Health and Adult Social Care Overview and Scrutiny Committee – Supplementary agenda no. 1

A meeting of the Health and Adult Social Care Overview and Scrutiny Committee will be held on:

Date: 18 January 2024

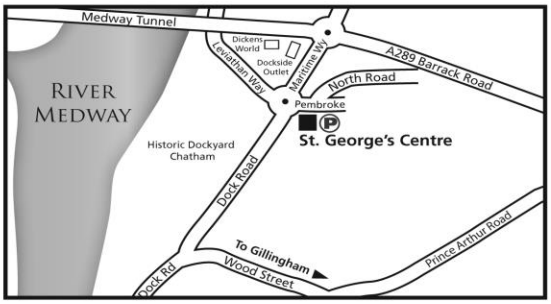
Time: 6.30pm

Venue: St George's Centre, Pembroke Road, Chatham Maritime, Chatham ME4 4UH

Items

For further information please contact Michael Turner, Principal Democratic Services Officer on Telephone: 01634 332817 or Email: democratic.services@medway.gov.uk

Date: 11 January 2024



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HEALTH AND ADULT SOCIAL CARE

OVERVIEW AND SCRUTINY COMMITTEE

18/01/2024

COMMIUNITY SERVICES TRANSFORMATION UPDATE

Author

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Context

As an Integrated Care Board (ICB), we are a health leader in Kent and Medway's Integrated Care System. We play a pivotal role in making sure the people we serve are receiving the health and care they need.

We are an organisation that – working with our partners – wants to be transformational in the way we develop service models, both now and in the future.

Community services play a vital, integral role in health and care in Kent and Medway and they must be of the highest quality.

Community services support our population to be cared for outside of a hospital, in places where people live, as well as providing support to primary care, in particular general practice. We are acutely aware that people recover faster at home.

Detailed below are 11 ambitions for areas to transform community care. This list provides some of the key features we believe should feature in a new model of care as part of the transformation of these services, as well as key considerations, principles, and broad transformational outcomes.

It is essential these ambitions are brought about through collaboration, partnerships and implementing new models of care at place.

NHS Kent and Medway ICB commissions a number of community out-of-hospital services which are predominantly delivered through three main providers, in Medway the majority of services are delivered by Medway Community Healthcare (MCH). While delivered with a high level of clinical quality, these services have not previously been examined with the whole of community provision across Kent and Medway in mind.

We are aware that in parts of community services, there is variation and inequality in terms of access to services and delivery, as well as the potential for duplication, fragmentation and a lack of consistency and efficiency.

Our services can be complex and difficult to navigate for patients, clients and service users and this can result in people defaulting to use acute services.

Whilst our community service providers deliver great care every day, we cannot ignore that there are inefficiencies in the system such as duplication of services and workforce in close proximity for example 3 separate Speech and Language Therapy services running across MCH, HCRG Group and Kent Community Health NHS Foundation Trust (KCHFT). In Medway Foundation Trust (MFT) Hospital we are particularly seeing an issue with discharges of those patients no longer needing to be there (not fit to reside), which are facilitated by the Integrated Discharge Teams (IDT), working for the community providers (MCH & HCRG). When comparing the month of December 2022 with December 2023 there was a 52% increase in the total bed days lost to patients no longer fit to reside in MFT this represents over 1200 bed days lost in December 2023 and about 18% of the total bed base.

Previously we presented papers proposing to reprocure the community services across Kent & Medway on an as is basis with a 12-18month transformation period built into the new contracts. However, after considering feedback from both this Committee and the Kent Health Overview & Scrutiny Committee (HASC and HOSC) as well as discussion internally the decision has been taken to extend existing contracts to align the timeframes and begin the transformation of some of the pathways over the next 12 months before reprocuring the contracts. This will mean that through engagement and collaboration services will be in a better position for patients prior to the procurement however there will be no fundamental changes to the core community service provisions.

Early transformation planning to service delivery will form the building blocks and foundation for the new overarching model of care for community services across Kent & Medway which in turn will form a basis for the procurement process which must take place through 2024 and be concluded by late 2025. At relevant points through the transformation and before the tendering process resumes, we will bring this back to HASC and HOSC to gain the views of members and discuss any potential significant variations that may arise. At this time we are informing of intentions to begin transformational engagement and improvement projects rather than informing of any immediate significant changes.

It is key that community services are delivered through local Health and Care Partnerships (H&CPs) ultimately working seamlessly across councils, primary care, mental health, acute care services and the voluntary sector. However, the service user must always be at the centre of what we do.

In line with our ambition for services outside of hospital care, the new services must ultimately empower people to be in control of their healthcare outcomes, with a particular focus on neighbourhoods.

During the initial phase of the community redesign programme, we plan to hold a series of workshops and surveys involving patients, carers, Healthwatch and professionals; interviewing people who currently receive community services. We hope to also capture professionals' experiences as a patient, user or carer, rather than just as clinicians, in a bid to empower people and place patients at the centre of the redesign. This will help us to build a more comprehensive understanding of the issues

people face in Medway and the wider county, how they access services and receive care and their experiences of what has and hasn't worked for them in the past.

We will review the present systems of patient involvement and engagement with a view to developing a new patient involvement approach to gain live and strategic patient information. This may include reviewing our service information and accessibility to ensure that it is as simple as possible to access information on self-care, community and acute care.

Our previous engagement has shown an overwhelming determination from people and patients to lead independent lives, but many become frustrated due to constraints in accessing services and an inequality in services and support.

Key transformation aims include:

- A shift from 'doing to' to 'working with' patients
- Contractual boundaries reduced between providers leading to greater integration between the different services and providers, working together improving efficiency, sustainability and quality of care
- Embedded partnership and shared responsibility between providers and service users. Promoting provider collaboratives model which give providers the opportunity to combine resources to address the challenges they are facing
- Greater focus on prevention and early intervention, empowering self-care and mutual aid

People want to see a simplified care system, easy to navigate, sharing a common language and processes, with more efficient communication and information sharing that delivers effective multi-disciplinary working.

A key driver from NHS England is for providers to collaborate and work at scale to reduce unwarranted variation in health and care outcomes and access to services, including a focus on reducing health inequalities. This is where standardisation of pathways, protocols and policies can be leveraged to improve outcomes and patient experience, whilst ensuring local delivery meets local need. Standardisation through provider collaboratives should be clinically and professionally led and focused on addressing ongoing challenges with new models of care across an area and standardising protocols to reduce variation. Provider collaboratives underpins NHS England's concept of system collaboratives and the benefits of working at scale. This also gives the opportunity to review capacity in a combined sense rather than on an organisational footprint. Working in this way is also becoming increasingly important as providers tackle the backlog of care.

Next key steps

- Co-production of service specifications and establishing new ways of working while promoting local system-based pilot or initiatives
- Taking an asset based approach which values the skills and knowledge of a community, creating tools to underpin collaborative working
- Establish networks, sharing best practice and enabling professionals to share expertise, while also providing user forums

- Develop the workforce culture and capabilities, building the skills of those involved and equipping local change champions with the skills need to implement services transformation.
- Developing relationships between providers which broker partnerships and shared responsibility.

Health Inequalities

Everyone deserves the same opportunities to lead a healthy life, no matter where they live or who they are. In Kent and Medway, people in more affluent areas live longer than those in more deprived areas.

Life expectancy is significantly shorter for some groups of people, including homeless people, those with learning disabilities and people with severe mental illness compared to the general population. There are inequalities in access to all services and digital exclusion can play a key role in this.

Emergency admissions to hospital are more common in areas with higher levels of deprivation. Research also shows people from more deprived communities are less likely to engage in preventative programmes, such as immunisations, screening, dental check-ups and eye tests, when facing no immediate discomfort or disability.

People from deprived areas are more likely to present to healthcare providers at a later stage of illness.

Medway has five main towns - Strood, Rochester, Chatham, Gillingham and Rainham. While the towns are densely populated, there are larger, much more sparsely populated rural areas on the Hoo Peninsula and in Cuxton and Halling. Swale (as per the H&CP boundries) consists of the town of Sittingbourne and the Isle of Sheppey which includes Sheerness, Minster and Queensborough as the main towns, there are also 3 prisons on the island which house around 2800 prisoners at any given time.

Deprivation is higher than the England average and Medway contains some of the most deprived neighbourhoods in England; these neighbourhoods are in Gillingham and Chatham.
Medway has a population of 279,142. The population is younger compared to England. In Medway, 23.4 per cent are aged under 18, 60.3 per cent are 18 to 64 and 16.2 per cent are 65 years and over. Swale's population is around 150,000 people who are also served by Medway Hospital and as a whole has a slightly older demographic than that of Medway.

Most of the population is classified as White British, with the next largest ethnic group being Asian.

As explained in Kent and Medway's Integrated Care Strategy, a collaborative, partnership approach to population health and management and tackling inequalities will be needed to make sure all services address these issues and reduce avoidable unfairness in people's health and wellbeing outcomes.

Transformation Ambitions

The 11 areas for transformation are:

1. Intermediate Care
2. Integrated Specialist Services
3. Rehabilitation Services
4. Frailty
5. Community Nursing
6. Community Out-patient appointments
7. Diagnostics
8. Elective Community Hubs
9. Ageing Well
10. End of Life Care
11. Single Point of Access

Community services play a significant role in supporting acute hospitals in prevention of the exacerbation of health issues, reducing the need for admission and in rehabilitating people to prevent re-admission.

Due to pressures across the system and in particular on Medway Hospital, and the need to ensure safe and consistent care for patients, we are proposing that the top 4 ambitions will be the focus over the coming 12 months as they could have the biggest impact and on the system.

The other ambitions may be looked at over this period also and some of the milestones reached. However, it is following considerations of the data, current position, and forecasts that we believe the focus should be on Intermediate Care, Integrated Specialist, Rehabilitation and Frailty Services.

Intermediate Care

Reviewing and redesigning the range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living.

Step-down intermediate care involves community-based assessments and interventions provided to people in their own home (home-based; discharge pathway 1), or in short-term community bedded settings (bed-based; discharge pathway 2). Home-based intermediate care is the default pathway as per the 'home first' approach (a person's home is their usual place of residence). Someone may be discharged from bed-based to home-based intermediate care to continue their intermediate care. For the majority of people in acute hospitals, a simple discharge home without the need for step-down intermediate care is the most appropriate pathway (discharge pathway 0).

Intermediate care services can be entirely health care, entirely social care, or ideally have elements of both delivered by multi-disciplinary teams working in integrated ways.

Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

The ambition is to implement a new intermediate care model which transfers patients from acute within 24/48 hours of the clinical ready for discharge decision.

Development of a new model will include redesigning Integrated Discharge Teams (IDT) into Transfer of Care Hubs, increasing domiciliary care capacity (to work in conjunction with services commissioned by local authority's (LA's), home care support at scale, and voluntary sector integration and development.

This will ensure that intermediate care is provided in an integrated way by working towards the following:

- a single point of access for those referring to the service
- a management structure across all services that includes a single accountable person, such as a team leader
- a single assessment process
- a shared understanding of what intermediate care aims to do
- an agreed approach to outcome measurement for reporting and benchmarking
- Consider deploying staff flexibly across intermediate care, where possible following the person from hospital to a community bed-based service or directly to their home.

This work will be overseen by the Social Care, Primary Care and Community Care Collaborative which will be chaired by a nominated provider Chief Executive Officer (CEO) from Kent & Medway.

Key Milestones:

We will have a new intermediate care model which supports delivery of at scale home care and domiciliary care.

We will deliver against the 4 priorities laid out by NHSE in 'A new community rehabilitation and reablement model (2023)' which are:

1. **Improve demand and capacity planning which helps ensure an appropriate level of capacity in a system is commissioned and provided, within available budgets over 365 days of the year, with flexibility to manage surge pressures. The plans should be based on needs of the population, rather than previous referral patterns which historically may have been driven by available capacity.**

2. **Improve workforce utilisation through a new community rehabilitation and reablement model to build capacity and capability in community settings through workforce planning, training and organisation. Enabled**

by system (including clinical/professional) leadership, with a focus on behaviours and culture.

3. **Implement effective care transfer hubs which will be the Medway focal point for coordinating discharge for people with new or increased needs who require post-discharge health and/or social care and support (i.e. those on discharge pathways 1, 2 and 3). All complex discharges into intermediate care will therefore be managed by the hub.**

4. **Improve data quality and prepare for a national standard by developing and implementing system-wide live dashboards to show capacity, flow, delays, and outcomes.**

Further Reading:

NHS England » Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge

Understanding intermediate care, including reablement | Quick guides to social care topics | Social care | NICE Communities | About | NICE

Multi-disciplinary / multi-agency discharge teams | Local Government Association

Integrated Specialist Services

Kent and Medway ICS aims to work together to improve population health and people's lives especially targeting that cohort of population, which will be best served by integrated services, for example people with long-term conditions such as Dermatology, Rheumatology and Stroke Rehabilitation.

To deliver this ambition, high-quality and equitable integrated care pathways (ICPs) will need to be developed to achieve the best outcomes and experience for patients.

Integrated care pathways will need to be patient centric, promoting personalization, as well as self-care, as previously mentioned in order to achieve a higher proportion of patient with long term conditions being managed and supported in the community.

Pathways are developed, implemented and facilitated by multi-disciplinary teams that cover the whole continuum of care from prevention to rehabilitation and include a full range of interventions at each stage.

This pathway approach will enable patients to receive care across the entirety of their needs, within and between organisations and within a clear timeframe, which will help reduce unnecessary variation in patient care and outcomes.

Incorporating national and local guidelines, integrated care pathways will support collaborative working and help empower patients, carers and families, as well as manage clinical risk.

The pathways will look to address:

- primary prevention and risk factors
- early detection and accurate diagnosis
- a reduction in variation in clinical outcomes.

- reducing inappropriate admissions to secondary care
- appropriate management, including prescribing and patient education
- discharge and follow-up
- support specific patient groups
- experience of care
- personalised care
- social prescribing
- reducing unexpected mortality.

Integrated care will cover end-to-end service delivery across all partners in Kent and Medway and will look to facilitate a shift towards community-based care.

This will help reduce dependence on the acute health sector, resulting in better hospital efficiency, enhanced care and experience of the patient and will promote self-management, allowing patients to manage their own health and wellbeing.

There will be a continuing focus and refinement of care pathways to make sure patients receive timely and appropriate care in the most appropriate setting.

Each integrated care pathway will have defined stages that detail the steps involved for specific disease/illness and describe expected progress and outcomes. The stages of the pathway and appropriate clinical interventions are defined by clinical experts, clinical guidelines and peer reviewed literature.

The benefit realisation in terms of clinical outcomes, patient goals and financial value would be identified within development of the pathway. It will be agreed how these measured and monitored for continuous improvement.

This work will be overseen by the Elective Care Board - Out of Hospital Team and chaired by a nominated Provider Chief Executive Office or another Senior Responsible Officer (CEO/SRO) from Kent & Medway.

Key Milestones:

Integrated pathways for various long term conditions will be reviewed with a focus of delivering 4 key objectives aligned to NHSE's objectives to implement integrated delivery networks:

1. **Provide robust leadership through clinical and operational engagement with a nominated SRO**

2. **A strategic approach to improving integrated pathways delivered through a fully assured project plan**

3. **Optimal configuration and collaboration through full review of service specifications using quality improvement techniques to harmonise services**

4. **Data monitoring and regular standardised reporting.**

Further Reading:

NHS England » What are integrated care systems?

NHS England » National Stroke Service Model: Integrated Stroke Delivery Networks

Transforming dermatology services in the East of England - Technology for the NHS - NHS Transformation Directorate

Rheumatology pathway - Rheumatology digital playbook - NHS Transformation Directorate (england.nhs.uk)

Rehabilitation

A new model for rehabilitation will be developed which places the patient at the centre of a Multi-Disciplinary Team (MDT) which facilitates rapid rehabilitation of a patient against agreed rehabilitation goals.

The World Health Organisation states rehabilitation intervention should be aimed at:

- preventing the loss of function
- slowing the rate of loss of function
- improving or restoring function
- compensating for lost function
- maintaining current function.

NHS England's Improving Rehabilitation Programme applies these principles in a holistic way to encompass mental and physical health. Rehabilitation focuses on the impact of the health condition, developmental difficulty, or disability on people's lives rather than just diagnosis, and equips people to live their lives, fulfil their maximum potential and optimise their contribution to family life, community and society.

Rehabilitation intervention can help to achieve the following ambitions:

- prevention and reduction in demand for health services
- support for people to stay in or get back to employment
- support for people to gain greater control of and self-manage their care
- integration of out-of-hospital care, where possible, so length of stay and unplanned admissions can be reduced
- breaking down of traditional barriers, such as services for mental and physical health, ensuring a holistic approach.

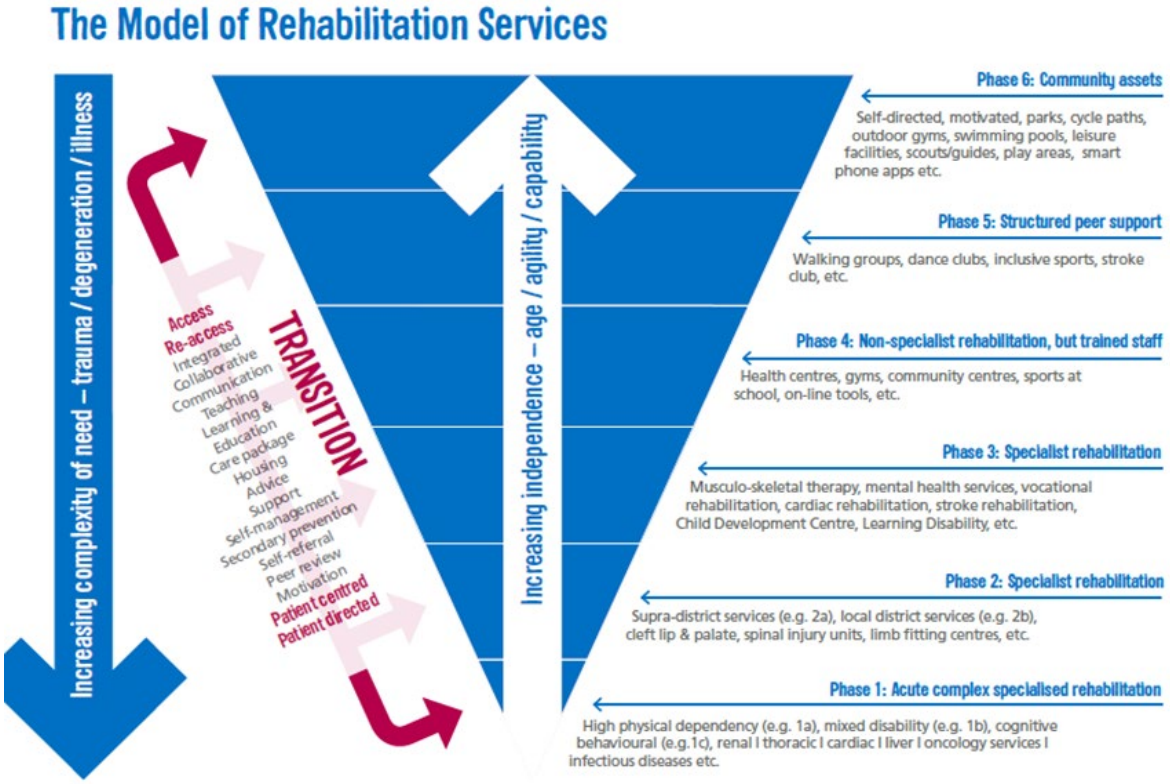
There is compelling evidence that rehabilitation services can deliver long-term cost reductions and add value and equality across the health and care system, as well as economic benefits by getting people back into employment or occupation through vocational rehabilitation and reducing the psycho-socioeconomic burden of disability.

The key principles of rehabilitation that need to be considered are:

- Work in partnership with the person and what is important to them.
- Inclusion of the person into their communities, employment and education rather than being isolated from the mainstream into seclusion.
- Rehabilitation may be appropriate at any age as a person's needs change through the course of their life.

- Use a person centredness and a multi-disciplinary approach to help a patient attain their goals.

Effective rehabilitation takes a holistic and individualised approach. This is because two people with the same diagnosis may have very different abilities and needs because of a complex interaction between their health conditions, the environments they live in, their values and beliefs, and their aspirations and motivations.



This work will be overseen by the Social care, Primary care and Community collaborative, chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestones:

Implement NHSE recently published new community rehabilitation and reablement model following the guiding principle (page 5).

Maximising the use of the registered and unregistered therapy workforce based on the expertise and skills required and the point in the pathway where it is required.

Supporting delivery by a multi-disciplinary, multi-agency workforce working in integrated ways, pulling in relevant skills, expertise and community assets as required.

Ensuring rehabilitation assessments and interventions are therapy-led, i.e. overseen by a registered therapist who will offer advice, support and guidance as required, with strategic oversight for quality, including safety.

Utilising digital interventions to supplement and support access to rehabilitation and to clinical expertise.

Further Reading:

NHS England » A community rehabilitation and reablement model

Goal Setting in Rehabilitation - Physiopedia (physio-pedia.com)

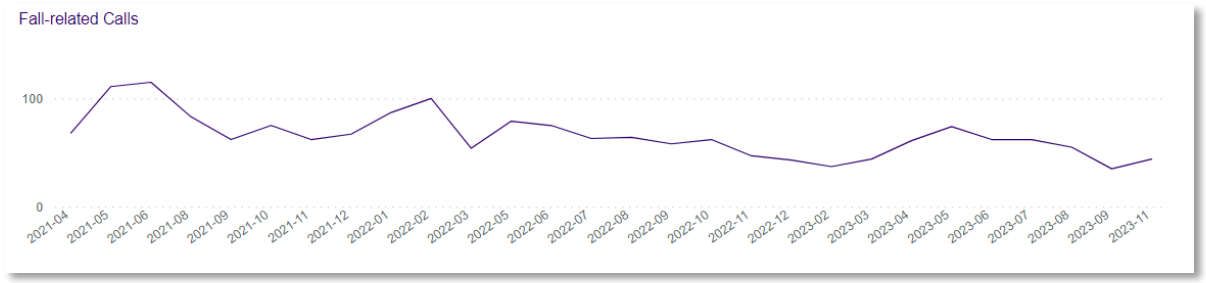
Commissioning guidance for rehabilitation (england.nhs.uk)

Layout 1 (england.nhs.uk)

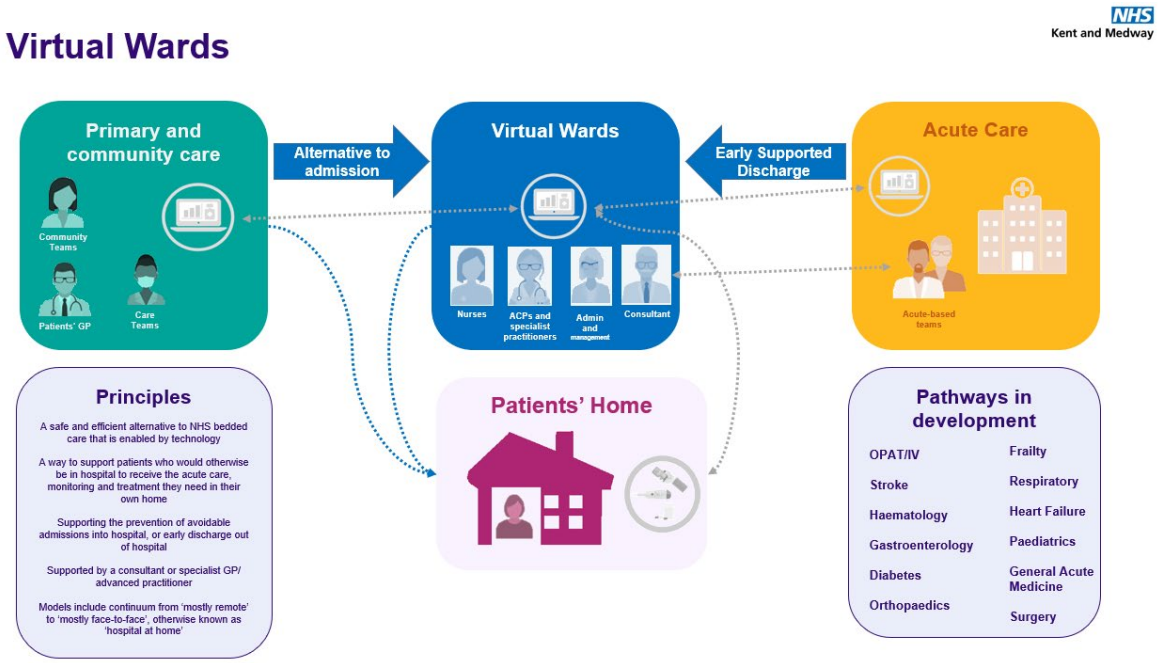
Frailty

An agreed frailty model that maintains patient in their normal place of residence will be implemented at scale. This will include frailty out of hospital hubs, virtual ward capacity and rapid equipment deployment. The new model of care for Ageing Well will be embedded in the frailty model with focus on prevention, reduction in social isolation, enabling communities to care for older people and an increase in respect and recognition for care of older people. This care will be delivered where possible in people place of residence or within the local communities.

Through having a community-based frailty team we will aim to reduce the number of calls made to 999 for fall related issues as these will be managed a single point of access in Medway & Swale.



Medway and Swale H&CP fall-related calls.



Kent & Medway Virtual Ward Model

This work will be led by the Frailty Steering Committee, chaired by an ICB Clinical Lead.

Key Milestones:

We will continue to build capacity in the community, particularly for frail people, to increase alternatives to emergency department attendance and hospital admission through more integrated models for urgent community response and virtual wards.

We will implement a single point of access model to ensure patients are directed to the most appropriate service outside of the hospital.

Further development of Urgent Community Response (UCR) services.

We will have implemented a system wide frailty service which can scale to the demand predictions for the next 8 years.

Further Reading:

B1207-ii-guidance-note-frailty-virtual-ward.pdf (england.nhs.uk)

NHS Long Term Plan » Ageing well

Social isolation - Oxford Health NHS Foundation Trust

What is the value of an older person's life? | Discover | Age UK

Community Nursing

Development of an integrated neighbourhood model with social, community and primary care colleagues. Implementation of an agreed nursing and care skills development model based on national standards of care which are supported by a new training and development skills centre.

This work will be led by the Skills Centre Development Implementation Committee, with the chair to be agreed.

Key Milestones:

There will be an agreed integrated care and nursing model encompassing primary, social and community care.

Implementation of joint nursing and care teams in Neighbourhoods based on the agreed competency model.

There will be a recruitment and retention plan for care, allied health and nursing workforce across out of hospital care.

Further Reading:

NHS England » Community nursing contribution

Putting neighbourhoods at the heart of integrated care - NHS Providers

Oustanding-Models-of-District-Nursing.pdf (qni.org.uk)

Community Out-Patients Appointments (OPAs)

All community out-patients to transition to EROS (Electronic Referral Optimisation System) processes and systems. OPA communication to be standardised with the same waiting list management tools developed across community waiting times including patient portal, two-way text messaging, advice and guidance and Patient Tracking List (PTL) management to reduce long waiters. NHSE's new 'Faster Data Flows' to be used.

This work will be overseen by the Elective Care Programme Board, Chair to be a nominated Provider CEO/SRO from Kent & Medway.

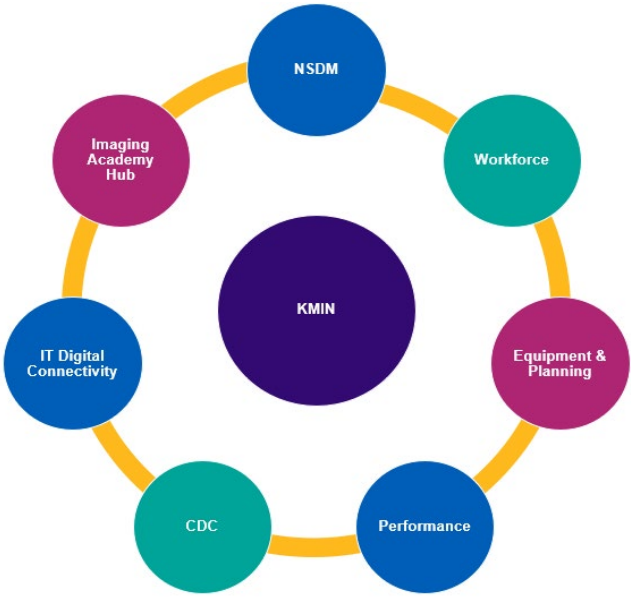
Key Milestones:

All community Out Patient Data (OPD) will be on one dashboard, have been validated via the national validation standard and implemented the elective care Did Not Attend management protocol.

All community OPD will be on the EROS system, using shared PTL protocol and Kent and Medway access policy.

Diagnostics

Integration of our diagnostic investigations will be essential to development of seamless community pathways. Integration and alignment of phlebotomy, screening, and CDC capacity to our community services is key to developing full and robust patient pathways.



Kent & Medway Imaging Network

This work will be overseen by the Diagnostic Board and chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestones:

An implementation plan will be agreed for screening across neighbourhoods to prevent ill health.

A single PTL management system will be in place to maximise diagnostic capacity.

Systems will be in place to enable transparency of waiting times for diagnostic care and reporting of investigations. Order comms and EROS will be integrated across our diagnostic services to enable maximum clinical decision-making information is available.

Further Reading:

Can we reduce waiting lists in community and mental health trusts? - News & Insights (thepsc.co.uk)

What matters when waiting? – involving the public in NHS waiting list prioritisation | The Strategy Unit (strategyunitwm.nhs.uk)

Elective Community Hubs

The introduction of elective community hubs, which bring together elective care in the community at scale. This will include endoscopy provision, surgical capacity hubs in the community, same day emergency care and coordination's hubs for long term conditions. Within the first 12 months, a 'blueprint' will be agreed for the development of provision across Kent and Medway in Neighbourhoods.

This work will be led by the Primary Care Team working with the Elective Care Board, Diagnostic Board and Community Collaboratives alongside H&CPs, a task and finish group chaired by the ICB Chief Delivery Officer will be set up to oversee the implementation of the centres.

Key Milestones:

A blueprint for all H&CP areas and integration of Pharmacy, Ophthalmology and Dentistry (POD) will be co-developed.

The providers will have collaborated to co-design with the ICB an estates plan to utilise current resources and estate for endoscopy hubs, elective community hubs and include pharmacy, podiatry and optometry.

Further Reading:

The multispecialty community provider (MCP) emerging care model and contract framework (england.nhs.uk)

NHS England » Hundreds of thousands more patients to benefit from major NHS surgical capacity boost

Strategies to reduce waiting times for elective care | The King's Fund (kingsfund.org.uk)

NHS England » NHS and social care hub helps people at risk stay well and out of hospital

Ageing Well

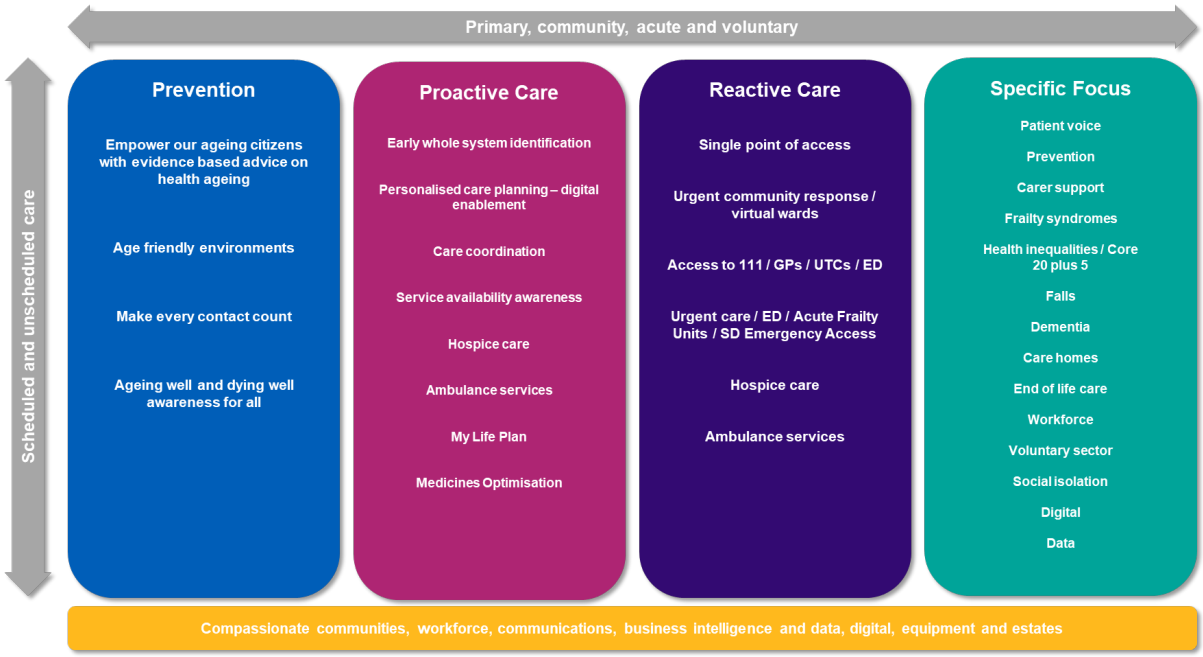
Our ambition is to enable those who are ageing and living in our communities to receive the best support and care they need, in the place that is best for them.

There is a collective agreement to move to a different model of care where:

- We will be guided by the voice of our ageing communities.
- Ageing and dying is not just a medical matter, but a societal matter, and we will support all involved in Kent & Medway.
- People age well and stay well so they can enjoy the best quality of life for as long as possible.
- When people do need healthcare, we move to an out-of-hospital model, delivering services in the community and at home as much as possible with a single front door
- As people reach the latter stages of life, it becomes normal to have an end-of-life plan so people are supported to die at home if that is their wish.

Implementation of the ageing well strategy and models of care will ensure our communities have the best possible health care to age well and sustain health living.

This includes integration and adaption of the World Health organisation model for healthy ageing communities.



Kent & Medway Ageing Well Model-Our Ageing Well Pillars

This work will be led by the joint NHS and LA Ageing Well Board chaired by an ICB Clinical Lead.

Key Milestones:

We will have agreed an implementation plan for the ageing well strategy for Kent and Medway which all providers will have participated in creating and be integral to delivering by:

- **Promoting a multidisciplinary team approach**
- **Giving people more say about the care and support they receive**
- **Offering more support for people who look after family members, partners or friends**
- **Improving rapid community response teams, to support older people with health issues**
- **Supporting care homes including making sure there are strong links between care homes, local general practices and community services.**

Further Reading:

NHS England » Ageing well and supporting people living with frailty

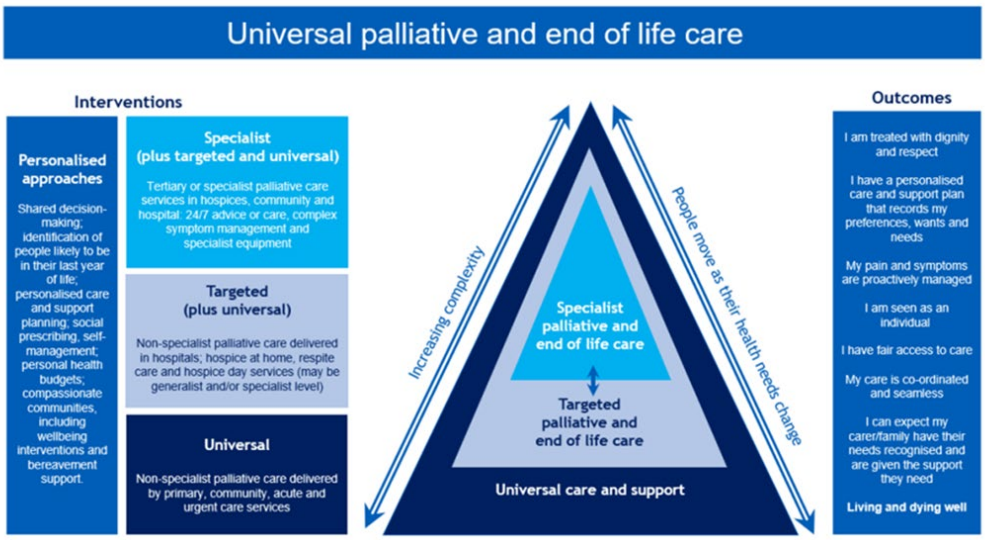
NHS Long Term Plan » Ageing well

End of Life Care (EoLC)

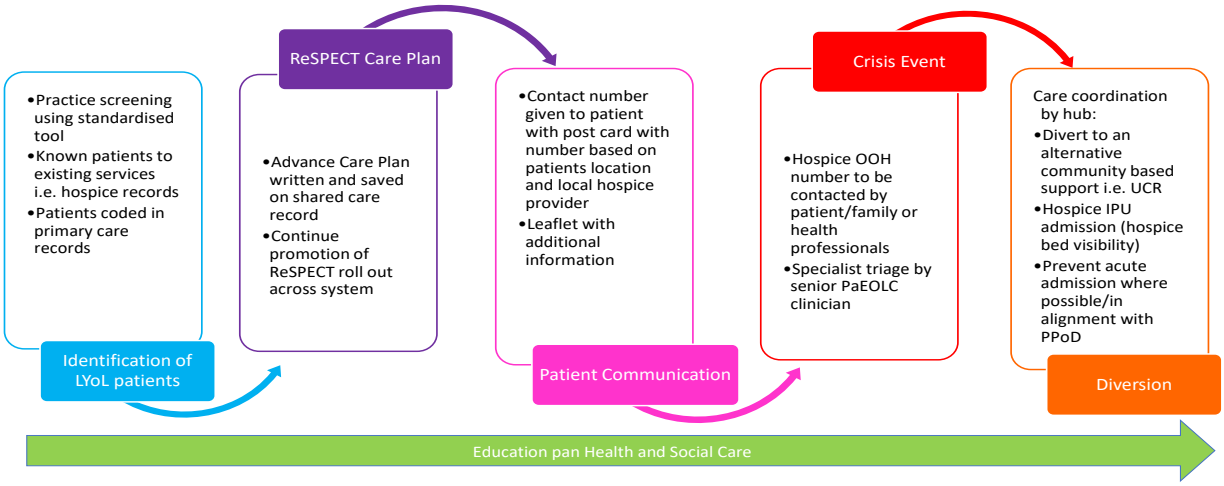
The ambition for end of life care is*: "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me".*

The new model of care for Kent and Medway aims to address this by formulating a Triangle of Care model of care based on the National Ambitions and the national "Universal Palliative and End of Life Care' approach shown below.

Universal care and support focuses on improving access, early engagement with services and reducing health inequalities. Personalised care and support planning is central and essential to integrate the services around the person, so they have one joined-up plan that covers their health and wellbeing needs.



The implementation of a single integrated system for EoLC including early identification, personalisation and co-ordination of 24/7 out of hospital capacity will be key to support access to care and achieving what matters to people at end of life.



Principles of EoLC

This work will be overseen by the End-of-Life Committee and chaired by an ICB Clinical Lead.

Key Milestone:

We will have an integrated end of life care model linked to the NHSE Ambitions for Palliative and End of Life Care – Framework Foundations (Page 7, NHSE 2002).

Further Reading:

Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf (england.nhs.uk)

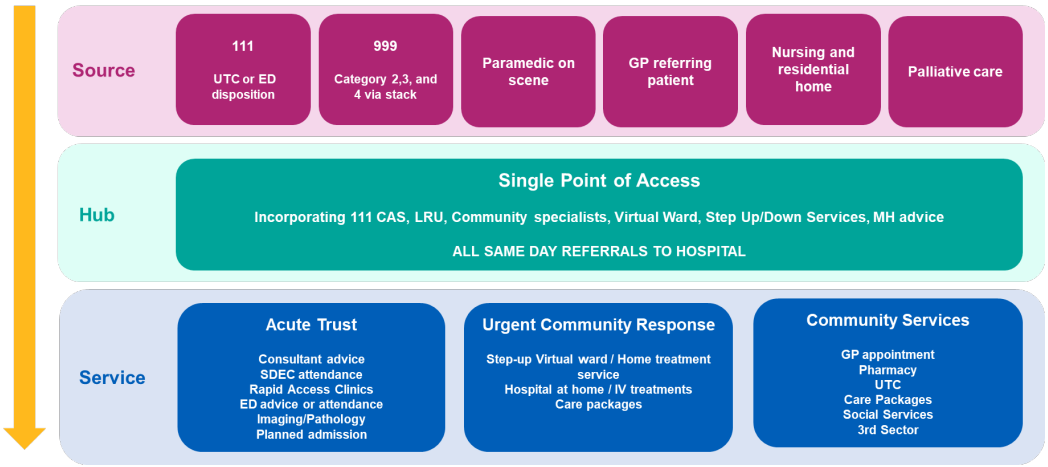
WHO's work on the UN Decade of Healthy Ageing (2021-2030)

Enhanced health in care homes :: NHS Kent and Medway (icb.nhs.uk)

Single Point of Access (SPoA) - Out of hospital Urgent Care

Implementation of a single urgent care system which is coordinated via an urgent care hub will be implemented to ensure patients are provided care out of hospital as much as possible. This includes primary care streaming for urgent appointments, community treatment centres, frailty hubs/assessment centres, virtual ward and 2-hour community response and other out of hospital services to prevent acute hospital admission. Overnight services will be incorporated into this single urgent care system to ensure services out of hospital 24/7.

UEC – Single Point of Access



Kent & Medway Urgent & Emergency Care(UEC) SPoA Model

This work will be overseen by the UEC Board and chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestones:

The provider(s) will have collaborated with the ICB to develop an out-of-hospital urgent care hub coordinating urgent care and managing patients' pathways to the relevant services.

We will have a Kent and Medway urgent care system that can flex and scale over the next 8 years to meet our patient demand.

Further Reading:

NHS England » NHS and social care hub helps people at risk stay well and out of hospital

NHS England » Urgent treatment centres

Transforming urgent and emergency care (nice.org.uk)

Re-envisioning urgent and emergency care | NHS Confederation

Recommendations

We are planning on issuing contract extensions to all 3 community providers which will align contracts to end September 2025.

We will work with provider partners, H&CP's and Healthwatch (to ensure patient engagement at all steps of the process) to begin transformation projects aligned to the ambitions as detailed above.

We will return to HASC and HOSC as required when pathway redesign is underway.

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