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 the 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

Tower Hamlets Clinical Commissioning Group
Creation of one primary care provider

36 practices

8 networks

1 provider

4 localities

Multidisciplinary Locality Integrated Care teams:

- Community nurses
- Therapists
- Mental health teams
- Elderly care
- Social workers
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 9th December 2015
- Go-live in the South West Locality with 8 GP practices scheduled for 24th December 2015
Key successes so far

- 8812 people enrolled onto Integrated care
- 4,842 (54%) people have a care plan\(^{(1)}\)
- # 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\(^{(1)}\)
- # 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

\(^{(1)}\) 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?