Community Services Alliance

TOWER HAMLETS TOGETHER

Delivering better health through partnership

Presentation to Overview & Scrutiny Committee

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TOWER HAMLETS GP CARE GROUP thcvs Council for Voluntary Service NHS Barts Health NHS Trust East London NHS Foundation Trust Tower Hamlets Clinical Commissioning Group

Barriers to meeting Population need that we are trying to address

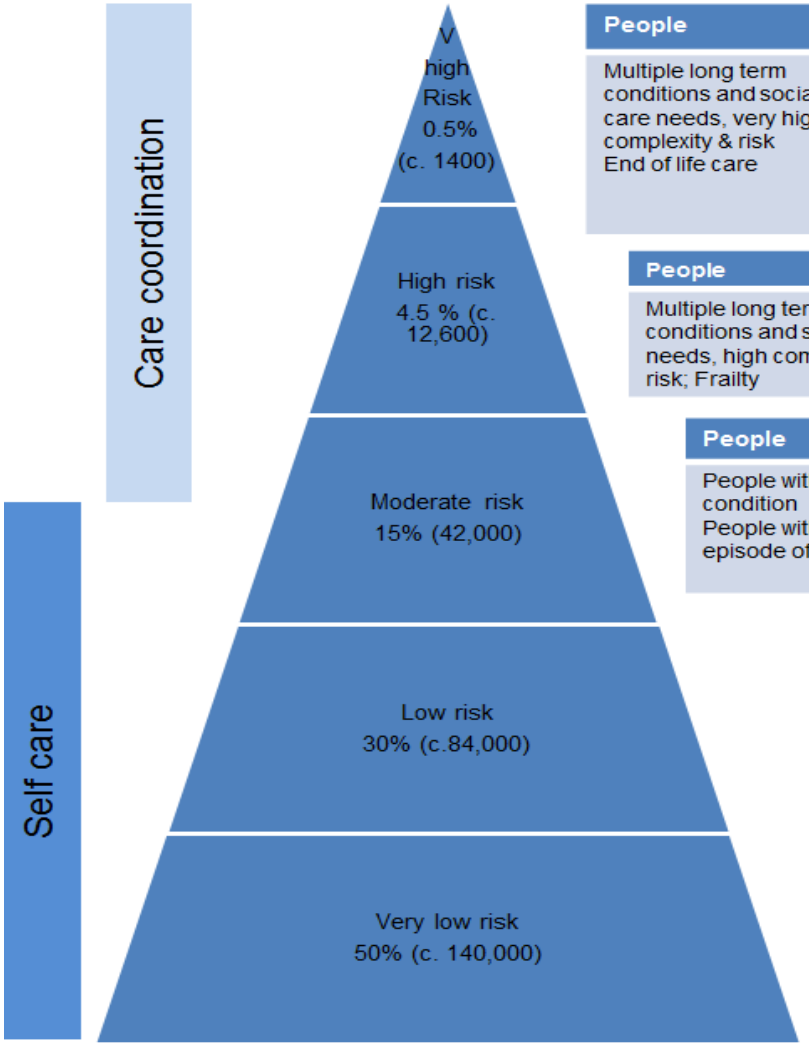
Challenges we face:

- **Siloed workforce** with separations between the staff working for the different services getting in the way of integrated working and a unified culture
- **Siloed organisations** with different ownership, payment mechanisms and regulators leading to misaligned incentives and targets, and causing fragmented delivery from front-line staff
- **Insufficiently integrated IT systems and limited access to data** meaning staff can't access the information they need
- **Separate budgets** by provider/ care areas meaning we don't get the best value from our allocation of resources and efforts are duplicated
- **Disjointed transformation efforts** not aligned where the need is greatest
- **Inflexible contract mechanism** meaning limited ability to drive change within an annual cycle
- **Funding is limited and diminishing** while the needs of our population are growing

Population experience:

- People tell their story multiple times, and experience a **fragmented patient journey**
- 60% of **people die in hospital**, despite most wanting to die at home
- **High death rates and morbidity** related to long term conditions, premature death rates from cancer among highest in country
- Unnecessarily high rates of **acute hospital admission**, especially A&E
- There are **large variations** in the quality of care received even in the same setting
- **50% of children are malnourished**
- Inefficiencies in the system result in **additional burden and waste to the taxpayer**

Model of care for adults with complex needs



People	Process	Typical Interventions	Typical CC
Multiple long term conditions and social care needs, very high complexity & risk End of life care	MDT assessment Care plan Allocated care coordinator Review Rapid Response	Case management Person centred care planning Tertiary prevention Carer support Social prescribing	Professional lead, e.g. DN, RMN etc.

People	Process	Typical Interventions	Typical CC
Multiple long term conditions and social care needs, high complexity & risk; Frailty	Care plan Review Care navigation	Tertiary prevention Person centred care planning Carer support Self-management; social prescribing	GP

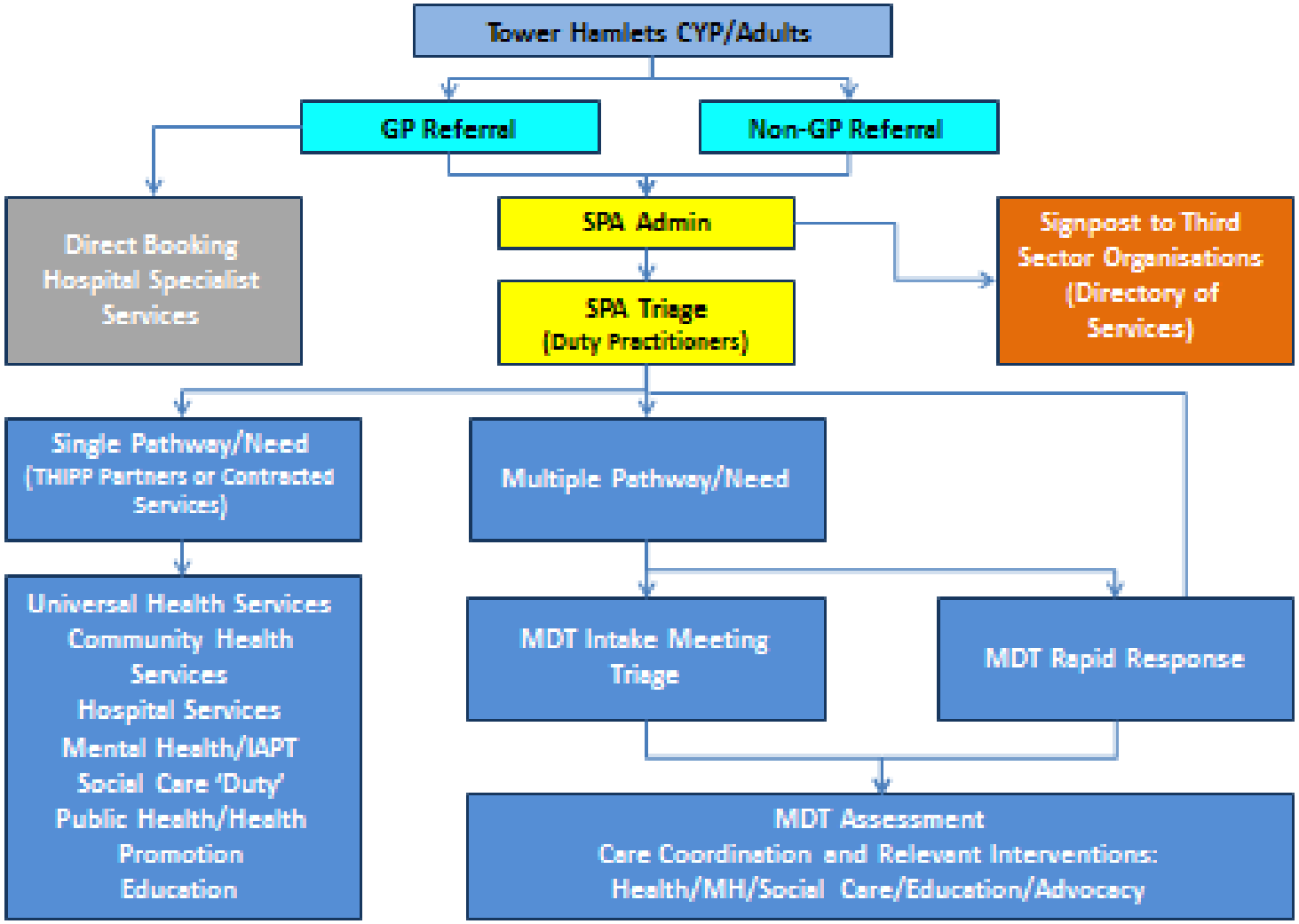
People	Process	Intervention	Typical CC
People with one long term condition People with a single episode of care	Care plan Review	Secondary prevention Self-management Social prescribing	GP

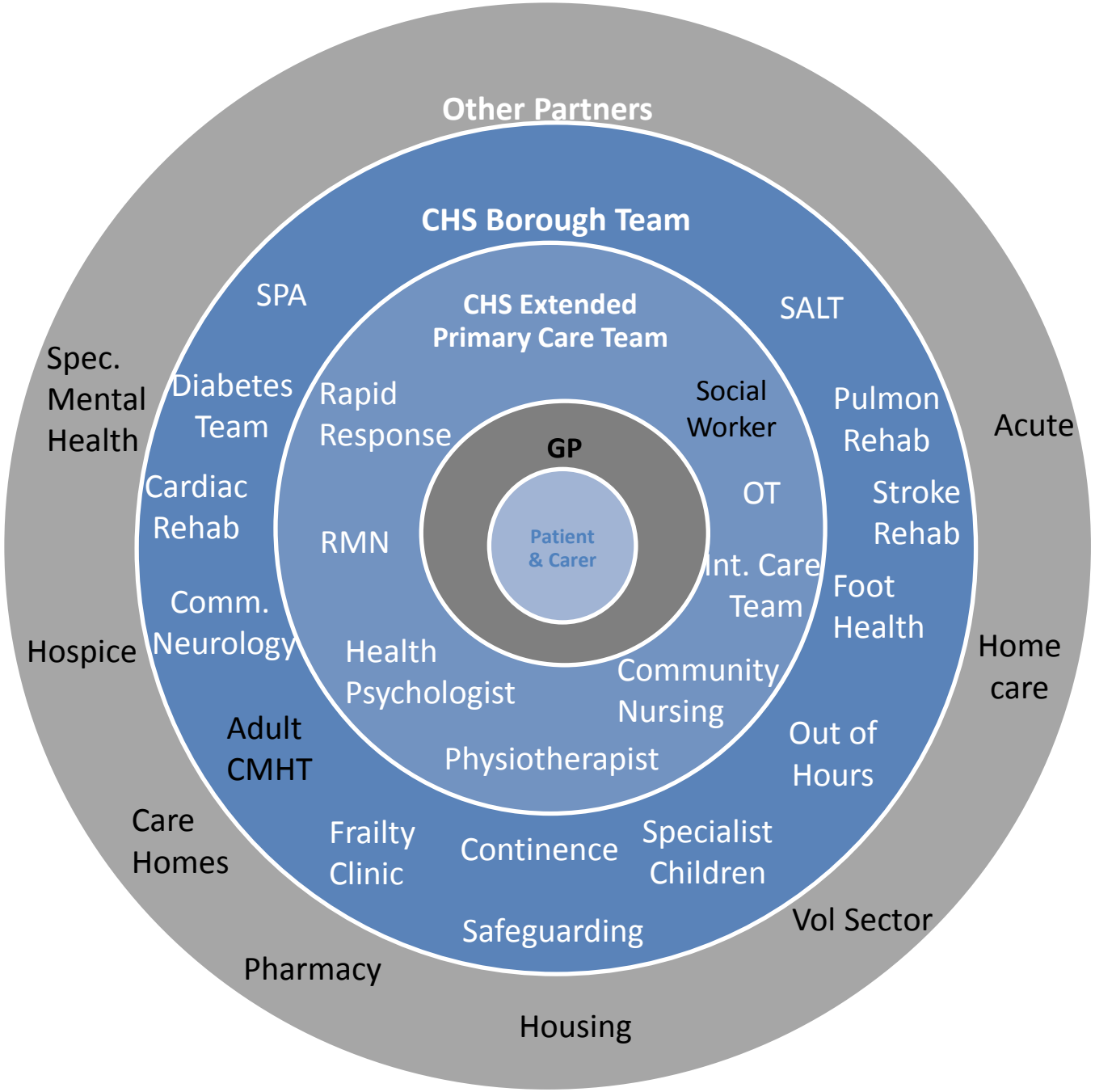
People	Process	Typical Intervention
People with risky lifestyle factors	Self care	Primary prevention Social prescribing

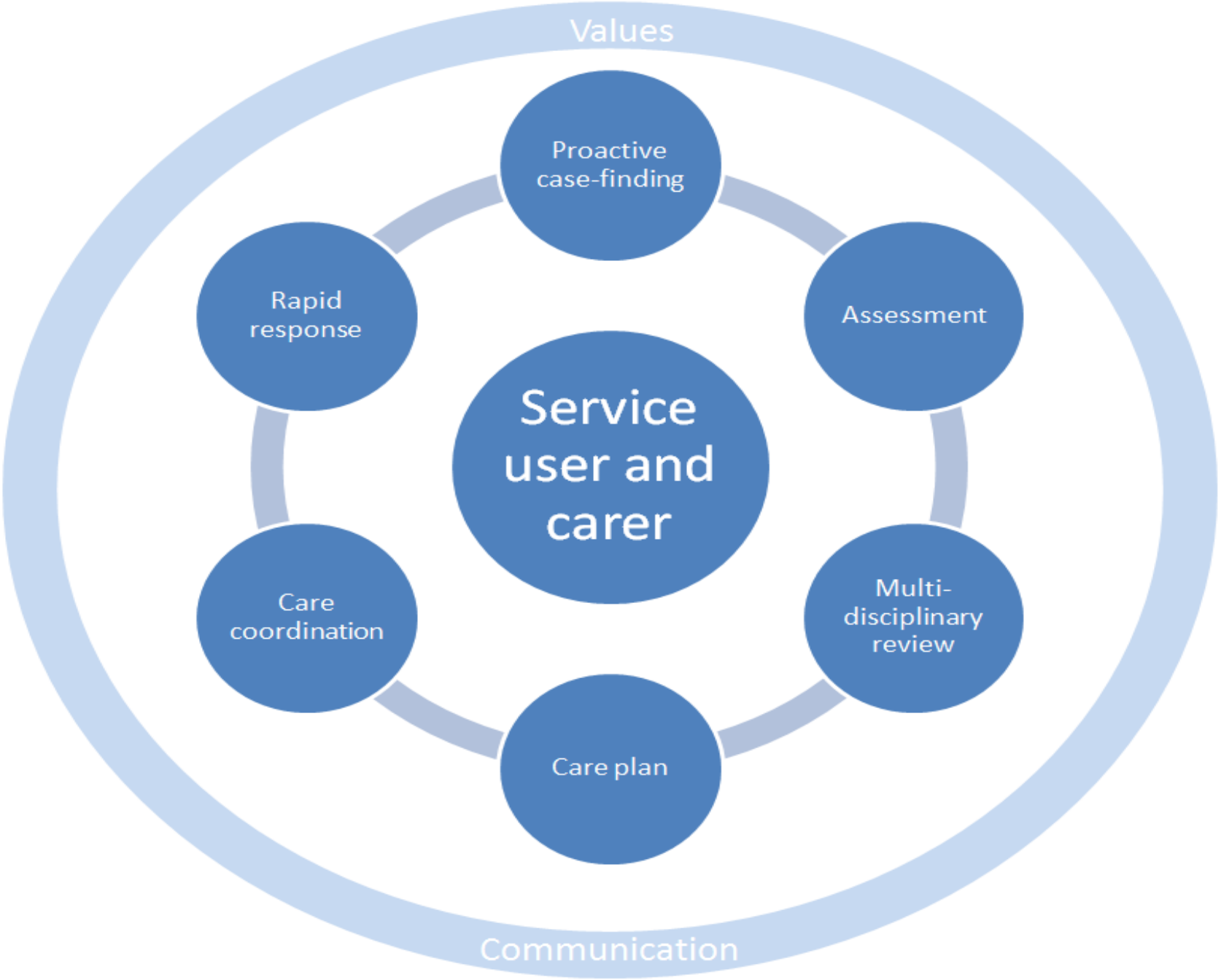
The delivery model

- A single point of access for all health and social care services
- Extended “whole person care” primary care teams
- A new integrated community rehabilitation service
- A new rapid access integrated frailty assessment service
- A new model for complex children’s services, provided from one site, with the aim of developing a comprehensive integrated delivery model for children
- Specialist services for adults working across acute and community
- IT that works, with mobile working fully rolled out
- Promoting prevention and self-care, including through social prescribing and a wellbeing hub.

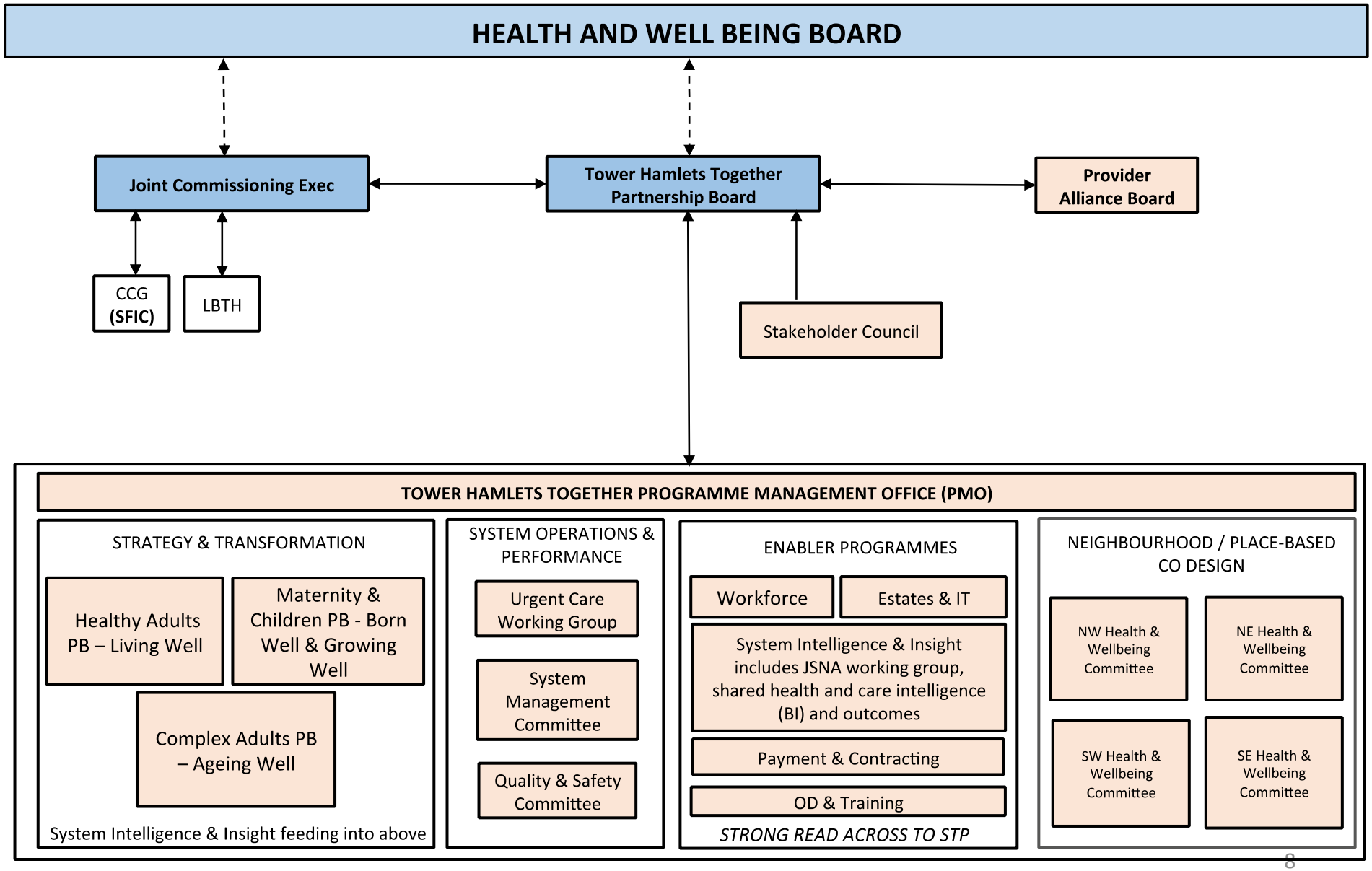
Single Point of Access Pathway



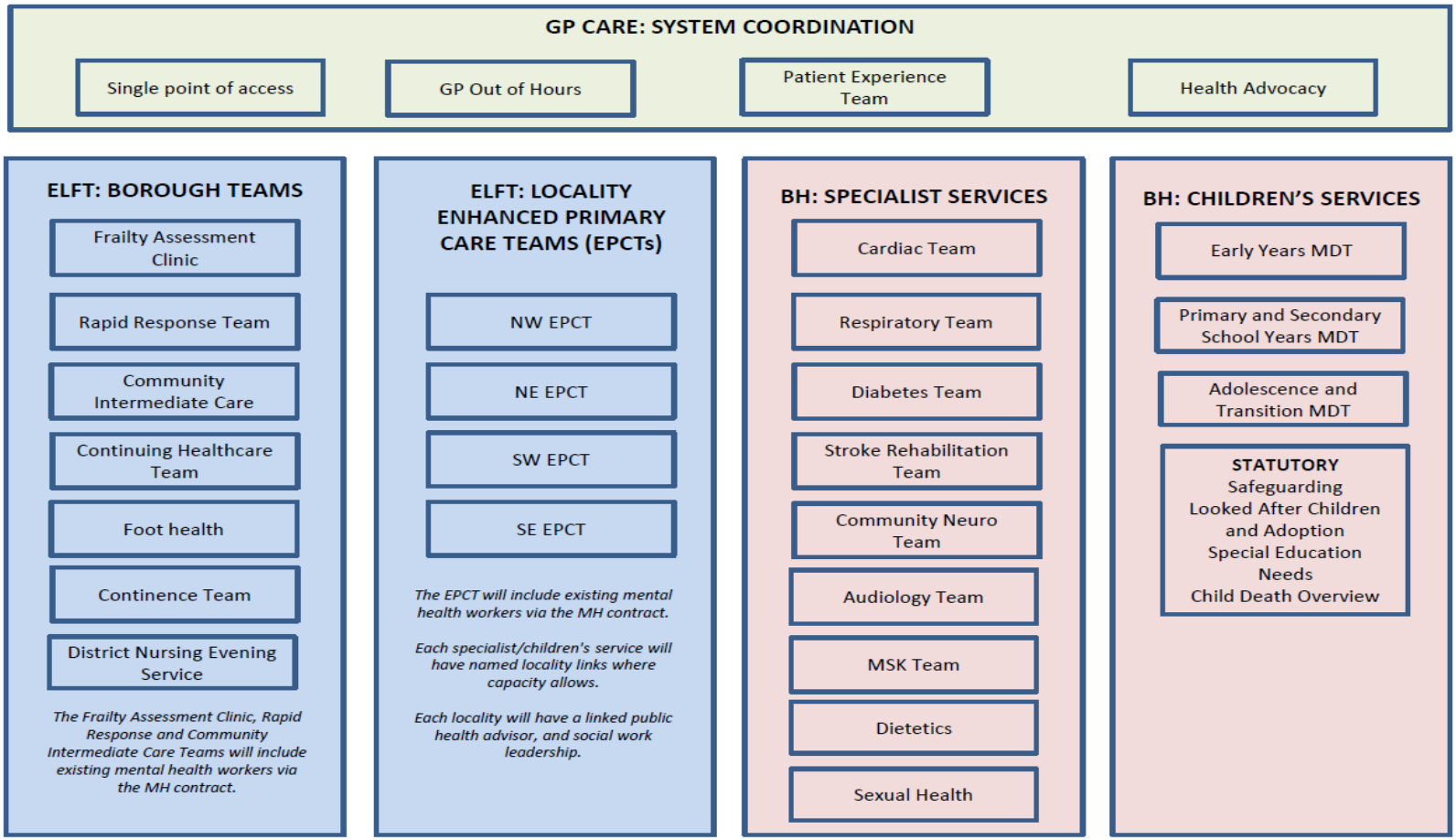

Other Partners
CHS Borough Team
CHS Extended Primary Care Team
GP
Patient & Carer
SPA
SALT
Spec. Mental Health
Diabetes Team
Rapid Response
Social Worker
Pulmon Rehab
Acute
Cardiac Rehab
OT
Stroke Rehab
RMN
Int. Care Team
Foot Health
Comm. Neurology
Hospice
Health Psychologist
Community Nursing
Home care
Adult CMHT
Out of Hours
Physiotherapist
Care Homes
Frailty Clinic
Continence
Specialist Children
Safeguarding
Vol Sector
Pharmacy
Housing


Values
Proactive case-finding
Assessment
Multi-disciplinary review
Care plan
Care coordination
Rapid response
Service user and carer
Communication

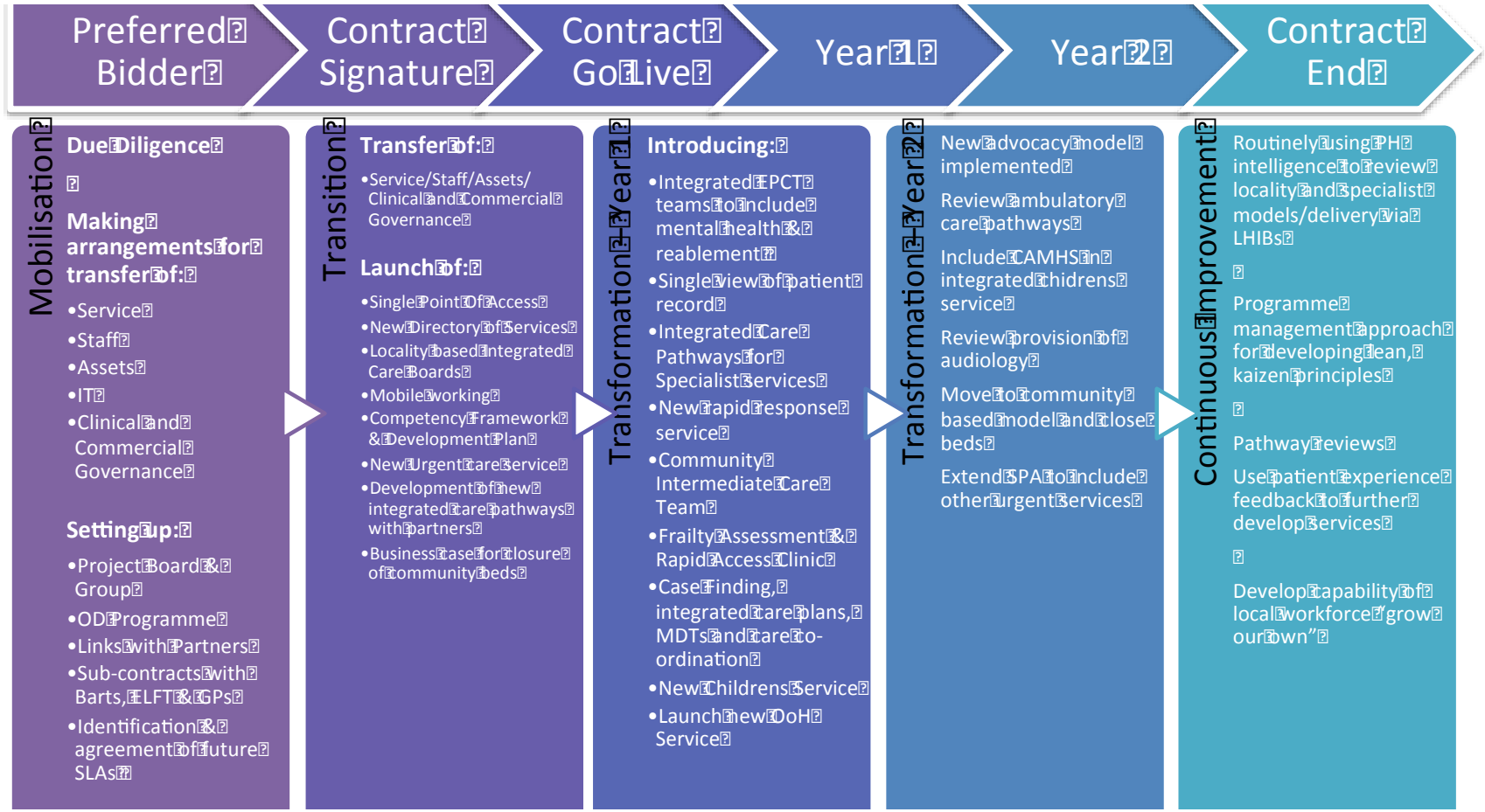
Tower Hamlets Together Operating Framework 2017-18



Alliance Partner Responsibilities



Transformation plan



Impact

- Greater support for self management
- Improved links with community services and more patients managed in the community
- Change in staff bases, rationalisation of desks/offices, mobile working
- Patients have greater influence in service design and delivery
- More responsive support to avoid admission
- Care co-ordination – identified care co-ordinator, joint MDTs, shared care planning
- Increased role of Locality Boards to plan & manage local population health

Contract Structure and Payment

- The contract is for 5 + 2 years.
- GPCG, Barts Health and ELFT all have contracts directly with the CCG for the elements they deliver.
- There is an Alliance Agreement and an Alliance Board comprising of the three providers and the CCG.
- GPCG is the Alliance Manager and has a co-ordinating role to support the delivery of the model and the associated outcomes.
- The contract is outcomes based with 5% increasing to 25% of the contract value dependent on the achievement of a range of PROMs, PREMs and process based proxies for outcomes

Next steps - emerging plans to expand the alliance (1)

- The CHS alliance arrangements were a pragmatic answer to issues arising in the mobilisation and due diligence of the CHS contract, that meant a prime provider model was not deemed sustainable
- The alliance is in effect an overarching contract/MOU that sets expectations and rules as to how the GP Care Group, Barts and ELFT, and the CCG, work together to deliver the CHS contract
- One benefit of an alliance model is that it can be flexed in terms of scope and scale with agreement of all parties.
- Tower Hamlets Together has explicitly recognised that this could provide the basis upon which an accountable care system of provision could be based

Next steps - emerging plans to expand the alliance (2)

- The current alliance contract oversees the delivery of CHS only
- The CHS bid and emergent service model is explicit about the links it must have with other providers and services in order to deliver high quality community based integrated care for Tower Hamlets residents
- This is in line with a long standing strategic objective of the CCG and LBTH to achieve greater integration of services
- The CCG currently has limited levers to achieve this in the short to medium term for other CCG commissioned services (procurement), and no levers for health and social care integration
- An alliance model allows for services and budgets to be included in the alliance, whilst maintaining the existing bilateral arrangements with the CCG
- The THT Board allows for joint strategic planning but is not a vehicle for integrated delivery of services. The alliance could provide that.
- It is clear from emerging national policy that there is an accelerated move towards a) health and social care integration and b) the development of accountable care