

Appendix 2

Development of the Kent and Medway Sustainability and Transformation Plan

Initiation Document

Initiation Document

Document Control

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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 Programme 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 table¹ 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	EKUFT	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

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%

 = Performance below national target

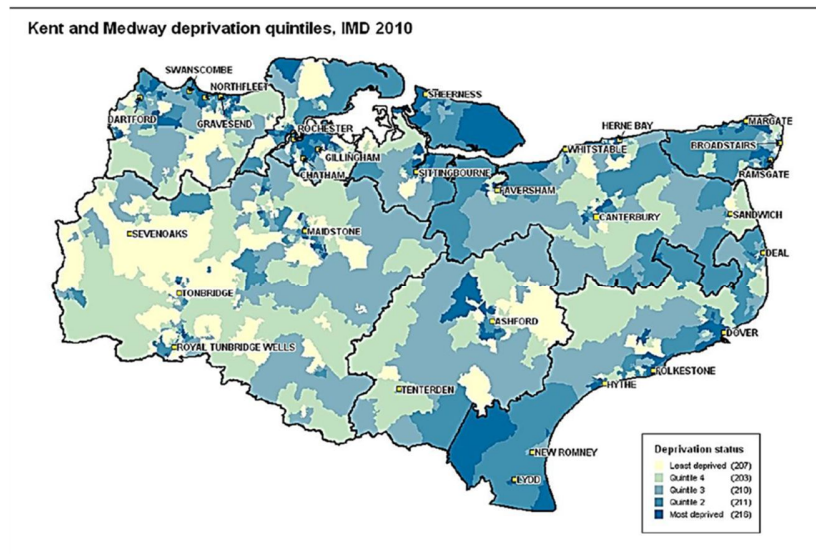
DN update figures to take account of the latest position

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.

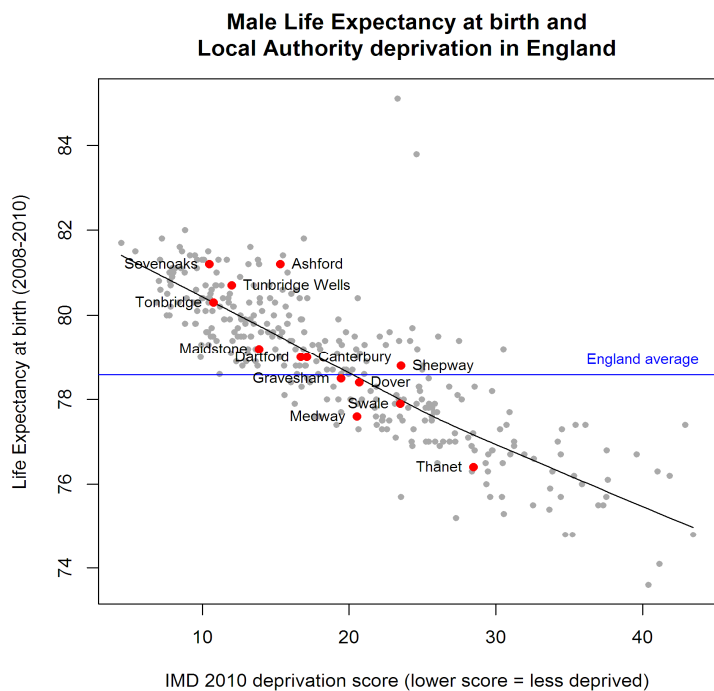
17. Within Kent and Medway there are significant health inequalities. The following map gives an overview of deprivation across the area. The darkest areas are the most deprived.



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

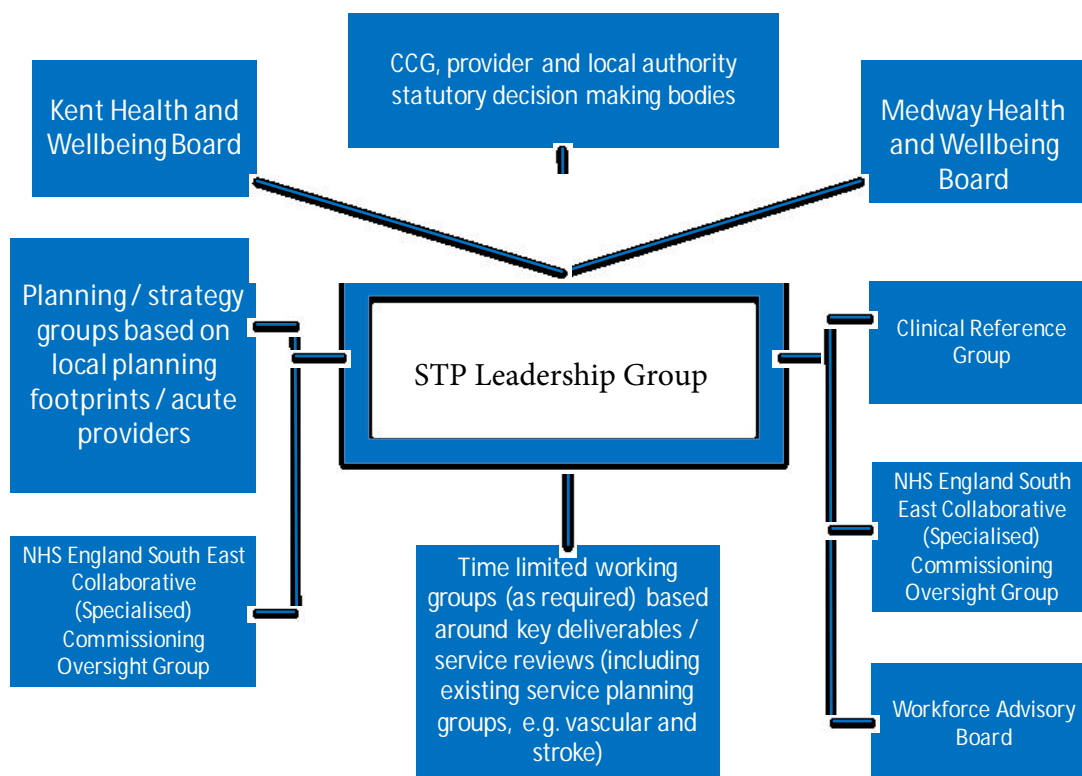
Governance infrastructure

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 NHS England Clinical Senates KSS Academic Health Sciences Network
The Kent and Medway Urgent and Emergency Care Board (UECN)	CCGs Local providers KCC 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 to;
- 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
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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:	Aggregate from local plans
<ul style="list-style-type: none"> Urgent care – broken down by paediatric care, adult services and older people Emergency care – broken down by paediatric care, adult service and older people 	
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> More specialist emergency care (hyper acute stroke, emergency vascular surgery, specialist paediatrics, trauma and pPCI): 	Kent and Medway level arrangements (linking to work already in place around vascular and hyper-acute stroke)
<ul style="list-style-type: none"> Specialist planned care – broken down by paediatric care, adult services and older people: 	Kent and Medway level arrangements
<ul style="list-style-type: none"> Cancer care 	Kent and Medway level arrangements / draw from local plans
<ul style="list-style-type: none"> End of life 	Aggregate from local plans
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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
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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 stream 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 stakeholders 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. <ul style="list-style-type: none"> Major Trauma Some cancer Other NHS England commissioned Services 	Clinical Networks – larger than Kent and Medway		
4	Specialist Acute e.g. <ul style="list-style-type: none"> Hyper Acute Stroke Vascular Emergency pPCI 	Clinical Networks - within Kent and Medway <ul style="list-style-type: none"> All K&M Trusts 		<ul style="list-style-type: none"> Emergency Care networks Specialised care
3	Specialist partnership services <ul style="list-style-type: none"> Children’s services Learning disabilities 	Local Authorities <ul style="list-style-type: none"> Kent Medway 	<ul style="list-style-type: none"> Children’s Services LD Services 	
2	Routine Acute <ul style="list-style-type: none"> Maternity Care Elective Care Some cancer care Emergency Care (incl 999) 	Acute trust based <ul style="list-style-type: none"> EKUHFT MTW & MFT & Hastings (A21/229) DVH (working with GST) 		<ul style="list-style-type: none"> PACs Urgent Care networks Hospital Chains Small hospitals Modern maternity Services
1	Out of Hospital <ul style="list-style-type: none"> Urgent Care (incl GP OoH & 111) Primary Care Community Care <ul style="list-style-type: none"> Community nursing and therapy Community hospitals, hubs, MIUs etc Primary care MH & Dementia Adult social care Secondary care in primary care or community settings Care homes 	Local population based <ul style="list-style-type: none"> CCG clusters – East CCG Cluster – West CCG Cluster – Medway CCG Cluster – DGS & Swale 	<ul style="list-style-type: none"> Adult’s Services Mental Health Services 	<ul style="list-style-type: none"> MCPs 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

1	INTRODUCTION
2	CASE FOR CHANGE
3.	OVERARCHING STRATEGIC NARRATIVE ON QUALITY
4.	SUMMARY OF LOCAL FOOTPRINT PLANS: <ul style="list-style-type: none"> • West (West Kent CCG) • North East (Medway CCG and Swale CCGs) • North West (Swale CCG and Dartford, Gravesham and Swanley CCG) • East Kent (South Kent Coast, Thanet, Ashford and Canterbury and Coastal CCGs)
5.	WHAT DOES GOOD LOOK LIKE? – DESCRIBING THE SUSTAINABLE END STATE
5.	DEVELOPMENT OF A KENT AND MEDWAY PREVENTION AND SELF-CARE STRATEGY
6.	HEALTH AND SOCIAL CARE INTERVENTIONS
Non-elective care:	
Urgent care – broken down by paediatric care, adult services and older people:	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity
Emergency Care – broken down by paediatric care, adult service and older people:	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity
Planned care (excluding cancer care), covering both independent and NHS providers – broken down by paediatric care, adult services and older people:	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity
More specialist emergency care (hyper acute stroke, emergency vascular surgery, specialist paediatrics, trauma and pPCI):	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity
Specialist planned care – broken down by paediatric care, adult services and older people:	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity
Cancer care:	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity
End of life care:	
Prevention / Self care focus	New care models Improving efficiency
Mental health (forensic services, inpatient services, crisis intervention, community care) – paediatric care, adult services and older people:	
Prevention / Self care focus	New care models Improving efficiency Expanding capacity

Maternity:	
Improving efficiency	New care models
	Expanding capacity
6.	IMPROVING ACCESS TO DIAGNOSTICS AND INVESTIGATIONS
7.	SUPPORTING PEOPLE WITH LONG TERM CONDITIONS AND DISABILITIES: <ul style="list-style-type: none"> - Hypertension - Depression - Asthama - Diabetes - Coronary heart disease - Stroke / TIA - Chronic obstructive pulmonary disease - Cancer - Atrial fibrillation - Mental health - Heart failure - Epilepsy - Dementia - Physical disability - Learning Disability
8.	EXPLOITING INFORMATION TECHNOLOGY
	- 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

	= balance of planning at a Kent and Medway level
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