



# Integrated Health and Social Care

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# Context

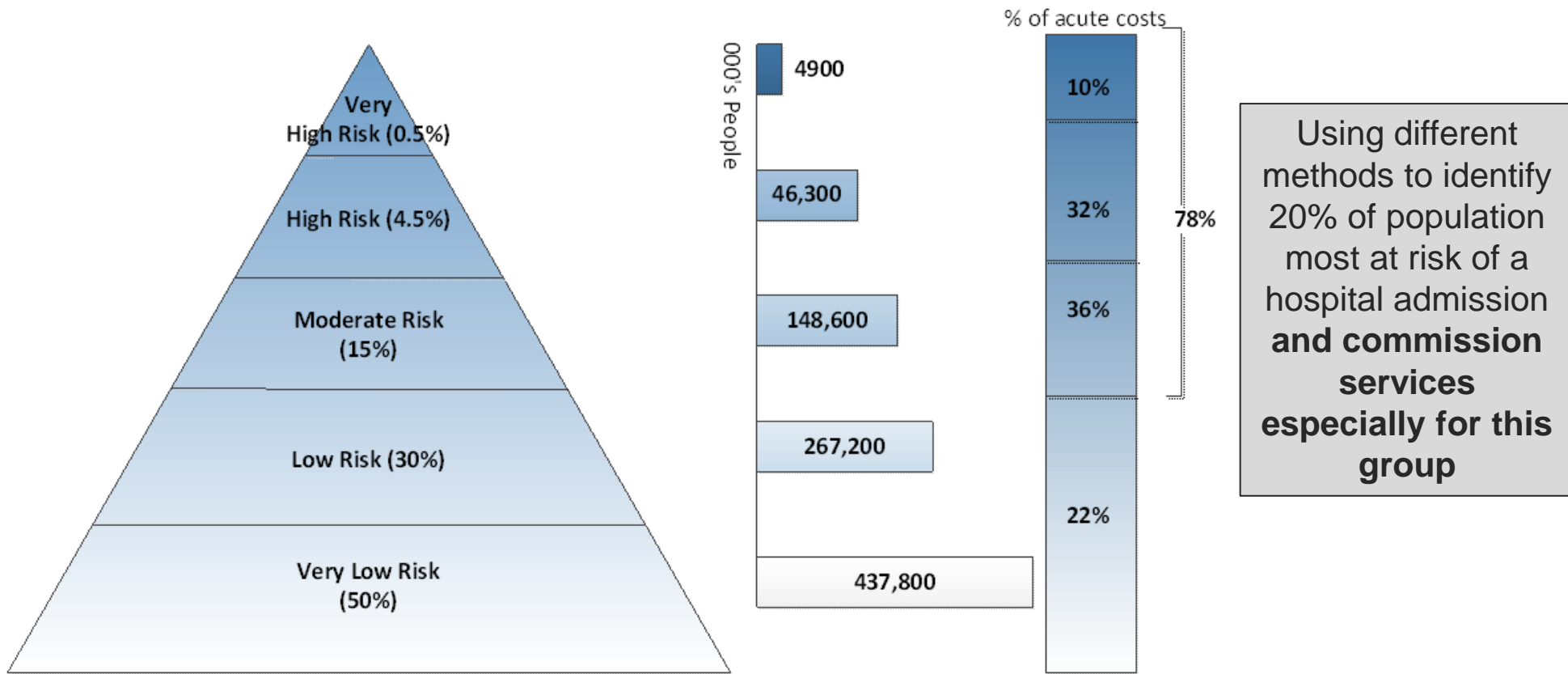
- Rising population across East London and Tower Hamlets in particular
- Spending restrictions in Health, long term deficits in Barts Health. CSR likely to be challenging
- Large reductions in council budgets, including social care
- Need to continue to improve outcomes for our citizens, whilst exploring transformation, efficiency and integrated services

# What is Integrated Care?



“My care is planned with people who **work together** to **understand** me and my carer(s), **put me in control**, co-ordinate and deliver services to achieve my **best outcomes**”

# Who are we targeting for integrated care ?



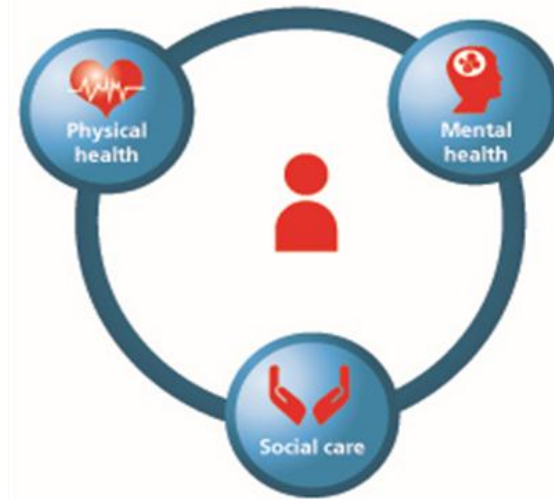
Using different methods to identify 20% of population most at risk of a hospital admission and commission services especially for this group

Moving to a focus on:

- outcomes for population health,
- new models of care (e.g. Tower Hamlets Integrated Provider Partnership (THIPP))
- Improving how we pay for services to encourage better care, rather than just more care

# Integrated Care Programme

We want to deliver at scale and pace to achieve radical transformation across WELC



## By shaping the local health economy around the patient

- Using National Voices principles to embed patient-centred care focusing on patients needs and preferences
- Proactively manage people's care, responding rapidly to crises, avoiding emergency admissions and residential care where possible
- Ensuring most effective use of care resources and avoiding duplication

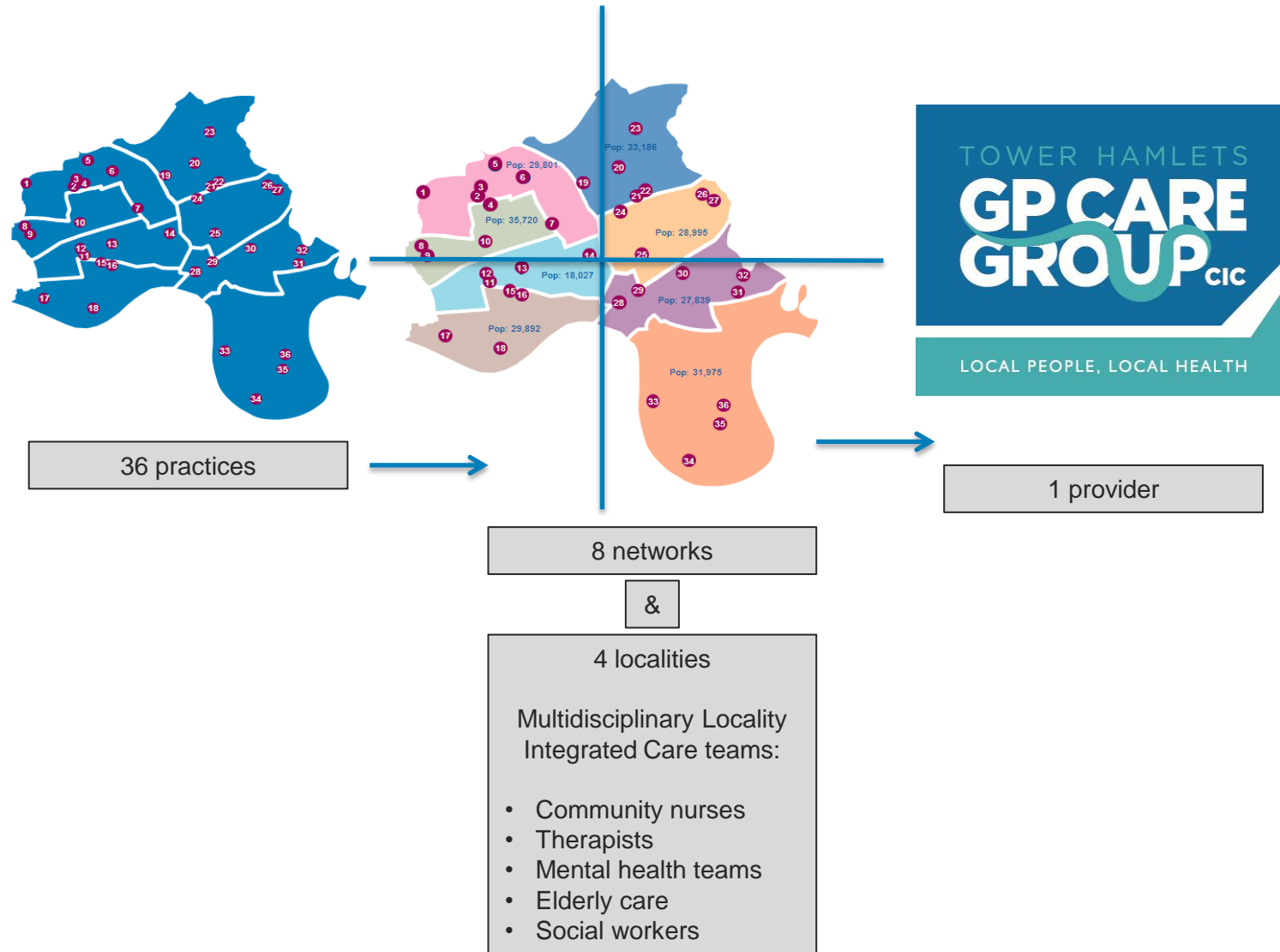
## By changing behaviours across the system

- Supporting staff to work together across organisational boundaries
- Helping people to feel empowered and supporting self care
- Enabling people to stay socially active and live independently
- Aligning our commissioning intentions across health and social care

## By developing the provider landscape

- Taking a whole system approach to change, using technology to deliver effective and timely care
- Aligning incentives and payment structures for providers to take ownership for system-wide outcomes
- Developing system wide performance measures and feedback mechanisms to support continuous improvement

# Creation of one primary care provider



## The “Integration Function”

- Developed in 2013/14 as a way of assuring the CCG that providers are able to work together
- Arranged around a number of key principles:
  - Clinical governance and shared standard operating procedures
  - Clear joint work on operations, pathways, SOPs and resilience
  - Joint communications and engagement
  - High quality and shared data and reporting
  - Development of shared care record

# Tower Hamlets Integrated Provider Partnership (THIPP)

## Four partners

Formed in 2013, initiated by the CCG to deliver integrated care

- TH GP Care Group - Primary care
- Barts Health – Community Services and Acute Care
- East London Foundation Trust – Mental Health
- London Borough of Tower Hamlets - Social Care & Public Health

Develop further links with:

- Housing,
- Education
- Third sector

## One vision

- Working in partnership to deliver seamless care to patients, carers and their families
- Care will be patient led and well coordinated to make a real positive impact
- Services will be provided in the right way, in the right place and at the right time
- Provide services in the homes of patients and service users (when possible) and in community, hospital or other locations (when necessary)

## Partnership delivery

Already established

- Networks delivering Primary Care
- Community based specialist support
- Integrated health and social care teams
- Strong desire for quality improvement
- Commitment to the Integrated Care programme

Developed programmes of work

- Awarded “Vanguard status” by NHS England
- THIPP bidding to run Tower Hamlets Community Health Services
- TH GP Care Group successful in Prime Ministers Challenge Fund to improve primary care access

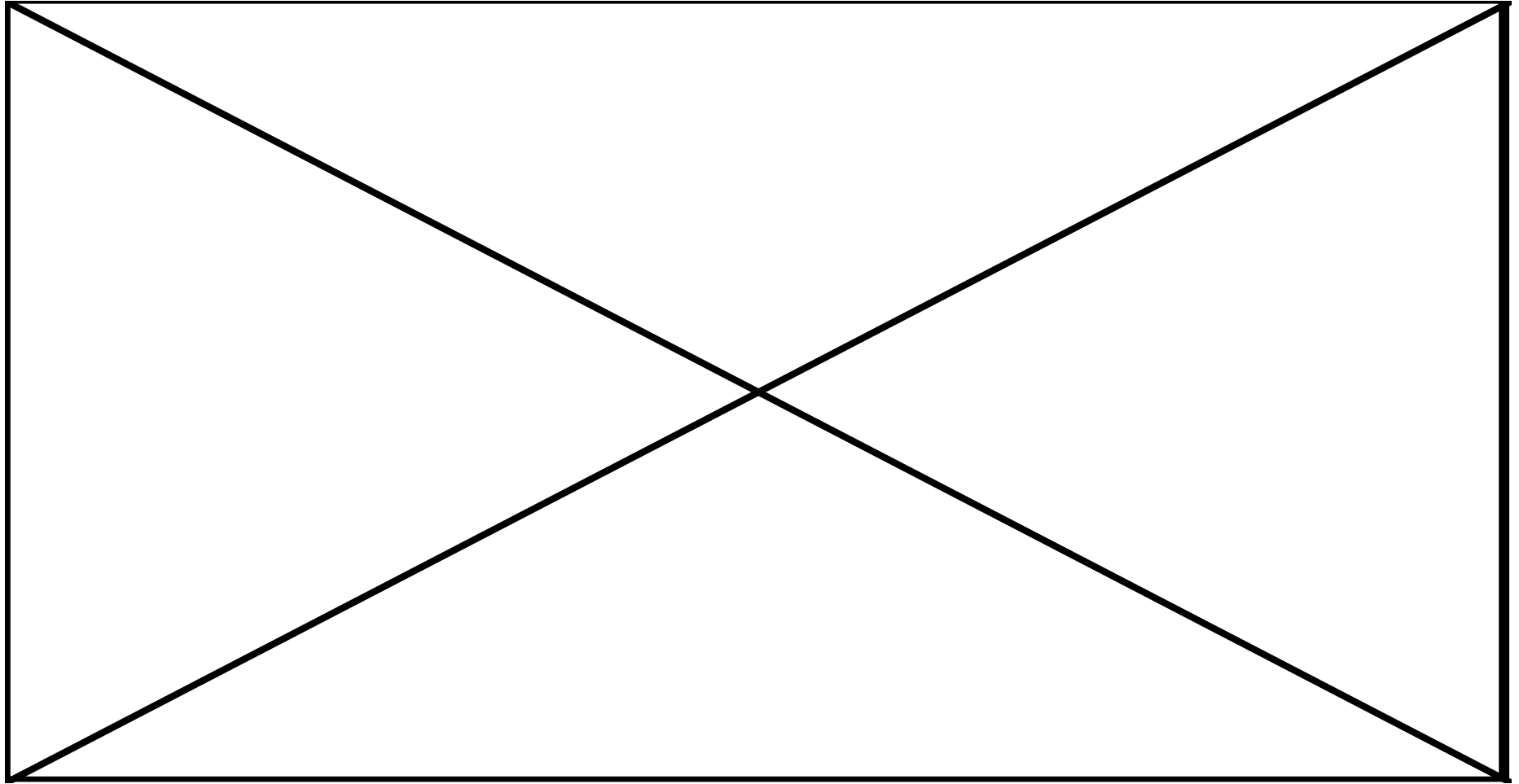


# What will this mean for patients?



<https://www.youtube.com/watch?v=cdFk5AJCJB4>

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# Case Studies

## Community Health Team (Social Care Input)

- Expansion of existing integrated Community Health Teams in Tower Hamlets.
- It seeks to improve the experience and outcomes for those with long term conditions and aims to offer assessment and support to carers
- 10 social workers deployed to cover the Integrated Care Cohort
- At least one named social worker for each locality, working within a multidisciplinary team
- The social workers give information and advice to Community Health Team colleagues regarding Social Care



## Hospital Social Work Team

- Extension of the hospital discharge team at the Royal London Hospital from a Monday to Friday to a 7-day service, 9am to 8pm
- Social work staff assist the assessment and discharge of patients on acute wards
- The service provides multidisciplinary assessments, which avoid unnecessary admissions to acute wards. Social workers within the Acute Assessment Unit (AAU) and ED aim to respond to referrals within the hour.
- During the first year of operation (since 25 November 2013), the service prevented 703 unnecessary admissions to acute beds.

# Case Studies

## Community Geriatrician

- Multidisciplinary visits with nurses, GPs and physios etc
- Proactive monitoring to minimise hospital admission
- Accessible by mobile phone and email used mainly by GPs and care navigators
- Provide follow-up to people identified by the Hospital Ward Team
- On call in the hospital and provides cover on the acute wards
- Education to new consultants on elderly care



## IT Integration

- Information sharing agreements signed by Barts, ELFT, LBTH, Primary Care
- Interfaces creating a single view of the individual's record with Barts Health, Primary Care, Social Care and Mental Health
- Interim Crisis Plan being developed
- Prototype in South West Locality (8 GP practices) User acceptance testing planned 9<sup>th</sup> December 2015
- Go-live in the South West Locality with 8 GP practices scheduled for 24<sup>th</sup> December 2015



# Key successes so far

- 8812 people enrolled onto Integrated care
- 4,842 (54%) people have a care plan<sup>(1)</sup>
- # of avoided A&E attendances over the last 2 years
  - 14/15 : 2088
  - 15/16 : c1000 forecast
- 3790 avoided admissions over the last 2 years<sup>(1)</sup>
- # of professionals embedded within the community teams
  - 8 additional social workers, support by Head of Service
  - 4 additional mental health professionals, supported by a consultant psychogeriatrician
  - 1 consultant community geriatrician
- £5.1m saved for the local health and care economy over the last 2 years
  - 14/15 : £3,527,081
  - 15/16 : £1,554,318 planned

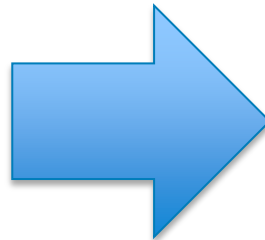
Note (1) : Activity covers period August 2013 to July 2015



# Joint Commissioning Development


Currently have a number of joint commissioning arrangements:

- Better Care Fund – focused on services supporting adults with complex needs, and reducing demand for emergency care
- Learning Disabilities
- Mental Health
- Substance Misuse
- Children
- Public Health



Joint commissioning review:

- Review jointly held objectives
- Review of current partnership arrangements
- Examine additional opportunities
- Make recommendations for future joint commissioning arrangements



**Thank you**

**Questions?**