INTEGRATED health and social CARE South Kent Coast

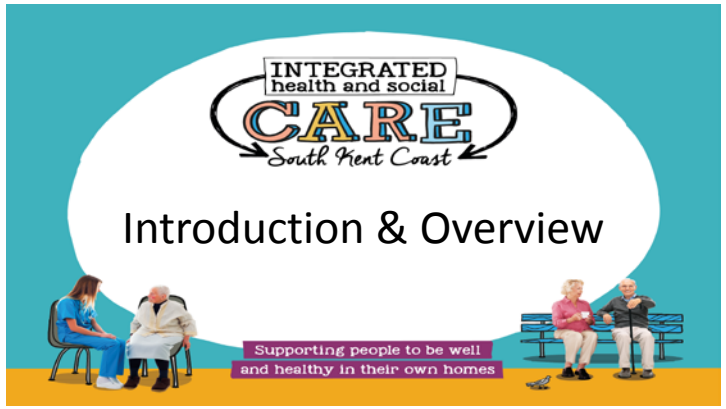
Integrated Accountable Care Development

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

*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

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

South of England Commissioning Region

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')

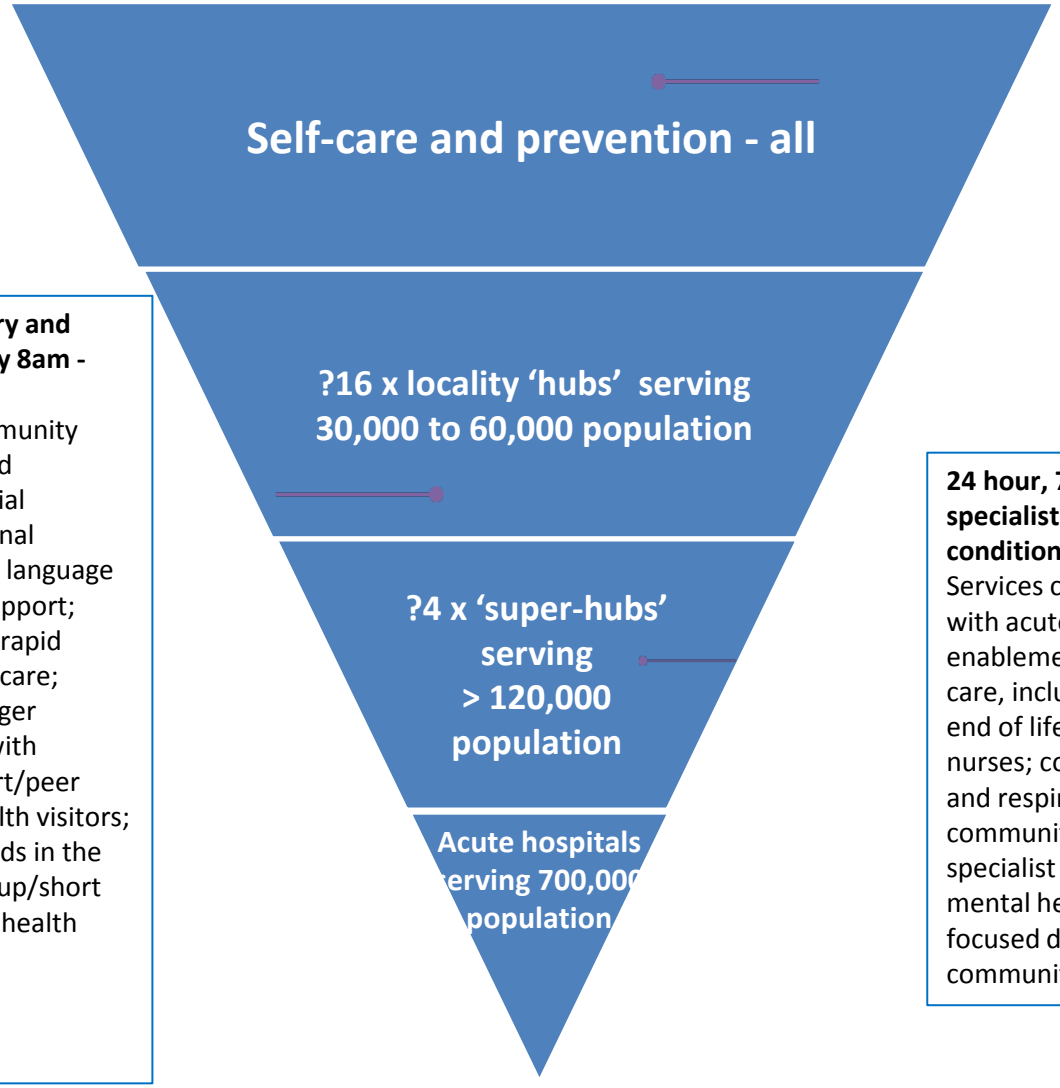
Introduction

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

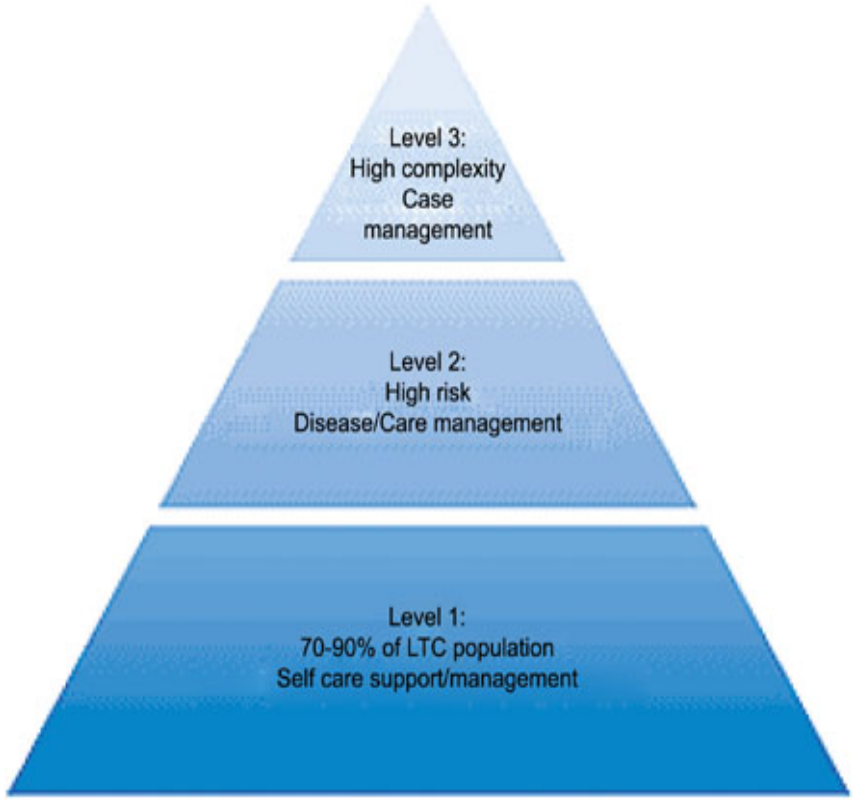
this includes clinical decision making on when best to involve more specialist expertise in patients care

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).

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)

Introduction

Authors
Shilpa Ross
Natasha Curry
Nick Goodwin

November 2011

Case management

What it is and how it can best be implemented

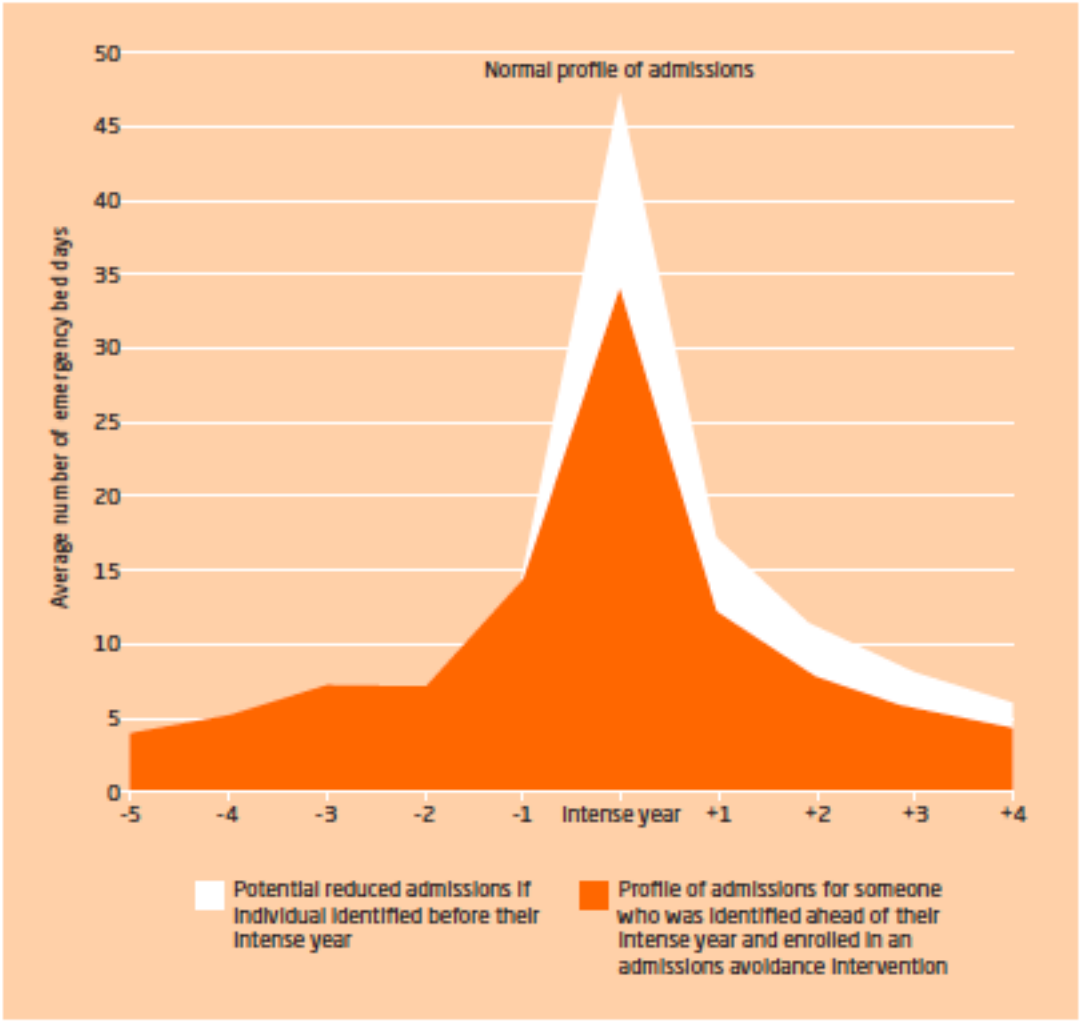
Any case-finding method needs to be able to identify individuals at high risk of future emergency admission to hospital.

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

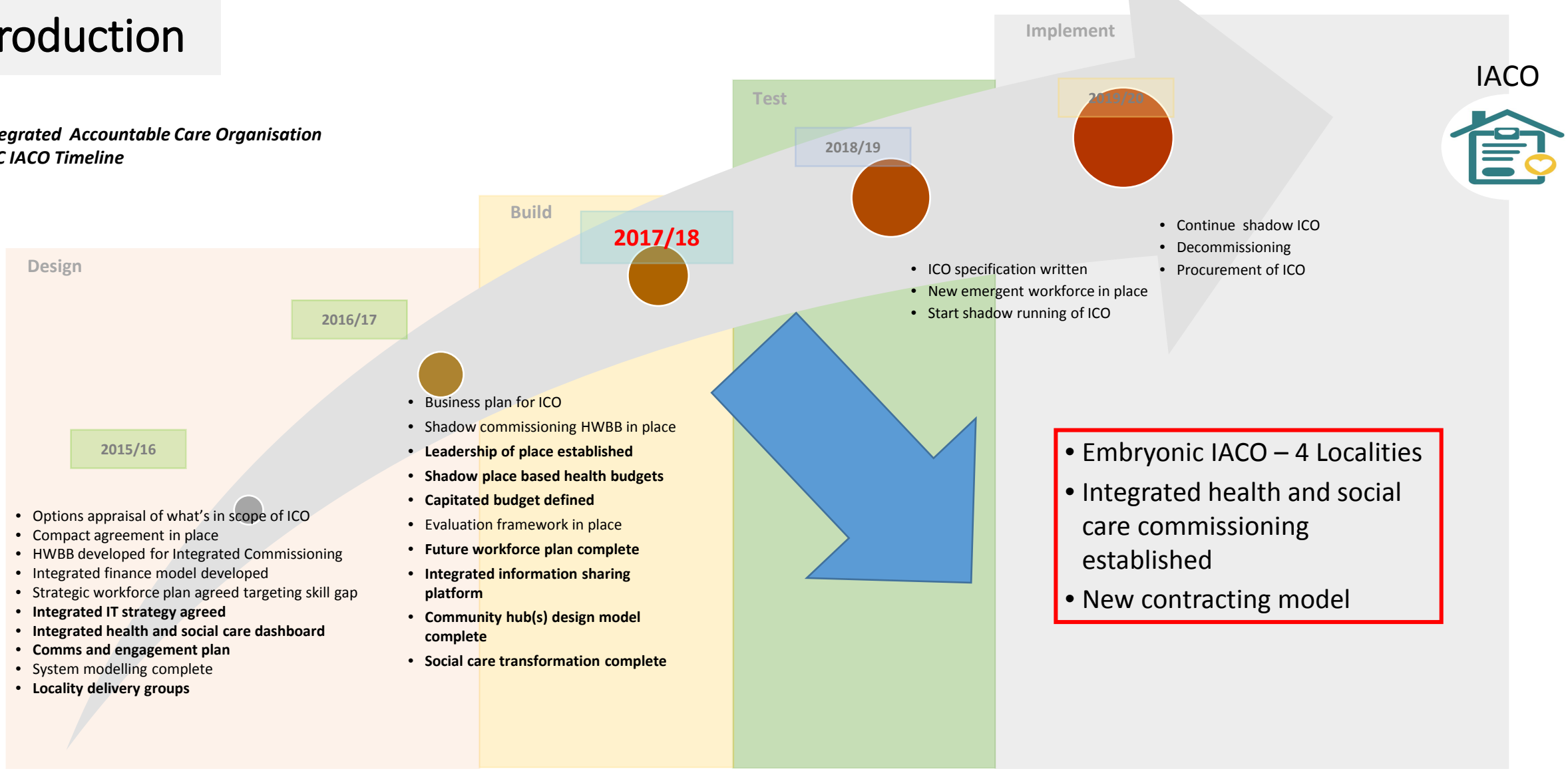


(From Lewis GH, 'Predictive modelling and its benefits', Nuffield Trust)

Introduction

Integrated Accountable Care Organisation
SKC IACO Timeline

IACO



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

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?

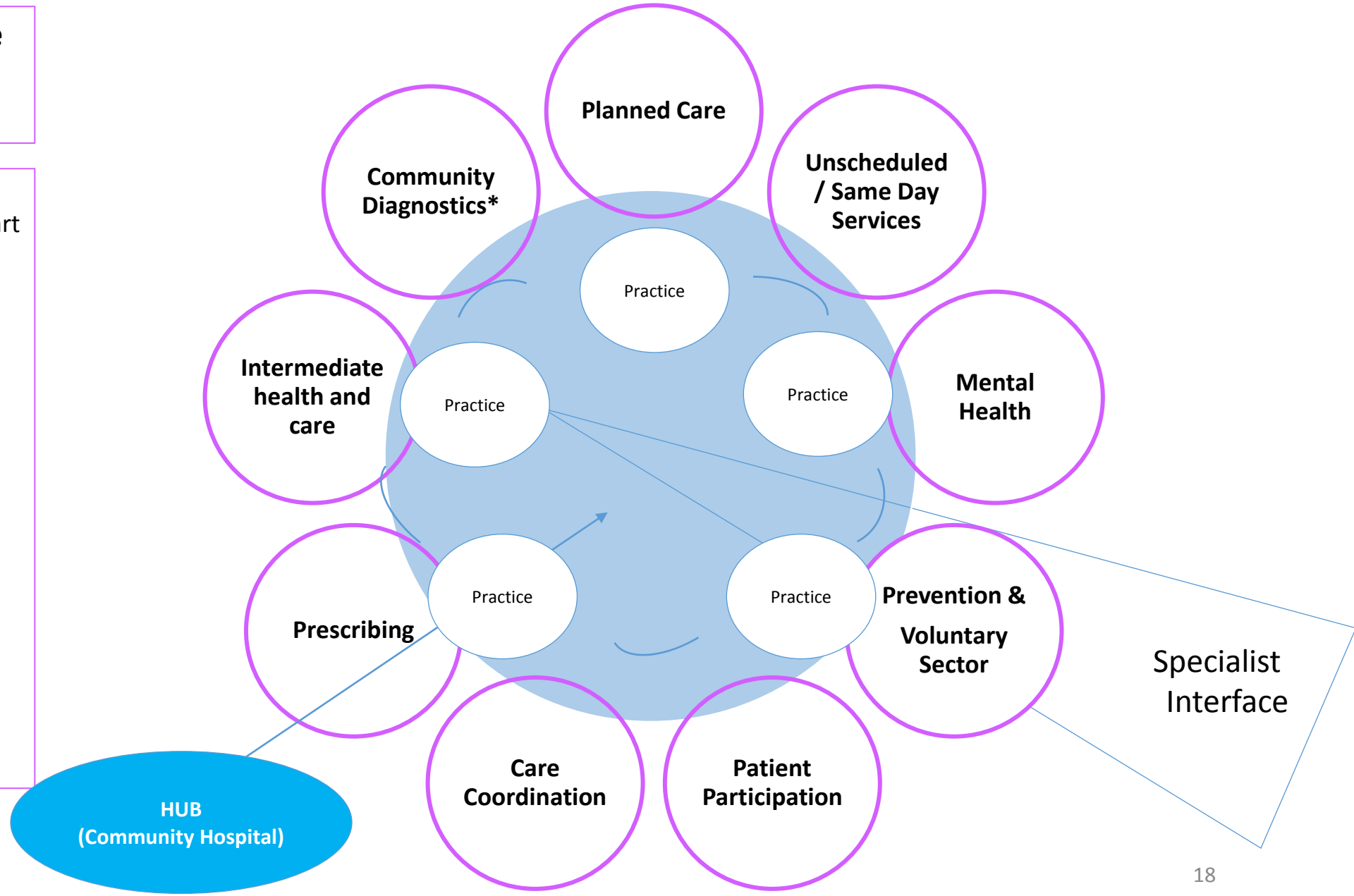
Our engagement sessions have proposed what care should be available in each locality.

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

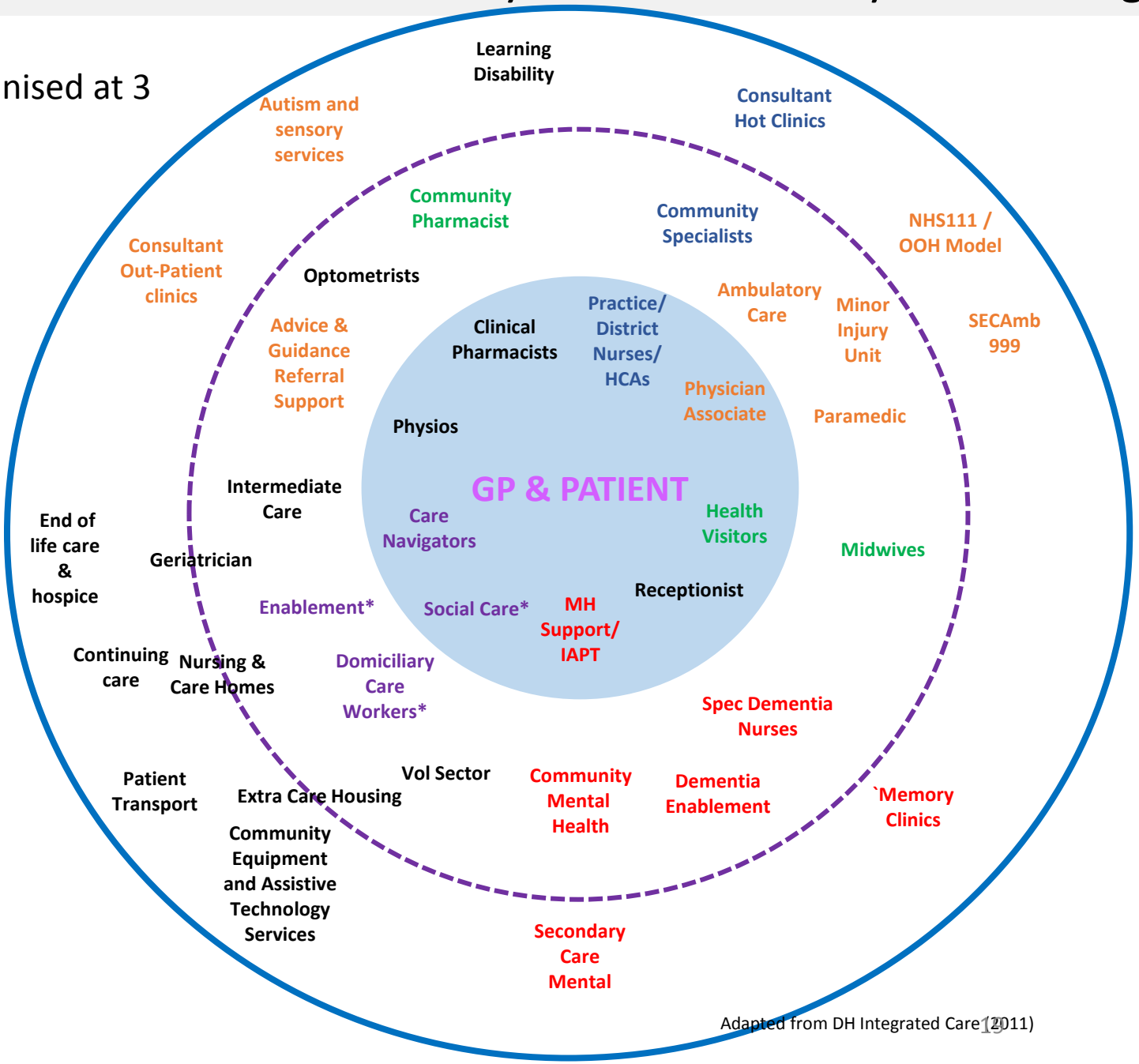
3. Supra locality services with more specialist provision due to small patient numbers and specialist professionals (across localities, East Kent or South East England)

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

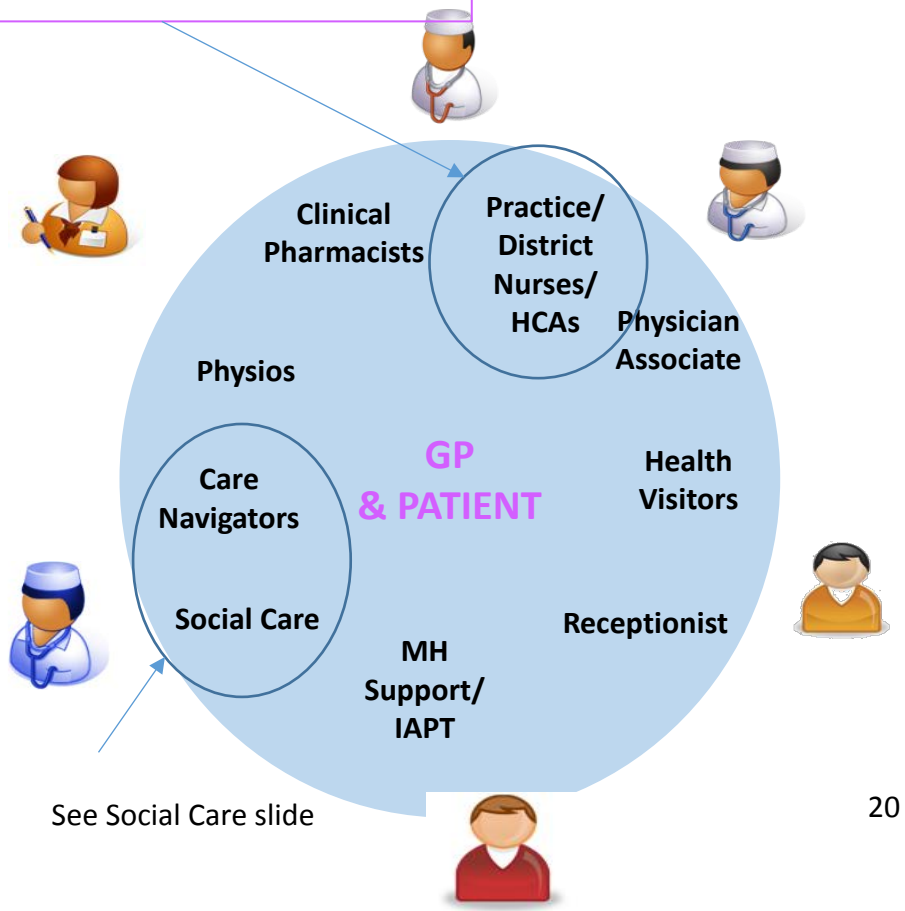
One care plan - held by the GP as the senior responsible doctor – which all professionals can read/write to

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

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

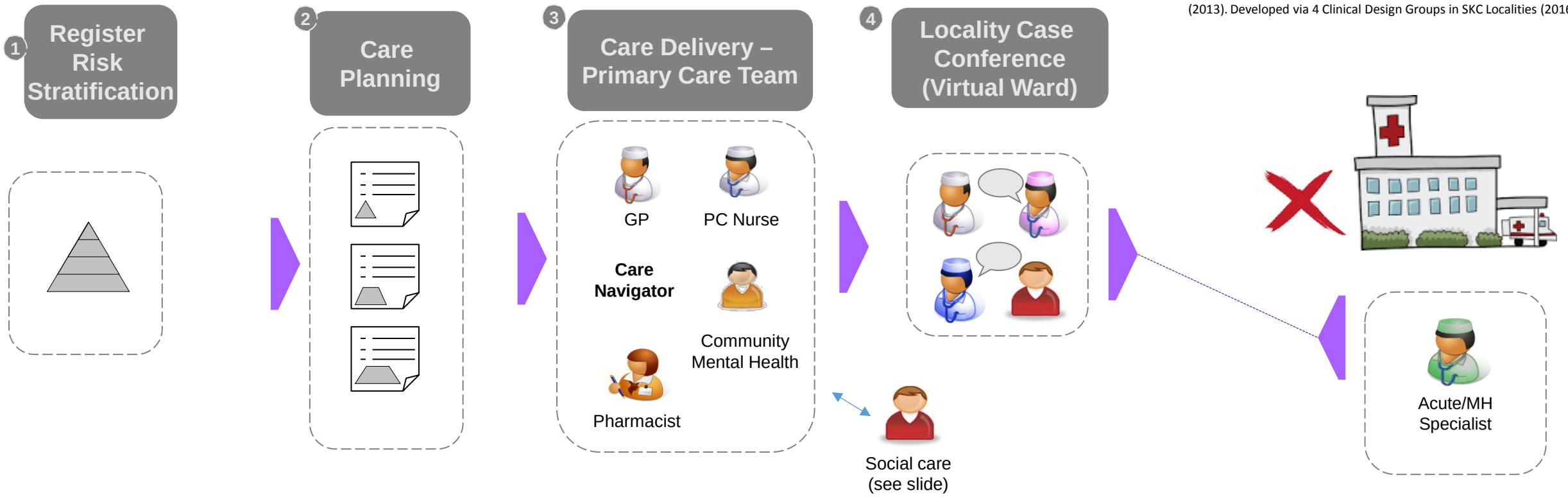
for all practices to offer and be supported by care planning system

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

Locality Service Model

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

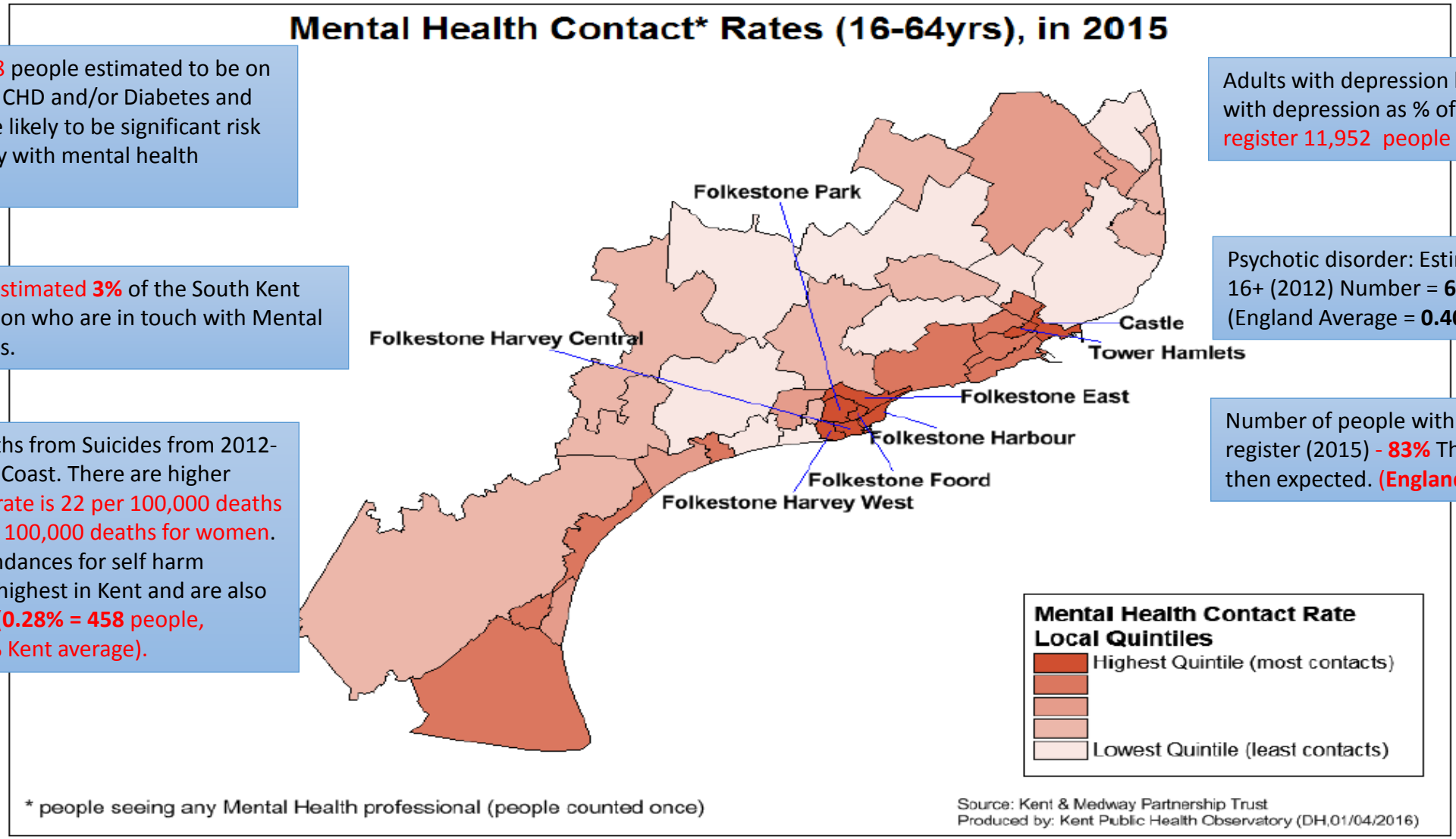
Supporting people to be well and healthy in their own homes

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

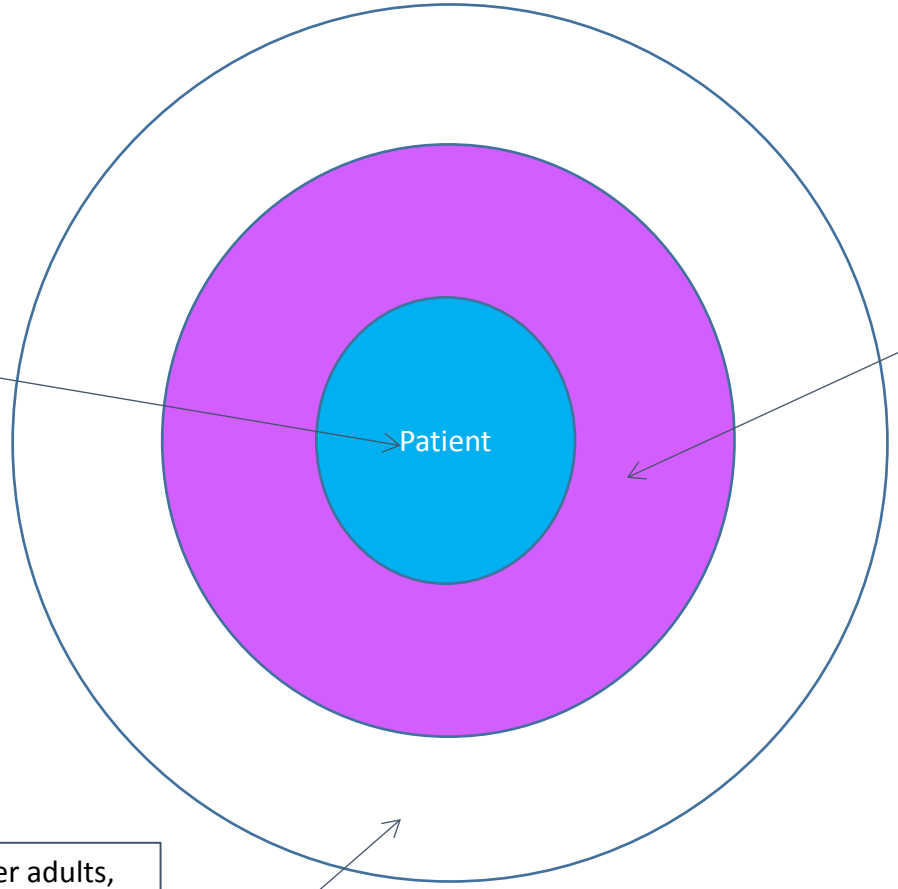
The **Primary Care Team** will have Mental Health and Dementia Practitioners.

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?

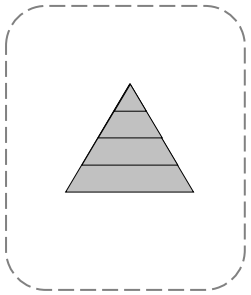
(2013). Developed via 4 Clinical Design Groups in SKC Localities (2016)

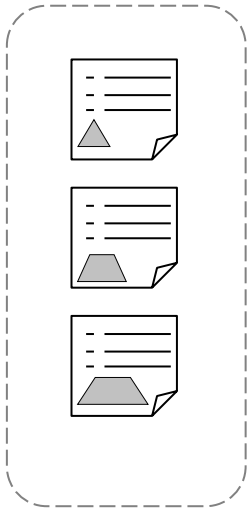
1 **Register Risk Stratification**

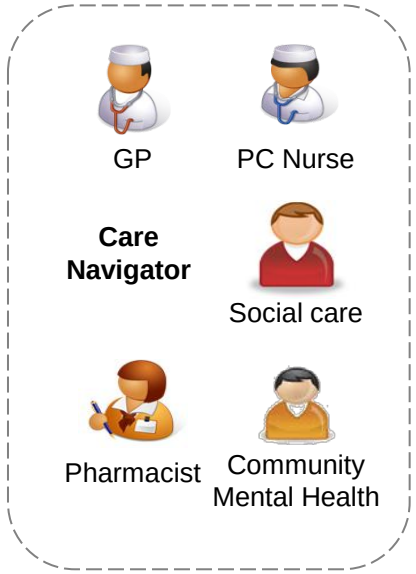
2 **Care Planning**

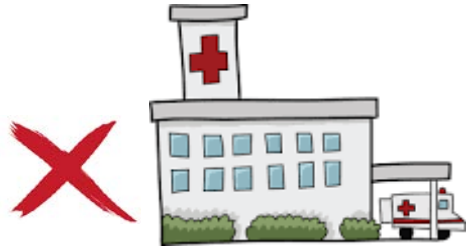
3 **Care Delivery – Primary Care Team**

4 **Locality Case Conference (Virtual Ward)**









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)**

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

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 Psychiatry interface in liaison with Practice GP**

The system enables effective use of Consultant Psychiatry input into case conferences:

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

Questions and Discussion