APPENDIX 1

Update June 2017

Kent & Medway Sustainability and Transformation Partnership

What we are covering today…

APPENDIX 1

Context

Local care

System transformation

Hospital care

Next steps

Context: the case for change

APPENDIX 1

Health and wellbeing

- **Population changes,** with significant growth in the number of over 65s; an aging population means **increasing demand for health and social care**.
- **Health inequalities,** with the health gap growing in many areas and the main causes of early death are often preventable.
- A significant number of the population **living with (often multiple) long-term health conditions**, many of which are preventable.

Quality of care

- Many individuals treated **in hospital beds who could be cared for elsewhere if services were available; b**eing in a hospital bed **for too long is damaging for many patients.**
- We are **struggling to meet performance targets** for cancer, dementia and A&E.
- Many providers are in 'special measures' because **of financial or quality pressures** and numerous local nursing and residential homes are **rated 'inadequate' or 'requires improvement'**.

Sustainability

- Already facing **significant financial pressures** and the position is generally deteriorating.
- Our **workforce is aging** and we have difficulty recruiting in some areas (across both primary and secondary care / health and social care); not just about professional staff but growing problems with recruitment of domiciliary care staff.

Context: we are pursuing transformation around four themes

APPENDIX 1

Care Transformation

- Prevention
- Local (out-of-hospital) care
- Hospital transformation
- Mental health

System Leadership

- System / commissioning transformation
- Communications and engagement

Productivity

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

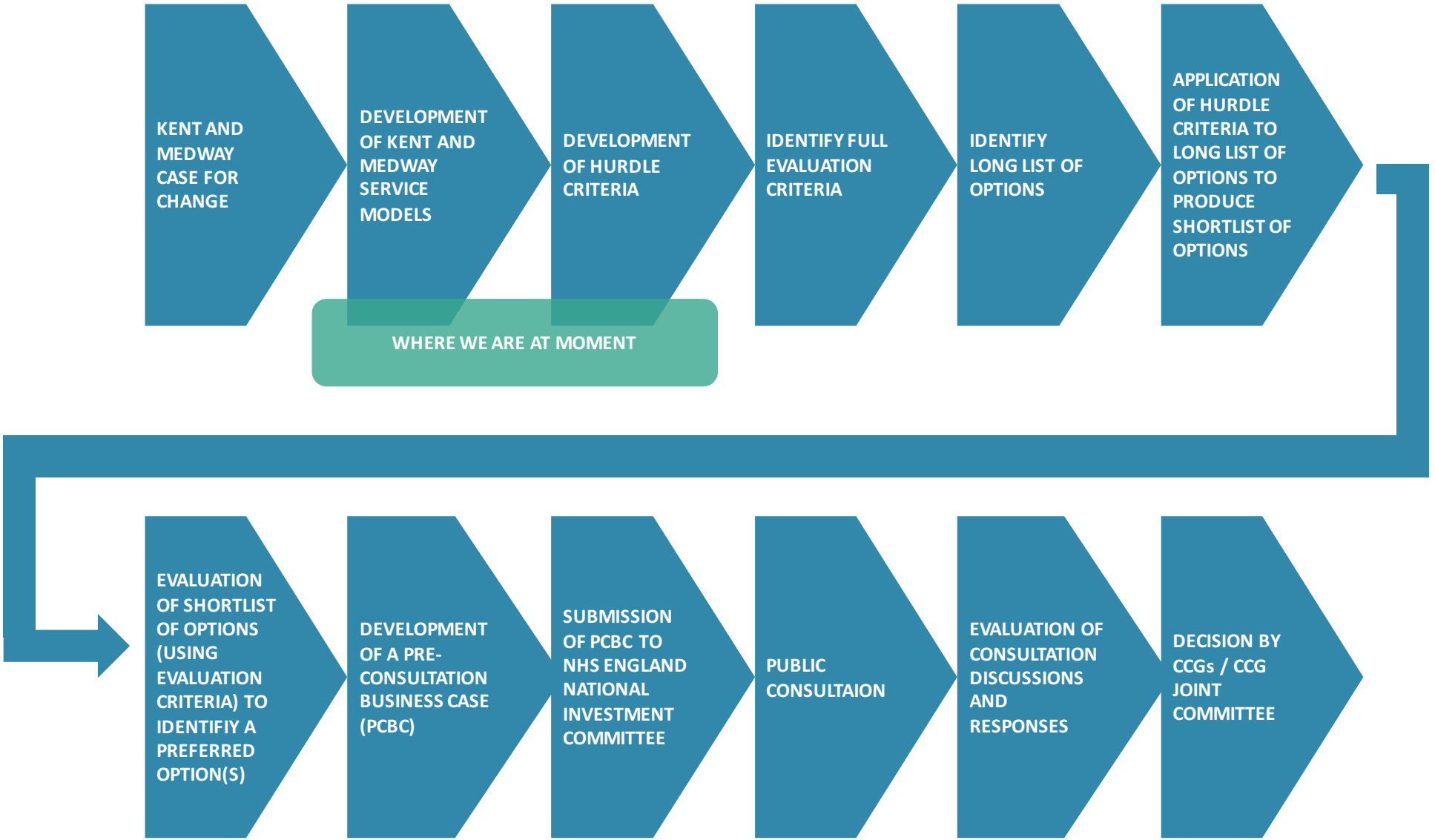
Enablers

- Workforce
- Digital
- Estates

SOURCE: Kent and Medway STP October 2016 submission

Context: the process we are following

APPENDIX 1



What we are covering today…

APPENDIX 1

Context

Local care

System transformation

Hospital care

Next steps

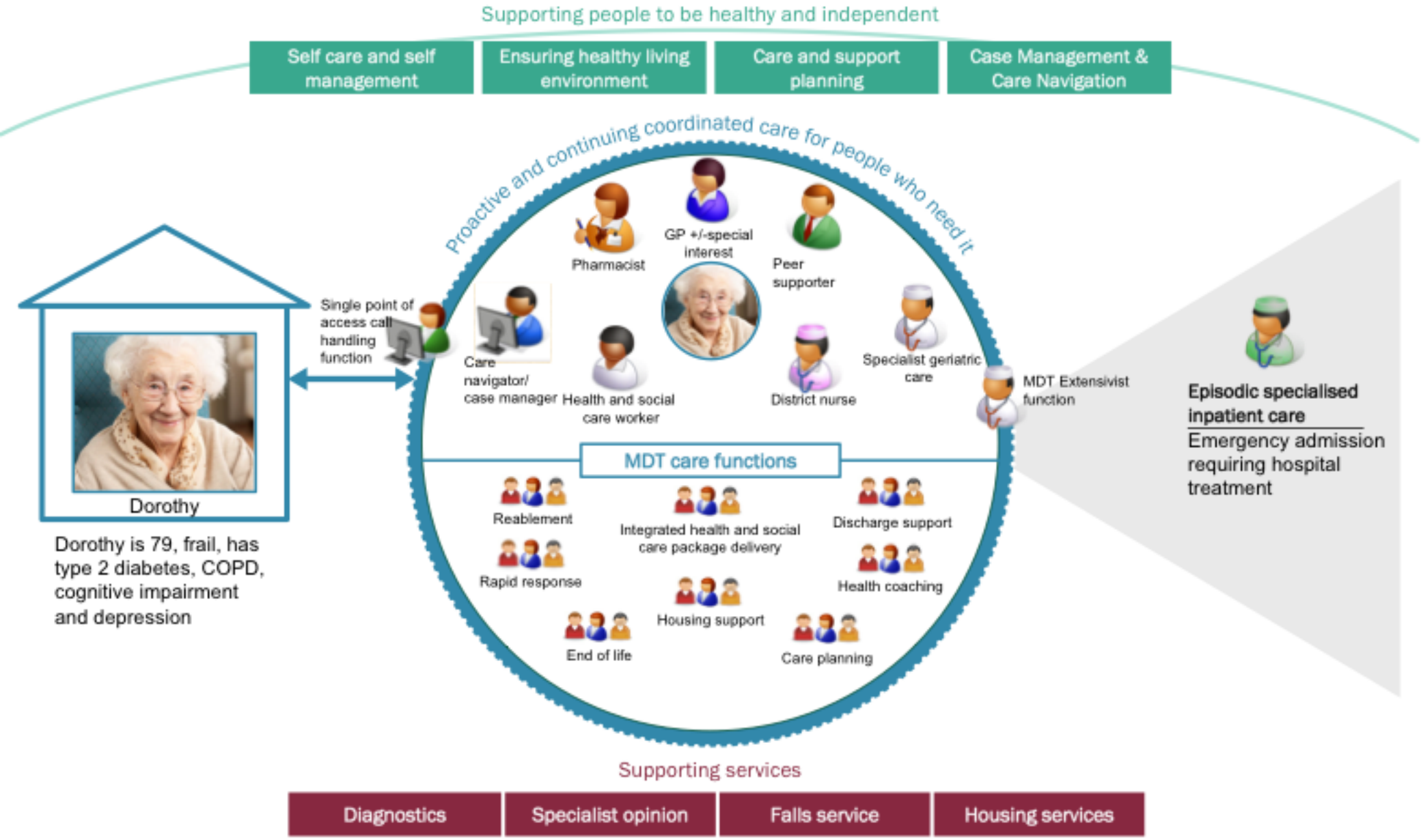
Local care: the future…

APPENDIX 1

- More **self-care** thanks to better tools, information and services
- **Connected care** from NHS, social care and voluntary sector
- More treatments **locally** with strong **GP leadership**
- **Fewer hospital visits**
- Initial focus on **complex elderly frail** as we know this population are not well served by an acute hospital based service model (plus this group are 12% of the our population and use 32% of resources)

Local care: multi-disciplinary team

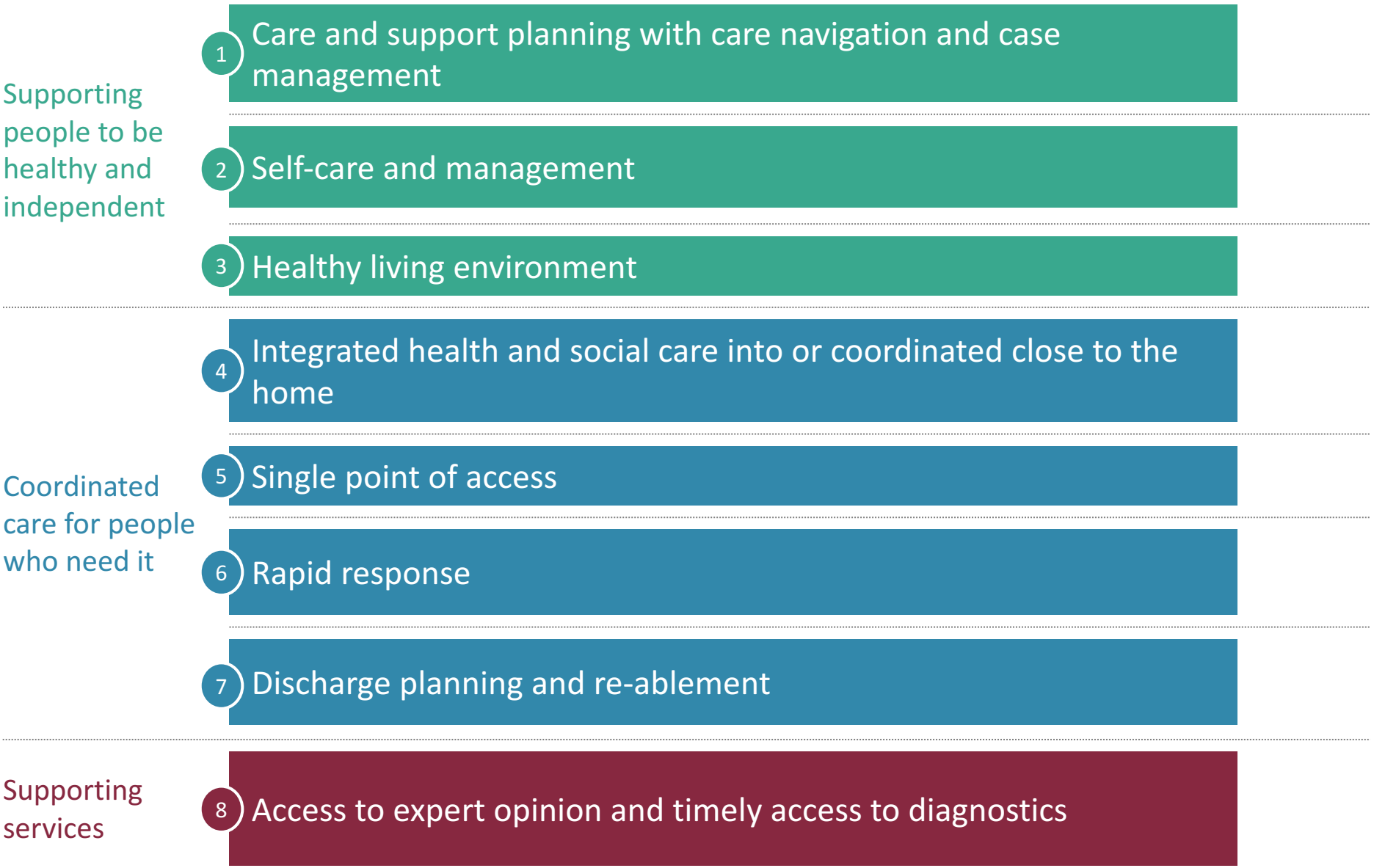
APPENDIX 1



Source: K&M STP Local Care

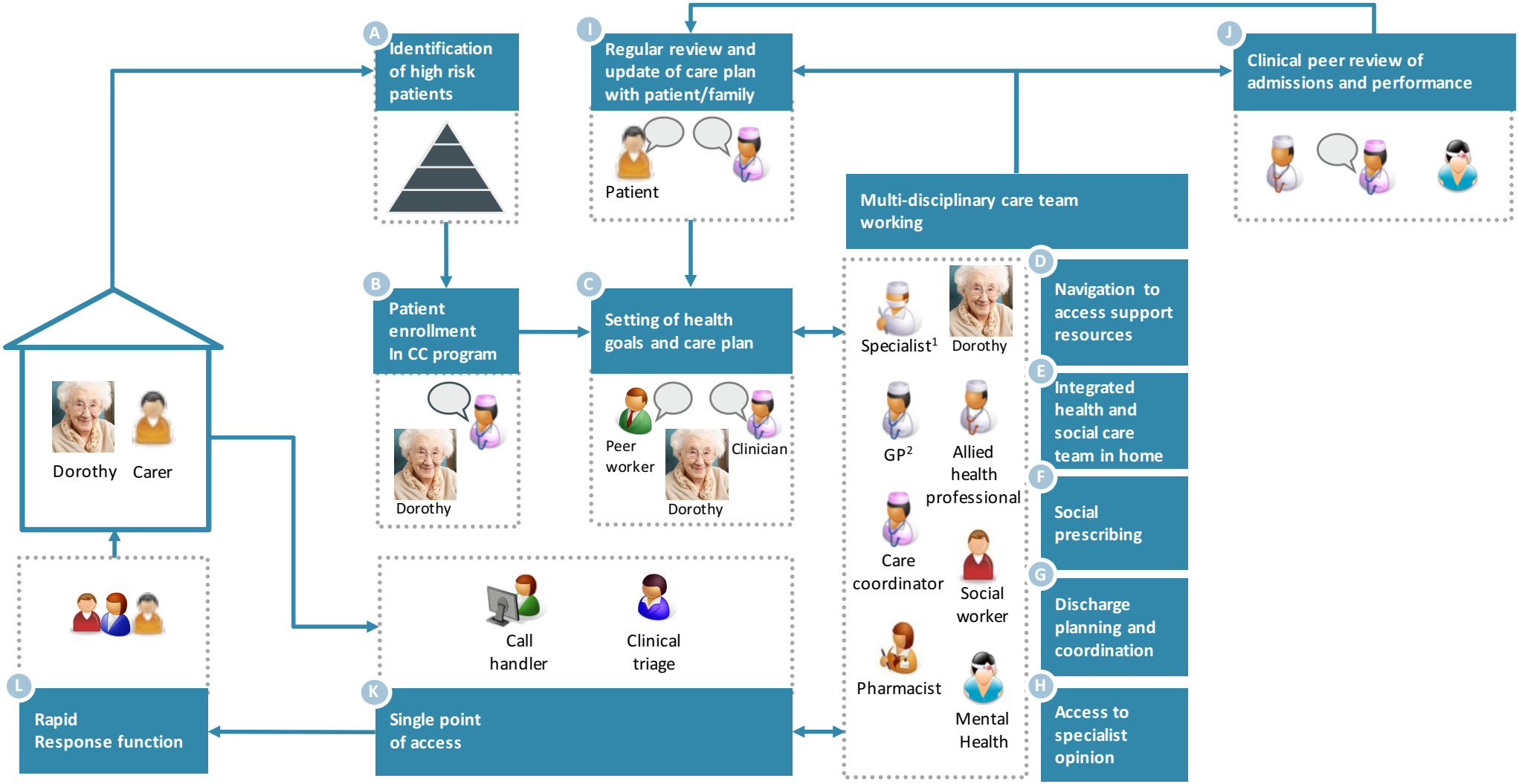
Local care: model for older people with complex needs

APPENDIX 1



Local care: model for older people with complex needs - flow

APPENDIX 1



1 Specialists in both inpatient or outpatient settings 2 Includes primary care physicians, advanced practice nurses, physicians assistants

Source: Carnall Farrar

Local care: what next?

APPENDIX 1

- We will focus next on how we could deliver care in better ways for:
  - adults with chronic conditions
  - children
  - people who are mostly healthy
  - and people with serious and enduring mental illnesses.

Local care: what does the STP mean for primary care teams?

APPENDIX 1

- Local care
- Role of the generalist
- Multi-specialty Community Provider (MCP) models
- Discussions about
  - larger practices and federations
  - MDTs, including integrated health and social care, and their leadership and accountability
  - seven-day and evening services.

What we are covering today…

APPENDIX 1

Context

Local care

System transformation

Hospital care

Next steps

System transformation: straw man

APPENDIX 1

Accountable Care Partnerships/ Systems / Organisations

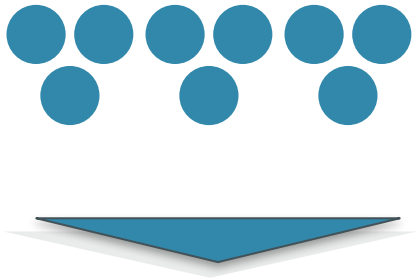
SIZE big enough to take on responsibility for whole populations, small enough to reflect differences
ENGAGEMENT views of staff, patients and stakeholders central
DELIVERY of local (out-of-hospital) care to meet local needs and commissions 80% other care

Strategic commissioner

STRATEGY – a single organisation responsible for resource allocation, strategic direction and planning
ROLE - takes some functions from regulators (NHSE, I) and can intervene, and facilitates and accelerates the development of ACOs/ACP.
OUTCOMES - improves prioritised clinical outcomes and other constitutional objectives
INEQUALITY - addresses health inequalities

System transformation: link between primary care and ACOs / ACP

APPENDIX 1

Local care infrastructure		Comment	Population served
GP practices		• Individual GP practices providing G/PMS + some other services • Many working well at scale, others struggling with small scale and related issues incl. workforce	• Various
Tier 1 Extended Practices with community and social care wrapped around		• Larger scale general practices or informal federations • Providing enhanced in-hours primary care and enable more evening and weekend appointments.	• 20 – 60k
Tier 2 MCPs/PACS based around community hubs		• Multi-disciplinary teams delivering physical and mental health services locally at greater scale • Seven day integrated health and social care	• 50 – 200k
Accountable care organisations / partnerships		• Needs some legislative changes but unlikely to happen soon, so need to use current statutory vehicles	• 400 to 800k?

What we are covering today…

APPENDIX 1

Context

Local care

System transformation

Hospital care

- Emergence and urgent care
- Stroke

Next steps

Hospital care: NHS England Review of Urgent and Emergency Care (2014)

APPENDIX 1

 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

Hospital care: what happens in the emergency department

1. 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.

2. Referral

- 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. Registration

- 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

Hospital care: what happens in the emergency department

4. Assessment

- 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

5a. Treatment or transfer

- 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

5b. Discharge

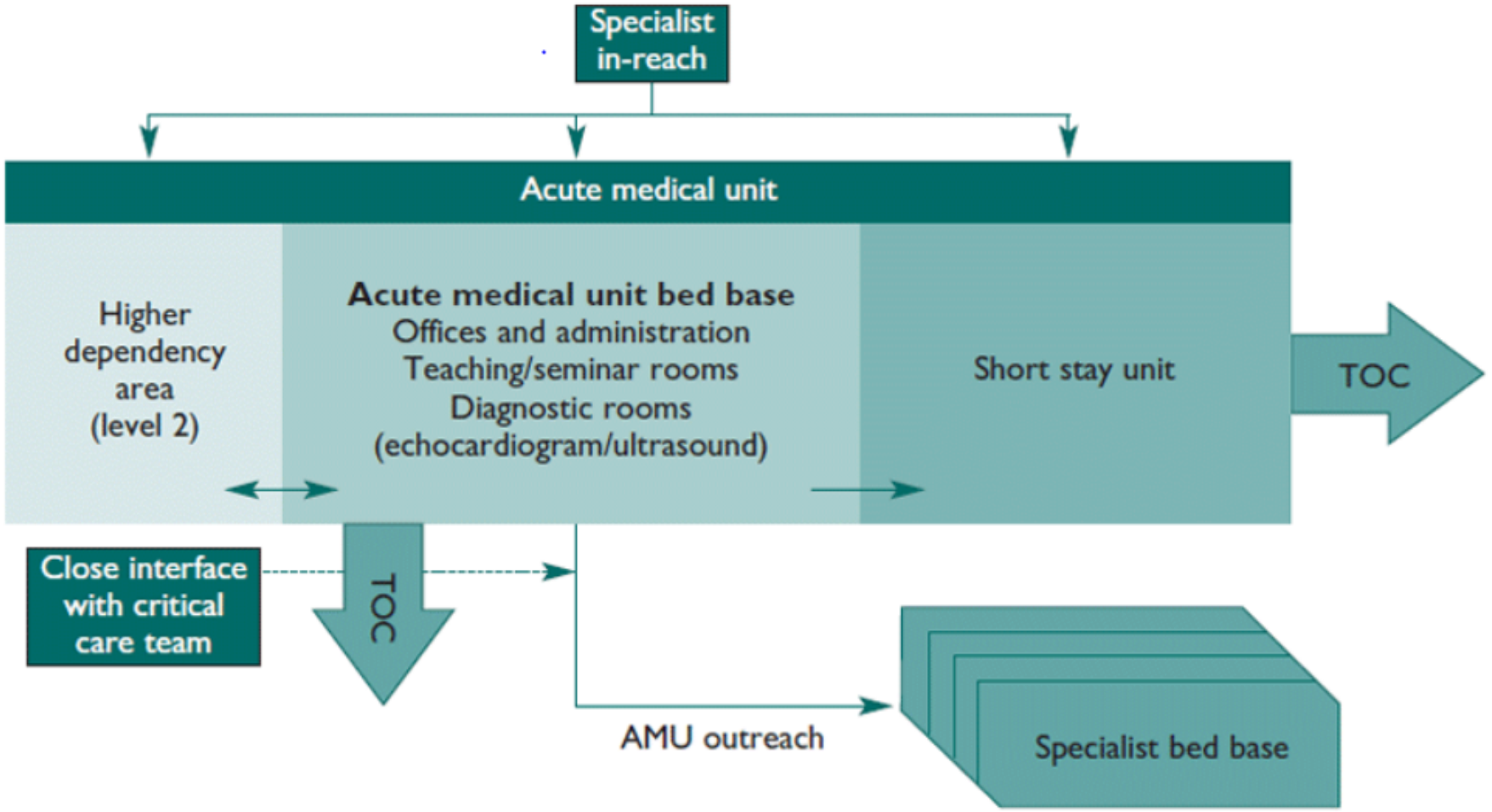
- Discharge: If nurse or doctor feels situation is not a serious accident or emergency, the patient may be sent home and asked to refer themselves to a GP, referred to a nearby urgent care centre, minor injuries unit or referred to a GP on site.

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

APPENDIX 1

Acute Medical Unit - Medicine Clinical Model

The term Acute medical Unit (AMU) is defined in an RCP report as '**a dedicated facility within a hospital that acts as a focus for Acute medical care for patients that have presented as medical emergencies to hospitals.'**



Hospital care: proposed acute stroke model

APPENDIX 1

TODAY

- All seven units deliver acute Stroke Care
- The units operate combined HASU/ASU models although the specific beds are not always identifiable
- 7 day medical ward rounds only operate in TWH, not always consultant led (on a 1:3 rota)
- Consultant assessment is available in all units over the weekends via telemedicine rotas
- 7 day therapy only available in MFT
- No unit meets the recommended workforce across any profession
- Only half of all patients admitted within 4 hours and performance is below national average.
- Less than 50% of patients receive thrombolysis within 60 mins.
- Performance against SSNAP is variable and inconsistent.

FUTURE

- 7 day specialist consultant led stroke service available (able to respond to twice daily ward rounds requirement Autumn 2017)
- Consolidate onto fewer sites; that meet the critical criteria including travel times
- Combined HASU and ASU units
- Direct access from ambulance transfers to the stroke assessment unit
- Early Supported Discharge available for min 50% of patients
- Improved rehabilitation services available
- Development of a centre able to deliver thrombectomy on one of the three sites across K&M
- Co-located with critical co-dependencies that improve patient outcomes and support staff

Hospital care: elective orthopaedic service model

APPENDIX 1

1. MDT clinic
2. Preoperative assessment
3. Re-check prior to surgery
4. Short-notice reserve list
5. Consultant-level feedback
6. Effective planning for discharge
7. Enhanced recovery
8. Ring-fenced elective beds
9. Theatre utilisation

What we are covering today…

APPENDIX 1

Context

Local care

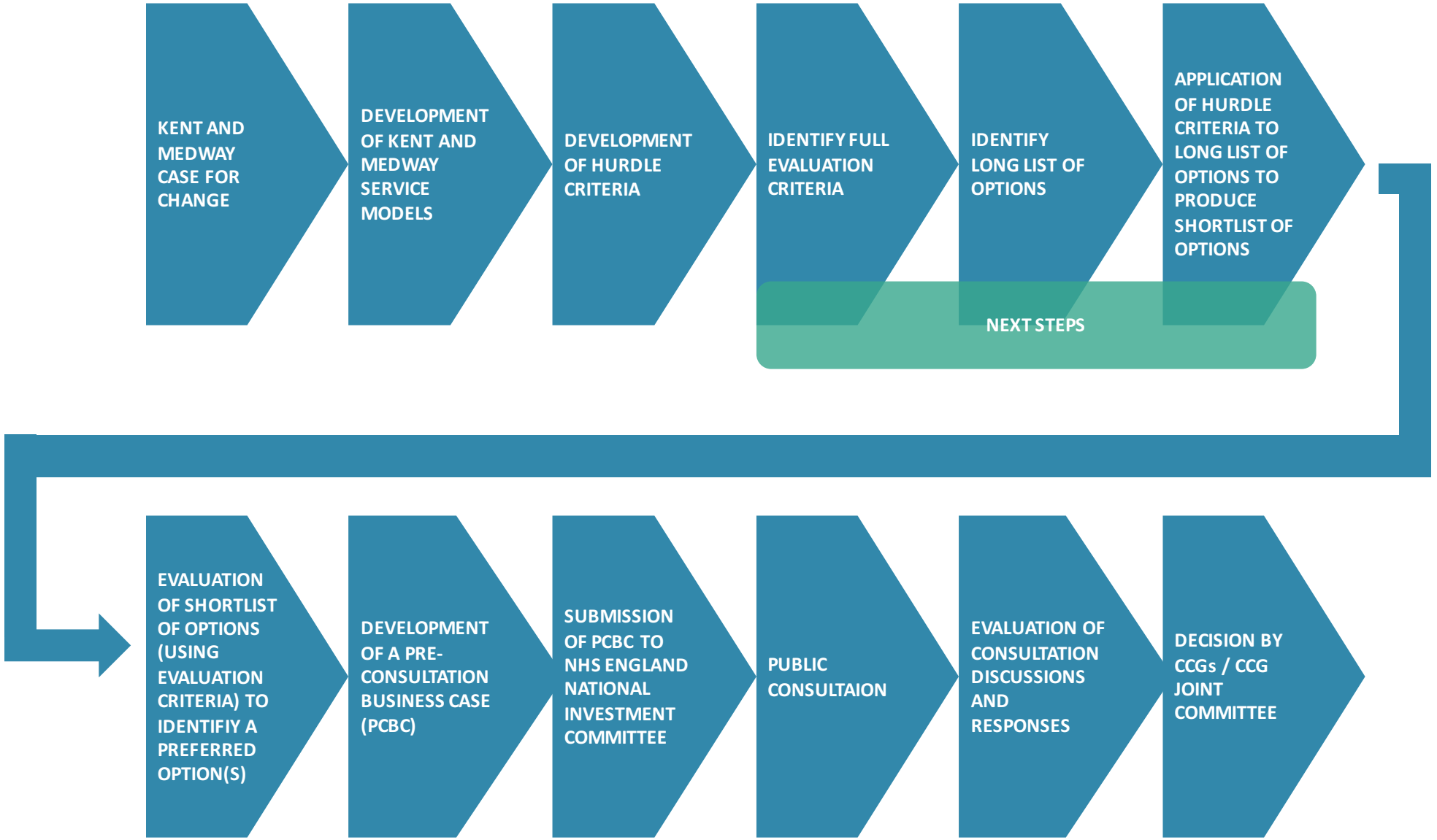
System transformation

Hospital care

Next steps

Next steps: the process we are following

APPENDIX 1



Next steps: key programme milestones ahead

APPENDIX 1

DESIGN

- Fully develop hospital care strategy, incl. clinical models
- Further develop Local Care model with clinical engagement
- Publish public-facing case for change and engagement
- Bottom up plans developed in productivity focus areas
- Mobilised commissioning transformation work

ENGAGE

- Engagement
- Establish joint decision-making arrangements
- Appoint full-time executive leadership
- Source and transition to permanent PMO
- Locality development of Local Care plans
- Develop pre-consultation business case (PCBC)
- Begin NHSE assurance processes
- Begin to deliver productivity savings

PREPARE FOR CONSULTATION

- NHSE assurance processes
- Transition to commissioning transformation future model
- Develop productivity performance transparency
- Develop mental health transformation plans

CONSULT THE PUBLIC

- Consult the public on wave 1: Stroke across Kent & Medway; Vascular across Kent & Medway; Emergency services in East Kent (incl. acute medicine, A&E, critical care); Elective orthopaedics in East Kent
- Respond to feedback on consultation
- Prepare for wave 2 consultations (2018): Emergency services and Elective orthopaedics in rest of K&M; Community beds; Cancer; Paediatrics

SOURCE: Kent and Medway STP PMO