DGS ICP Local Care
Kent and Medway CCG

Programme Update

Presentation for Sevenoaks District Council
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Tina Cook, Commissioning Programme Manager, Local Care

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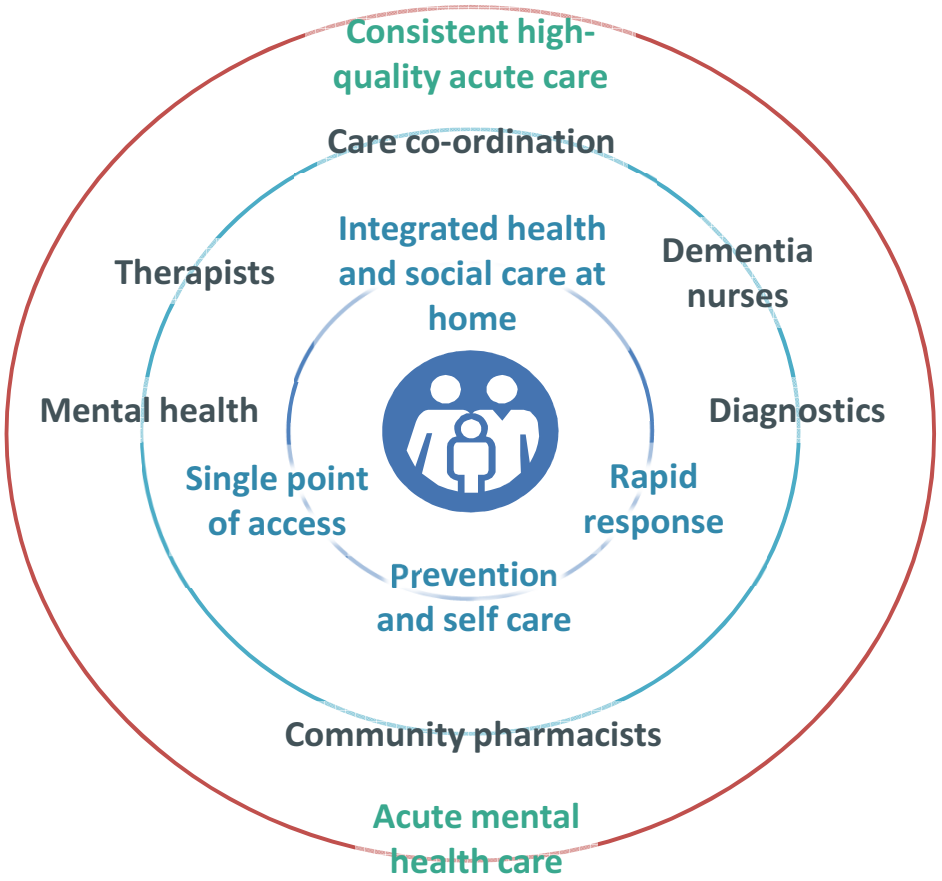
The Local Care model

- **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:

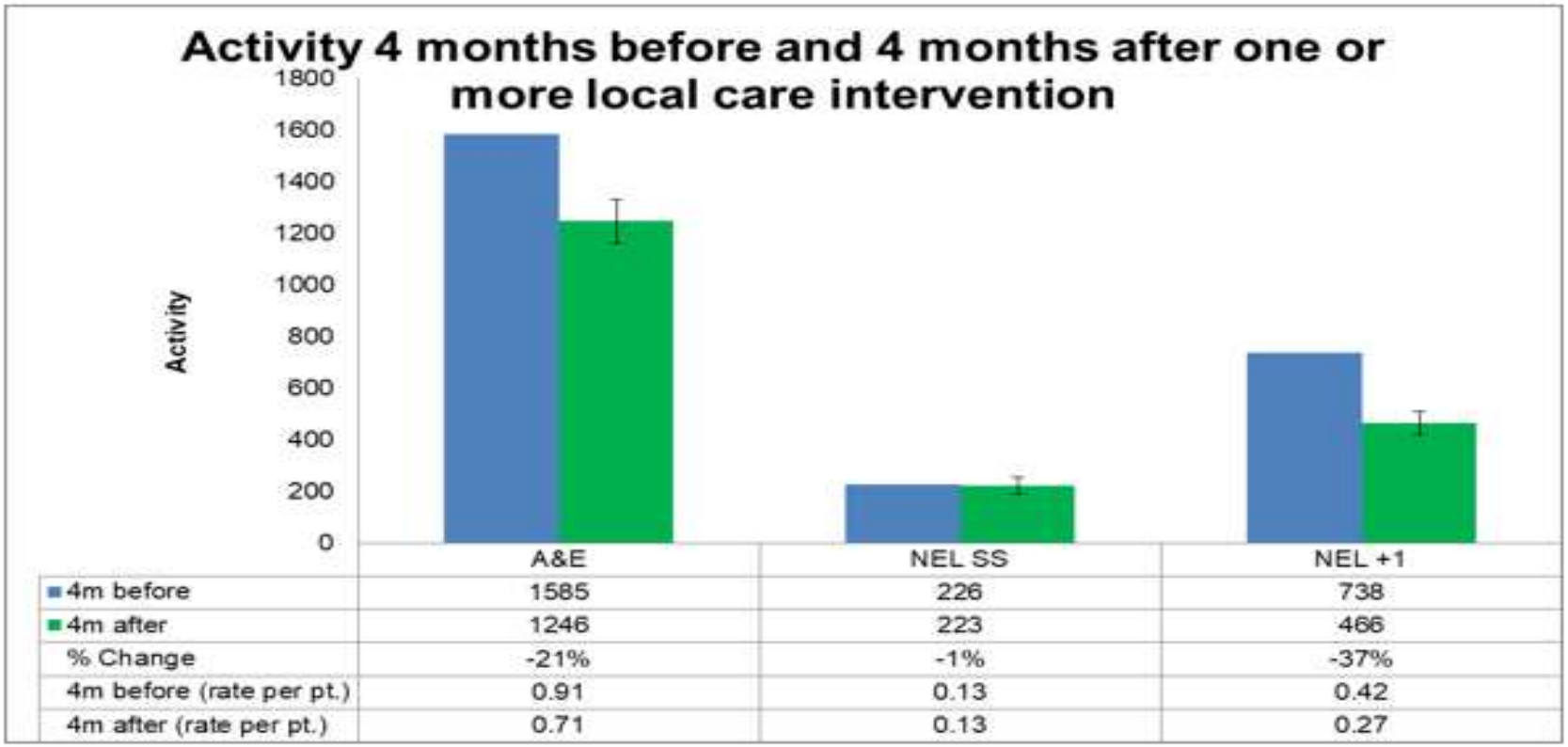
- Rapid Response – Virgin Care
- MDT Coordination – Virgin Care
- Community Geriatrician – Virgin Care
- Primary Care Home Visiting Service – DGS Health

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

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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)