Transforming health and social care in Kent and Medway

K&M STP: William Harvey Hospital

Ashford Health and Wellbeing Group

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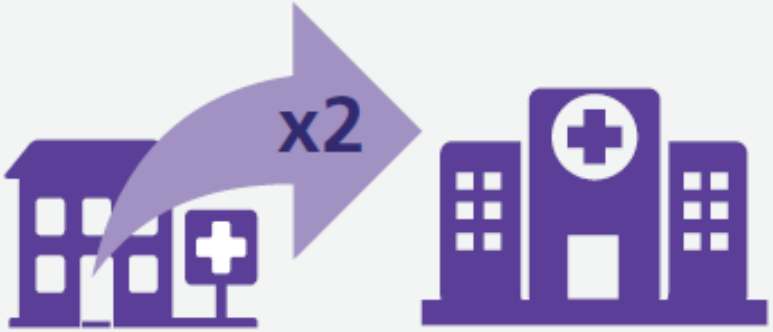
About today

- Why services need to change
- K&M Sustainability and Transformation Partnership (STP)
- What people have told us so far
- Our proposals for change
  - ✓ **Kent and Medway** – stroke and vascular services
  - ✓ **East Kent** - urgent and emergency care including acute medicine and inpatient elective orthopaedics (major joint surgery)
- Next steps and timeline

Services need to change

In some areas you are **twice as likely** to end up in hospital because of a problem that could have been avoided if it had been better managed in primary care.

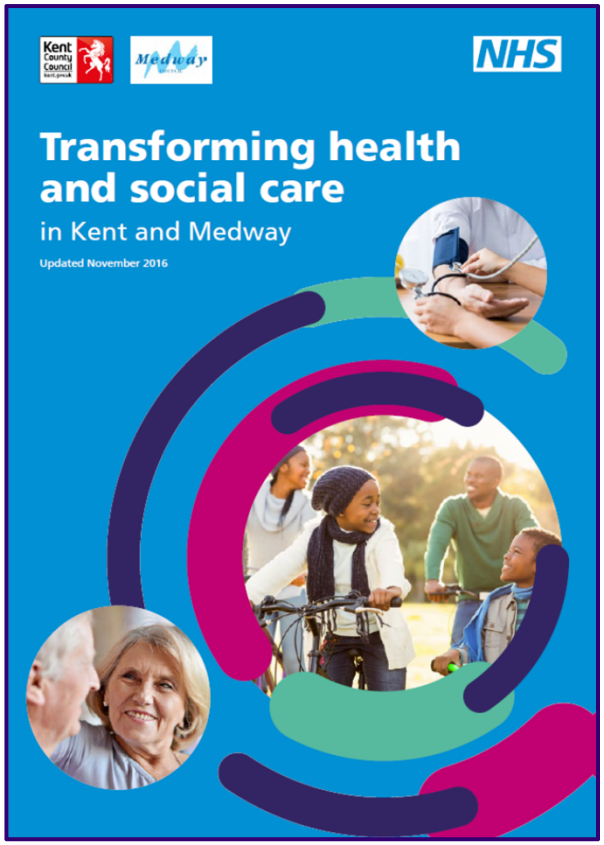


The equivalent of 10 days bed rest can have the same impact on the muscles as roughly **10 years of ageing** for people over 80

At any one time there are around **300** people in hospital beds who could be discharged if the right support was available elsewhere.

Sustainability and Transformation Partnership (STP)

- One of 44 in England
- Joint NHS and social care
- Five-year plan
- Significant change to services and how they are delivered
- We are engaging on ‘how’ – with staff, patients and the public



K&M STP is pursuing Transformation around 4 themes

Care Transformation

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

System Leadership

- System / commissioning transformation
- Communications and engagement

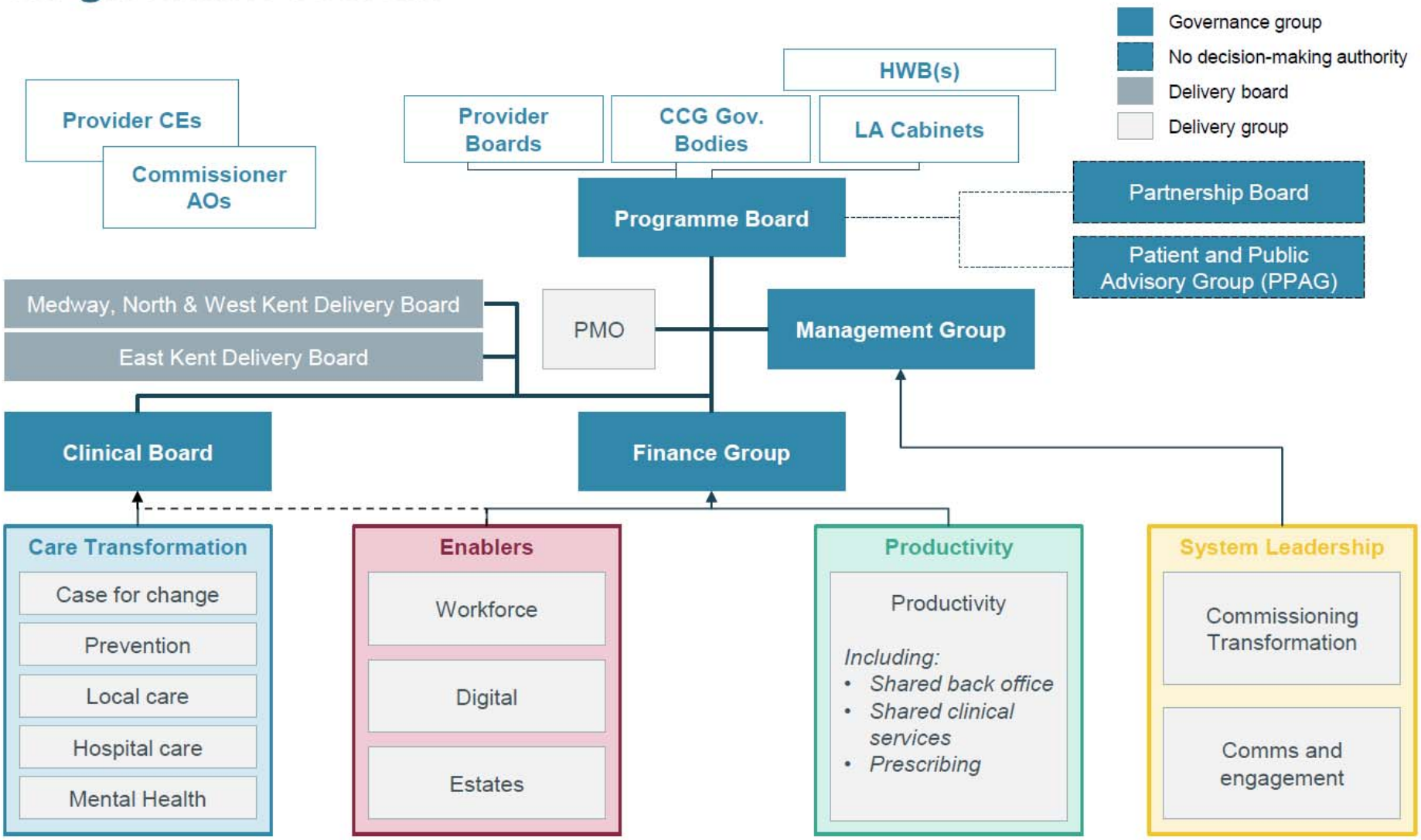
Productivity

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

Enablers

- Workforce
- Digital
- Estates

STP governance structure



Source: Kent and Medway STP

Listening to the public

- People **don’t want to go to hospital** if they don’t need to
- People are willing to go to **specialist centres** for the most specialist treatment;
- Concern about **travelling further** for some hospital services
- People want care **as close to home as possible** e.g. more outpatient appointments locally
- **Improved discharge from hospital** for people who need further care

Our model of care

Helping you stay well

Doing much more to help you stay well so you don't develop some of the illnesses we know can be caused by unhealthy lifestyles

Doing more out of hospital

Redirecting more of our resources into local care services so we can offer more care out of hospital

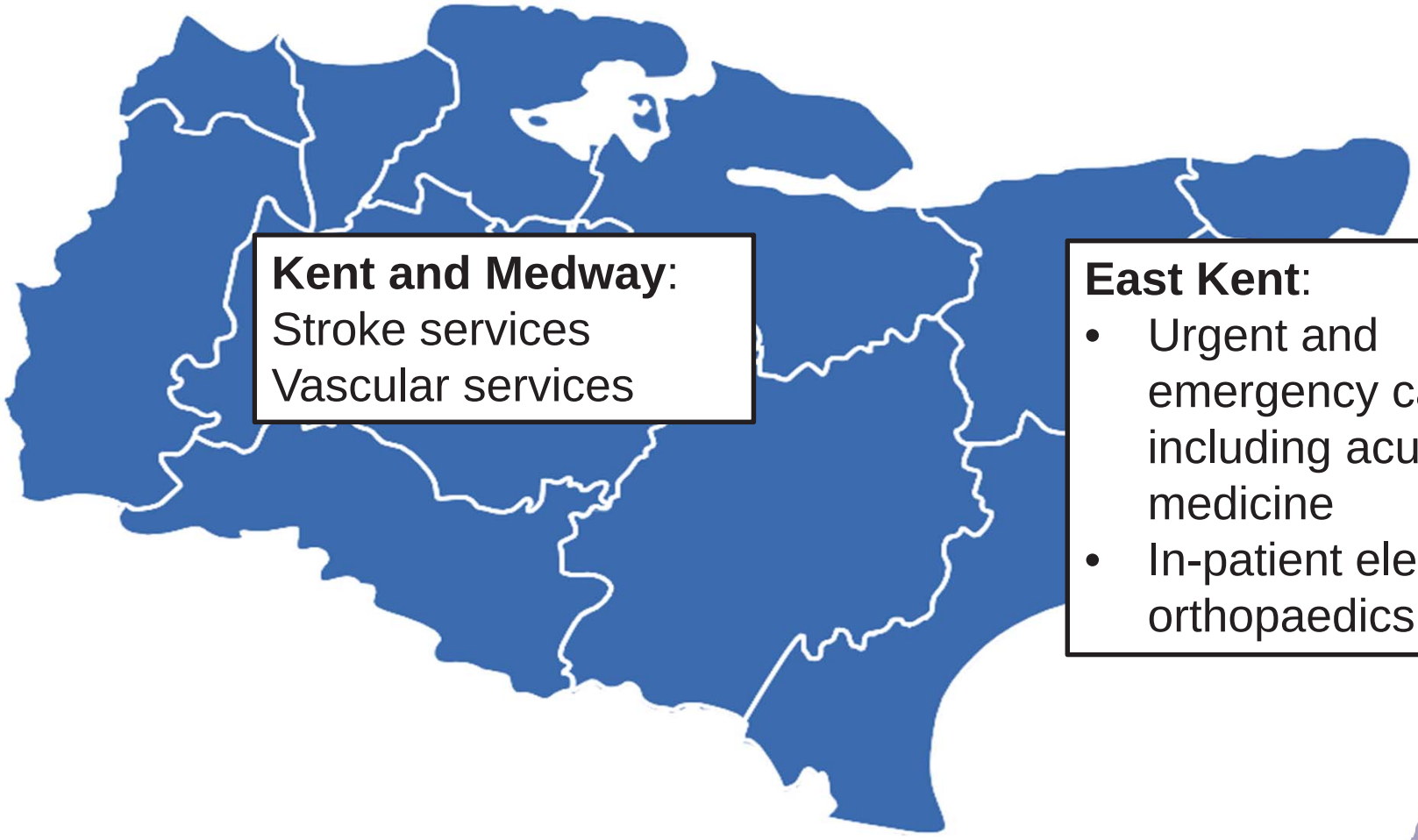
Making hospital services more effective

Organising acute hospital services in the most efficient and effective way

Vision for future hospital services

- For patients to have the **best, most effective, hospital care when they need it**, with greater support at home and locally for people who don’t
- This means **using our hospitals in different ways in future** to improve standards for patients
- **Three vibrant hospitals in east Kent** offering patients a wide range of health and care services

Improving hospital care in Kent and Medway



Kent and Medway:
Stroke services
Vascular services

East Kent:

- Urgent and emergency care including acute medicine
- In-patient elective orthopaedics

Transforming health and social care in Kent and Medway

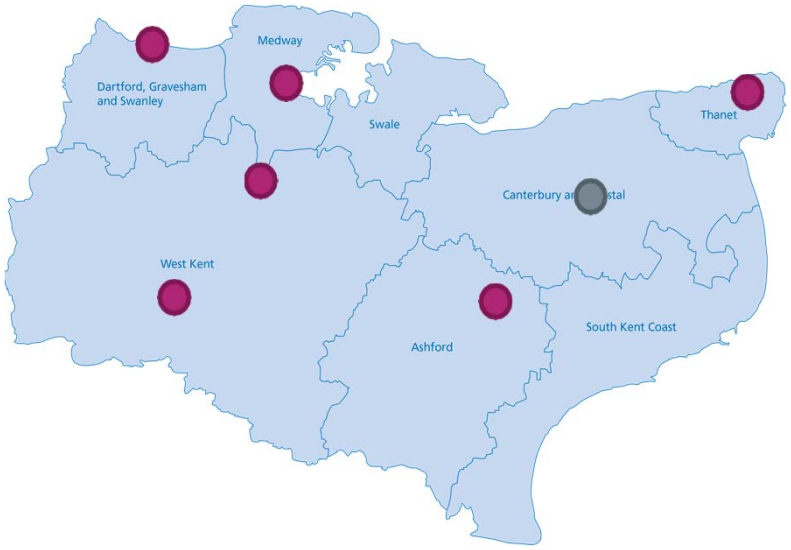
Kent and Medway: Stroke Services Review

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Stroke and current services in Kent and Medway

Stroke is a serious life-threatening condition caused by a blood clot or bleed in a blood vessel in the brain.

- Around 3,000 people living near a Kent and Medway hospital have a stroke every year
- Over 800 people in Kent and Medway die from stroke each year and many more suffer on-going disability



Six of our seven hospitals currently provide some urgent stroke care across Kent and Medway.

But we are **not consistently meeting national quality standards** or delivering best practice care.

How well people recover is affected by speed and quality of treatment

Current challenges – the case for change

Stroke care has changed in recent years - we have **new treatments and a better understanding of how to reduce death & disability**

Specialist stroke resources are spread too thinly and most hospitals do not meet national standards and best practice

Consultants, brain scans and clot busting drugs **aren't consistently available 24/7**

One in three stroke patients are **not getting brain scans in the recommended time**

We have **only 1/3rd stroke consultants needed** to deliver best practice in all our hospitals

Half of appropriate patients **are not getting clot busting drugs** in the recommended time

Only one unit sees enough stroke patients for staff to maintain their skills (recommended minimum is 500 patients per year)

Benefits of hyper acute stroke units

- Services run 24 hours a day, 7 days a week
- Staffed by teams of stroke specialist doctors, nurses and therapists 24/7
- Daily consultant ward rounds, including at weekends
- Able to do brain scans and give clot-busting drugs within 2 hours of calling an ambulance, round the clock
- Care for first 72 hours is on the hyper acute unit, follow up care is also on specialist acute stroke unit

- ✓A reduction in deaths from stroke
- ✓Fewer people living with long-term disability following a stroke
- ✓Fewer people losing their independence and being admitted to nursing/care homes
- ✓Fewer vacancies and lower staff turnover
- ✓Shorter stays in hospital
- ✓Better patient and staff experience as a result of excellent working practices

How did we choose the shortlist of options?

We looked at a number of different areas to decide which options to shortlist. These areas were discussed and agreed with a wide range of stakeholders including patients and the public

Quality of care for all

Access to care for all

Workforce

Ability to deliver

Affordability and value for money

Options for consultation

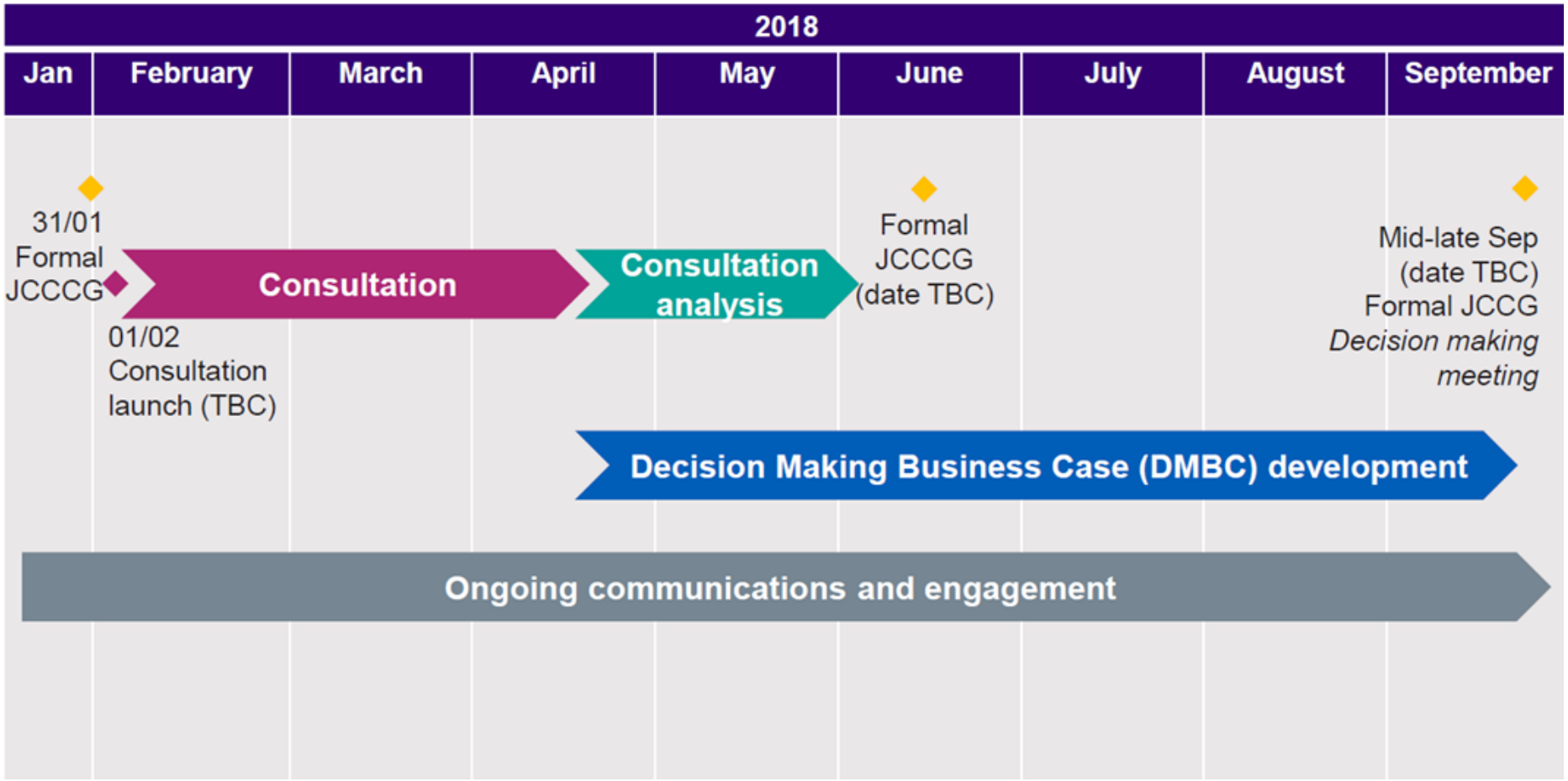
We are consulting on proposals to:

- Establish new hyper acute stroke units, run 24/7
- Have three of these in Kent and Medway
- A shortlist of deliverable three-site options

Option	Hospitals
A	Darent Valley | Medway Maritime | William Harvey
B	Darent Valley | Maidstone | William Harvey
C	Maidstone | Medway Maritime | William Harvey
D	Tunbridge Wells | Medway Maritime | William Harvey
E	Darent Valley | Tunbridge Wells | William Harvey

- Options are not ranked in order of preference
- A preferred option will be agreed after consultation
- Urgent stroke services would **not be available at other hospitals** in Kent and Medway

K&M Stroke review - draft timeline



Transforming health and social care in Kent and Medway

Kent and Medway: Vascular Services Review

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Kent and Medway Vascular services

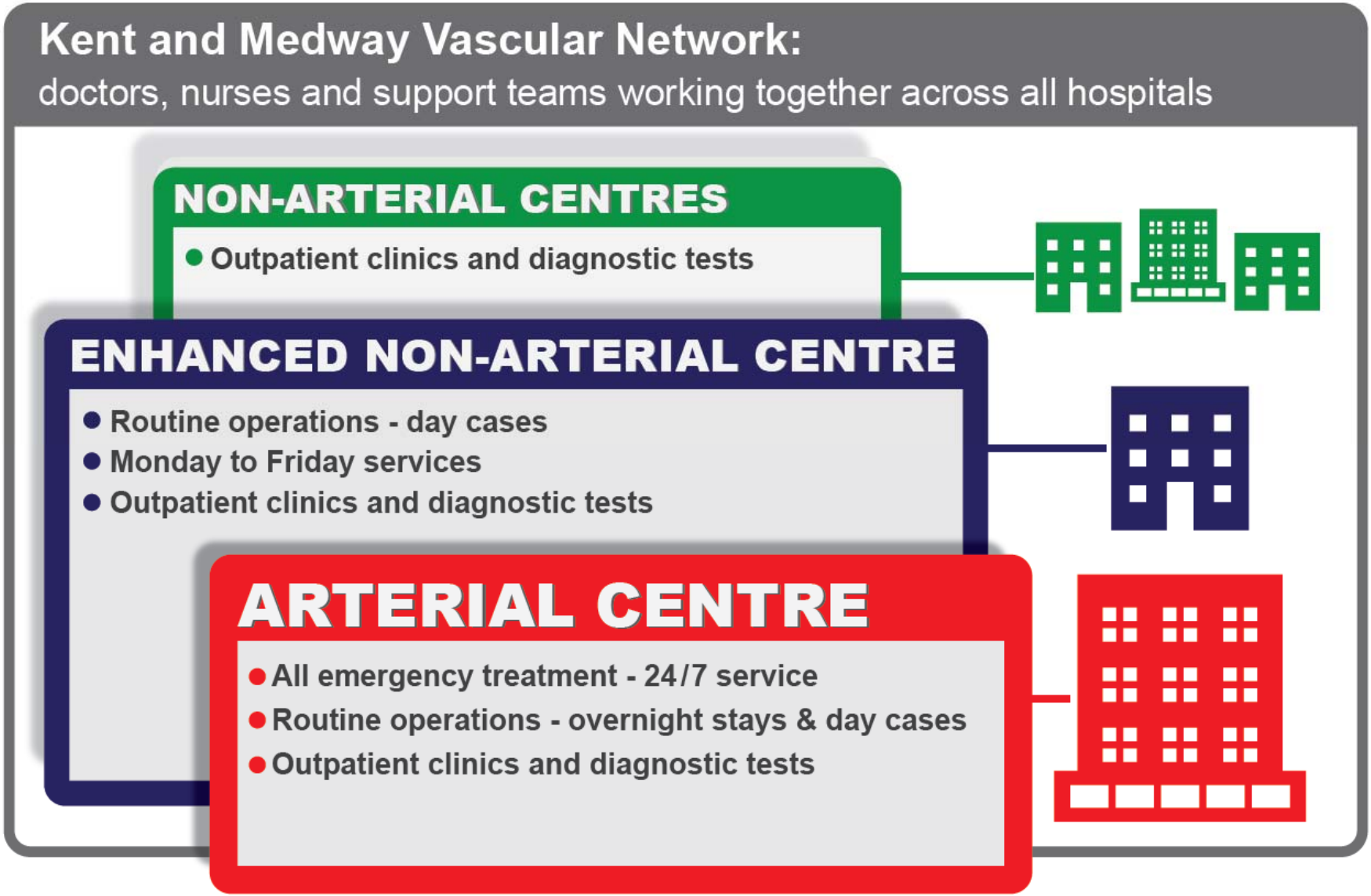
Current situation

- Two hospitals currently provide services which do not fully meet national standards
- See fewer patients a year than recommended
- Staffing challenges
- Kent and Medway Vascular Network

Future model

- Move to a single arterial centre (in patient) and enhanced non-arterial centre (day case)
- Improve patient outcomes and experience
- Sustainable, consistent and joined-up service
- More attractive to staff

Kent &Medway Vascular services



Transforming health and social care in Kent and Medway

East Kent: Urgent and Emergency Care and Acute Medicine

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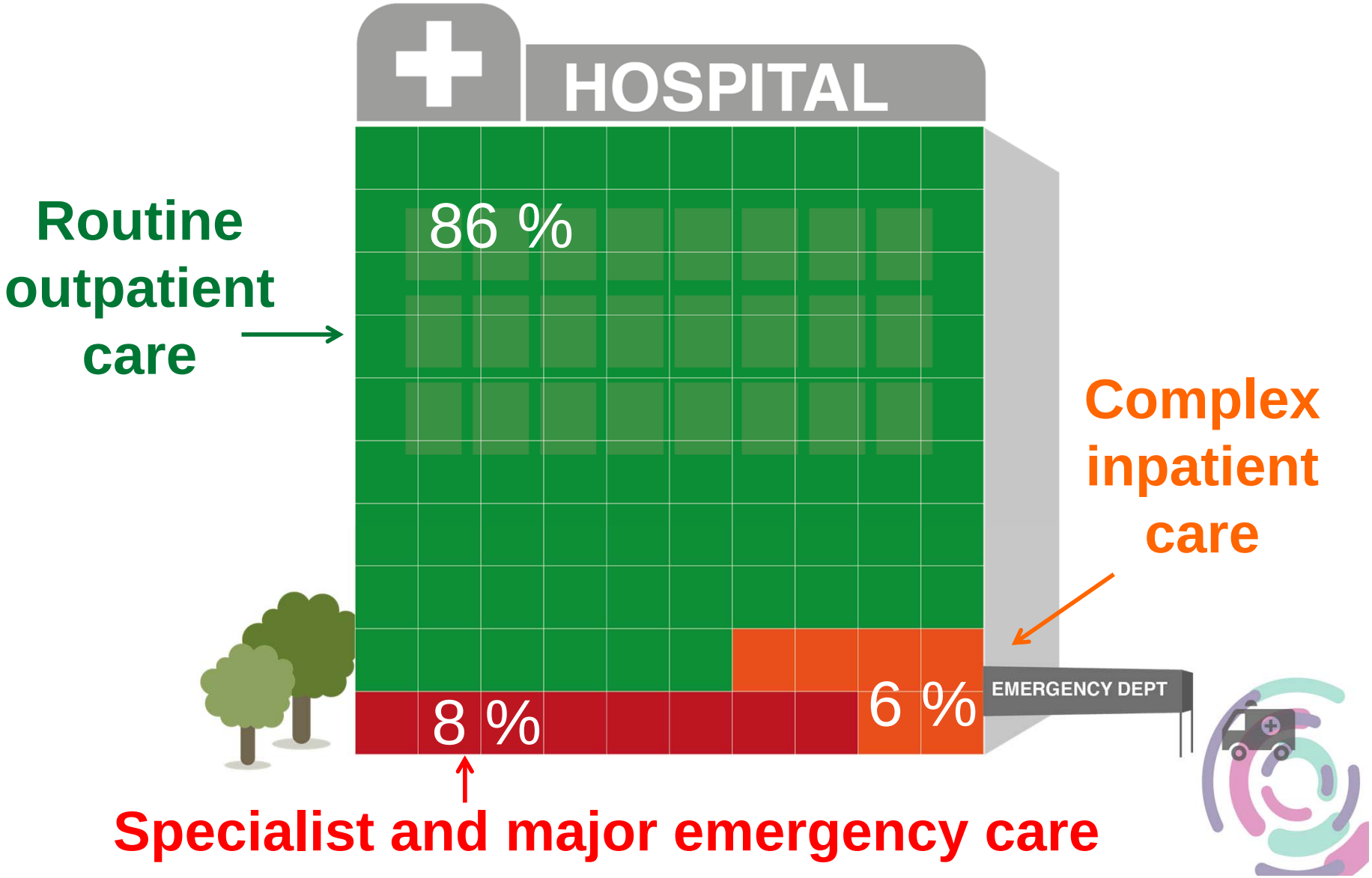
Most hospital care is routine



Guidance for urgent and emergency care

		What	Services offered
①	**Major trauma centre**	• Specialised centres co-locating tertiary/complex services on a 24x7 basis • Serving population of at least 2 -3million	• Neurosurgery, Cardiothoracic surgery • Full range of emergency surgery and acute medicine • Full range of support services, ITU etc
②	**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	• Hyperacute cardiac, stroke , vascular services • Trauma unit • Level 3 ICU • Moving towards 24x7 consultant delivered A&E, emergency surgery, acute medicine, inpatient paeds • Full obstetrics and level 3 NICU
③	**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	• Moving towards 24x7 consultant delivered A&E, emergency surgery, acute medicine • Level 3 ICU • Inpatient paeds and obstetrics with level 2/3 NICU
④	**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	• Consultant led A&E • Acute medicine and critical care/HDU • Access to surgical opinion via network • Possibly paeds assessment unit and possibly midwife-led obstetrics
⑤	**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	• GP-led urgent care incorporating out of hours GP services • Step up/step down beds possibly with 48 hour assessment unit • Outpatients and diagnostics • Possibly midwife-led obstetrics
⑥	**Urgent care centre***	• Immediate urgent care • Integrated outpatient, primary, community and social care hub • Serving population of ~ 50-100K	• As above but no beds

Long list of options

We started with a **long list** of possible options

We considered any of our three acute hospitals as:
- a **major emergency centre** with specialist services
- an **emergency centre** or medical emergency centre
- an **urgent care centre** or integrated care hospital

We also considered:
- Building a new hospital on a new site
- Consolidating our hospitals onto one existing site
- Closing an existing hospital

Hurdle criteria

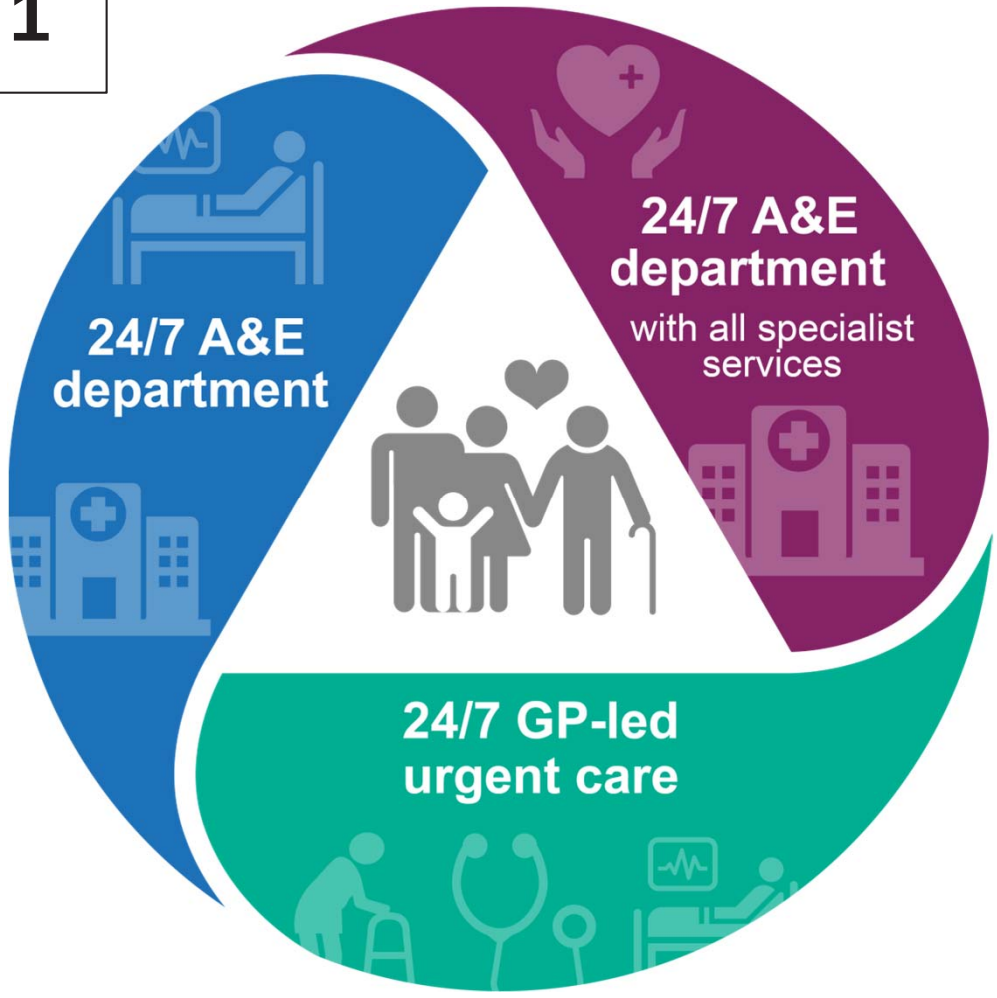
We then asked five questions to help filter out the options that are not viable

1. Is the option **clinically sustainable**?
2. Can we **implement** it?
3. Can people **access** the services?
4. Does it fit with **previous decisions**?
5. Is it **affordable**?

Medium list: two potential options

OPTION 1

QEQM Hospital



William Harvey Hospital

Kent and Canterbury Hospital

Medium list: two potential options

OPTION 2

A single major emergency hospital for all east Kent

William Harvey Hospital

Kent and Canterbury Hospital

QEQM Hospital

Transforming health and social care in Kent and Medway

East Kent:
Elective inpatient orthopaedics (major joint surgery)

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Current challenges – the case for change

- Long waiting lists for planned care (75% increase in the last 4 years);
- Increasing number of on-day cancellations (31 in Jan 2017) due to increasing pressures from emergency admissions -“crowding out” planned care;
- Trust beds on orthopaedic wards are not “ring fenced” which is impacting on beds availability;
- Increasing demographics driven demand:
  - High elderly population in east Kent - over 60’s
  - Thanet – over 68% of population are overweight or obese.
- Increasing demand for trauma services:
  - Elective theatre schedules frequently disrupted by trauma patients;
  - Substantial evidence show that surgeons need to operate on a minimum number of patients per year to improve quality and patient outcomes.

Long list ⟶ Hurdle criteria applied ⟶ Medium list

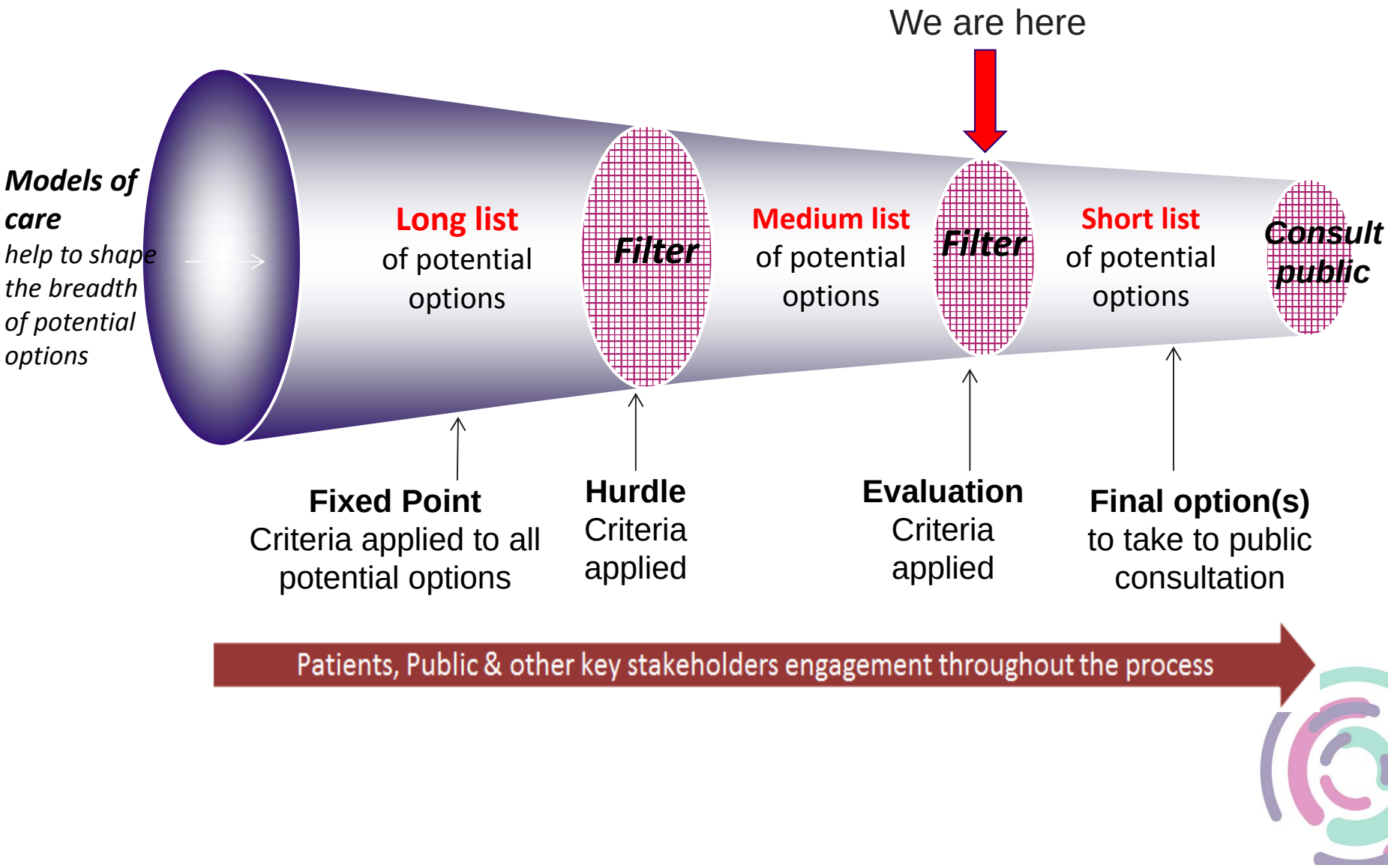
Long list of options

- A single east Kent inpatient orthopaedics unit on any of each of the three hospital sites
- An inpatient orthopaedics unit on all three hospital sites
- Combinations of two orthopaedics units on any two of the acute hospital sites
- No inpatient orthopaedics unit in east Kent.

Medium list of options

1. Only K&C
2. Only QEQM
3. Only WHH
4. Both K&C and WHH
5. Both K&C and QEQM
6. Both WHH and QEQM

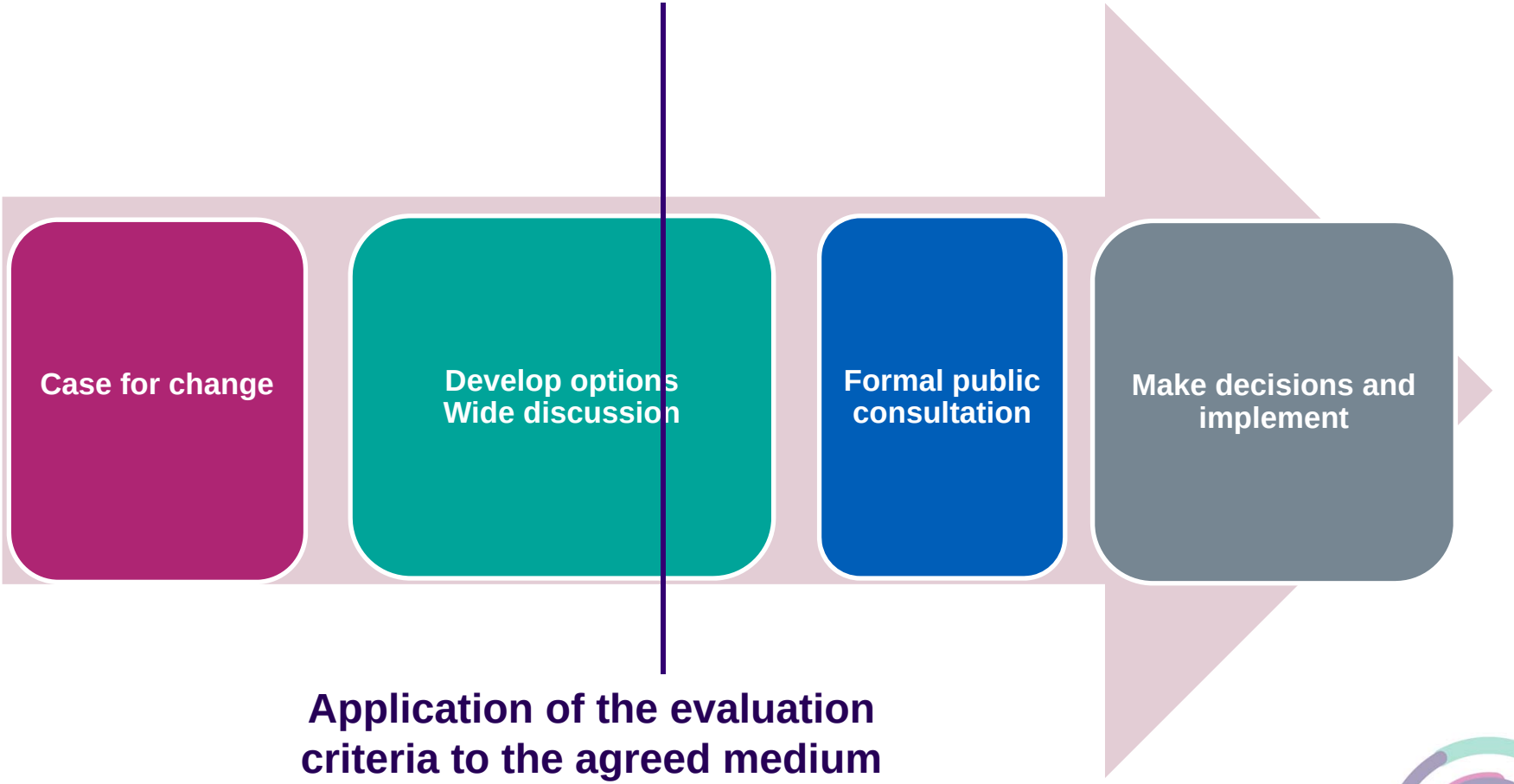
Decision making process



Evaluation criteria

QUALITY CARE	**ACCESS TO CARE**	**AFFORDABILITY**
Will it improve patient care?	Can patients get there?	Is it affordable and good value for money?
STAFFING	**DELIVERABILITY**	**RESEARCH and EDUCATION**
Do we have the right number of staff?	Is it implementable in the timeframe?	Will it support research and education?

Next steps and timeline



Application of the evaluation criteria to the agreed medium list of options to identify short list of options for the public consultation

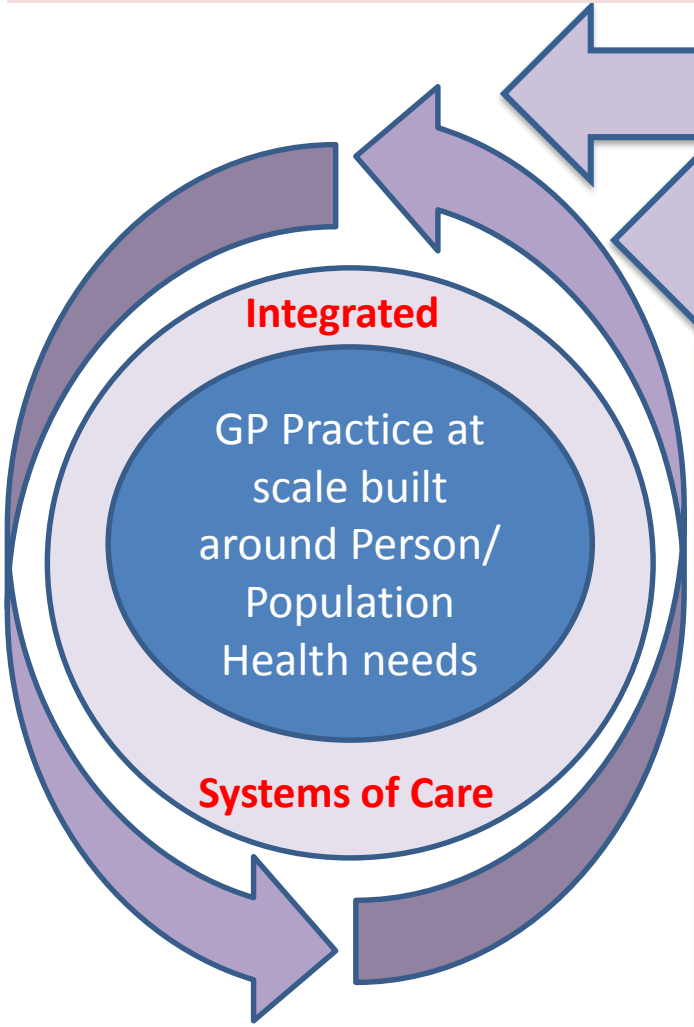
Implementation of Local Care

Ashford CCG

Key areas of Local Care Implementation

- The Local Care Model
- Implementation to date
- Plan for roll out across Ashford footprint
  - Detailed timelines
  - Anticipated impact
- Extended Access
- Frailty and other Tiers of Care Priorities

Local Care Model – Health, Social Care, Voluntary and Community involvement working together at scale – The Community Hub Operating Centre (CHOC) model



Number of People

Admission Avoidance

Routine, Prevention and Proactive Care –Integrated Case Management (ICM patient centred approach for admission avoidance, anticipatory care planning.

Emergency and Reactive Care – ICM approach for admission avoidance, rapid/ emergency response to avoid hospital admission to keep people well at home.

Acute Care - When intervention is essential. Working with IDT for repatriation at the earliest opportunity.

Tertiary Care - For highly specialist intervention. Repatriation at the earliest opportunity.

Level of Acuity

GP/MDT Clusters
Total Population 132,419
Each Cluster – 35-60,000

Ashford Rural Model and Impact

- Cluster level MDT working in place since late 2016
- Shared principles with Vanguard area of
  - regular multidisciplinary/ multi agency meetings
  - Identification of complex and vulnerable patients
  - Responsive care planning to maintain community care where appropriate
- Weekend urgent care response to avoid attendances at A&E
- Activity at month 6 shows reduction of 12.8% against contract baseline for the 5 frailty specialities combined.

Planned implementation of Local Care Integrated Case Management model to all localities

- Ashford CCG:
  - Ashford Rural Cluster ***In Place***
  - Ashford North Cluster ***December 2017***
  - Ashford Urban Cluster ***December 2017***

Implementation Progress

- Principles of Encompass Vanguard model agreed across Ashford CCG area and reflected in Kent and Medway Local Care model
- Detailed summary of maturity of each locality undertaken
- Detailed road map of roll out of full model undertaken per locality (ongoing)
- Detailed activity impact modelled per locality based on planned timelines

Implementation key milestones

- Ashford Rural/ Encompass MDT model to roll out to Ashford Urban and North Clusters with initial mobilisation in November 2017 and full implementation from January 2018.

- Ashford Clusters to mobilise integrated pathways in Catheter Care, Wounds Care and Aural Care in a cluster phased approach from January 2018.

Extended Access- Ashford

- Ashford CCG on track to deliver GPFV extended access across CCG in a phased approach by end 2018/19:
  - Development scheme in place to support practices
  - Enables Ashford practices to mobilise early with a phased approach, plan to achieve 25% of GPFV seven day access by March 2018.
  - Initial mobilisation across all three clusters planned for quarter 4 – go live achieved in December 17
  - Scaling up of provision planned to full delivery during 2018/19.

Frailty Implementation

- Rolling out integrated case management forms the core of the local delivery of frailty intervention across Ashford
  - Identification of patient with moderate and severe frailty
  - Planned care approach to anticipatory care planning and community MDT support
  - Reactive element to initiate rapid response and facilitate discharge from hospital
- East Kent wide frailty pathway implementation linked to locality deliver via a single strategic/ clinical steering group for key elements of pathway:
  - Clinical Support to Care Homes
  - Enhanced senior clinical workforce
  - Review of falls pathway
  - Planning digital solutions/ supports to pathway (use of PTL and telemedicine).

Tiers of Care Implementation

Planned local delivery (via Clusters) of Tier 1 and 2 elements of the East Kent Clinical Transformation Plans:

- Cardiology – Plan to implement T2 across Ashford & Canterbury areas from April 2018
- Rheumatology – decision re: EK procurement
- Dermatology - Triage process in place in Ashford, implementation.
- Respiratory

How is the integrated case management model is supporting the Frailty Pathway:

In the following ways;

- Been part of the **pneumonia pathway** work across east Kent, which went live on the 2/10/17 (attached). This has been extensively socialised with each GP, clinical leads and practice managers

- From Decemer 2017, **increasing numbers going through MDTs** – risk stratified per practice using programme to identify vulnerable and at risk patients,

- Working with all partners to have a **coordinated approach** with SECAmb, to avoid hospital admissions

- From Dec 2017 have implemented **extended hours** (as per our GPFV) creating capacity for extra consultations

- Part of the **urgent care pathway work** across east Kent, supporting GP pathway/access within Acute setting (to alleviate pressure on the Acute)

- Linking in with the **care home strategy**- supporting care planning, early identification of the deteriorating patient and training for staff

- Linking in **with New provider for OOHs/111**, as of Dec 2017 (existing provision has not met expected requirements).

Enablers

- Digital solutions: Common digital systems and solutions being used to support consistent working at scale and integration between organisations (EMIS clinical services, Local Care PTL development)
- Alignment of CCG resources to Local Care implementation to enable rapid roll out of successful models
- Development of Alliance working with Kent Community Trust to align all partner organisations and workforce to the model of care

Risks

- Enhanced Frailty Workforce Recruitment to deliver frailty implementation plan
- Primary Care workforce demands to deliver in hours, extended access, out of hours and support to emergency system
- Fragility of immature alliance partnerships
- Delay in NHS Digital procurement - support implementation of key milestones

Winter Preparedness Proposals– East Kent Initiatives

- Recommission 80 health & social care beds Dec-March
- Spot purchase 10 additional packages of care for dementia/challenging behaviour patients
- Extend length of rapid response package to 5 days
- Dedicated fast track hospice beds
- Dedicated nurse practitioner for care homes
- Expansion of Care Navigator service to community hospitals
- Health Navigators in secondary care to support self management
- Additional support for non weight bearing packages

NHS Ashford Clinical Commissioning Group
NHS Canterbury & Coastal Clinical Commissioning Group

Ashford CCG

Estates strategy and implementation plan

What did we do

We considered:

- CCG vision and strategic goals
- Population , health need and regeneration drivers for change
- Service drivers – five year forward view, vision for local care, local primary care ambitions
- Technological drivers
- Estate drivers

We then

- Sought to align Ashford growth strategy with individual practices
- Looked at current use patterns
- Looked to assess if there is sufficient capacity for primary and community care services in out of hospital settings
- Looked to improve access to effective care
- Ensure all premises meet minimum standards
- Maximise building potential for service delivery
- Consider technology use to facilitate patient care

What did we find

- Two buildings do not meet minimum standards (Hollington and Stanhope)
- 4 practices are at capacity
- A further 6 are close to capacity
- There is very limited capacity to allow for future primary care provision and for local care shift to be delivered

Primary Care investment

- Ashford Urban
  - Sydenham House Surgery
  - Musgrove Branch
  - Kingsnorth Medical Practice
  - Willesborough Medical Practice
  - Chilmington Green Development
- Ashford North
  - Sellindge Surgery
  - Wye Surgery
  - Kennington developments – possibilty of a new site
- Ashford Rural
  - Charing
  - Ivy Court
- Estimated capital costs (exc Chilmington and Kennington) £6million

Local care shift

- Assumed one hub per cluster
- No defined strategy to allow scope and size assessment

Possible solutions:

Generic

- Maximising void space
- Convert existing public sector assets to hubs
- Opportunities to co-locate healthcare services with other public sector bodies
- New build
- Construction is £3500 psm, running costs £700 psm

Ashford North

- Use of repurposed hospital estate
- Await Otterpool Park decision

Ashford Rural

- Use of East Cross clinic (void space)

Ashford Urban

- New build (site to be identified)
- Extend new provision at Chilmington
- Utilise S106 at key sites

Key challenges

- Changing growth scenarios
  - Maximising all sources of funding
  - Access to funds – capital and revenue
  - Maximising benefits of technology
- Communication and Engagement
  - Stakeholder management (in particular Ashford Borough Council)
  - Patient engagement
- Improving access to services
  - Increasing primary care capacity
  - Incentivising practices to deliver/work at scale
  - Co location of services
- Pressures on Primary Care
  - Demand on core primary care services
  - Workforce pressures
  - Incentivising practices to grow lists
- Out of hospital /local care strategy
  - No dedicated facilities for out of hospital care/local care
  - Tariff in acute includes a premises element – needs to shift with the services
  - Cross boundary issues/move to a single strategic commissioner

Sources of funds

ETTF is funding the Ivy Court extension but no other Ashford projects

Section 106 – work underway with LA to determine level of funds and conduct a source and application of funds review

NHS England capital which is subject to PID and business case processes and competes with schemes nationally

Private Finance which can be used to design, build and finance new premises

Landlord funds – we could approach landlords and ask them to fund extensions in return for increased rent

What we will do

- Vacate Inca House
- Provide new hubs for out of hospital services working with key partners
- Fill existing voids
- New primary care provision though extension of practices
- New Chimington Green premises
- Productivity reviews of key estate (e.g. St Stephens)
- PID and business case development needed
- Development of projects
- Construction management

Resources

Ashford (and Canterbury) CCG needs resources to:

- Lead implementation of strategy with stakeholders, support PID and business case development and procurement of schemes – access to finance
- Manage engagement with local authority and STP workstream
- Offer guidance to practices and support delivery
- Manage section 106 funding and drawdown
- Engage with residents and practice communities
- Manage hub delivery programme (design, build, finance and operate)

We consulted

- GP federation (Ashford Clinical Providers)
- All GP practices via Ashford estates group
- NHS England
- NHS Property Services
- Ashford Borough Council

Risks

- Lack of capacity to manage agenda
- National economy
- NHS funding
- S106
- Failure to get engagement from stakeholders
- Workforce
- GP providers closing lists
- GP aspire to take on local care but not open to increasing primary care – impacts on quality of core primary care provision
- Managing expectations – the premises cost directions limit what funds can be given to General Practice for premises developments