Medway COUNCIL
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# Health and Wellbeing Board – Supplementary agenda no. 2

**A meeting of the Health and Wellbeing Board will be held on:**

| | |
|---|---|
| **Date:** | 15 March 2016 |
| **Time:** | 4.00pm |
| **Venue:** | Meeting Room 2 - Level 3, Gun Wharf, Dock Road, Chatham ME4 4TR |

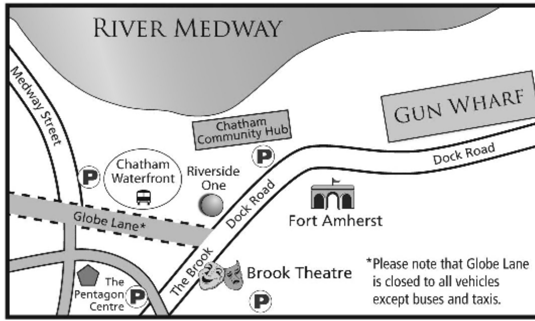
## Items


| | | |
|---|---|---|
| 9 | **Sustainability and Transformation Plan Update**<br><br>This report updates the Board on the development of the Medway CCG Sustainability and Transformation Plan. To Follow. | **(Pages 3 - 40)** |



**For further information please contact Stephen Platt, Democratic Services Officer on Telephone: 01634 332011 or Email: democratic.services@:medway.gov.uk**


**Date: 10 March 2016**

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A summary of this information can be made available in other formats from **01634 333333**

If you have any questions about this meeting and you want to speak to someone in your own language please ring **01634 335577**

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| বাংলা | 331780 | ગુજરાતી | 331782 | ਪੰਜਾਬੀ | 331784 | کوردي | 331841 | اردو | 331785 | Русский | 332374 |
| 中文 | 331781 | हिंदी | 331783 | Polski | 332373 | এহ্ৎশফব | 331786 | فارسی | 331840 | Lietuviškai | 332372 |

Agenda Item 9

# HEALTH AND WELLBEING BOARD

## 15 MARCH 2016

## MEDWAY CLINICAL COMMISSIONING GROUP – SUSTAINABILITY AND TRANSFORMATION PLAN


Report from: Caroline Selkirk, Interim Chief Operating Officer, Medway CCG

Author: Anthony Ford, Programme Management Office (PMO) Manager, Medway Clinical Commissioning Group



**Summary**

This report updates the report provided to the Health and Well Being Board on the 4 February 2016.

National Health Service England (NHSE) has requested the health and care systems come together and create a Sustainability and Transformation Plan (STP). This plan will cover the period between October 2016 and March 2021.

A meeting was held between the CCG and Councillors to discuss how we jointly ensure that the issues and priorities which are important for Medway are articulated in the STP discussions.

A local Medway and Swale Strategy Group has been established and is currently meeting fortnightly. The Group are facilitating joint working between local partners in implementing change within Medway and Swale as well as informing the STP discussions.

This group includes representatives from Medway Council and is chaired by the CCG.

The STP Plans, including activity and finance, were agreed and submitted to NHS England on the 29 February. These were at a Kent and Medway level with sub divisions which are:

i. West (West Kent CCG)

ii. North East (Medway CCG and Swale CCGs)

iii. North West (Swale CCG and Dartford, Gravesham and Swanley CCG)

iv. East Kent (South Kent Coast, Thanet, Ashford and Canterbury and Coastal CCGs)

## 1. Budget and Policy Framework

1.1 This report is for information only.

1.2 The Chairman has agreed to accept this report as an urgent item because of the need to meet NHS England deadlines. It could not be despatched with the main agenda as discussions on the way forward were ongoing and sufficient time was needed to draft the report

## 2. Background

2.1 The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

• NHS England (NHSE)

• NHS Improvement (Monitor and the NHS Trust Development Authority)

• Health Education England (HEE)

• The National Institute for Health and Care Excellence (NICE)

• Public Health England (PHE)

• Care Quality Commission (CQC)

2.2 The six national NHS bodies have set a clear list of national priorities for 2016/17. Clinical Commissioning Groups are required to contribute to a five year Sustainability and Transformation Plan (STP), which is place based and drives the Five Year Forward View. Also, to produce a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

2.3 The STP Plan will:

- Enable place-based planning (partnerships and whole system working)
- Secure the earliest additional funding from April 2017 onwards
- Co-create new models of care (e.g. Primary Care, urgent care, maternity, and specialised care)
- Demonstrate strength and unity of local system partnerships with clear governance structures
- Address prevention of illness through closing the gap in health inequalities
- Empower patients (e.g. personal health budgets)
- Engage communities (e.g. carers and volunteers)
- Provide a clear sequence of implementation actions

## 3. Risk management

3.1 Risk assessments, with mitigating actions, will be undertaken once the STP has been approved by NHS England in April 2016.

## 4. Consultation

4.1 Regular meetings have been established with local health providers and Medway Council to collaboratively deliver the STP.

4.2 Engagement with GPs to discuss and develop the principles and actions of the STP, have taken place with further activities planned in March and April.

## 5. Financial implications

5.1 These will be articulated as further information becomes available.

## 6. Legal implications

6.1 The Health and Wellbeing Board has a statutory obligation under section 195 Health and Social Care Act 2012 to encourage persons who arrange for the provision of any health or social care services, to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in Medway. Supporting the development of a Sustainability and Transformation Plan is therefore within the remit of the Health and Wellbeing Board. However should there be a requirement within the Plan for any commitment to the use of Council resources or action by the Medway Council, decisions to that effect would need to be taken by either the Council, the Leader and Cabinet or the relevant Director (under delegated authority).

## 7. Recommendation

7.1 The Health and Wellbeing Board is asked to note this report.

**Lead officer contact**


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Tel: 01634 335171


**Appendices**

Appendix 1 Developing Sustainability and Transformation plans to 2021 NHS England Letter

Appendix 2 Development of the Kent and Medway Sustainability and Transformation Plan Issued v4

**Background papers**

Delivering a Forward View, NHS Planning Guidance 2016/17 – 2020/21
https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

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To: CCG Accountable Officers,
Chief Executives of NHS trusts,
NHS foundation trusts and Local
Authorities and LETB Geographical
Directors

**By email**

16 February 2016

Dear colleague

**Re: Developing Sustainability and Transformation Plans to 2020/21**

The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV). Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

We have been encouraged by the speed and enthusiasm with which most areas have already come together to agree their footprints and start the conversations. The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

If we get this right, then together we will:

- engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS;
- develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the 5YFV (health and wellbeing, care and quality, and finance and efficiency);
- mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver;
- provide a better way of spreading and connecting successful local initiatives, providing a platform for investment from the Sustainability and Transformation Fund; and

- develop a coherent national picture that will help national bodies support what local areas are trying to achieve.

This will require a different type of planning process – one that releases energy and ambition and that focusses the right conversations and decisions. It will require the NHS, at both the local and national level, to work in partnership across organisational boundaries and sectors.

This letter sets out our initial thinking on STPs – please see **Annex A** for further detail. We recognise that you and your teams are also working hard on operational plans, so over the next few weeks and months we will develop an active programme of support for our local and national teams, based on what you tell us you need.

We look forward to continuing to work closely with you to deliver this important work.

Yours faithfully

**David Behan**, Chief Executive, Care Quality Commission
**Ian Cumming**, Chief Executive, Health Education England
**Sir Andrew Dillon**, Chief Executive, National Institute for Health and Care Excellence
**Jim Mackey**, Chief Executive - Designate, NHS Improvement
**Duncan Selbie**, Chief Executive, Public Health England
**Simon Stevens**, Chief Executive, NHS England

NHS

**Annex A**

**Stage 1: Before Easter – developing local leadership and collaboration**

1. To have a realistic prospect of developing good plans by the summer, we will need to have agreed three things for each of the STP footprints by Easter:

   (i) the governance arrangements and processes needed to produce an agreed STP and then to implement it;
   (ii) the scale of the challenge locally for each of the three gaps; and
   (iii) key priorities identified to address each gap.

2. **Governance arrangements**: Building the relationships and collective leadership needed to make STPs real will take dedicated time, effort and resource. Different areas will be at different starting points. In some areas, local leaders are already working together on established transformation projects. In other areas, relationships and strategies are less mature, requiring intensive focus in the early stages.

3. Each footprint will need to set out governance arrangements for agreeing and implementing a plan. This should include the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG Chief Officer, a provider Chief Executive or a Local Authority Chief Executive. They will be responsible for convening and chairing system-wide meetings and facilitating open and honest conversations that will be necessary to secure sign-up to a shared vision and plan. We would expect to see time and resource dedicated to this system leadership role.

4. STPs will need to be developed with, and based on the needs of, local patients and communities and command the support of clinicians, staff and wider partners. We therefore anticipate robust plans for genuine engagement as part of the decision making process. This doesn't mean beginning from scratch. Where relevant, areas should build on existing engagement through Health and Wellbeing Boards and other existing local arrangements. Health Education England has agreed that they will establish a local Workforce Advisory Board to coordinate and support the workforce requirements for each STP footprint.

5. **The scale of the challenge:** Partners in each footprint area will need to quickly get a sense of the scale of the forecast challenge in their local area, by working out the extent of the three gaps. To accelerate this process, we will provide a method with data to enable local partners to diagnose current and projected gaps in health and wellbeing, care and quality and finance and efficiency, including current and expected delivery on key service priorities such as cancer and seven day services. We will publish more detail on this during the week commencing 29 **February 2016**.

6. **Identify key priorities:** An assessment of the three gaps, alongside a consideration of local challenges where patients and populations need to see most improvement, will help each area to identify the key priorities they need to tackle over the next five

years to achieve sustainable transformation. Where, for example, Vanguards and Integrated Care Pioneers are leading the transition to new care models, local leaders will want to set out how the learning from these can be applied in the coming years.

7. There is clearly a lot to do in a short space of time. To help support local and national learning, each footprint will be asked to attend one of four regional 'development days' to share their emerging thinking with one other and with the Chief Executives of the national bodies. This will help us to identify further areas for support and shape the next stage of the process. Ahead of these regional 'development days' we will ask each planning footprint to make a short return on the above three issues (governance, gap analysis and key issues).

8. **National support until Easter:** By March, we will provide each local system with:

   - **Input into assessing each of their three gaps** – this will set out the key health and well-being outcomes the NHS and partners need to improve by preventing illness, diagnosing disease earlier and treating it more effectively; the quality improvement and service change priorities by 2020, such as moving to seven day services and (by the end of March) provide each area with analytical support to help assess its financial gap.
   - **Share information and provide support –** based on what you tell us you need and using some of the tools that Vanguards and other collaborations have found useful as they have developed new systems and relationships. This will include using logic models as a basis for longer-term planning, and information about the core components of the different care models (e.g. multi-speciality community providers (MCPs) and primary and acute care systems (PACS) or devolved arrangements).
   - **Publish advice on engaging individuals, communities and staff** – drawing on exemplar practice from the service and partners and the 'six principles' developed by the People and Communities 5YFV Board.

   In addition we will:

   - ask our regional teams and partners to support the process of building local leadership and effective decision-making, sharing what we've learned from working with, for example, Vanguard sites and others through communities of practice;
   - work with you to identify and enlist a group of respected individuals who have the experience and credibility to mentor and catalyse system leadership where it is needed. This could include people with experience of health leadership roles, as well as local government and the voluntary sector. We will make this offer to all local areas that would benefit from individual support to accelerate progress; and
   - share some further tools, templates and guidance along with some exemplars to support local development of returns. For example we will work quickly with a small number of leading systems as they develop their plans to provide models for what good Easter returns and June plans look like and make these available to everyone.

**Stage 2: after Easter – developing the STP**

9. After Easter, local area partners will be able to focus on more of the detail of their plans and the actions required to close the three gaps over the next five years. To do this, they should consider their response to the set of questions outlined in the annex to the Shared Planning Guidance, given the results of their gap analysis and continuing engagement with local communities, staff and other partners.

10. The Shared Planning Guidance sets out nine 'must dos'. Many, if not all, of these will require action beyond 2016/17. A good STP will therefore set out how areas will maintain and deepen the progress they will make by implementing their operational plans. This is one tangible way in which 2016/17 operational plans need to be closely linked to STPs, and conceived as the first steps on the way to wider transformation.

11. Strong STPs will set out a broader platform for transforming local health and care services. We will work with the footprints to help us develop the detailed requirements. However, as a minimum, we expect that all plans will:

- describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people;
- increase investment in the out-of-hospital sector, including considering how to deliver primary care at scale;
- set out local ambitions to deliver seven day services. In particular: (i) improving access and better integrating 111, minor injuries, urgent care and out-of-hours GP services; (ii) improving access to primary care at weekends and evenings; and (iii) implementing the four priority clinical standards for hospital services every day of the week;
- support the accelerated delivery of new care models in existing Vanguard sites; or in systems without Vanguards, set out plans for implementing new models of care with partners;
- set out collective action on quality improvement, particularly where services are rated inadequate or are in special measures;
- set out collective action on key national clinical priorities such as improving cancer outcomes; increasing investment in mental health services and parity of esteem for mental health patients; transforming learning disabilities services; and improving maternity services;
- ensuring these and other changes return local systems to financial balance, together with the increased investment that will come on-stream as set out in NHS England's allocations to CCGs; and
- be underpinned by a strategic commitment to engagement at all levels, informed by the 'six principles'.

12. We must avoid creating distinct plans for each specialty or initiative, and instead grasp the opportunity to achieve greater alignment and coherence between programmes and priorities. Local leaders will also want to ensure that their plans are underpinned by action on the key enablers of change, including harnessing technology and workforce redesign, working closely with their Local Education and

Training Boards (LETBs). Local areas should also have considered the fit between their STP footprint and their local plans for integrated health and social care more broadly, and decided on the high-level model of person-centred, coordinated care that they would look to develop.

13. The aim should be to produce an STP that is based upon strong analysis and insight rather than a glossy brochure. The process of exposing these issues and having real conversations about the potential benefits for patients is as least as important as the final product itself. A robust process will enable STPs to set out the actions that will make a difference for local people rather than abstract principles or vision statements. The examples we publish at Easter will give local areas a better sense of what a good final document looks like, but we are clear that a good process is one that unleashes energy, facilitates real conversations and strengthens local relationships around a shared sense of purpose.

14. **National support after Easter:**

- In April and May, we will host a programme of regional workshops and webinars with subject matter experts to provide practical help with developing plans. We will continue to make available online collaborative tools so that local areas can share information and examples of emerging best practice, based on what you tell us would be most helpful.
- These will be supplemented by a suite of 'how to' materials so that we can develop a shared understanding of what good looks like on topics including implementing the Cancer and Mental Health Taskforce reports, developing and spreading new models of care, workforce redesign and planning for interoperability and digital services.
- Our regional teams and their partners will continue to work closely with local footprints as they develop the detail of their plans, to enable effective communication and learning across the system.

**Sustainability and Transformation Funding**

15. There will be tangible benefits for areas with good STPs. The Spending Review settlement enabled us to invest £2.139bn in a Sustainability and Transformation Fund in 2016/17. Of this total, £1.8bn of funding has been allocated to the sustainability element of the fund to bring the NHS provider trust sector back to financial balance.

16. Quarterly release of sustainability funds to NHS trusts and NHS foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. It is not a case of recovery followed by transformation. They are not alternatives; we must do both simultaneously.

17. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign-off of a robust STP during 2016/17.

18. The Sustainability and Transformation Fund will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21, with an increasing share of the growing fund being deployed on transformation.

19. The STPs will become the single application and approval process for being accepted onto programmes with transformation funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

20. Recognising that different systems are at different starting points, the most credible and compelling STPs will secure the earliest funding. We will assess plans in July, and – as the Shared Planning Guidance sets out – we will consider:

   - the quality of plans, particularly the scale of ambition and track record of progress already made in addressing each of the three gaps. The best plans will have a clear and powerful vision across health, quality and finance, owned by all local partners in the system. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new models of care; trusts in special measures and finance. They will systematically borrow good practice from other geographies and adopt national frameworks;
   - the reach and quality of the local process, including community and voluntary sector engagement;
   - the strength, maturity and unity of local system leadership and partnerships, with clear governance structures to deliver them;
   - how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities; and
   - the extent to which systems can already point to tangible, early progress.

21. Part of this process will involve a second series of regional events hosted by the Chief Executives of the national bodies. Taking place in July, these regional summits will be an opportunity to test the plans that local systems have submitted, and agree the actions we will take to deliver them.

22. **Contacts:**

For any queries, please contact the Regional Director from the relevant national body in the first instance or please email england.fiveyearview@nhs.net.

23. **Key Dates:**

| What | Who | When |
|---|---|---|
| Further engagement and support on gap analysis and STP development | National bodies | Week commencing 29 February 2016 |
| Gap analysis / data developed with each footprint | National bodies / Regional Directors / footprints | Throughout March 2016 |
| Short return, including | Each footprint | 11 April 2016 |

| | | |
|---|---|---|
| priorities, gap analysis and governance arrangements | | |
| Outline STPs presented | Footprints to attend regional events to discuss emerging plans with peers and national bodies | w/c 22 April 2016 |
| Each footprint area to develop plans and build support with their boards and partners | As set out in local governance arrangements | During April/May/early June 2016 |
| Ongoing engagement and support from national policy experts and teams to support priority development | National policy teams and experts | During April and May 2016 |
| Each footprint to submit their STP | To Regional Directors and then the 5YFV Board of national body Chief Executives | 30 June 2016 |
| Series of regional conversations between national teams and footprints | The NHS national body Chief Executives, National Directors, partners and footprints | Throughout July 2016 |

# Appendix 2

# Development of the Kent and Medway Sustainability and Transformation Plan

# Initiation Document

Document Control

## a. Document Identification

| **Programme** | Development of the Kent and Medway Sustainability Plan |
|---|---|
| **Author(s)** | M. Ridgwell |
| **Version** | 1.0 |
| **Status** | Draft |
| **Last updated** | 22/02/16 |
| **Approved by** | Subject to approval |
| **Distribution** | CCG AOs, K&M provider CEs, NHS England |

## b. Document History

| Version | Date | Status | Author | Comment / Changes from Prior Version |
|---|---|---|---|---|
| 1.0 | 22/02/16 | Draft | M. Ridgwell | First full draft |
| 2.0 | 24/02/16 | Draft | M. Ridgwell | Second draft |
| 3.0 | 25/02/16 | Draft | M. Ridgwell | Third draft |
| 4.0 | 9/03/16 | Draft | M. Ridgwell | Draft four |
| | | | | |

## c. Document Reviewers/Approvers

| Name | Position / Department / Organisation | Reviewed |
|---|---|---|
| R. Jones / D. Stock (initial comments) | EKUHFT / DGS & Swale CCGs | 24/02/16 |
| CCG AOs / L. Sheridan (Initial comments) | CCGs / MFT | 25/02/16 |
| Misc | Misc | 07/03/16 |
| | | |

## Document Purpose and Scope

This document outlines the governance arrangements for developing the Kent and Medway STP and the outline structure of the plan.

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## INTRODUCTION

1. Kent and Medway have a range of well developed operational system leadership arrangements at a local level. There are also other arrangements supporting the strategic planning for acute care (A21/229 corridor and East Kent Strategy Board), the Kent and Medway Urgent and Emergency Care Network and the Executive Programe Board in North Kent. Stakeholders in Kent and Medway have agreed to implement an overarching Sustainability and Transformation Plan (STP) based on the Kent and Medway geographical footprint but this arrangement will be complimentary to the planning arrangements that are already in place.

2. This document outlines the governance arrangements for developing the Kent and Medway STP and the outline structure of the plan. The principle objectives of the Kent and Medway STP governance structure is to:

    - develop a Kent and Medway STP that delivers the best possible health and social care for the local population, within available resources, and meets the requirements of national planning guidance (including the nine 'must dos' – see Attachment 1);
    - consolidate local plans to aggregate these at a Kent and Medway level (including supporting local health and social care systems to develop a consistent structure for the production of local plans);
    - ensure links and consistency with Better Care Fund plans and the newly formed Sustainability and Transformation Fund (STF);
    - to agree those projects and initiatives / strategies that need to be progressed at a Kent and Medway level (and conversely those areas that are being progressed locally); and
    - establish a planning arrangement to ensure the successful delivery of the Kent and Medway initiatives / strategies.

3. In terms of developing the STP the principle of subsidiarity will be adopted. Attachment 2 gives further consideration to the types of services that will be planned at different levels. Wherever possible and appropriate planning will take place at as local a level as possible, with cross-area planning focusing only on those issues that cannot be planned by individual CCGs or local CCG collaboratives. Even with regard to local plans there will be a need to aggregate intentions to present these at a Kent and Medway level, therefore, the intention is to ensure local plans cover certain core content against defined headings to support this aggregation. The intention is that as well as presenting aggregated information, the STP would also include a summary of local plans against the following footprints:

i. West (West Kent CCG)

ii. North East (Medway CCG and Swale CCGs)

iii. North West (Swale CCG and Dartford, Gravesham and Swanley CCG)

iv. East Kent (South Kent Coast, Thanet, Ashford and Canterbury and Coastal CCGs)

4. Swale CCG is sitting in two footprints to reflect the complexity that:
   - for social care, and to support the health and social care integration agenda, Kent County Council have organised their business units into North Kent unit (DGS/Swale), East and West Kent; and
   - in relation to planning around acute care Swale residents largely look to Medway Foundation Trust.

## BACKGROUND

5. The national planning guidance, Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (NHS England, December 2015), outlined the requirement for local health and social care systems to develop:
   - a five-year Sustainability and Transformation Plan (STP), place-based and outlining how the Five Year Forward View (FYFV) will be delivered; and
   - a one-year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP (to form year-one of the five-year STP).
6. The planning guidance indicates that the three interdependent and essential tasks that need to be progressed through the STP are to:
   - implement the Five Year Forward View;
   - restore and maintain financial balance; and
   - deliver core access and quality standards for patients.
7. The STP will not only cover CCG commissioned services but will need to consider NHS England commissioned specialised services, where the planning will be led from the local collaborative commissioning hubs, and primary medical care. The plan will also need to cover local authority funded social care. This includes ensuring consistency with Better Care Fund (BCF) plans that will focus on delivering integrated health and social care services by 2020. The BCF plans need to be submitted and signed off by Health and Well Being Boards by the 25th April 16.
8. The STP is also a joint commissioner and provider place-based plan (a system plan), against which commissioner and provider plans will be developed.

## THE PLANNING CONTEXT

9. Changes in the demographics of the local population mean that the model of care needs to develop to meet the associated changing demand placed upon services. There are a number of factors that need to be considered when looking at how the Kent and Medway population is going to change. In 2011 the base population for Kent and Medway was calculated as 1,731,400. By 2031 this is projected to increase to 2,024,700, an increase of 293,300 that is equivalent to a 17% rise (circa 42,000 for Medway and 251,000 for Kent).

10. In particular, the percentage of old people, who are living longer with multiple co-morbidities, is changing and by 2021 it is projected there will be a:
    - 25.5% increase in number aged 65 years +
    - 34.1 % increase in the number aged 85 years +

11. The projected 17% increase in the local population also includes population increases as a result of a planned 158,500 additional dwellings that are expected between 2011 and 2031. These developments will have a skewed impact on different areas. There are significant developments planned in Dartford, Ebbsfleet and Ashford (as well as significant housing development in Bexley, South-East London, which are not factored into the housing numbers referenced above but whose residents would look to Darent Valley Hospital as their local acute provider).

12. As with many areas of the country providers and commissioners are facing significant financial challenges. These also need to be addressed through the STP and a key requirement of the plan is to bring the local NHS into financial balance (i.e. both commissioners and providers). The following table[1] provides an indication of the projected year-end financial outturn for the Kent and Medway commissioners and providers:

| Organisation | Forecast financial outturn position for 31/03/16 (£/m) |
|---|---|
| MTW | (23.5) |
| MFT | (52.1) |
| DVH | (7.9) |
| EKUHFT | (36.4) |
| KCHT | 3.0 |
| KMPT | (4.3) |
| SECamb (across Kent, Surrey and Sussex) | 0 |

[1] Figures have been drawn from provider month 9 and 10 board reports and CCG figures have been provided by NHS England.

| Swale CCG | 1.4 |
|---|---|
| Medway CCG | 3.6 |
| DGS CCG | 0 |
| West Kent CCG | 5.6 |
| Ashford CCG | 0 |
| Canterbury and Coastal CCG | 2.7 |
| South Kent Coast CCG | 2.8 |
| Thanet CCG | 2.1 |
| **Total** | (103) |

13. Considering the scale of the economic challenge identified above the STP will need to look a far reaching options that reconsider how care is delivered, including far greater collaboration between providers around the delivery of care.
14. The quality concerns raised by the regulators at a number of providers also need to be recognised and addressed in the STP. All local acute providers are struggling to deliver performance targets to some extent and the following table provides a snapshot of current performance challenges.

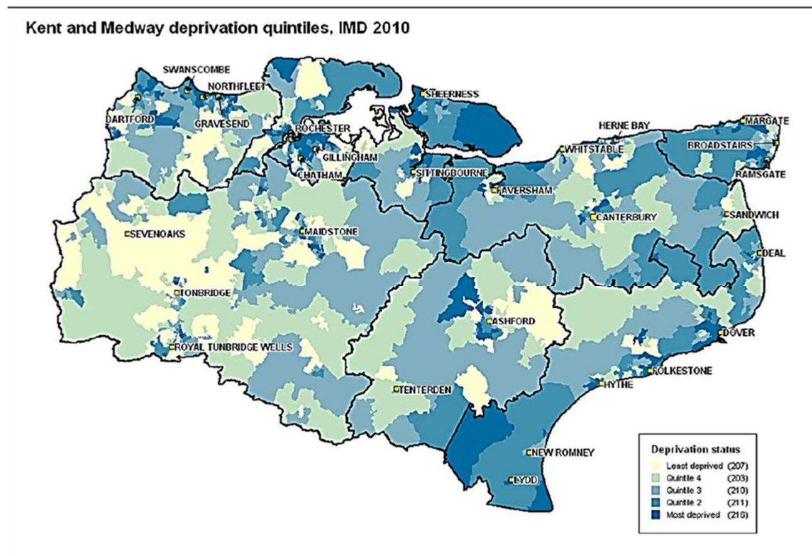
| Indicator | Data period | Standard | DVH | EKUHFT | MTW | MFT |
|---|---|---|---|---|---|---|
| **Cancer: Two-week wait (GP referrals)** | Sept 2014 to Aug 2015 | 93% | 93.2% | 90.0% | 95.3% | 91.6% |
| **Cancer: 31-day wait (diagnosis to treatment)** | | 96% | 100.0% | 94.0% | 97.9% | 91.0% |
| **Cancer: 62-day wait (urgent GP referrals)** | | 85% | 89.0% | 69.2% | 72.8% | 86.3% |
| **Diagnostics - over 6 week waits** | | 1% | 0.0% | 0.1% | 3.8% | 7.4% |
| **RTT - Incompletes** | | 92% | 96.8% | 88.1% | 96.6% | 73.1% |
| **RTT - 52+ week waiters** | | 0 | 0 | 8 | 1 | 3 |
| **Summary Hospital-level Mortality Indicator (SHMI)** | June 2014 to May 2015 | Ratio Observed to Expected Excludes Specialist | 106.9 | 103.8 | 103.7 | 119.5 |

7

| **Hospital Standardised Mortality Ratio (HSMR)** | Aug 2014 to July 2015 | Ratio Observed to Expected | 99.9 | 92.6 | 104.8 | 114.4 |
|---|---|---|---|---|---|---|
| **Weekend HSMR - Non-Elective** | | Ratio Observed to Expected | 107.3 | 97.0 | 112.5 | 116.7 |
| **A&E 4 hour waits** | Sept 2014 to Aug 2015 | 95% | 94.5% | 88.6% | 89.9% | 77.9% |

**DN update figures to take account of the latest position**

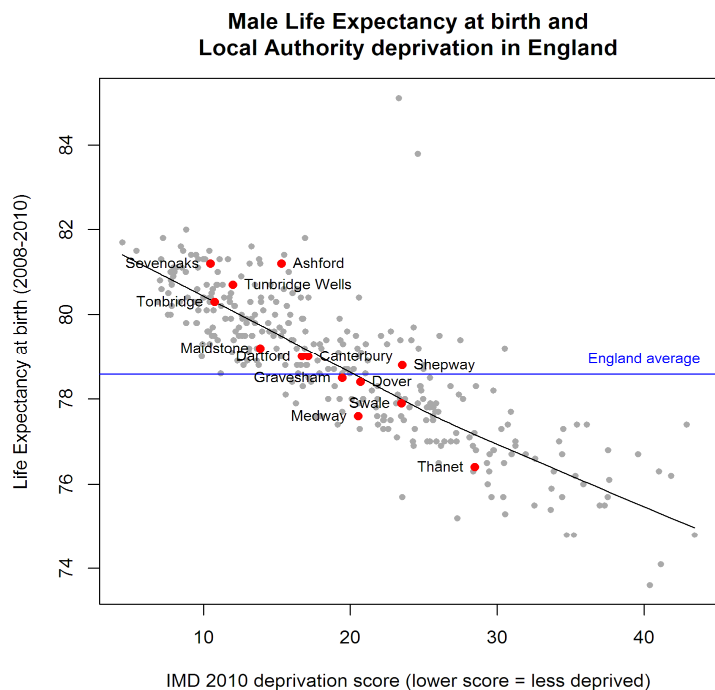
15. A number of quality concerns, in addition to the performance challenges outlined above, have also been identified by the Care Quality Commission at local hospitals and primary care providers. This includes, but is not limited to, issues around:
    - the provision of a number of core services;
    - stabilising the leadership of organisations;
    - addressing workforce issues, including staff shortages and ensuring staff are well supported;
    - reporting and learning from incidents and complaints;
    - improving the flow of patients through hospitals and discharge arrangements; and
    - mortality rates.
16. There are also marked health inequalities across Kent and Medway. These are preventable and unjust differences in the health status experienced by certain population groups. Health inequalities are the result of a complex and wide-ranging network of factors. People in lower socio-economic groups are more likely to experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness. They are more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population. The STP will need to be clear on how work will be taken forward to tackle health inequalities and narrow the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall.
17. Within Kent and Medway there are significant health inequalities. The following map gives an overview of deprivation across the area. The darkest areas are the most deprived.




18. Whilst many areas of Kent and Medway are affluent, with higher levels of "wellbeing" (this includes indicators on life satisfaction, how worthwhile life is considered to be, happiness and anxiety) there are also a significant number of areas in the most deprived quartile of the national population. This is illustrated in the following table which shows life expectancy and the "slope of index inequalities" (a measure of deprivation) by CCG.

| Clinical Commissioning Group | Average Life Expectancy | Slope index of Inequalities (SII) (is calculated by taking into consideration Indices of Multiple Deprivation (IMD) and Life Expectancy at birth and is an indicator of the gap between the most and least deprived). |
|---|---|---|
| **Ashford CCG** | **82.6** | **3.0** |
| **Canterbury And Coastal CCG** | **81.6** | **4.6** |
| **Dartford, Gravesham and Swanley CCG** | **80.9** | **5.8** |
| **Medway CCG** | **80.3** | **4.9** |
| **South Kent Coast CCG** | **80.7** | **5.0** |
| **Swale CCG** | **79.8** | **5.5** |
| **Thanet CCG** | **79.4** | **7.1** |
| **West Kent CCG** | **82.3** | **4.2** |
| **Kent and Medway** | **81.1** | **5.6** |

19. This variation in health inequalities is further illustrated by the following chart that shows a correlation between deprivation and male life expectancy (i.e. this shows the link between deprivation and reduced life expectancy).




20. Whilst the information above shows a difference of about 5 years in life expectancy between the least and most deprived areas (e.g. between Thanet and Sevenoaks), this data is presented at CCG or district council level and hides the greater disparity between the least and most deprived wards. More information on this is in CCG and local authority plans (including the Annual Public Health Report and the Joint Strategic Needs Assessment).

21. The current acute healthcare arrangements, when considered against the projected changes in the population, are not sustainable either from a financial or workforce perspective. Careful planning is also needed to address the quality concerns and inequalities issues that are present in Kent and Medway. It is envisaged that the change in population demographics will result in a mismatch between demand for health and social care services and the capacity of health and social care systems to meet this need (i.e. supply). This is the fundamental assumption upon which the STP will be established. This mismatch has a detrimental impact across the three key areas of quality, performance and finance.

22. The mismatch between supply and demand; the health status of those in higher versus lower socio-economic groups; the financial over-performance of organisations against plan and the quality shortfall against required standards will need to be offset through a combination of the following four approaches:

    a. prevention and self-care to help people to stay healthy or manage their long term conditions;

    b. developing new care models (e.g. redesigning care pathways and services to strengthen primary care, development of integrated out-of-hospital care, delivery of more care in in non-hospital settings, consolidation of more specialist services onto a smaller number of sites…);

c. improving the efficiency of providers (e.g. delivering broadly the same model of care but improving operational processes to improve patient flow and use of resources); and
d. increasing capacity (including through the development of seven day working which will be considered further through the STP).

23. The above start to provide a set of high level strategic considerations to support planning.

## QUALITY AND PERFORMANCE FOCUS

24. Through the work on the STP the statutory organisations in Kent and Medway need to clarify how they will ensure the quality of services and that access targets will be delivered. Whilst it is important that there is a clear focus on how quality and access standards will be met, and the how the system will work together to enable this, quality needs to be intrinsic to all the areas of work within the STP (i.e. it cannot be a standalone consideration).
25. Whilst the STP will need to capture the over-arching approach to how the quality of services is ensured (i.e. to re-affirm the quality framework that is already operating in Kent and Medway), all aspects of the plan will need to be scrutinised to determine how they support improvement in the quality and performance of services.
26. The reality of the inter-relationship between quality, finance and workforce is also recognised. The implication of this is that unless there is financial balance, with a robust workforce in place, then risks around the quality of services and delivery of access targets increase.
27. In particular, the STP will need to recognise where services have been deemed to be inadequate, as outlined earlier in this document, and build on work to date to address the identified issues.
28. The STP will also need to set out the collective action that needs to be taken to deliver key national clinical priorities, including:
    - improving cancer outcomes;
    - increasing investment in mental health services and parity of esteem for mental health patients;
    - transforming learning disabilities services; and
    - improving maternity services.

## STRUCTURE OF THE STP

### Taxonomy – focus areas

29. It is necessary to consider conditions and services against the strategic headings shown in Point 22. However, the importance of the different strategic approaches will vary dependent on the condition or service under consideration. For example, a prevention focus will be very important for many areas of care, whereas the ability to increase capacity within many services will be limited due to funding and workforce constraints (i.e. expanding capacity may only be possible for a very limited number of services, whereas for other pathways the focus will be on service redesign to offer care in a different way). The STP will need to consider the relative priority of the different strategic approaches.

30. Before the different strategic approaches can be prioritised it is necessary to consider the taxonomy (the arrangement of groups or categories) of health and social care. However, health and social care is complicated and involves a wide range of clinical and social care interactions, to address a range of patient needs. NHS and social care can be divided based on a number of considerations:

    - services, either described in terms of specialties or teams / units (e.g. paediatrics, critical care, emergency departments, oncology, dermatology etc…)
    - conditions (e.g. long term conditions, cancer care…)
    - groupings of services (e.g. planned care, emergency care…)
    - care groups (e.g. mental health, learning disabilities, older people…)
    - care pathways (e.g. end of life care, frailty…)

31. The reality is no taxonomy is perfect, including in relation to planning healthcare. For example, a person with a learning disability can have intermittent mental health problems and, as an older person, may develop a cancer. This example crosses a number of the above categories. For the purposes of the STP it is intended to use an amalgam of the above approaches by focusing the plan around the following key focus areas:

    a. Prevention and self-care, like quality, needs to be a theme running through all of the key areas (with a focus on the national priorities of diabetes and obesity)

    b. Investigations / diagnostics

    c. Health interventions (to be considered against the four headings identified in Point 22):

        - Maternity
        - Urgent care - paediatric, adult and older people
        - Emergency Care - paediatric, adult and older people
        - More specialist emergency care (hyper acute stroke, emergency vascular surgery, specialist paediatrics, trauma and pPCI)

- Planned care (excluding cancer care), covering both independent and NHS providers - paediatric, adult and older people
- Specialist planned care - paediatric, adult and older people
- Cancer care
- Palliative care
- Mental health (forensic services, inpatient services, crisis intervention, community care) - paediatric, adult and older people

d. Long-term conditions and disabilities

## Key strategic enablers

32. Alongside the above focus areas the STP will also describe, or in some cases initiate, a number of key enabling strategies, that support the delivery of health and social care transformation. These will focus on a number of key areas, including:

    a. **Finance:** Ensuring the proposals in the STP return local systems to financial balance, together with plans for how the increased investment will be utilised.

    b. **Workforce:** Understanding the current workforce pressures (e.g. challenges in recruiting to certain roles) and the future workforce requirement, including whether there is a need for different and new roles to be developed to support new models of care.

    c. **Equipment and facilities (estates):** Understanding the implication of the plans on the building from which care is delivered, including how these resources can be used optimally, and the requirement in relation to the equipment that is needed to deliver care.

    d. **Information technology:** Ensuring that technology is exploited to optimise service delivery, including in relation to supporting the development or rollout of new care models. This also needs to focus on how clinical information is shared between organisations and professionals, whilst ensuring there is good information governance.

    e. **Informatics:** Outlining how we will develop a shared understanding (shared intelligence) around what is happening in the local health and social care system(s), including through linking the different data and information held by the statutory bodies. In the short-term the initial requirement is to support system modelling across Kent and Medway to quantify projected demand against the ability of the health and social care systems to meet this.

## Structure of the STP

33. When the contents of this paper are considered, a high-level structure for the STP emerges. This is summarised in Attachment 3.

34. This structure effectively sets the STP as an umbrella plan that brings together a set of other strategies and plans (both functional plans / strategies and geographically based plans / strategies).

## GOVERNANCE

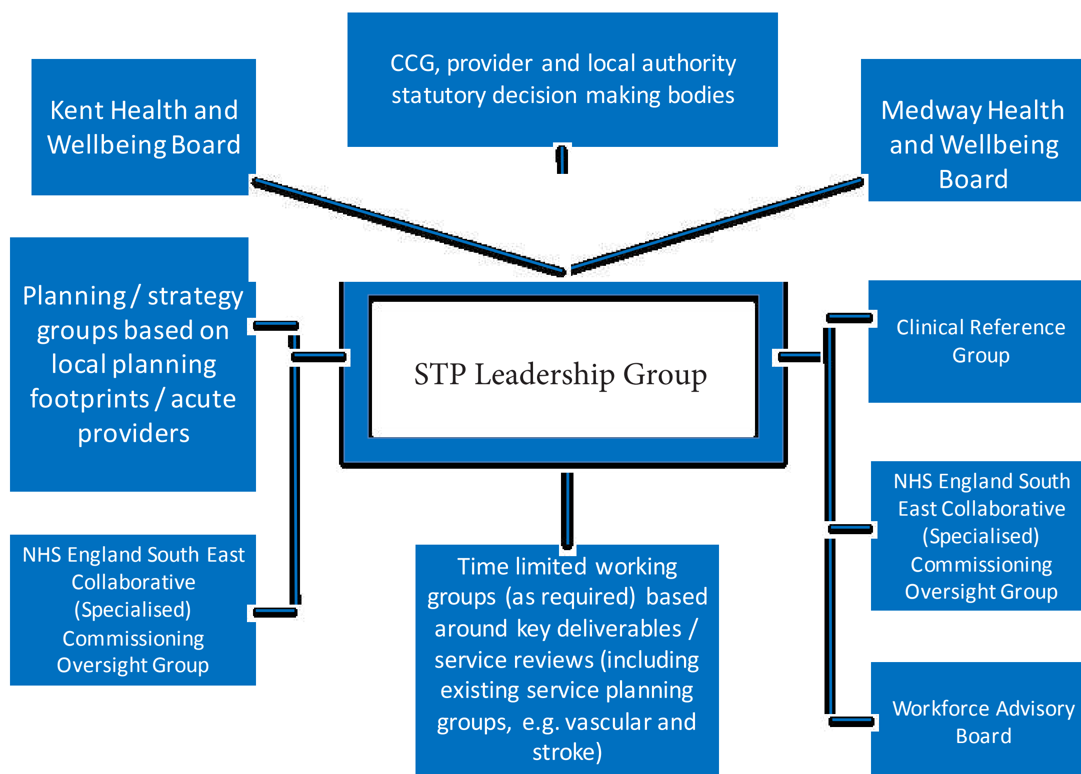
### Governance infrastructure

35. It is important that any governance arrangement that is put in place for the STP does not duplicate existing arrangements and minimises meeting requirements. In addition, it is important that the governance arrangements support meaningful clinical input into the development of the STP.
36. The governance arrangements will need to facilitate joint decision making and the principle of subsidiarity, including making sure there is maximum operational devolution. Not just between CCGs but also with the local authorities and providers. More fundamentally, the arrangement will only be effective if the statutory bodies are committed to working to deliver an agreed shared objective(s), underpinned by a shared vision and set of values.
37. For CCGs there is an option to set up joint committees between CCGs (or with NHS England) with delegated authority to take responsibility for the decisions around clearly defined areas. However, it is not possible to establish formal joint committees with providers. Therefore, the focus of the governance structure will be to propose recommendations back to the boards, governing bodies and committees of the individual statutory organisations to allow them to take informed decisions.
38. The merits of establishing joint CCG committees around specific commissioning decisions will be kept under consideration. Whilst CCGs can now form joint committees these need to be for clearly defined decisions and will require CCGs to amend their constitutions and review their governance arrangements to ensure they are appropriate. The joint committees, if mandated by the CCG governing bodies and enshrined through amended constitutions, would need to operate within a clear framework and terms of reference that have also been formally agreed by all the CCG governing bodies.
39. There already exist a number of meeting that operate at a Kent and Medway level. These include:

| Meeting | Membership |
|---|---|
| The Kent and Medway Commissioning Assembly | CCGs, both accountable officers and clinical chairs<br>NHS England<br>Clinical Senates<br>KSS Academic Health Sciences Network |
| The Kent and Medway Urgent and Emergency Care Board (UECN) | CCGs<br>Local providers<br>KCC<br>Medway Council |

40. It is felt there is a need to review the above arrangements and a revised Kent and Medway governance arrangement is proposed. This is felt to be needed to support the development of the STP but more fundamentally to establish, and exert, effective collective senior leadership across the Kent and Medway health and social care system(s).

41. The following governance arrangement is proposed:




42. The above arrangements would see the role of the Urgent and Emergency Care Board subsumed within the STP Leadership Group. It is proposed that the STP Leadership Group's

role would be to ensure the delivery of the Kent and Medway STP through:

- establishing a senior leadership team from across health and social care to take forward strategic planning, including establishing a shared vision and objectives (including developing a Kent and Medway STP that delivers the best possible health and social care for the local population, within available resources, and meets the requirements of national planning guidance);
- ensuring the principle of subsidiarity is adhered to but also ensure it is possible to consolidate local plans and aggregate these at a Kent and Medway level to support planning (including supporting local health and social care systems to develop a consistent structure for the production of local plans);
- provide the strategic guidance and support to the development of plans against local footprints;
- to agree those projects and initiatives / strategies that need to be progressed at a Kent and Medway level (and conversely those areas that are being progressed locally);
- establish a planning arrangement to ensure the successful delivery of the Kent and Medway initiatives / strategies;
- identify strategic priorities and hold each other to account for their delivery;
- ensure links and consistency with Better Care Fund plans;
- take on the mandated role of the Urgent and Emergency Care Board;
- take account of and support the delivery of the objectives of the Kent and Medway Learning Disability Transformation Board; and
- problem solve to ensure the effective delivery of shared objectives.

43. The STP Leadership Group would have two parts:

- Part 1: Separate commissioner and provider meeting
- Part 2: A joint commissioner and provider meeting

44. The Commissioning Assembly would evolve to become a Clinical Reference Group consisting of CCG Clinical Chairs and provider Medical Directors. It is suggested that the SRO for the STP (see below), and others working on the STP as required, would be in attendance to brief the group. The group would have the following functions:

i. To provide a clinical steer to development of the STP (and other strategic plans as

appropriate).

ii. To critique proposals.

iii. To champion the principle of subsidiarity but also support the identification and planning of items that need to be planned at a Kent and Medway level.

iv. To act as a clinical sounding board by acting as a forum to discuss emerging proposals and models.

v. To act as a conduit to the wider cohort of clinical professionals working in Kent and Medway, including advising on effective approaches to engage clinical colleagues.

## Senior Responsible Officer

45. In order to support the arrangements detailed in this paper there is a need to identify a senior responsible officer (SRO).
46. In addition to the SRO senior executive leads will be identified to lead specific work areas (as outlined later in this document).
47. The purpose of the SRO role is to:
    - chair the STP Leadership Group;
    - ensure the successful production of the STP, in line with the approach outlined in this document, and the delivery of the proposals enshrined within this;
    - champion, with the chair of the clinical reference group, the principle of subsidiarity and facilitate agreement around items and issues that need to be progressed at a Kent and Medway level;
    - liaise with the leads of the local planning groups and ensure that there is two-way dialogue between local and county-wide planning;
    - facilitate the development of senior shared leadership across Kent and Medway;
    - identify and secure the resources needed to delivery the Kent and Medway STP.
    - Maintain an oversight of the STP governance arrangements and ensure these are fit for purpose.
    - Ensure robust engagement takes place with a wide range of local and national stakeholders.

## Rules of engagement and behaviors to support collaborative working

48. If the development and delivery of the STP is to be effective, then the senior executives from health and social care organisations will need to work effectively as a senior leadership team. In working collectively to develop the Kent and Medway STP there is an expectation that organisations and individuals will:
    a. work together and not undermine each other;
    b. voice constructive criticism and ensure this is appropriately delivered;
    c. recognise, challenge and understand and work with constraints;
    d. when collective authority is given to team members to act, CCGs will let them deliver;
    e. will aim to reach a consensus on how to take forward the programme through discussion;
    f. where an agreement is reached it will be adhered;
    g. where it is not possible to reach agreement we will first seek informal external facilitation to a resolution;
    h. speak well of each other inside and outside of meetings;
    i. will try our hardest to work on a 'no surprises' basis and will involve each other as early as possible on an issue requiring cross-organisational input; and
    j. will listen and understand before we act and judge.
49. Finally, where possible clinicians will be involved or, preferably, lead the delivery of key areas of work.

## STP work areas

50. The STP work will also potentially need to initiate some areas of work where a Kent and Medway focus is needed but is not in place. The following table gives an indication of the different work areas that are needed to support the development of a Kent and Medway STP, including which:
    - of these can be drawn from local planning arrangements; and
    - areas need to have work convened at a Kent and Medway level.

| Work area | Local or Kent and Medway focus |
| --- | --- |

| | |
|---|---|
| Developing the case for change | Aggregate from local plans |
| Development of a Kent and Medway prevention and self-care strategy | Draw from local plans but also ask local authority public health leads to develop an over-arching Kent and Medway level strategy |
| Health interventions: | |
| Non-elective care:<br>• Urgent care – broken down by paediatric care, adult services and older people<br>• Emergency care – broken down by paediatric care, adult service and older people | Aggregate from local plans |
| • Planned care (excluding cancer care), covering both independent and NHS providers – broken down by paediatric care, adult services and older people: | Aggregate from local plans |
| • More specialist emergency care (hyper acute stroke, emergency vascular surgery, specialist paediatrics, trauma and pPCI): | Kent and Medway level arrangements (lnking to work already in place around vascular and hyper-acute stroke) |
| • Specialist planned care – broken down by paediatric care, adult services and older people: | Kent and Medway level arrangements |
| • Cancer care | Kent and Medway level arrangements / draw from local plans |
| • End of life | Aggregate from local plans |
| • Mental health (forensic services, inpatient services, crisis intervention, community care) – paediatric care, adult services and older people | Kent and Medway level arrangements / draw from local plans |
| • Maternity | Aggregate from local plans |
| Improving access to diagnostics and investigations | Aggregate from local plans but may also require a Kent and Medway focus |
| Supporting people with long term conditions and disabilities | Aggregate from local plans but ensure a degree of consistency |
| Exploiting information technology | Aggregate from local plans but will also require a Kent and Medway focus |
| Strategic narrative on workforce gaps and requirements | Aggregate from local plans but will also require a Kent and Medway focus (ask HEE to support) |
| Strategic narrative on equipment and facilities (estates) | Aggregate from local plans but will also require a Kent and Medway focus |
| Understanding the health and social care system – the informatics strategy | Will require a Kent and Medway approach, including around initial system modelling (ask local authority public health colleagues to lead) |
| The strategic finance narrative and summary | Aggregate from local plans but will also require a Kent and Medway focus |
| "Organisational" development plan for the STP | Will require a Kent and Medway approach |
| Communication and Engagement | Will build on local arrangements but will require a degree of coordination and consistency across Kent and Medway |

| Development of integrated budgets and provision between the NHS and local authorities | Aggregate from local plans but will also require a Kent and Medway focus |
|---|---|

51. The above does not, in general, reference particular services or sectors (e.g. primary care, secondary care….). It is intended that through reaching clarity on the intentions around the above, it will be possible to determine what needs to happen in relation to particular services or sectors of care in order to deliver the planned requirements (i.e. the intentions around the above should drive provider and commissioning strategies).
52. In relation to the work areas linked to the STP that are taken forward at a Kent and Medway level, the intention is to identify a CCG accountable officer, provider chief executive or senior local authority officer to act as the work steam sponsor for each of these. The role of the sponsor will be to:
    - provide leadership and ensure delivery of the objectives;
    - support the management team;
    - act as the link between the area of work and the STP Leadership Group
    - where relevant chair the working group;
    - ensure appropriate engagement with key stakeholders; and
    - work with the STP SRO to identify and secure resources.

## SUPPORTING DELIVERY OF THE STP

53. There are also a number of supporting activities that will be progressed to support the delivery of the STP. These include:
    - Organisational development
    - Engagement and Communication
    - Programme Management
54. **Organisational Development:** The intention is to use organisational development principles across the Kent and Medway system to ensure the effective delivery of the STP. The focus of these activities will be to:
    - work with the senior leadership team across health and social care to develop a shared vision and aims;
    - prioritise interventions that will deliver the greatest gain in terms of delivering the shared vision and aims; and
    - develop a high-functioning leadership team across the Kent and Medway health and social care system
55. **Engagement and Communication:** The development of a robust STP will be contingent on robust engagement with a range of stakeholders. However, the intention is to use the

communication and engagement infrastructure that has already been put in place by the CCGs, providers and local authorities.

56. In particular, there will be a need to engage, particularly with local communities, around new services models, including developing a shared vision with the local population on how health and social care will be delivered. Specific communication and engagement plans are likely to be needed around key work areas and change proposals. The 'six principles' developed by the national People and Communities Board, alongside the New Models of Care Vanguard Sites, will support engagement with local stakeholders by supporting a dialogue on what constitutes good person centred care, against which new models of care can be considered:
    - Care and support is person-centred: personalised, coordinated, and empowering
    - Services are created in partnership with citizens and communities
    - Focus is on equality and narrowing inequalities
    - Carers are identified, supported and involved
    - Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers
    - Volunteering and social action are recognised as key enablers

57. **Programme Management:** The delivery of the STP, and its execution, will require strong programme and project management to ensure shared objectives are supported and delivered. This will be needed to coordinate the different activities and deliver the different constituent parts of the STP.

## SUMMARY

58. This document outlines the governance arrangements for developing the Kent and Medway STP and the outline structure of the plan. This document now needs to be tested with key statekholders across Kent and Medway and with NHS England. The intention is to do this during March 2016 in order to finalise the document. After this the document can be taken back to the statutory bodies for ratification. However, in recognition of the tight timescales, within which the STP needs to be developed, work will commence immediately to put in place the governance arrangements and develop the work areas associated with the plan.

59. Any comments on the proposals outlined in this document should be sent to:

mridgwell@nhs.net

07850 301 302

## ATTACHMENT 1: THE NINE 'MUST DOS' FOR 2016/17 FOR EVERY LOCAL SYSTEM

1. Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.
3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.
4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.
5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.
6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

## ATTCHMENT 2: SUPPORTING SUBSIDIARITY – LEVELS OF PLANNING

Different services need to be planned across different planning footprints and no one footprint is ideal for all services. Below is an illustrative table setting out five different levels around which care in Kent and Medway needs planning.

| Planning Levels | Services | Operational Planning Footprints | Integration with Social Care | New Care Models |
|---|---|---|---|---|
| 5 | **Highly Specialist Services e.g.**<br>• Major Trauma<br>• Some cancer<br>• Other NHS England commissioned Services | Clinical Networks – larger than Kent and Medway | | |
| 4 | **Specialist Acute e.g.**<br>• Hyper Acute Stroke<br>• Vascular<br>• Emergency pPCI | Clinical Networks - within Kent and Medway<br>• All K&M Trusts | | • Emergency Care networks<br>• Specialised care |
| 3 | **Specialist partnership services**<br>• Children's services<br>• Learning disabilities | Local Authorities<br>• Kent<br>• Medway | • Children's Services<br>• LD Services | |
| 2 | **Routine Acute**<br>• Maternity Care<br>• Elective Care<br>• Some cancer care<br>• Emergency Care (incl 999) | Acute trust based<br>• EKUHFT<br>• MTW & MFT & Hastings (A21/229)<br>• DVH (working with GST) | | • PACs<br>• Urgent Care networks<br>• Hospital Chains<br>• Small hospitals<br>• Modern maternity Services |
| 1 | **Out of Hospital**<br>• Urgent Care (incl GP OoH & 111)<br>• Primary Care<br>• Community Care<br>  ○ Community nursing and therapy<br>  ○ Community hospitals, hubs, MIUs etc<br>  ○ Primary care MH & Dementia<br>  ○ Adult social care<br>  ○ Secondary care in primary care or community settings<br>  ○ Care homes | Local population based<br>• CCG clusters – East<br>• CCG Cluster – West<br>• CCG Cluster – Medway<br>• CCG Cluster – DGS & Swale | • Adult's Services<br>• Mental Health Services | • MCPs<br>• Enhanced care in care homes |

Population Catchments: East Kent 695k, West Kent 480k, DGS & Swale, 367k, Medway 295k
Bed numbers (G&A + Maternity): EKUHFT 1038, MTW 729, MFT 604, DVH 513

## ATTACHMENT 3: HIGH-LEVEL STRUCTURE FOR THE STP

<table>
<tr><td>1</td><td colspan="4">INTRODUCTION</td></tr>
<tr><td>2</td><td colspan="4">CASE FOR CHANGE</td></tr>
<tr><td>3.</td><td colspan="4">OVERARCHING STRATEGIC NARRATIVE ON QUALITY</td></tr>
<tr><td>4.</td><td colspan="4">SUMMARY OF LOCAL FOOTPRINT PLANS:<br>• West (West Kent CCG)<br>• North East (Medway CCG and Swale CCGs)<br>• North West (Swale CCG and Dartford, Gravesham and Swanley CCG)<br>• East Kent (South Kent Coast, Thanet, Ashford and Canterbury and Coastal CCGs)</td></tr>
<tr><td>5.</td><td colspan="4">WHAT DOES GOOD LOOK LIKE? – DESCRIBING THE SUSTAINABLE END STATE</td></tr>
<tr><td>5.</td><td colspan="4">DEVELOPMENT OF A KENT AND MEDWAY PREVENTION AND SELF-CARE STRATEGY</td></tr>
<tr><td>6.</td><td colspan="4">HEALTH AND SOCIAL CARE INTERVENTIONS</td></tr>
<tr><td colspan="5">Non-elective care:<br>Urgent care – broken down by paediatric care, adult services and older people:</td></tr>
<tr><td colspan="2">Prevention / Self care focus</td><td>New care models</td><td>Improving efficiency</td><td>Expanding capacity</td></tr>
<tr><td colspan="5">Emergency Care – broken down by paediatric care, adult service and older people:</td></tr>
<tr><td colspan="2">Prevention / Self care focus</td><td>New care models</td><td>Improving efficiency</td><td>Expanding capacity</td></tr>
<tr><td colspan="5">Planned care (excluding cancer care), covering both independent and NHS providers – broken down by paediatric care, adult services and older people:</td></tr>
<tr><td colspan="2">Prevention / Self care focus</td><td>New care models</td><td>Improving efficiency</td><td>Expanding capacity</td></tr>
<tr><td colspan="5">More specialist emergency care (hyper acute stroke, emergency vascular surgery, specialist paediatrics, trauma and pPCI):</td></tr>
<tr><td colspan="2">Prevention / Self care focus</td><td>New care models</td><td>Improving efficiency</td><td>Expanding capacity</td></tr>
<tr><td colspan="5">Specialist planned care – broken down by paediatric care, adult services and older people:</td></tr>
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<tr><td colspan="5">Cancer care:</td></tr>
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<tr><td colspan="5">End of life care:</td></tr>
<tr><td colspan="2">Prevention / Self care focus</td><td>New care models</td><td colspan="2">Improving efficiency</td></tr>
<tr><td colspan="5">Mental health (forensic services, inpatient services, crisis intervention, community care) – paediatric care, adult services and older people:</td></tr>
<tr><td colspan="2">Prevention / Self care focus</td><td>New care models</td><td>Improving efficiency</td><td>Expanding capacity</td></tr>
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| **Maternity:**<br>Improving efficiency New care models Expanding capacity | |
| **6.** | **IMPROVING ACCESS TO DIAGNOSTICS AND INVESTIGATIONS** |
| **7.** | **SUPPORTING PEOPLE WITH LONG TERM CONDITIONS AND DISABILITIES:**<br>- **Hypertension**<br>- **Depression**<br>- **Asthama**<br>- **Diabetes**<br>- **Coronary heart disease**<br>- **Stroke / TIA**<br>- **Chronic obstructive pulmonary disease**<br>- **Cancer**<br>- **Atrial fibrillation**<br>- **Mental health**<br>- **Heart failure**<br>- **Epilepsy**<br>- **Dementia**<br>- **Physical disability**<br>- **Learning Disability** |
| **8.** | **EXPLOITING INFORMATION TECHNOLOLGY** |
| | - **Supporting new models of care** |
| | - **Facilitating the sharing of clinical information / care planning** |
| **9.** | **STRATEGIC NARRATIVE ON WORKFORCE GAPS AND REQUIREMENTS** |
| **10.** | **STRATEGIC NARRATIVE ON EQUIPMENT AND FACILITIES** |
| **11.** | **UNDERSTANDING THE HEALTH AND SOCIAL CARE SYSTEM – THE INFORMATICS STRATEGY** |
| **12.** | **THE STRATEGIC FINANCE NARRATIVE AND SUMMARY (INCLUDING HOW THE RETURN TO FINANCIAL BALANCE ACROSS THE STP AREA WILL BE ACHIEVED)** |
| **13.** | **PRIORITIES BY YEAR OVER THE FIVE YEARS OF THE STP** |

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|---|---|
| | = balance of planning at a Kent and Medway level |

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