Organising Integrated Care
Thanet CCG

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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……..

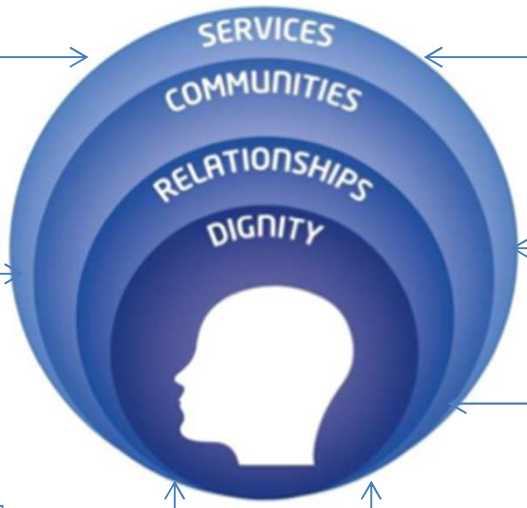
- **Change the service model** by right sizing health and care capacity and intentionally working to support individuals, families and communities to stay strong, diverting people from formal services wherever possible through sustainable, local, flexible individual and community solutions?

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

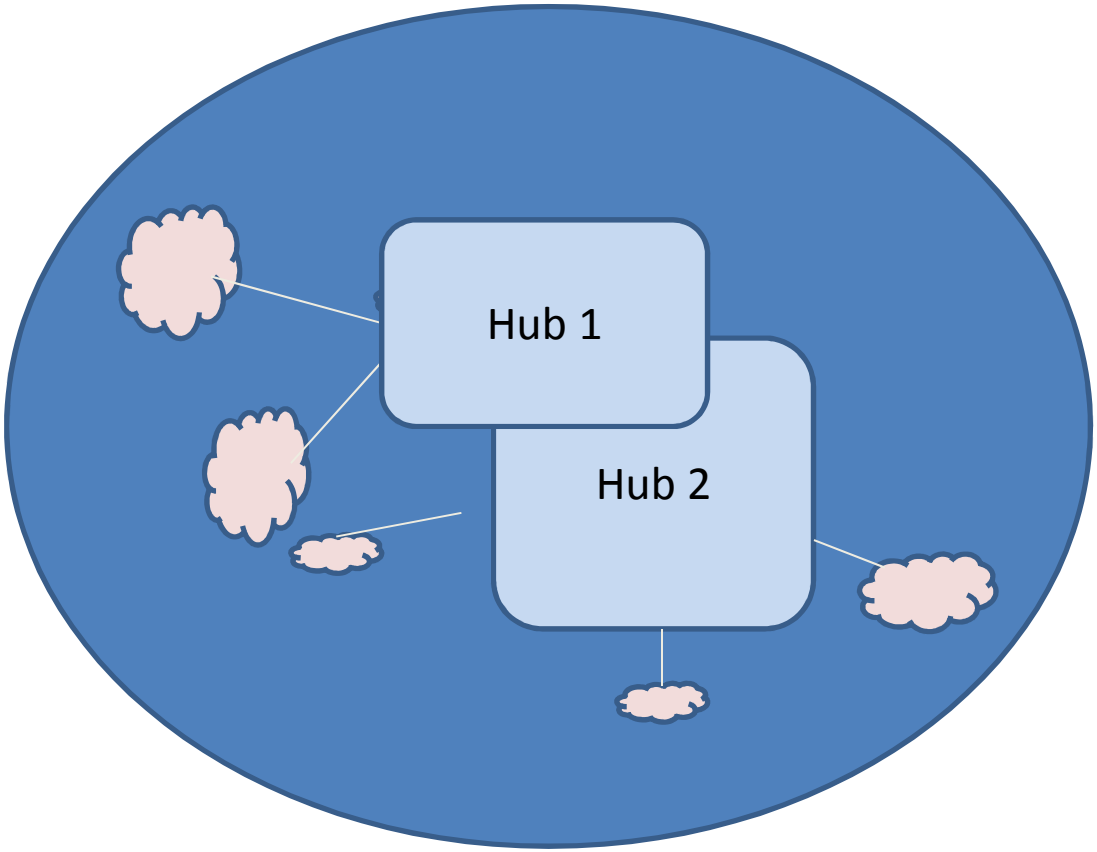
- Bottom up design which is professionally led
- Work together with partners across health and social care and voluntary sector
- Agreement on an Incremental process
- Strongly influenced by providers
- Form to follow function

Through

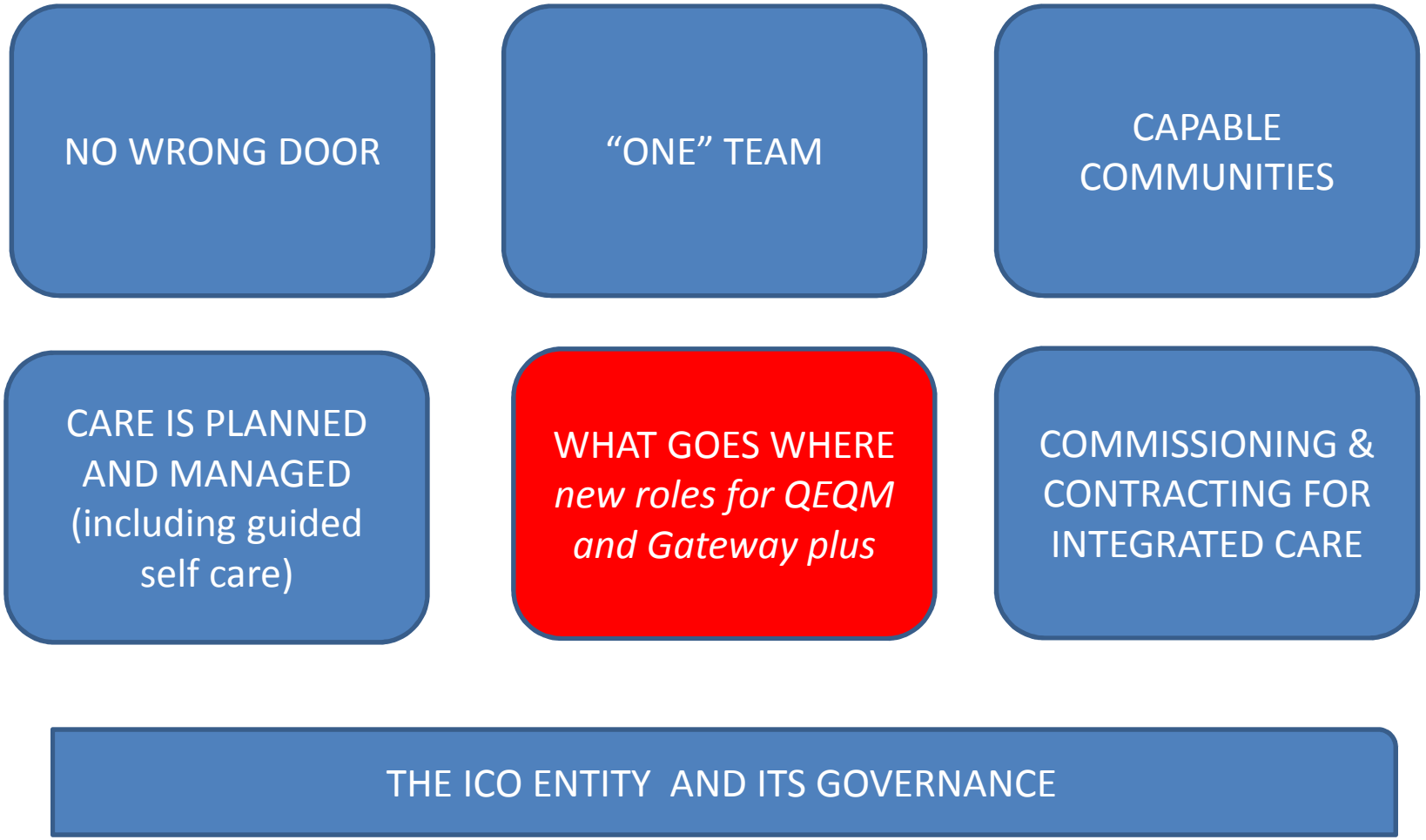
- Workshops to build and develop a shared “big picture” of what integrated care should look like
- Inclusive oversight and governance – leadership group
- A peoples panel to co design and drive change
- Corporate infrastructure groups: finance, commissioning, workforce
- CCG membership meeting, and acute 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



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