NHS
West Kent
Clinical Commissioning Group

Sustainable and transformed health for West Kent
March 2017

Challenges for the NHS and social care

- More people need care
- People need more care
- Expensive advances in treatment
- Tight budgets
- Short of staff
- Quality of care not always good enough

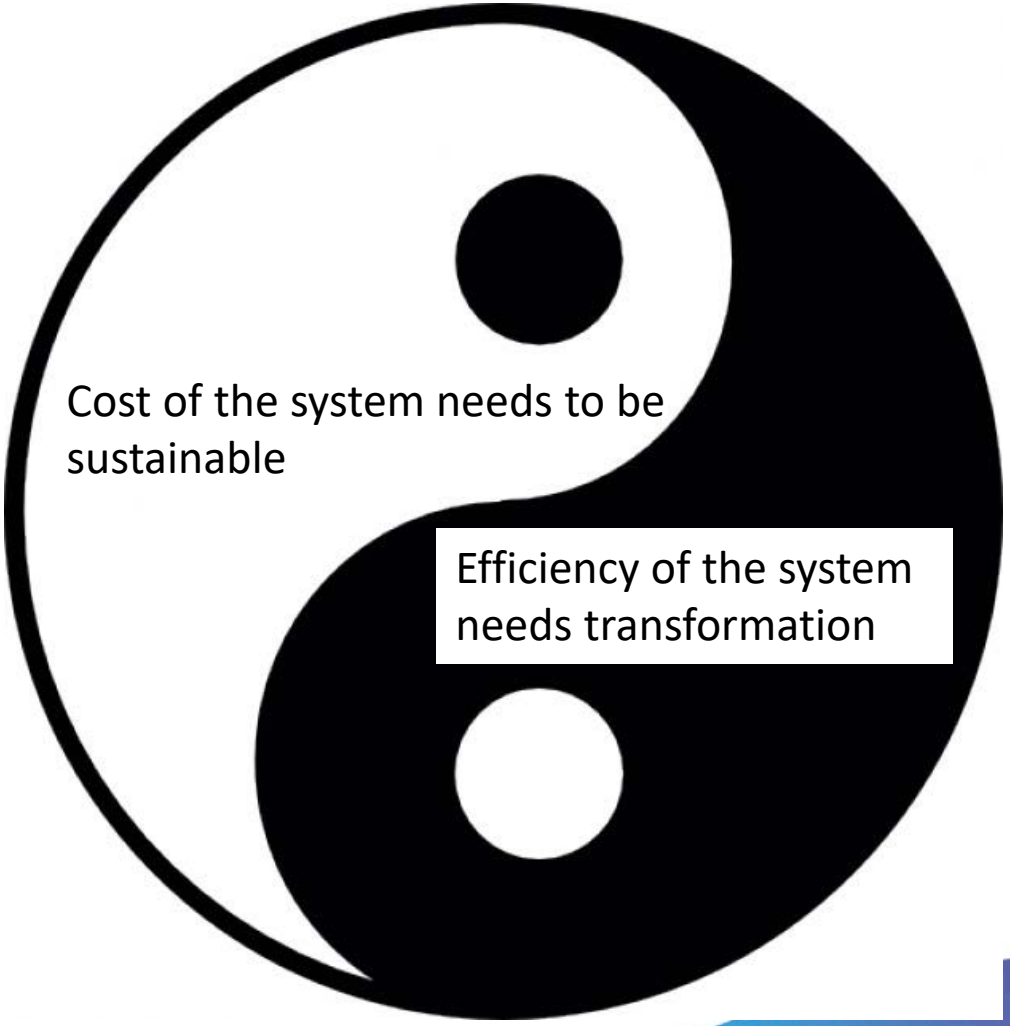
It's not just us

Everywhere across the country the NHS and social care needs to:

- Prevent ill-health
- Work together better
- Work differently
- Eliminate duplication and waste.

Hence Sustainability and Transformation Plans.

What are we trying to achieve?



Local plans to address local challenges

- We have been talking with you about changing care over the last four years, since “Mapping the Future”.
- Kent and Medway **Sustainability and Transformation Plan** published in November 2016 on all CCG websites.
- All NHS and social care organisations are working together
- We have four priority areas: Prevention; Local care; Hospital care; Mental health

How will we achieve this?

What you have told us

You like the idea of more local care with a team to meet patients' needs

You want:

- continuity of care
- advice quickly especially at night
- reliable appointments and phone consultations
- range of services in GP practices.

60-75% of people try to eat well but accept the need to be more active and manage their weight.

STP Care Transformation workstreams

Prevention	Enlisting public services, employers and the public to support health and wellbeing
Local Care	A new model of care closer to home for integrated primary, acute, community, mental health and social care
Hospital Care	Optimal capacity and quality of specialised, general acute, community and mental health beds
Mental Health	Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Local Care

- GP practices co-operating
- Doctors, nurses, therapists, mental health, social care, voluntary sector working as a team
- Hubs providing care currently at acute hospitals
- Emphasis on prevention: every contact counts, everyone has a part to play.

Key elements of the complex frail, elderly care model

1	Care and support planning with care navigation and case management
2	Self care and management
3	Healthy living environment
4	Integrated health and social care into or coordinated close to the home
5	Single point of access
6	Rapid response
7	Discharge planning and reablement
8	Access to expert opinion and timely access to diagnostics

Supporting people to be healthy and independent

Coordinated care for people who need it

Supporting services

Past, present and future

Mr and Mrs C

Their problems

Mr C, 88

- COPD (emphysema)
- Type 2 diabetes
- Osteoarthritis of his knees

Mrs C, 82

- Moderate dementia

Today's problem

- Mr C is **short of breath** and has used 'rescue meds'
- Asking for a **home visit**
- **Mrs C distressed** by Mr C being unwell
- He can't care for them both at home
- He is **scared**.

What happens next?

Past

Visited by GP in the afternoon

Mr C admitted to hospital

Mrs C admitted to hospital and then residential home for respite

Present

Triage by GP

Visit by GP/ paramedic / community nurse by mid morning

Local Referral Unit – multiple sources of help

Mrs C to dementia drop-in

Future

Planning in advance by care co-ordinator/ specialist nurse

Possibly, IV antibiotics at home

All key staff can access notes