APPENDIX 2

Kent and Medway STP

Overview

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- Care Transformation: Local Care
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We are pursuing transformation around four themes

Care Transformation

- Prevention
- Local care
- Hospital transformation
- Mental health

Productivity

- CIPs and QIPP delivery
- Shared back office
- Shared clinical services
- Procurement and supply chain
- Prescribing

Enablers

- Workforce
- Digital
- Estates

System Leadership

- Commissioning transformation
- Communications and engagement

= Focus of this presentation

Health and care in Kent and Medway is unsustainable and needs to change

	Case for change	Our ambition
Health and wellbeing	• Our population is expected to **grow by 414,000 people** by 2031. Growth in the number of over 65s is **over 4 times greater** than those under 65; an aging population means **increasing demand for health and social care**. • There are **health inequalities** across Kent & Medway; in Thanet, one of the most deprived areas of the county, for example, a woman living in the best ward for life expectancy in Thanet can expect to live **almost 22 years longer** than a woman in the worst. The main causes of early death are **often preventable**. • Over **500,000 local people live with long-term health conditions**, many of which are preventable. And many of these people have multiple long-term health conditions, dementia or mental ill health.	• Create services which are able to meet the needs of our changing population • Reduce health inequalities and reduce death rates from preventable conditions • More measures in the community to prevent and manage long-term health conditions
Quality of care	• There are over 1,000 people who are **in hospital beds who could be cared for elsewhere if services were available.** Being in a hospital bed **for too long is damaging for patients** and increases the risk of them ending up in a care home. • We are **struggling to meet performance targets** for cancer, dementia and A&E. This means people are not seen as quickly as they should be. • Many of our local hospitals are in 'special measures' because **of financial or quality pressures** and numerous local nursing and residential homes are **rated 'inadequate' or 'requires improvement'**.	• Make sure people are cared for in clinically appropriate settings • Deliver high quality and accessible social care across Kent and Medway • Reduce attendance at A&E and onward admission at hospitals • Support the sustainability of local providers
Sustainability	• We are **£110m 'in the red'** and this will rise to **£486m by 20/21** across health and social care if we do nothing. • Our **workforce is aging** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time and there are high numbers of temporary staff across health and social care.	• Achieve financial balance for health and social care across Kent and Medway • To attract, retain and grow a talented workforce

SOURCE: Kent and Medway 5yrFV

Several services have been agreed as the priority services to consider for consultation

Very high · High · Medium · Low · Prioritised services

Service	1A Clinical case inc workforce	1B Requirements to consult*	2A Work done to date (EK / WK)	2B Wider readiness of public and stakeholders	2C Deliverability
Stroke (prioritised)	Very high	Very high	High	Very high	Very high
Vascular (prioritised)	Very high	Low	High	Very high	Very high
Acute medicine, A&E, Critical Care (prioritised)	Very high	Very high	Medium / Medium	Medium	Very high
Elective orthopaedics (prioritised)	Very high	Medium	High / Low	Medium	Medium
Community beds (prioritised)	Very high	Very high	Medium / High	Low	Medium
Cancer (prioritised)	Very high	Medium	Low	High	Medium
Paediatrics (prioritised)	Medium	Very high	Low / Low	Low	Low
Wider elective surgery	High	High	Medium / Medium	Low	Low
Diagnostics	Low	Low	Low / Low	Low	Low
Outpatients	Low	Low	Low / Low	Low	Low
Maternity	Low	Very high	Low / Low	Low	Low
Smaller specialist services	Medium	Medium	Low / Low	Low	Low

Programme Board has proposed two waves of public consultation

	Wave 1	Wave 2
Services in scope	• Stroke across Kent & Medway • Vascular across Kent & Medway (if consultation is required) • Emergency services in East Kent (incl. acute medicine, A&E, critical care) • Trauma and orthopaedics in East Kent	• Emergency services and trauma and orthopaedics in rest of Kent & Medway • Further services to be determined

Source: K&M STP Hospital Care workstream

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Key elements of the complex elderly care model

Coordinated care for people who need it

1. Integrated health and social care into or coordinated close to the home
2. Single point of access (SPoA)
3. Rapid Response
4. Discharge planning and reablement

Supporting people to be healthy and independent

5. Care and support planning with care navigation and case management
6. Self-care and management
7. Healthy living environment

Supporting services

8. Access to expert opinion and timely access to diagnostics

Source: K&M STP Local Care workstream, Carnall Farrar

CO-ORDINATED CARE FOR PEOPLE WHO NEED IT - MDT

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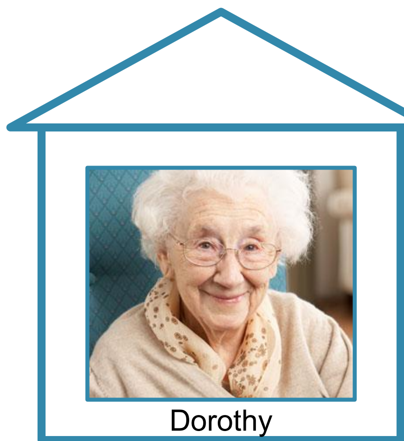
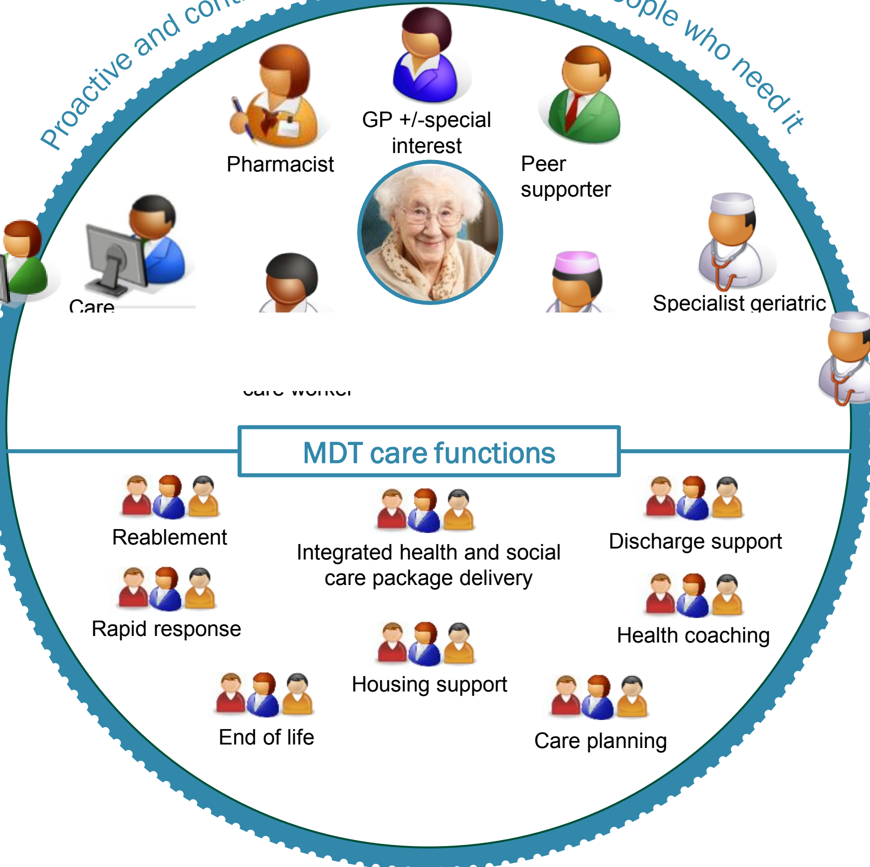


Dorothy is 79, frail, has type 2 diabetes, COPD, cognitive impairment and depression



Episodic specialised inpatient care

Emergency admission requiring hospital treatment

Supporting services

Source: K&M STP Local Care

CO-ORDINATED CARE FOR PEOPLE WHO NEED IT -SPoA

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1. Vera is 79, frail, has type 2 diabetes, COPD, dementia and recently suffered a stroke. She lives with her husband who is also frail and often unwell himself. Although she fits the criteria for a care plan, currently she hasn't been identified by an MDT

2. After receiving care for her stroke she is now medically fit to be discharged from the hospital

3. She doesn't't have an anticipatory care plan but hospital staff have identified she has specific care needs upon discharge to ensure her condition continues to improve. She has limited mobility and her condition needs monitoring; her husband is not well enough to be her carer whilst she recovers

4. The acute discharger calls the SPoA and provides them with Vera's collated discharge support details gathered through a discharge support form, including the recommended community services she will require in the short term. The call handler uses this information to contact and coordinate the necessary services

5. An assessment within 24 hours determines Vera will require services for a period of 6 weeks including a domiciliary care worker to help with household tasks and provide personal care and a district nurse to provide continued care and an in-depth review of Vera's condition. Her husband will also be provided with carer support. The SPoA is contacted to arrange this

6. Vera can be discharged to her home with the appropriate care package in place, with ongoing review through the MDT

Vera recovers fully, her care package ends and she lives independently in the community

Source: K&M STP Local Care workstream

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Local Care for those with mental health problems will delivery parity of esteem, integrating physical and mental health services and improve crisis care

Our vision is to:

- ***ensure we create an environment where mental health is everyone's business where every health and social care contact counts***
- ***work together to encourage and support anyone with a mental health problem, or at risk of developing one, to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.***

Local Care:

- Promoting wellbeing and reducing poor health
- Delivering integrated physical and mental health services

1. **Live well service**: Cross-sector partnership to strengthen wellbeing by increasing access to wellbeing navigators and community link works
2. **Open Dialogue Pilot:** Investing in holistic family intervention in first episode of psychosis to reduce admission
3. **Local care hubs:** Ensure MH professionals are an integral part of the model, with integrated care plans for individuals with LTC and MH comorbidity
4. **Single point of access:** Dedicated, clinically-led MH screening, assessment and signposting 24/7
5. **Complex needs:** Reviewing patients with complex needs in out-of-area specialist placements and seeking to repatriate; refining out-of-area placement process

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Our service models build on the England review of Urgent and Emergency Care (2014) undertaken by Sir Bruce Keogh around the development of networks of urgent care

Service model	Description
Major trauma centre	• Specialised centres co-locating tertiary/complex services on a 24x7 basis • Serving population of at least 2 -3million
Major Emergency Centre with specialist services	• Larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist hyper-acute services • Serving population of ~ 1-1.5m
Emergency Centre	• Larger units, capable of assessing and initiating treatment for the overwhelming majority of patients but without all hyper-acute services • Serving population of ~ 500-700K
Medical Emergency Centre	• Assessing and initiating treatment for majority of patients • Acute medical inpatient care with intensive care/HDU back up • Serving population of ~ 250-300K
Integrated care hub with emergency care	• Assessing and initiating treatment for large proportion of patients • Integrated outpatient, primary, community and social care hub • Serving population of ~ 100-250K
Urgent care centre	• Immediate urgent care • Integrated outpatient, primary, community and social care hub • Serving population of ~ 50-100K

Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

Emergency department

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Interventions: 8 key interventions have been developed as part of the Kent and Medway Local Care strategy that are aimed at preventing unnecessary hospital admissions including the integration of health and social care. These are outlined previously in the pack.

1

2

- Patients may be referred to ED by NHS 111, 999 South East Ambulance Service, by their GP or by other services.
- Alternatively, patients present at ED without a referral.

- Ambulance responds to 75% ‘Category A’ calls within 8 minutes and 95% within 19 minutes

3

- If patient arrives by ambulance, the ambulance crew reports to staff, otherwise the patient must register themselves at reception.

- 15 min ambulance handovers
- ED must have separate dedicated children’s facilities, for waiting and treatment

4

- Patients undergo a comprehensive** pre-assessment by a nurse or doctor before further actions are taken. This is called triage and will ensure people with the most serious conditions are seen first. Sometimes further tests need to be arranged before a course of action can be decided.

- No patient waits >12 hours on a trolley
- Presence of a senior ED doctor (ST4 or above) as a clinical decision maker 24/7

5

- Discharge: If nurse or doctor feels situation is not a serious accident or emergency, the patient may be sent home and asked to refer themselves to a GP, referred to a nearby urgent care centre, minor injuries unit or referred to a GP on site.

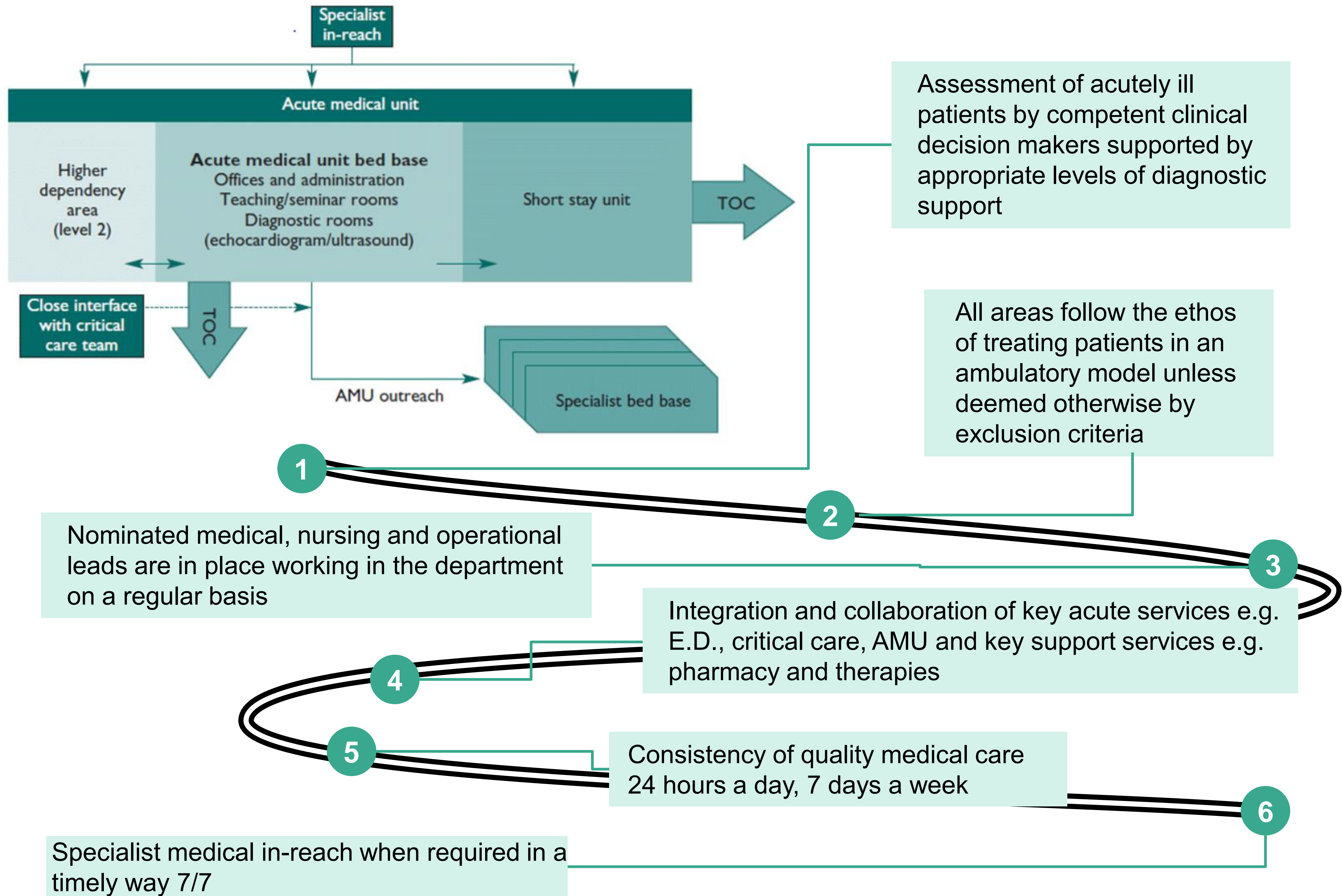
- Consultant accredited in Emergency Medicine [CCT holder] on the Emergency Floor Consultant between 08:00 and 24:00, 7 days per week

6

- Treatment or transfer: If situation is complicated, the patient my be seen by an ED doctor or referred to a specialist unit.

- 24/7 On site senior support within the core specialties
- Presence of a named paediatric consultant with a designated responsibility for paediatric care
- Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability Interventional radiology services for highest acuity patients are available within one hour of referral

Acute medicine (in-hospital)



Elective orthopaedics

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1. MDT Clinic:
- Identify frail patients to follow proactive care for older people undergoing surgery (POPS) pathway
- Combined clinic with consultant, extended scope physio, GPwSI allows in clinic triage to most appropriate clinician
- Greater co-working between community staff, primary care and consultants – orthopaedic qualified nurses are key
- Lower average staff cost per appointment
- Spinal injections
- Focus on MSK pathway

2. Pre-operative assessment:
- Conducted at first outpatient appointment; if patient found not fit then plan reviewed same day
- Greater use of self-assessment to support, which patients can complete from home
- Ensure social circumstances support the treatment plan, pre-booking of rehab/post-op package of care prior to admission
- Flags patients at risk of long length of stay

3. Recheck prior to surgery:
- Contact at 48-72 hours before day of surgery to reduce late cancellation
- Ensure patient is well and still wants surgery

4. Short notice reserve list: Ensures effective use of theatre capacity by filling gaps caused by late cancellation

5. Consultant level feedback:
- Transparency of list utilisation, case volumes per list
- Peer challenge
- Team working to increase available capacity by reducing cancelled sessions due to leave

Elective orthopaedics - continued

6

Effective planning for discharge:
- Discharge planning at preoperative assessment
- Referral to discharge services earlier in the process (i.e. before admission)
- Access to community support services

7

Enhanced recovery:
- Consistent application of Enhanced Recovery Pathway (ERP) pathways
- Clear expectations of predicted length of stay for patient

8

Ring-fenced elective beds:
- Reduction in wasted theatre time
- Reduction in infection risk for elective cases

9

Theatre utilisation:
- Scheduling of theatre cases to optimise utilisation
- Ensure critical equipment is scheduled to maintain the order and running of the list

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Straw man commissioning model – for discussion

Accountable Care Organisations/Systems

Design principles

- ACOs big enough to take on responsibility and accountability for whole populations
- Small enough to reflect differences in place/geography
- Close enough to clinicians to influence behaviours
- Responsible for the delivery of local care in a way which meets local needs

Activities and functions in scope

- Specifying how much spend should be spent in each specific silo
- Determining what services are delivered where
- Making local design decisions about the shape of how services are delivered
- Managing performance of individual clinicians, people management
- Making patient level decisions about care provision
- Engaging local stakeholders
- Stimulating third sector and voluntary sector
- Primary Care development
- Partnership working with Local Government

Strategic commissioner

Design principles

- A single organisation
- Responsible for resource allocation
- Accountable upwards
- Ability to intervene
- Improves outcomes and other constitutional objectives
- Facilitates and accelerates the development of ACOs/ACSs

Activities and functions in scope

- Allocation of funds based on population need
- Establishment of capitation for segments of the population and specific geographies defined by patient lists
- Setting and measurement of outcomes
- Holding accountable providers to account for delivery within budget and to outcomes
- Setting where appropriate clinical standards that are known to drive quality and outcomes
- Maintain information data sets including underpinning information governance and information standards and analytics function to support above
- Specialised commissioning
- Workforce – planning, training, delivery
- Integrated commissioning with LAs

SOURCE: As discussed during preliminary meeting, 30 January, Carnall Farrar

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Key programme milestones ahead

SOURCE: Kent and Medway STP PMO

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Questions

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