Public Document Pack

SOUTH KENT COAST HEALTH AND WELLBEING BOARD

White Cliffs Business Park Dover Kent CT16 3PJ
Telephone: (01304) 821199 Facsimile: (01304) 872300

14 November 2016

Dear Member of the Health and Wellbeing Board

NOTICE IS HEREBY GIVEN THAT a meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** will be held in the HMS Brave Room at these Offices on Tuesday 22 November 2016 at 3.00 pm

Members of the public who require further information are asked to contact Rebecca Brough on (01304) 872304 or by e-mail at rebecca.brough@dover.gov.uk.

Yours sincerely

Chief Executive

South Kent Coast Health and Wellbeing Board Membership:

P A Watkins (Chairman)	Dover District Council
Dr J Chaudhuri (Vice-Chairman)	South Kent Coast Clinical Commissioning Group
P M Beresford	Dover District Council
Ms K Benbow	South Kent Coast Clinical Commissioning Group
S S Chandler	Local Childrens Partnership Group Representative
Ms C Fox	Community and Voluntary Sector Representative
Councillor J Hollingsbee	Shepway District Council
Mr S Inett	Healthwatch Kent
Mr M Lobban	Kent County Council
Councillor M Lyons	Shepway District Council
G Lymer	Kent County Council
Ms J Mookherjee	Kent Public Health, Kent County Council

AGENDA

1 **APOLOGIES**

To receive any apologies for absence.

2 **APPOINTMENT OF SUBSTITUTE MEMBERS**

To note appointments of Substitute Members.

3 **DECLARATIONS OF INTEREST** (Page 4)

To receive any declarations of interest from Members in respect of business to be transacted on the agenda.

4 **MINUTES** (Pages 5 - 8)

To confirm the Minutes of the meeting of the Board held on 20 September 2016.

5 **MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD**

Any member of the Health and Wellbeing Board may request that an item be included on the agenda subject to it being relevant to the Terms of Reference of the Board and notice being provided to Democratic Services at Dover District Council (democraticservices@dover.gov.uk) at least 9 working days prior to the meeting.

6 **PROPOSALS FOR OTTERPOOL PARK: HEALTH IMPLICATIONS** (Pages 9 - 10)

To consider the attached report.

Presenter: *Julia Wallace, Otterpool Park Project Manager – Master Planning and Design, Shepway District Council*

7 **EAST KENT STRATEGY BOARD BRIEFING** (Pages 11 - 12)

To receive a presentation.

Presenter: *South Kent Coast Clinical Commissioning Group*

8 **KENT AND MEDWAY SUSTAINABILITY TRANSFORMATION PLANS UPDATE**

To receive a presentation.

Presenter: *South Kent Coast Clinical Commissioning Group*

9 **INTEGRATED ACCOUNTABLE CARE ORGANISATION UPDATE** (Pages 13 - 44)

To consider the report.

Presenter: *Mark Needham, Chief Officer, South Kent Coast Integrated Accountable Care Organisation*

10 **CHILDREN AND YOUNG PEOPLE GROUP UPDATE**

To receive an update.

Presenter: *Councillor Sue Chandler, Dover District Council*

11 **URGENT BUSINESS ITEMS**

To consider any other items deemed by the Chairman to be urgent in accordance with the Local Government Act 1972 and the Terms of Reference. In such special cases the Chairman will state the reason for urgency and these will be recorded in the Minutes.

Access to Meetings and Information

- Members of the public are welcome to attend meetings of the Council, its Committees and Sub-Committees. You may remain present throughout them except during the consideration of exempt or confidential information.

- All meetings are held at the Council Offices, Whitfield unless otherwise indicated on the front page of the agenda. There is disabled access via the Council Chamber entrance and a disabled toilet is available in the foyer. In addition, there is a PA system and hearing loop within the Council Chamber.

- Agenda papers are published five clear working days before the meeting. Alternatively, a limited supply of agendas will be available at the meeting, free of charge, and all agendas, reports and minutes can be viewed and downloaded from our website www.dover.gov.uk. Minutes are normally published within five working days of each meeting. All agenda papers and minutes are available for public inspection for a period of six years from the date of the meeting.

- If you require any further information about the contents of this agenda or your right to gain access to information held by the Council please contact Rebecca Brough, Team Leader - Democratic Support, telephone: (01304) 872304 or email: rebecca.brough@dover.gov.uk for details.

Large print copies of this agenda can be supplied on request.

Declarations of Interest

Disclosable Pecuniary Interest (DPI)

Where a Member has a new or registered DPI in a matter under consideration they must disclose that they have an interest and, unless the Monitoring Officer has agreed in advance that the DPI is a 'Sensitive Interest', explain the nature of that interest at the meeting. The Member must withdraw from the meeting at the commencement of the consideration of any matter in which they have declared a DPI and must not participate in any discussion of, or vote taken on, the matter unless they have been granted a dispensation permitting them to do so. If during the consideration of any item a Member becomes aware that they have a DPI in the matter they should declare the interest immediately and, subject to any dispensations, withdraw from the meeting.

Other Significant Interest (OSI)

Where a Member is declaring an OSI they must also disclose the interest and explain the nature of the interest at the meeting. The Member must withdraw from the meeting at the commencement of the consideration of any matter in which they have declared a OSI and must not participate in any discussion of, or vote taken on, the matter unless they have been granted a dispensation to do so or the meeting is one at which members of the public are permitted to speak for the purpose of making representations, answering questions or giving evidence relating to the matter. In the latter case, the Member may only participate on the same basis as a member of the public and cannot participate in any discussion of, or vote taken on, the matter and must withdraw from the meeting in accordance with the Council's procedure rules.

Voluntary Announcement of Other Interests (VAOI)

Where a Member does not have either a DPI or OSI but is of the opinion that for transparency reasons alone s/he should make an announcement in respect of a matter under consideration, they can make a VAOI. A Member declaring a VAOI may still remain at the meeting and vote on the matter under consideration.

Note to the Code:

Situations in which a Member may wish to make a VAOI include membership of outside bodies that have made representations on agenda items; where a Member knows a person involved, but does not have a close association with that person; or where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position. It should be emphasised that an effect on the financial position of a Member, relative, close associate, employer, etc OR an application made by a Member, relative, close associate, employer, etc would both probably constitute either an OSI or in some cases a DPI.

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 20 September 2016 at 3.00 pm.

Present:

Chairman:	Councillor P A Watkins
Councillors:	Councillor P M Beresford Ms K Benbow Dr J Chaudhuri Ms C Fox Councillor J Hollingsbee Councillor M Lyons Councillor G Lymer Ms J Mookherjee
Also Present:	Mr T Godfrey (Health Education England) Mr M Lemmon (Kent County Council) Ms J Leney (Shepway District Council)
Officers:	Head of Leadership Support Leadership Support Officer Team Leader – Democratic Support

12 APOLOGIES

An apology for absence was received from Councillor S S Chandler.

13 APPOINTMENT OF SUBSTITUTE MEMBERS

There were no substitute members appointed.

14 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

15 MINUTES

It was agreed that the Minutes of the Board meeting held on 28 June 2016 be approved as a correct record and signed by the Chairman.

16 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised on notice by Members of the Board.

17 DOVER AND SHEPWAY HEALTH PROFILES 2016

Ms J Mookherjee (Public Health Consultant, Kent County Council) introduced the Dover and Shepway Health Profiles for 2016.

The health priorities for Dover were as followed:

- Improving life expectancy by preventing suicide and heart disease and reducing smoking prevalence;
- Reduction in teenage pregnancy rates; and
- Improving physical activity in children and adults

The health priorities for Shepway were as followed:

- Improving physical activity in children and adults;
- Reduction in teenage pregnancy rates; and
- Reducing smoking during pregnancy.

In both districts the concentration of poor health was in the most deprived areas.

It was hoped that by sharing best practice in the two districts improvements could be achieved.

RESOLVED: That the Dover and Shepway Health Profiles be noted and actions agreed.

18 HEALTH INEQUALITIES STRATEGY

Ms J Mookherjee (Public Health Consultant, Kent County Council) introduced the Health Inequalities Strategy.

Across Dover and Shepway there were 19 areas of significant deprivation. The main groups affected were young people affected by a lack of opportunities and poor housing, deprived rural areas and areas with large social housing concentrations.

As part of tackling health inequalities, a place shaping approach was required. There was a need to map assets and areas of greatest need and identify what actions were needed and what could be done to sustain positive change. The NHS work forces also needed to be equipped to tackle these issues.

A range of organisations held community health data and this needed to be drawn together. Members of the Board agreed on the importance of changing behaviour at a young age and programmes such as healthy eating policies in schools were cited. However, it was noted that positive behaviour change had to be sustained at home as well.

It was noted that the first piece of work that needed to be undertaken was to identify assets and ownership and this could be done through the local hubs.

RESOLVED: (a) That the Health Inequalities papers from Kent County Council, and in particular the new locality data profiles published by Public Health England, be noted.

(b) That the approach to tackling the most economically vulnerable communities first and gathering more information on the communities in question be supported.

(c) That a joined up approach not duplicating existing work be adopted.

19 WORKFORCE STRATEGY

Mr T Godfrey (STP Workforce Programme Manager (Kent and Medway), Health Education England) presented the report to Members.

The Board was advised that five priority areas had been identified for detailed examination by the Workforce Task and Finish Group, which submitted. These were:

- existing and emerging gaps
- new models of care
- productivity
- recruitment and retention
- developing a cross-cutting 'Brand of Kent'

Health Education England had agreed an allocation of £200,000 with Kent County Council to support the implementation of these actions.

A Local Workforce Action Board (LWAB) for Kent had been established as part of the Sustainability and Transformation Plan (STP) and would build upon the Task and Finish Groups work.

In response to members questioning how the individual STPs being developed by local organisations would link with the wider STP, it was stated that the LWAB would provide a co-ordination role. The co-ordination of local organisation plans and models of care would allow planning for workforce training needs and the challenge was to bring together the differing views of each organisation so that they fit within the wider need.

In acknowledging that there was a movement of staff within and between organisations, it was noted that there was a need to ensure that training was 'passported' with the member of staff. Health Education England and Kent County Council had been working to develop new roles, upskill the existing workforce and improve the education, training and experience of trainees/students as part of the Skills Development Strategy. The need to support primary care and take pressure off of GPs was also acknowledged.

RESOLVED: That the report be noted.

20 CHILDREN'S ARRANGEMENTS ACROSS KENT

This item was withdrawn.

21 INTEGRATED COMMISSIONING BOARD DEVELOPMENT UPDATE

Ms M Farrow (Head of Leadership Support, Dover District Council) provided an update on the development of the Integrated Commissioning Board (ICB).

The Board was advised that the working group had met and was looking to work with Thanet on how they could both progress the development of an ICB. The next meeting would discuss options for resourcing and there needed to be agreement on how the ICB would function and the respective partners would meet their needs and responsibilities.

RESOLVED: That the update be noted.

22 EAST KENT STRATEGY BOARD UPDATE - TIME TO CHANGE

Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) presented the East Kent Strategy Board update.

The Board was advised that the next stage was to develop options for change to improve health and social care. A number of public engagement events would be held over the course of the next six weeks and proposals would have to be submitted to NHS England by 8 November 2016.

RESOLVED: That the update be noted.

23 URGENT BUSINESS ITEMS

The meeting ended at 4.18 pm.

Health and Wellbeing Board 22 Nov 2016

Briefing paper on the proposed new garden town - Otterpool Park

Introduction

Shepway District Council (SDC) and its landowner partner are bringing forward exciting proposals for transformational housing and employment growth at Otterpool Park, located next to Junction 11 of the M20 and Westenhanger Station. This new garden community will deliver up to 12,000 new homes, employment and community facilities in a rich landscape setting. The Council has a significant land-holding in the project and therefore can commit to delivery of a high quality place over the long term (the next 30 years). The project has active support politically from both district and county members, and from other local stakeholders such as East Kent College.

The council has been working closely with Department for Communities and Local Government on our proposals, and we are awaiting a decision on our bid to its Locally Led Garden Cities, Towns and Villages programme. The Expression of Interest to the programme provides further information and can be found on the SDC website: http://www.shepway.gov.uk/news/otterpool-park/EOI

Designing for health and wellbeing

Creating a new town presents a great opportunity to consider how heath and social care can be planned and provided for to meet current and future needs of our community. The council would also like to exploit the potential for encouraging healthier lifestyles that tackle issues of, for example, obesity and mental health.

SDC would like to discuss with partners how we can work together to deliver these wider social objectives for Otterpool Park, and think innovatively about practical steps to take that help do this. The purpose of this paper is to:

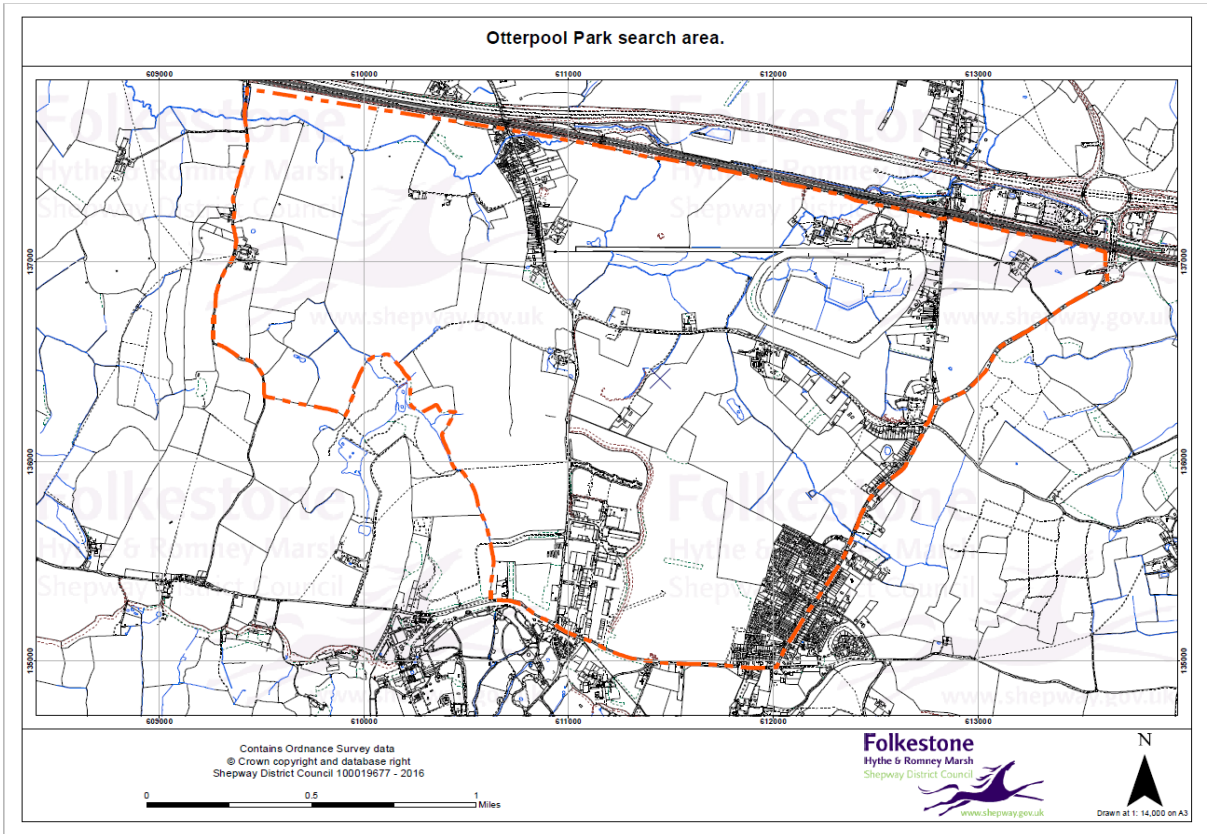
- seek the Board's views on the important issues that should be included in developing a vision and objectives for health and wellbeing at Otterpool Park; and
- discuss who needs to be involved and agree initial actions.

Planning context

Shepway District Council has two discrete roles at Otterpool Park – landowner and Local Planning Authority (LPA). Work on the Strategic Housing Market Assessment by the LPA has demonstrated a rise in housing need in Shepway, in part due to its aging population. The LPA has therefore begun work on a new Local Plan for the district which is likely to conclude that a new settlement is the best way of meeting its long term housing and jobs needs. This is due to the constraints that inhibit new development elsewhere in the district and the strain on services in existing towns and villages.

Shepway District Council landowner role

The council and its partner (the owner of Folkestone Racecourse) have commissioned a team to prepare a masterplan and planning application for the site, led by consultants Arcadis. The Area of Search within which the development will sit is show below.



The masterplan will be based on the set of Guiding Principles included in the Expression of Interest submitted to government, which includes social, environmental and economic objectives. Arcadis began the technical work in August 2016, with a planning application expected to be submitted in 2018.

Issues for discussion

- understanding the opportunities for Otterpool Park to address or improve health services in East Kent, and current examples of good practice in Kent and beyond.
- Considering how Otterpool Park can be designed to improve the wellbeing of those living and working there.
- Agreement on a way forward, including who needs to be involved and who leads. How would the Board like to be involved in future?

East Kent
Strategy Board

NHS

EKSB Board Update – October 2016

About the East Kent Strategy Board

The East Kent Strategy Board was established in September 2015 by local health and social care commissioners to spearhead a new drive to determine how best to provide health and social care services to the population of east Kent. The Board's ambition is to design a new way of delivering services in east Kent that will meet the future health needs of the population in the most appropriate way; improve the quality, effectiveness and efficiency of services; meet challenges around the availability of a scarce skilled workforce by delivering care in new ways; and do so in a way that is affordable and sustainable for the long-term.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS, public health and social care services. The Board oversees a work programme and advises local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

The East Kent Strategy Board last met on Thursday 13 October 2016. This briefing is an overview of the core content discussed at the October meeting, the Board's decisions and work to date.

Key programme highlights from September

- An evaluation criteria development workshop took place at the beginning of September.
- Members of the Board including Clinical Commissioning Group (CCG) clinical chairs met with east Kent MPs in Westminster to discuss the case for change, which was launched in August 2016.
- The Programme Director and CCG clinical chairs met with the Clinical Senate to discuss the potential scale of and scope of the consultation process.
- The first local care (out of hospital) modelling workshop took place with representation from all member organisations of the East Kent Strategy Board. It was decided this would be aligned and taken forward at a Kent and Medway level as part of the coherent development of the Sustainability and Transformation Plan for the area.

Programme timeline

The Board discussed recent feedback from NHS England following the first stage of their assurance process and progress in developing the Kent and Medway Sustainability and Transformation Plan (STP). The East Kent Strategy Board's work is closely aligned to work in neighbouring areas and is a part of the Kent & Medway STP.

The East Kent Strategy Board agreed that with the depth of modelling and other workforce, activity and financial analysis still to be done, together with the agreement at STP level that one approach to designing a model of local (out of hospital) care across Kent and Medway would be taken, the programme timeline will change. Undertaking the detailed work to design a system-wide model of care for east Kent and to develop options for service delivery from this, together with time allocated

to go through necessary assurance processes, means that a formal public consultation on any proposed service changes is now anticipated to begin in the summer of 2017. In addition, the Board noted that as local elections take place in May 2017, the 'purdah' process that allows for political campaigning in the run up to these elections will also impact on the timetable and it will not be possible to commence a formal public consultation until June 2017 at the earliest.

The Board recognised that there is still much work to do to get to this point of readiness and agreed the pace and urgency for transforming the way that health and social care services are delivered across east Kent has not changed.

Focus group research

The Board received a presentation on the output of a series of focus groups which took place at six locations across east Kent during August 2016. The groups were commissioned as part of the communications, engagement and involvement programme supporting the EKSB and were carried out by research company, Curved Thinking. Participants were recruited as a representative sample of the east Kent population according to age, gender, ethnicity, social group etc. A full report was presented to the Board outlining the key themes and issues discussed by the focus groups. It was agreed that these findings should inform the programme's work as new models of care and potential service options are designed and developed, as well as providing helpful insights on communicating change.

Finance stocktake

The Board received a presentation from the Finance workstream outlining the finance stocktake that has been in development following earlier modelling work completed by GE Finnamore to inform the programme. The exercise has enabled the workstream to gain an in-depth understanding of the activity delivered at a variety of different sites and to understand the scale of change that will be needed to help bring the east Kent system back into financial balance.

The Board also received updates from the IT, Estates and Communications and Engagement workstreams. The Chair of the Patient and Public Engagement Group (currently the Canterbury and Coastal CCG lay member) attended the Board meeting as a full member.

For more information about the work of the East Kent Strategy Board visit: http://eastkent.nhs.uk/

INTEGRATED health and social CARE South Kent Coast

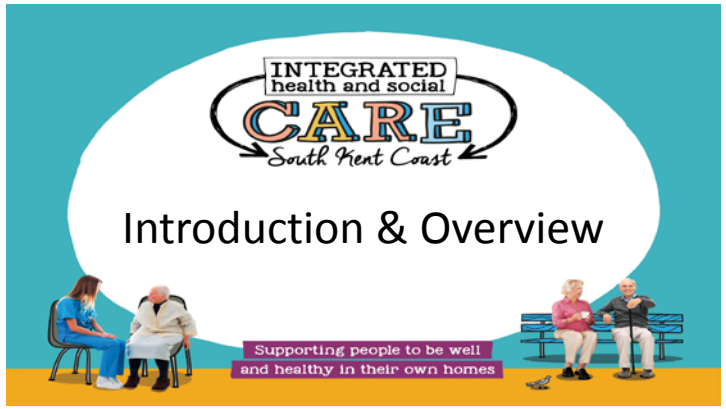
Integrated Accountable Care Development

Overview

v1.8 DRAFT

Supporting people to be well and healthy in their own homes

Our story



FOR TODAY

Agreement on service design principles

Pending agreement on Locality Service Model

Under development

To support people to be well and healthy in their own homes

15

*Deliver a model for health and care service out of the acute hospital, wrapped around the patient and co-ordinated by their GP; designed and delivered around local patients in **4 neighbourhoods**, supporting people to be as **independent** as possible. Ultimately delivering **one service** which is provided by **one team**, with **one budget***

Introduction

South Kent Coast Integrated Accountable Care

A partnership of health and care providers with a shared purpose – to support people to be well and healthy in their own homes in Deal, Dover, Folkestone and Hythe & Rural Localities.

Integrated commissioning to improve health and care outcomes - SKC Health & Wellbeing Board

How will care be reorganised?

To ensure high quality out of hospital care is available to all by mobilising support around practices:

1. Practice Partnerships supported by **Primary Care Teams**

2. Dedicated **Multidisciplinary Locality Teams** (without organisational boundaries)

3. Supra Locality Services offering more specialist provision

What will care look like in the new system?

- **One service, one team, one budget**
- **Organise** services more effectively in relation to settings of care – scheduled / unscheduled care
- **Virtual teams** – Health and care professionals work in flexible networks across organisational boundaries
- **Enablement, Preventative and proactive care -** promote multidisciplinary care planning for vulnerable, frail and elderly patients as an alternative to hospital
- **Freed up GP time –** to offer longer appointments for Long Term Conditions
- **Specialist interfaces –** Consultants input into case conferences as an alternative to Out-Patient clinics and provide 'hot clinics' for rapid assessments
- **Self-care -** proactively involve patients in their own care planning
- **Coordinate access to voluntary sector** – provide more practical and social support - via Care Navigators

Enablers

- **Integrated IT systems** – all professionals can read/write onto One Care Plan to reduce multiple assessments
- **Adopt digital innovation** – promote virtual consultations / interoperable systems
- **Federated care** - share resources / partnerships between practices

New approaches to accountability

- Commission for outcomes and quality
- Integrate Executive governance and planning systems

Reasons to transform local care

17

the aging population and burden of long term conditions has led to rising demand for care, which coupled with workforce pressures, can result in hospital or long term care being the default setting of care

Redesigning out of hospital care for 200,000 patients in 4 Localities

Introduction

South Kent Coast CCG covers the areas of Shepway and Dover, which include the main towns of Folkestone and Dover respectively.

Deprivation statistics are higher than the Kent average and the England average, with generally worse health outcomes.

The towns have an important location on the South Coast of England, with major transport routes between mainland Europe and London.

19 LSOAs feature in the most deprived decile for deprivation in Kent, 8 in Shepway (around Folkestone) and 11 in Dover (around Dover town).

There is another pocket of deprivation in the village of Aylesham.

Deprivation and health inequalities

Main Issues

Young adults in private rented accommodation

Particularly high levels of shared dwellings and overcrowding

Particularly pool living environment with high crime rates

Low incomes

High levels of out-of-work benefit claimants

Poor scores for education

Particularly high levels of movement / transiency

Health Risks / Behaviors

High smoking prevalence

Low levels of wellbeing

Health Outcomes

High premature mortality rates

Alcohol-related premature mortality and from ‘external causes’ particularly high

Deprived rural households

MAIN ISSUES

**Please note that this analysis is based on a single LSOA, meaning wide confidence intervals for some measures.*

Characteristics

- Low educational attainment and lack of qualifications
- Fewer out-of-work benefit claimants than other deprived groups
- Car ownership is higher than for other deprivation types
- Better living environment and lower crime rates than many other deprived areas
- Low levels of movement/transiency

Health Risks/Behaviours

- Fairly high smoking prevalence
- Low levels of wellbeing

Health Outcomes

- Particularly high rates of disability ('activities limited a lot')
- High premature mortality

Families in social housing

MAIN ISSUES

Characteristics

- Families with children in social housing
- Low incomes
- Poor scores for education
- High number of single parents
- Better living environment and lower crime rates than other deprived areas

Health Risks/Behaviours

- High smoking prevalence
- Low levels of wellbeing

Health Outcomes

- High premature mortality rates
- High emergency hospital admission rates
- High rates of disability ('activities limited a lot')

Young people in poor quality accommodation

MAIN ISSUES

Characteristics

- Young adults in private rented accommodation
- Particularly high levels of shared dwellings and overcrowding
- Better educated than other deprived types
- Particularly poor living environment with particularly high crime rates
- High levels of out-of-work benefit claimants
- Particularly high levels of movement/ transiency

Health Risks/Behaviours

- High smoking prevalence
- Low levels of wellbeing

Health Outcomes

- High premature mortality rates
- High rates of disability ('activities limited a lot')

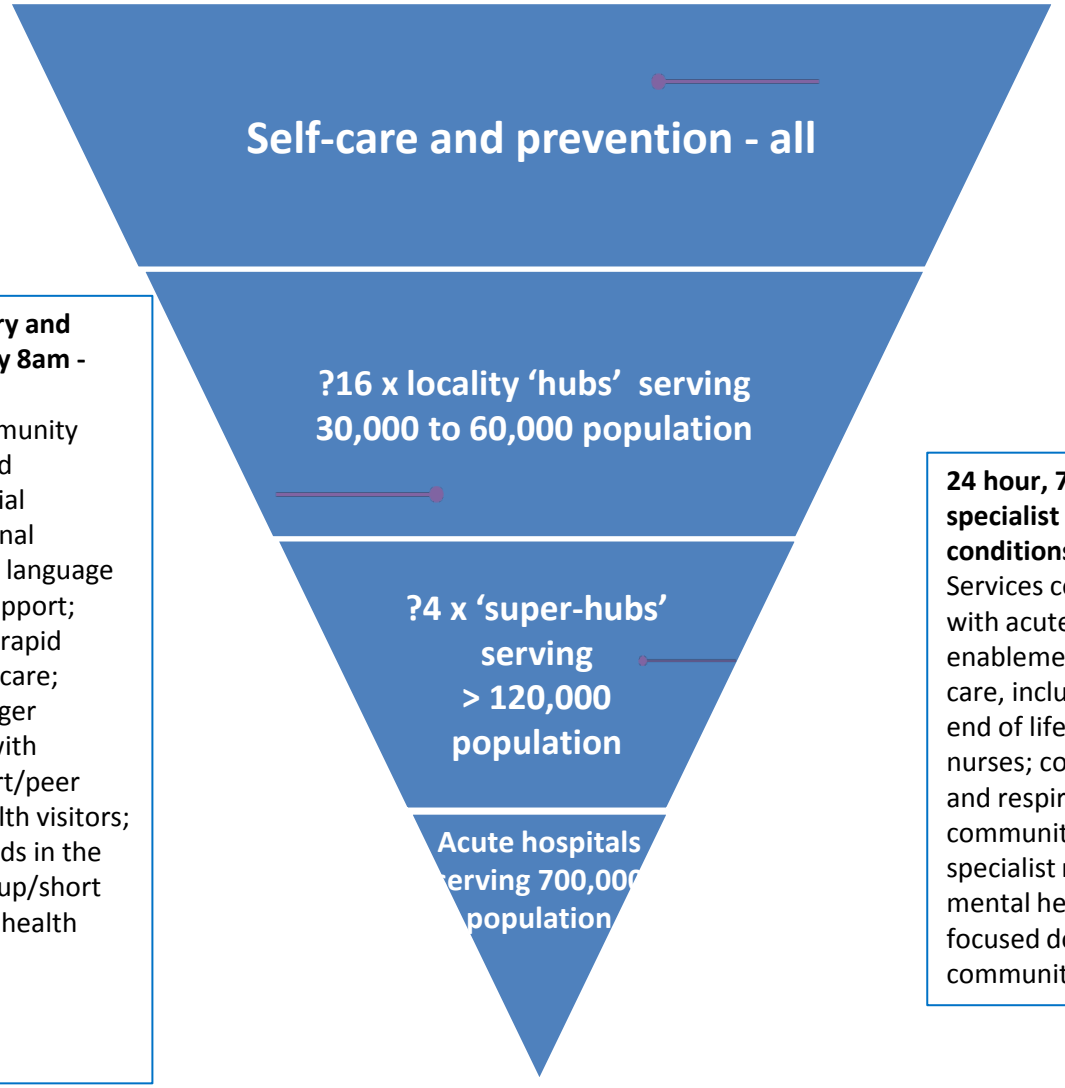
Introduction

Our approach to delivery of East Kent Strategy and STP

East Kent Strategy emerging thinking for 'out of hospital'/community-based services - for discussion

SKC approach: Our Out of Hospital service model is being developed 'bottom up' and aligned with the East Kent Strategy and the Kent and Medway Transformation Plan to ensure we have robust care systems to provide more care in the community at pace.

This includes alignment with the Kent County Council transformation programme around social care.



Greater focus on helping people to lead healthier lifestyles, stay well, and self-care where possible. Support to prevent ill-health and the worsening of existing conditions

Delivering enhanced primary and social care services, possibly 8am - 8pm, 7 days per week.
Services could include: community nursing, GPs, counselling and psychological therapies; social /domiciliary care; occupational therapy, physio, speech and language therapy; voluntary sector support; intermediate care including rapid response; urgent/same day care; community paramedics; longer appointments for patients with complex cases; carer support/peer support; palliative care; health visitors; health trainers; access to beds in the community to support step up/short term crisis care; and annual health care check services.

24 hour, 7 days per week services as well as specialist services for those with more acute conditions.
Services could include: rapid response/link with acute services; diagnostics, eg enablement, MRI; higher acuity ambulatory care, including mental health crisis; specialist end of life; specialist dementia care; specialist nurses; community geriatrician, cardiology and respiratory support; outpatient services; community midwifery; minor injury units and specialist mental health including perinatal mental health services, nurse led outcome focused domiciliary care. Could include community beds.

Better outcomes for the whole population

further discussion is required on how best to support the needs of the whole population with available resources

this includes clinical decision making on when best to involve more specialist expertise in patients care

22

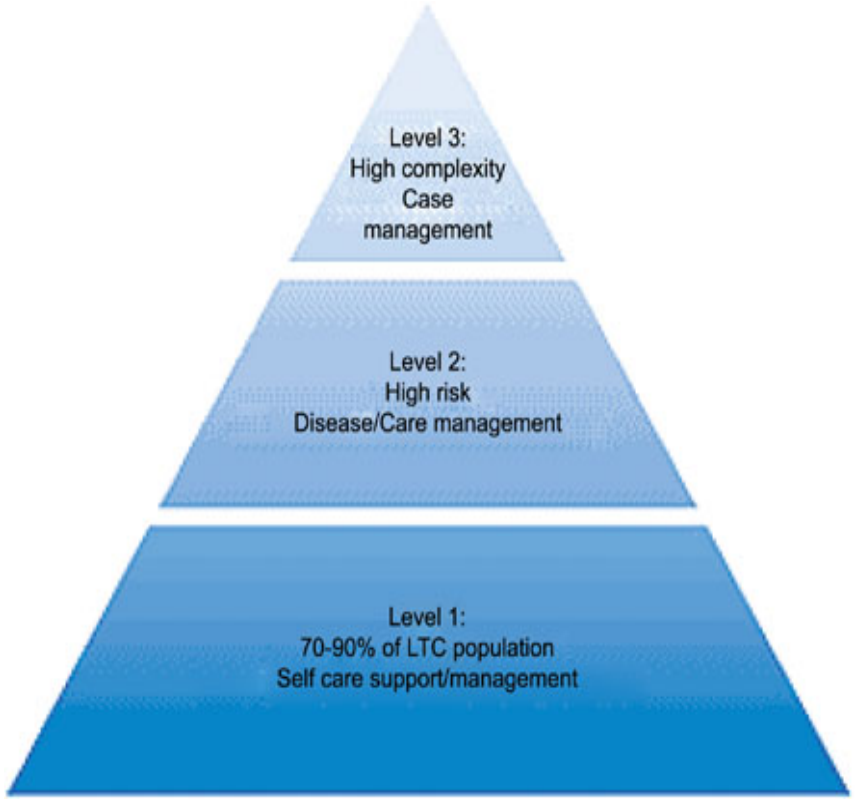
Our approach to delivering outcomes for the whole population

National policy has advocated for using risk stratification to identify the top **2% of people** with long-term conditions at high risk of frequent hospital admissions (2,000 people in SKC) (Direct Enhanced Service, Admissions Prevention).

23

In some localities this will be significantly more due to the gap in life expectancy.

However, further clinical discussion is required in view of evidence on 'regression to the mean'. See next slide.



NHS & Social Care LTC Model (2008)

The Kings Fund
Ideas that change health care

Authors
Shilpa Ross
Natasha Curry
Nick Goodwin

November 2011

Case management

What it is and how it can best be implemented

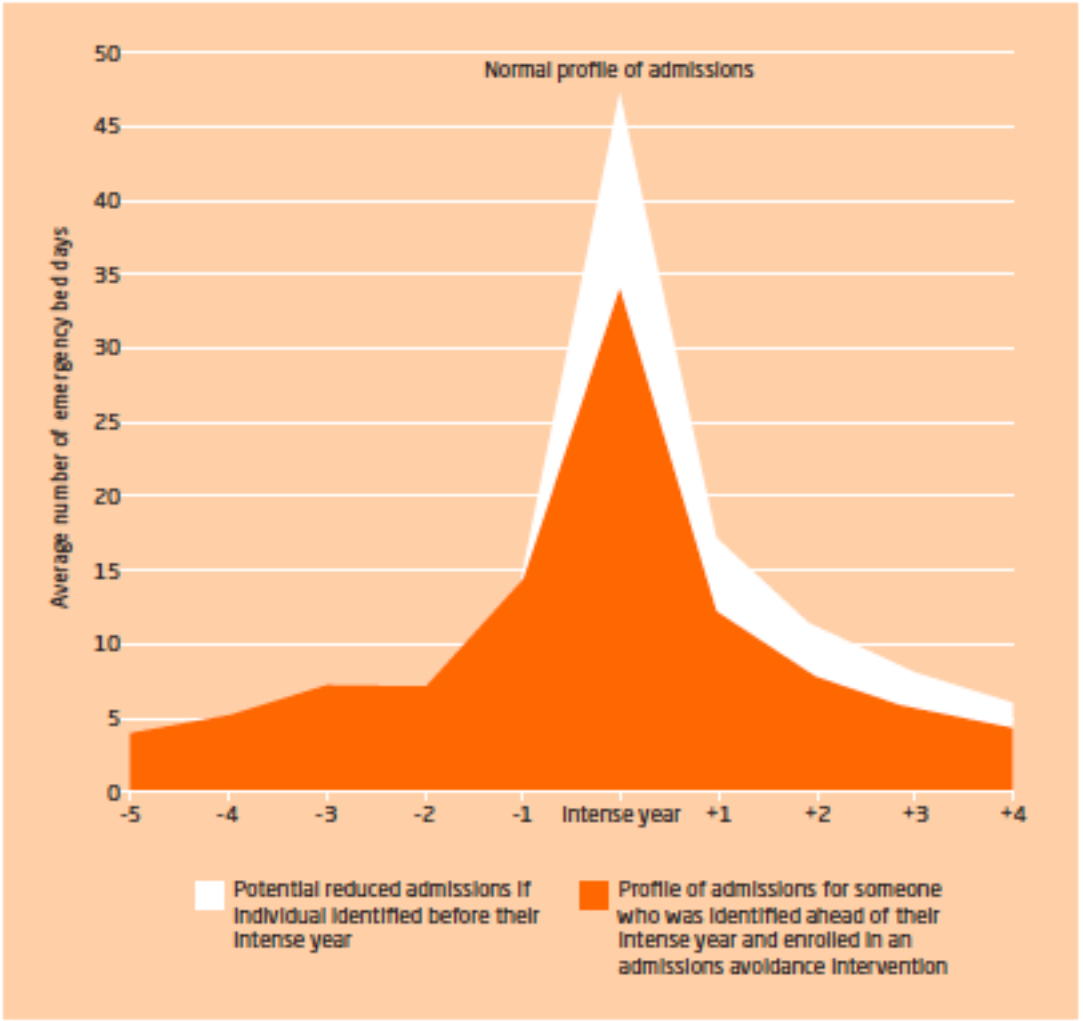
Any case-finding method needs to be able to identify individuals at high risk of future emergency admission to hospital.

Patients who are currently experiencing multiple emergency admissions typically have fewer emergency admissions in future – a phenomenon known as 'regression to the mean' (Roland et al 2005; Nuffield Trust 2011).

Therefore, offering case management to patients who are currently experiencing emergency admissions can be inefficient.

If a patient can be identified before they deteriorate, there is more potential to reduce admissions. Figure 1 above shows the pattern of admissions among a cohort of people with an intense year of admissions.

Figure 1 Regression to the mean



(From Lewis GH, 'Predictive modelling and its benefits', Nuffield Trust)

Introduction

IACO

Integrated Accountable Care Organisation
SKC IACO Timeline

INTEGRATED health and social CARE South Kent Coast

Integrated Accountable Care Development

Locality Service Model

v1.8

Supporting people to be well and healthy in their own homes

What's the big idea?

to refocus resources on preventative and proactive care by re-organising care more effectively

at the centre of the model is the conscious uncoupling of scheduled and unscheduled Primary Care

social outcome based care focused on promoting and supporting independence and wellbeing.

this will avoid the inevitability of unscheduled care being a daily add on due to the current model which is overstretched

Introduction

Our approach to developing a service model

VISION
To ensure high quality out of hospital care is available to all by mobilising support around practices

THE MEANS
To enable multidisciplinary working and care coordination

OPPORTUNITY
To refocus resources on preventative and proactive care

IMPACT
To improve outcomes and reduce inequalities for all patients

Creating the environment where all our practices are resilient and sustainable so that high quality out of hospital care can be offered to all.

For example:

- Widening the scope of Primary Care as part of the foundations of a fully integrated out of hospital system

- Greater resource sharing and partnership working between practices

At present there are multiple levels of care coordination which have the right intention, but can result in confusion.

An agreed system of multi-disciplinary working at a practice and locality/town level, will enable better care coordination.

This has the potential to reduce duplication and prevent avoidable admissions to hospital.

The aging population and burden of Long Term Conditions has led to rising demand for care, which coupled with workforce pressures, can result in hospital being the default setting of care.

Redesigning unscheduled care may free up clinical time to offer a proactive approach:

- Longer GP appointments for patients with chronic conditions
- Proactive management of patients to prevent the development of **chronic conditions**
- Enhanced care packages for **vulnerable and highly complex** patients that require community, mental health and acute services, wrapped around the practice.

New Ways of Working

to plan for what type of care needs to be available out of hospital through an inclusive approach with professionals and patients

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to promote new ways of working based around multidisciplinary care planning that leads to integrated care

to establish a Primary Care Team of health and care professionals around the patient

Locality Service Model

What types of care will be provided for a locality?

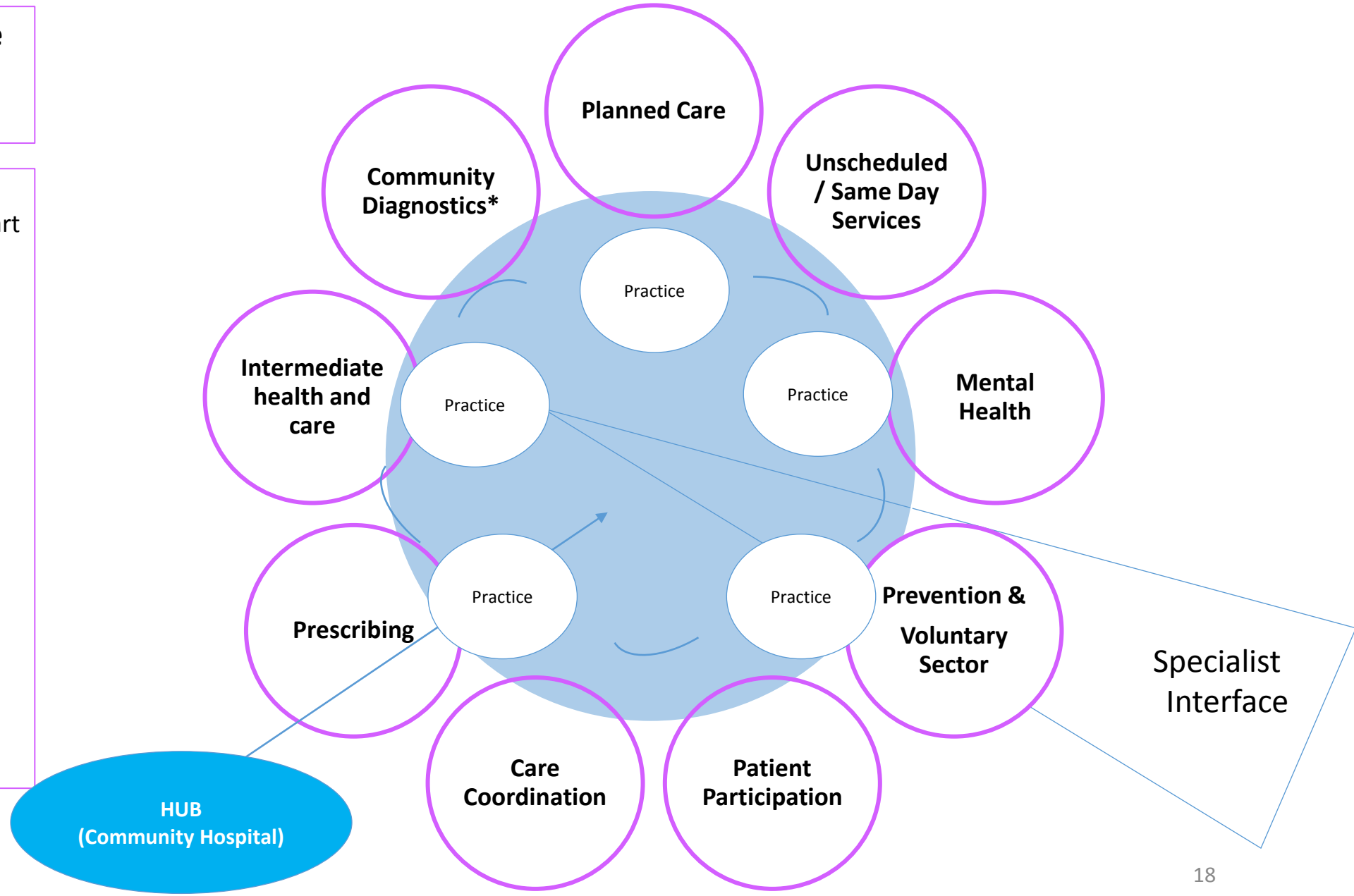
Our engagement sessions have proposed what care should be available in each locality.

It would be beneficial for all practices to work in partnership with providers as part of one **Primary Care Team**.

Each locality requires a **Hub**, such as a Community Hospital, that will provide diagnostics, same day services (illness and trauma) and other out of hospital services

A Specialist Interface, with consultants, working out of hospital to support Primary Care Teams and prevent avoidable hospital admissions.

*Including Social Care- functional Occupational Therapy assessments, use of equipment and assistive technology



Locality Service Model

Our engagement sessions suggest care should be organised at 3 levels in a locality and around the GP list:

1. **Practice Partnerships** supported by **a Primary Care Team**

2. A dedicated **Multidisciplinary Locality Team** (without organisational boundaries) based on trusted relationships and one care plan

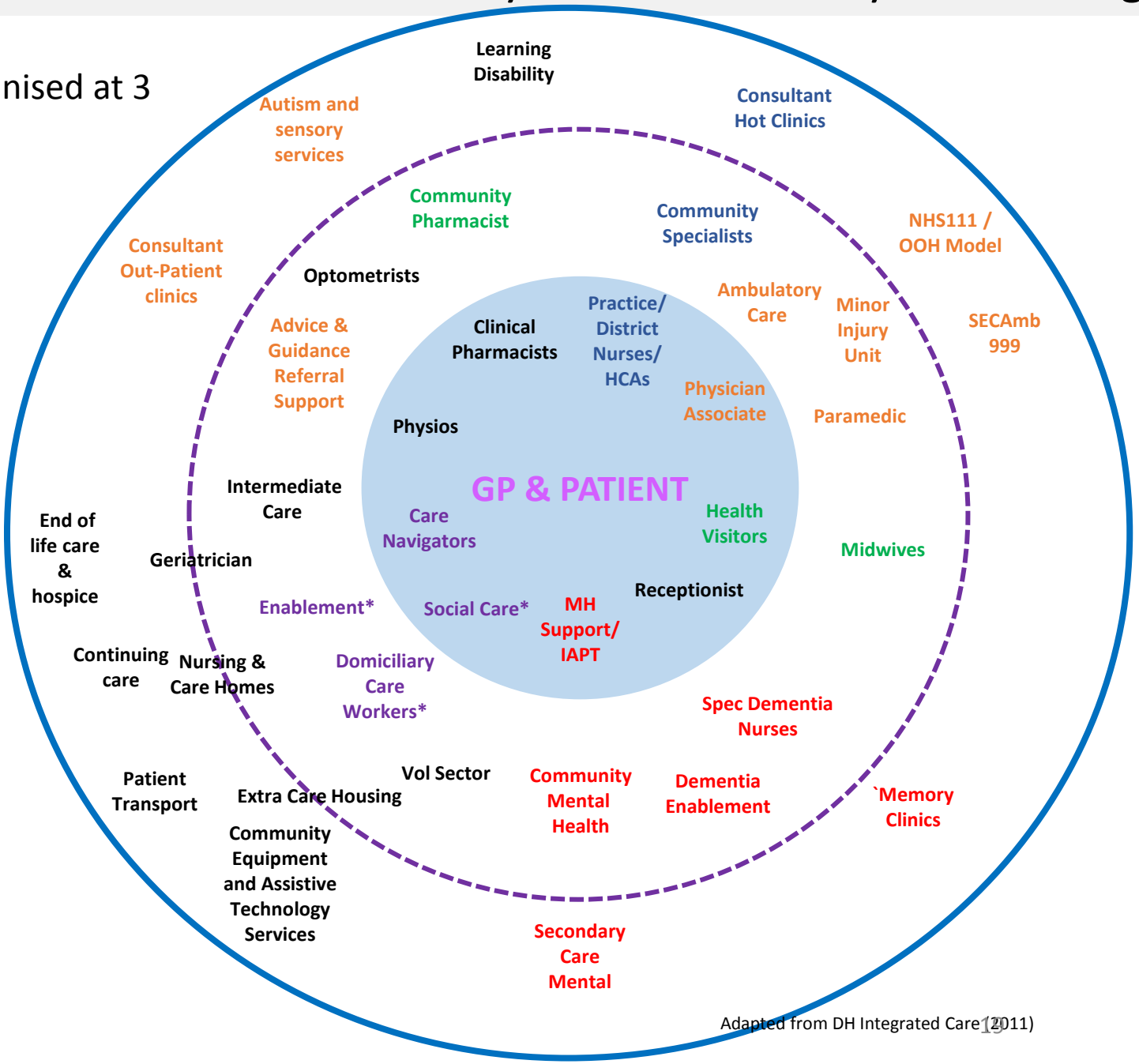
3. **Supra locality services** with more specialist provision due to small patient numbers and specialist professionals (across localities, East Kent or South East England)

Best **practice pathways** be followed at each level, but not resulting in fragmented care, or service gaps

Professionals work in **loose networks / clusters** across Primary Care and MDLT (colour coding is indicative of which professionals may work closely together)

*** See Social Care slide.**

Locality Model: New Ways of Working



Adapted from DH Integrated Care (2011)

Locality Service Model

Thoughts on what would a Primary Care Team would look and feel like to work in?

Health and care professionals working as one team to support a practice / group of practices

Virtual network of professionals - readily offering assessments, consultation, advice, guidance and treatment as **one package of care**

Multidisciplinary care planning at practice and locality level for more complex patients requiring specialist input

A holistic approach – to address health, mental health and care/lifestyle needs of the person

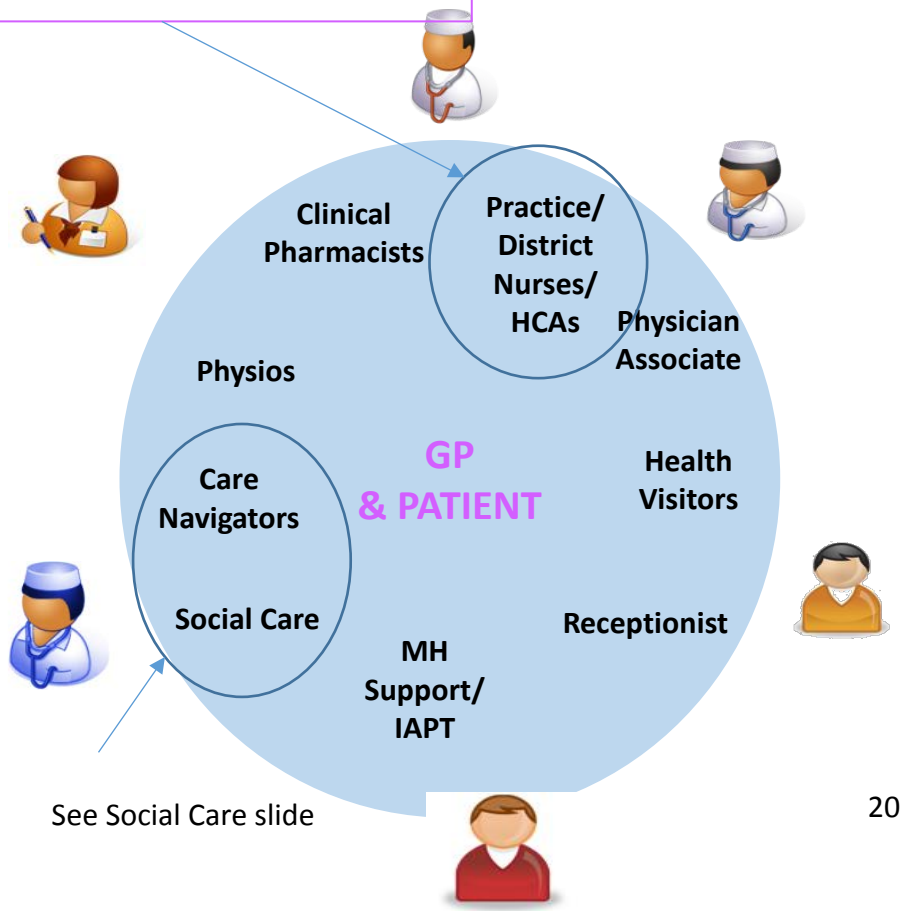
One care plan - held by the GP as the senior responsible doctor – which all professionals can read/write to

Employment and governance - Professionals can be employed by a range of organisations but agree to work to the principles of one locality service model

No 'send and receive'
- Referrals are made in person, in team meetings, wherever possible to promote joint working, reduce unnecessary referrals; supported by single points of access in each organisation.

Primary Care Nurse – develop one role for out of hospital nursing care as part of the Primary Care Team – this encompasses the traditional roles of both practice and district nurses

Case Manager- The team agrees the most appropriate professional to be the care coordinator (not the GP wherever possible)



Peripatetic working - in practice, community hubs, home settings of care, but can also have a team base with their employing organisation.

See Social Care slide

Options for meeting patients needs in different settings of care

Scheduled Care

Practice

Managed Care

Tier 1 – Primary Care

Tier 2 - Secondary Care in the community (Allied Health Professional Specialists)

Tier 3 – Consultant

Secondary Care in the Community

Chronic Disease

Management & Prevention

Multidisciplinary care planning and delivery

Named Care Coordinator

GP extended appointments for LTCs

Advice & Guidance from Consultant

Care Delivery – Practice & Primary Care Team

Locality

Complex & Vulnerable

Patients requiring **dedicated case conference and case management via a Virtual Ward,** who may otherwise default to hospital**.**

Led by Locality GP and multidisciplinary team

Supported by Consultant Interface

Locality Case Conference: *Step up to Virtual Ward*

Unscheduled Care

Locality/Hub

Home Visits

Patients requiring same day visits at home / care homes

Response times 2-4 hours

GPs, Paramedics, Allied Health, Professionals, Intermediate care

Home Visiting Team

Minor illness

Patients currently seen in practice or A&E minors

All same day access in one hub?
Streaming/triage via one number?
Co-located with Minor Injury Units?
8-8?
GP led & Nurse led

Primary Care Access Hub

Uncouple scheduled and unscheduled Primary Care

to create the right environment for Primary Care to thrive

to consider options for meeting patients same day care needs - Primary Care Walk In Hubs and Home Visiting Service

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to free up GP capacity to lead multidisciplinary care planning and offer longer appointments for patients with chronic disease

to manage demand for health and care through self management and services that support independence and self management .

Multidisciplinary care planning & coordination

to mobilise the right support, at the right time around the patient

to prevent avoidable hospital admissions through multidisciplinary care planning

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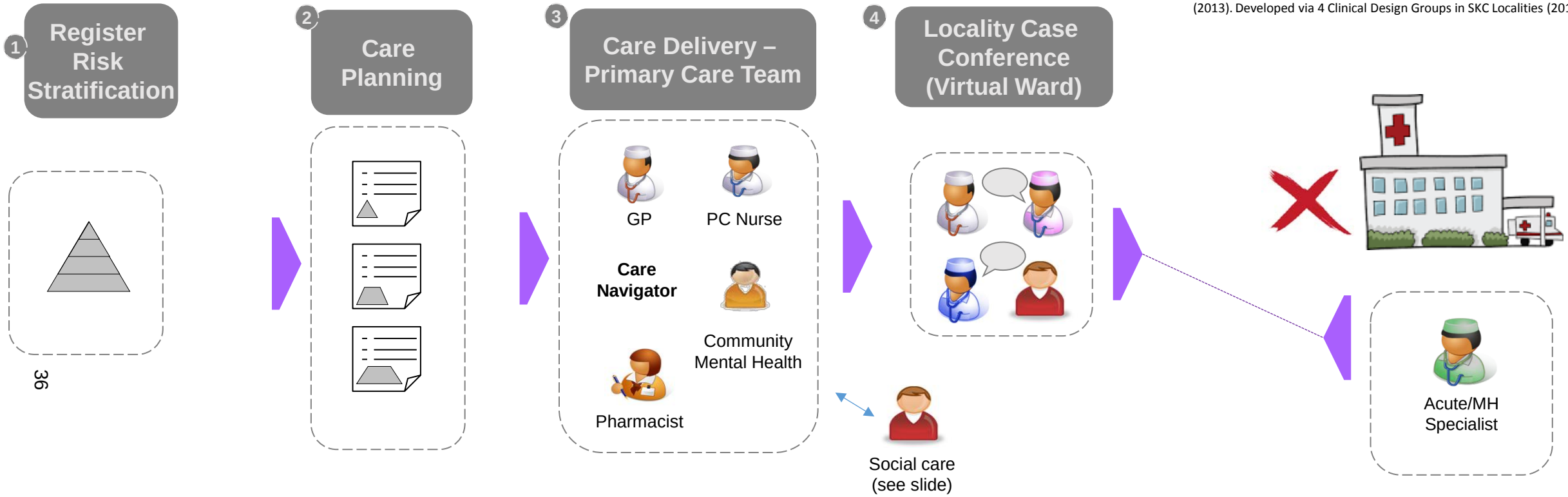
for all practices to offer and be supported by care planning system

to provide enhanced care for vulnerable patients with complex needs on a virtual ward with support from specialists

Our approach to multidisciplinary care planning – what will it look like in the future?

References: Kings Fund (2010); NW London (2012); Nuffield Trust (2013). Developed via 4 Clinical Design Groups in SKC Localities (2016)



At practice level: (Chronic Disease Management)

Each Practice holds a register of all patients who are in need of **enhanced care** (vulnerable, frail, elderly, LTCs etc).

Each patient is then given **One Care Plan**

All professionals can **read/write** onto CP (using interoperable GP systems and MIG)

Patients receive a **coordinated package of care.**

Professionals decide most appropriate **care coordinator (only the GP if essential)**

Frees up GP time for longer **LTC appointments**

At Locality Level (Complex patients)

For complex patients requiring **dedicated case conferences,** who may otherwise default to hospital**.**

Localities agree the **trigger point for referral to case conference to enable fair share** of intensive resources.
Led by **Locality GP(s)** supported by **Consultant interface in liaison with Practice GP**

Consultant Interface

The system enables effective use of consultant input into case conferences:

- Advice & Guidance
- Video conferences
- Hot Clinics / diagnostics

INTEGRATED health and social CARE South Kent Coast

Mental Health and Dementia Care in the IACO

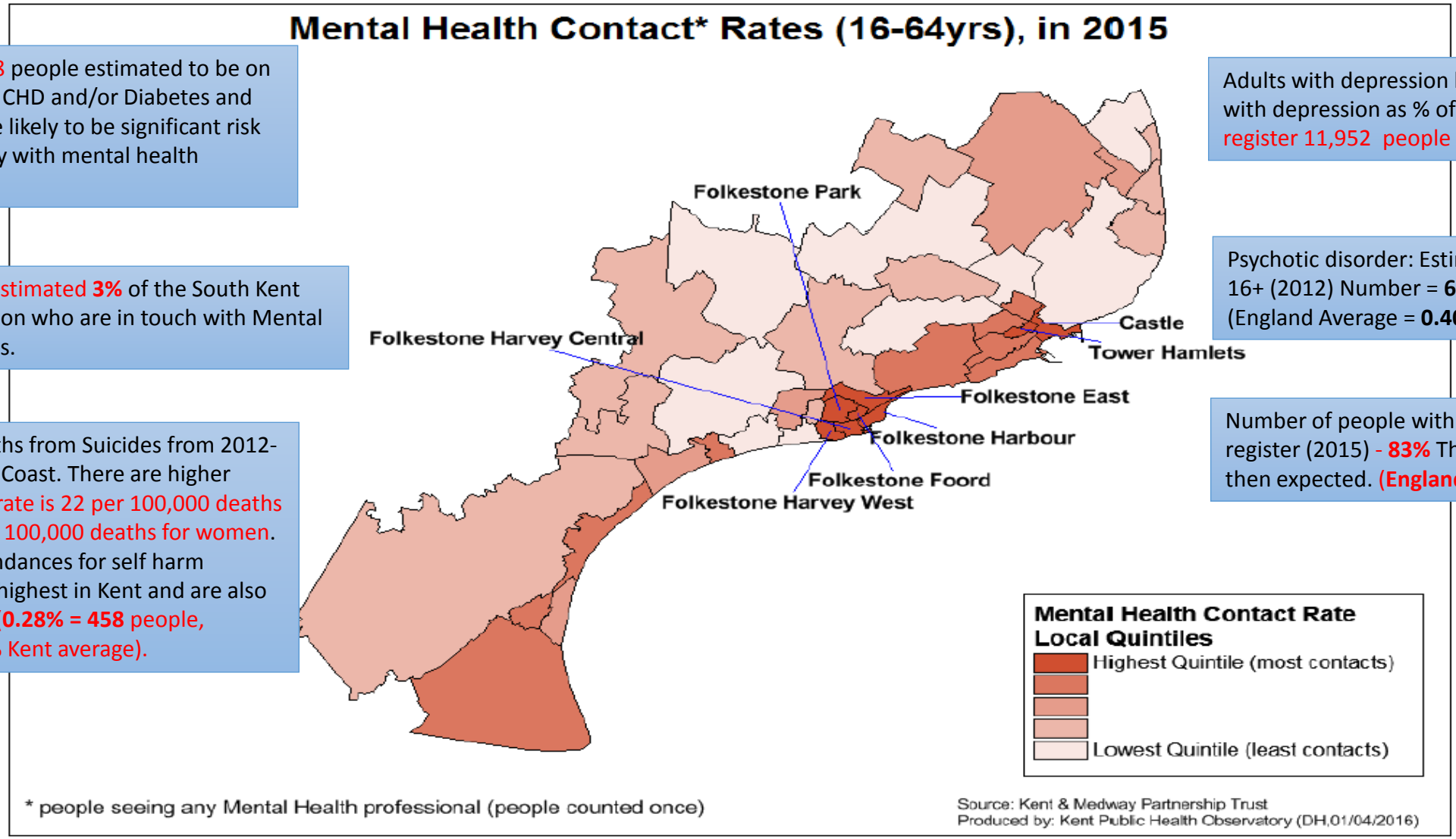
Supporting people to be well and healthy in their own homes

Mental Health need in SKC

There are 16,658 people estimated to be on a GP register for CHD and/or Diabetes and these people are likely to be significant risk and co-morbidity with mental health problems.

There are an estimated **3%** of the South Kent Coast Population who are in touch with Mental Health Services.

There were **70** deaths from Suicides from 2012-2014 in South Kent Coast. There are higher rates for men. The rate is 22 per 100,000 deaths for men and 13 per 100,000 deaths for women. Trends in A&E attendances for self harm continue to be the highest in Kent and are also rising year on year (**0.28% = 458** people, compared to **0.12%** Kent average).



Adults with depression known to GPs: Patients with depression as % of all patients on the GP register 11,952 people **7.5% (England 7%).**

Psychotic disorder: Estimated % of people aged 16+ (2012) Number = **645**. **Rate = 0.38%.** (England Average = **0.40%**).

Number of people with SMI known to GPs: % on register (2015) - **83%** This is somewhat lower then expected. **(England Average 0.88%)**

Sources ONS, HSCIC, PHE, Kent PHO

What's the big idea for mental health and dementia?

to refocus resources on prevention, early intervention and proactive care by organising care more effectively

to provide access to mental health and dementia expertise in the practice

to support people in mental health crisis within their communities

to 'connect' all community resources (housing, employment, carer and peer support) together in a locality to facilitate recovery and living well with dementia

to provide a 'whole person' approach to physical, mental health and dementia care

Locality Service Model

Mental Health and Dementia Care in the Locality
Under development

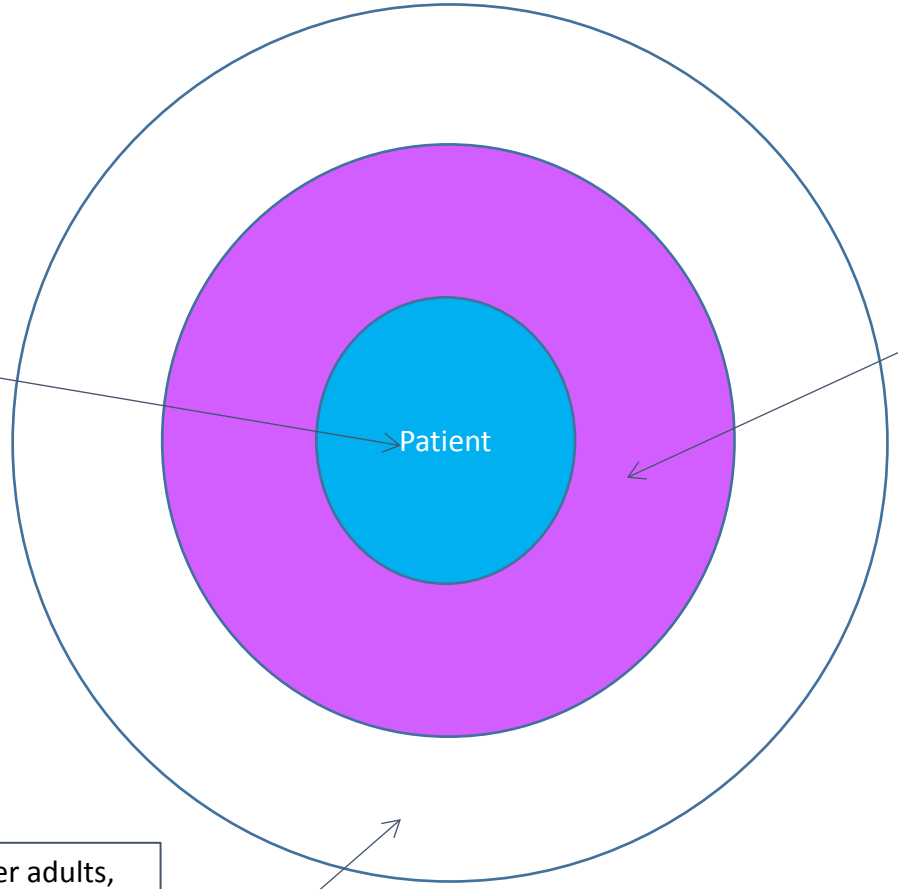
The **Primary Care Team** will have Mental Health and Dementia Practitioners.

These professionals will support the GP offering advice, consultation, short term interventions and treatment guidance.

Practitioners will be the named care coordinator for patients with mental health issues, as appropriate.

More clinical triage will be undertaken in the Primary Care Team to avoid unnecessary referrals to secondary care.

There will be an aligned Consultant Psychiatrist and Older Adult Consultant Psychiatrist to each locality to support multidisciplinary care planning and to provide specialist advice and consultation to support management of mental health and dementia in primary care.



The gateway for community mental health services is via the MH Practitioner in the **Primary Care Team** and/or directly to Single Point of Access.

Community mental health is provided by a virtual integrated **multi- disciplinary/multi-agency team** including - IAPT, Live Well, Primary Care Social Workers, DWP Link Workers and Drug and Alcohol services (Dual Diagnosis).

For patients with dementia the Older Adult Secondary Mental Health team will work together with the Intermediate Care and Enablement teams to provide joint assessment and treatment. These teams will work closely with third sector partners to optimise community resources for the person with dementia and their carer.

Same Day Access for unscheduled mental health care is via the Primary Care Walk In Hub, which interfaces with the Primary Care team, A&E liaison service and the Mental Health Single Point of Access.

Secondary Mental Health Care Services, for younger and older adults, these teams will provide CPA based interventions and case management (including medicines management) for secondary complex and high risk need.
The Community Mental Health Team will provide 'stepped up' and crisis support for people who are in crisis through an integration of CRHT and CMHT capacity. This includes access to inpatient services.
Access to specialist services such as Forensic, Learning Disability and Eating Disorder services are provided pan county with locality aligned clinical staff.

Options for meeting the needs of patients with mental health concerns in different settings of care

Scheduled Care

Practice

Emotional Difficulties

Access to IAPT

Navigator Connecting people to:

Public Health initiatives
Local council resources
Citizens Advice
Job Centres
Peer Support
Self Help
Drug and Alcohol services
Live Well

Self Care and Prevention In the community

Moderate Emotional Difficulties

Access to IAPT

Access to the Primary Care Team Mental Health Workers and Practice level Depot and Clozaril Clinics

Coordinated support to social care, 'Live Well 'and other voluntary sector services

Access to CBT and group work interventions and support for LTC

Care Delivery – Practice & Primary Care Team

Locality

Complex & Vulnerable (Emotional Disorders and Psychosis)

Patients requiring **dedicated case conferences,** who are complex but stable where risk management is critical and who may otherwise default to hospital .

Led by Locality GP and including the wider multidisciplinary team

Supported by Consultant Psychiatrist

Locality Case Conference

Virtual Ward

Unscheduled Care

Locality/Hub

Crisis Referrals

Patients presenting in crisis which may require a same day response are triaged by the Mental Health Workers.

Response times 2-4 hours.
Referral to the CMHT or Single Point of Access for access to Crisis Resolution Home Treatment or 'stepped up' care.

Crisis and Home Treatment Response

Mental Health Escalation

All access in one hub, co-located with Minor Injury Units?

Minor Illness, 8-8?

Nurse and GP led including mental health screening.

Primary Care Walk-In Hub including mental health screening

Options for meeting the needs of patients with dementia in different settings of care

Scheduled Care

Practice

Dementia and Carer Support

Access to IAPT

Navigator Connecting people and their carers to:
Dementia community resources
Admiral Nurse Support
Voluntary Sector services

Self Care and Support in the community

Dementia Diagnosis and Support

Pre and post diagnostic support.
Access to the Primary Care Team Dementia/Mental Health Workers
Coordinated support to social care services.
'Dementia Drop-In' providing coordinated support to voluntary sector services
Access to Cognitive Stimulation Therapy and group work interventions.

Care Delivery – Practice & Primary Care Team

Locality

Complex & Vulnerable (Emotional Disorders and Psychosis)

Patients requiring **dedicated case conferences,** who are complex but stable where risk management is critical and who may otherwise default to hospital **.**
Led by Locality GP and including the wider multidisciplinary team.
Supported by Consultant Psychiatrist and Geriatrician.
Coordinated 'End of Life' care.

Locality Case Conference

Virtual Ward

Unscheduled Care

Locality/Hub

Crisis Referrals

Patients presenting in crisis who may require a same day response are triaged by the Mental Health Workers.

Joint Intermediate Care/Enablement Service assessment.

Response times 2-4 hours.

Referral to the CMHSOP or Single Point of Access for access to 'stepped up' and crisis support and inpatient services.

Crisis and Acute Care

Intermediate Care

Access to Intermediate care and Respite Care beds.

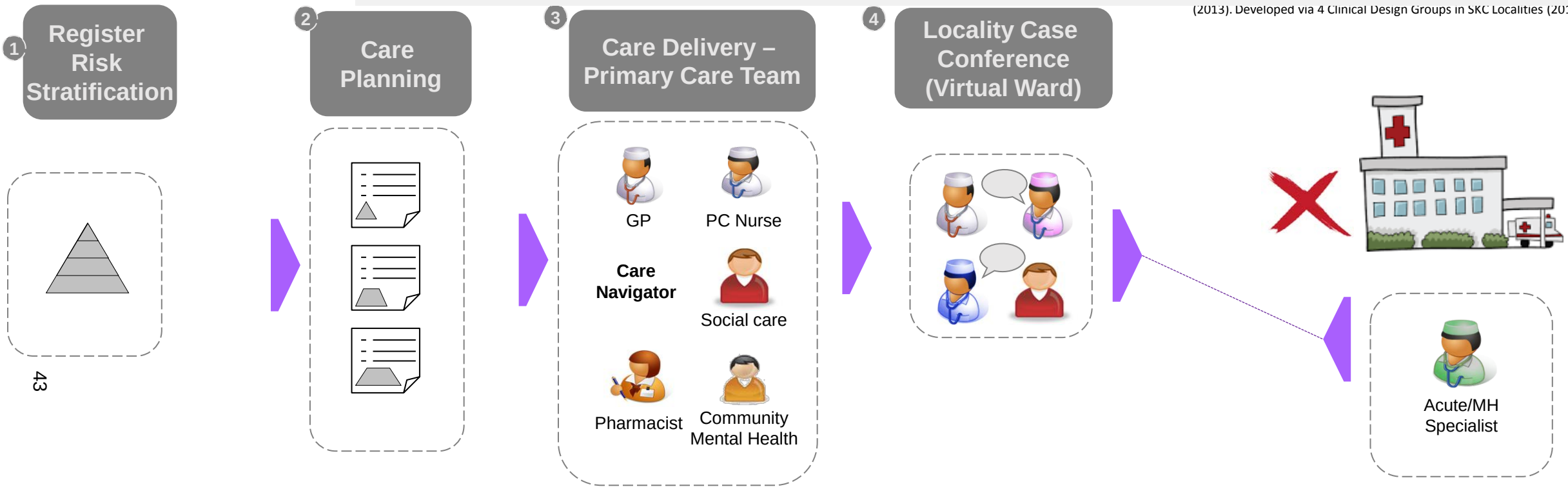
Coordinated 'End of Life' care.

Intermediate Care/Step up/Step Down beds

Locality Service Model

Our approach to multidisciplinary care in mental health and dementia planning – what will it look like in the future?

(2013). Developed via 4 Clinical Design Groups in SKC Localities (2016)



At practice level: (Chronic/Complex Disease Management)

At Locality Level (Complex/high Risk Patients)

Consultant Interface

Each Practice holds a register of all patients who are in receipt of care from multiple agencies and who's needs are complex and where there may be associated risk.

Each patient is then given **One Care Plan**

All professionals can **read/write** onto CP (using interoperable GP systems and MIG)

Patients receive a **coordinated package of care.**

Professionals decide most appropriate **care coordinator (only the GP if essential)**

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Questions and Discussion