BHR Integrated Care Partnership update

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Barking and Dagenham Health Scrutiny Committee

3 September 2019
East London Health and Care Partnership (ELHCP)

**Councils**
Local councils commission social care services such as sexual health, drug and alcohol, and some mental health services, and residential care homes.

**NHS Clinical Commissioning Groups (CCGs)**
Plan and buy health services for the residents in their borough: from cancer care to mental health; hospital operations to prescriptions.

**Providers**
These organisations deliver health services such as GP practices, hospitals, mental health, and community services. Providing inpatient, outpatient, emergency and planned services, mental health and community services, in hospitals, clinics and people’s homes.

Together these organisations plan and coordinate health and social care across north east London = East London Health and Care Partnership (ELHCP).
To accelerate improved health and wellbeing outcomes for the people of Barking and Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services.

Source: BHR Accountable Care Strategic Outline Case, November 2017
The ICPB has agreed a set of values and principles (see below)

- The ICPB recognises there is a lot more work to be done to engage with staff and is exploring how to take this forward with comms leads from each respective ICP organisation.

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<tr>
<th><strong>Values</strong></th>
<th><strong>Principles</strong></th>
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<tr>
<td>✓ To sign up to our joint vision, putting the patient and public at the centre of our work</td>
<td>✓ We work in partnership and demonstrate respect for all professional perspectives</td>
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<td>✓ To put quality and safety at the heart of everything we do</td>
<td>✓ We aim for agreement wherever possible and stick to it</td>
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<td>✓ To work together to deliver the vision, not undermine each other</td>
<td>✓ We aim for honest closure where we cannot agree</td>
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<td>✓ To lead, not blame</td>
<td>✓ We speak well of each other</td>
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<td>✓ To look for answers not give excuses</td>
<td>✓ We involve each other as early as possible</td>
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<td>✓ We try our hardest to work on a ‘no surprises’ basis</td>
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<td>✓ When we collectively give authority to team members to act, we let them deliver</td>
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Locality model
A geographically aligned community of care with a population of 50,000 – 80,000 supported by a network of 8-15 GP practices
Population segmentation of:
- Children
- Chronic elderly

Enabling:
- Strong and more joined up IT platforms
- A single communication strategy and message, so everyone in the ACO knows who the patient should be referred to and who they have already seen
- Educating the population to empower them to be responsible for their own care
- Preventative care programmes – home adaptation and healthy lifestyle
- Educating the population so they are aware of how the health system works, and who they should go to, rather than turning up at A&E

Services provided by Community Hubs:
- GP / community nursing walk-in clinics
- Health and wellbeing programmes
- Employment support
- Housing support
- Healthy living prevention activities
- Education (adults and schools)
- Welfare and housing support
- Work and skills support

Contributors to the design of the locality model:
- GPs
- Local authority members
- Voluntary sector
- Clinicians (NELFT BHRUT PELC)
- The public

We have spoken with almost 8,000 people who work in health and care, or live, in Barking and Dagenham, Havering and Redbridge; the outputs of these conversations and surveys have fed into the development of the locality model.
Corporate objectives

Vision

BHR Joint Commissioning Board; Developing cross system strategic commissioning to deliver integrated care system vision

Frailty

Older people, frailty & end of life

To be scoped

Children & Young People

Diabetes & AF

Long term conditions

Key enablers including:
- Develop Joint Commissioning opportunities
- Population Health management
- New digital platform
- Robust workforce plan
- Robust comms and engagement
- Fit for purpose estates

Mental health

Medicines optimisation

Maternity

Cancer

BHR Provider Alliance

Development of Integrated Care System delivery model

System challenges

BHR CCGs; High impact transformation areas targeted to address key challenges using principles of integrated care vision

Health and wellbeing challenges

Care and quality challenges

Funding and efficiency challenges

BHR CCGs; High impact transformation areas targeted to address key challenges using principles of integrated care vision

Prevention
Moving care upstream to prevent deterioration, includes wider determinants of health. Focussed on prevention of disease and ill health

Primary care
Develop primary care at scale including workforce and supporting delivery of more integrated care through GP Fed development

Planned care
Care in right place, first time, reducing inappropriate activity, and improving effective decision making

Unplanned care
Reducing inappropriate demand, admissions and ensuring appropriate length of stay (reducing delayed discharges)

BHR CCGs; High impact transformation areas targeted to address key challenges using principles of integrated care vision

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BHR Provider Alliance

Development of Integrated Care System delivery model

New delivery model achieving improved health and wellbeing outcomes for local people
ICPB leaders are currently undertaking a governance review.
Children and young people

• Full multi-agency agreement on the shared vision for CYP services and the requirement for cultural change.
• An agreed whole system view and a common understanding on the areas requiring prioritisation.
• Full agreement to ensure focus on service user experience and outcomes and an avoidance of operational distractions.

Older people and frailty

• Falls prevention: published BHR Falls Strategy and expansion of Age UK led strength and balance exercise groups across BHR.
• Home-is-best (admission avoidance): 2 week trial in July as part of BHRUT’s a “Perfect Tweek Week” successfully diverted 19 patients from admission and established daily collaborative decision-making “huddle” between multiple-provider teams.
• Care homes: “Significant 7” training for nearing 1000 care-home staff to recognise early signs of health deterioration and alignment of a GP practice with named nursing home through an integrated nursing homes scheme.
• End of life care: roll-out of “Coordinate My Care” from April 2019, with the commencement of a local incentive scheme and targeted IT support.
Cancer
• Health Promotion Champions to engage with BME and other hard to reach groups (five champions per CCG).
• Implemented bowel screening coordinator to increase screening rates.
• Implemented faecal immunochemical testing to enable GPs to test patients who have blood present in stools, preventing the need for endoscopies.
• Became part of the SUMMIT study to increase early lung cancer detection.

Long term conditions (LTC)
• 2019/20 LTC GP Local Incentive Scheme in place with continuing focus on diabetes treatment targets and targeted atrial fibrillation detection.
• Developed opportunistic atrial fibrillation detection scheme with BHRUT and community pharmacy partners – business case to be brought in early September.
• Agreed to pilot LTC multidisciplinary team (MDT) focussing on complex patients – pilot will test the hypothesis that MDT working can reduce non elective admissions for this patient group.

Mental health
• Developed and agreed a tool for measuring system impact.
• Undertook and completed a draft mapping of adult mental health system to inform the new model of care.
• Agreed a new service model for the delivery of Improving Access to Psychological Therapies.
Integrated Care System in Context

General practice as the foundation of a wider Integrated Care System, working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget.

Larger-scale General Practice Organisation (Federations)

Usually at a borough level and often a single formal organisation e.g. Federation, this is the platform to provide the scale to develop and train a broad workforce, create shared operational systems and quality improvement approaches including use of locally owned data, support the delivery of collective back office functions to reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the ‘voice for general practice in the local health economy.

Locality Team

Serving populations of 30,000 – 50,000, bringing together groups of practices and other community providers around a natural geography. Support multi disciplinary working to deliver joined up, local and holistic care for patients. Key scale to integrated community based services around patients’ needs who require collaboration between service providers and long-term care coordination.

Primary Care Network

The **Primary Care Network** model is at the core of both the development of General Practice in its own right, and as the foundation of place-based, integrated care. The **GP Federations** are a key platform to expand on the benefits of PCNs and enable further commissioning and to achieve economies of scale at both a borough (single GP Federation) and multi borough (e.g. three BHR Federations working together) level.

General Practice Based Team

General practice as the foundation of a wider Integrated Care System, working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget.
Source: Google maps
• Commissioner landscape in NEL
• 7 CCGs = 3 local integrated care systems (ICS)

• Barking and Dagenham
• Havering
• Redbridge
• Waltham Forest
• Newham
• Tower Hamlets
• City and Hackney

• 7 NELCA CCGs to merge into a single CCG by April 2021
Questions?