KENT AND MEDWAY SUSTAINABILITY PARTNERSHIP

Service Models and Hurdle Criteria

Introduction

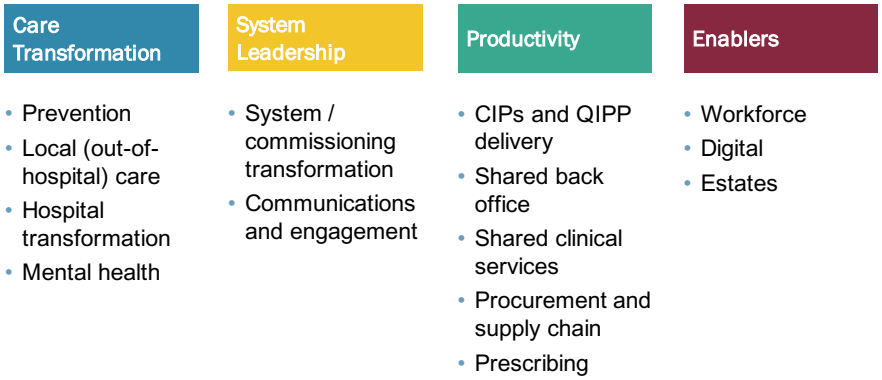
1. This paper summarises the service models and hurdle criteria that have been developed through the Sustainability and Transformation Partnership (STP) and asks for support for these from Kent and Medway clinical commissioning group (CCG) governing bodies, trust boards and local authority committees.
2. This paper covers:
    i. Local care model
    ii. Emergency department service delivery model
    iii. Acute medical service delivery model
    iv. Stroke service delivery model
    v. Elective orthopaedic service delivery model
    vi. Urgent care / elective orthopaedics and stroke hurdle criteri
3. The service models and hurdle criteria were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway. The development and progress of the design phase has regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate[1] and their feedback has been taken into account in preparing the final versions that are now being presented.

Context

4. Sustainability and Transformation Plans were proposed in the annual NHS planning guidance Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 issued in December 2015[2]. This outlined the triple aim of the plans was to address health inequalities; quality failings and under-performance against NHS Constitution targets; and financial challenges.
5. The further development of Sustainability and Transformation Plans, and a further recognition that these arrangements are about collective system leadership through the change of name to Sustainability and Transformation Partnerships, was outlined in Next Steps on the Five Year Forward View[3] published in March 2017. The October STP

[1] Clinical Senates have been established to be a source of independent, strategi advice and guidance to commissioners and other stakeholders. This includes reviewing proposed changes through bringing together a range of health care professionals, with patients, to review proposals presented to them. This is also part of the NHS England service change assurance process.
[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

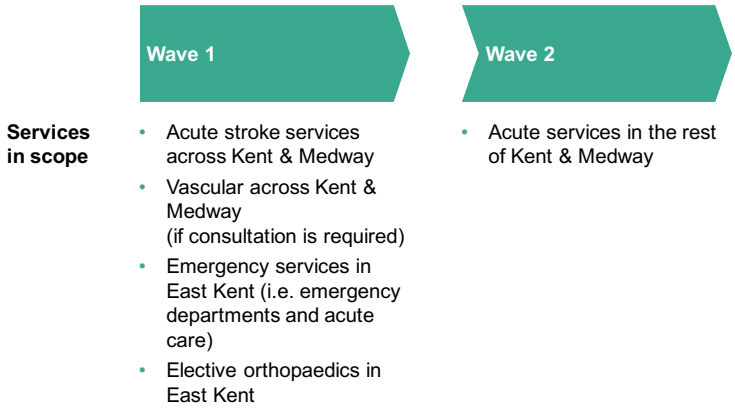
submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:



6. Work streams were established to take forward each of the above areas, comprising clinicians, leaders and practitioners from across Kent and Medway NHS and local authority organisations. They have been meeting since the autumn of 2016, and test and discuss their work with the programme's Patient and Public Advisory Group (including its precedessor the PPEG) and the programme's Partnership Board as part of an ongoing programme engagement infrastructure and as one strand of engagement activity

7. The STP Programme Board took stock of the progress being made by these work streams in February 2017. It was recognised that different parts of the Kent and Medway area were at different stages in relation to their readiness and development.

8. The STP stocktake concluded from an analysis of patient flows within Kent and Medway that there are negligible potential activity flows from East Kent to the rest of Kent and Medway. It was proposed that it is possible to consult on service changes in East Kent around urgent and emergency care alone, though the impact on future options in the rest of Kent and Medway will need to be considered. Therefore, two waves of public consultation are proposed but undertaken within a clear strategic framework for all of Kent and Medway:

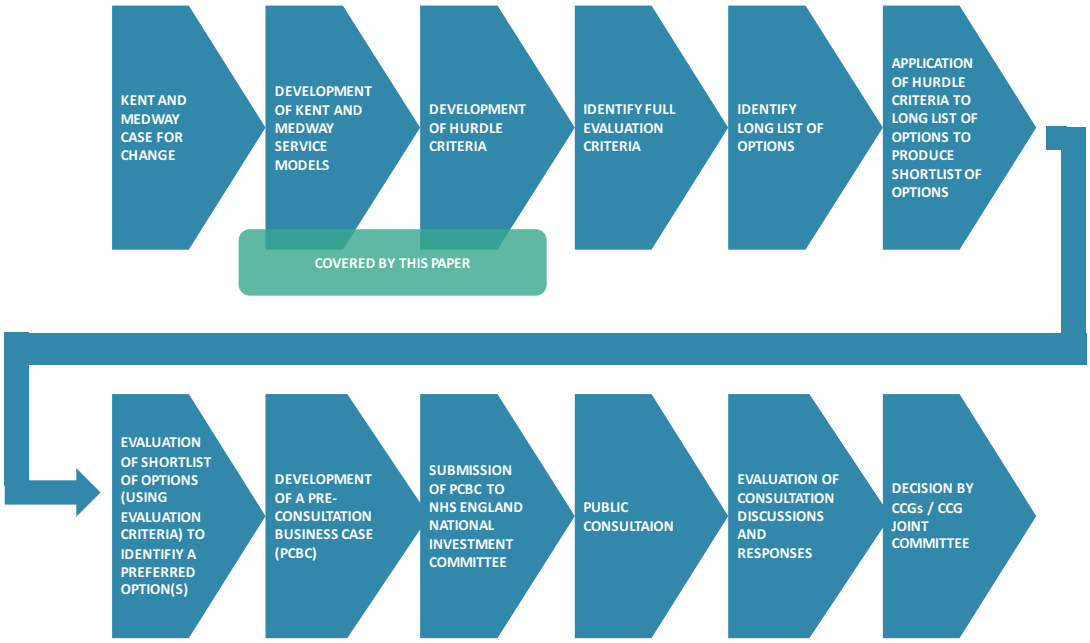


9. It had previously been hoped to consult on proposed wave 1 service changes in 2017 but a number of delays have been incurred, including the:

   - need to undertake more public engagement;

- need to put in place joint decision-making arrangements across the CCGs, which require a change to some of the CCG constitutions;
- impact of purdah due to the local and general election[4]; and
- not wishing to start any consultation too close to the Christmas holidays.

10. It is now envisaged that any required consultation would not take place until 2018.
11. In moving to consultation we are following a process that covers a number of stages as outlined in the following diagram (as outlined in the process diagram this paper covers the proposed service models and hurdle criteria):



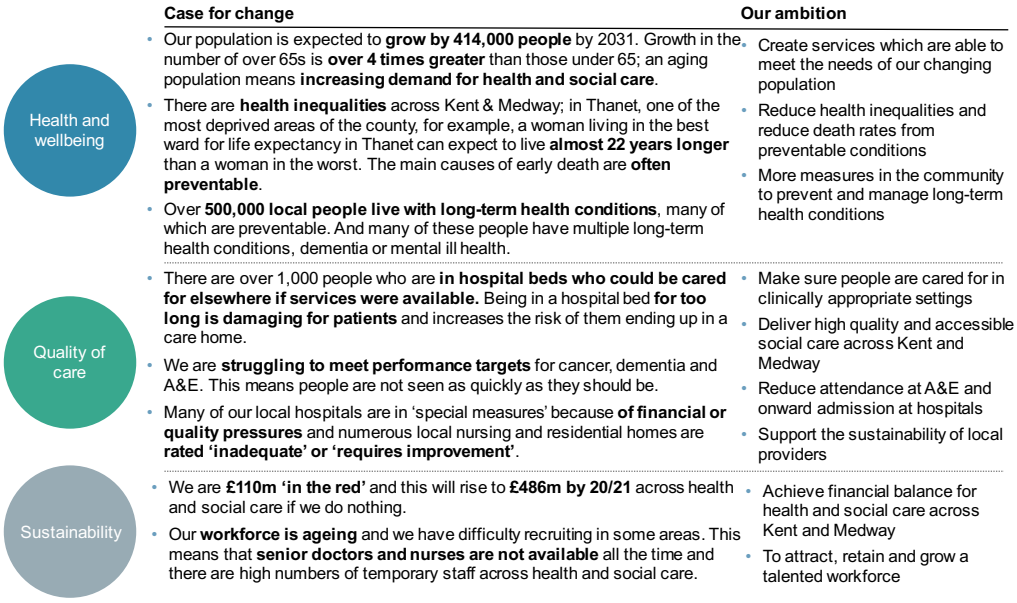
Case for change

12. The Kent and Medway STP Clinical Board has prepared a technical case for change[5] which has been used to prepare a more accessible public facing case for change to support engagement with patients, carers, local communities and stakeholders[6].
13. These documents outline the strategic rationale for why change is needed. Whilst there is much to be proud of about health and social care services in Kent and Medway there are several issues that we need to tackle; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care, through self-management, ill health prevention and earlier diagnosis. The following provides a summary of the case for change:

[4] The term 'purdah' is used across central and local government to describe the period of time immediately before elections or referendums when specific restrictions on the activity of civil servants and other public bodies are in place in order to ensure there is no breach of Section 2 of the Local Government Act 1986 (this states to "not publish any material which, in whole or in part, appears to be designed to affect public support for a political party")

[5] http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/Kent-Medway-Case-for-Change-technical-doc-FINAL-UPDATED.pdf

[6] http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf



SOURCE: Kent and Medway 5yrFV

14. The position outlined in the case for changes provides further details of the challenges against the triple aims of STPs (as outlined in Point 4, namely:

    i. health inequalities – there continue to be significant health inequalities within Kent and Medway, with the main causes of early death often being preventable:

    ii. quality failings and under-performance of NHS Constitution targets – with large numbers of patients not supported in the most appropriate setting of care, widespread non-delivery of NHS Constitution targets and a significant number of organisations facing quality challenges; and

    iii. financial challenges – a net over-performance on £110m in 2015/16 on the NHS total system budget which is projected to rise to £486m by 2020/21.

15. The challenges outlined above, and in more detail in the case for change, impact detrimentally on the health and lives of the population we service and on the sustainability of NHS and social care services. The strategic remit of the STP is to address these challenges.

How our service models link together

16. Through developing our local care services we will be able to offer care closer to the patients home. It is recognised that many elderly patients are supported in acute hospital settings inappropriately, when there needs would be better met in a non-acute setting (e.g. outside of a hospital). This is outlined in the Kent and Medway Case for Change and it is well documented that supporting these patients in an acute setting has a detrimental impact on their long-term outcomes.

17. Whilst it is vital to develop our local care services, we also recognise that there will always be circumstances where individuals need to access secondary care. We are therefore developing revised models for emergency care, covering emergency departments (accident and emergency departments) and acute medical care, as well as for stroke care. However, our aim is to minimise reliance on secondary care, including facilitating discharge from the acute setting at the earliest opportunity.

18. Where it has been necessary for an individual to be admitted to acute care our Local Care and acute medical model will facilitate timely discharge, as outlined below for the elderly frail:

	1. Upon admission	2. Reduce time spent in a bed	3. Optimise the discharge process	4. Facilitate re-ablement and return to independence
Hospital care	• Assess patient for function and care needs on day 1 • Assessment needs to include cognition – early recognition of dementia/delirium	• Day 2 mobility plan • Work on mobility every day • Transparency within hospital to measure LOS >10 and medically fit • Trigger reviews of long stays • Early role of pharmacy in meds review	• Advance care plan • Discharge process run by community (below) • Early provision of discharge medication	• Enhanced transport offer
Interface	• Access to care record • Ownership retained by community teams • Direct link made between hospital team and community MDT to capture requirements • Planned day of discharge agreed by MDT • Determine social care means testing	• Daily MDT discharge meeting including community and care coordinators, nursing and medical team • Ensure assessment of care need has been made • Ensure funding decision is made	• Ensure rapid decision made about care packages required (e.g. within 2 hours) • Ensure care record reflects needed details of ongoing care	• Single point of access that works across CCGs in STP • Access to patient record • Better use of telemedicine and tele care to manage people out of hospital
Local care MDT	• Carers consulted by MDT about support needed	• Discussion with self-funders for care needs • Home environment assessed to see meets anticipated needs on discharge at the point of admission	• Discharge to assess • Care package in place (self/public) • Home modifications made • Carers prepared for requirements	• Support carers to reable • Provision of rapid response • Shift therapy workforce to out of hospital • Night sitting • Support individual decision making

19. We have also developed a revised elective orthopaedic service model. Whilst it is possible for elective orthopaedic services to operate on a standalone basis there are a number of interdependencies that need to be taken into consideration, in particular:

- the critical clinical service co-dependencies for orthopaedic elective work are anaesthetics and access to simple diagnostics, which need to be available on the same site; and
- the level of complexity of the procedures that can be undertaken is determined by access to Level 2 critical care facilities on site.

Service model for local care

20. The STP has prioritised the development of local (out-of-hospital) care. This is in recognition of the vital role these services play, including the current challenges they face as outlined in the case for change. This is also in response to what local people have said they want in recent years' insight work about more joined up services, better access to primary care and more support with staying well and managing their own care, and, importantly, in recognition that it is difficult to make change to the way hospital care is delivered without developing these services.

21. The Kent Integrated Dataset[7] has been used to interrogate spend and this has identified that approximately 32% of resources are used on 12% of the population, namely the elderly frail population, with multiple complex needs:

[7] Kent is one of the early implementers of the linked dataset initiative in England. The KID is possibly the largest linked dataset of its kind and one of the very few programmes with ambition to link data across the wider public sector. The Information Governance (IG) agreement behind the KID is that it can only be used for planning purposes, and cannot be used for informing direct patient care.

Spend per head, £
Population, Thousands
Spend, £ Millions

2015/16 population size, total spend and spend per head by condition and age band

Age	Mostly healthy		Chronic conditions (1-3)		Cancer		Neurological disorders		Dementia		Serious and enduring mental illness		Chronic conditions (4+)		Learning disability	
0-15	426		942		9,849		3,805						2,767		3,378	
	257.2	109.4	28.5	26.8	0.2	1.6	1.5	5.8					0.1	0.2	0.5	1.6
16-69	349		985		2,362		3,796		11,772		15,565		2,764		26,855	
	501.9	175.2	404.1	398.0	14.1	33.4	12.6	48.0	0.4	4.9	5.1	78.8	92.8	256.5	5.3	143.5
70+	1,901		1,782		2,420		4,262		7,681		24,943		4,576		42,310	
	21.8	41.4	79.1	141.0	8.5	20.6	4.1	17.6	3.6	27.8	0.5	12.3	84.8	388.2	0.4	15.7

Notes: KID data covers 55% of population and 32% of spend for scope area. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. non-PbR acute activity). Children's social care, CAMHS, prescribing costs and continuing care costs are not included. People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to "mostly healthy" segments. KID data quality issues cause some people with long term conditions (incl. physical disability and SEMI) to be categorised erroneously as 'mostly healthy', artificially raising those segments' spend and populations.
Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 31/03/2017

22. Therefore, the focus of the work around local care has been on developing new service models to support this group of individuals but is now looking at how other groups of patients and users are now supported, e.g. children with complex needs, the mostly healthy with urgent care needs, adults with chronic conditions.

23. Our proposed service model for older people with complex needs model has been built around eight key interventions:

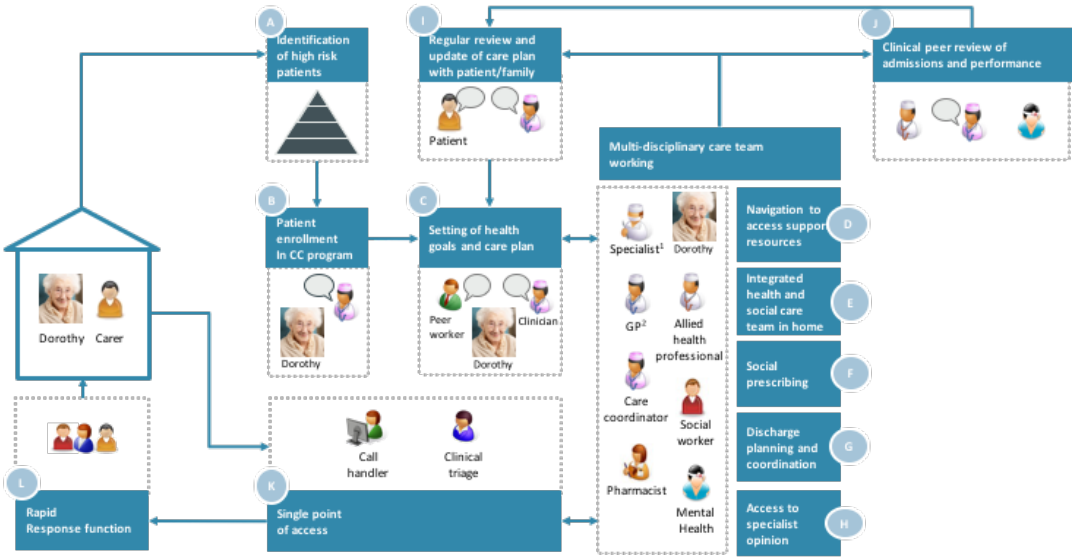
Source: K&M STP Local Care workstream, Carnall Farrar

24. These interventions will be delivered through a revised service model that sees the integration of primary and community services working in multi-disciplinary teams. Key components of this working arrangement include:

PROCESS STAGE:		DESCRIPTION:
A	Identification of high risk patients	• Patients are identified through a monthly KID data refresh, highlighting their appropriateness to be cared for by the "older person complex care and support model", and are placed on their local MDT list to be assessed • Alternatively, patients are identified by clinicians in the community or in hospital care they are in contact with and are placed on their local MDT list to be assessed
B	Patient Enrollment in complex care programme	• Patients are informed of the older people with complex needs model and asked if they would like to enroll, informed of what the model requires and what the initial steps will be to ensure efficient inclusion
C	Setting of health goals and care plan	• There are two conversations, one with a peer and another with a clinical MDT member, ensuring personal goals and care and support needs are identified in partnership with the patient and their carers • Peer and clinical conversation outputs are captured in a care and support plan owned by the patient • The plan is used as the primary focus for the holistic care of an individual and is accessible to all teams interacting with the patients and by the patient themselves
D	Navigation to access support resources	• Case managers and care navigators support condition management, integration of services and care according to the patient's care plan and are supported by "social prescribing"
E	Integrated health and social care team in home	• MDTs deliver integrated care and support to both the patient and their carer
F	Social prescribing	• The MDT uses a highly accessible and user friendly digital directory of community resources for the patients, their carers and health and social care professionals, facilitating robust social prescribing practices • The MDT also work to empower people to become or remain highly engaged regarding their own health and wellbeing
G	Discharge planning and coordination	• The community MDT (led by the patients care navigator or case manager) in-reach into the hospital to assist with and speed up the discharge process using a patient's care and support plan to determine change in need and plan for additional care and support requirements in the community upon discharge
H	Access to specialist opinion	• MDT GPs, community nurses and consultants can access specialist healthcare professionals through various communication channels, who have time dedicated to answering questions regarding specific patients • MDT clinical staff have rapid access to diagnostic services (diagnostic and result) to quickly inform a clinical decision about a specific patient
I	Regular review and update of care plan with patient/ family/peer	• Annually, patients review their care plan with their peer supporter and with their CM/CN, ensuring their personal goals and care and support needs are still being fully and effectively addressed • The care and support plan is updated as a result of these reviews • MDTs meet regularly and when needed, to discuss and review the needs of specific individuals within the patient cohort

J	Peer review of admissions and performance	• Any admissions are clinically peer reviewed to understand the reasons and to learn for the future
K	Single point of access	• Patients with a care plan, their carer, the GP and community services have access to a single number (SPoA) that can be used when patients are experiencing an urgent health or social care need, and that provides individualised support through access to their care and support plan
L	Rapid response function	• The SPoA is used to access the MDT rapid response function, which guarantees a 2-hour response time when required, 24 hours a day • Patients receive and initial assessment by an MDT first responder who determines their short-term needs • When required, the patient and their carers will be supported for a short time period post-intervention, including a telephone and home visiting service • People requiring further clinical care will be transferred to the appropriate service quickly and efficiently

25. The above components of the service model are depicted below as a flow diagram that outlines the model of how it is intended that local care would be delivered:



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

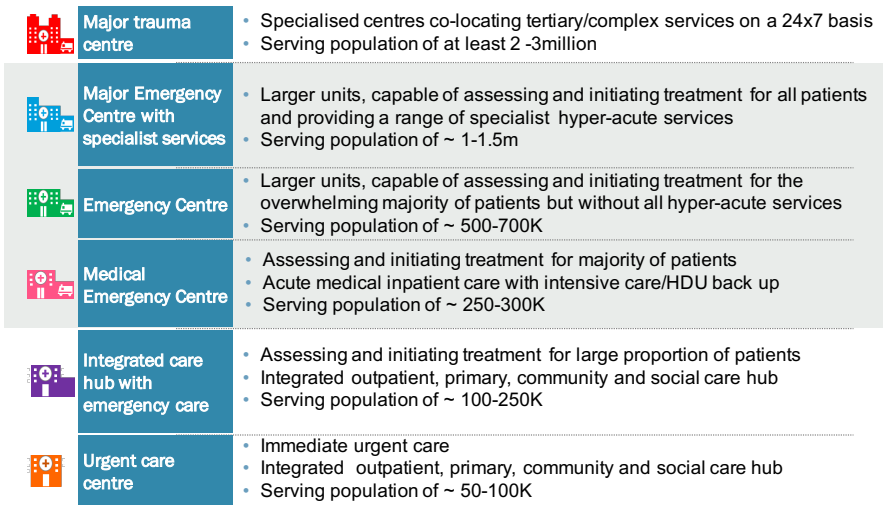
Emergency department clinical model summary

26. At present emergency department (ED) services are delivered at all seven acute hospitals sites in Kent and Medway. In 2015/16 there were 219,812 major emergency department attendances (including 254,441 adults and 57,507 children) and 311, 948 minor emergency department attendances (including 156,084 adults and 63,728 children). Emergency department attendances have grown by 3.6% per year over the last three years in Kent and Medway (the national average is 2.6%). Conversely, performance on the four-hour waiting target has deteriorated over the last two years; in

2015/16 on average 86% of people were discharged from emergency departments within four hours, compared to 92% nationally.

27. Some providers in K&M have amongst the worst patient satisfaction scores in the country. Patient stories show the current system is characterised by long waits, multiple contacts with health care professionals, and poor patient experience. A range of interventions are being developed to avoid emergency department attendances, as outlined in the previous section on our local care model. A new model for emergency departments will incorporate triage to the most appropriate pathway.

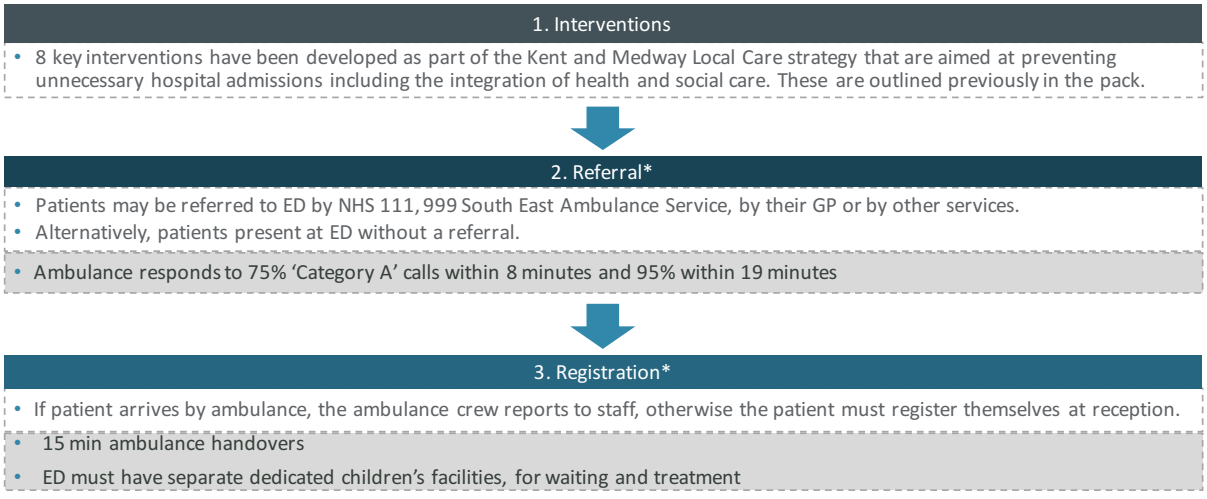
28. The models in the Keogh report have been used as a basis for developing building blocks of services (i.e. the service models we would see our current hospitals develop to become):



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

29. The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.

30. The following diagram outlines the standard process that patients attending an emergency department would expect to experience:



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

* Category A calls relate to immediately life-threatening incidents

* Many places across Kent and Medway are introducing a first step based on the Barking, Having and Redbridge (BHR) 'Redirection' where the eyeball 'streaming' takes place by a GP or Consultant who in less than 4 minutes will assess the patient and redirect out to community services, GP's, Pharmacy, Minors/UCC, or hot clinics'. Those that remain go through the comprehensive triage.

** The detail of these aspects of the model is being developed as part of the local care work stream.

Acute medicine

31. At present acute medical care is delivered at all seven acute hospital sites in Kent and Medway and there were 115,626 medical admissions in 2015/16.

32. The population registered with GPs in Kent and Medway is 1.8 million (i.e. includes patients from outside the area registered with local GP practices). The population is forecast to grow over the next five years, with a majority of growth occurring in the elderly population. Partly linked to this there are rising numbers of emergency admissions and bed occupancy across Kent and Medway.

33. In a recent bed audit, there were 1,007 patients in hospital beds who are medically fit to leave their current setting of care (as at 22nd November 2016). The vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital.

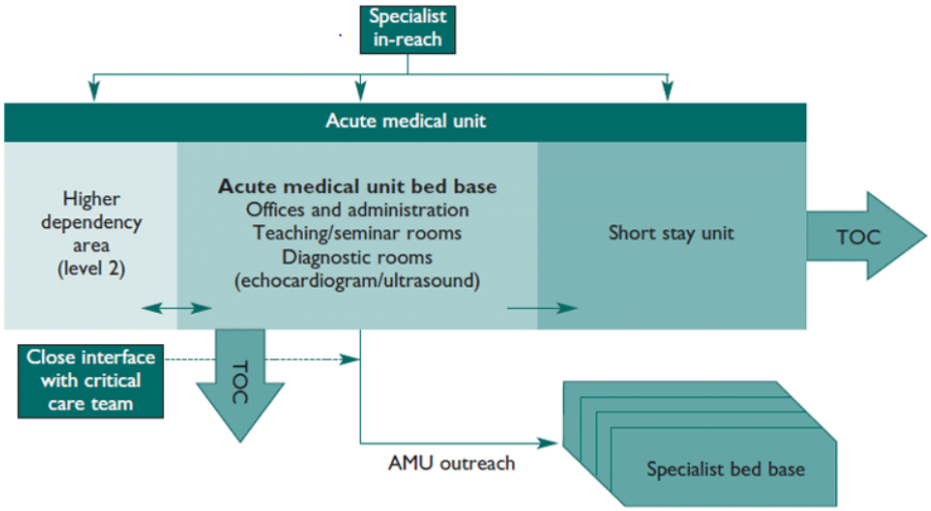
34. In line with national policy, the NHS aspires to provide seven day services but workforce constraints are challenging the delivering of this, including the inability to put in place 24/7 consultant cover in hospitals across Kent and Medway for those who need acute medicine.

35. The Kent and Medway acute medical care model is partially consolidated, but is still largely based on historic dispersal of services. Acute emergency medicine is currently delivered from seven sites using a variety of models. All Trusts aspire to deliver best practice models but constraints with capacity, estate and workforce only allow this to happen to varying degrees.

36. Our proposed service model covers:

- streaming to a fully functioning acute medical unit to reduce acute admissions;
- timely and appropriate discharge from the emergency department supported by schemes (e.g. such as occurs in the voluntary sector Take Home & Settle service in East Sussex);
- reduced non-elective length of stay, incorporating the NHS England pathway for people with dementia;
- Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models; and
- delivery of 7-day services in acute medicine to allow timely access to a senior specialist medical opinion.

37. The term Acute Medical Unit (AMU) has been defined by the Royal College of Physicians (RCP)[8] 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.' The report provides a detailed description of the rationale and requirements for an AMU but allows for local design. The structure of an AMU is schematically represented below:



38. Ideally an AMU should be co-located with other acute and emergency services as part of an emergency floor incorporating the ethos of Emergency Ambulatory Care. Strong clinical (medical and Nursing) and operational leadership is essential for an AMU to function successfully.

39. In delivering the acute medical take through an AMU a number of key principles need to be adopted:

- Assessment of acutely ill patients by competent clinical decision makers supported by appropriate levels of diagnostic support
- All areas follow the ethos of treating patients in an ambulatory model unless deemed otherwise by exclusion criteria
- Nominated medical, nursing and operational leads are in place working in the department on a regular basis

[8] Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time.* Report of the Acute Medicine Task Force. London: RCP, 2007.

- Integration and collaboration of key acute services e.g. emergency department, critical care, AMU and key support services e.g. pharmacy and therapies
- Consistency of quality medical care 24 hours a day, 7 days a week
- Specialist medical in-reach when required in a timely way 7/7

Stroke services

40. In 2015/16 approximately 2,500 acute stroke patients were supported in the seven acute hospitals in Kent and Medway. Currently all of these hospitals provide acute stroke care and, following the immediate acute episode, patients are discharged without further rehabilitation or discharged back to their home with a community rehabilitation package or to a new home, such as a residential care home that is suitable for their needs
41. In 2015/16 only half of all patients were admitted within four hours and this performance is below national average. In addition, all of the hospitals:
    i. only provide five-day stroke consultant face-to-face cover;
    ii. none provide seven-day consultant ward rounds;
    iii. less than 50% of patients receive thrombolysis within 60 minutes; and
    iv. performance against Sentinel Stroke National Audit Programme (SSNAP) is variable and inconsistent.
42. Currently patient volumes are too small to deliver clinical sustainability hyper acute stroke units on all seven acute hospital sites. In particular, there are significant challenges that cannot be met with the current service model of all seven hospitals providing acute stroke care. We need to ensure there is 24/7 consultant availability with a minimum 6 trained thrombolysis consultant physicians on rota and consultant led ward round 7 days a week. This will be supported by a multi-disciplinary team including nurses, physiotherapists and occupational therapists.
43. In order to achieve the above we need to consolidate stroke services on fewer sites to ensure there are sufficient volumes of patients supported on each site to sustain the staffing numbers. For Kent and Medway this means delivering a combined hyper acute stroke unit and acute stroke unit service on a smaller number of sites. In practice for Kent and Medway this means developing hyper acute stroke units that support volumes of over 500 patients and less than 1500 confirmed stroke patients.
44. Alongside the acute stroke provision it is recognised that we need to develop robust early supported discharge and rehabilitation services.

Elective orthopaedics

45. There are 7,921 elective orthopaedic inpatient and 13,331 elective orthopaedic day case procedures undertaken in hospitals in Kent and Medway (plus 2,110 inpatient and 425 day case procedures in private hospitals under “choose and book arrangements”, which give patient a choice about where they receive treatment). The majority of the people having these procedures are older (with most procedures in the 64-69 age band).

46. In addition, Kent and Medway acute providers outsource approximately a further 2000 elective orthopaedic procedures each year to private hospitals and there are an additional 6,000 patients waiting for elective orthopaedic procedures across the area, with referral levels for elective procedures varying between CCGs and between practices. Some hospital waiting lists for planned care are long and growing. The number of cancellations on the day of the operation are increasing.

47. Right Care[9] analysis shows a potential significant opportunity in musculoskeletal elective bed days across the patient pathway, circa £8m compared to peers, and an additional £1.8m related to areas such as falls and primary care prescribing.

48. All acute hospital sites in Kent and Medway deliver a mixture of elective (planned) and non-elective (unplanned / emergency) orthopaedic services, with the exception of Kent & Canterbury Hospital which does not undertake any non-elective activity and Maidstone General Hospital which does not undertake any non-elective orthopaedic surgery.

49. Our proposed service model is based on:

- a focus on prevention and self-care and the benefit of a community-led integrated musculoskeletal (MSK) pathway;
- a set of principles including standardised approach, use of multi-disciplinary teams, one-stop services, senior support and better use of digital technology;
- a greater use of multi-disciplinary teams, consultant feedback, earlier discharge planning and ring-fenced elective beds; and
- consolidation of elective orthopaedic surgery onto fewer sites will lead to an improvement in outcomes.

50. The following diagram outlines our proposed service model:

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 play a key role • Lower average staff cost per appointment • Spinal injections • Focus on MSK pathway
2	Preoperative 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
3	Re-check 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
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

[9] RightCare is an NHS England programme aimed at improving people's health and outcomes by promoting that the right person has the right care, in the right place, at the right time, making the best use of available resources. It uses data and evidence to highlight unwarranted variation to support quality improvement.

Hurdle criteria

51. As with the clinical models, the hurdle criteria have been developed through the hospital care workstream, with clnical and patient engagement, and then reviewed and signed-off by the STP Clinical Board, ahead of being approved at the STP Programme Board.

52. Through consideration of the service models we will identify a long list of options around potential service changes. As outlined in the process diagram at Point 11, these will be evaluated using the hurdle criteria. An option must meet the requirements of each of the hurdle critieria or it will be rejected. This means that through assessing the long list of options by applying the hurdle criteira to them, a short list of options will be generated. This shortlist of options will go forward to more detailed evaluation:

Criteria	Description in relation to application against long list of options for emergency care, acute medicine and elective orthopaedics	Description in relation to application against long list of options for stroke services
Is the potential configuration option clinically sustainable?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective?	• Does it deliver key quality standards? • Does it address any co-dependencies? • Will the workforce be available to deliver it? • Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively?
Is the potential configuration option implementable?	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view, this may mean that some organisations have a net negative financial impact as well as some have a net positive impact.	• Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view
Is the potential configuration option accessible?	• Is the maximum travel time (by car) an average of one hour or less?	• Can the population access services within a window of 120 minutes from call to needle?[10]
Is the potential configuration option a strategic fit?	• Does it implement the outcome of other recent consultations or designation processes?	• Does it implement the outcome of other recent consultations or designation processes?

[10] Using 95% accessing services within 60 mins (off-peak) as a proxy

Is the potential configuration option financially sustainable?	• Must not increase the 'do nothing' financial baseline	• Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting more at PFI sites, this will be considered in detail at evaluation stage)*

Summary

53. As indicated at the start of this paper it is envisaged that consultation will take place in two waves, with the first services that are intended to be consulted on being:

    i. Acute stroke services across Kent and Medway

    ii. Emergency services in East Kent (i.e. emergency departments and acute care)

    iii. Elective orthopaedics in East Kent

54. The HOSC is asked to consider the contents of this paper.