Appendix 1

BHR Integrated Care Partnership
Better care, better lives, together

Barking Riverside and Thames Ward; a new approach to wellbeing – model of care update

Barking and Dagenham Overview and Scrutiny Committee

Dr Jagan John, Chair, Barking and Dagenham CCG

3 September 2019

Recap: the Barking Riverside development

- 443 acres in south of Barking between Barking Town Centre and the River
- By 2037 – development in four phases will see:
  - 10,800 new homes
  - c22,000 new residents
- Thames Ward will eventually develop into 4th locality in B&D
- Announced as one of NHSE's 'Healthy New Towns' – the only one in London
- Developers are required to provide financial contributions to the development of health and care infrastructure to support the new population
- Opportunity to develop a genuinely integrated service with a focus on prevention, where there is currently a 'blank slate'

The building that will house the new model of care is now expected to be 'live' from 2022

Recap: Health provision now and in the future

- In the short term (2016/17– 2020/21), the CCG is working with three existing practices in the vicinity - Dr John's and Dr Kalkat's practices at Thamesview, and St Albans GP practice - to increase capacity and extend opening hours to provide primary care access to local people from 2017 to 2020/21 (up to potentially early 2022), until the new facility is in operation. Each practice developed a business case for the additional capacity, which underwent due scrutiny and review before approval.

- We expect that Barking Riverside residents will be able to register with the new wellbeing hub from 2022 - this timeline has slightly extended from April 2021, based on an update from the Developers

- The new facility / model needs to be flexible, seamless and person-orientated, with a focus on wellbeing, getting things right first time, and improving outcomes for local people.

- There is an opportunity to link health and wellbeing services to the physical assets of the site:
  - There will be a leisure centre in the footprint of the hub, alongside the clinical space. The principles emerging from the workshops and engagement with local people suggest that these spaces should feel integrated and seamless.
  - There is particular opportunity to capitalise on linking health and wellbeing services with the gym/leisure facilities, and to community assets such as education campuses e.g. the nearby Riverside Campus School, and other schools in the area.
  - The design of the wider environment is essential to the promotion of wellbeing i.e. green spaces that support walking and cycling and a commercial offer that promotes a nutritious food environment

Recap: where?

New station

Rivergate Primary School

New primary school

New primary school

Riverside Campus

Integrated Health & Wellbeing Hub

Key work streams for the Barking Riverside / Thames Ward development

With the Healthy New Town programme coming to an end, a workshop focussed on creating a thriving Thamesward took place on Thursday 25th April 2019 to ensure local people and community organisations are able to co-produce conversations about health and wellbeing in the South Locality of Barking within which Barking Riverside is situated. There was clear passion from all attendees including a number of local people to create a new environment and way of integrated working for the South Locality.

Next steps which are being taken forward following this workshop include establishment/continuation of the following groups:

- **Built Environment Group**; being taken forward by the Developer and Graeme Cooke (Director of Inclusive Growth from LBBD) – focussed on the wider Barking Riverside/Thames View environment
- **Community Focussed Group**; Matthew Cole (Director of Public Health, LBBD) and Leila, a member of the Community are leading establishment of this group; focussed on designing the community element of the space within the new building
- **Leisure Group**; Focussed on the development of proposals for the leisure element that will be housed in the new building
- **Model of Care Group**; this is led by Dr John, is comprised of health, care and community partners, and is working to develop the proposed model of care for Barking Riverside. This gropu has been meeting since February 2019
- **Thamesview**; There is also a group who meets to discuss testing elements of the proposed model of care at Thamesview Health Centre, for example, proposals to create a single welcome desk a the front door
- **Wellbeing Hub Design Group;** who will focus on the physical design of the building

These groups will feed into an overarching **Board**, the first meeting of which is taking place on 25th September 2019. The name of this is to be confirmed; it is currently being referred to as the 'not a traditional Locality Board, Board' – to reflect the desire to move away from corporate branding and traditional approaches to health, care and wellbeing.

Barking Riverside Model of Care Design Group

Stakeholders have convened a 'Model of Care Design Group' who have been meeting monthly since 27th February 2019 as a task and finish group, with meetings planned up to 30th October 2019 when it is anticipated that we will have a strong articulation of the proposed model of care.

Current membership includes:

Membership	
Organisation	**Name and Role**
NELFT	Mohan Bhat, Associate Medical Director
	Melody Williams, Integrated Care Director, Barking and Dagenham
	Laura Stuart-Neill, Allied Health Professional Lead (Deputy for LSN) Clare Linger, Deputy Allied Health Professional Lead (Deputy for LSN) Wendy Ennifer, Deputy Allied Health Professional Lead
Barking and Dagenham, Havering and Redbridge University Hospitals	Fiona Peskett, Director of Provider Alliance Development
Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups	Dr Jagan John, B&D CCG Chair and GP
	Dr Kalkat, Clinical Director and GP
	Dr Amit Sharma, Clinical Director and GP
	Dr Uzma Haque, Clinical Director and GP
	Simon Clarke, Primary Care Delivery Manager
	Emily Plane, Head of Primary Care
	Sarah See, Director of Primary Care
Jointly funded post – BHR CCGs and LBBD	Mark Harrod, Director of development – Barking Riverside
Dentistry	Dr Hirekodi, Local Dentist
BHR GP Federations	Dr Ravi Goriparthi, B&D GP Federation Lead and GP
NEL Pharmacy Federation	Nader Siabi, Clinical Pharmacist
	Faisal Chowdhury, Pharmacist
London Borough of Barking & Dagenham	Stephan Liebrecht, Operational Director, Adults Care and Support
	Susanne Knoerr, Head of Service for Integrated Care
	Dr Usman Khan, Consultant in Public Health
	Rhodri Rowlands, Community Solutions
	James Hodgson, School Investment Advisor
East London Health and Care Partnership	Alison Goodlad, Head of Primary Care
	Gohar Choudhury, Assistant Head of Primary Care
GP Trainees via Health Education England	James Cook, GP Trainee Mayukh Bhattacharyya, GP Trainee
Community leads	Matt Scott, Thames Ward Community Partnership

In addition the group plan to keep the following organisations/leads briefed:

- Care City, John Craig, Innovation Partner
- NEL CSU, Danny Lawlor, NELFT contracts
- Health Education England
- BHR CEPN
- East London Health and Care Partnership
- Citizens Advice Alliance Network
- Riverside Residents Association

The framework for the model of care design

A series of five key workshops, alongside a programme of engagement with local people to feed into the development of the proposed model of care were held between September and October 2018 to ascertain key requirements of the physical building and wider Riverside environment.

The following key principles were agreed through this process and are deeding in to the design of the model of care:

- The service will be jointly procured/commissioned by B&D CCG and LBBD
- The service will be delivered by a single provider alliance through a single contract, the form of which is to be explored
- There is particular opportunity to capitalise on linking health and wellbeing services with leisure facilities, and to community assets such as education campuses e.g. the nearby Riverside Campus School, and other schools in the area
- Exploration of the GP as a point of escalation rather than the first port of call, and a universal nursing role
- There will not be a traditional GP practice with a list size, however, GPs will be key to leading the team / model of care
- Access to the leisure and community facilities will be key to the model of wellbeing and should feel part of an integrated offer, not a separate service
- The model of care should be based on the approach of 'getting it right first time' with a strong focus on Care Navigation and ensuring that local people have access to high quality information and advice
- Neutral branding will be employed (not NHS-focussed) that embodies empowerment, community and friendship to promote the concept of 'wellness' rather than a focus on illness
- The space will be as flexible as possible to ensure that it is able to adapt to a model of care that will evolve over time to meet the changing needs of local people
- There will be a strong focus on supporting local people to stay well, intervening further upstream where possible, enabled by technology and different ways of working

Our approach: Experience Based Design – The Kings Fund

Experience Based Design is described by the Kinds Fund as;

'A change method and process aimed at improving patient and staff experiences of health [and] care.'

It focusses on designing **experiences**, not just improving performance, and brings decisions around the design of health and care services back to what works best for local people, and the health and care staff delivering the interventions.

Because services are designed with the end user in mind, they are streamlined, with a strong focus on quality. This also lends itself to services which are naturally more efficient.

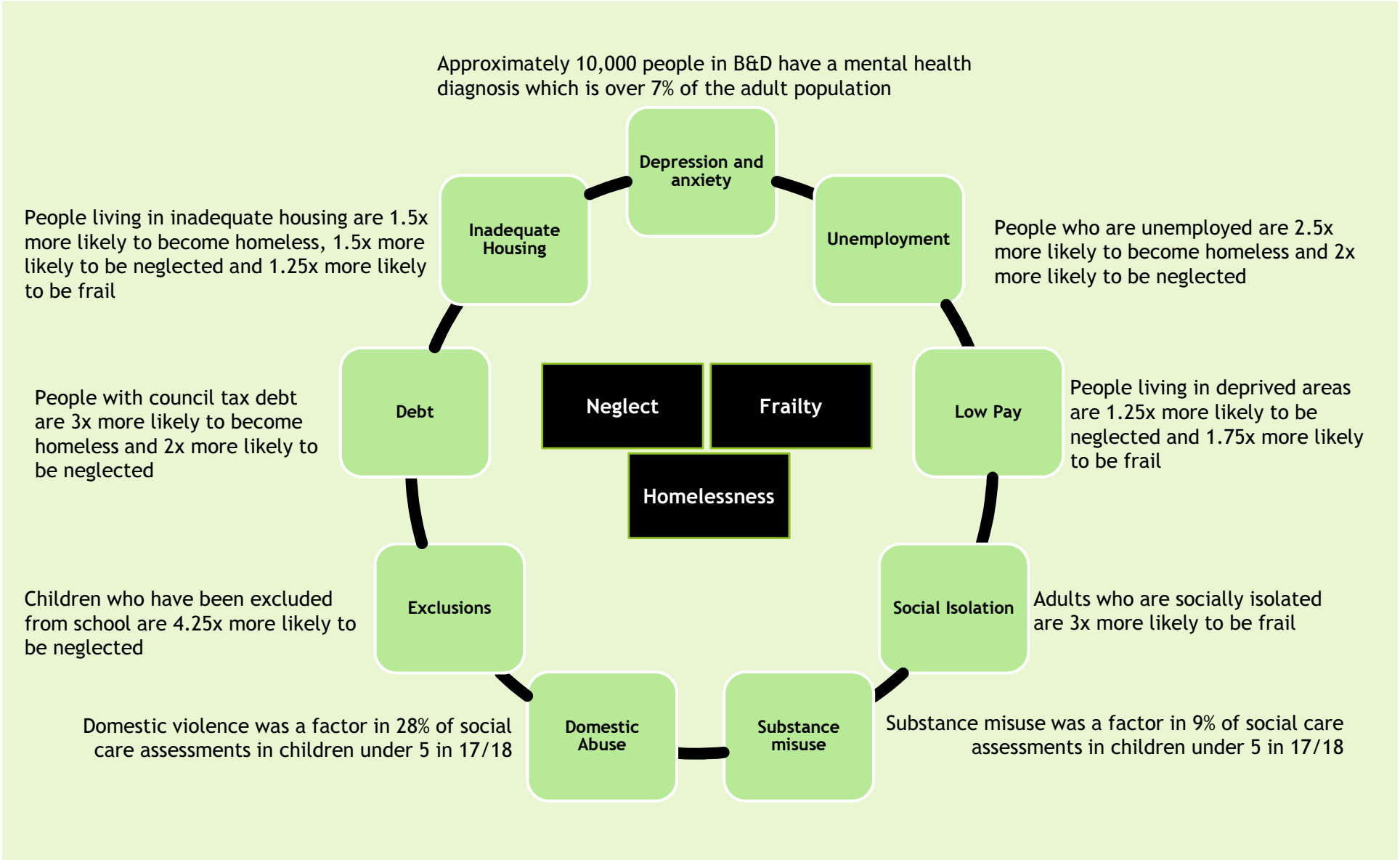
The approach to designing services is therefore;

- consider what the ideal experience of support would be to deliver the outcomes that local people want
- map the interventions that need to take place to achieve this
- map the workforce/team/services that need to be in place to deliver this

Through this approach the Model of Care group are designing what the team delivering care will look like within the framework of the principles already agreed. Personalised Care will also feature strongly.

Key information being played into the model of care design

Key information from public health, secondary and primary care data is being fed into the 'model of care' design to ensure that it will address local needs. The key statistics below are taken from Local Authority analysis on the wider determinants of health (part of the B&D Borough Manifesto work).



Key progress since our last update

- Working with Health Education England, we have identified two local GP trainees who have chosen Barking Riverside as their Quality Improvement project and will support development and design of the model of care and physical building of the wellbeing hub as part of this. Their time is fully funded by Health Education England and their perspective and input will be invaluable to embed innovation in the model of care for Barking Riverside and wider South Locality. We are continuing to brief leads at Health Education England of the progress to develop a new model of care for Barking Riverside and the wider South Locality; this will enable us to work together in the future to create tailored education and training programmes to support new roles and ways of working if it is identified that these are required to deliver the new model of care. Health Education England leads are also sharing learning with us from other areas who are exploring new and innovative ways of working.

- The 'Model of care' design group has been established to design a proposed new model of care for Barking Riverside, led by local people and health and care staff, including leads from the community and voluntary sector. This is a task and finish group, meeting monthly until the end of October 2019 at which point it is anticipated the group will have developed a clear proposal articulating what the new model of care is and how it will operate in practice. The group are taking an 'Experience Based Design' approach, described by Kings College London as 'a change method and process aimed at improving patient and staff experiences of health [and] care.' It focusses on designing experiences, not just improving performance, and brings decisions around the design of health and care services back to what works best for local people, and the health and care staff delivering the interventions. Because services are designed with the end user in mind, they are streamlined, with a strong focus on quality. This also lends itself to services which are naturally more efficient. Input from local people will be key to this process and the group are using case studies (**see appendix one**) based on real experiences of those living in the area, to begin to design optimum experiences and pathways. The outputs and proposals from this group will be robustly tested with local people.

Key progress since our last update

- North east London and Barking and Dagenham, Havering and Redbridge (BHR) Primary Care Leads developed a paper to explore contracting options for the proposed new model of care for Barking Riverside. The paper was reviewed at the BHR Primary Care Commissioning Committee on Wednesday 17th April 2019 who agreed that, in line with the recommendation of the paper, an Integrated Care Provider contract should be **explored** for the Barking Riverside new model of care. A working group has been convened to explore the financial modelling for the health element of the model of care, which will include updated detail of the ramp up of the population in the area, to inform which contracting model is used.

- Through the course of partnership discussion around a new model of care for Barking Riverside, workforce has been clearly identified as a key enabler and the multidisciplinary leads involved in the discussion have identified opportunity to link with local schools to promote careers in health and care. We will continue to explore further opportunities to promote careers in health and care with local children and people, and to work together to find strategic, integrated solutions to some of the biggest challenges we are facing.

Next steps

- Continue to develop/design a new model of care for Barking Riverside through the Barking Riverside New Model of Care Design Group, working closely with local people.

- Establish the key groups described in this update, following the 'creating a thriving Thamesward' workshop on the 25th April, to drive forward the programme of work at pace.

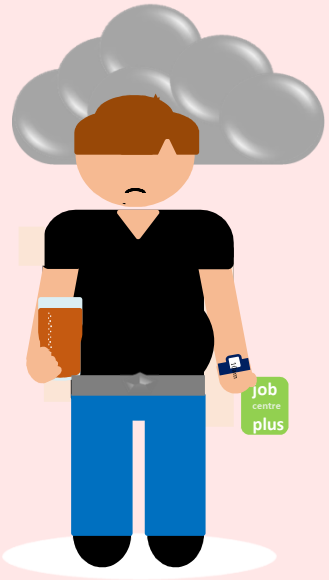
- Receive and discuss/respond to feedback from the Developer on the Single Client brief at the 'South' locality boar, and progress agreed next steps following the first meeting on 25th September 2019

- Work with North east London and Barking and Dagenham, Havering and Redbridge (BHR) Primary Care leads and contracting leads, alongside finance leads via the newly established working group to explore the financial modelling for the health element of the model of care, which will include updated detail of the ramp up of the population in the area, to inform which contracting model is eventually adopted for the health and care element of the new model of care

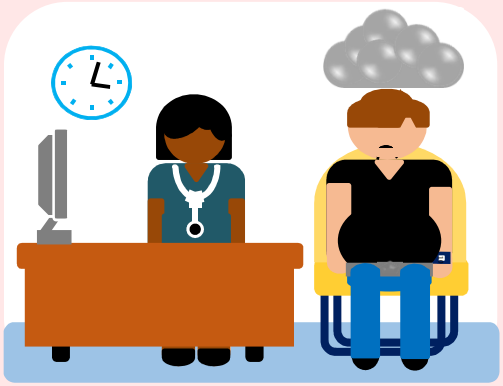
Appendix one
Experience Based Design Case Studies

Case study one: Bob

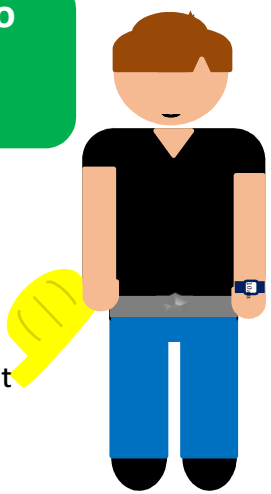
- 45 year old Bob was made redundant in 2015
- Despite looking, has struggled to find work
- He has become less active and put on weight
- He has started drinking every evening
- Bob feels depressed about his situation and doesn't know who to speak to for support. He feels embarrassed to speak about how he is feeling with his family and friends



- Bob visits his GP because he feels depressed
- His GP really wants to help but cannot get to the route of Bob's depression within a 10 minute appointment
- The GP suggests that Bob cuts down his drinking and exercises more but Bob doesn't feel in the right frame of mind to achieve this on his own
- Bob's GP isn't aware of local services that could help in this situation, or how to refer him for support



The outcome that Bob really wants is to feel happy again; he feels that if he is able to get back to work, and find an outlet to socialise that doesn't involved drinking, this would have a big impact on his wellbeing.

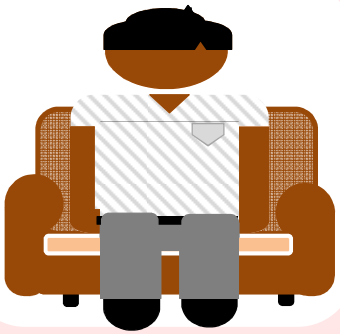


CONSIDER:

- What are our opportunities to support Bob to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Bob be identified for support/intervention at the RIGHT time before things get worse? Can he self refer? What if it's not in his nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for Bob? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study two: Parvinder

- Parvinder is 30 years old
- He is in severe financial difficulty and relies on short term loans, often struggling to keep up with repayments
- Pavinder is very embarrassed about the situation and hasn't even told close family and friends
- The stress of being in significant debt is taking a toll on Parvinder's emotional and physical health and is beginning to impact on his relationships and ability to work



- Parvinder has been to see his GP as he feels very anxious all the time and is having trouble sleeping; he has even had to take some time off of work due to feeling on the brink of a nervous breakdown
- His GP signed him off of work for a number of weeks to recover, but Parvinder didn't have time to go into the details of the cause of his stress during his consultation

Parvinder really wants support and guidance from a confidential and trusted source so that he can see a way out of his debt situation which will significantly alleviate his stress levels.

CONSIDER:

- What are our opportunities to support Parvinder to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Parvinder be identified for support/intervention at the RIGHT time before things get worse? Can he self refer? What if it's not in his nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for him? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study three: Amanda

- **Amanda is 85; up until a year ago she had a voluntary job in a local school library which she loved, and an active social life**
- **Amanda's only relative, her niece, lives 2+ hours away and she has always lived alone**
- **Amanda's friends notice a significant decline in Amanda's functional mobility, but don't know how to address this with her. It's possible she has stopped drinking as much water and due to feeling lightheaded, hasn't been walking as much as she used to**

- **Following an initial fall and 2 month stay in hospital, Amanda has a series of falls over a period of six months, visiting hospital numerous times**
- **Eventually Amanda is transferred to a nursing home**
- **Amanda's condition deteriorates significantly following admission to the home and it becomes apparent that she may be entering the last six months of her life**
- **Amanda is having significant difficulty breathing and the home dial 999**
- **Amanda is transferred to hospital via ambulance**
- **Amanda spends 10 weeks in hospital and eventually passes away there**

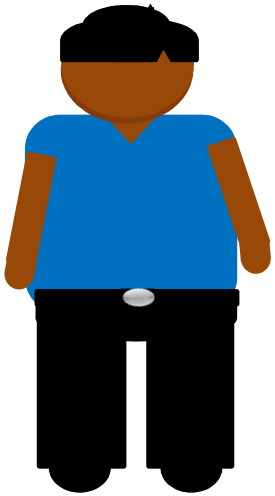
The intervention that Amanda really wanted was support when she started to forget to drink enough water and her mobility was beginning to decline. This would have supported her to remain independent, at home for longer. When she did reach the last six months of life, her preference would have been to die peacefully at home.

CONSIDER:

- What and where were the opportunities to support Amanda earlier in her journey to give her the outcomes that she wanted?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How could Amanda be identified for support/intervention at the RIGHT time before things get worse? Can she be supported to self refer? What if it's not in her nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for Amanda?
- What are our requirements of the key enablers e.g. workforce and IT?

Case study four: Amit

- **Amit is 15 years old**
- **He has experienced bullying at school which focussed on his weight, and he feels like he doesn't have many friends**
- **Amit never goes out after school or at the weekends and playing computer games is his main hobby**
- **Amit has never been to see a dentist and sometimes experiences tooth pain**



- **His teachers and friends don't know that Amit is a child carer for his mother who had a stroke when he was 12 related to her diabetes**
- **She finds it difficult to mobilise and carry out tasks so Amit helps her with cleaning, cooking, and other household chores, including helping her to move around and put her shoes on etc.**
- **Amit is continuing to be physically inactive and his BMI is increasing each year**
- **He is falling behind with his studies because he feels tired all the time and struggles to find time to support his mother as well as do his homework every evening**

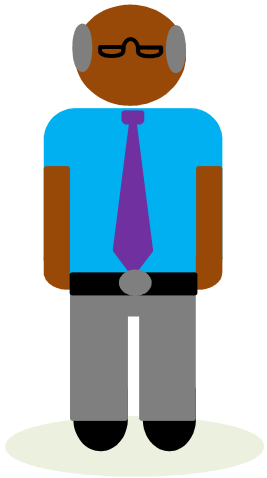
The outcome that Amit wants is to have support to care for his mother, giving him more time to explore opportunities to increase his physical activity

CONSIDER:

- What are our opportunities to support Amit to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Amit be identified for support/intervention at the RIGHT time before things get worse? Think of the people in his life who may spot that he is struggling. What do we need to have in place to enable early referral/intervention at the right time for Amit? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study five: Abel

- **Abel is 60 years old**
- **He has a number of long term conditions but is struggling to manage his COPD**
- **Because of his COPD, he finds it very difficult to walk and doesn't get out of his flat much**
- **He feels very lonely; his son has moved out of the country for work and Abel now only sees him about three times a year**
- **Abel's wife also has a long term condition and Abel tries to support her as much as possible as her mobility is more limited than his**
- **Abel's wife receives a care package of two visits a day in the morning and evening but may need an increase in visits due to her increasing needs**



- **Abel's COPD exacerbations are getting worse and in the past year he has had to call an ambulance three times**
- **On one occasion he was admitted to hospital for two days**
- **He is feeling very stressed about the impact this is having on his wife and the amount of support that he can give her**
- **He fears for the future for him and his wife and doesn't want to be separated from her, particularly if she has to be transferred to a care home which neither of them want**

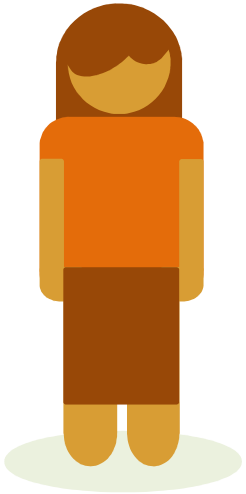
The outcome that Abel wants is to be supported to manage his COPD and maintain his independence at home. He would like some support to look after his wife, and would love to be able to be able to go out, particularly to socialise if there was the opportunity.

CONSIDER:

- What are our opportunities to support Abel to achieve the outcomes that he wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Abel be identified for support/intervention at the RIGHT time before things get worse? Can he self refer? What if it's not in his nature to seek help? What do we need to have in place to enable early referral/intervention at the right time for Abel? In practice; what will the 'front door' to the service look like?
- What is our list of requirements of the key enablers e.g. workforce and IT?

Case study six: Lena

- **Lena has a 2 year old child**
- **English is not Lena's first language and she struggles to converse in English at the moment although she is trying to learn more**
- **Lena recently moved to the UK/B&D, and doesn't have any family or friends who live close to her**
- **Lena is unsure where to go for advice or the process to get support, and isn't aware of the support she is eligible for**
- **Lena is not currently registered with a General Practitioner**
- **Lena lives in a rented flat**



- **Lena has attended the ED at KGH three times this year with her child when they became unwell; each time upon investigation in the ED, her child has been found to have an ambulant condition that could have been addressed through her local pharmacy or by calling NHS 111**
- **Lena may not be aware that she can register with her local GP and book an appointment, or that she can call NHS 111 for information and advice, see her local pharmacist, or take her child to an Urgent Care Centre**
- **Lena may also not be aware of the wider support and services that she may benefit from accessing**

The outcome that Lena really wants is to understand what services and support are available to her and the best place to take her child when she is unwell. She would also love to build her social network and make new friends, particularly with other young mothers.

CONSIDER:

- What are our opportunities to support Lena to achieve the outcomes that she wants?
- What do we need to build in to the model of care to achieve this? What roles/competencies are required? Do we have these within the current workforce / community or is this something that we need to build in/develop?
- How will Lena be identified for support/intervention at the RIGHT time before things get worse? What do we need to have in place to enable early referral/intervention at the right time for Lena?
- What is our list of requirements of the key enablers e.g. workforce and IT?