Appendix E

Local Care Updates Sept 2018

V4 CB

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

East Kent

- Consistent care model signed up to across East Kent – current finessing the specific workforce configuration as part of the Pre-consultation Business Case (PCBC) work
- Focus on Integrated Case management for patients with complex needs
- Robust third sector and community development and primary care at scale (30-50,000 population)
- Investment for general practice transformation to support delivery of local care plan -expansion of MDTs, delivery of GP Forward View working at scale (30-50,000population) and development of 10 high impact changes.
- Alignment to East Kent Urgent/Emergency reconfiguration
- Developed and agreed a realistic trajectory for activity for integrated Case Management Model
- Hospital patient tracking list live in 2 areas, with plans to implement across East Kent (to support data sharing for Multi-disciplinary Team [MDT] discussions)
- Agreed consistent methods to measure activity and impact
- Contracts awarded to deliver Improved Access across East Kent from October 2018
- All areas have established extended primary care networks
- Development of collaborative/alliance arrangements; Place based models
- East Kent to pilot the STP Organisational Development toolkit at MDT and Federation level
- EK wide Governance structured agreed
- Communications support across strategic priorities

West Kent

- Governance structure for Local care delivery in west Kent
- All 7 MDT cluster up and running April 2018
- Provision of medical cover under Local enhanced services to care homes in place
- Training complete and signposting/ care navigation in general practice launched July 2018
- Implementation of new Falls prevention Service planned for Oct 2018
- Rapid response and Home Treatment service being expanded (planned from October 2018)
- Integrated communications and engagement plan in place for 2018/19
- Work is underway to develop a mental health local care model at pace and involving all stakeholders as equal and active partners.
- Implementation of an integrated Community Diabetes model – started Sept 2018
- Outpatient Transformation;
  - Stage 1- Integrated MSK Service Hip, knee, Spine integrated pathway implementation completed
  - Stage 2 - Integrated Pain Management Service completed.

Medway

- Governance arrangements to support Local Care
- Joint Better Care Fund framework for next 4-5 years
- A restructure of Adult Social Care Services into localities aligned to the Medway Model for Local Care took place in September 2017
- Underway with Community Service re-procurement (2/3 Local Care)
- Support for care homes – aligning GPs for weekly ward rounds and medicines review
- 18 new step up/step down beds -support for 72hrs post discharge– with Continuing Healthcare Assessment completed once discharged
- New Social Prescribing model
- Roll out of MDTs underway Co-ordinator role in Place (MCH)
- Almost all practices on EMIS WEB
- Identification of 6 localities – all with identified CCG support and clinical leadership
- Successful capital funding for 2 new Healthy Living Centres
- Undergoing a gap analysis on workforce requirements – using Whole Systems Partnership dynamic modelling tool
- Shifting from specialist to generic roles with providers working together
- Worked with patients and stakeholders to develop the “case manager” role – working with local university to support training (to meet 40% shortage)
- Medway CCG (with the Partnership Commissioning Team) are procuring a comprehensive Care Navigation service from a provider, to begin on October 2018 – part of a bigger social prescribing project lead by Medway Public Health
- Long term condition Pilot focussing on different levels of patient self-activation

DGS & Swale

- Implementing MDTs, working at scale of 30,000 – 50,000 population - first two MDT meetings in DGS. The aim is for 50% of MDTs to be in place and operating by the end of Q3.
- Provide effective Rapid Response services to support reductions in hospital admissions of the frail elderly population and reducing hospital Length of Stay
- Develop and align care navigation models currently operating to better manage patients who require support to manage their medical conditions, access the care they need and to live independently, ensuring avoid hospital admission.
- The focus for 18/19 is on older people with complex needs.
- For DGS 50% MDTs functioning by end Oct 18
- Swale has aligned practices to 3 hubs that meet the 30-50K population levels considered best practice for MDT working– on track, started Sept 2018
- Primary Care home visiting service to be established as per business case
- Business case for wider rapid response service being developed
- Alignment of CCG and provider staffing to MDTs with “team on a page “being developed
- Plan includes interim step of ensuring this alignment is reflected in practice based MDTs already in operation
- There are staffing risks in all providers, therefore working with partners to make best use of staff resources
- This is a key reason to move to locality MDT meetings and away from practice based
- Realignment of existing Care Navigators from Sept 2018 -procurement of new service from April 2019 aligned with Kent County Council