

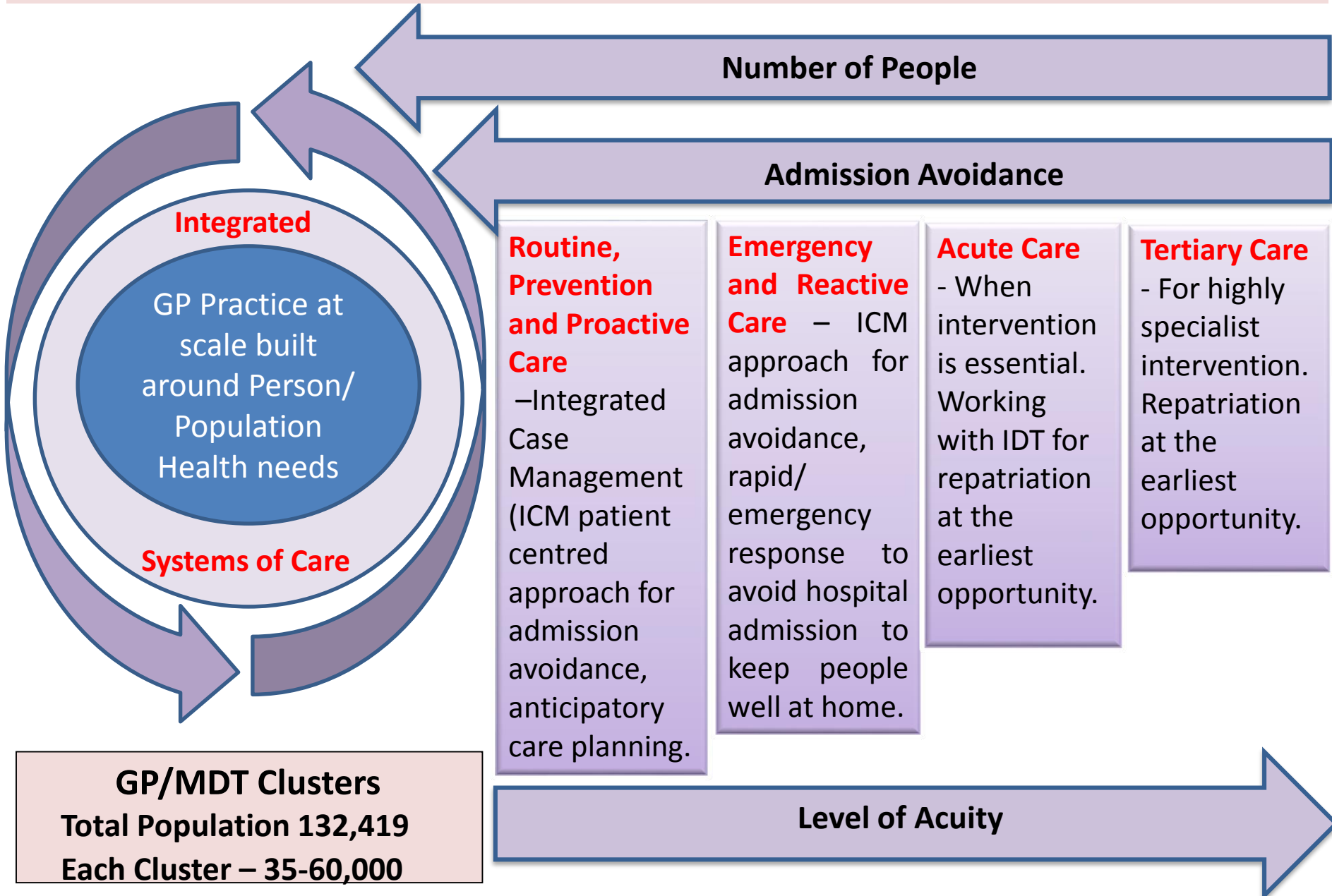
# Implementation of Local Care

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



# 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:

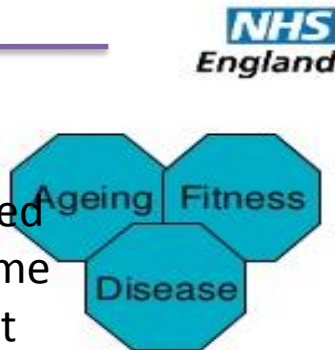
- Cardiology – Plan to implement T2 across Ashford & Canterbury areas from April 2018
- Rheumatology – decision re: EK procurement
- Dermatology - Triage process in place in Ashford, implementation.
- Respiratory

## How is the integrated case management model 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 Dec 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