09 September 2020 at 12.00 pm

This meeting was held virtually

Health Liaison Board

At the above stated meeting the attached presentations and documents were tabled for the following items

		Pages	Contact
4.	**Update on Health Integrated Care Partnerships**	(Pages 1 - 22)	Hayley Brooks Tel: 01732 227272
6.	**Update on Sevenoaks Men's Shed Project**	(Pages 23 - 30)	Hayley Brooks Tel: 01732 227272
7.	**Update of Local Care Plans**	(Pages 31 - 44)	Hayley Brooks Tel: 01732 227272

If you wish to obtain further factual information on any of the agenda items listed above, please contact the named officer prior to the day of the meeting.

Should you need this agenda or any of the reports in a different format, or have any other queries concerning this agenda or the meeting please contact Democratic Services on 01732 227000 or democratic.services@sevenoaks.gov.uk.

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Integrated Care Partnership Update

Sevenoaks Elected Members Forum

September 2020

Sue Braysher- Programme Director DGS ICP
Bob Cook- Head of Strategy & System Integration MTW & WK ICP

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?

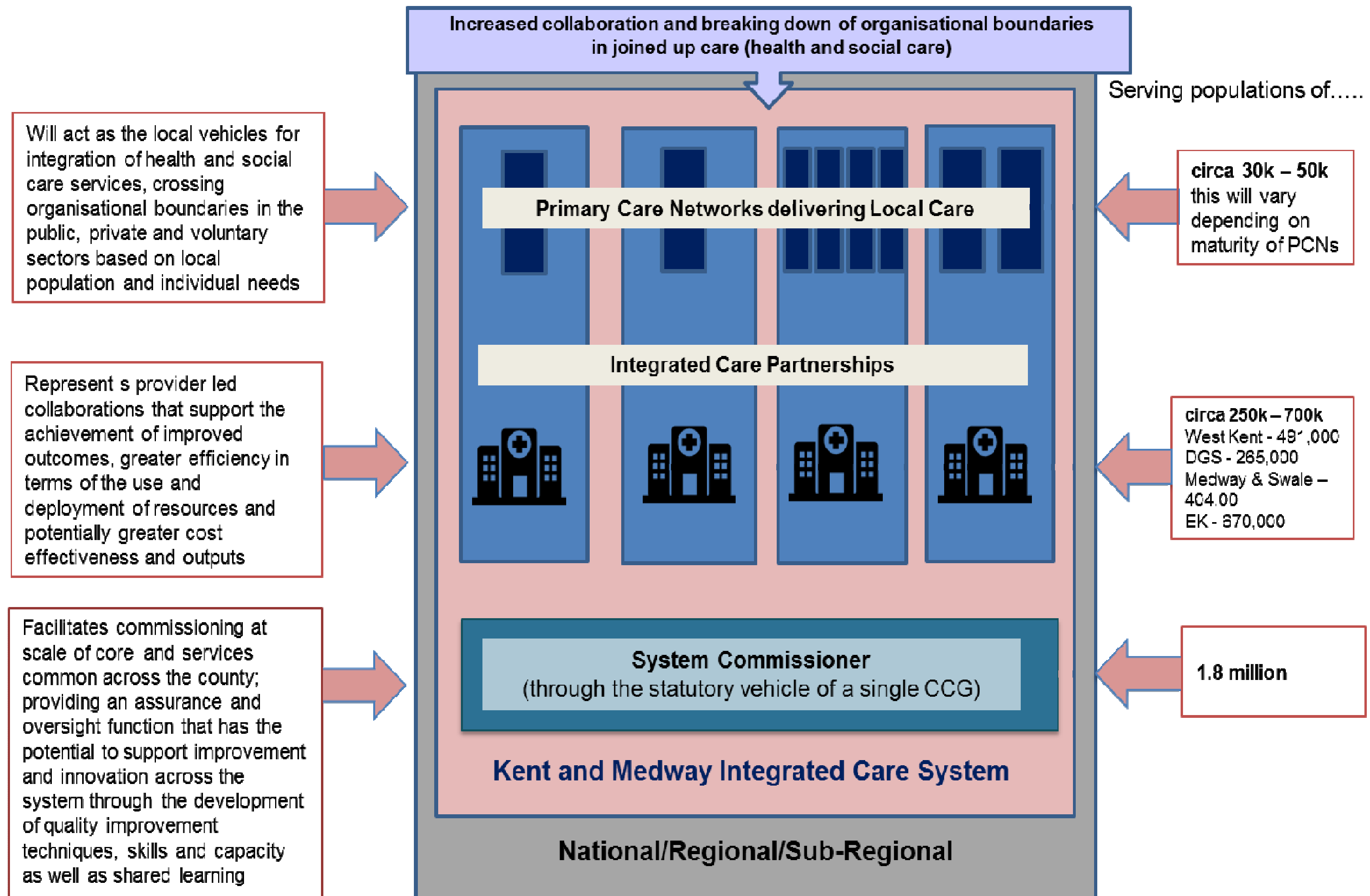
Aim: to improve the physical, mental and social health and wellbeing of the local population, and reduce inequalities

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

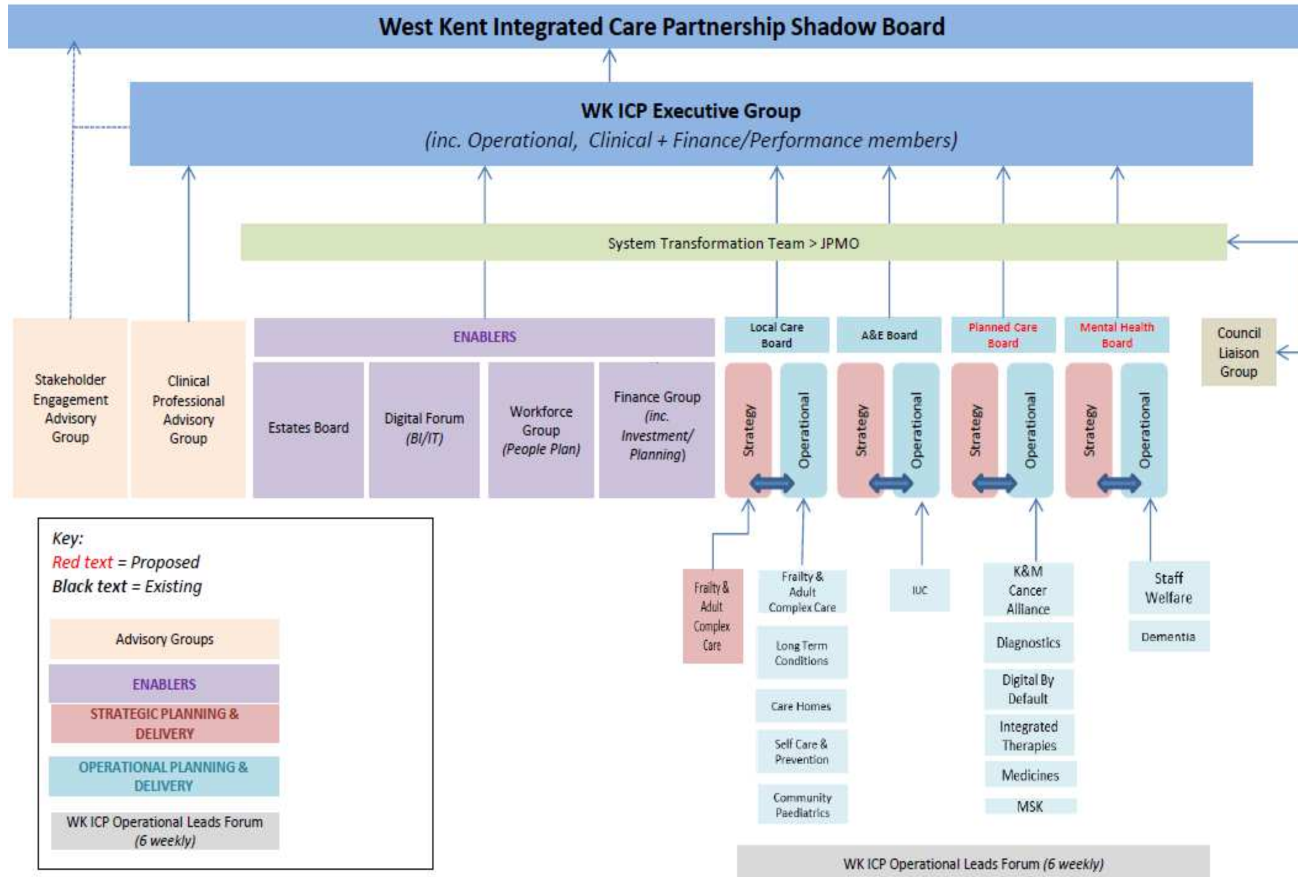
Kent & Medway ICS is organised into 4 ICPs, which are not co-terminus with Local Authority geographies



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)

Agenda

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

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 Integrated Care Partnership – Our governance

Kent and Medway ICS

K&M Clinical & Professional Board

K&M Health & Wellbeing Board

DGS ICP Partnership Board

DGS Clinical and Professional Board

DGS ICP Operational Steering Group

Advisory Group

Estates | Workforce and OD | Comms & Engagement | Finance and Contracting | Data & Digital | Population Health Needs

Mental Health and Wellbeing | Frailty | Targeting those at risk from Long Term Conditions | Urgent & Emergency Care

Key:
- Four Main ICP Committees
- Working Groups
- Health Improvement Programmes
- Link into ICS

- We work inclusively and as equals and are working towards establishing a collaborative alliance model. Our PARTNERSHIP BOARD is supported by an ADVISORY BOARD (both meeting every other month), CLINICAL & PROFESSIONAL BOARD and OPERATIONAL STEERING GROUP (both meeting on a monthly basis).
- Our SRO is the Chief Executive of Dartford & Gravesham NHS Trust.
- The SRO co-chairs our Partnership Board with a nominated PCN Clinical Director.
- Our NED lead is Acting Chair of KMPT.
- The Leader of Kent County Council sits on our Advisory Board.
- The Partnership Board is also supported by an Elected Members Forum with members from our 4 local councils

DGS ICP Governance: The Partnership Board

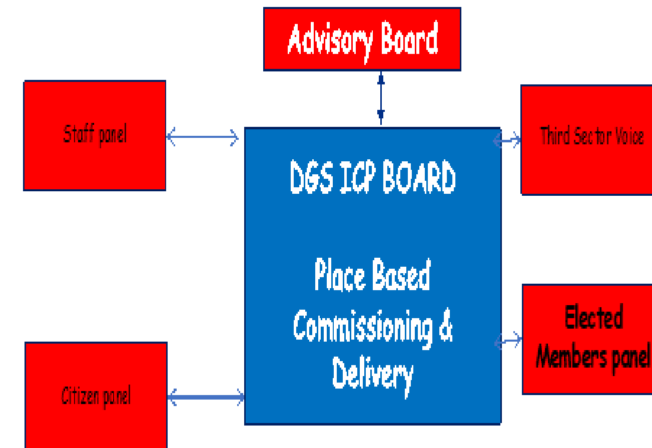
- The **Partnership Board** has been working since August 2019 and has formally met 5 times plus held a developmental workshop in February.
- Membership in August 20 is being extended to IC24 & 111.
- Its role is to:
  - Improve the health of the local population
  - Reduce health inequalities
  - Ensure 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:

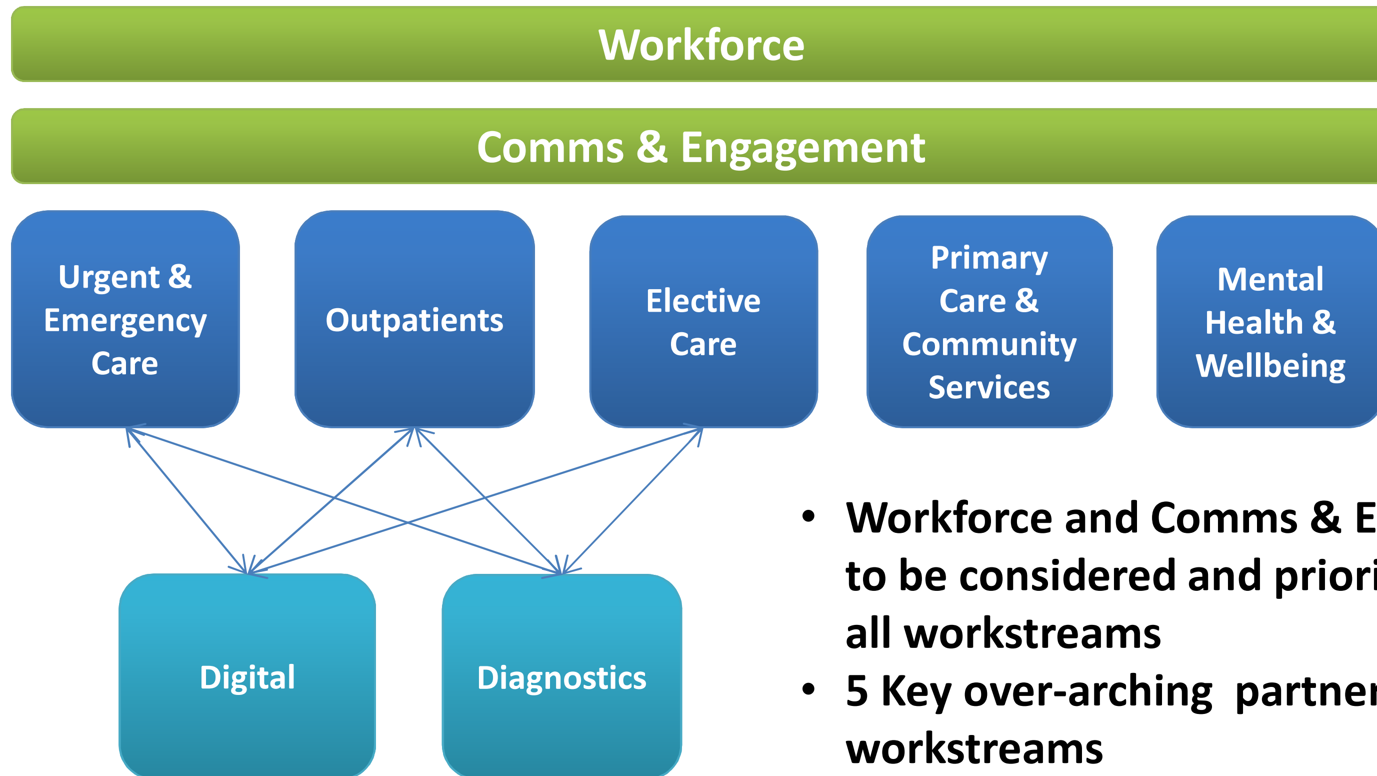
Year 1 (by March 21)	Years 2 & 3	Outcome Measures
• Implement the Urgent Treatment Centres. • Ensure best practice A&E pathways to avoid unnecessary admissions. • Improved access to Ambulatory Care and Same Day services to avoid admissions. • Improved collaborative working across system partners to ensure 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**

UK Men's Sheds Association

Dunton Green Shed Project

- **October 2016**
  - **Based – Abacus Furniture Warehouse, Greatness Lane, Sevenoaks**
    - **Membership**
      - **Operating**
        - **Pre_Covid**
        - **Post Covid**
          - **Constitution**

UK Men's Sheds Association

Dunton Green Shed Project

- **Woodwork Based**
  - **Variety of abilities**
    - **H&S priority**
      - **New members assessed**
        - **Equipment**
          - **Funding**
            - **Fixed Costs**
              - **Income**

UK Men's Sheds Association

Dunton Green Shed Project

Output

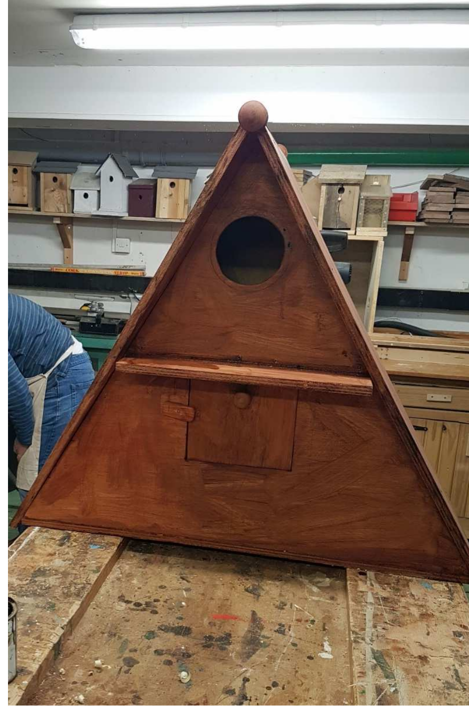
- Bird Boxes/ Bat Boxes
- Benches
- Schools Equipment
- Abacus
- Mud Kitchens
- Unusual

UK Men's Sheds Association

Dunton Green Shed Project

UK Men's Sheds Association

Dunton Green Shed Project



UK Men's Sheds Association

Dunton Green Shed Project

COVID 19

- Closed March 2020
  - Re-Start September 2020
    - Restrictions
      - Maximum people in workshop

UK Men's Sheds Association

Dunton Green Shed Project

Work in Progress

- Two Benches – Marsh Green
- Memorial Bench – SDC
- Display Board – SDC (Dunton Green)
- Outdoor Nature Equipment – Seal Primary School
- Owl Boxes/ Floats - NWKCP

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Presentation for Sevenoaks District Council

9 September 2020

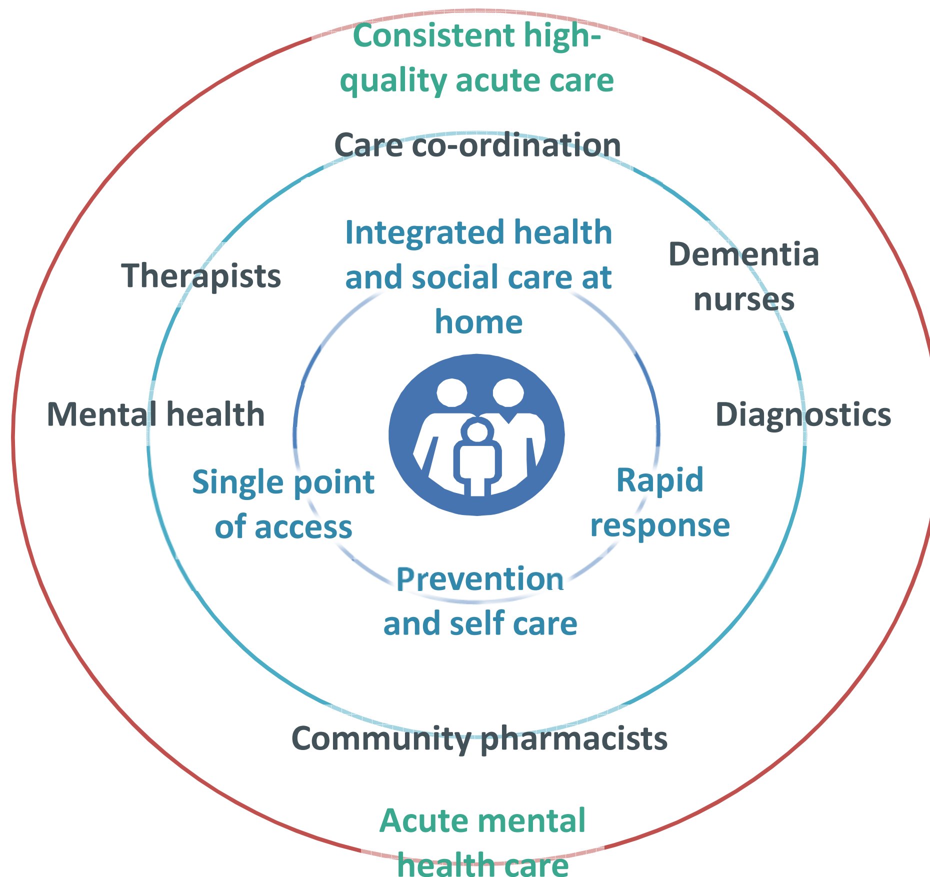
Tina Cook, Commissioning Programme Manager, Local Care

Contents

1. Local care model
2. Evaluation of additional investment
3. Response to COVID-19

The Local Care model

- **Local Care** is a **collective commitment** of the health and care system in Kent and Medway, focusing on cross organisational, multi-disciplinary teams, who will deliver **integrated health and care** services **close to where people live**. It is the model of delivery for the **Primary Care Networks.**



Aim is to:

- prevent ill health
- intervene earlier
- support wellbeing and independence
- deliver integrated care closer to home.

Additional investment in Local Care

In Q3 2018/19 Dartford, Gravesham and Swanley (DGS) CCG approved a £2.1m investment to implement the local care model for older people with complex needs. The services created were:

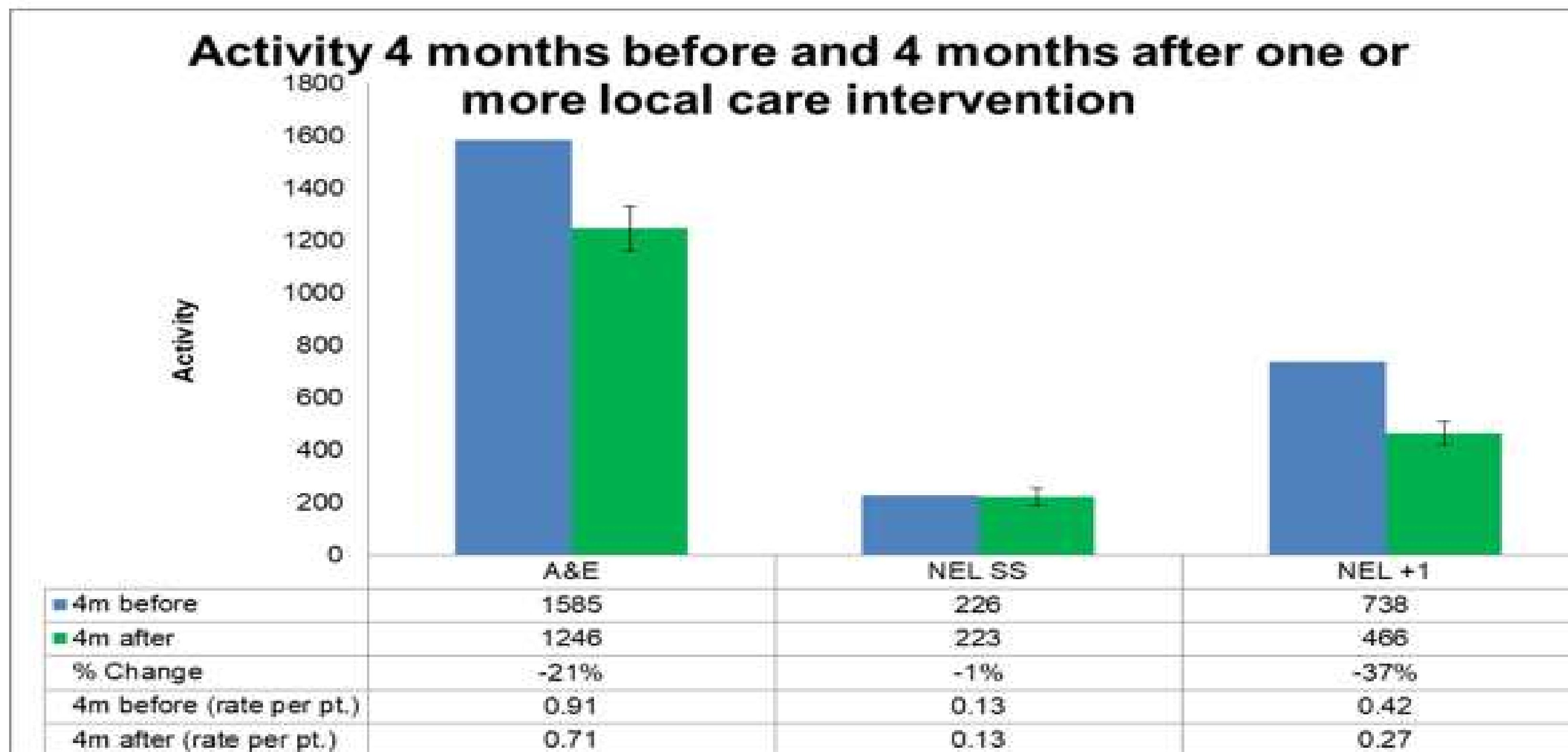
- Rapid Response – Virgin Care
- MDT Coordination – Virgin Care
- Community Geriatrician – Virgin Care
- Primary Care Home Visiting Service – DGS Health

Evaluation of Additional Investment

Draws on three main sources:

- CCG track and trace analysis to gauge impact on unplanned hospital activity
- CCG survey of stakeholder feedback
- Engage Kent independent patient/carer engagement
- Provider data

Impact on unplanned hospital activity



	A&E	NEL SS	NEL +1
4m before	1585	226	738
4m after	1246	223	466
% Change	-21%	-1%	-37%
4m before (rate per pt.)	0.91	0.13	0.42
4m after (rate per pt.)	0.71	0.13	0.27

Patient's A&E attendances, 4 months after their local care intervention was **21% less** than 4 months before. Similarly, their **NEL admissions was 37% less** for the same period

Patient Feedback

We found that all those we interviewed felt that the services they received had coordinated and talked to other services supporting them, and that this gave them a joined up, personalised package of care and support. 15 of the 16 people we interviewed felt that the services had listened to them and understood their needs. This would indicate a high level of positive feedback of integrated services

Whilst people feel heard in determining their health and social care needs, they still don't feel that services as an entity are hearing public feedback.

Stakeholder Feedback

- All services received some positive feedback.
- The Primary Care Home Visiting Service was considered most benficial
- Community Navigation, MDTs and Care Home Support team were also considered very beneficial.
- Rapid Response service had a lower score, and the Geriatrician Service scored considerably lower - issue around consistency of service.
- Common themes for improvement
  - improved feedback on referrals,
  - better service promotion,
  - increasing capacity in some services considered under-resourced:

COVID-19 Response
Overarching Themes from Local Care System Providers

- Clear and sustained shift across all services to virtual and online services for patients as the preferred approach, but face to face contact has continued where necessary and appropriate, and has gradually increased
- The benefits of increased collaboration were clearly recognised as something on which to build
- Recognition that Social prescribing services, Local Authorities and community volunteers responded quickly to support vulnerable groups
- The crisis exacerbated the situation of some marginalised groups and highlighted the need for service redesign to meet their needs
- Frailty services and hospital discharge emerge as key areas on which to focus as a system

Current Priorities

- Completion of evaluation and implementing recommendations for service improvement
- Development of integrated system approach to supporting people living with frailty and adults with complex care needs
- Seacole model - whole system approach to bolster integrated out of hospital rehabilitation for those recovering from COVID-19

-

DEVELOPING OUR FRAILTY and ADULT COMPLEX CARE MODEL

Rationale:

Frailty predicts future disability, long term care needs, potential falls & mortality. Our older population is predicted to grow rapidly over the next 5-10 years with 56% of our over 65 population living with 2 or more comorbidities. 30% of our population currently has mild frailty, 11% moderate frailty and 3% are severely frail. Social isolation is a major factor in deteriorating physical and mental health. Our social prescribers can enable greater self reliance and resilience reducing dependence on a medicalized model of care.

Our Ambition:

1. To support the frail elderly to maintain their health and wellbeing
2. To retain people in their home with wrap around care, as the system default
3. To integrate services for older people living with comorbidities across primary care, community, acute and social services.
4. Design and implement an integrated frailty pathway across our local health and care system

Health Goals and Outcomes (Year 1):

- 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

SEACOLE

The K&M response to 'Seacole' is revenue based, rather than capital; the intention not to invest in the building of new premises for rehabilitation, but to tailor the approach to deliver a flexible model that promotes personalised care, ensuring individuals have choice in going to a place that suits their needs upon discharge from hospital;

- Rehabilitation bed in the community (if unable to return home) or
- Rehabilitation in their own home, wherever that is (including care homes).

The K&M approach would;

- Support the patient pathway working in partnership, across community and acute colleagues; from discharge with consistent Trusted Assessment, flexibility in MDT workforce approach for assessment of needs and ongoing therapy requirements, to aid holistic recovery and avoid readmission.
- Is revenue based, which is relatively quick to implement and does not require a capital build (which would delay implementation, as well as incur depreciation costs).
- Allow most people to be able to return home or a community setting which reduces infection rates and allays anxiety about the infection risks associated with healthcare facilities and allows them to remain close to their community.
- Supports the wider determinants of wellbeing support, including access mental health, social prescribing and community navigation
- Support the use of digital technology to monitor people at home remotely, and
- Underpinned by a rehabilitation assistants workforce, who would be quick to recruit and would be overseen and integrate with the existing workforce model.

N.B. This presentation provides a summary of a paper which provides a greater level of detail.

Seacole Pathway

Discharge

- Integrated discharge teams (acute/community notified of MFFD)
- Trusted Assessment and personalised care
- Senior clinical decision /triage (flexibility to support in community).
- Use of step down beds (131) along with community support at home. (this is currently covered by COVID cost recovery scheme expenditure)

Community support

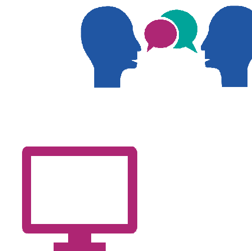
- MDT integrated approach (to meet all health and wellbeing needs , including social prescribing
- Maximised opportunity to provide care for people within own home/ care home, minimising spread of infection between environments
- Clinical leadership and support for more complex health needs.

Ongoing rehabilitation

- Rapid access to support (as those post COVID-19 are usually more typical of someone with a neurological condition)
- Therapy to build heart/lung function, muscle strength and range, independence with activities of daily living, ability to care for family and friends, returning to work, sound/pitch/strength of voice, dietary needs, continence support, psychological support for post intensive care syndrome, cognitive impairments etc.

Enablers

- NHS on line COVID rehab service being launched later this month - https://www.england.nhs.uk/2020/07/nhs-to-launch-ground-breaking-online-covid-19-rehab-service/
- Access for virtual consultation s and on-going monitoring at home (docobo or equivalent)



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