East Kent
Delivery Board

NHS

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.

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.

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