Integrated Care Partnership Update

Sevenoaks Elected Members Forum

September 2020

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Agenda

- **National Context**
- West Kent ICP Update
- Dartford & Gravesend ICP Update

Integrated Care Systems & Partnerships

- Integrated care systems (ICSs) have been proposed as the future model for the health and care system in England.
- Integrating health and social care is currently seen as the only way to deal with an ageing population with increasing levels of frailty by focusing on directing resource where it can deliver the best return on investment for the population
- In the longer term it is envisioned capitated budgets, directed at holistic need identified by joined up data sets will support better care, outcomes and population health imporvements.
- Development of ICSs is mandated in the NHS Long term plan which says: Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere.
    - **By April 2021 ICSs will cover the whole country**
    - NHS England/Improvement will take a more proactive role in supporting collaborative approaches between trusts.
    - **Funding flows, contract reform, accountability and performance frameworks will support the move to ICSs**
- ICSs' development has been locally led and there is **no national blueprint**.
- The **systems vary widely in their size and complexity**. Larger ICSs are working to improve health and care through neighbourhoods and places as well as across whole systems, emphasising the principle of subsidiarity.

Overview of K & M ICS

Kent and Medway is on the journey to becoming an integrated care system (ICS) to support the delivery of joined up and personalised care and to drive consistency of outcomes across Kent and Medway.

We are aiming to achieve ICS accreditation in December 2020, which means we will start the process with a submission in September.

A workshop was held on 20 July with members of the System Transformation Executive Board and guests to consider the vision and principles for Kent and Medway ICS.

K & M ICS- Draft vision

Kent and Medway ICS will work to reduce physical and mental health inequalities and achieve the **best possible health and wellbeing outcomes** for people.

We will work in partnership to:

1) Add years to life and life to years: Help people to manage their own health and wellbeing at home so they can live happy and fulfilling lives
2) Give children the best start in life and work to make sure they are not disadvantaged by where they live, their background or what they do
3) Help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on preventing people becoming ill in the first place.
4) Support people with multiple health conditions to be part of a team with health and care professionals working to improve their health and wellbeing
5) Make Kent and Medway a great place to live, work and learn.

K& M ICS- Draft principles

We agree to:

- Be an all-sector partnership where partners are equally committed, equally treated and hold each other accountable
- Apply subsidiarity and work as close to communities as possible
- Be clinically and professionally-led with ambition for and with our population to achieve the very best **quality of life, quality of care**
- Agree on the analysis of problems and population need
- Do the work once, learn together and from each other
- Focus on value and making the best use of resources by planning and paying for things once between the NHS, local councils and community organisations
- Involve people in the design, delivery and assurance of services.

Draft purpose

The purpose of Kent and Medway ICS is:

We will work together to make health and wellbeing better than any partner can do alone

What is an ICP?

- ICPs are the vehicle for planning, co-ordinating and delivering care at a local level within a defined geography and patient population. They bring together providers of health and social care to collaborate on the design and delivery of care tailored to the needs of their local communities.

- ICPs will be responsible for commissioning the majority of health and care services for their local populations. However, there will be a number of services which will be commissioned at scale/county level, or wider still.

- As there is no legislation in place to set out a standard set of responsibilities for ICPs, there is a requirement to establish a way of working that supports this type of approach.

What could an Integrated Care Partnership (ICP) look like?

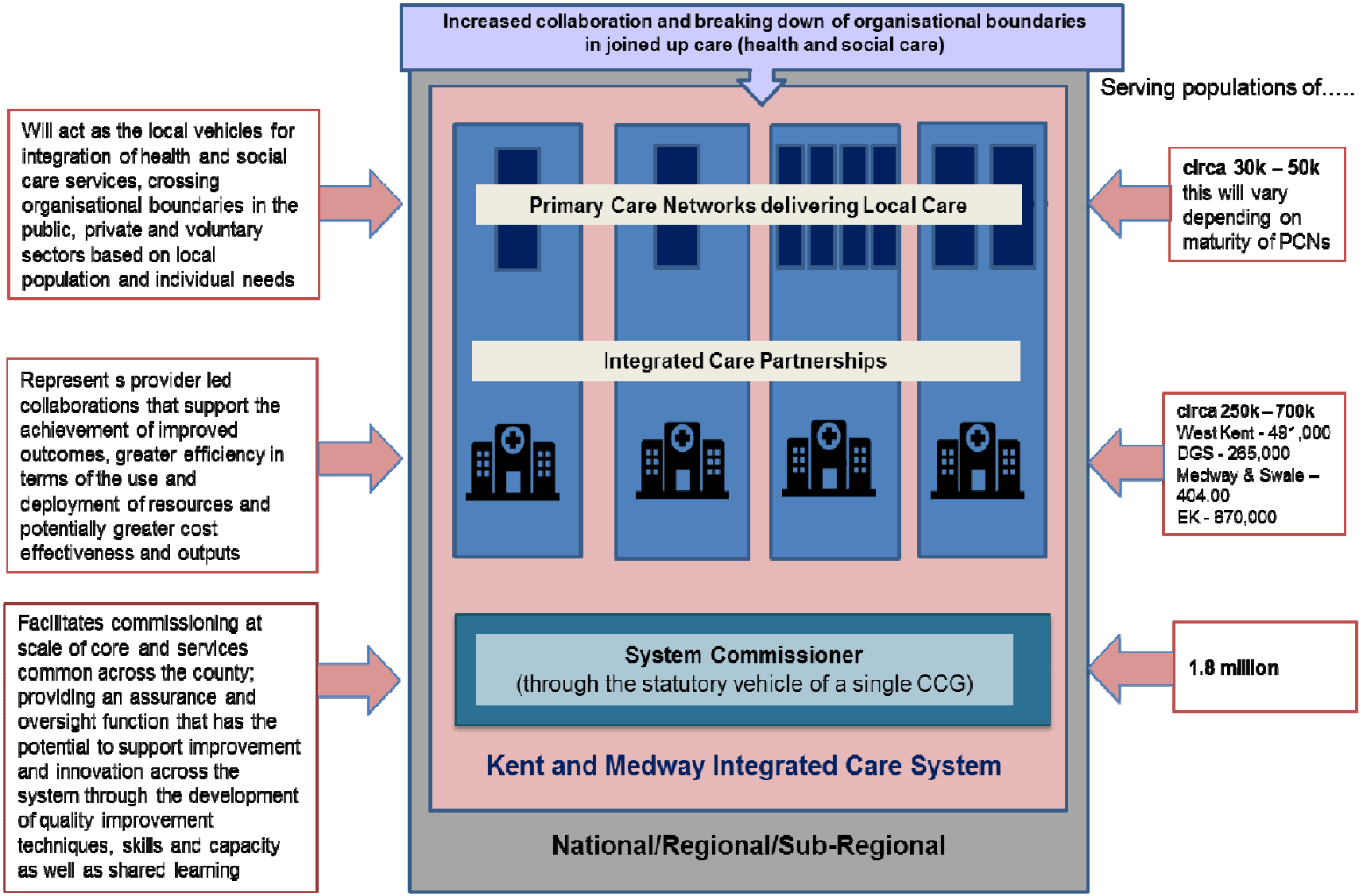
Aim: to improve the physical, mental and social health and wellbeing of the local population, and reduce inequalities

Approach: create a population-based care model based on the GP registered list across a clearly defined geography, with providers working collectively together as members of an Integrated Care Partnership Board

Implementation:

- Brings together health and care providers with shared goals and incentives to deliver services that meet population needs and uses available resource (£, workforce and estate) to provide efficient and effective services, providing good value for money for the local taxpayer and deliver great patient experience and improved clinical outcomes.
- Delivers new integrated model of cares, supported by a new payment, contracting and organisational model with the single strategic commissioner
- Clinically led, management enabled
- Patient centric with personalised care plans

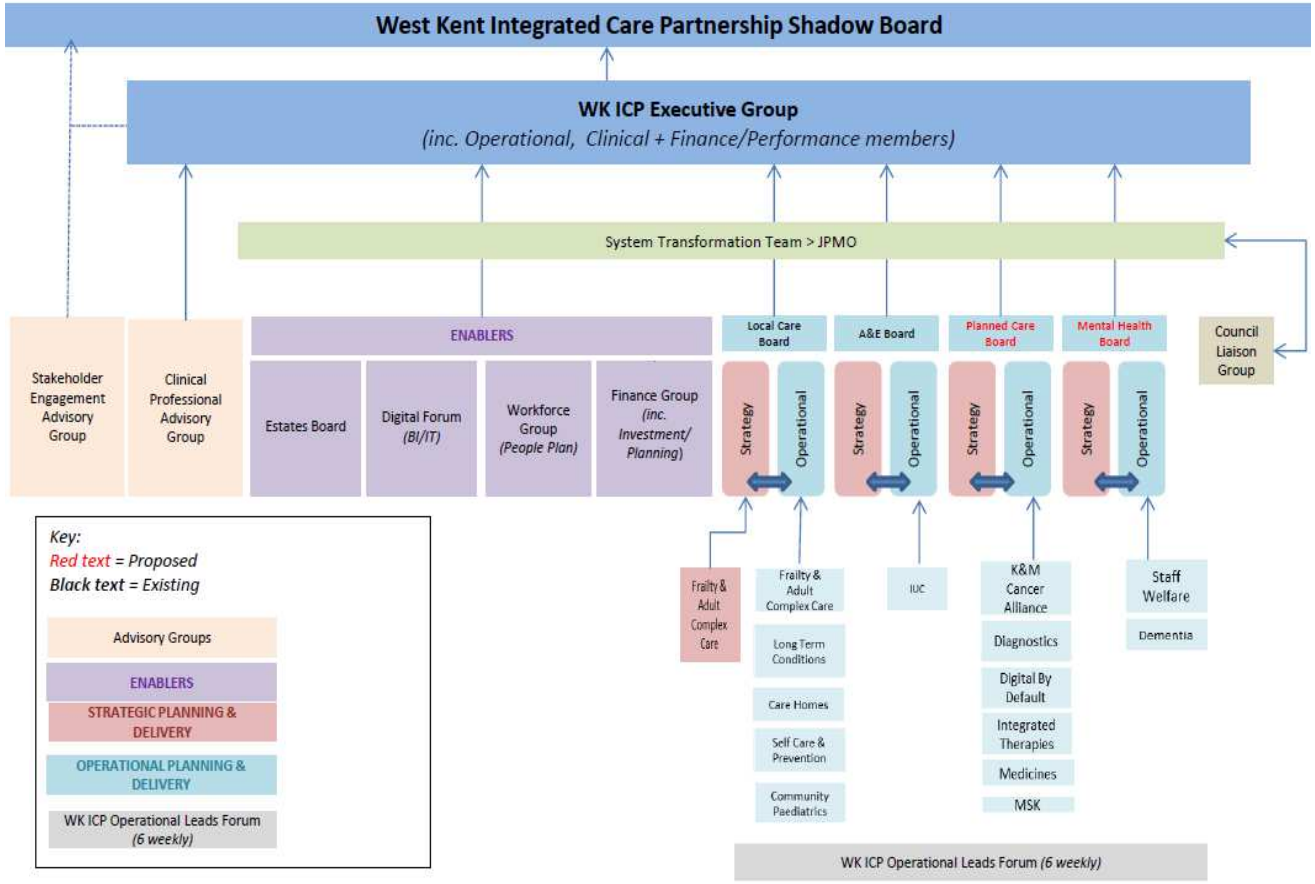
Kent & Medway ICS is organised into 4 ICPs, which are not co-terminus with Local Authority geographies



Agenda

- National Context
- **West Kent ICP Update**
- Dartford & Gravesend ICP Update

West Kent Integrated Care Partnership – our governance



- Joint working is facilitated through the both the Integrated Care Partnership Development Board and the West Kent ICP Executive Group where operational and transformational schemes across the system are driven
- We have good working relationships and representation from both upper and lower tier local authorities at the highest level.
- We need to deepen our engagement with the third sector as the ICP matures

How we are working together

Our initial improvement priorities prior to COVID were set primarily by the programmes of work that we were already working toward with the deployment of more joined up care across West Kent. These were programmes of work that were already being undertaken across specific pathways and cross cutting several pathways. These programs were:

- Proactive cluster MDTs and high risk patients
- Signposting
- Prevention
- Integrated acute and community reactive care
- Community mental health
- Frailty
- Dementia
- Diabetes
- MSK
- Outpatients transformation
- Medicines management
- Integrated therapies
- Care navigation, social prescribing and community wellbeing

With COVID 19 these priorities were paused while the system focused on responding to the pandemic. The system has come together successfully during the COVID pandemic and some of the areas where we made substantial improvements including:

- Developing new service innovations – e.g. establishing new teams such as overnight End of Life and Frailty Services which delivered care in a variety of settings to avoid unnecessary admissions
- Delivering digital and agile working by default – With both patients receiving digitally enabled appointments and staff being enabled to work from home

West Kent ICP – our next steps

- During recovery and restart our clinical and professional advisory group has undertaken a review of our ICP priorities following COVID, utilising both population health data and the clinical intelligence they have identified 3 key priority areas:
  - Mental Health - Adults
  - Mental Health – Children including deliberate self-harm
  - Frailty (including falls and dementia)
- While the work on both Mental Health for Adults and Children is being worked through the work on frailty commenced prior to COVID has continued at pace
- Given both the ageing population within West Kent and the population health metrics which show us lagging behind the rest of England and the rest of Kent on hospital admissions due to falls one of our key areas of focus moving forwards is frailty
- A strategic plan for frailty services has been jointly created with the vision that: All partners within Health and Social Care in West Kent will work together to describe a concept for a fully integrated system using new and creative solutions to care for people who are living with frailty and adults who have complex health needs. Irrespective of how and where patients enter the service, care will be delivered by the same team who work across the whole health and social care landscape.
- Operationalising this plan through a jointly led Frailty and Adult Complex Care (FACC) Programme will be a key focus for both supporting recovery and restart, dealing with Winter pressures, and dealing with the health inequalities within our system.
- In addition to these 3 key priority areas the ICP executive group is also advancing its plans across the transformation agenda, a re-prioritisation is currently underway in light of COVID recovery and restart focusing on both the transformational and operations opportunities and the resources required to deliver on these, a summary of the programmes of work are shown on the next page

West Kent ICP– Transformation priorities

Our ICP executive Group will oversee an ambitious range of programmes combining both the input from the Clinical and Professional Board and priority programmes linked to COVID recovery and restart

Live Priority Projects:

- **Integrated Urgent Care* (IUC)** *(original programme – deliver Oct)*
- **Integrated Therapy*** *(linked to original programme – deliver from Aug)*
- **Digital By Default*** *(linked to original OPT – deliver from Aug)*
- **Staff Welfare*** *(new – deliver from Aug/Sep)*
- **Diagnostics** *(new – deliver from June)*

Original Programmes on hold/restart proposal papers due Aug/Sep 2020 for Priority inclusion consideration:

- **Community Paediatrics***
- **Dementia***
- **Frailty & Adult Complex Care*** *(links to IUC, dementia, care homes, integrated therapies, digital by default)*

New Programme proposal paper due Sep 2020 for Priority inclusion consideration:

- **Care Homes** *(links to frailty/adult complex care, dementia, digital by default)*

Original Programmes that remain on hold:

- **Medicines Management**
- **Outpatient Transformation**
- **MSK** *(BAU conversion/post project review)*

Aligned to the WK ICP Clinical Professional Advisory Group three reset priorities

(Mental health adults & children, Elderly/Frail)

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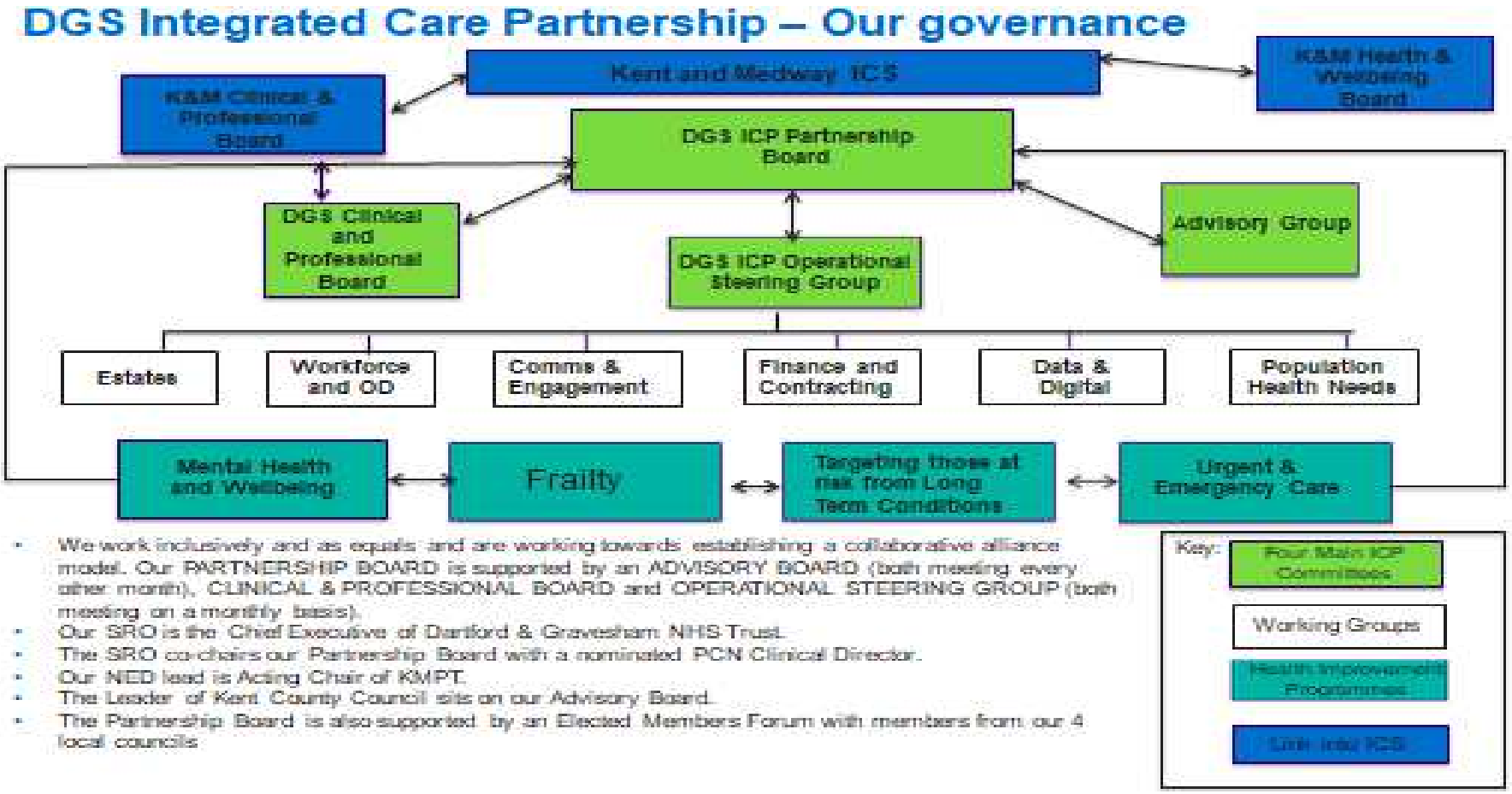
DGS ICP 20/21 ICP Work Programme

- The ICP is focusing on 3 things:
  - Supporting the system in remaining CV ready
  - Supporting the systems RESTART Programme of clinically urgent services
  - Supporting the 4 Health Improvement Programmes:
    - Developing & implementing our Frailty Model
    - Supporting & implementing the K&M Urgent & Emergency Care Programme
    - Post CV Mental Health & Wellbeing of staff, survivors & the bereaved
    - Targeting those at risk of Long Term Conditions

DGS ICP Governance



DGS ICP Governance: The Partnership Board

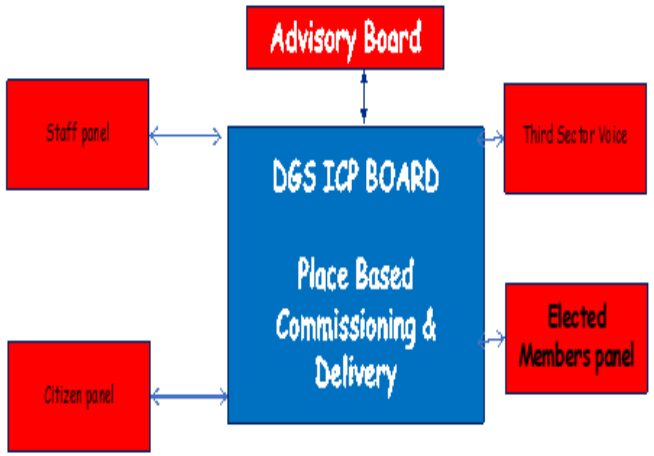
- The **Partnership Board** has been working since August 2019 and has formally met 5 times plus held a developmental workshop in February.
- Membership in August 20 is being extended to IC24 & 111.
- Its role is to:
  - Improve the health of the local population
  - Reduce health inequalities
  - Ensure that we get best use from collective resource
- It sets the Strategy for the ICP and signs off /oversees delivery of the work plan.

Dartford & Gravesham NHS Trust	Kent County Council	Dartford Central Primary Care Network
Virgin Care	Sevenoaks District Council	Dartford MODEL Primary Care Network
KMPT	Gravesham Borough Council	Garden City Primary Care Network
SECAMB	Dartford Borough Council	Gravesend Alliance Primary Care Network
KCHFT	Healthwatch	Gravesend Central Primary Care Network
Kent & Medway CCG	DGS Health GP Federation	LMN Primary Care Network
Kent LPC	Kent LMC	Swanley & Rural Primary Care Network
NHS 111	IC24	

DGS ICP Governance: the Advisory Board

- The ICP is supported by an **Advisory Board** whose members are:
    - Louise Ashley DGT CEO / SRO
    - Sue Braysher Programme Director
    - Roger Gough KCC leader
    - Jackie Craisatti - Acting Chair KMPT
    - Sarah MacDermott K&M CCG Elected Governing Body member
    - Liz Lunt Co Chair of Partnership Board & PCN Clinical Director
  - Its role is to ensure the Partnership Board has and delivers against an appropriate work plan
- 4 other independent advisory functions will support the Partnership Board:
  - Elected Members Forum (introductory meeting 4th Aug 20)
  - Staff Panel (to be established)
  - Citizens Panel (to be established)
  - Third Sector Voice (to be established)

ICP DEVELOPMENT: independent Advisory functions



2 of the 5 advisory functions have now been established:

- **Advisory Board: Established & working**
- **Elected Members Forum: Established – first introductory meeting August 20**
- Staff Panel: to be established
- Citizens Panel & Third Sector Voice: development under discussion with Healthwatch

DGS ICP Governance: the 4 Health Improvement Priorities

DGS Priority 1: Frailty Goals and Outcomes

Year 1 (by March 21)	Years 2 & 3	Outcome Measures

• Continuing development of the integrated frailty team using the MDT approach to frailty
• Increased no of patients identified as at risk through:
  • Primary Care using the eFi tool proactively case finding mild to moderate cases
  • Care Homes & service providers using the GATE assessment test
  • Rockwood being used as part of the diagnosis / treatment plan
• Increasing the numbers of Personalised Care Plans in use
• Increased referrals to support services including social prescribing & psychological support
• 2 hour Rapid Response reducing NEL admissions
• Increasing the number of Advanced Care & End of Life Care Plans in use supported by active case management
• Universal adoption of the Care Homes DES
	• Continuing development of an integrated frailty team to improve holistic care planning and support
	• Proactive falls service in place in the community
	• Increased geriatrician input to MDTs.
	• Joint review of unplanned admissions resulting in appropriate care planning
	• Increased patient satisfaction regarding joined up services/holistic approach
		• Improved rate of people dying in place of choice.
		• Reduction in NEL attendances, admissions and re-admissions, all population and care homes specifically
		• Reduction in #NOF as a result of a fall
		• Improved mental health and wellbeing scores
		• Increased patient satisfaction regarding joined up services/holistic approach

DGS Priority 2: Mental Health & Wellbeing Goals and Outcomes:

Year 1 (by March 21)	Years 2 & 3	Outcome Measures
• To provide appropriate support to staff concerned about their physical work environment and how it could impact on their health (including those Shielding or vulnerable because of long term health conditions) • To put appropriate systems in place to track survivors of COVID post-discharge to ensure appropriate support is offered by community and primary care services or specialist services where necessary. • To increase provision and access to psychological support 24x7, such as IAPT and on-line counselling, liaison psychiatry, telephone helplines, resilience coaching and Touch Base sessions • Ensure SMI & BAME populations participate in full Annual Health Checks. • Increase in the detection of depression, anxiety & PTSD using an agreed screening tool in primary care using the expected prevalence of common MI as our baseline • Ensure no one falls between different providers of community based Tier 1&2 services and more specialist Tier 3&4 services	• Development of a 111/CAS Single Point of Access (SPOA) and signpost people to the open access crisis services and improved specialist support in the community (7 days a week). • Investment in Mental Health Link workers • Improve data capture and share intelligence across the system using the KMCR (K&M Shared Care Record) to ensure effective end to end patient management. • Improved collaborative working and care plans for patients across primary/community/acute/MH and voluntary sector.	• Increased community/primary care contact with post-COVID patients, with reduction in NEL attendances for these patients. • Increase in Annual Health Check uptake in SMI/BAME population • Reduced suicide rate • Reduction in mental health related illness. • Increased activity associated with staff helpline / support uptake. • GAD-7 score improvements pre and post support/intervention

The ICP has, at the request of the CCG, submitted new proposals to focus on 4 Health Improvement Priorities:

- Developing & implementing our Frailty Model
- Supporting the K&M Urgent & Emergency Care Programme
- Post CV Mental Health & Wellbeing of staff, survivors & the bereaved
- Targeting those at risk of Long Term Conditions

The Programme management arrangements for these 4 programmes must now be reflected in an updated Governance Structure.

DGS Priority 3: Urgent & Emergency Care Goals and Outcomes:

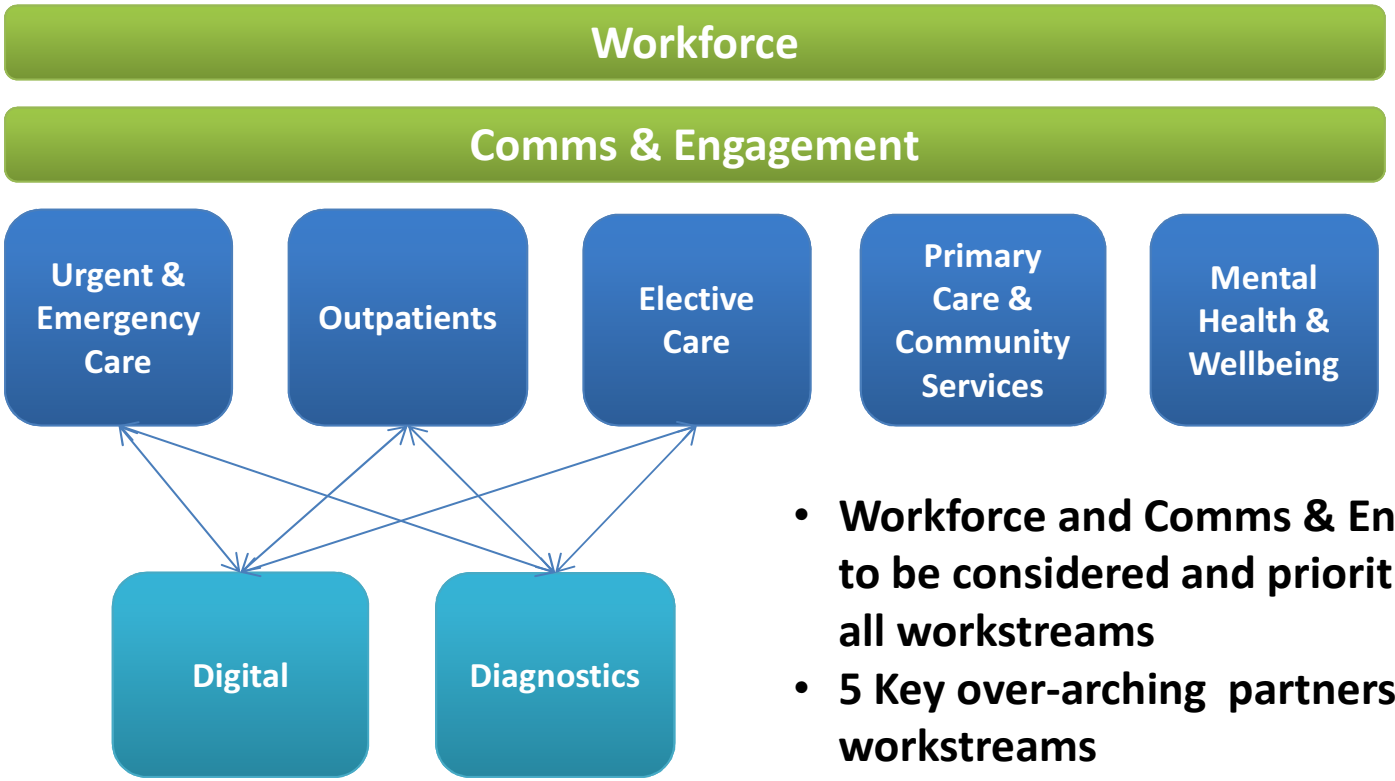
Year 1 (by March 21)	Years 2 & 3	Outcome Measures
• Implement the Urgent Treatment Centres. • Ensure best practice A&E pathways to avoid unnecessary admissions. • Improved access to Ambulatory Care and Same Day services to avoid admissions. • Improved collaborative working across system partners to ensure MFFD / DTOC numbers are kept to a minimum. • Health and Social Care workforce integration, where possible. • Review of need for dementia bed provision in the community. • Review of step-down need/capacity. • Increased access / use of shared patient records. • Improved access to MH beds and psychiatric liaison.	Implement a booking system for A&E, following telephone and/or online 111/999 triage. Development of improved access to urgent care services for children. Fully embedded trusted assessor processes for discharge.	• Reduced A&E attendances / NEL Admissions, adults and children • MFFD long stayers decreasing. • Overall shorter lengths of stay • Increase same day discharge • Reduce inappropriate use of community rehab hospital. • Increased activity flow to UTC / ACU.

DGS Priority 4: Targeting LTC risk factors & improving LTC management Goals and Outcomes:

Year 1	Years 2 & 3	Outcome Measures

• Reduce health inequalities by targeting high risk groups identified from practice registers by:
  ○ Effective risk stratification and increasing the use of available tools to run reports on GP systems to identify at risk patients.
  ○ Ensuring identified at risk patients are placed on disease registers, enabling practices to actively signpost patients to support services, e.g. One You, and undertake regular reviews
  ○ Delivering increased uptake of Annual Health Checks
• Ensure robust services in place to support those patients who may have developed LTCs following COVID/hospital discharge (linking with priority 2).
• Set success criteria (weight / blood pressure management etc) & measure success of interventions
• Evaluation and review of current tools and support services available and the health outcomes achieved, to determine clinical and cost effectiveness and whether different delivery models are required to support the level of change required.
	• Continue to reduce health inequalities through improved behavioural management training and support to patients to improve their health, which may include:
	  ○ health coaches working in PCNs.
	  ○ Group consultations
	  ○ Effective joined up working and utilisation of all current support services staff to provide an integrated service offering.
	• Increasing out of hospital care in the community / primary care to embed preventative and pre-emptive management of patients with diabetes, cardiology or respiratory related conditions.
		For Hypertension, Obesity, CHD, Stroke, CKD, diabetes:
		
		• Increased diagnosis rates
		• Decreased mortality
		• Increase in disease registers in line with expected prevalence.
		• Decrease in overweight/obese adults
		• Reductions in diabetes complications
		• Reductions in stroke
		• Reducing the health inequalities gap between PCNs and across districts within the DGS geography.

DGS ICP RESTART Programme Structure : (restarting clinically urgent services)



- Workforce and Comms & Engagement to be considered and prioritised across all workstreams
- 5 Key over-arching partnership workstreams
- Digital and Diagnostics to be workstreams in their own right, but heavily inter-linked as enablers to Urgent Care, Outpatients and Elective Care