Date: **24 May 2017**
Our ref: **Thanet HWB/Supplementary Agenda**
Ask For: **James Clapson**
Direct Dial: **01843 577200**
Email: **james.clapson@thanet.gov.uk**

thanet district council

THANET HEALTH AND WELLBEING BOARD

25 MAY 2017

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 25 May 2017** in the Austen Room, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman); Hazel Carpenter, Councillor L Fairbrass, Councillor Gibbens, Clive Hart, Madeline Homer, Steve Inett, Mark Lobban, Sharon McLaughlin, Colin Thompson and Councillor Wells

SUPPLEMENTARY AGENDA

Item No	Subject
7.	**EAST KENT DELIVERY BOARD UPDATE** (Pages 3 - 10)

This page is intentionally left blank

East Kent
Delivery Board

Update from the meeting of the East Kent Delivery Board on 9 March 2017

About the East Kent Delivery Board

The East Kent Delivery Board has been set up by local health and care commissioners to spearhead the drive to determine how best to provide health and care services to the population of east Kent. Its work is part of the wider Sustainability and Transformation Plan (STP) for Kent and Medway.

Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board oversees a work programme and advises local health and care commissioners whose role it is to plan the future pattern of services across east Kent.

As of 17 November 2016, the East Kent Delivery Board has a new and formalised role within the governance structure of the Kent and Medway STP. This allows the Board to build on the work it has done at an east Kent level with colleagues in health and social care across Kent and Medway.

The hospital care workstream

There was a detailed update from the Kent and Medway hospital care workstream, for members of the EKDB to have the opportunity to fully understand and discuss the emerging acute hospital model in east Kent as part of the east Kent transformation work.

A similar presentation had been given that morning to the South East Clinical Senate by the Kent and Medway STP Clinical Board Co-Chairs and the Medical Director of EKHUFT; giving progress to date on the development of the emerging clinical model and service templates that have been designed by the hospital workstream and clinicians across Kent and Medway.

There was a presentation, including from consultants in stroke and elective orthopaedics leading this work. There was discussion around the draft service templates in the areas of:

- acute medical care
- emergency care
- elective orthopaedic care
- stroke care
- vascular care

Each draft template carries significant detail and describes for that specialty:

- The population being served
- Which particular issues from the Case for Change evidence need to be addressed
- The current service model
- A proposed service delivery model for the future (ie a future patient pathway)
- The co-dependencies and building blocks that need to be identified to deliver a new model
- The engagement that has taken place thus far around the emerging thinking for that model.

East Kent
Delivery Board

Just as an example the following describes, through a fictional patient story from the presentation, the impact of the current model of care vs the impact of the future proposed model for acute medical care, particularly around frailty.

Service delivery model – patient story: frailty
Douglas is a 74 year old gentleman. He lives with his devoted wife in their family home. He has recently taken to his bed finding little energy or interest to participate in activity. His walking has become erratic and unsteady. His GP has called in a few times recently for injuries from falls.
What can happen now to some patients: • Douglas has seen his GP who is very keen that he attends the falls clinic. Douglas is less keen. • Whilst being helped out of bed on Friday Douglas falls as his legs give way. His wife dials 111; following assessment a paramedic crew brings him into the Emergency Care Centre (ECC). Douglas arrives at 11am, and waits for a nurse and junior doctor review. • As his time approaches 4 hours, he is placed in a bed on the Clinical Decisions Unit; he is 74 years old, so is admitted under the general physician on-call, not the cconsultant geriatrician. • The consultant physician on-call happens to be a specialist respiratory physician and he is called to see a patient who requires a chest drain. This takes him away from his ward round. He returns to review Douglas at 4pm. No clear cause for the fall is found and Douglas is deemed to be medically fit for discharge. • He is referred to the Integrated Discharge Team (IDT) at 5pm. Following assessment, they attempt a bed transfer. As Douglas has lain in bed all day, it is deemed unsafe; he is admitted into the hospital to the frailty ward and seen by the consultant over the weekend. • By Monday (Day 3), Douglas is delirious. Later the ward pharmacist discovers Douglas has been taking Diazepam for years but this has been omitted from his drug chart since day of admission. Part of the delirium is attributed to sudden benzodiazepine withdrawal. • Sadly, his delirious state worsens and results in a further in-hospital fall on Day 5. • By Day 7, it is clear that Douglas' delirium is unlikely to settle quickly. His level of mobility cannot be supported in his own home with care provision to support his wife. Therefore, he is referred to a community step-down bed for a prolonged period of rehabilitation.
What might happen in the future: • Douglas is taken to the Acute Medical Unit (AMU) after he falls. • He is assessed as being frail by the clinical streaming nurse who communicates this to the team on AMU. In spite of his age, he is placed under the care of the on-call geriatrician due his frailty needs. This triggers an urgent IDT review and an immediate medications reconciliation. • The IDT recognise that Douglas is at risk for frequent falls through deconditioning and balance issues. They discuss the provision of equipment to support safe living within a micro-environment. They also arrange an immediate twice daily package of care to facilitate a safe discharge. The IDT

provide Douglas' wife with details of carer support to prevent carer burden.
• During the medications reconciliation, the pharmacist notices that Douglas was previously on Diazepam and ensures that this is correctly prescribed. The need for Diazepam is reviewed and a withdrawal regimen is agreed with the GP after Douglas has returned home.
• Douglas is seen by the frailty consultant at 10am. A comprehensive geriatric assessment is performed. Medication changes are made. An assessment of mood is done and it is agreed that Douglas' apathy is probably related to depression for which he is happy to accept treatment. In addition, advanced care planning is discussed. Douglas does not wish to be resuscitated and this is documented on the agreed form. He expresses a wish for future treatment to be carried out in his own home. This is communicated to the GP via the discharge notification.
• With all the equipment in place and the carers to arrive for their first visit at 4pm, Douglas is discharged home safely with his wife at 2pm.

Source: EKHUFT

Members were asked for any additional feedback as the templates are further developed over the coming weeks. There was a discussion about ensuring, and doing more to extend, the reach of clinical engagement – both out to GP members and more widely within clinical leadership teams within provider organisations. The hospital workstream team agreed to continue building on ongoing work, and CCG AOs and Clinical Chairs supported facilitating detailed discussions around the templates and emerging models with GP colleagues.

Update on Kent and Medway critical path/timeline

It was acknowledged that there was still quite considerable work to do to align various elements of the critical path towards formal consultation later this year. One key area of current focus is ensuring that governance structures for consultation are in place i.e. ensuring that the CCGs (who are the bodies with the statutory duty to decide on and lead any consultation) are able to take a decision in common through some sort of joint committee, or committee in common, or similar arrangement, and that this meets constitutional requirements for each CCG. There are four potential options around governance arrangments for consultation that the Governing Bodies in east Kent are currently discussing and considering. This is specifically about joint governance arrangements for consultation decision-making only.

The commissioning transformation workstream

There is work underway, as part of the Kent and Medway future plans for health and social care, to look at how commissioning should be developed in the future. There is broad acknowledgement amongst health and social care leaders in the area that it would be advantageous to have a strategic commissioning function across Kent and Medway, working with and aligned to a number of local accountable care type organisations. A workstream has been set up to explore this further.

East Kent
Delivery Board

NHS

Listening events report

Four listening events were held across east Kent in February 2017. They were specifically to update people on developments in local care – how things are now compared to how they used to be, but also what the ambition for the future is in terms of more joined-up care delivered closer to home for people, and to gather feedback on that – and to seek views on the draft evaluation criteria developed by the hospital care workstream.

A headline report was given to the East Kent Delivery Board outlining the key themes and issues raised in feedback from the events. Slides from the events can be found at www.eastkent.nhs.uk. A full report will be published in due course.

The Board also received updates from the IT, Finance, Communications and Engagement workstreams, and from the last Patient and Public Engagement Group meeting. They received local care locality reports from across east Kent. The Canterbury and Coastal CCG lay member attended the Board as Chair of the Patient and Public Engagement Group as a full member.

For more information about the work of the East Kent Delivery Board visit: http://eastkent.nhs.uk/

Ends

Transforming health and social care in Kent and Medway

Kent and Medway Sustainability and Transformation Partnership: Programme Board Meeting Update, April 2017

About the Kent and Medway Sustainability and Transformation Partnership and Programme Board

The Kent and Medway Sustainability and Transformation Partnership has been set up by local health and social care leaders. We are spearheading the drive to determine how best to encourage and support better health and well-being, and provide improved and sustainable health and social care services, for the population of Kent and Medway into the long-term. The Partnership is a collaboration of all NHS organisations across Kent and Medway, Kent County Council and Medway Council; all of whom are involved in the planning and delivery of health and social care services.

You can read the Kent and Medway Sustainability and Transformation Plan, published in November 2016, at www.kentandmedway.nhs.uk/stp. You can read the Kent and Medway Case for Change, published in March 2017, at www.kentandmedway.nhs.uk/stp/caseforchange.

The Kent and Medway STP Programme Board is an advisory board with a non-affiliated Chair. This means the Chair is not linked to any single NHS or local authority organisation and so can ensure the Programme Board works for the good of the whole Kent and Medway population. You can find out who is on the Programme Board on our website. The Board oversees the Sustainability and Transformation Partnership work programme and advises local health and social care commissioners, whose role it is to plan services across Kent and Medway.

The Kent and Medway STP Programme Board meets monthly. This update provides an overview of what was discussed at the most recent meeting.

Update from the Programme Board meeting held on 24 April 2017

Workstream progress

The Board received an overview of how each of the programme's ten workstreams is progressing, following recent detailed discussions between the workstream leads, and the core programme management team. These discussions focused on the aims and objectives of each workstream, their progress against agreed workplans, resourcing requirements, and current risks and issues. The Programme Board agreed there needed to be further detailed discussion about the priorities and resourcing requirements across the workstreams; acknowledging there would need to be some prioritisation and not everything could be done at once. Join-up between the workstreams was raised; acknowledging that the 'enabling' workstreams (digital, workforce, estates) needed a clearer brief and more detail from the 'transformation' workstreams (prevention, local care, hospital care, mental health) about what support those workstreams need from the enabling functions and by when.

The Kent Integrated Dataset (KID) was referenced as an important resource as the workstreams' plans progress. (The Kent Integrated Dataset links routinely collected administrative patient activity and cost data in an anonymised way from almost all NHS providers across Kent and many non-NHS organisations, as well as from social care). The Programme Board agreed that this should now

be managed as a system-wide tool, including ensuring the right governance was in place for this across both NHS and local authority organisations.

CCG governance for joint decision-making

The Board heard how all eight CCGs across Kent and Medway are making progress on agreeing how they could put in place an effective governance infrastructure for any joint decision-making needed to allow them to publicly consult on any service changes. Creating a governance infrastructure to allow joint decision-making will require changes to be made to some CCG constitutions. This has a lead time that is feeding into the programme's overarching timeline. Any new governance infrastructure will allow the CCGs to take joint decisions on agreed issues (such as service change across a shared geography); it will not be for all aspects of CCG business.

Longer term commissioning transformation

Leaders in both commissioning and provider organisations generally agree there should be a strategic commissioning function for Kent and Medway (with a role focused on strategic planning, resource allocation and commissioning those services which serve a large population and operate on a Kent and Medway-wide basis), working alongside local commissioning for local populations – through local accountable care systems. The commissioning transformation workstream has been set up to look at this in more detail. The Programme Board discussed how there were areas of complexity to work through, for example, exactly how NHS England specialist commissioning, local authority commissioning, and day-to-day NHS commissioning could be better integrated and work in practice; and how best to define and identify appropriate accountable care systems for Kent and Medway.

Hospital care workstream

The Programme Board received an update on the hospital care workstream. The Programme Board has previously recommended that there should be an initial phase of work to address challenges in acute services and elective orthopaedics in east Kent, and stroke and vascular services across the whole of Kent and Medway. Discussion was focussed on quality improvements and clinical outcomes, workforce sustainability, financial affordability and ensuring join-up between the hospital care workstream and the local care workstream. This latter point was seen as critical, so that by the time CCGs consult on any service changes a detailed picture can be described for people about where and how they could receive services in the future, and how that may differ to now. There was a discussion on the availability of capital and whether that had been fully examined in terms of developing the options available for the future provision of services. It was clear that conventional (government) sources of capital were not readily available – particularly in terms of the scope and scale of any new build – current benchmarking indicates costs would be around £750 million to £1 billion. Other sources of capital would take longer than five years to prepare and implement, so whilst nothing is ruled out at this stage, nor for the longer term, action does need to be taken imminently to create sustainable services for the immediate and medium-term future for local people. There was a discussion around the 'evaluation criteria' that the hospital workstream has developed to help it define realistic options for service configuration. These have been tested over recent months in meetings with clinical colleagues and stakeholders, and with members of the public through a series of public listening events.

Recruitment update

Advertisements were placed in March for a full-time Senior Responsible Officer/CEO for the Kent and Medway transformation programme, and for a Director of Commissioning Transformation. Interviews for these posts will be held in May. There has also been a good response to programme

management office roles that have recently been advertised, with approximately 130 applications received.

For more information about the work of the Kent and Medway Sustainability and Transformation Partnership please visit www.kentandmedway.nhs.uk

Ends

This page is intentionally left blank