QEQM HOSPITAL CABINET ADVISORY GROUP

Minutes of the meeting held on 21 April 2016 at 7.30 pm in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Councillor Lesley Ann Game (Chairman); Councillors Ashbee, J Fairbrass, L Fairbrass, Falcon, I Gregory, Matterface and Wells

In Attendance: Hazel Carpenter

1. ELECTION OF CHAIRMAN

Councillor Wells proposed, Councillor Matterface seconded and Members agreed that Councillor Game be the Chairman of the QEQM Hospital Cabinet Advisory Group.

Councillor Game in the Chair.

2. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Glenn Coleman-Cooke who was substituted by Councillor Jeremy Fairbrass.

Councillor Wells, Leader of the Council advised the meeting that after his appointment to the Cabinet Advisory Group, Councillor Coleman-Cooke became an employee of the East Kent Hospital University Foundation Trust (EKHUFT). He therefore would have had to declare a pecuniary interest at all meetings of the advisory group and leave the meeting room. Councillor Jeremy Fairbrass was now his replacement moving forward.

3. DECLARATIONS OF INTEREST

There were no declarations made at the meeting.

4. SUSTAINABLE TRANSFORMATION PLAN PROCESS - REORGANISATION OF EKHUFT

Hazel Carpenter, Accountable Officer for Thanet CCG and South Kent Coast CCG led discussion with a PowerPoint presentation, which is hereby attached as Annex 1 to this minute item. She explained that the Clinical Commissioning Group (CCG) was a grouping of General Practitioners from whom one GP is elected chairman to lead the group. They hold a National Health Services (NHS) budget for Thanet which was currently at £200 million per year. This budget excludes services like primary care or specialist services where cases are usually referred to London.

The Thanet CCG was currently working with three other CCGs in the South East Kent to develop approaches for future integrated working. EKHUFT has been discussing proposals for a health service strategy for the future. However the Trust cannot go it alone. There is a need for a more holistic approach moving forward that would involve engaging the various CCGs who hold the legal obligation to consult in cases where new health delivery strategies are being proposed.

Case for Change

Hazel Carpenter said that there was a rising demand for care in a situation where service provision was fragmented and there was a need reconsider how health services can be provided in a seamless way to enhance the patient experience. Care Quality Commission (CQC) performance results show poor performance. Whilst the constitutional performance targets for A&E are a four hour wait for 95% of the people, QEQM

Hospital's A&E results are more likely to be under 70% in some weeks. There was shortage of specialist skills in the NHS and locum staff are being used to fill in the gaps, and this was not sustainable in the long run.

There were inequalities in health standards. For example, in Thanet life expectancy goes down 17 years as one moves from one area to another. There was therefore a case for addressing these issues through a holistic re-organisation of health service delivery. Chief Executives and Medical Directors of all major health organisations (Ambulance Services, NHS, Social Care Services etc), Kent County Council, four clinical Commissioning Groups Chairs meet as a Strategic Board chaired by Sarah Philips to come up with a model for integrated working which is sustainable and closes the current gap of quality, affordability and inequalities.
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The Board is building a case for change through understanding the various needs and gaps at local level (Thanet level), sub-district level and county level. They are looking at some work streams which are:

a) Maternity and Paediatrics;
b) Mental health care;
c) Urgency and Emergency care;
d) Prevention and self care;
e) Learning disabilities;
f) Long term conditions and frailty;
g) Planned care and Specialist care;
h) End of life care

The Board is looking at what the best should be like for each of these services and developing a model for integrated care. In the process the board is developing a Kent Integrated Data set that allows for the analysis flow across health and social care. This facility is new and unique nationally.

Time Scale
Originally the governance arrangements were scheduled to be in place by Easter. These arrangements would enable Thanet CCG to make a decision on this matter. By end of April – early May clinical models need to have been described and set out. Stakeholders and the public will be engaged in the process. A Patient Panel will be set up to keep patients informed of the progress.

By June 2016 there should be a Plan to take to public consultation. The intention is to have one service, one team and one budget.

After the presentation by Hazel Carpenter, Members asked questions that she responded to. She said that although the end of life care budget in the slides reflected 0%, that budget is covered for within the hospital budget, community budget and primary care budget. There was a general shortage of GPs nationwide, but plans are being worked out to address the problem.

Doctors do not have the right contacts that would incentivise them or the right staff to work with. At a national level an additional £60,000 for each GP is to be allocated. This includes attempts to bring together GPs to work together as a group of surgeries. For example in Thanet, four localities (Margate, Broadstairs Ramsgate and Quakes Locality) have come together and are to receive CCG allocated funding to incentivise them working together.

Hazel Carpenter said that there will be criteria for the public consultation for the changes in services across east Kent. This included looking at safe service, same service standards, access to services by the local community (including non health seeking

community) Clinical outcomes are critical in the proposals for a new model of working and service change. The GP members and managers are very clear about that and aware of that requirement. However some very specialist services need concentrating to ensure the right number of patients are being seen and specialist skills can be brought together in safe clinical rotas.

With regards to patients being referred to William Harvey for certain appointments and not at QEQM Hospital, GPs can see the patient information on how many individuals would take an earlier appointment at William Harvey rather than sit back and wait for a longer waiting time appointment at QEQM Hospital. These issues will be taken into consideration when working out the new model.

Speaking under Council Procedure Rule 20.1, one Member asked what the CCG was doing to address the issue of low morale in the NHS, recruit and retain staff, improving moral and tackling agency spend (and reduce the financial gap). Early change management programme would need to be used to fully engage NHS staff right from an early stage of the change process.

Hazel Carpenter said the Board was already looking at ways of promoting and developing opportunities to work in those health sectors and support the work of the NHS without encouraging employees leaving some organisations in great numbers.

Members observed that if the Cabinet Advisory Group waited for the public consultation in order to feed into the process might be too late as some significant decisions would have been made. There is a need for the sub group to look at the right points to influence the change process. Hazel Carpenter said that she welcomed the input from the Council. She said that there was no likelihood of the A& E Department being moved away from QEQM Hospital. The Chairman said that it was good news that the department would not be closing down.

GPs across Thanet are currently working on an initiative that would set up the Thanet Hub which will based in QEQM Hospital, which will be at front door and the A&E would then be moved to an area within the QEQM Hospital behind the Hub.

Hazel Carpenter said that after the closure of the GP surgery in Garlinge, all the patients will receive notification letters advising them where they have been allocated a registration with another GP. She also said that the NHS has got an internal recruitment agency and it was worth noting that 70% of recruitment is passed on between NHS organisations.

With regards to shortage of consultants at the A& E, Hazel Carpenter advised the meeting that plans were being drawn up to address this across the Trust. She urged Members to write to the CCG and NHS to raise these clinical concerns. A new medical model is being implemented to enable consultants to attend A& E within the expected best practice time scales.

Members received and noted the presentation. The Chairman also thanked Hazel Carpenter for her presentation.

5. AGREE TERMS OF REFERENCE OF THE QEQM HOSPITAL CABINET ADVISORY GROUP

Madeline Homer introduced the item for discussion and referred members to the draft terms of reference in Annex 1 to the sub group report. The Leader said that it was important to get timing for the intervention by Council right to influence the decision. This would call for getting the information from the Thanet CCG at the appropriate time.

Councillor Wells proposed, Councillor Matterface seconded and Members agreed that the following be the amended terms of reference of the QEQM Hospital Cabinet Advisory Group:

1. Consider or shadow the proposed re-organisation of East Kent health services through the work of the East Kent Strategy Board;

2. In the event of a public consultation relating to the provision of health services at QEQM Hospital in Margate, prepare a draft Thanet District Council response to the consultation;

3. Prepare a final report for consideration by Cabinet.

The amended terms of reference will need to be approved by Cabinet.

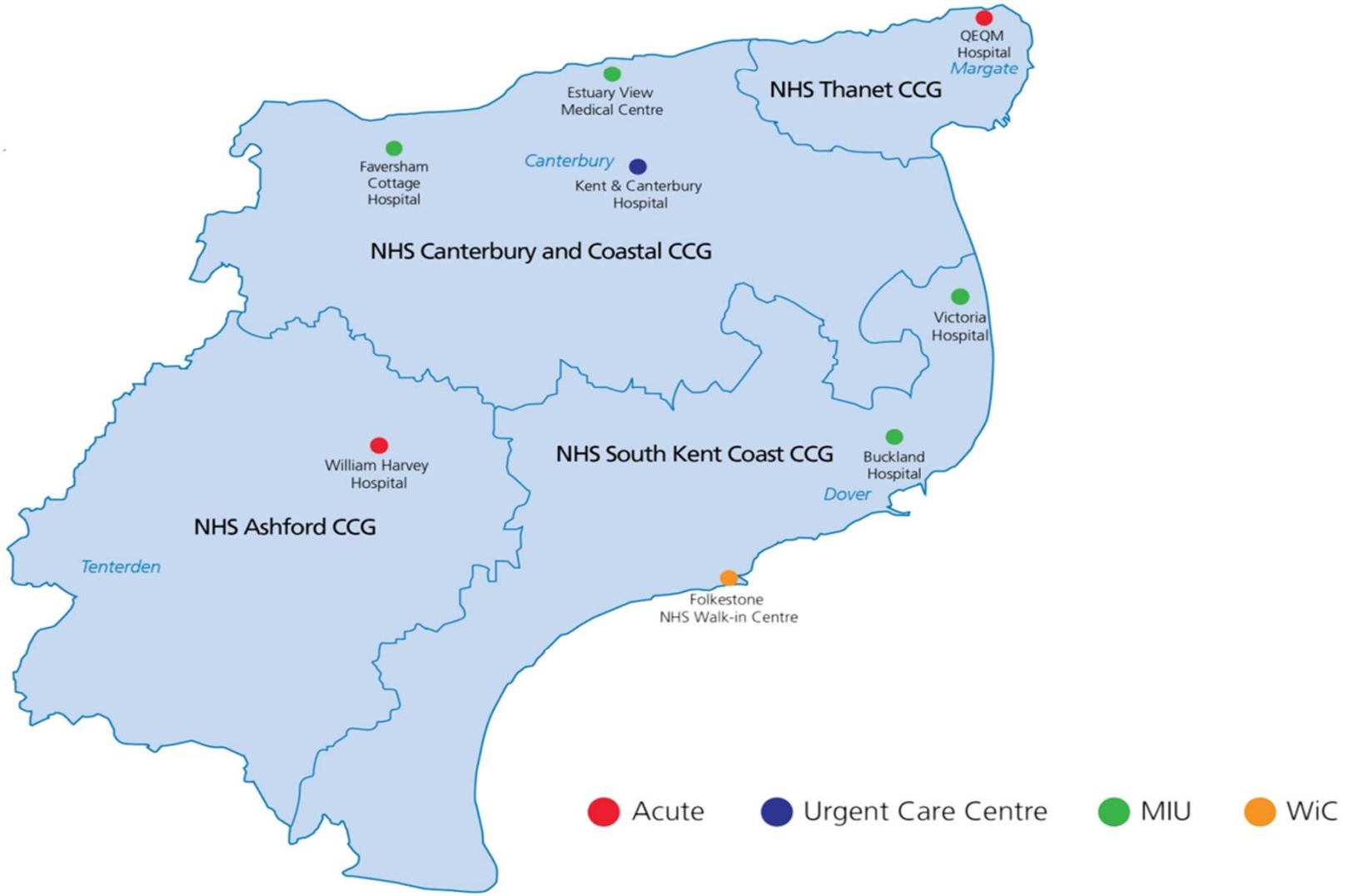
Madeline Homer said that there was need to clarify how the public consultation process will be conducted and the role of the Thanet Health & Wellbeing Board in this process. In response to a suggestion to increase the membership size of the advisory group, Councillor Wells indicated that the size was appropriate for the time being and any Members who wanted to take part in the discussions of the sub group could attend meetings and speak under Council Procedure Rule 20.1.

Meeting concluded: 8.40 pm

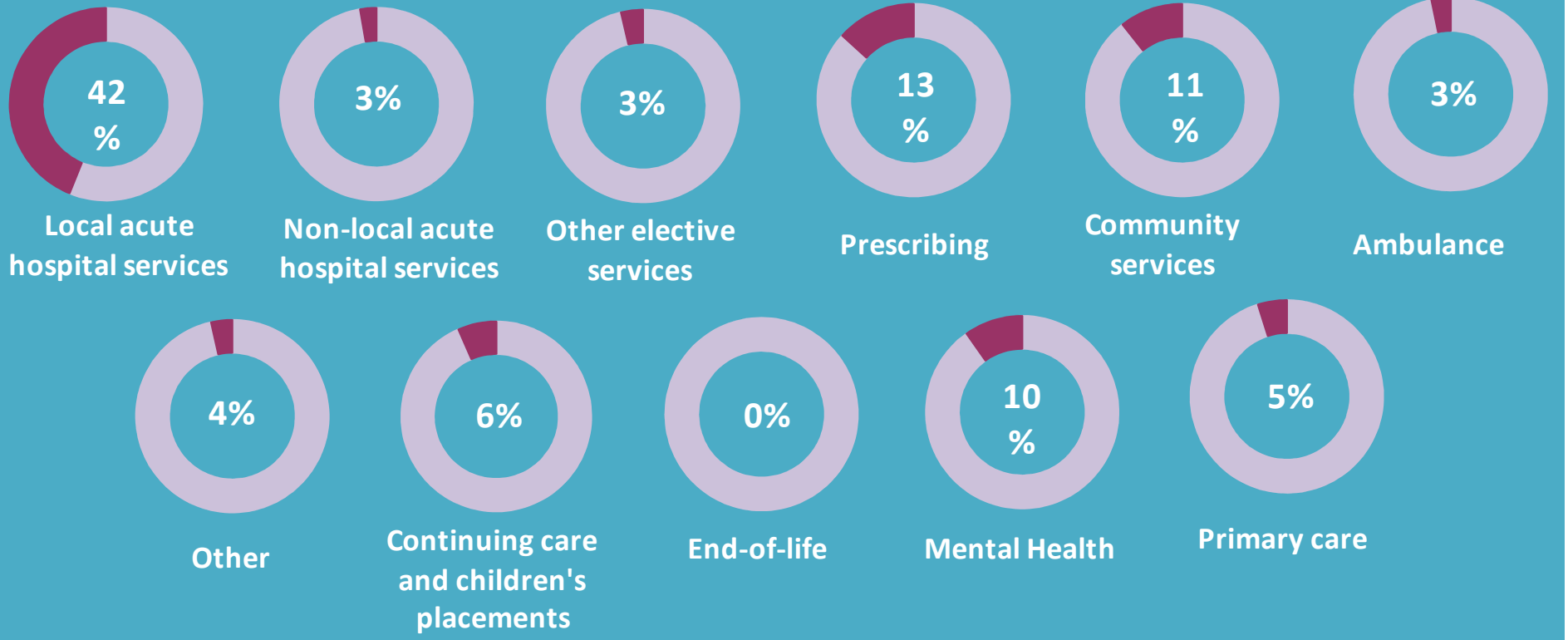
Thanet District Council
QEQM Hospital
Cabinet Advisory Committee

Hazel Carpenter
Accountable Officer
NHS Thanet Clinical Commissioning Group
21 April 2016

CCGs in east Kent



Financial scope of CCGs including primary care



Case for change

- Ongoing rising demand for care
- Fragmented services
- Unattractive clinical and practitioner roles
- Perverse incentives for clinical professionals and providers
- Insufficient funding for current way care is funded
- Poor performance
- Specialist skills shortages
- Gaps: Finance, Quality and Inequalities

East Kent Strategy Board Update

- Through the autumn the Board have been focussing on:
  - Forming a coalition of local health and social care leaders and developing a shared vision;
  - Understanding the map of current and planned reviews and initiatives in place across the economy;
  - Developing a robust Kent Integrated Data set (formerly Year of Care) which allows us to really understand flow across the health and social care system and;
  - Working with colleagues across Kent and Medway to understand the impact in east Kent of the Vascular and Stroke reviews.

Future Timetable

By Easter:

- Governance arrangements and an agreed process will be in place;
- The east Kent case for change will be agreed and;
- Key priorities for the gaps will be identified;

By end April:

- We will be able to describe the emerging clinical models for the key priorities
- We will be developing the criteria by which those models will be tested
- Engagement with key stakeholders, including the public will be underway

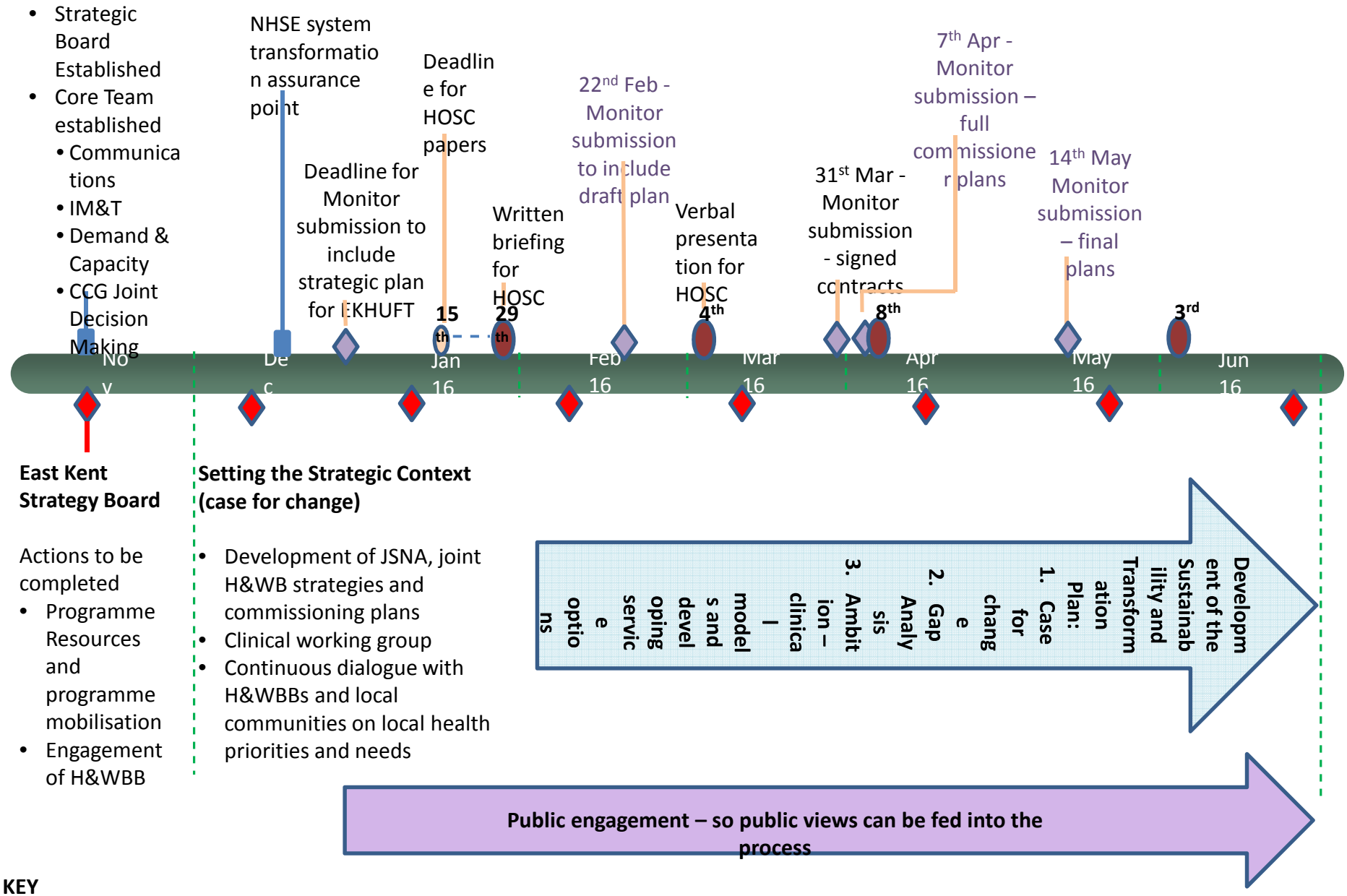
Future Timetable

By end of May:

- Governance arrangements and an agreed process will be in place;
- The east Kent case for change will be agreed and;
- Key priorities for the gaps will be identified;

By end April:

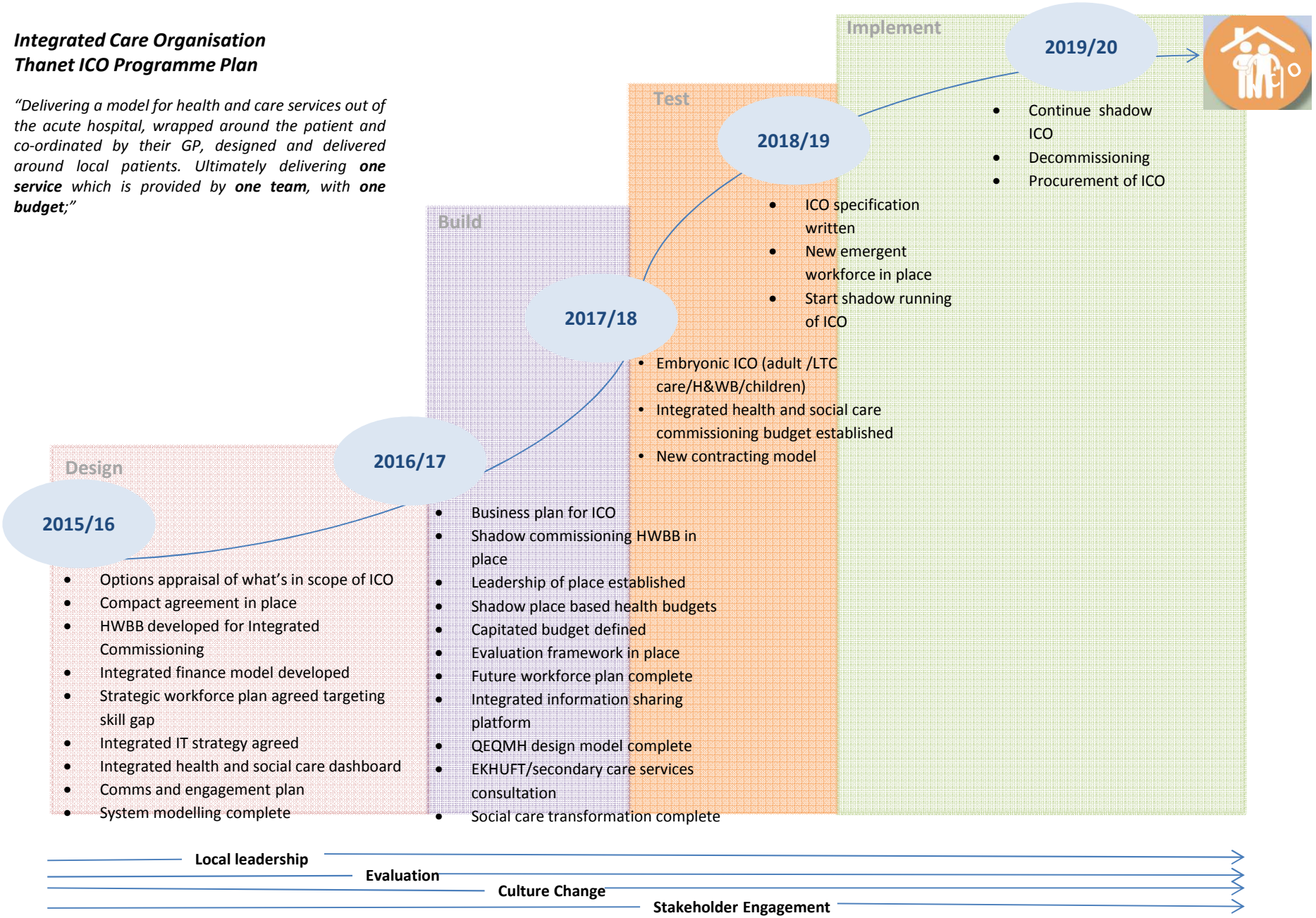
- We will be able to describe the emerging clinical models for the key priorities
- We will be developing the criteria by which those models will be tested
- Engagement with key stakeholders, including the public will be underway


Strategic Board Established
Core Team established
Communications
IM&T
Demand & Capacity
CCG Joint Decision Making
NHSE system transformation assurance point
Deadline for Monitor submission to include strategic plan for EKHUFT
Deadline for HOSC papers
Written briefing for HOSC
22nd Feb - Monitor submission to include draft plan
Verbal presentation for HOSC
31st Mar - Monitor submission - signed contracts
7th Apr - Monitor submission – full commissioner plans
14th May Monitor submission – final plans
15th
29th
4th
8th
3rd
Nov
Dec
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
East Kent Strategy Board
Setting the Strategic Context (case for change)
Actions to be completed
Programme Resources and programme mobilisation
Engagement of H&WBB
Development of JSNA, joint H&WB strategies and commissioning plans
Clinical working group
Continuous dialogue with H&WBBs and local communities on local health priorities and needs
Development of the Sustainability and Transformation Plan:
1. Case for change
2. Gap Analysis
3. Ambition – clinical models and developing service options
Public engagement – so public views can be fed into the process
KEY
East Kent Strategy Board Meeting
HOSC meeting

Thanet Future
Accountable Care Organisation

Integrated Care Organisation
Thanet ICO Programme Plan

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP, designed and delivered around local patients. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*



Thanet ICO
Model of Care Roadmap

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP, designed and delivered around local patients. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*

2015/16

- Integrated health and social care teams
- Integrated pathway for diabetes, COPD, HF
- Elective pathway re design
- Extended access to PCMH
- Falls and frailty pathway
- Enhanced care in care homes
- Discharge to assess
- Ambulatory care
- Community equipment
- Care act
- Dementia diagnosis
- Community navigators

2016/17

- Integrated care planning
- NHS 111 procurement
- Community ownership model (Newington)
- Exemplary end of life care
- Primary care hub in QEQMH
- Enhanced support for living with Dementia
- Patient transport
- MH crisis teams and psychiatric liason
- Carers supported
- Expanded community provision
- Personal health budgets

2017/18

- QEQMH functioning as community hub
- Self-management model
- Fully integrated urgent response in community
- Visiting paramedic/999 teams

2018/19

2019/20

Local leadership

Evaluation

Assistive Technology

Codesign

DRAFT Nov 15

Accountable Care Organisation (ACO)

Thanet HWBB commission integrated OUTCOMES & PRIORITIES

Thanet Integrated Commissioning Plan

Locality Commissioning Priorities

There are 4 Localities within Thanet ACO

Key Components

- **Quex** – population 30k
- **Ramsgate** – population 51k
- **Margate** – population 42k
- **Broadstairs** – population 20k

That will become a provider of integrated out of hospital care

Key Components

- Access to specialist clinics in the community
- Pathways to prevent admission and to facilitate earlier discharge from hospital
- Rehabilitation
- Prevention
- Supporting independence
- Primary mental health
- Provider risk share agreement across localities

They will have an Integrated (capitated) commissioning budget

Key Components

- Accountability for budget spend
- Accountable for purchasing local services to deliver model of care
- Lead provider commissioning model
- Financial risk management

And become a locality Commissioner

Key Components

- Integrated locality capitated commissioning budget
- Accountability to develop local commissioning plan
- Risk share agreement across 4 localities
- Commissioning for quality and outcomes
- Commission to meet locality health needs and priorities
- Integrated commissioner

Thanet Compact

Ensuring that the people of Thanet are supported to be well and healthy in their own homes and communities. Delivering a connected system, designed and delivered around local people, located in neighbourhoods.

Delivering improved integrated health and social care for the population of Thanet.

THANET COMPACT is made up of NHS Thanet CCG, Kent County Council, Thanet District Council, Kent Community Health Foundation Trust, East Kent Hopsitals Foundation Trust, Kent and Medway Partnership Trust, Kent Integrated Care Alliance (KICA), Local Medical Committee (LMC), Integrated Care 24 (IC24), South East Coast Ambulance Service (SECAmb) and the University of Kent.

Thanet Compact

To maximise the health benefits to the whole community through integrated working, sharing knowledge, experience, expertise and resources.

Delivering improved integrated health and social care for the population of Thanet.

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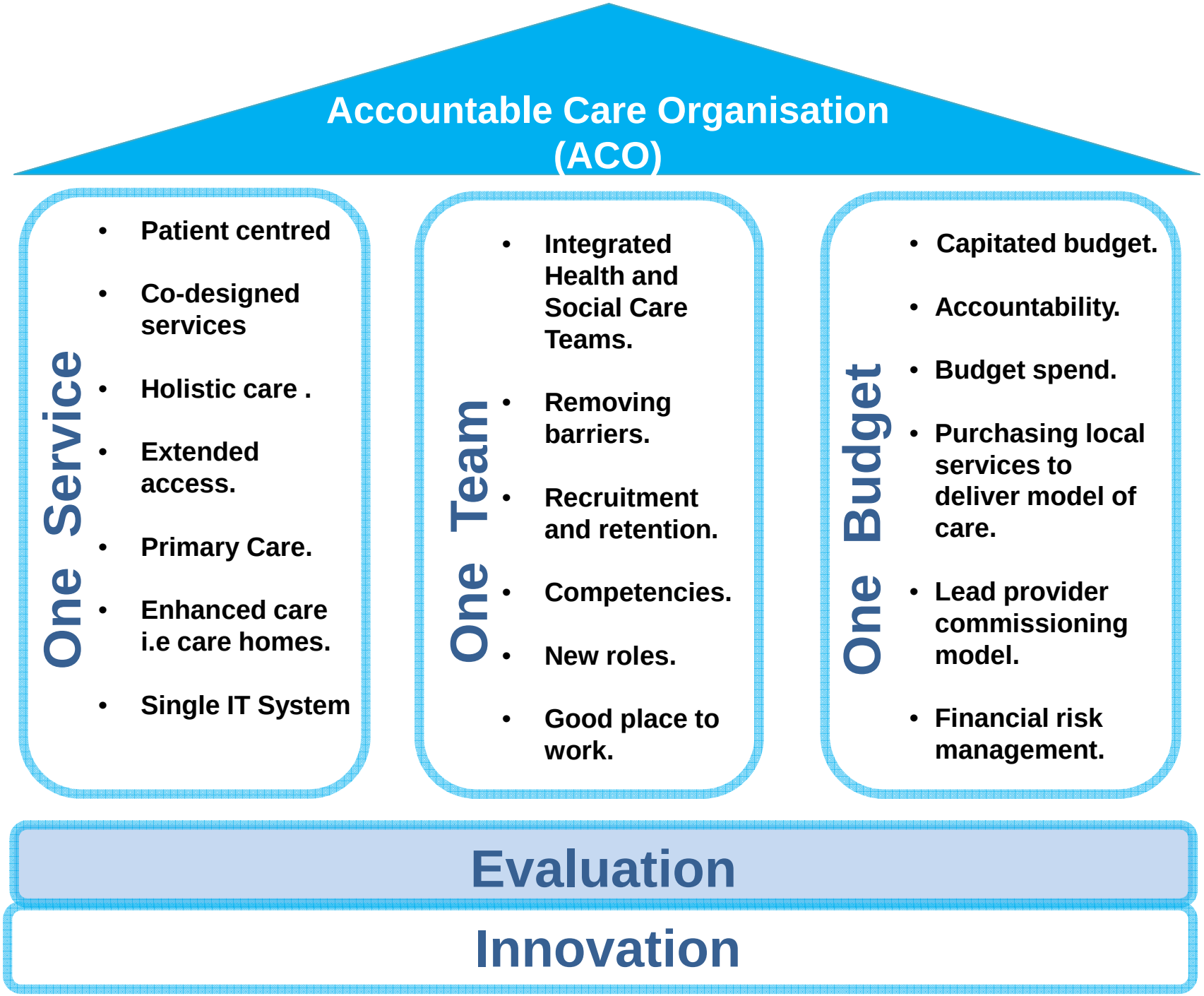
Accountable Care Organisation
(ACO)
One Service
Patient centred
Co-designed services
Holistic care .
Extended access.
Primary Care.
Enhanced care i.e care homes.
Single IT System
One Team
Integrated Health and Social Care Teams.
Removing barriers.
Recruitment and retention.
Competencies.
New roles.
Good place to work.
One Budget
Capitated budget.
Accountability.
Budget spend.
Purchasing local services to deliver model of care.
Lead provider commissioning model.
Financial risk management.
Evaluation
Innovation

Thank You

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