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Tower Hamlets Integrated Care Provider Partnership

**Workshop write up**

**Developing a Transformational Model of Community Health Services in Tower Hamlets**

**Wednesday 1st April, 1.00pm – 4.30pm,**

**Barts Health, 1 Prescott Street, London E1**

**The aims of this workshop were:**

* To further develop the THIPP transformational model of Community Health Services (CHS), that will be used in the competitive dialogue process with Tower Hamlets CCG, focusing specifically on the following areas for the development of the CHS model:
	+ Care coordination
	+ Single assessment
	+ Tackling the wider determinants of ill health
	+ Multi-disciplinary team working
	+ Deployment of technology in the new model of care
* To strengthen partnerships with the local voluntary sector, and to get their input into developing the CHS model
* Devise ways to best involve patients and the voluntary sector in CHS
* To engage front-line staff in the continued development of this service model

**Attendees (full list of attendees attached as Appendix A):**

Reps from all THIPP organisations

Voluntary sector groups that operate in Tower Hamlets

**Facilitators:**

**Tony Hoolaghan, Director of Transformational Change, NEL CSU**

**&**

**Lisa Henschen, Assistant Director – Primary Care, NEL CSU**

**Report of the workshop held on 1st April 2015**

**Agreed ground rules:**

* **Confidentiality** – information discussed today is commercially sensitive and should be treated with a high level of confidentiality
* **Listen** – listen to the views of others and let others speak. Everyone should be allowed to express their views
* **Participate** – Please take part and say what you are thinking. We are keen to get the views of everyone present
* **Transformational** – Please try to be creative with your ideas and be positive. The CCG wants a transformational model of CHS and we need lots of new ideas
1. **Developing a transformational model for Community Health Services: The THIPP Journey so far**

Phil Bennett-Richards presented an overview of the THIPP journey so far and presented the emerging model of care. See appendix 2 for a copy of the presentation.

Participants were then asked to reflect on this presentation on their tables.

Comments were noted as follows:

**Clarification about the THIPP partnership**

* What is the philosophy of THIPP? What’s its culture?
* What is the contractual and organisational situation – and relationship between THIPP and existing providers?
* Concerns about THIPP being a ‘takeover’
* How can messages about partnership and collaboration be communicated on the ground?
* How do we engage other services not currently in the THIPP community
* How does this link to the TST programme?
* The vision should be led by the patient journey
* Transformational model of CHS – what is it going to look like and how are staff going to be involved?

**Clarification about Community Health Services: current position**

* Lack of knowledge about which organisation currently provides the services – presumption that it is just Barts
* Need to improve the relationship between acute and community services at Barts – will THIPP do this?
* How can current resources be used more efficiently to reduce reliance on the need for new resources?
* What does care coordination mean? Is it linked to the lead professional?
* Journey of participation in CHS raised as an issue – needs to be a process of engaging partners in this work

**What we need to improve**

* Need to end the haggling between providers about who should pick up the patient
* Breaking down silos – key driver
* Blockages need to be addressed – especially in relation to social care and local authority
* Which parts of the system provide the best sources of information?
* How can all parts of the system drive innovation
* Workforce – recruitment and retention challenges, particularly for district nurses
* ‘Joining-up’ and partnership = good things but how will the opportunities be sized
* Need shared understanding about each other’s services
* Example of different professionals providing different elements of a care package in the patient’s home – need to change this so it is only one person and to avoid transforming the home into Waterloo Station
* Need feedback from referrals
* IT should support clinical mobility
* We are currently too risk adverse

**What this means for the developing model**

* Need single care plans and information sharing
* Information-sharing needs to be improved – ensure it is continuous and works across boundaries
* Shared funding / flexibility around funding
* Talking to each other and integrated and seamless systems
* Patient at the heart of the care
* Need the confidence to take risks
* Aligned governance
* Generic workers / new roles
* Simple single access for patients and carers
* Joint commissioning and planning
* Community care high on the agenda
* Focus on prevention
* Equitable care
* Brokerage and sharing resources
* Do-able job
* Need a single training programme
* Need to develop trust, culture and mutual support
* Need to get information to front-line staff – better communication, more access and IT
* Need more patient involvement
* Investment in training and role development
* Equitable access to services through supported navigation
* Support equitable access for isolated patients
* Health and social care integration
* Supporting live in care and links with housing
* Effective carer and family feedback in place
* Easier bureaucracy, nice place to work, achievable job
* Work to eliminate inequalities in health
* Need good links to housing
	+ Able to put aids and adaptations in peoples homes
	+ The home can effect the patient functioning and needs to be adaptable
* Carers with health issues need to be well looked after
* There needs to be good support for the housebound or where circumstances make a person housebound
* Need supported housing for End of Life Care (EOLC) and high risk patients
* Need access to a range of support services e.g.
	+ Housing
	+ Social prescribing
	+ Link age plus
	+ Visiting wardens / virtual wardens
	+ Voluntary sector checking in on people (i.e. HACRA in Polar)
* Governance is very important to make new model work
* Communication is very important
* Single point of access
* How do we deliver standardized and consistent levels of care that is equitable?
	+ How do we get assurance that this is happening?
* We need to engage schools / head teachers or “lead” in THIPP and understanding the framework
* Access to resources across the system
* Avoid duplication
* Shared / single person-centred care plan that includes social needs and the wider determinants of health
* Understand where blockages are in terms of data sharing and work to address these
* Develop a common understanding of what goals / aims are
* Training and support for healthcare professionals to undertake assessment

**Positive observations**

* We are seeing the benefits of working together already
* Voluntary sector involvement is a great opportunity

**Concerns**

* Anxiety about change and risk
* Busy people and concerns about commitment – too many meetings
* How will changes to what staff are required to do impact on job descriptions?
* If my job changes will there be capacity implications?
* Can we make sure what currently works well remains and is not compromised by other changes?
* Who are our competitors?
* When will consultation with current staff on proposed changes take place? – important to engage with them early to make new model of care work
* How do we manage tensions?
1. **Taking forward the model: focus areas for discussions**
2. **Care coordination**

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| **Key principles** | **Implications for the mode** |
| * There are plenty of low level interventions – is prevention a priority?
* Smooth – not having to answer lots of questions
* Carers are able to talk to one person
* People do what they say they are going to do
* Family coordination
* People have authority
* No fragmentation
* Leadership for care
* Single point of care
* Address blockages
* Need to understand roles of others
* Don’t forget to ask service users what they prefer
* Coordination – commissioning as well
* Stop passing the buck on funding
* Think about the model – and then ask for views?
* Make THIPP the partner of choice
* Work for patients and work for staff – bring them with you
* Learn lessons from mental health experience of care coordination
* The best coordinator is the professional who understands the needs best
* Avoid reliance on individuals – it should be the system that works
* Remove idea of “transition” to idea of journey
* Get out of silo working – overcome boundaries defined by budgets – budget for care instead?
* Change the mindset – it is not individual vs system
* Change from medical model to psycho-social?
* Focus on the age spectrum
* Not just about sick people – healthy behaviors, broader then health/
* Think about which structures best deliver the outcomes
 | * Link workers
* Training for new roles and responsibilities e.g. of barriers such as equipment
* Look at ways to reward successful coordination
* A job or one member of team?
* Is the role in General Practice a support call?
* DV / Alcoholism – recognize drug and alcohol worker as coordinator?
* Coordinator becomes administrator
* Respected by clinicians?
* Existing care navigators – what good examples do we have?
* Have a directory of services
* Role of dentists etc?
* Care transformation – essentials of care coordination – generic / specialist skills
* Resources and referrals – certain services only you can use
* Define what is specialist
* Is it a case of one or the other? Flexibility? - health, social care, education – system around the people
* Opportunity costs of not integrating
* Care coordinator – knows, prevents, identifies cracks and gaps – but doesn’t step on other professional’s roles
* Mental health in integrated teams – specialists or otherwise?
* If role not clearly defined, fall back to what the patient knows
* Do existing roles have the capacity to take this on?
* Is the lead professional role best or is it better to have focus on the family (rather than child) – team around the child
* GPs as hubs – but emphasizes the medical model
* Share information across organisations
* Bromley-by-Bow example?
* How to flex the model based on demographics and meeting different needs
* Service to brank out away from hub to voluntary and community organizations? Community hubs?
* Need integrated records
* Need appropriate skills for triage
* Single point of access – if resourced properly – social care / clinical staff
* Personalized budgets:
	+ Will this lead to some services not being delivered?
	+ Unintended consequences?
	+ What happens when patients demand something not available?
	+ Is this a counter to integrated care?
* Team around the person (using the children’s model)
	+ Need to do it properly
	+ CAF: key worker role (doesn’t happen in TH)
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**Barriers**

* IT
* Referrals from voluntary / community sector (no NHS.net address)
* Culture and mindset – need to focus on patient care
* How to get to meet people from different parts of the system
* Haggling over responsibility
* Systems that don’t talk to each other
1. **Single assessment**

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| **Key principles** | **Implications for the model** |
| * What does it mean? Do partners understand what we mean?
* Consider non-statutory third sector
* Ensure permission for involved
* Ownership of the patient / service users / client / carer of the single assessment and subsequent care plan – they determine their journey
 | * Barriers to information sharing due to perceptions (differences)
* Develop a shared information governance protocol / policy
* Work with service users / patients / clients to get agreement of what voluntary sector sharing means
* Address blockages to service delivery after single assessment is done
* Get all partners to share good practice
* Manage expectations and early triage
* “care navigation?” often the 3rd sector coordinates
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1. **Tackling the wider determinants of ill health**

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| **Key principles** | **Implications for the model** |
| * Need to focus on housing – it plays a big part on health
* Young people need support
	+ But many are undiagnosed
	+ Need to identify early signs
* OBC?
* Allow individuals to take more responsibility for themselves
	+ Start young when people are at ‘pre-need stage’
	+ Stop co-dependency.
* Inverse care law – how do we reverse? How do we engage Identify and alleviate causes of stress and anxiety
	+ Need to work with and listen to communities
	+ Need to form robust partnerships
* Ensure staff have time and resources to do their jobs well
* Empower people to manage their own health
* Put in support to help avoid loneliness and isolation
* Local and specific needs – need to know local people
* Challenge is to connect wide range of people
* Open groups to wide range of people
* Should be a THIPP work stream focusing on wider determinants of health
	+ Needs ownership and leadership
	+ Needs shared commitment
	+ Setting and keeping of standards
	+ Brand work in this area
 | * Need for diverse roles joining up physical and mental health
	+ Stop silo working
	+ Encourage social prescribing
	+ Help staff communicate better (with patients, families and other professionals)
	+ Promote concept of social value
* Prevention = transformation
	+ Need to stop progression of problems via early intervention
	+ Integration should allow this (vascular dementia good example)
	+ Pharmacy counter assistants should be used more
* Need focus on smoking cessation
* Allow/enable staff to deliver prevention interventions
* Need to increase awareness of all services that are available
	+ Form long term relationships
	+ Central database of services
	+ Should be role of CCG to do this?
* Need to increase access to EMIS records
* Need single assessment
* Use Council services to offer a range of support
	+ Housing
	+ Education
	+ Employment
* Key role for health promotion
	+ How to engage broader more diverse groups?
	+ Capacity needed to do this
* Use personal budgets to help provide support
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1. **MDT working**

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| **Key principles** | **Implications for the model** |
| * Approach is PKB – ‘Patient Knows Best’
* Build up trust amongst colleagues in the MDT
* Complaint systems are different across the MDT – need to be harmonized
* Need for multi-professional teams
* Colocation and coordination of teams and their work
* Learn from Burtzog model in Holland (i.e. DNs who can do physio assessments)
* Learn from Leicester University – Patient Knows Best project
* Need protected time for MDT working
* Need cultural changes to make it work – work together on issues will help make it happen
* Relationships key to making it work
* Needs clear governance to make it work
* Doing things differently – not shuffling around silos but really working differently
* Locality is important in building relationships between different disciplines
* Important to get culture change from bottom up to ensure can work well
* Important to have accountability
* Expanding roles – non-disciplinary working
 | * Triage – who is trained?
* Referral system for each specialty – standardize and publicize
* Patient and family are part of the MDT
* IT systems needs to work to make MDT work
* Patient needs to be seen as part of the MDT
* Patient and family are new to this
* Need mechanisms for making changes to things not working
* Patient knows best – patient holds records and discloses to who he/she wants to
* Barriers – IT system 🡪 sharing information, consent, patient held records
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1. **Technology**

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| **Key principles** | **Implications for the model** |
| * Individual needs: provide a pick and mix of support that take language and culture into account
* Consider how to access patients who don’t want to use technologies
* Issues around consent need to be resolved e.g. carers notifications
* Think about the balance of social isolation
* Technology should support relationships, not replace them
* Need to understand the different systems and look at remote access
* LEAN access to the system
* Simple and basic – easy to use
* Importance of leadership to support technology
* Need to ensure teams are build and technology supports it rather that teams creating the systems
* Support carers
* Trust is key to maximize the benefits of technology
 | **Self-care:*** Use assistive technologies / telehealth
* Use of “Flo”
* SMS reminders for medication
* MS patients
* Self-management portals
* Explore telehealth options e.g. blood sugars, blood pressure monitoring, telephone support, supporting patients to keep well
* Use technology to access support such as physio exercises, falls prevention exercises via video, preventative exercise groups
* Physiological measure with “green status” – and advise people where to go (have awareness of not alarming the patient though)
* Access to therapeutic support

**MDT triage*** Get the basics right
* Secure email access
* Viewing information across shared providers (note potential for lower quality though)
* Balance the risks of not losing conversation and personal interactions
* Links to ORION (Graph.net functionality)
* Skype / VC links to access other providers
* Virtual MDT systems across localities
* HIE / MIG
* Single shared visible care plan
* Link to education opportunities

**Supporting access to services*** Schemes to support patients to use everyday technology to support wellbeing
* Support carers to access technology
* Look at referring differently e.g. self-referral
* Front-line staff to use technology to access patients
* On-line shopping
* Web link consolidations for IC patients / care navigators
* Note anxiety about sharing data
* Secure email access to patients to contact community teams
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1. **It is April 2018 and the CHS contract (being delivered by THIPP) has been up and running for two years. It is seen as a resounding success, with patients and the voluntary sector fully involved in how the service is delivered and the experience of.**
* Patients have fewer people involved, but it is high quality care that is being delivered
* Shared information
* Identified relationship with one person – link person
* When asked for help there is quick access to somebody to help with clear timeframes – people are given accurate expectations
* People are informed about their care
* The system listens and is flexible to needs
* Listen to individual experience and acting on it
* More open with the voluntary sector and access to resources
* More accessible services
* Stable workforce with good staff morale
* Information is readily available and accessible in the preferred way
* Range of different media is being used
* No answer phones, no outsourcing, ine people
* Appointment tracking and access results directly
* Choose Doctors?
* Stop working in silos
* Everybody involved in working together
* Voluntary sector helping patients to feedback on personal budgets
* Centralized money for all services
* Personalized budgets: know how to use them and have access to services to support them.
* Patients and carers are represented at all levels in THIPP
* Strong focus on patient/carer communication
* Lots of self management and self care
* Patient involvement -
	+ Cost effective
	+ Clear outcomes
	+ Focus on safety
* THIPP could adopt ELFT Model – Governing Body that has patient reps?
	+ But ensure spread of members is diverse enough
* Need to have ability to respond well to individual feedback
* Need to work out how to access ‘hard to reach’
* Role of ‘Discovery Group’
* ‘Just in time’ – learning from this and how to use it
* Promote use of technology – hand held?
* Clinicians need to be unafraid of feedback
* There is s culture of learning
* Stronger public health focus
	+ Activation of patients
* Regular staff surveys
* Should not matter who you are employed by – it should feel all in the same organisation
* Stable workforce – happy to be here
* Combined employer of choice
* Develop the THIPP employment brand and emphasise Tower Hamlets elements
* Third sector deliver elements of CHS services they are good at
* Celebrate success – As a draw
* Patients celebrating as well
* Map of services
	+ Make clear key links within services
	+ Make clear referral routes
* Listening to service users
* Learn from what is/is not working
* Be flexible and responsive
* Bring in new partners
* Staff who care, listen and empathize
* Training available to staff and workforce support
* Staff are knowledgeable, can meet needs and are credible
* Communication – based on a strategic approach
* Open house to offer choice and ownership
* Passionate permanent staff
* Respect from partners
* Look at and learn from outside organizations
* Need drive and resources
* Local focus – how do we achieve?
* Co-locating
	+ Links between people are important
* Leadership at local level needed
* Respond well to complaints
* Outcome measures -+ processes would be in place e.g. grade ¾ pressure ulcers
* Accountability – for culture change. Shared accountability – asking questions
* Prevention
* Evidence base
* Quality initiatives
* MDT – all signed up
* Patients and families – working with them
* Innovation – constant improvement
* Patient at the forefront of decision making