To:	Thanet Health and Wellbeing Board – January 2014
Subject	Patients with Multi-Morbidity – Over 75's
From	Ralph McCormack Interim Chief Operating Officer – Thanet CCG
Classification	Unrestricted

Introduction

Appendix 1 reminds us of the work done with partners in Thanet to agree a set of priorities for commissioning intentions in formulating a work plan for 2013/14. The first 2 of these are of particular relevance to the over 75's.

Thanet Clinical Commissioning Group held a workshop to gather views on the issues facing the above population in order to inform strategic thinking and development to ensure improved service responses. Appendix 2 represents the conclusions of the clinicians who attended the event and is intended to inform the debate about the strategic direction of travel.

Recommendation

Members are asked to consider the content of this report and agree that a summit should be held with partners to inform the development of a Thanet strategy and set priorities for this group of residents.

Ralph McCormack
Interim Chief Operating Officer
Thanet CCG

Appendix 1

Thanet Integrated Commissioning Priorities 2013/14

Representatives from Kent County Council, Thanet Clinical Commissioning Group, Thanet District Council and Public Health met to discuss areas where joint commissioning was a high priority for each stakeholder. Rather than producing a long list of common areas, it was agreed to focus on 4 key themes to be included in the work plan for delivery during 2013/14. The table below shows, at a high level, how each of the four themes meets the priorities of each organisation and link with the Kent Health & Wellbeing Strategy. The first 2 have particular relevance to the population of over 75's.

	Why is this important for the CCG?	**Why is this important for KCC?**	**Why is this important for TDC?**	**Why is this important for Public Health?**	**Links to Kent Health & Well Being Strategy**
Short Term Care and Support Work streams - Reducing unnecessary hospital admissions/ supporting better discharges.	Unscheduled emergency admissions are a significant cost to the local NHS budget and put added pressure on precious urgent care resources. It is better for patients to have their care managed in a more proactive way reducing the risk of emergency admissions and giving patients greater choice.	• supporting independence, preventing decline into dependence • hospital episodes recognised as one of the pre-cursors to permanent admission to care homes, a significant and on-going cost to KCC/clients • KCC are keen to manage support in a proactive, enabling way to provide right intervention at right time for right amount of time rather than services that maintain a level of dependence • KCC are keen to promote enablement and IAG to support self-care	An indirect impact for TDC but we wish to reduce levels of poverty in the local area and a decent proxy for monitoring that, is that people are not attending hospital inappropriately and registering and attending a local GP. This is	Health commissioning resources are scarce, yet demand is increasing as the population ages. Hospital admissions is one area that we all consider there are efficiencies to be gained through more care being community	Outcome 1, 3, 4 & 5

			particularly clear in the work undertaken by the Margate Task Force and Troubled Families programmes as well as through more broad community engagement. Supports the financial position of the Public Sector by ensuring residents take up universal services first, and specialist services as necessary and not the other way round.	based and more preventative in nature. Resources freed up can then be channelled into areas of greater need.	
Long Term Care and Support Work streams - Developing an integrated health and social care response (i.e. integrated teams/ pathways,	The delivery of seamless health and social care is a local and national priority. It is better for the patient that their care is co-ordinated and that there is a single access point to support when help is needed. Primary care led integrated multi-disciplinary teams can deliver more targeted proactive support to patients.	• Delivery of the right support to the individual in the right environment through an integrated response • Proactively managing people's support needs rather than managing people as they reach crisis point • Utilising risk stratification to enable proactive management of individuals	Stabilises the community and residents receive the services that they need, and not the services that they request. Clear opportunity to develop new skills and jobs in care sector to support growth of	Long terms conditions, the aging population are the biggest Public Health challenge of the 21st Century. Evidence suggests we should systematically	Outcome 2 & 3, 4 & 5

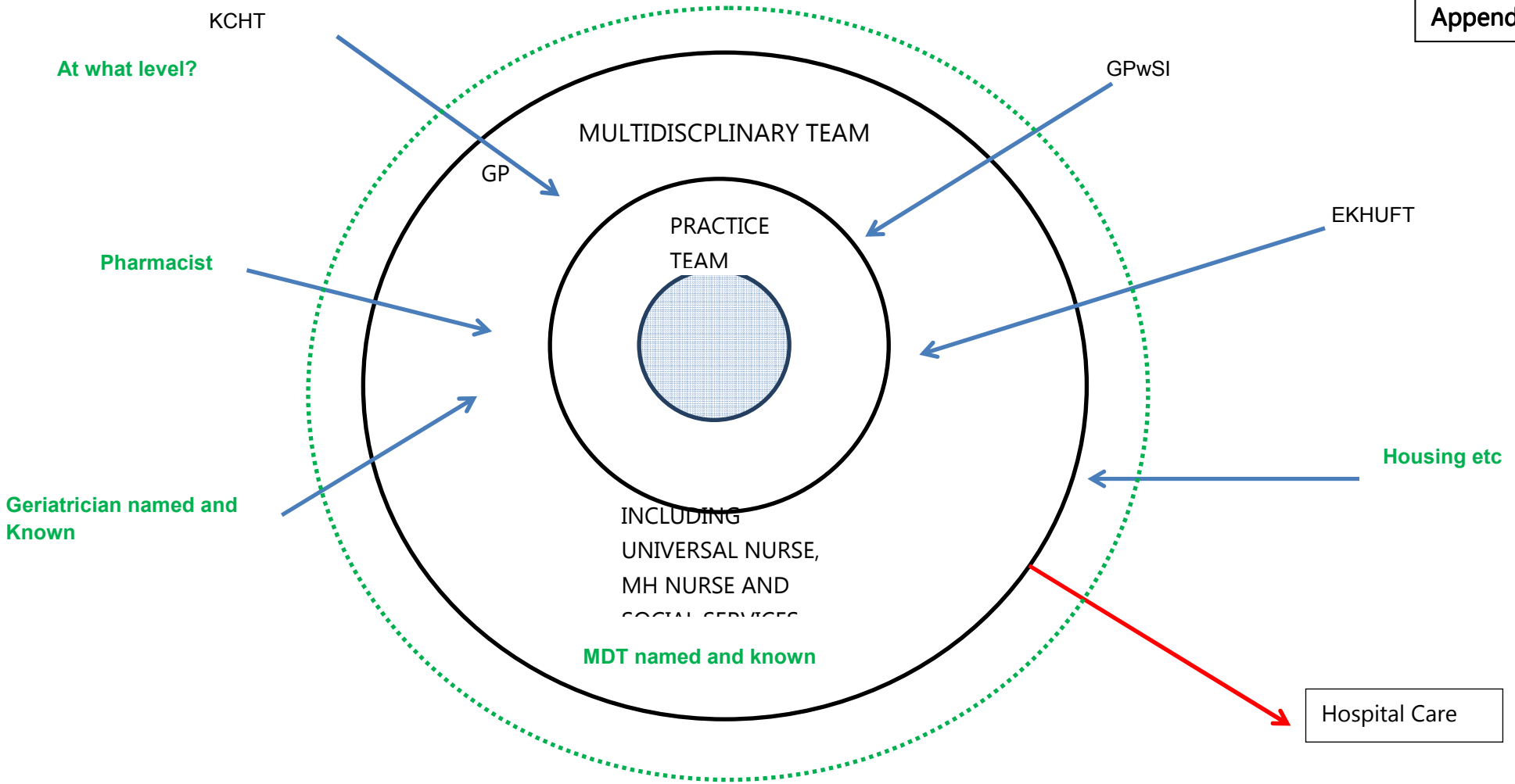
Key Strategic Partnerships)		• Proactive management of Long Term Conditions • Integrated H& SC response delivered through a range of partners including the Private and Voluntary Sector • Supporting the meeting of outcomes through teletechnology, equipment and enablement, supported by universal services that promote self-care	local elderly populations.	work through who is most at risk of utilising care resources, wrap holistic care around individuals to improve their experience, improve their ability to self-manage, improve outcomes whilst minimising costs. KCC Public Health has a particular interest in developing integrated care as the Commissioner of Health Trainer service which is envisaged to become an integral element of integrated teams supporting self-management strategies for individuals.	
Improving	Thanet GPs have made improving Mental Health	•	TDC staff often	There is an overwhelming	Outcome

Mental Health	services their highest priority. This will include improving access to talking therapies and supporting patients to have their conditions better managed within Primary care.	Mental wellbeing is crucial for everyone, 1 in 4 people will have a mental health issue at some point in their lives. Having access to preventative services saves money across the system • We currently invest £126 million in adult mental health services, there is a joint mental health strategy 'live it well' to deliver health and wellbeing services across Kent • The three key drivers outlined in the Live it well strategy for the next 3 years are: increased personalisation, partnership working to improve services and better use of primary care. • Mental health continues to be a high priority for Public Health to address inequalities and stigma and improving mental health outcomes	report concerns for the mental health of residents when dealing with a range of issues including Community Safety/ASB cases, through to MTF and TF work. Need to understand demand levels and see services provided against that.	case to suggest that need and demand for mental health services is over and above what is actually available in Thanet. Understanding this need, what that need is and how distributed will allow for better integrated commissioning of health and social care to meet that need.	3 & 4

Tackling medication processes to improve patient outcomes	• More business in ensuring that medicines management processes are safe, clinically and cost effective. • Medicines not taken as prescribed pose a high risk in terms of patient safety and finance (waste) • Medicines taken incorrectly can also lead to unplanned hospital admissions • Reduce substance misuse by identifying more people who should be treated, especially those with a dual diagnosis of mental health	• Poor medication management can lead to deterioration of an individual's condition, hospital admission and escalation of care needs, sometimes requiring a change in care environment from community to Long Term Care. • KCC are introducing the Flexing of Domiciliary Care and trusting providers to flex to meet a persons changing needs, we need to dovetail this with the right health response to prevent hospital admissions • Inappropriate medication in Dementia Care Homes • Poor medication management does not support proactive management of long term conditions, can lead to confusion and falls and ultimately can lead to hospital admission/care home referrals.	The good or bad management of a drug users' treatment programmes can have an impact on the safety of the community. But overall, substance misuse is a key priority for the Community Safety Partnership.	Using medicines is one of the key medical interventions and yet, adverse effects of using multiple medicines, particularly in the elderly (e.g. falls) are a key driver for admissions, and for on-going morbidity.	Outcome 3,4 & 5

OVER 75s SERVICE REMODELLING

Appendix 2



All named and known individuals in team follow patient wherever they are in Thanet.

Also need to identify roles of SECAmb and primary care OOH

Care co-ordinator to be considered by practices/teams

Over 75 terminology should be changed to reflect the care of elderly patients requiring long term care with multiple morbidities such that a single care pathway is no longer appropriate.

What needs to happen?

1. Identify patients
2. Anticipatory care planning
3. Effective single point of access
4. Prioritisation of patients for enhances specialist input

OUTCOMES

The group discussed possible areas for outcomes if the pathway was working effectively.

- (Avoidable) admissions
- Re-admission
- Accessible services
- Maximising number of patients in non-care home environment
- Length of stay
- DTOC
- Dementia – better integration with MH teams
- Good information flows
- Efficient in terms of value for money
- Patient experience
- Preventative care in A & E
- % of appropriate patients with anticipatory care plans
- DNs etc become part of an integrated team
- Each individual provides appropriate input to their role
- Performance measured at team level
- Clinical champions and leaders empowered to lead the team
- SECAmb – number of times access patient notes before conveying
- Flags on systems for patients known as LTC (therefore don't need all the tests)
- Episodic care – no continuity of care. Therefore need geriatrician to follow known patients through the system
- All geriatric consultants are generalists
- Virtual clinics/wards
- All frail LTC (more than one LTC) have an anticipatory care plan OR those patients identified as likely to require hospital admission in the next year

There was also a question on how to effectively break down the barrier between providers to provide an integrated pathway for the patient

The group then considered implications for each provider to make the model happen:

GPs

- Identify patients (through DES)
- Anticipatory/Advanced care plans which should be jointly owned by all in the multidisciplinary team i.e. Health and Social Care + geriatrician.

- The care plans and communication within the team needs to work for individual teams and so is not proscriptive
- Design care co-ordinating arrangements in the new GP contract

Community services

- Work with GPs on risk profiling, identifying patients and anticipatory care plans
- Robust communication with GPs, secondary care, social care, OOH and SECAmb
- Robust IT transfer
- Nurses who
  - Know their patients
  - Are contactable
  - Are empowered to make decisions
  - Communicate with the MDT

Secondary care

- Geriatrician available for advice 7/7
- Continuity of care with geriatrician linking to practices
- Named geriatrician and back up