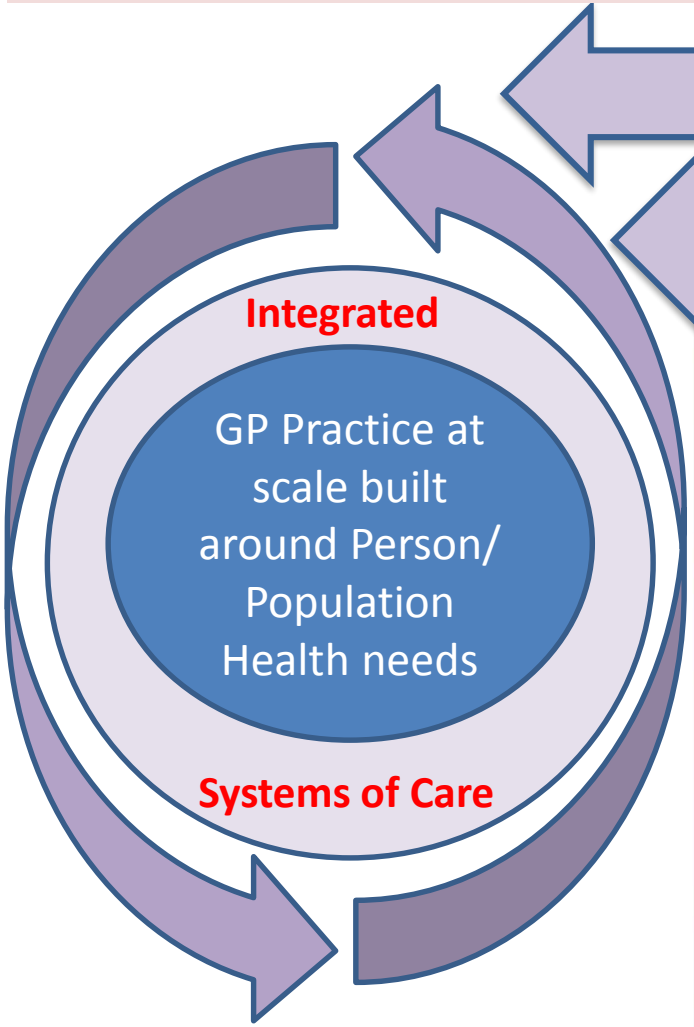
Implementation of Local Care

Ashford CCG

Key areas of Local Care Implementation

- The Local Care Model
- Implementation to date
- Plan for roll out across Ashford footprint
  - Detailed timelines
  - Anticipated impact
- Extended Access
- Frailty and other Tiers of Care Priorities

Local Care Model – Health, Social Care, Voluntary and Community involvement working together at scale – The Community Hub Operating Centre (CHOC) model



Number of People

Admission Avoidance

Routine, Prevention and Proactive Care –Integrated Case Management (ICM patient centred approach for admission avoidance, anticipatory care planning.

Emergency and Reactive Care – ICM approach for admission avoidance, rapid/ emergency response to avoid hospital admission to keep people well at home.

Acute Care - When intervention is essential. Working with IDT for repatriation at the earliest opportunity.

Tertiary Care - For highly specialist intervention. Repatriation at the earliest opportunity.

Level of Acuity

GP/MDT Clusters
Total Population 132,419
Each Cluster – 35-60,000

Ashford Rural Model and Impact

- Cluster level MDT working in place since late 2016
- Shared principles with Vanguard area of
  - regular multidisciplinary/ multi agency meetings
  - Identification of complex and vulnerable patients
  - Responsive care planning to maintain community care where appropriate
- Weekend urgent care response to avoid attendances at A&E
- Activity at month 6 shows reduction of 12.8% against contract baseline for the 5 frailty specialities combined.

Planned implementation of Local Care Integrated Case Management model to all localities

- Ashford CCG:
  - Ashford Rural Cluster ***In Place***
  - Ashford North Cluster ***December 2017***
  - Ashford Urban Cluster ***December 2017***

Implementation Progress

- Principles of Encompass Vanguard model agreed across Ashford CCG area and reflected in Kent and Medway Local Care model
- Detailed summary of maturity of each locality undertaken
- Detailed road map of roll out of full model undertaken per locality (ongoing)
- Detailed activity impact modelled per locality based on planned timelines

Implementation key milestones

- Ashford Rural/ Encompass MDT model to roll out to Ashford Urban and North Clusters with initial mobilisation in November 2017 and full implementation from January 2018.

- Ashford Clusters to mobilise integrated pathways in Catheter Care, Wounds Care and Aural Care in a cluster phased approach from January 2018.

Extended Access- Ashford

- Ashford CCG on track to deliver GPFV extended access across CCG in a phased approach by end 2018/19:
  - Development scheme in place to support practices
  - Enables Ashford practices to mobilise early with a phased approach, plan to achieve 25% of GPFV seven day access by March 2018.
  - Initial mobilisation across all three clusters planned for quarter 4 – go live achieved in December 17
  - Scaling up of provision planned to full delivery during 2018/19.

Frailty Implementation

- Rolling out integrated case management forms the core of the local delivery of frailty intervention across Ashford
  - Identification of patient with moderate and severe frailty
  - Planned care approach to anticipatory care planning and community MDT support
  - Reactive element to initiate rapid response and facilitate discharge from hospital
- East Kent wide frailty pathway implementation linked to locality deliver via a single strategic/ clinical steering group for key elements of pathway:
  - Clinical Support to Care Homes
  - Enhanced senior clinical workforce
  - Review of falls pathway
  - Planning digital solutions/ supports to pathway (use of PTL and telemedicine).

Tiers of Care Implementation

Planned local delivery (via Clusters) of Tier 1 and 2 elements of the East Kent Clinical Transformation Plans:

- Cardiology – Plan to implement T2 across Ashford & Canterbury areas from April 2018
- Rheumatology – decision re: EK procurement
- Dermatology - Triage process in place in Ashford, implementation.
- Respiratory

How is the integrated case management model is supporting the Frailty Pathway:

In the following ways;

- Been part of the **pneumonia pathway** work across east Kent, which went live on the 2/10/17 (attached). This has been extensively socialised with each GP, clinical leads and practice managers

- From Decemer 2017, **increasing numbers going through MDTs** – risk stratified per practice using programme to identify vulnerable and at risk patients,

- Working with all partners to have a **coordinated approach** with SECAmb, to avoid hospital admissions

- From Dec 2017 have implemented **extended hours** (as per our GPFV) creating capacity for extra consultations

- Part of the **urgent care pathway work** across east Kent, supporting GP pathway/access within Acute setting (to alleviate pressure on the Acute)

- Linking in with the **care home strategy**- supporting care planning, early identification of the deteriorating patient and training for staff

- Linking in **with New provider for OOHs/111**, as of Dec 2017 (existing provision has not met expected requirements).

Enablers

- Digital solutions: Common digital systems and solutions being used to support consistent working at scale and integration between organisations (EMIS clinical services, Local Care PTL development)
- Alignment of CCG resources to Local Care implementation to enable rapid roll out of successful models
- Development of Alliance working with Kent Community Trust to align all partner organisations and workforce to the model of care

Risks

- Enhanced Frailty Workforce Recruitment to deliver frailty implementation plan
- Primary Care workforce demands to deliver in hours, extended access, out of hours and support to emergency system
- Fragility of immature alliance partnerships
- Delay in NHS Digital procurement - support implementation of key milestones

Winter Preparedness Proposals– East Kent Initiatives

- Recommission 80 health & social care beds Dec-March
- Spot purchase 10 additional packages of care for dementia/challenging behaviour patients
- Extend length of rapid response package to 5 days
- Dedicated fast track hospice beds
- Dedicated nurse practitioner for care homes
- Expansion of Care Navigator service to community hospitals
- Health Navigators in secondary care to support self management
- Additional support for non weight bearing packages