga Mafu (B&D CCG)
- Emily Plane (BHR CCGs)

The following pages reflect the discussion at the workshop and agreed next steps to take forward locality development

Setting the scene

Mark Tyson provided an update on the background to locality development including development of the Strategic Outline Case for BHR to test the benefits of devolution.

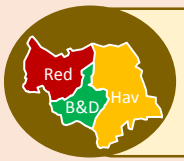
A lead from each organisation then provided an update on thinking and progress to date to align workforce to localities as follows:

Melody Williams; NELFT

- Clinical leads and operational staff within NELFT have come together to undertake a review of the service provision in B&D including which services could be provided at **locality**, **borough** and **system** (BHR) level to ensure economies of scale; this work will eventually provide a clear core service offer for each level. They have begun to scope how this could work operationally within the current contractual framework
- NELFT will require access to dedicated resource to support any reconfiguration and may have to undertake a staff consultation (between 30 – 90 days) due to the subsequent changes to working locations (with the move from 6 clusters to 3 localities) and caseloads. Any changes would have to be phased rather than big bang
- NELFT's preference is a 'cradle to grave' 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 assessor agreements may begin to develop through relationships born of co-location and recruitment and retention may also be improved
- The next step will be reviewing 'need' by locality through the locality profiles and weighting services in each locality based on the level of need
- 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);
- Community Health and Social Care Service
- Universal children's' functions (school nursing / health visiting etc.)
- Talking therapies (IAPT)
- Community recovery services (mental health)
- Some therapy services in the future (e.g. SALT)

Borough level services (current thinking);
- Access and brief intervention team (mental health); as the locality develops there is the possibility of this moving to localities
- Adult and memory services
- Perinatal infant mental health
- Eating disorder services



System level services (current thinking);
- Walk in Centre
- Community Treatment Team
- Intensive Rehab Service
- Community Rehab Beds

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

Locality level services (current thinking);
- 4 social workers
- Locality manager
- Consultant social worker role

Borough level services (current thinking);
- Central business unit
- Assessment team

Dr John; GP Networks

- Dr John confirmed that 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 are GP Network leads for the 3 networks in B&D
- An extraordinary PTI meeting will be taking place tomorrow (13/12) to explore the development of networks and localities in greater detail
- Dr John noted that 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

Bas Sadiq: BHRUT

- Clinicians aware of developments in the community but not of the detail
- Need to be sure to communicate information at the right time in the right way; JG noted ICP meeting this pm will discuss Comms support from January 2017

The group 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.

Group discussion; the locality vision for B&D

The group considered their 'dream' vision and aspirations for B&D responding to;

- What do I want
- What is my vision
- What are the benefits

The Dream; key themes

- **Whole system should be joined up** and consider health in its broadest terms (everyone should refer to 'our patients' and 'our targets'), with a strong **focus on outcomes** for our population. There should be no bouncing people around the system, everyone who works in health and care and the third sector should feel responsible for each person using our services/living in B&D
- **Integrated care organisation** to remove all issues that arise from multiple organisations delivering care to the same people; this would also increase productivity and efficiency and remove duplication
- People should be supported to be as happy as possible, be **proud to live and work in B&D** and want to work here (recruitment and retention issues solved). This would include GPs who don't want to retire early due to workload pressure and a reduction in pressure on all staff
- People in B&D should **live longer and be healthier** for longer (longer life and healthy life expectancy)
- **Work much more closely with the community and voluntary sector and wider community** to enrich peoples lives and ensure that they are fully supported and that everyone has a say in the design of services
- **Simple and easy to use system** so that both our population and staff know the right service to access, first time
- Support people to be **independent** as much as possible
- Embed **prevention** in all services
- Patients/service users feel **empowered**
- **Address poverty** and improve the number of those with **qualifications**, going into well paid work with high aspirations
- Develop a **strong and joined up IT platform** so that all services (subject to the right controls) can access a persons information when needed to greatly improve the care and treatment of that person
- Have **access courses** and **training locally** to enable people to go into nursing or social care etc.
- Support the people of B&D to reach their **full potential**
- **Reduce workloads** of clinical staff (burden of bureaucracy)
- **Freedom and time to think/innovate and effect change**, especially for front line and operational staff, as well as patients/community and voluntary sector
- **Parity of esteem for both physical and mental health** through the locality model
- Utilise **new technologies**
- **Improving the culture** of those working in B&D; people to have positive attitudes and believe that they can make a difference
- **Make best use of estate**

Group discussion; the locality vision for B&D

The group considered the 'reality' of the current situation in B&D, responding to;

- How long will the dream take
- Who needs to be involved
- What steps do I need to take this forward
- How far away are we

Reality; key themes

- Need to develop clear milestones for the next 5 years and then longer term; will need plans with timeframes from each organisation and bring these together into a master plan for B&D
- Frontline/operational staff along with the community and voluntary sector and the public need to be involved in the development of the model
- If we are talking about radical change, need to create the space for people to think about this and make it happen
- There is a Borough Manifesto which has been developed by the local authority with partners from across BHR; should we use this opportunity to feed the locality vision into this document that will then be shared with all partners to seek ownership
- Will need to bring locality teams together on an ongoing basis to develop the proposals / design how the locality will operate in practice and support establishment of the model
- Noted that we do trust our partners but the way that we work is different and we each have different (and sometimes competing) priorities and rules governing us which makes full cooperation difficult at times; noted therefore that to establish successful localities based upon trust, would need one form of regulation for the locality as a whole. JG noted that the joint commissioning in board in development under the BHR Integrated Care Partnership may go some way to address this
- Need to take this opportunity to propose local leadership to take forward the locality model in B&D; need strong local leadership to ensure that there is a strong link and dialogue between leadership and operational staff
- Important that time and resource is dedicated to developing local leadership
- Need to discuss and agree how to engage with the community and voluntary sector going forward and include them in locality development discussion. EP noted that the ICP initiated a programme of engagement with the community and voluntary sector through the development of the Strategic Outline Case which was well received and created some positive momentum to support closer and better ways of working; another workshop in the series is planned to take place around February 2017. The group agreed that they need to give some thought to the inclusion of a community and voluntary sector voice in the discussion around locality model development in B&D. In addition LBBD have commissioned Locality Matters to map community assets in the Gascoigne area and to explore how to mobilise these assets to support the locality model of care
- Dr John noted that Health 1000 did develop a joint care plan so there is some learning to be taken from this. The group also noted that there is a lot of care plan sharing for the most vulnerable across the patch, but we need to develop a solution that works to improve the delivery of care for the whole population; a joined up IT solution for everyone. Noted that the local authority are about to go out to procurement for a new IT system, NELFT have just procured an updated IT system and GPs work on three different systems but EMIS seems to be the most prevalent. One of the key barriers to information seems to be information governance rules rather than technology. Locality model development is a chance to see if we can work together to address this and test a joined up care plan in B&D providing that the relevant safeguards are in place.

Group discussion; Resourcing Requirements

The group discussed the resourcing required to take forward further development of the vision, along with development of the plan and establishment of the model.
The group will be required to update the Integrated Care Partnership on the resources required to take this forward when attending their meeting (possibly 23 January) to update on progress in B&D.

Resourcing discussion key points

- Acknowledge that more likely to receive support in the form of people rather than money although noted that there will be a requirement to backfill clinical time for GPs
- Commissioning; discussion is underway to develop a Joint Commissioning Board
- Project support (half of EP's time offered to B&D to support development of the model)
- Service manager – NELFT
- Social Care manager – LA (adults and children)
- BHRUT; FD to provide support
- Support for primary care development from CCG to be reviewed
- Intelligence which needs to be aligned to the intelligence being produced for the other boroughs and feeding up into the BHR system and the wider STP
- Communications support required; JG noted that the Integrated Care Partnership are going to discuss the Communications support for the programme in January 2017
- Noted that although LBBD adult services are in the process of reconfiguring, children's services are yet to take this step which will need to take place to allow alignment with the locality model

Agreed actions / next steps

Key messages:

- ✓ Big dreams
- ✓ Collective leadership
- ✓ Consensus Re localities and the benefits of coterminous working
- ✓ Borough Manifesto as the route to 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

Actions/next steps agreed:

13	B&D localities need names, not numbers to avoid confusion and need to work together on a shared language; 'ours' not 'my' etc.	All	23/01	
14	Once locality profiles are completed, NELFT will review the level of need within each locality and weight service provision in each locality accordingly	All	Subject to completion of locality profiles	
15	Tudur Williams and Melody Williams 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 need to bring these plans together	TW/MW	23/01	
16	Need to develop a prevention strategy to be embedded in the locality model	All	23/01	
17	Need to consider how to engage with the community and voluntary sector in the development of the locality model at a B&D level	All	23/01	
18	EP to share the realising the value' document with the group	EP	13/12	Complete
19	Seek to include the locality vision in the B&D borough manifesto document which can then be used to communication the vision going forward	All	23/01	
20	Establish a plan for Leadership development	All	23/01	
21	Need to prepare for the B&D update to the Integrated Care Partnership Group meeting in January 2017	All	23/01	
22	Bas to check with BHRUT RE who can support development of the locality model in B&D from their organisation	BS	02/01	
23	JG to share how the Redbridge discussion on locality development goes at the Integrated Care Partnership meeting this evening	JG	20/12	