

Integrated Community Health and Social Care – Integrated Localities in Havering

1. Background

1.1 The BHR CCGs' Integrated Care Coalition 'Case for Change' sets out the plans for the shift of resources from acute to community and to provide better care and services closer to peoples' homes.

1.2 The priorities for our integrated care system include developing further the integrated locality model. Our design principles underpin this by stating: 'Localities will be central to organising and co-ordinating peoples' care'.

1.3 Our Better Care Fund 2015/16 plan states:

The strategic objective will deliver by 2019: 'A locality based integrated health and social care workforce comprising multi- disciplinary workforce across six GP cluster-based localities. Remaining sensitive to practice list profiles, the service will incorporate adult social care eligibility criteria in its risk profiling. It will include voluntary sector provision of local information and advice and integrate mental health professionals. This will ensure a smooth pathway between locality and specialist provision and to provide support to GPs and their patients in a similar way to physical health specialists. 'Individuals will have a named care professional who will be responsible for ensuring their care is appropriately coordinated for their needs.'

This will build on the successes of Integrated Case Management (ICM and ICM+) the Community Treatment Team (CTT), the Joint Assessment and Discharge (JAD) team and the recently launched Health and Social Care Service (HSCS) and integrate fully the social work function across the services.

1.4 The locality model will be based on 6 clusters of GP practices co-locating health and social care staff wherever possible, to ensure that multi-disciplinary working is embedded in daily practice and as well as through multi-disciplinary meetings. The approach will be targeted and proactive with joined up assessment, care planning and care co-ordination.

1.5 The patient cohort being targeted by the locality working model are frail elderly people, mostly over the age of 65 with one or more long term

conditions. The cohort also includes patients with dementia, End of Life patients, those at risk of hospital admission / re-admission, and those being discharged from hospital. It is our intention to expand integrated locality working to include paediatrics/vulnerable children in due course, once the adult focused approach has been piloted, evaluated and adjusted to deliver the intended benefits.

2. Progress to date and next steps

- 2.1 Co-located teams are now in place in Cranham and Harold Hill, with two more locations in Romford and Rainham/Elm Park to be co-located by April 2016. Once the four teams are co-located the service delivery model will be reviewed to agree how we can then progress towards full integration. The locations house social work and health teams.
- 2.2 Performance measures are in place to track the benefits and impact of the move to co-location. There is a joint governance framework in place as well as an operational group.
- 2.3 It is expected that we will be able to respond more quickly and effectively at earlier points in the pathway to a non-elective admission, managing the increase in demand that is likely to occur with Havering's specific demographic.
- 2.4 Early intervention and the provision of the right services at the right time will have the impact of enabling people to stay at home rather than move to a residential setting. The patient and service user experience is expected to be positively impacted as a more joined up approach will be in place to enable better information sharing and more timely decision making as we move towards full integration. Pathway mapping will improve as the model develops further.

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