

Overview of Integrated Care Agenda Tower Hamlets

John Wardell
Programme Director of Integrated Care

Overview and Scrutiny Committee

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NHS
Tower Hamlets



Overview

- Local needs and priorities for borough
- Polyclinic/polysystem plans
- Enabling changes in acute care
 - Admission prevention
 - Discharge support
 - Children's services
- Local engagement

Local Needs

By demographics ...

- 4th most deprived borough in England (IMD)
- Diversity: 50% BME of which 33% is Bangladeshi
- A young borough with 35% under 25 years-old, 70% from BME communities
- Population growth +13% to 2013
- 18% of families living on less than £15,000
- High unemployment of 11%
- Highest rate of housing overcrowding in London – 14%
- Population will grown by 11% over next 6 years



And on health our JSNA tells us ...

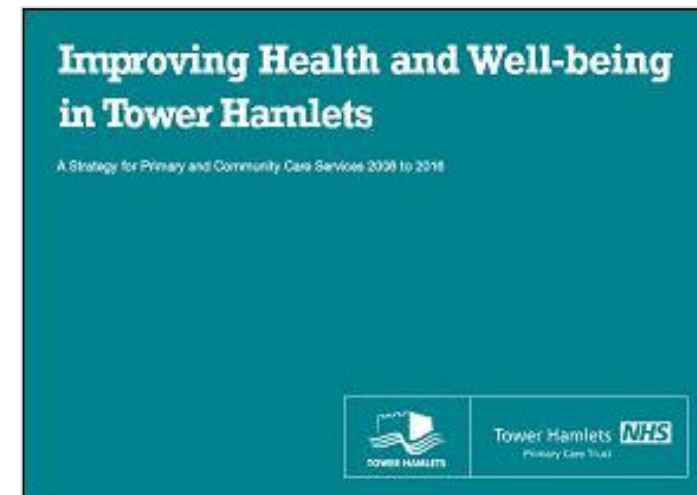
- Low life expectancy and the health inequalities gap; male life expectancy is 2.1 years lower than national average
- High mortality rates– cancer, cardiovascular disease, chronic resp disease,
- High burden of disease – diabetes, mental health, diabetes, obesity, HIV
- Significant health inequalities within the borough – 8 year male life expectancy gap
- 2nd highest standardised emergency admission rates in London in 08/09
- Mean length of stay is the 4th highest in London (07/08)

Our Vision

“is to improve the quality of life for everyone who lives and works in the borough by building One Tower Hamlets.”

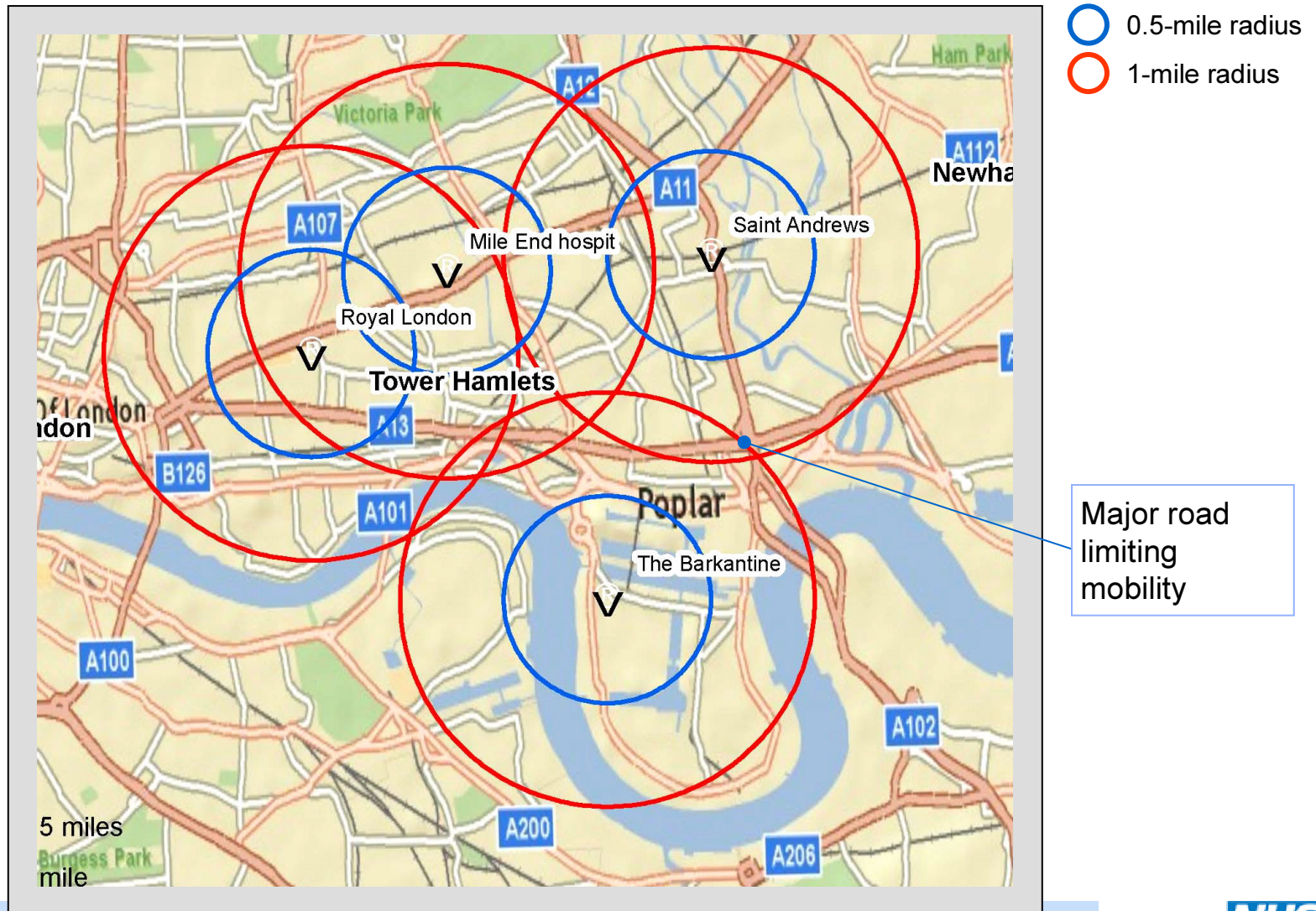
Our Strategic Aims

- Reducing inequalities in health
- Improving the experience of those who use services
- Developing excellent integrated and more localised services
- Promoting independence, choice and control by service users
- Investing resources effectively



Health4NEL and our Care Closer to Home strategy are critical to delivering these aims

4 Proposed Polysystems – geographical, aligned with LAPs and networks



Our proposed Polysystem model

Polysystems will consist of *hubs* and *spokes*

- Each polysystem will consist of a **hub** (e.g Barkentine)
 - We plan for 4, aligned with the 4 geographic localities
 - Each locality is co-terminous to PBC and is composed of 2 paired network areas and 2 LAPs
 - Each of the 8 networks consists of a number of GP and health centre practices, pharmacies, childrens centre etc (**spokes**)
 - Will be open 8am – 8pm, 7days a week and cover a population of 60-75,000 people
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- Mile End in the NW
 - St Andrews in the NE – planned 2011
 - Royal London Hospital in the SW
 - Barkantine* in the SE - currently offers primary care and extended hours, community mental health, birth centre, dental services, diagnostics, children's centre activities, community health services, therapies, community gynaecology, voluntary sector activities, pharmacy and a cafe
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- Hubs will offer a variety of services across planned care, unplanned care (urgent care centres), maternity and children and Long Term Conditions
 - Networks of practices and community services have been established to drive our integrated care and long term condition strategy – bringing together health and social care services to deliver care for that population. It is also aligned to the delivery of evidence based care packages, which put the patient at the centre of their care.

Role of Polyclinic Hubs

What a hub will do

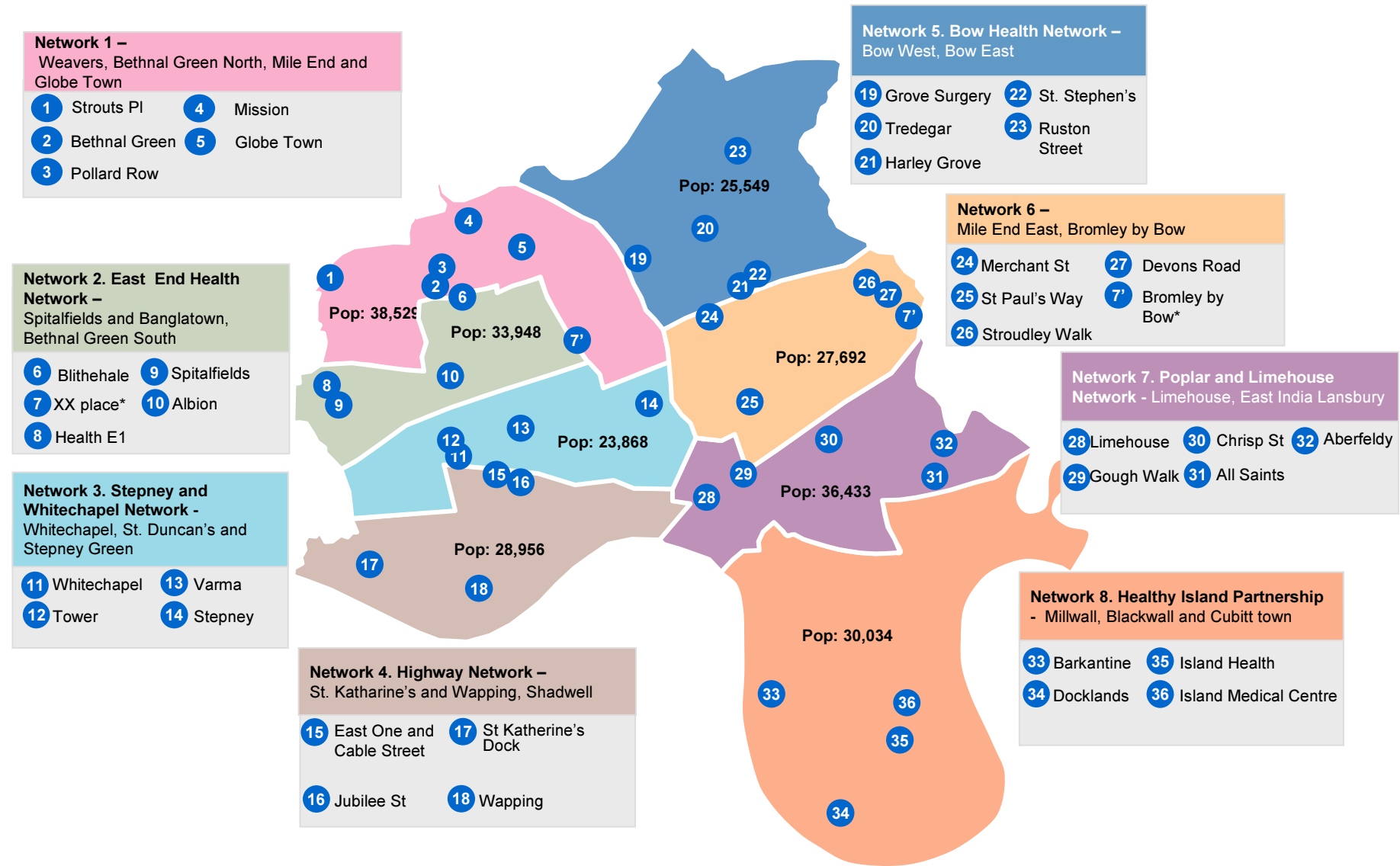
- Provide an integrated non-acute setting for care delivered by specialists, GPs, and AHPs
- Serve as a base for consultants when they work in the community, and for mobile AHP/CHS providers
- Host regular contact among consultants, MDTs, CHS and GPs
- Allow local access to advanced diagnostic equipment
- Provide specialist care in a selection of clinical areas



What a hub will not do

- Function only as an outpatient specialist centre
- Displace GP practices, or 'spokes' (although some may co-locate)
- Operate in isolation from spokes
- Duplicate what is already provided in other settings (e.g. transitional community beds in Mile End)
- Provide care in all clinical areas
- Be identical to other hubs

In 2009 we established 8 networks across the borough (2 per locality)



Care packages, being delivered through networks of practices, have already started to reduce variability, improve and provide care in community settings

Why Care Packages?

- Access to **acute consultants through multi-disciplinary team (MDT)** meeting approach
- **Reduce variability** through the use of evidence based protocols
- Ensure the **right people to do the right tasks**
- Ensure **transparency of data** to individual patient, clinician, practice, and network level
- Ensure an **integrated and coherent** approach to care that harnesses the disparate work underway

Why Networks?

- Focus on **population health** across a geography
- Ensure **sufficient scale and cost efficiencies** to
 - Access rare skills and resources (e.g., equipment)
 - Ensure access
 - Allow specialisation of staff
- Build collaborative relationships with **wide range of partners** (e.g., Borough, schools, charities)
- Integrate with **estates plan**
- Serve as basis to **coordinate with NHS**
 - Acute sector (e.g., for consultants to work in community)
 - CHS services (e.g., for coordination of field deployed staff)

Details of our Polysystem plans

Care Closer to Home modelling work completed:

- Aim to shift 125,000 appointments across several specialties from acute setting by 2019
- Local clinical focus groups reviewed shifts and determined requirements for community delivery
- Re-provision costs, workforce implications and estates requirements in 2019

Currently developing plans for optimal configuration in each locality:

- Locality health needs assessments
- Detailed modelling of activity, estates and inter-dependencies
- Analysis of travel accessibility, including transport links, and cross-border flows for each locality
- Review of existing estate and finalise business plans for proposed developments
- Ongoing engagement with GP practices (completed and planned) and CHS
- Extended clinical groups for all specialties with proposed shifts

Workforce being considered to ensure appropriate development and recruitment:

- primary care in 2019*
- Skill mix required to deliver care in the community assessed at service line level**

Working closely with Local Authority and CHS on integrated care plans:

- Includes co-location of social and health teams, in hubs within each polysystem
- Analysis of available estate (all organisations) and opportunities to use this most effectively

* including CHS staff and additional staff required due to PCIP best care growth and activity shifted from acute

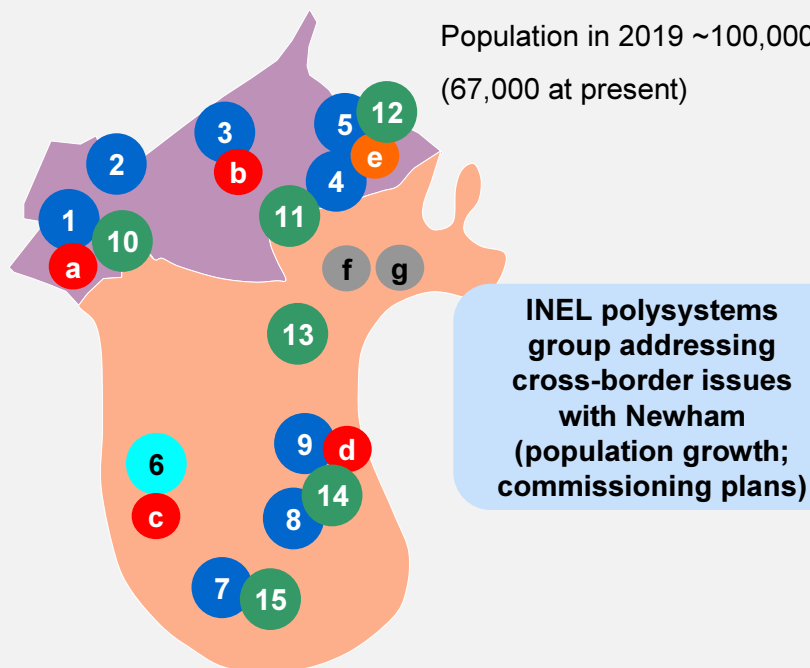
** Based on Health4NEL assumptions ('core' HfL assumptions)

Polysystem plans using South East locality (locality 7&8) as an example: Possible developments and planned polysystems

Geography

- GP practices
- Phase 1 Children's Centres
- Phase 2 Children's Centres
- Proposed hub
- Possible planned developments
- LBTH Adult Services

Population in 2019 ~100,000
(67,000 at present)



- 1 Includes clinical and non-clinical area
- 2 Assumes 45% clinical space
- 3 Data includes new space being developed

Relevant data

Practice	Total ¹ m ²	Clinical ² space m ²
1 Limehouse	1,040	468
10 Gill St / Farrance St ³
2 Selvan	150	68
3 Chrisp Street	624	281
4 All Saints	271	122
5 Aberfeldy	370	167
6 Barkantine (GP)
6 Barkantine (hub)	3,749	1,687
7 Docklands	537	242
15 Docklands Medical ³
8 Island Health	1,465	659
9 Island Med centre	347	156
11 Newby Place	1,887	...
12 Aberfeldy	+630	...
13 Wood Wharf	+650	...
14 Asda / Island Health	+1,000	...

Children's Centres

- a Around Poplar and East India Children's Centre
- b Chrisp Street Children's Centre
- c Millwall Children's Centre
- d Blackwall Children's Centre
- e Aberfeldy Children's Centre

LBTH Adult Services

- f Mulberry Place
- g Anchorage House

Enabling changes in acute care (1/2)

Admission prevention

- Plans to reduce admissions include:
 - Demand management schemes to reduce GP elective referrals through PBC
 - Decommissioning of low or no value acute services
 - Acute assessment unit to 'diagnose to admit' rather than 'admit to diagnose'
 - Community consultant access from care packages/MDTs and shifting acute appointments
 - Care packages focus on self-care, management and prevention as per local health need
 - Integrated care to focus on crisis prevention, early intervention and condition management

Supporting discharge

- Plans to reduce hospital length of stay include:
 - Best care packages for management of long term conditions
 - Tighter integration across primary care/acute for long term conditions and closer integration of community health services and social services
 - Targeting excess bed day numbers and reducing lengths of stay
 - Reducing the ratio of first to follow-up outpatient procedures

Enabling changes in acute care (2/2)

Children's Services

Child health services hub incorporating an ambulatory care service, urgent care services and a paediatric assessment unit

- Facilities for primary care and the care of children with complex needs/long term conditions in a community-based hub
- Multi-disciplinary teams of health professionals (including community teams) working across traditional care settings and boundaries

Urgent Care Centre

▪ Current initiatives include:

- Urgent Care streaming at RLH A&E (patients streamed to community option or self-care if appropriate; service currently streams 13% of total attendances away)
- 3 walk in centres (7 day) across Tower Hamlets (which will be decommissioned in order to fund Urgent Care Centre and Acute Assessment Unit on the BLT site)
- GP extended hours (35 of 36 practices provided services) accounts for 50,000 appointments as an acute alternative
- Urgent care strategy refresh with planned provision within each locality

Local engagement

Improving Health and Wellbeing

- IHWB strategy refresh
- Community Plan development and delivery

Integrated Care programme

- Large integrated care agenda including adult social care integration of provision and commissioning with the Local Authority and CHS
- Clinical leads for each network
- Primary care development programme – large stakeholder engagement
- Locality workshops for practices and service providers
- Year of Care pilot – patient engagement
- Joint Integrated Care launch event in Nov '09 was run by PCT with Local Authority representation for all internal staff and primary care networks
- Care Closer to Home programme started in 2009:
- Clinical Focus Groups (trios) across acute and community care
- Borough-wide workshop and the four locality workshops

ELCA

- Aligned work programme in polysystem development