Future Planning

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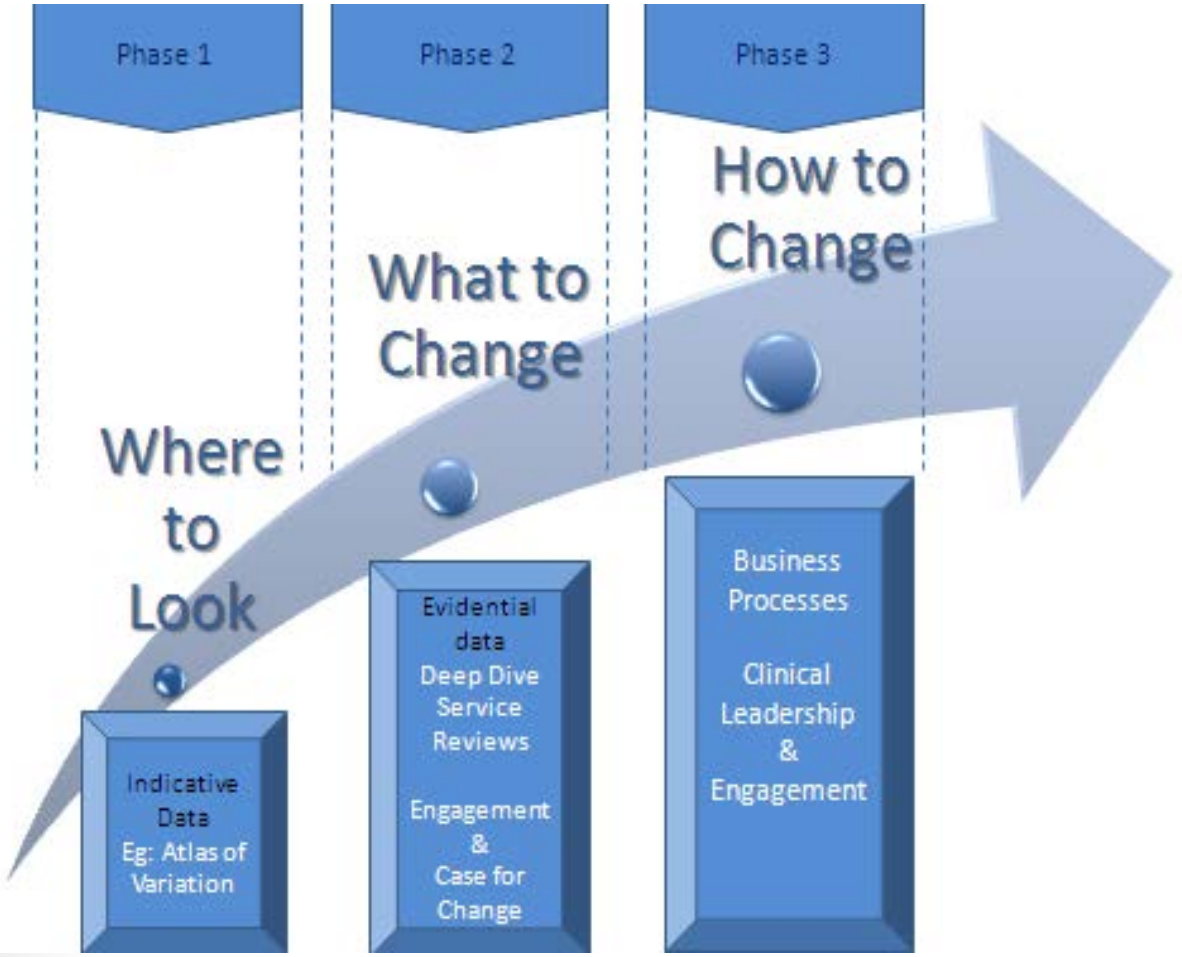
NHS Ashford Clinical Commissioning Group

Achievements 2014/15

- **Long Term Conditions**
  - Community Networks have been set up
  - Increased our dementia diagnosis rates
  - Our care homes projects have led to a reduction in urgent care attendances and admissions
- **Mental Health**
  - Primary Care base mental health workers are now in place
  - Significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.
- **Urgent Care**
  - New integrated discharge teams
  - Local Referral Units to maximise potential of community services (building an urgent care network)
  - Reduced delays in having care packages in place for timely discharge following inpatient care
  - Pilot 7 day Primary Care
  - Local Referral Unit ensures that patients are offered support within their own homes
- **Planned Care**
  - Glaucoma (access issue),
  - Orthopaedic Triage (addressing access standard failure through improved demand and system management)
- **Financial Duties**

Year Two: Commissioning for Value



Five Key Ingredients:

1. **Clinical Leadership**
2. **Indicative Data**
3. **Clinical Engagement**
4. **Evidential Data**
5. **Effective processes**

2015/16 Projects

- **Priority Projects**
  - Musculoskeletal (MSK) Programme – Programme Lead: Sue Luff
    - MSK Triage – Project Lead: Paula Smith
    - Spinal Surgery/Pain Pathway – Project Lead: Sue Luff
  - Dermatology – Project Lead: Laura Counter
  - Discharge to Assess – Project Lead: Ruth Davoll
  - Improved Access to Psychological Therapies – Project Lead: Lisa Barclay
  - Cardiology Diagnostics and Referral Pathway – Project Lead: Laura Counter
  - Elective/Demand Management Programme – Programme Lead: Lisa Barclay
- **Other Ongoing Projects**
  - A/E Recovery - Project Lead : Alistair Martin
  - Age UK PID – Project Lead: Clare White
  - OOH/111 – Project Lead: Thariea Whisker
  - Over 75 Admissions – Project Lead: Sue Luff
  - Dementia – Project Lead: Carol Boorman
  - Prescribing Scheme – Project Lead: Sheila Brown
  - Diabetes – Project Lead: Sue Luff
  - WAMD - Project Lead: Paula Smith

Project Updates – July 2015

- **Red – Risk to Delivery**
  - Elective/Demand Management Programme
    - Additional resource required
  - A/E Recovery
    - Significantly off trajectory for achievement of NHS Constitutional Standard
  - Discharge to Assess
    - Funding remains unidentified
- **Amber – Not Progressing As Plan**
  - Dermatology
  - Musculoskeletal (MSK) Programme
- **Green – Progressing as Plan**
  - Improved Access to Psychological Therapies
  - Cardiology Diagnostics and Referral Pathway
  - Age UK PID
  - OOH/111
  - Diabetes
  - WAMD
  - Dementia
  - Over 75 Admissions
  - Prescribing Scheme

National Drivers

- Increasing demands on services
  - Growing, ageing population
  - More complex needs.
- Tight financial envelope
- Increasing, yet often under-reported, prevalence of long term conditions.
- Overall satisfaction with primary care services remains high
- Growing challenges in relation to patient experience of access.
- Inequity in distribution of workforce, and recruitment.
- Retention and retirement issues are facing GPs and practice nurses in particular.
- Recognition that integrated models of health and social care should be more clinically and cost effective
- National drive to move care closer to home (FYFV).

Five Year Forward View

- Represents the shared view of the NHS national leadership
- Reflects an emerging consensus among patient groups, clinicians, local communities and frontline NHS leaders.
- Sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.
- Identifies that, in order to meet patients' needs and expectations, we need to develop a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.
- As a result there is now quite wide consensus on the direction that the NHS should taking:
  - Increasingly we need to manage systems – networks of care – not just organisations.
  - Out-of-hospital care needs to become a much larger part of what the NHS does.
  - Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them.
  - Patients with mental illness need their physical health addressed at the same time.

Local Drivers

- 2014 approval to build 5,750 homes at Chilmington Green with 3,350 by 2021;
- Potential of 13,800 new residents (increase of 12% from 2011 census);
- Average life expectancy in Ashford is 83.4 years for women and 80.7 years for men;
- Long Term Conditions increasing
  - 25%+ population have LTC
  - 12% have 3+ conditions;
- By 2019 Ashford 0ver 65's will grow by 10% and comprise 20% of the population
- Proposed development at Tenterden – 500 houses by 2021

Five Year Plan Aspirations

Priority One: Community Networks

- We want our patients to recognise that the local NHS is sited within their own community and not around specific estate or hospitals. We want these networks to offer the largest possible range of services meeting the largest possible range of needs and that most aspects of any patient journey, through the health and social care system, is local to them.

Priority Two: Primary Care

- We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

Priority Three: Urgent Care/Long Term Conditions

- We want care that crosses the boundaries between primary, community, hospital and social care.

Priority Four: Planned Care/Long Term Conditions

- We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Priority Five: Achieving “Parity of Esteem”

- We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities

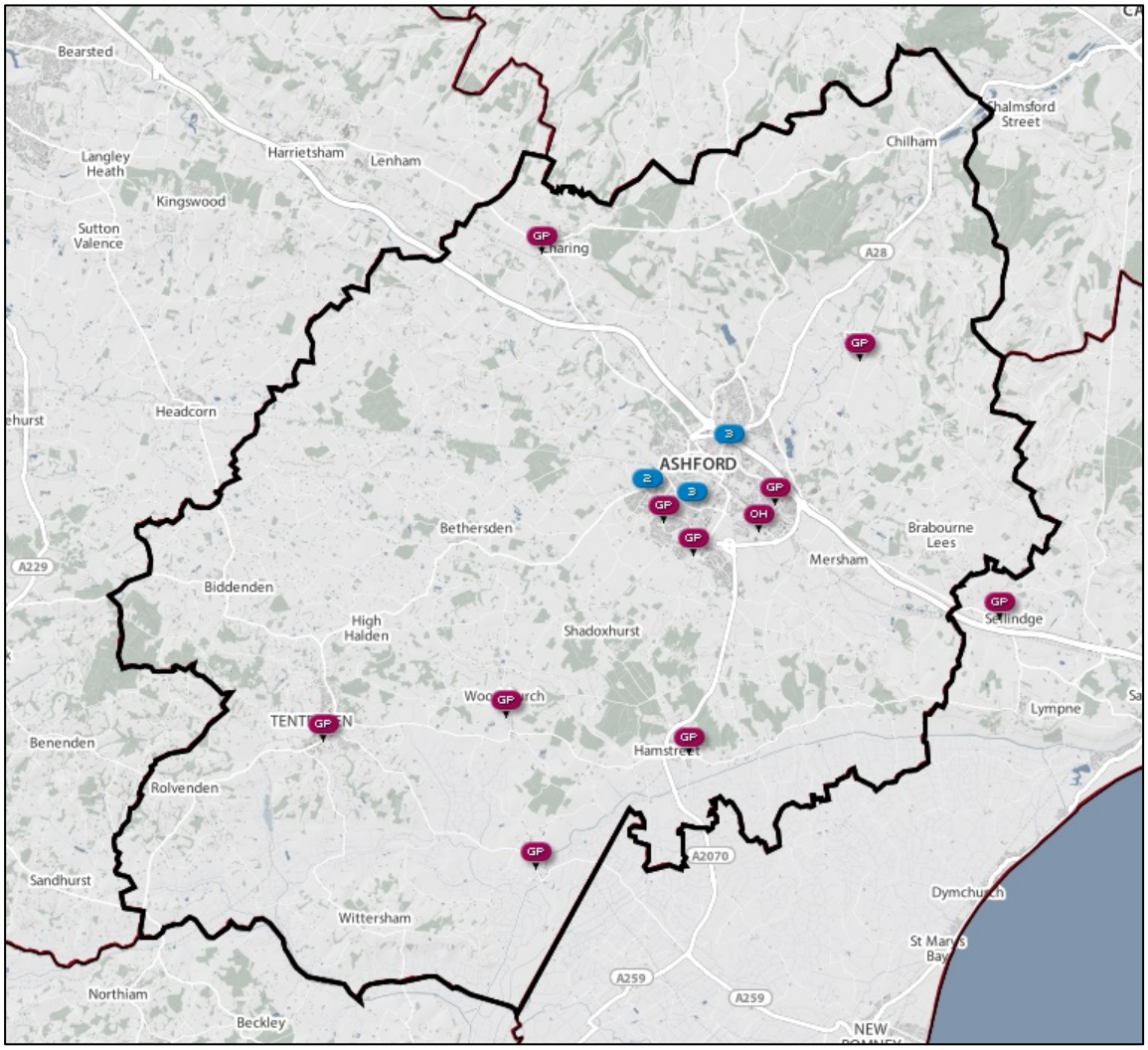
Priority Six: Children and Young People

- We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation

Impact of Our Vision

- Short term
  - Expansion in the provision of referral triage, outpatient clinics, diagnostics, screening, physical and psychological therapies all as one stop services closer to home (Network)
  - Reduction in hospital admissions by horizontal collaboration with EKHUFT to become a vanguard in “acute care”
  - Roll out the weekend service currently running in the rural Hub
  - Ramp up this service to cope with additional demand during peak winter pressures.
  - Facilitate re-ablement of patients to their own homes wherever possible
  - Introduce a ‘virtual ward’ where patients in the community at risk of hospital admission can be discussed by MDT’s
  - Repatriate community/specialist nurses and health visitors back to the practice
- Longer term
  - Form a “Multidisciplinary Community Provider” (MCP) holding its own unified budget for the provision of all local health and social care
  - Smaller “hotter” acute hospitals trust.

Current Location of Ashford Surgeries



New Models of Care

- A broad consensus on what a better future should be
- Radical upgrade in prevention and public health
- NHS will take decisive steps to break down the barriers in how care is provided
- England is too diverse for a one size sits all. Nor is the answer to let a thousand flowers bloom.
- Multispecialty Community Provider (MCP)
- Primary and Acute Care Systems (PACS)
- Redesign of Urgent and Emergency Care services to obtain integration.
- Smaller hospitals
- List based primary care

Multispecialty Community Provider (MCP)

- Groups of GPs to combine with nurses, community health services, hospital specialists, mental health, social care
- Integrated out-of hospital care
- A clear and robust governance structure
- Extend beyond primary care at scale
- Core primary medical care
- Community-based NHS services
  - District Nursing
  - Health visiting
  - Pharmacy
  - Step-down beds
  - Domiciliary Care
- Social care

An essential building block

- Lists of registered patients
- Minimum population of approx. 100k
- Joined up electronic records
- New types of contract
- Use risk stratification and population data to identify patients who will most benefit from intensive support
- Run expanded multi-disciplinary community based teams including for example pharmacists, social workers and nurse leaders
- Strong Voluntary Sector input
- Incorporate some specialists [employment or partnership]
  - Consultant Geriatricians
  - Psychiatrists
  - Paediatricians
  - “Generalist” consultants

Primary and Acute Care Systems (PACS)

- Integrated hospital and primary care provider
- Combining general practice and hospital services
- Similar in many ways to MCPs
- But…
  - It is an approach to full “vertical” integration
  - Incorporate all core hospital services
- NOT supported by Ashford GPs

Learning from MSK Triage Pilot

- Joined up working with CCG/EKHUFT has released savings in first 6 months of pilot
- Patients are being seen quicker and closer to home
- Surgeons only consult with surgical cases. De-pressurised hospital outpatients for the benefit of all East Kent residents.
- GP referrers have peer to peer education and feedback
- Increased trust and collaboration between practices.
- Increased confidence for commissioners to think “outside the box” by utilising local skills and expertise.

Major Risks

- **Strategy**
  - Balancing localism and strategic direction across CCGs and providers
  - Alignment of CCG networks to national models (size)
  - KCHFT community services – desire to change operating model enabling greater integration with primary, secondary and social care
  - EKHUFT proposed Clinical Strategy – sustainable acute hospitals, hotter and smaller
  - KCC Strategy – Social Care Transformation Programme and Accommodation Strategy
- **Engagement**
  - Significant engagement of patients, public and voluntary sector in design of local services
  - Clinical Engagement – increasing emphasis on new models of care
  - May require “brave” de/re-commissioning of services
- **Delivery**
  - Financial Recovery Plan
  - A&E Constitutional Standard achievement
- **Resources**
  - System wide commissioner capacity
  - Failure of other operational target on management capacity
  - Reduction of beds capacity within the Trust;
  - Implications of revised GP contract to be released

NHS Ashford Clinical Commissioning Group

Any questions?

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