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THANET HEALTH AND WELLBEING BOARD

12 FEBRUARY 2015

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 12 February 2015** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Councillor Johnston (Vice-Chairman), Hazel Carpenter, Dominic Carter, Esme Chilton, Councillor Gibbens, Councillor E Green, Madeline Homer, Mark Lobban and Andrew Scott-Clark

A G E N D A

Item
No

5. **INTEGRATED CARE ORGANISATION** (Pages 1 - 18)

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Developing integrated care in South Kent Coast and Thanet

1. Introduction

NHS Thanet CCG is made up of 19 member practices covering a population of 143,000 with a budget of £200m to spend on hospital, community and mental health services for the 199,000 people living in this area

The CCG has a five-year strategy that sets out our objectives for the coming years. Key to the delivery of this strategy will include:

- Improving care in hospital care and making sure that acute care requiring specialist facilities, whether for physical or mental health needs, will be highly expert to ensure high quality. This will involve us working closely with East Kent Hospitals University Foundation Trust (EKHUFT) on their clinical strategy.

- Improving out of hospital care, making sure that only those services which really need to be delivered in a hospital setting are there.

Part of this will involve developing an integrated model of care out of any acute hospital setting, wrapped around the patient, and clinically co- ordinated by their GP.

This briefing outlines the CCG's plans for developing their own Integrated Care Organisation (ICO) and progress in developing out of hospital care in our local communities.

2. Background

A case for change

Local NHS and social care partners recognised that the current pattern of health and social care locally could not continue in its current form for four key reasons:

a) It will not be able to cope with the rising level of demand for care that can be anticipated over the next few years
b) It is highly unlikely that the funding available for health and social care will be sufficient to meet that growth in demand
c) Patients have indicated that they want health and care to be more joined up and better able to meet their needs. Currently, the fragmentation of responsibilities for commissioning and provision makes it difficult to do this systematically and consistently
d) There are already difficulties in attracting and retaining a clinical workforce in the right numbers and with the right skills to deliver the care we need – these problems

will worsen unless services are designed in a way that makes working in them attractive to health and care professionals

With an increasing demand for services, a growing older population with a rise in multiple long term conditions and health and social care budget restraints better integrated care is seen as an essential requirement to improve the quality and efficiency of the NHS.

At present the provision of out of hospital care is highly fragmented. It is provided by multiple organisations that are often differently engaged and governed through the NHS or local government. Provision spans statutory public organisations such as NHS Trusts, Kent County Council (KCC) and local government directly managed provision, private sector, voluntary and charitable organisations.

Individual organisations are incentivised to do things in their own parochial interests shaped largely by the current business practice of their commissioners/ funders .This is not universally systematic nor aligned to provide a seamless integrated approach. It is also not focused on common outcomes for patients and the local population.

3. Achieving our vision for out of hospital care

NHS Thanet CCG's strategic plans includes the development of a systematic model for health and care services out of any acute hospital setting, wrapped around the patient, co-ordinated by their GP.

We want to facilitate the development of a more coherent and sustainable service model, designed and delivered around patients rather than the needs of patients being forced to fit around services already available.

Achieving this will involve reorganising the local provider market to focus on a common purpose of improved local population outcomes, experience and value.

It will also involve us working closely with local people and organisations, including Kent County Council, district councils, providers of health and social care and the voluntary and community sector to prioritise and design the services that each community needs.

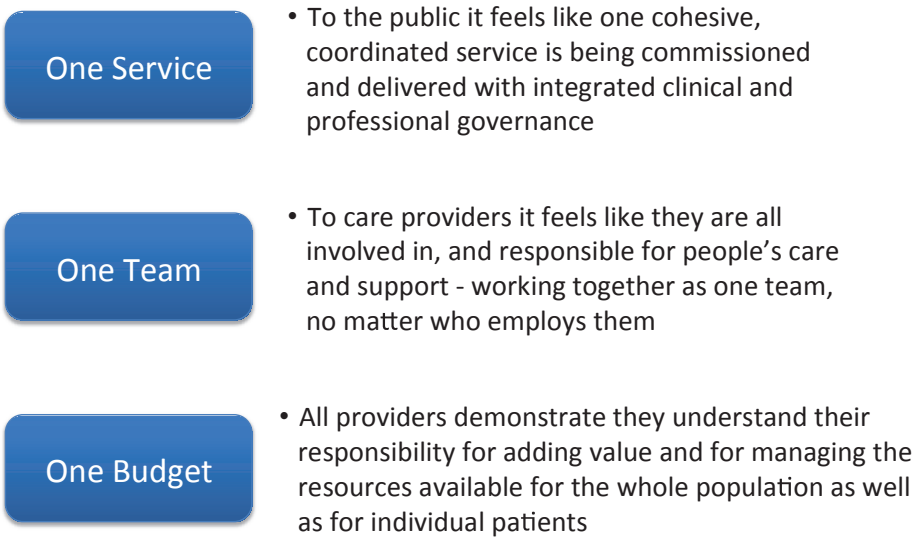
4. A local vision for integrated care

Integrated care is a fundamentally different way to meet health and care for a defined population and tailored care to meet individual needs. It means changing the design of services, the people that deliver them and how services are paid for.

Integrated care service models mean that the traditional segmentation of care by provider organisations (e.g., primary, secondary, community, social, mental health) is no longer appropriate. In the first instance, integrated care means that care services, the care team,

and the overall budget for the health and care for a defined community have to be brought together.

The vision for integrated care can be explained as:



5. Benefits of integrated care

By providing care in an integrated way and ensuring that the citizen is at the centre the following benefits can be expected

- Better health and wellbeing
- Greater responsibility born by patients/public
- Better patient and carer experiences
- Better coordination/greater efficiency/better value
- Better preventative health (universal)
- Better preventative care for at risk groups
- A sustainable health and care system

6. Approach taken

The CCG appointed independent consultants to establish a 12 week programme of work that enabled current providers serving Thanet to establish a coordinated and robust service model for the provision of sustainable comprehensive services outside hospital, working together with partners across health and social care and voluntary sector.

The approach has been to develop a shared view of the future service model 'bottom up'. The aim was to encourage front line staff and patients across local services to be engaged

in the final design from the outset. It was also believed that this would encourage more innovative solutions.

Public and patients have been engaged in an initial stakeholder event and a patient and public panel will now be established to ensure on going co design and drive change.

An oversight group was established at the beginning consisting of key provider stakeholders this provided senior organisation “sign up”, commitment and leadership to the overall direction and process.

Workshops were held to build consensus about the scope of integrated care and a further workshop to provide a more detailed blue print for each locality and Thanet overall is planned for early March. Over 100 frontline health, social care and voluntary sector practitioners came together to map current services for each CCG and design what integrated care could look like in the future. A “Big Picture” of integrated care for the future was developed. This was followed by a workshop for GP leaders to review the emerging model as this might work and agree the natural ‘localities’.

In developing the right out of hospital care it is critical to establish the right relationship between GP’s and hospital consultants to ensure services are developed in the right place. Working together in designing the future service models will also inform EKHUFT’s own clinical strategy. For Thanet this includes the opportunity to develop Queen Elizabeth the Queen Mother Hospital (QEQMH) as a modern community asset.

A number of infrastructure workshops took place focusing on finance, workforce, information and IT and commissioning. These were to consider the type of infrastructure support and capacity that would be needed by the system as it moves into implementation of integrated care.

Further meetings have been held with the CCG membership to discuss where GPs and practices see themselves in the emerging framework. These discussions will continue with the full support of Local Medical Council (LMC).

The University of Kent has developed an evaluation framework and therefore this integration programme is underpinned with best practice, action research and evaluation and learning.

7. Progress

NHS Thanet CCGs are now at the position where an outline model for integration has been designed locally. Whilst this work was happening the *Five Year Forward View* was

published which outlined 4 new models of care for integration. The work that the CCG is doing fully aligns with this direction of travel.

The local GPs will now be considering the establishment of a 'Multi Specialty Community Provider'. Ultimately this could become a full risk-sharing, population-based approach to organising integrated care locally.

A further design session is being planned to advance thinking on the locality model for integration focusing on the role of QEQMH as an integral element of the model providing community orientated acute provision ensuring that services are drawn into Thanet wherever possible.

There is further engagement planned to design with residents and clinicians the service details of the local areas within Thanet (Broadstairs, Margate, Ramsgate) and those services which are all across Thanet.

A number of integration projects in each locality are already in place locally moving localities towards the developing vision for integrated care these are outlined in **Appendix 1& 2**

8. Next steps

This is an ambitious programme of work and will need to be taken forward in a phased approach. It will be necessary to ensure that safe care continues to be delivered whilst totally transforming the way that health and social care is provided in the future.

A detailed integrated programme plan will be developed with clear phasing and governance for delivery. There is a significant amount of detailed preparation and planning work still to be done before the model can be fully agreed by all stakeholders. Implementation of integrated working practices are beginning to be implemented these are working towards the defined vision.

There is the opportunity to become a test bed site (outlined in the *Five Year Forward View Planning Guidance). The* CCG is exploring this opportunity.
National Support will be given to areas who become test bed sites, there are a number of challenges that will require significant work locally and nationally in order for new integrated models to be established focusing on challenges such as organisational legal forms, procurement routes, new contractual models.

APPENDIX

1. Thanet CCG

Thanet has further work to do in defining the model of integrated care across the locality. This includes the design of hospital services at QEQMH and the function of the acute

hospital within a community focused model of care. A future event is planned to take this design work forward.

There are a number of projects that are happening locally that contribute to the development of integrated care in Thanet and will ultimately support the direction of travel. These are:

(a) Redesigning Thanet

Work has started to look at defining the natural communities of Thanet and designing the primary care model around these. Workshops have been held with GPs and the acute trust consultants to initially agree the communities for primary care followed by discussion on what "out of hospital care" delivered by consultants could look like.

(b) Prime Ministers Challenge Fund bid

A bid has been submitted to establish a primary care centre at QEQMH. This will improve access to GP's providing an 8 – 8 pm service seven days per week.

(c) Integrated primary care teams

These teams are being established (including Nurses, mental health, social care) centred around localities with GP s at the heart of an integrated health and social care team.

(d) **Over 75yrs primary care initiatives**

Thanet has a number of local service developments based around individual practices supporting local care homes.

(e) **GP step up beds**

12 beds have been purchased from local care homes used as step up beds to reduce the need for hospital admission.

(f) **Integrated discharge team**

A hospital based team has been developed, supporting the discharge of patients from hospital and reducing the admissions from A&E.

(g) **Carers' breaks**

The pooling of funding to support integrated carers support services.

Hazel Carpenter

Accountable Officer
NHS Thanet CCG and NHS South Kent Coast CCG

6th February 2015

Organising Integrated Care
Thanet CCG

Hazel Carpenter - Accountable Officer Thanet CCG

Case for change

- Ongoing rising demand for care
- Insufficient funding
- Fragmented services
- Unattractive clinical and practitioner roles
- Perverse incentives

What we have now?

- Not enough emphasis on wellbeing
- Lack of a clear contract between patients/public/community and the system
- Sub-optimal patient and carer experiences
- A lot of complexity with too many 'boundaries' and hand-offs
- Questionable efficiency and patchy value – some gaps, some duplication
- Not enough focus on preventive health for everyone
- Inadequate preventive care and early intervention for at-risk groups
- A health and care system that even in the short run is *not* sustainable

Should we?

- **Increase the size of services** to deal with rising demand including increasing numbers of those in crisis?
- **Manage demand** by rationing services, tightening eligibility, hiking charges?

or intervene positively to……..

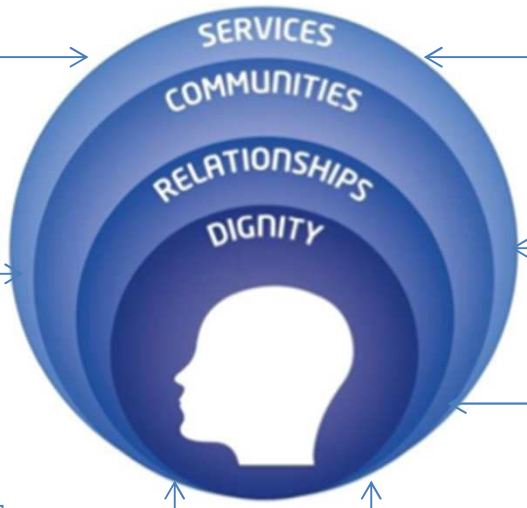
- **Change the service model** by right sizing health and care capacity and intentionally working to support individuals, families and communities to stay strong, diverting people from formal services wherever possible through sustainable, local, flexible individual and community solutions?

What will it be like for me……

7. Information is given to me at the right times. It is appropriate to my condition & circumstances. And is provided in a way that I understand.

8. No door is the wrong door

1. I can access my GP if I need to from 8am – 8pm seven days a week



6. I am supported to actively participate in my local community, enabled by environments that are inclusive

2. I can access my own GP record 24 hrs a day 7 days a week

5. I have more choice and control to manage my condition, I am supported to use an integrated personal budget to meet my health & social care needs in different ways.

3. I receive enhanced care within my community to prevent me going into hospital

4. I receive a cohesive coordinated service that meets my needs

Integrated Care: How would we know if we had it?

One Service

- To people it feels like one cohesive, coordinated service is being delivered

One Team

- To care providers it feels like they are all involved in and responsible for people's care and support - working together as one team, no matter who employs them

One Budget

- All providers understand their responsibility for adding value and for managing the resources available for the whole population as well as individual patients

Provider Development approach

- Procurement – why not?

- Difficulty in specifying the requirement for a new service model; as yet undeveloped.
- Need for commissioner led tight project management of delivery to align with the management of activity shifts from EKHUFT into a different setting.
- Variation in potential time lines for alignment of some service procurement which could prevent optimal scope of the project and alignment of key services.
- Distraction from the core purpose of the project to improve outcomes and experience for a better per capita cost

- A 'bottom up' approach

- Built on delivery of 'I' Statements
- Enables form to follow function.
- Development of a common purpose across the local clinical and care community (putting quality as the primary focus)
- Development of a genuine sense of affiliation and common code of ethics.
- Focus of better patient outcomes.
- Single version of the truth.
- Built on Triple Aim principles of:
- Better patient experience
- Better clinical outcomes
- Better value for money
- Engages the entire front line clinical and caring community in real time change and improvement through collaborative, co-design social movement model
- Avoids costs of organisation structural change to an unknown end point
- Creates a 'safer' environment for multi-organisation service model redesign

Approach Taken

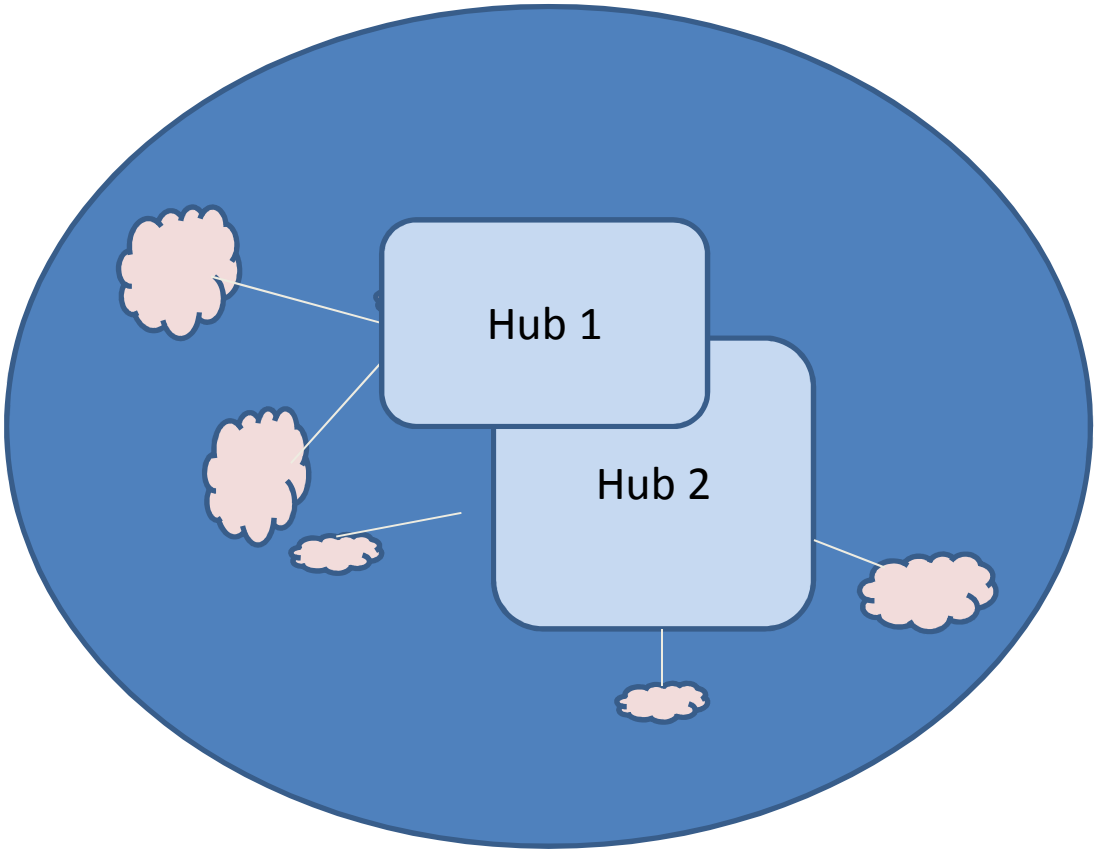
- Bottom up design which is professionally led
- Work together with partners across health and social care and voluntary sector
- Agreement on an Incremental process
- Strongly influenced by providers
- Form to follow function

Through

- Workshops to build and develop a shared “big picture” of what integrated care should look like
- Inclusive oversight and governance – leadership group
- A peoples panel to co design and drive change
- Corporate infrastructure groups: finance, commissioning, workforce
- CCG membership meeting, and acute consultants/GP meeting
- Social Care transformation programme
- Local implementation and leadership
- Underpinned with best practice, action research and evaluation and learning

THANET'S ICO

- NOT a solely medical model, it needs to focus on reducing health inequalities
- Thanet's communities are enabled to support health and wellbeing with multi specialty teams
- The option of 1 or 2 hubs.
- QEQM is a central point for the community
- Maximise delivering care in Thanet



Thanet's integrated care building blocks

NO WRONG DOOR

"ONE" TEAM

CAPABLE COMMUNITIES

CARE IS PLANNED AND MANAGED (including guided self care)

WHAT GOES WHERE *new roles for QEQM and Gateway plus*

COMMISSIONING & CONTRACTING FOR INTEGRATED CARE

THE ICO ENTITY AND ITS GOVERNANCE

Challenges and next steps

Challenges

- Shared vision/tough choices
- Continued engagement – taking the public and workforce with us
- Workforce – skills and competencies and numbers
- Organisational form, risks and rewards to enable change
- Leadership to deliver and ensuring delivery of safe care through significant change
- Information sharing

Next Steps

- Develop integration programme plan
- Implementation of new models of care – phased approach
- Identify locality leadership to take forward
- Continuous stakeholder engagement
- Possibility of test bed site
- Design the evaluation model
- Explore integrated commissioning approach
- Model the financial flows

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