NHS
South Kent Coast
Clinical Commissioning Group

Report to:	Governing Body	**Agenda item:**	2.4
Date of Meeting:	08 March 2017		
Title of Report:	Local Care Update – Telling our Story		
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Status:	To note		
Appendices	NA		

1. Purpose of the Paper

The purpose of the paper is to tell the story of the development of local care. This is a particularly challenging task in the complex world of NHS policy, where there are a multitude of initiatives, incentives, funding streams and political. This paper aims to describe what we're doing locally for the Governing Body, our membership and local communities.

2 Introduction

Like everywhere else in the country, local health and care services are facing serious challenges: limited resources, an ageing population, increasing demand, lack of staff. The current system is very complex and often means people don't always get the care they could receive outside of hospital, when they need it.

According to the Kings Fund - demand for NHS services is running at 4% increase each year and funding at 2% - our gap is slightly wider in South Kent Coast c3%. This may be due to the aging population, a shortage of workforce in the community and there is an on-going debate in localities around levels of funding of the core contract and local initiatives.

The CCG can't **resolve national funding formula issues locally,** but transformation of services and re-educating the public on how they chose to access care and taking greater responsibility for our own self-care will help meet some, but not all of this challenge.

Our guiding principle of local care design is to ensure patients see a professional as quickly as possible and it is the **right professional, first time**. Not always and not necessarily a GP.

Over the past 3 years, working closely with local communities, GPs, nurses and other care professionals, we've developed an exciting shared vision to address our challenges, improve people's experience of care and develop healthier communities.

This is part of our development of an **Integrated Accountable Care Organisation (IACO)** - an alliance of the CCG, local GPs, county and district councils, NHS trusts and voluntary sector providers. The IACO involves providing local care differently through bigger primary care teams, which are wrapped around GP practices, to support frail and elderly patients, people with long term conditions including mental health, as well as managing demand for

same-day access to primary care.

In the future, colleagues of every discipline will work side by side, drawing on their full range of skills, experience and insight to help people get the right care and support. We believe this will help us to provide even better outcomes for the whole community, including helping people to:

- live healthier lives
- stay independent and out of hospital as much as possible.
- access safe, high-quality care when they need it
- have a positive experience of care.

Practices have innovated to deal with local staffing challenges by employing a wide range of clinical staff in new ways of working - paramedics, nurses and care navigators. We are not alone in taking this approach, but our local shortage of GPs means we need to go further and faster, particularly as 20 per cent of primary care staff are likely to retire in the next five years.

We are doing this in relation to the main different **policy initiatives** of which there are many: NHS Forward View; GP Forward View; Kent & Medway Sustainability & Transformation Plan; East Kent Strategy (which is part of the above); New Models of Care (which is the way we will contract for and deliver services in the future); The Better Care Fund (which involves investing in social care to prevent avoidable hospital admissions and other forms of structural and service integration).

3.	Summary of Issues, progress and challenges

The vision of the IACO to unite professionals working for different organisations in a single team with one budget is a big undertaking. Currently organisations have separate budgets, staff teams and management structures which can lead to disjointed care.

In December our membership said that rather than be a recipient of services, they wanted to actively shape how these were developed to support Primary Care through a joint venture approach with a community partner. This required us to do two things –

1. **We've engaged with local, national and international organisations to develop the very best local care.**

Our GPs believe it is now time to change how our care system is organised to deliver better clinical outcomes and value for money. We have invited local organisations, as well as those from across the country and internationally to tell us how they could help develop the IACO and devolve more clinical and financial decision-making responsibilities to the primary care teams. This is an exciting opportunity to look at how digital technology, new ways of working, care records and self-care can improve outcomes for patients and prevent avoidable admissions to hospital and care homes.

2. **Development of GP Provider – Channel Healthcare Alliance**

Most of our 30 practices have now signed up to developing one legal entity to deliver more services collectively. We have done this for several reasons:

- So that Primary Care has one voice and so that we can organise ourselves more effectively and efficiently to manage demand and provide better care in the community

- To prepare ourselves for future practice closures driven partly by a combination of finance, workforce and performance issues

- To break the chain of more people going to hospital, resulting in exponential growth of hospital budgets and more limited growth in the funding of out of hospital services

- To offer better recruitment and retention opportunities that make Primary Care more attractive employers to attract clinical talent

What are the future opportunities?

Firstly, a new Home Visiting Service
From 3rd April a new Home Visiting Service will be launched with 5 Paramedics Practitioners (PPs), 4 Senior Nurses and a team of Health Care Assistants. They will provide home visiting, often urgent same day visits, with PPs seeing and treating people; our nursing and HCAs providing follow-up clinical and enablement or social care. This will offer a bridging service so that patients do not default to hospital until our intermediate care services can provide longer term therapy, rehab and support from community services.

Secondly, we are planning to create 4 Primary Care Access Hubs
These will be in each of our Community Hospitals (Deal, Buckland, Royal Victoria Hospital), and most likely Oaklands Surgery in Hythe (with satellite branches for the Marshes). Our current thinking is that any patient can access any hub and wherever you go you will receive the same high quality care – on the same day.

Our audits show over 50% of the care provided by GPs for minor illness could be provided by another suitably qualified professional – such as a Nurse practitioner, Mental Health Nurse or Physiotherapist. **We call this skill mixing.**

The Hubs will be run by **local Doctors** with less reliance on locums who are expensive and do not have the same knowledge of local services. We want to bring locums into our Alliance as highly valued members of our workforce, here for the long term.

All patients with **chronic disease, frail and elderly and high risk factors** will continue to be seen by their own local GP, in their local practice with longer appointments and we will provide home visits for patients who are immobile and who become acutely unwell. This is what Doctors and Nurses in Practices specialise in and continuity of care is what patients have told us they want.

Starting with the **top 2-5% of patients**, who are defaulting to hospital, we will put good care plans in place and enact them with our **Primary Care Teams** involving packages of nursing, telehealth and care to help stabilise their conditions.

All patients in **their last year of life** will also have good care plans and the opportunity to die in their preferred setting of care – on average these patients are admitted to hospital 3 times before they die and over half of local people die in hospital. Doctors in local practices will continue to care for these patients with support from Primary Care Teams.

With sufficient funding and support we will be able to work through our caseloads and put

more proactive, better care packages in place. This cycle will continue as part of daily practice, but through this approach and within 18 months, we will be able to offer more proactive care to prevent patients who are at risk of developing multiple chronic disease conditions in the future. We will do this in a joined-up way via the SKC Health and Wellbeing Board.

Patients in Folkestone and Dover are used to this model, as we have run hubs for the past couple of years, and we will rapidly expand this in 2017. We've also had good feedback on the principle of – **right professional, first time**.

To make all of this happen requires a large and complex business case to describe how future services will work, the investment required and the value for money options. This will require a **blended approach** of:

- New investment in Primary Care via the GP Forward View (c. £2m for next year);
- Practices doing more of their work through these new service models (as part of General Medical Services contract),
- With the potential to seek additional investment and support from joint venture partners.

It is also worth flagging the **value for money** General Practice does provide when considering that the c.£75 payment, per patient, buys a whole year of medical care. The Governing Body will be asked to review our **unscheduled care business case** in May.

Thirdly – finding the right community partner(s) for the future
In December, the membership gave a unanimous view they were not happy overall with the current contract with Kent Community Health NHS Hospital Foundation Trust. Whilst clinical practice is generally very good and the care from clinical staff often exceptional, our feeling was that the leadership of the trust did not understand or respond to the challenges facing Primary Care. This led us to talk to other providers about what local care they could offer – **market engagement.**

Having completed over half the market engagement process, we thought it timely to set out our initial thinking:

- We have seen multiple examples of community innovation that are not available to us locally – these are called different things, but essentially use data, digital care, clinical leadership and joint working to provide more joined up care.

- We are not unhappy with the quality of the care overall but the **local care system is fragmented and variable**– we need a community partner to provide Primary Care Teams; Minor Injury Units integrated with our Primary Care Access Hubs and Intermediate Care Services that do as much 'step-up' work to help GPs prevent people going to hospital, as 'step-down' work to discharge people from hospital.

- A much leaner, **locally focused and clinically led management structure is required** to rapidly improve local performance and work with us to address local care

Where is our current thinking leaning towards?

- We are sharing our thinking with the Governing Body, the public and our partners, as it is important to set out the groundwork now so that all partners are aware of our journey

- We are looking for a **community partner in the future** who is committed to our vision with the ability to find solutions and transform local care at pace

- Our challenges mean we will need to rapidly **change how we currently contract for services to** meet future demand – whilst we wish to keep our GMS contract separate as it is a staple of Primary Care, the development of a Multi-Specialty Community Provider contract is the future direction of travel

- The clinical and corporate leadership needed to drive transformation is pivotal to making the contract work for all

- To rely on community services and influence how they operate, we require GPs to be invested in a joint venture, with one or more organisations, be it NHS, voluntary and private sector. Whoever can provide the best partnership and outcomes for patients

What could this mean?

- The community trust is beginning to understand our vision and should be **given time and support** to see if they can deliver this over the next 2 years - the life of the current contract.

- In the interests of patients and due to procurement law itself, we are leaning towards recommending to the Governing Body in May that a procurement process is initiated in 2017-18. We believe that many GPs across the country feel that local care will look need to look and feel very different by the time the current community contract ends in 2019.

- This is **not our final recommendation** and we would like to reassure all clinical staff that we wish to retain their expertise in the local care system

- We are meeting with the Trust on the 15th March to explore both current and future opportunities as part of our market engagement process and have shared this paper with them ahead of sharing in public.

4.	Recommendations

1. To note the progress on local care and current thinking of the localities for future joint ventures / partners for community services

2. To table our final recommendations and unscheduled care business case for the May Governing Body