Transforming health and social care in Kent and Medway

Sustainability and Transformation Plan

21st October 2016
Work in progress

Transforming Health and Social Care in Kent and Medway

Kent and Medway, like other parts of England, have the challenge of balancing significantly increasing demand, the need to improve quality of care and improve access all within the financial constraints of taxpayer affordability over the next five years. Health and social care, with partners, have come together to develop this Sustainability and Transformation Plan. We have a track record of working well together and, increasingly, of integrating our approach to benefit our population by achieving more seamless care, and workforce and financial efficiencies.

This is an exciting opportunity to change the way we deliver prevention and care to our population. We are working in new ways to meet people's needs and aspirations, ensuring an increased quality of support by a flexible NHS and social care provision.

Our main priority is to work with clinicians and the public to transform Local Care through the integration of primary, community, mental health and social care and re-orientate some elements of traditional acute hospital care into the community. This allows patients to get joined-up care that considers the individual holistically – something patients have clearly and consistently told us they want.

We believe the way to achieve this is to enhance primary care by wrapping community services around a grouping of GP practices, to support the communities they serve, and to commission and manage higher-acuity and other out-of-hospital services at scale, so that we are able to:

– meet rising demand, including providing better care for the frail elderly, end of life patients, and other people with complex needs, who are very clear that they want more joined-up care;

– deliver prevention interventions at scale, improve the health of our population, and reduce reliance on institutional care; done well this will:

– enable us to take forward the development of acute hospital care (through reducing the number of patients supported in acute hospitals and supporting these individuals in the community).

Clinical evidence tells us that many patients, particularly the elderly frail, who are currently supported in an acute hospital are better cared for in other settings. Changing the setting of care for these individuals will be truly transformational. We know it is possible to deliver this change and already have local examples to build upon where this new approach is being delivered (such as the Encompass Vanguard comprising 16 practices (170,000 patients) in east Kent who are operating as a multi-specialty community provider (MCP), providing a wide range of primary care and community services).

We also need to focus more on preventing ill-health and promoting good health and our Local Care model needs to deliver population-level outcomes through delivery at scale. This is needed to support individuals in leading healthy lives, as well as reduce demand and costly clinical interventions. We also need a disproportionate focus on the populations where health outcomes are the poorest.

In response to this, acute care will need to change to improve patient experience and outcomes; achieve a more sustainable workforce infrastructure; and make best use of our estate, reducing our environmental impact and releasing savings. We want to continue to create centres of acute clinical expertise that see a greater separation between planned and unplanned care. This would end the current pattern of much-needed surgery being delayed because of pressure on beds for non-elective patients. Through this we will deliver referral to treatment time (RTT) targets; improve workforce rotas, retention and morale; and release significant savings, alongside investment in Local Care.

This is an ambitious plan of work and we are committed to progressing it for the benefits of the people we serve.

Glenn Douglas
Senior Responsible Officer
Kent and Medway Sustainability and Transformation Plan

Executive summary (1/2)

- The Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting
- More than that, the system will transform services to deliver proactive care, and ensure that support is focused on improving and promoting health and wellbeing, rather than care and support that is solely reactive to ill health and disease
- Core to the model is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate the independent sector to deliver the right care, in the right place, at the right time
- Our transformation plan will bring a profound shift in where and how we deliver care. It builds on conversations held with local people about the care they want and need and has the patient at its heart:
  - Our first priority is developing **Local Care**, building on local innovative models that are delivering new models of care, which brings primary care general practices into stronger clusters, and then aggregating clusters into multispecialty community provider (MCP) type arrangements, and, potentially, into a small number of larger accountable care organisation (ACO) type arrangements that hold capitated budgets
  - Local Care will enable services to operate at a scale where it will be possible to bring together primary, community, mental health and social care to develop truly integrated services in the home and in the community
  - This model will manage demand for acute services, enabling significant reductions in acute activity and length of stay which amount to ~£160m of net system savings by 2020/21 and relieve pressure on our bed base
  - We have also therefore committed to a Kent and Medway-wide strategy for **Hospital Care**, which will both ensure provision of high-quality specialist services at scale and also consider opportunities to optimise our service and estate footprint as the landscape of care provision becomes more local
  - Work is ongoing to surface potential opportunities and evaluate them ahead of public consultation from June 2017

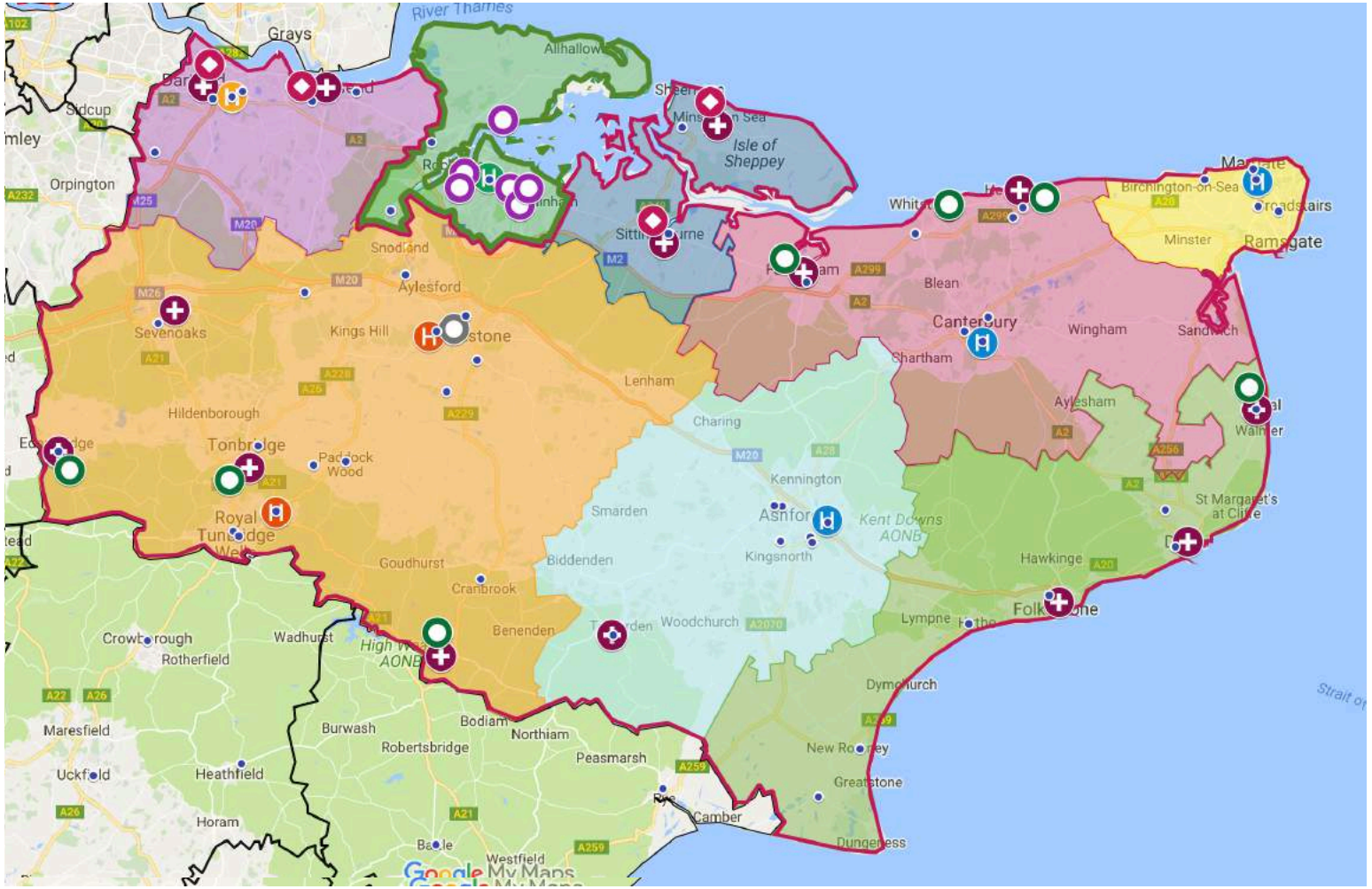
Executive summary (2/2)

- Over the last year we have built the new working relationships and launched the discussions which enable us to work at a greater scale and level of impact than before.
- In recent months we have made dramatic improvements in our STP, moving from a fragmented and unsustainable programme to one which has a truly transformational ambition, engages health and social care leaders from across the footprint, has robust governance oversight, and brings the system back towards sustainability.
- Our plan aims for a radical transformation in our population's health and wellbeing, the quality of our care, and the sustainability of our system by targeting interventions in four key areas:

Care Transformation	Preventing ill health, intervening earlier and bringing excellent care closer to home
Productivity	Maximising synergies and efficiencies in shared services, procurement and prescribing
Enablers	Investing in estates, digital infrastructure and the workforce needed to underpin a high-performing system
System Leadership	Developing the commissioner and provider structures which will unlock greater scale and impact

- Our financial strategy now directs the system back to sustainability, closing a £486m do-nothing financial challenge (including social care pressures) to a remaining £29m challenge in 2020/21. The remaining £29m challenge is associated to financial pressures that arise as a result of the Ebbsfleet Health New Town Development.
- Working with health and social care professionals, patients and the public, we are continuing to develop our plan and design the transformation programme which will deliver it
- We anticipate that some elements of the core transformation will influence 2017/18 operational planning and that a first wave of holistic transformation will launch in 2018

We are eight CCGs, 7 NHS providers and two local authorities, joining together with other partners, to transform health and care in Kent & Medway



- H — D&G NHS Trust
- H — EKHU NHS FT
- H — Medway NHS FT
- H — MTW NHS Trust
- \+ — Kent community hospitals
- Kent and Medway NHS and Social Care Partnership Trust
- Medway Community Healthcare services
- Kent Community Healthcare Foundation NHS Trust
- Virgin Health
- South East Coast Ambulance Service NHS Foundation Trust

Local Authorities:

- Kent County Council
- Medway Council

Since June we have made great strides in strengthening our change programme and raising our joint ambition

	Previous position	How we are strengthening the programme
Programme development	• Programme lacked a robust and active set of workstreams aligned with strategic priorities • No PMO to drive progress	✓ Workstreams mobilising around core priorities, with SROs now all in place and PIDs being completed ✓ PMO established with interim external support
Financial sustainability	• Plan did not balance, leaving a £196m NHS gap before STF allocation	✓ Analytical work undertaken across Kent and Medway has indicated significantly higher potential to transform the way we deliver health and care ✓ Our financial framework is now close to balance
System leadership and relationships	• Two-speed programme with little strategic work completed across Kent and Medway • Insufficient governance	✓ Commitment from leaders across the STP footprint to work together and drive further, faster ✓ Alignment around joint consultation timeline ✓ Strengthened governance arrangements in place
Communication	• Varying levels of communication with wider stakeholders beyond senior system leaders	✓ Consensus across all organisations around STP ✓ STP rationale and benefits communicated to staff, public, stakeholders and media in letter signed by leaders ✓ Comprehensive communications and engagement plan in place to March 2017 (incl. key stakeholders and timing)

We believe that health and care in Kent and Medway needs to change

Health and wellbeing

Case for change

- Our population is expected to **grow by 90,000 people** (5%) over the next five years; 20,000 of these people are in the new town in Ebbsfleet. Growth in the number of over 65s is **over 4 times greater** than those under 65; an aging population means **increasing demand for health and social care**.
- There are **health inequalities** across Kent & Medway; in Thanet, one of the most deprived areas of the county, a woman living in the best ward for life expectancy can expect to live **almost 22 years longer** than a woman in the worst. The main causes of early death are **often preventable**.
- Over **500,000 local people live with long-term health conditions**, many of which are preventable. And many of these people have multiple long-term health conditions, dementia or mental ill health.

Our ambition

- Create services which are able to meet the needs of our changing population
- Reduce health inequalities and reduce death rates from preventable conditions
- More measures in the community to prevent and manage long-term health conditions

Quality of care

- There are many people who are **in hospital beds who could be cared for nearer to home.** Being in a hospital bed **for too long is damaging for patients** and increases the risk of them ending up in a care home.
- We are **struggling to meet performance targets** for cancer, dementia and A&E. This means people are not seen as quickly as they should be.
- Many of our local hospitals are in ‘special measures’ because **of financial or quality pressures** and numerous local nursing and residential homes are **rated ‘inadequate’ or ‘requires improvement’**.

- Make sure people are cared for in clinically appropriate settings
- Deliver high quality and accessible social care across Kent and Medway
- Reduce attendance at A&E and onward admission at hospitals
- Support the sustainability of local providers

Sustainability

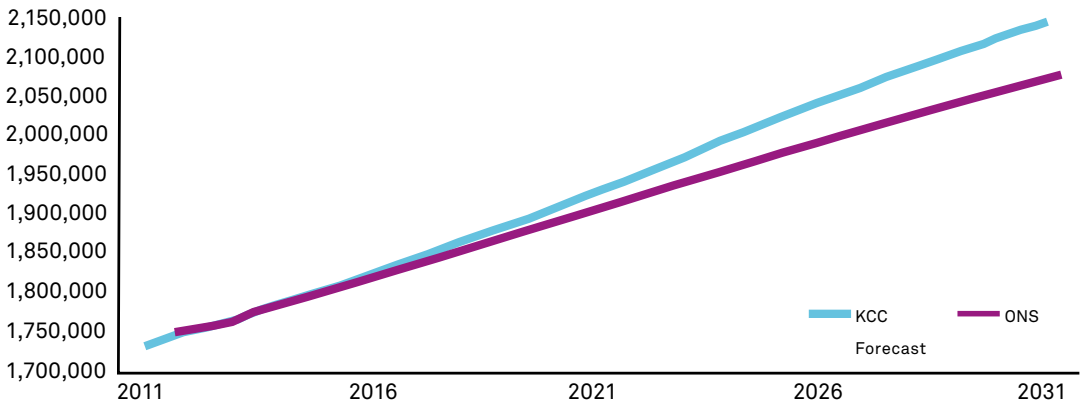
- We are **£109m ‘in the red’** and this will rise to **£486m by 20/21** across health and social care if we do nothing.
- Our **workforce is aging** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time.

- Achieve financial balance for health and social care across Kent and Medway
- To attract, retain and grow a talented workforce

Kent and Medway population is set to grow rapidly, faster than ONS projections

Housing developments will bring a higher population than ONS projections

Population growth forecast, Kent, KCC estimate vs. ONS



- Kent and Medway has planned significant housing growth (aimed at commuters and new families)
- The Kent and Medway Growth and Infrastructure Framework (KMGIF) has projected 188,200 new homes and 414,000 more people incremental to ONS projections
- Expected that the new population will place pressure on paediatric and maternity care especially

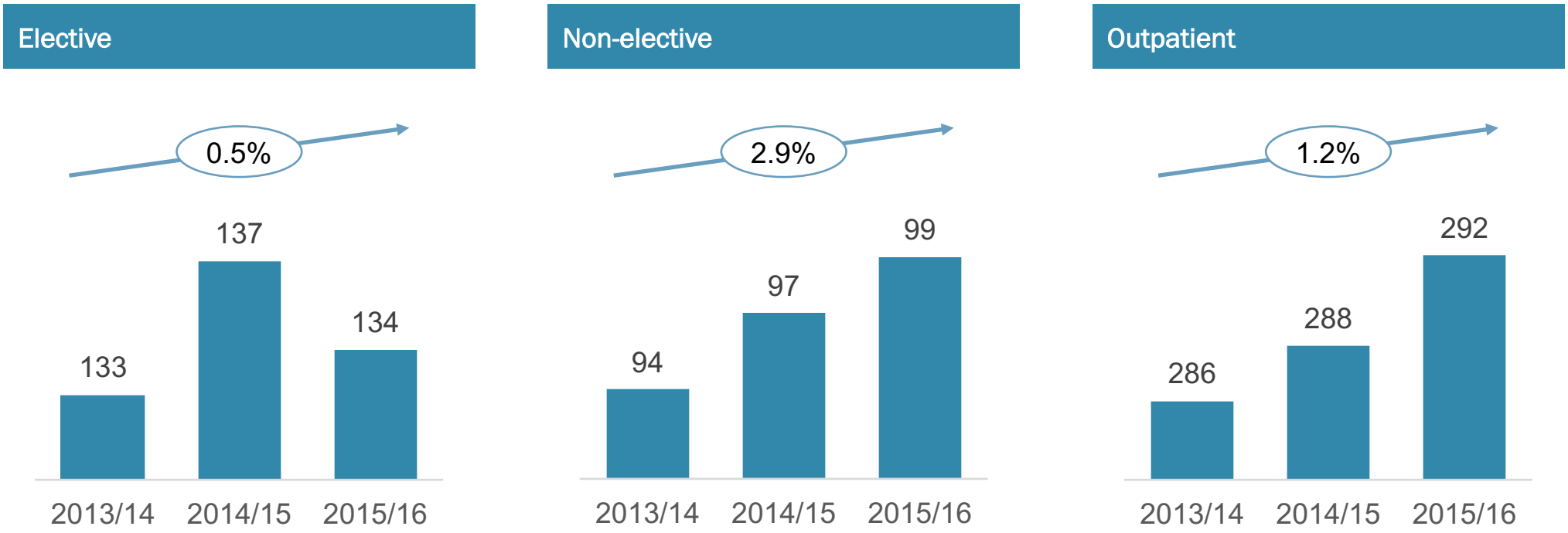
Ebbsfleet Health Garden City brings an additional pressure

- Ebbsfleet Healthy Garden City and wider local housing developments will grow Dartford, Gravesham and Swanley CCG population especially
- Population expected to grow by 21,000 by 2020/21
- Work by local NHS organisations suggests £28m health care commissioner pressure and £75m provider capital needs

Source: KMGIF, DGS CCG, DGT

The rate at which our growing population uses services is also rising, placing further pressure on services

Example: Acute activity per 1,000 population, Kent and Medway

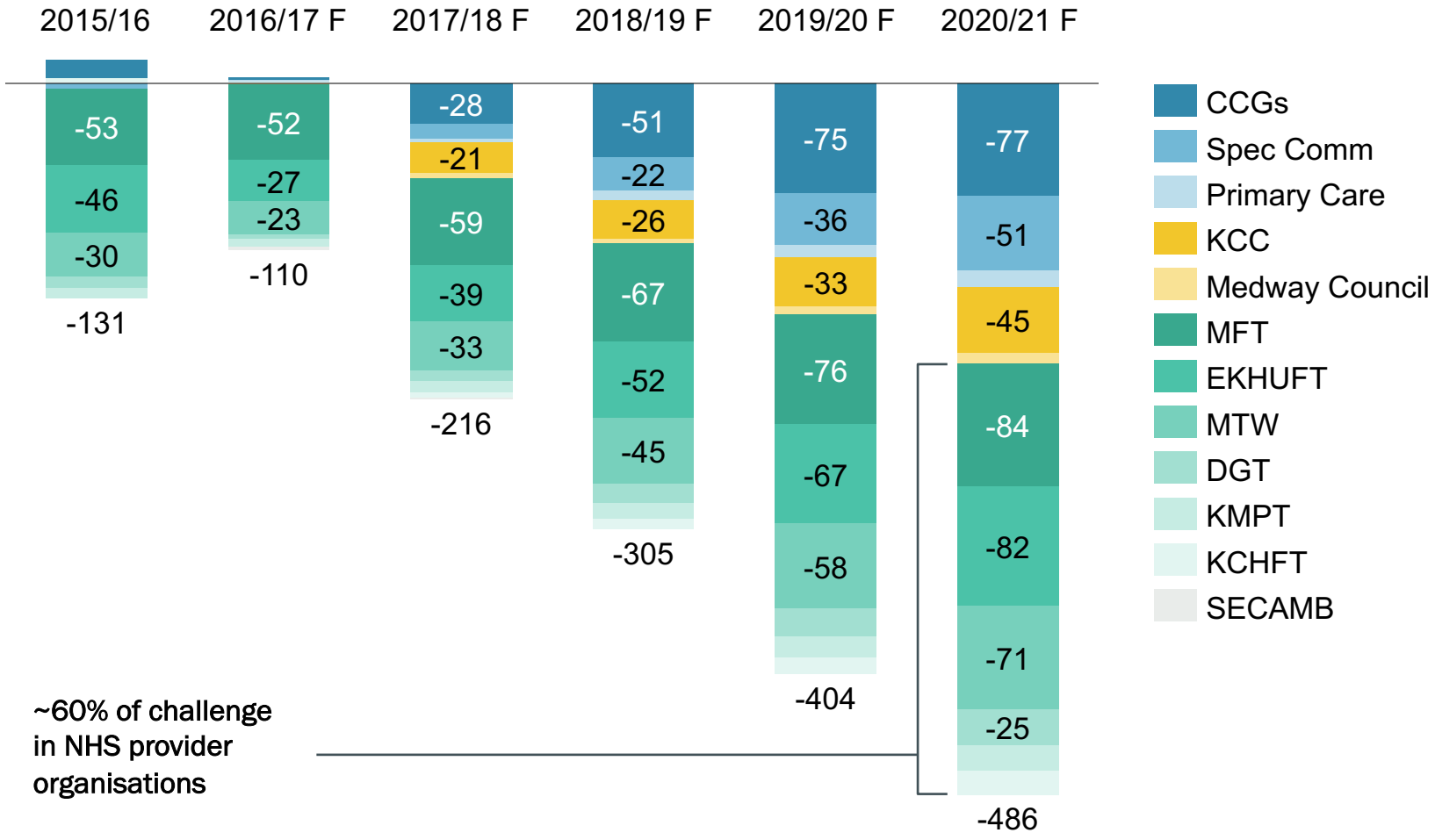


Notes: 1 Right Care peers for each K&M CCG selected and peer activity data aggregated, weighting by population
Source: MAR Data, Carnall Farrar analysis

Increasing demand is set to widen a £110m system deficit in 2016/17 into a £486m financial challenge by 2020/21 if nothing is done

£ Millions, health and social care system surplus/deficit, assuming ONS population growth

Kent & Medway system financial position, split by organisation



Note: 'No nothing' scenario is hypothetical; local authorities in particular confirm their statutory obligation and commitment not to run a deficit
Source: Kent and Medway STP Finance Group

We are pursuing transformation around four themes to tackle these challenges

Care Transformation

We are transforming our care for patients, moving to a model which prevents ill health, intervenes earlier, and delivers excellent, integrated care closer to home.

This clinical transformation will be delivered on four key fronts:

- **Prevention**: Enlisting public services, employers and the public to support health and wellbeing, with efforts to tackle the future burden of cardio-vascular disease and diabetes
- **Local care**: A new model of care closer to home for integrated primary, acute, community, mental health and social care
- **Hospital transformation:** Optimal capacity and quality of specialised, general acute, community and mental health beds
- **Mental health**: Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Productivity

We can achieve more collectively than we can as individual organisations.

This applies most immediately for Providers in Kent & Medway as they look to realise efficiencies and productivity improvements in non-clinical settings.

Learning the lessons from the Carter Review, we will undertake a programme to identify, quantify and deliver savings through collaborative provider productivity addressing the following areas:

- **CIPs and QIPP delivery**
- **Shared back office** and corporate services (e.g., Finance, Payroll, HR, Legal)
- **Shared clinical services** (e.g. Pathology integration)
- **Procurement** and supply chain
- **Prescribing**

Enablers

We need to develop three strategic priorities to enable the delivery of our transformation:

- **Workforce:** Transforming our ability to recruit, inspire and retain the skilled health and care workers we need to deliver high-quality services – including partnership with local universities to develop a medical school
- **Digital:** Unifying four local digital roadmaps within a single Kent and Medway digital framework, which both informs and is informed by the strategic clinical models we are implementing
- **Estates:** Achieving 'One Public Estate' by working across health organisations and local authorities to find efficiencies, deliver new models of care, and develop innovative ways of financing a step change in our estate footprint

System Leadership

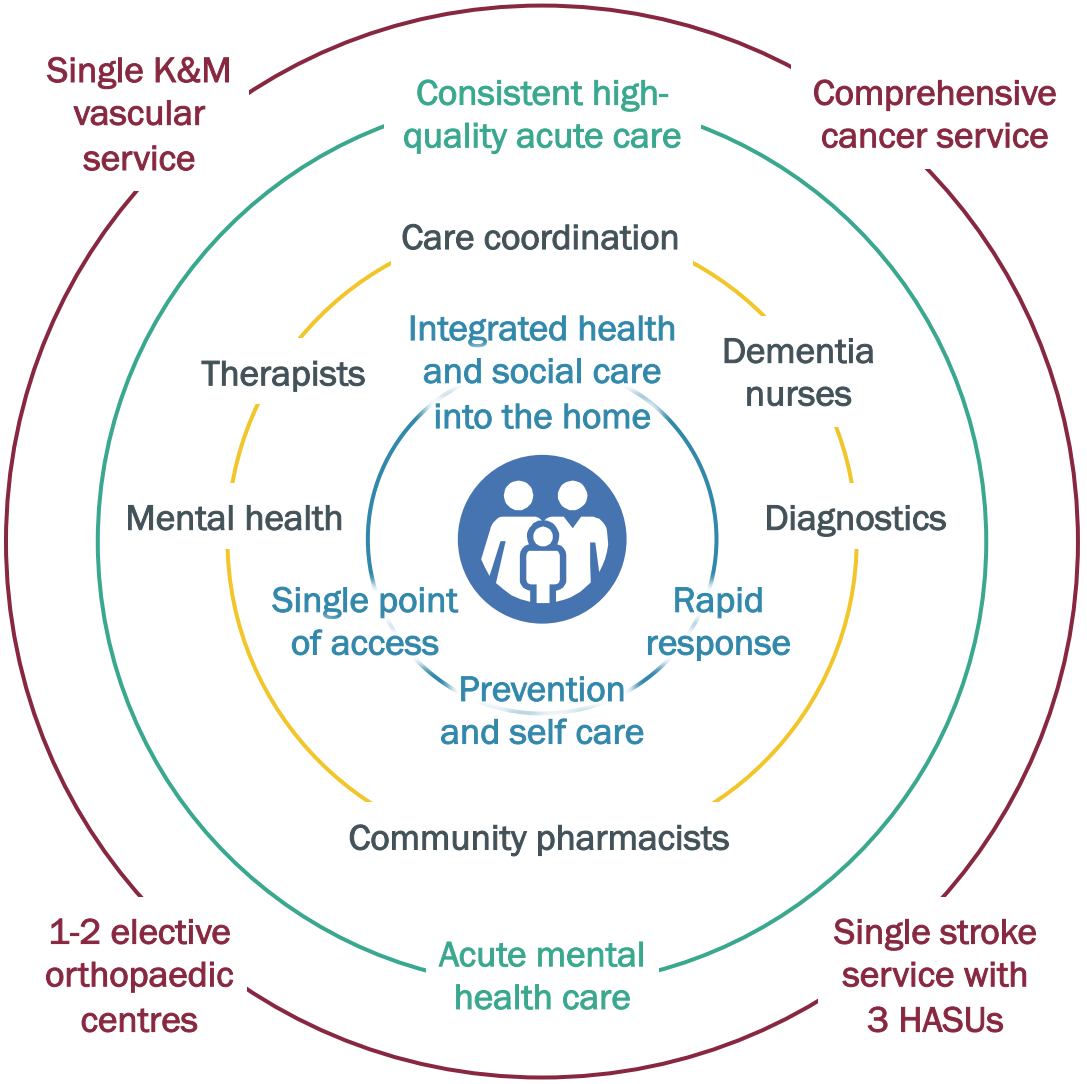
A critical success factor of this programme will be system leadership and system thinking. We have mobilised dedicated programmes of work to address:

- **Commissioning transformation:** Enabling plans for the future to be shaped by health and social care professionals, the public, patients, carers and stakeholders in an open and honest way, and responding to concerns
- **Communications and engagement:** Ensuring consistent communications and inclusive engagement which inform and include all key stakeholders in the design and development of the STP

We are currently designing a workstream to consider provider organisational form and develop the strategy to sustaining innovative provider models of care, including Accountable Care Organisations (ACOs).

Our vision for care has the patient at its core

Kent and Medway Future Care Model



How health and care services will work for patients

- Your own bed is the best bed: only the most seriously injured or ill will ever spend more than a few days in an acute hospital due to their need to be under the care of a consultant
- Teams will support frail older people and people with complex needs, including those reaching the end of their lives at home whenever possible to maximise their quality of life
- Health and social care teams will support people at home, providing care, treatment and support round-the-clock, including in a crisis – and will be based in GP practices and community hubs
- People in Kent and Medway will take good care of themselves and of each other – taking charge of their health and wellbeing, avoiding preventable illnesses, and being experts on their own health, knowing when they can manage and when they need to contact a professional
- People will have planned surgery under conditions that maximise their recovery, including improved health before their operation

We are enlisting the whole Kent and Medway community in improving health and wellbeing through our prevention programme

Our vision

- Improve health and wellbeing for our population, reducing their need for health and care services
- We aim to make this vision the responsibility of all health and social care services, employers and the public
- We will achieve this by:
  - delivering workplace health initiatives, aimed at improving the health of staff delivering services;
  - industrialising clinical treatments related to lifestyle behaviours and treat these conditions as clinical diseases;
  - treating both physical and mental health issues concurrently and effectively; and
  - concentrating prevention activities in four key areas

Our prevention priorities

- **Obesity and Physical Activity**: 'Let's Get Moving' physical activity pathway in primary care at scale across Kent and Medway. Increase capacity in Tier 2 Weight Management Programmes from 2,348 to 10,000
- **Smoking Cessation and Prevention**: Acute trusts becoming smoke-free with trained advisors, tailored support for the young and youth workers, pregnant and maternal smokers and people with mental health conditions.
- **Workplace Health**: Working with employers on lifestyle interventions and smoking and alcohol misuse, providing training programmes for improved mental health and wellbeing in the workplace
- **Reduce Alcohol-Related Harms in the Population**: 'Blue Light initiative' addressing change-resistant drinkers. 'Identification and Brief Advice' (IBA) in hospitals ('Healthier Hospitals initiative') and screening in GPs. Alcohol health messaging to the general population

Local Care aims to improve health, support independence and reduce reliance on hospitals through transformational, integrated health and social care

Our journey

Encompass Vanguard

MCP / PACS models[1]

Accountable Care Organisations

Our aspirations

- Identify patients' healthcare needs and provide integrated treatment which encompasses all of them
- Empower patients through person centered, proactive support
- Ensure increased patient participation in their own care
- Enable proactive care that supports improving and promoting health and wellbeing, supporting patients ability to live independently
- Facilitate clear signposting to the most relevant service that is driven by a 'community first' philosophy
- Utilise coordinated statutory, voluntary and where appropriate the independent sector services including: primary, community, secondary, social care, mental health and voluntary services that are wrapped around defined GP populations
- Provide a range of out of hospital services through Local Care hubs (incl. community hospitals) facilitating increased local accessibility
- Enable innovation in coordinated care provision

How we will deliver our vision

- Proactive identification
- Personalised care packages
- Self care and prevention strategies
- Multi Disciplinary Teams
- Integrated Care pathways
- Urgent and Community care
- Diagnostic and same day services

Note: 1 Multispecialty Community Providers and Primary and Acute Care Systems

Our Local Care model will be delivered across Kent and Medway through a series of strategic interventions both close to home and beyond

Key interventions

1. Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours
2. Bring integrated health and social care into the home
3. Provide rapid response service to get a community nurse to home within 2 hours and avoid ambulance or admission
4. Provide single point of access to secure any community and social care package
5. Care coordination, planning and management around GP practices and community services
6. Access to expert opinion without referral for outpatient appointment, including making use of GPSI and advanced nurse and therapist roles
7. Facilitation of transitions of care incl. discharge planning
8. Mental health liaison

Innovative interventions are also being developed and delivered locally to meet population needs

Selection of local interventions

Swale integrated care teams

Integrated care teams made up of community nurses and social care practitioners have been introduced and attached to **General Practice clusters**. Further supported by the successful procurement of adult community services, this has allowed us to move at pace to integrated new models of care (done jointly with DGS).

Dartford, Gravesham and Swanley new town

Having successfully won **healthy new town status** following a competitive process linked to the North Kent and specifically Ebbsfleet Garden City Development, significant focus is on reduction of health inequalities through new models of care.

Dartford, Gravesham and Swanley integrated commissioning

DGS has established an **integrated commissioning team** jointly with Kent Council Council for children's, Learning Disabilities and Mental Health services, including joint governance arrangements and full time posts.

Medway and Swale collaboration

Medway and Swale CCG, MFT and Medway Council have collectively created a **whole system improvement collaborative** called MASCOE to drive key components of delivery within the new models of care.

Herne Bay 7-day access

7-day access to a range of urgent and outreach services, including diagnostics have resulted in better patient experience and reduced acute admissions and A&E attendances.

Thanet IACO

The vision for integrated health and social care in Thanet is being delivered via a MCP operating as an **Integrated Accountable Care Organisation** (IACO). The IACO has just won National Association of Primary Care provider development of the year.

Encompass Vanguard CHOCs

Community Hub Operating Centres (CHOCs) have developed an Integrated Case Management (ICM) model to deliver community based integrated assessment, care planning and service delivery for people who are at risk of hospital admission.

Encompass Vanguard social prescribing

The **Encompass MCP Vanguard** has partnered with Red Zebra Community Solutions and now uses a web-based tool for NHS professionals and **social prescribing** services in the community to refer people to a range of local, non-clinical support. This has resulted in improved social, emotional or practical wellbeing for patients.

Canterbury and Coastal paramedics

Paramedic practitioners attached to General practices doing visits with the GP EPR. This has resulted in faster response rates, better patient satisfaction and a reduction in inappropriate admissions to hospitals. A similar initiative has been subsequently developed in Swale.

South Kent Coast

SKC are undertaking a Rheumatology pilot, delivering **rheumatology care closer to home**, supporting self-care, increasing capacity and primary care skill/knowledge. Potential savings of 30% against tariff. Ongoing work to replicate in cardiology and respiratory care.

Source: Kent and Medway CCGs

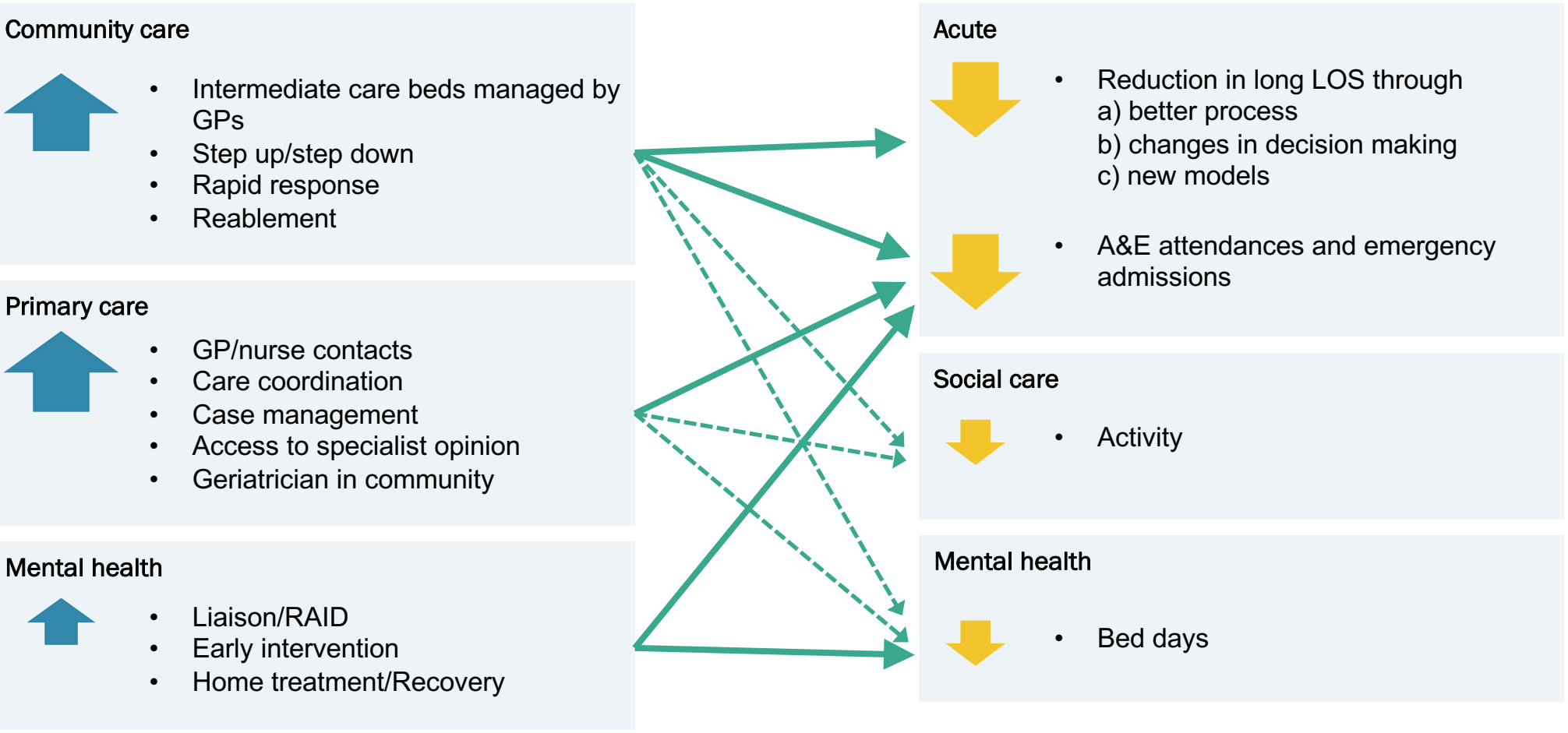
CARE TRANSFORMATION: LOCAL CARE

Growing our Local Care model will enable a change in care setting and drive large reductions in acute activity

Increased activity *from integrated care initiatives*

Drives

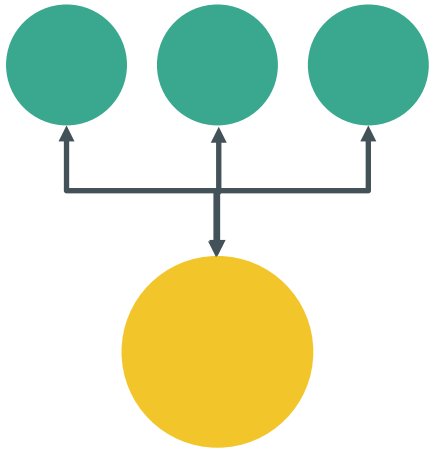
Large reductions *in acute activity (and small reductions system-wide)*



Source: Kent and Medway Local Care workstream; CCG presentation to HWBB

CARE TRANSFORMATION: LOCAL CARE

We are delivering Local Care by scaling up primary care into clusters and hub-based Multispeciality Care Provider models

Local Care infrastructure		Description	Population served
GP practices		• Individual GP practices providing limited range of services • Many working well at scale, others struggling with small scale and related issues incl. workforce	• Various
Tier 1 Extended Practices with community and social care wrapped around		• Larger scale general practices or informal federations • Providing enhanced in-hours primary care and enable more evening and weekend appointments.	• 20 – 60k
Tier 2 MCPs/PACS based around community hubs		• Multi-disciplinary teams delivering physical and mental health services locally at greater scale • Seven day integrated health and social care	• 50 – 200k

Our local implementation of the Kent and Medway model varies to meet the needs of our populations

Summary of Local Care models across Kent and Medway

	Ashford	Canterbury & Coastal	DG&S	Medway	Thanet	Swale	South Kent Coastal	West Kent
Population	129,000	220,000	261,000	295,000	144,000	110,000	202,000	479,000
No. GP practices	14	21	34	53	17	19	30	62
Average list size	9,200	10,500	7,700	5,600	8,500	5,800	6,700	7,700
Extended practices	3	5	TBC	9	4	TBC	4	9
Population	30 – 60 k	30 – 60 k	20 – 40k	30 k	30 – 60 k	20 – 40k	30 – 60 k	TBC
Hubs	1	1	5	3	1	2	1	3 – 5
Population	129,000	220,000	50 k	100 k	144,000	50 k	202,000	TBC
Chair	Navin Kumta	Sarah Phillips	Elizabeth Lunt	Peter Green	Tony Martin	Fiona Armstrong	Jonathan Bryant	Bob Bowes
AO	Simon Perks	Simon Perks	Patricia Davies	Caroline Selkirk	Hazel Carpenter	Patricia Davies	Hazel Carpenter	Ian Ayres

Notes: Whitstable Vanguard represents 4 of the 5 hubs in Canterbury and Coast CCG. Ashford, Canterbury & Coastal, South Kent Coast and Thanet have no extended practices; practices grouped directly into hubs.
Source: CCG returns, September 2016

We are investing in key initiatives which will enable our Local Care transformation and improve the way we commission and deliver health and care

	Our vision
1 **Pursue single shared record**	• Provide health and care professionals with immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history for all patients across Kent and Medway
2 **Industrialise the Kent Integrated Dataset**	• Enable information flow to support targeting, care delivery, planning, performance and payment by leveraging the unique KID dataset
3 **Develop capitated payment models**	• Enable the pooling of resource across health and social care • Breakdown silos to allow delivery of integrated care • Facilitate the development of accountable care organisations that support delivery of our vision
4 **Maximise value of one public estate**	• Release capacity that is surplus to needs from reduction in beds and release of unneccessary estate and invest in housing and community facilities • Maximise colocation of professionals in hubs to faciliate multidisciplinary working, extended hours and extended range of services available to patients • Make use of flexibilities from Local Authority to invest in one public estate
5 **Commissioning transformation**	• Develop single strategic commissioning across Kent and Medway to create the capability and capacity to drive the update of new information and payment models and secure the release of value from the estate

CARE TRANSFORMATION: HOSPITAL CARE

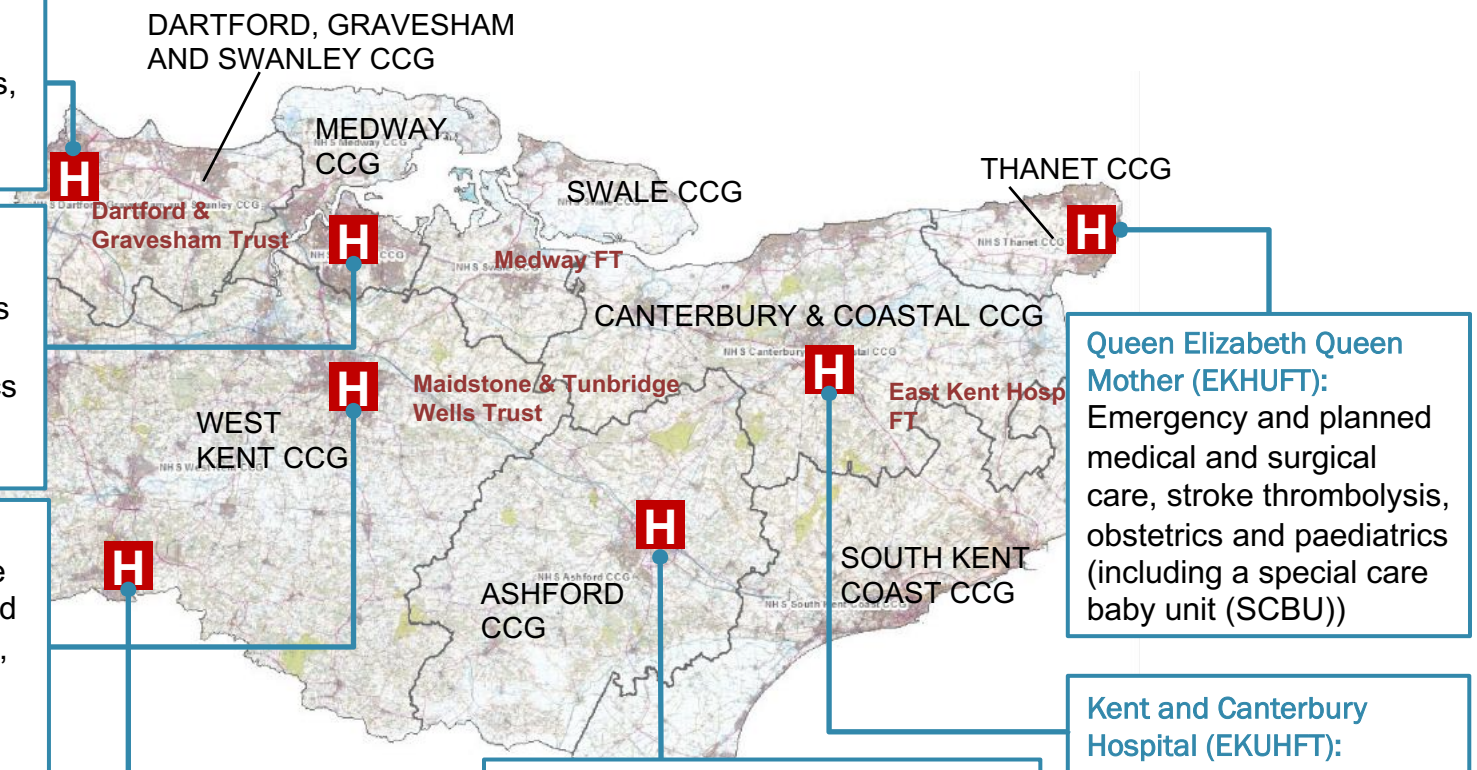
Our Acute Care model is partially consolidated, but is still largely based on historic dispersal of services

Darent Valley Hospital (DGT):
Emergency and planned medical and surgical care, plus stroke thrombolysis, obstetrics and paediatrics (including a special care baby unit (SCBU))

Medway Maritime Hospital (MFT):
Emergency and planned medical and surgical care, some specialist services (e.g. vascular, stroke thrombolysis, trauma unit), obstetrics and paediatrics (including a neonatal intensive care unit (NICU))

Maidstone Hospital (MTW):
Emergency and planned medical care (with midwife led birth centre), planned surgical care (no emergency surgery), including cancer centre, stroke thrombolysis, and ambulatory paediatrics

Tunbridge Wells Hospital (MTW):
Emergency and planned medical and surgical care, plus trauma unit, stroke thrombolysis, obstetrics and paediatrics (including a neonatal intensive care unit (NICU))



Queen Elizabeth Queen Mother (EKHUFT):
Emergency and planned medical and surgical care, stroke thrombolysis, obstetrics and paediatrics (including a special care baby unit (SCBU))

Kent and Canterbury Hospital (EKUHFT):
Emergency medical care (through acute medical take but no A&E) and some specialist provision, e.g. emergency / planned vascular, but no routine emergency surgery

William Harvey Hospital (EKUHFT):
Emergency and planned medical and surgical care, plus emergency primary percutaneous coronary intervention (pPCI), trauma unit, stroke thrombolysis, obstetrics and paediatrics (including a neonatal intensive care unit (NICU))

Progress has been made in the re-design of acute services across Kent and Medway

K&M strategic priorities: Consolidation of emergency and elective services

- Creation of emergency hospital centres with specialist services and separate emergency hospital centres;
- Establishment of specialist planned care hospital centres;
- Further consolidation and co-location of specialist services such as pPCI; vascular, renal, head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology in patient services;
- Further development of Kent's cancer centre;
- 10 clinical standards for urgent care being met;
- Exploration of more complex services in a shared care model between London and local providers;
- Development of new and innovative models of care;
- Agreement to widespread shared service arrangements with appropriate specialist service providers

East Kent

- EKHUFT has modelled the shift in activity and capital requirements for a range of acute configuration options, together with a significant and safe shift to local care models with potential activity savings worth at least 300 acute beds
- These options include the "as is" model, alongside an option that sees the closure of one site and the creation of a single site option
- EK's initial thinking sees the creation of one emergency hospital centre with specialist services[1] and a trauma unit for a natural catchment of over 1.5m
- This site will be supported by a further emergency hospital centre and a planned care hospital, supported by rehabilitation services and a primary care led urgent care centre
- Emerging model has potential to deliver over £90m efficiencies in EKHUFT

Medway, North Kent and West Kent

- The boards of MFT and MTW have agreed to a short process to complete primary objectives by the end of 2016:
  - The development of a single draft document setting out the strategic direction of acute services
  - The identification of opportunities for consolidation and greater efficiency in back office services
  - A coherent shared strategy for planned care, most likely taking the shape of a single shared centre
- A collaboration between DGT and GSTT to develop a Foundation Healthcare Group model

Note: [1] Including pPCI; vascular, renal head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology specialist in patient services

Investment in our Local Care model should enable ~£210m gross spend reduction in the acute sector by 2020/21

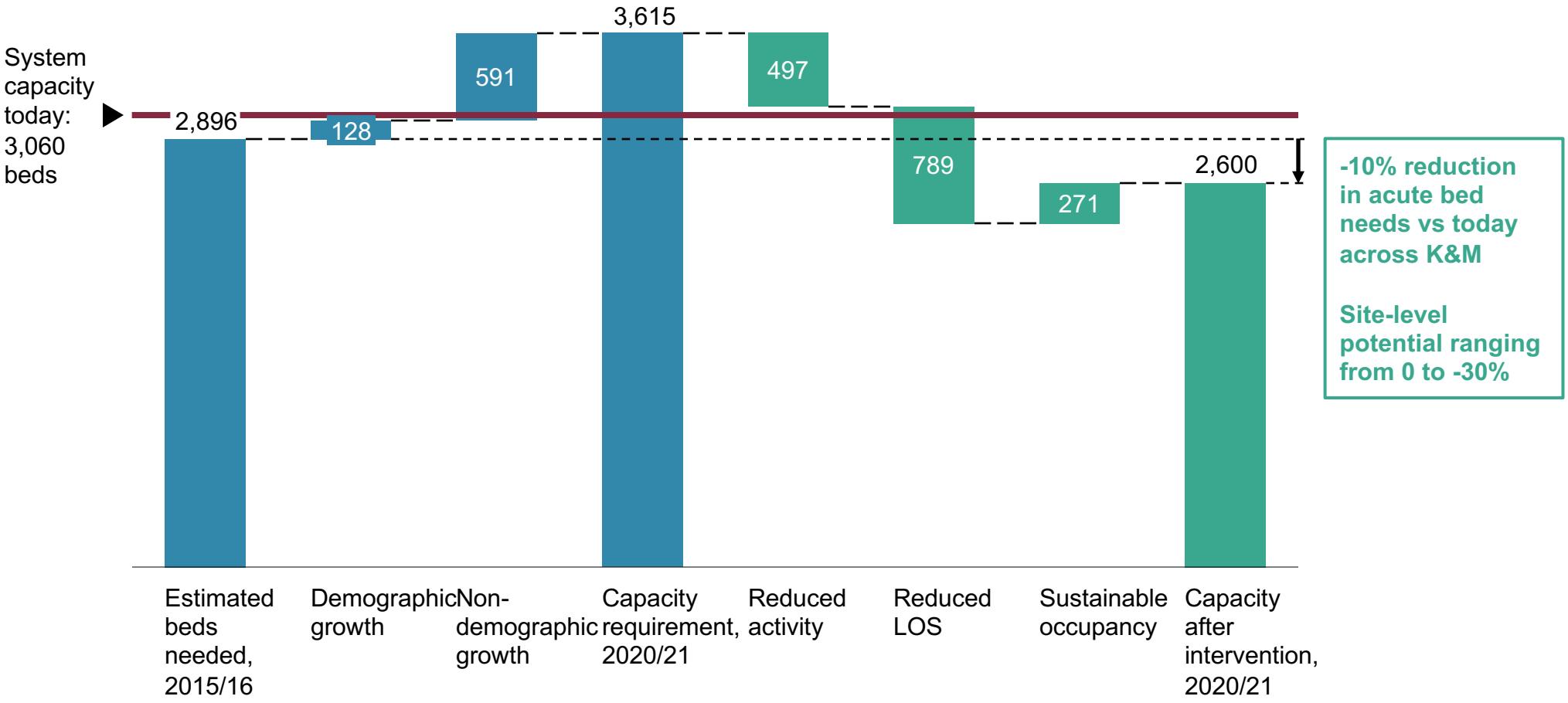
	Key enablers	Opportunity	System savings, 2020/21, £ Millions: Gross	Net[5]
1 **Avoid emergency admissions through more proactive and coordinated care**	• Care coordinators • Rapid response	• Internal and external activity benchmarking[1] suggests opportunity to reduce acute activity: – Non-elective: -13% – A&E: -16%	71	46
2 **Reduce avoidable non-elective inpatient length of stay**	• Effective discharge planning • Rapid response • Domiciliary care package • Single point of assessment	• Significant numbers of elderly patients in beds who are medically fit for discharge • Limiting non-elective stays by over-70s to 10 days would yield a ~27% bed day reduction[2]	64	48
3 **Optimise elective pathway**	• MDT clinic • Preoperative assessment • Consultant level feedback • Effective planning for discharge	• Activity benchmarking[1] suggests opportunity to reduce elective volume by ~14% • Limiting 3-9 day elective stays to 3 days would yield a ~17% bed day reduction[3]	53	49
4 **Optimise outpatient pathway**	• Expert first point of contact • Qualified referrals • Diagnostic protocols • Non-medical support and education	• Internal and external activity benchmarking[1] suggests opportunity to reduce outpatient activity by ~12%	26	22
		Total	**214**	**165**

Notes: 1 Internal benchmarking between GP practices and external benchmarking vs. Right Care peers of each Kent and Medway CCG 2 258k bed days, 830 beds vs. 2020/21 position after admission avoidance intervention. 3 16k bed days, 53 beds. Further potential to increase theatre throughput. 4 Not quantified
5 Reinvestment rates for activity reduction: NEL: 35%, EL: 5%, AE: 35%, OP: 35% first and 5% for follow-up; 25% for length of stay reduction

Source: Commissioner and Provider Data Returns, 2015/16 MAR Data, STP submission template, Carnall Farrar analysis

Improved Local Care could relieve pressure on acute capacity

Acute bed requirements to support elective and non-elective activity



Note: Assumed occupancy rates: DGT: 99%, MTW: 94%, MFT: 99%, EKHUFT: 91%. 'Sustainable occupancy' lever estimates the impact of reducing acute bed occupancy levels to 85% across the Kent and Medway system.

Source: Kent and Medway provider length of stay data; NHSE KH03 occupancy data, 2015/16; Carnall Farrar analysis

Work is ongoing to surface potential opportunities to improve the financial and clinical sustainability of hospital-based care

Current focus of our work

Phases	1 Programme mobilisation and developing our vision	2 Understanding baseline for activity, cost and spend	3 Developing our evaluation criteria	4 Identify and analyse opportunities	5 Prepare for consultation	6 Consult and agree final opportunities
Key steps	• Identify area of focus • Establish governance • Mobilise programme • Articulate and capture vision that clinicians have for how services are delivered in key areas	• Establish a clear case for change • Establish activity spend and capacity baseline • Develop and quantify change options • Assess estate and quantify capacity implications	• Develop a set of standards that are: – Guided by clinical evidence from literature – Clearly measure-able – Supported by clinical leaders • Consider co-dependencies	• Describe clinical models that are internally coherent and distinct, informed by vision, standards and co-dependencies • Perform analysis to understand impact of opportunities • Assess models against criteria	• Develop consultation plan and document • Develop PCBC and review by gateway process • Secure NHSE Gateway approval • Clinical Board and CCG governing bodies review and approve PCBC	• Engage with stakeholders and the public • Capture feedback including answers to the consultation questionnaire and more quantitative feedback • Make final decision • Plan for any implementation
Progress made	• Programme mobilised • Vision created with stakeholder buy in	• Case for change in progress • Analysis underway	• By end of November 2016	• By end of November 2016	• By April/May 2016	• June – September 2017

Our Mental Health programme will delivery parity of esteem, promote health and wellbeing, integrate physical and mental health services and improve crisis care

Our vision

We will ensure that our Mental Health provision delivers parity of esteem for any individual with a mental health condition

Our vision is to ensure that within Kent and Medway we create an environment where mental health is everyone's business, where every health and social care contact counts where we all work together to encourage and support children, their parents, young people and adults of all ages with a mental health problem or at risk of developing one to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.

Local Care:

- Promoting wellbeing and reducing poor health
- Delivering integrated physical and mental health services

1. **Live well service**: Cross-sector partnership to strengthen wellbeing by increasing access to wellbeing navigators and community link works and investing in training
2. **Open Dialogue Pilot:** Investing in holistic family intervention in first episode of psychosis to reduce admission by training more staff and peers in the approach
3. **Encompass MCP Vanguard:** Ensure MH professionals are an integral part of the model, with integrated care plans for individuals with LTC and MH comorbidity
4. **Single point of access:** Dedicated, clinically-led MH screening, assessment and signposting 24/7 linked to NHS 111, SECAMB, acute and primary care
5. **Complex needs:** Reviewing patients with complex needs in out-of-area specialist placements and seeking to repatriate; refining out-of-area placement process

Acute Care:

- Delivering improved care for people and their carers when in a crisis

1. **Improved patient flow**: Reach zero private beds by December 2016, implement alternative models of care to prevent admission and actively manage DToCs
2. **Therapeutic staffing and peer support:** Implementation of Therapeutic Staffing model on acute wards, with reduced LOS and use of temporary staff
3. **Liaison Psychiatry:** Implement Core 24 model in all acute EDs by 2018 and partner w. acute providers for Medically Unexplained Symptoms outpatient service
4. **Personality disorder pathway:** Implement NICE-compliant pathway ensuring effective prevention, community-based treatment and acute crisis response
5. **Single point of access:** Linked point of access, also providing tele-triage psychiatric assessments for people presenting in crisis

We are undertaking an ambitious programme to deliver efficiencies and productivity improvements through collaboration

Where are we today?

- Significant opportunities exist to design and deliver efficient and effective non-clinical services collaboratively
- In the first instance, we are focusing on the opportunity to consolidate corporate services between NHS provider organisations to both improve quality whilst driving down cost
- Furthermore, we will explore opportunities with local authorities where collaboration would make sense: predominantly in IT, estates and facilities, but potentially other areas in addition
- The services in scope of the initial wave of redesign programme are:
  - Finance
  - HR
  - Procurement
  - Legal services
  - IM&T
  - Estates & facilities
  - Governance & risk

What are our plans for the future?

- Our vision for the future of corporate services in Kent and Medway:
  - Tasks and resources are not duplicated between individual organisations
  - Standardisation of approach and process enables economies of scale to be delivered
  - Outsourcing of services is chosen where it provides the best route for service delivery at scale
  - Alternative methods and approaches are considered and where individual organisations work collaboratively for the greater benefit of all, balancing issues of sovereignty with issues of cost and efficiency
- The corporate services consolidation project has been incorporated in the STP financial plan with a target saving of **£39m by 2021**
- We intend to therefore undertake a larger-scale productivity programme to deliver collaborative savings in **networked clinical services, shared clinical support services and collaborative prescribing** as well as shared corporate services/back office

What are our design principles?

- In each area a consistent process will be followed to design a new shared model:
  1. Conduct a rapid review to understand the opportunity
  2. Complete a full benchmark to assess potential savings
  3. Define the collaborative strategy and identify the key initiatives through a hypothesis-driven approach
  4. Define the most appropriate sourcing strategy, e.g. in house/outsource
  5. Define the target operating model for the services
  6. Transition: establish the shared service, including organisation, people, process and technology
  7. Establish service and operating level arrangements
  8. Define supplier management arrangements:
     - A. Sourcing; scenario planning and options analysis
     - B. Procurement strategy including competitive dialogue and managing the procurement process

Source: Kent and Medway STP Productivity workstream

ENABLERS

We have mobilised Enabler groups to deliver our transformation

Workforce

Developing a workforce strategy to deliver the transformation required in K&M

Key objectives:

- Develop a fit for purpose infrastructure for workforce scheduling and planning assurance across K&M, particularly to support new care models
- Undertake an Organisational Design (OD) programme of work to ensure system leadership and talent management is in place to support the STP
- Analyse demand and projection of supply to support potential safe service and rota arrangements in K&M
- Develop a K&M Medical School for both undergraduate and post-graduate education
- Increase supply and develop specific roles in K&M proactively e.g. paramedic practitioners; dementia care workforce; pharmacy in community and primary care, physicians assistants

Estates

Establishing a single, K&M-wide view of estate held by health and care organisations (including LAs)

Key objectives:

- Establish a K&M-wide view of estate held by health and care organisations and develop a long-term estates plan to enable the transformation required in K&M
- Establish and maintain the baseline metrics for the estate, covering: land ownership, running costs, condition, suitability and occupancy
- Implement an estate efficiency savings programme through: optimising asset utilisation and occupancy; overall management of the estate; consolidation of support services; and realisation of surplus assets across the common estate.
- Redesign and align the estate footprint to support new care models , including the disposal of estates asset and exploring funding models

Digital

Delivering the digital capabilities that are necessary to underpin and facilitate the STP

Key objectives:

- Provide all STP workstreams with the Information Management and Technology capabilities necessary to deliver the transformation required
- Design and deliver a universal care record across K&M
- Ensure universal clinical access – facilitating effective and efficient care so that patients can get the right care in the right place by professionals with the right information the first time
- Establish universal transactional services and shared management information systems
- Improve communications and networking of clinical and non-clinical services across K&M
- Facilitate self care by harnessing technology such as wearable devices and patient-centric monitoring

Source: Kent & Medway STP PMO

We are innovating how patients experience care through digital initiatives

	Our vision	Progress across Kent and Medway
Universal patient record	• Health and care professionals have immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history, for all patients across Kent; with each digital footprint area determining their own delivery approach.	• West Kent currently implementing a solution across major providers; other areas working to identify preferred solution.
Universal clinical access	• Health and care professionals can operate in the same way independent of their geographic location	• No firm plans yet across KEM, although discussions are taking place with potential providers.
Universal transactional services	• Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway	• Across KEM there are plans to expand the use of eRS.
Shared management information	• Health and care professionals have the management information they require to run an efficient and effective service for patients e.g. details of bed occupancy and compliance with targets.	• Most provider organisations in Kent have deployed Shrewd to gather KPIs. • Core business intelligence under procurement jointly by KEM CCGs
Online patient services	• Patients can access their medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question	• Patients access GP records provided through the GP system in most parts of KEM. Ongoing work to develop online patient portals
Expert systems	• Health and care professionals and patients have access to knowledge bases to support the care processes	• Limited community wide expert systems exist. • Needs further definition to develop requirements
Personal digital healthcare	• Patients can use personal technology to support their healthcare e.g. a device can automatically send data to alert their GP. This can be collated and used to inform population health management	• Limited facilities in place at present and needs further definition

Source: Kent and Medway STP PMO

We are pursuing ACO arrangements and strategic commissioning and have agreed a series of next steps for our Commissioning Transformation workstream

Future of commissioning

ACOs and strategic commissioning

- Pursuing the potential for commissioning to move into new care models operating in ACO-type arrangements
- Strategic commissioning will need to be undertaken at a greater scale, across a wider geography, with focus on:
  - Defining and measuring outcomes
  - Putting in place capitated budgets
  - Appropriate incentives for providers to deliver outcomes
  - Longer-term contracts extending over five to ten years

Benefits

- Reduce transaction costs and free up resources to invest in improving health and care.
- Generate opportunities to bring together the current dispersed approach to enabling infrastructure
- Support streamlining of back office overheads to ensure that resources are focused on front line delivery.
- Drive integration of health and social care at all levels and support new care models to be implemented at pace and scale

Impacts to consider

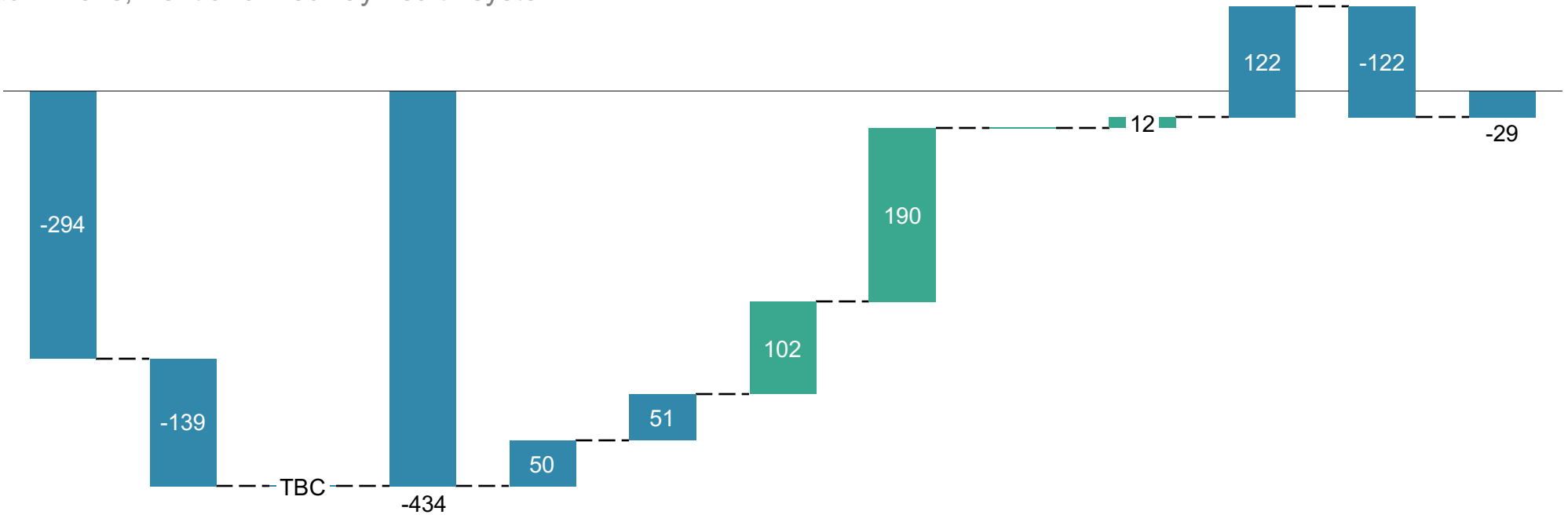
- Understand new contracting models to allow ACOs as lead providers to be commissioned to provide appropriate outcomes for defined populations with minimal transactional bureaucracy
- Understand evolution of CCGs and NHSE commissioning and impacts on form and function of CCGs

Next steps

- Reset the K&M leadership coalition for change (executives, practitioners and politicians)
- Develop and agree a more compelling case for change across K&M with absolute buy-in from all organisations
- Develop transformation plan to address the case for change which binds K&M together – story + numbers
- Clarify what model(s) are to be pursued for ACO/MCP/PACS and what will deliver
- Develop options and decide scale and subsidiarity
  - What to do at K&M and different levels?
  - What to do locally and what to aggregate up?
- Resourcing plan of money and people to deliver plans – put forward best people to drive. Build on existing success and deprioritise other things.

Our financial plan brings the system close to balance

£ Millions, Kent and Medway health system



- Assumed 100% investment of STF funding to deliver transformational change and service developments
- Further work required to refine this need.

- Outstanding gap relates to £29m funding for Ebbsfleet growth by 20/21
- Also a capital implication of £75m.

Notes: 1 Includes 7 day services, GP forward view, increased capacity for CAHMS and eating disorders, implementing mental health task force and cancer task force, maternity review, digital road maps, investment in prevention.

Source: STP financial template

STP NHS financial submission

Healthcare financial forecast, 'do nothing'

£m	15/16	16/17	17/18	18/19	19/20	20/21
Commissioner						
Income	2,850	2,937	3,019	3,102	3,190	3,327
Spend						
Secondary Care	1,631	1,652	1,704	1,751	1,801	1,867
Admin	39	40	41	41	42	43
Other	525	559	590	619	650	683
Primary Medical Care	221	228	239	249	259	273
Specialised	424	455	487	521	558	601
NR Spend - Transformation	0	0	0	0	0	0
Total	2,841	2,934	3,060	3,182	3,310	3,467
Commisioner Surplus (Deficit)	**9**	**3**	**(41)**	**(80)**	**(120)**	**(139)**
Provider						
Income (inc. Non-Footprint)	1,888	1,940	1,996	2,043	2,114	2,190
Spend						
Pay	1,263	1,280	1,329	1,377	1,438	1,502
Non-Pay	765	773	818	862	922	982
NR Spend- Transformation	0	0	0	0	0	0
Total	**2,028**	**2,053**	**2,147**	**2,239**	**2,359**	**2,484**
Provider Surplus (Deficit)	**(140)**	**(112)**	**(151)**	**(195)**	**(246)**	**(294)**
Indicative STF Allocation 2020/21	0	0	0	0	0	0
Footprint Surplus (Deficit)	**(131)**	**(109)**	**(191)**	**(276)**	**(365)**	**(434)**

Impact of interventions

15/16	16/17	17/18	18/19	19/20	20/21
0	0	0	0	0	0
0	0	0	0	0	0
0	0	(25)	(79)	(110)	(147)
0	0	0	(5)	(6)	(6)
0	0	(8)	(10)	(12)	(12)
0	0	0	0	0	0
0	0	(10)	(22)	(36)	(51)
0	0	0	0	0	61
0	0	(43)	(117)	(163)	(216)
0	**0**	**43**	**117**	**163**	**216**
0	0	(24)	(75)	(103)	(137)
0	0	0	0	0	0
0	0	(48)	(114)	(174)	(232)
0	0	(22)	(48)	(70)	(93)
0	0	0	0	0	61
0	**0**	**(70)**	**(162)**	**(244)**	**(264)**
0	**0**	**46**	**87**	**141**	**127**
0	0	34	34	0	122
0	**0**	**89**	**204**	**304**	**343**

'Do something', base case

15/16	16/17	17/18	18/19	19/20	20/21
2,850	2,937	3,019	3,102	3,190	3,327
1,631	1,652	1,679	1,671	1,690	1,719
39	40	41	36	37	37
525	559	582	609	638	671
221	228	239	249	259	273
424	455	477	499	522	550
0	0	0	0	0	61
2,841	2,934	3,017	3,064	3,147	3,311
9	**3**	**2**	**37**	**43**	**16**
1,888	1,940	1,972	1,968	2,011	2,053
1,263	1,280	1,281	1,263	1,263	1,271
765	773	796	814	852	888
					61
2,028	**2,053**	**2,077**	**2,077**	**2,116**	**2,220**
(140)	**(112)**	**(105)**	**(108)**	**(105)**	**(167)**
0	0	34	34	0	122
(131)	**(109)**	**(68)**	**(38)**	**(62)**	**(29)**

Capital implications are being assessed and outline capital requirements are detailed in the financial return. Lack of access to capital is potentially a significant barrier to change (including to support transformation but also to support smaller schemes to enable operational delivery, e.g. endoscopy). It is inevitable that transformation of the care model will require a re-profiling of estate and we are working with KCC, who are leading on estates for the STP, to identify innovative solutions. As part of this we are looking to work with NHS I, NHS E and NHS Property Services to develop a business case to reinvest receipts from disposals to enable transformation.

Source: STP financial template

Sensitivity analysis on STP financial submission

Health system impact, £ Millions

		Upside	Base case	Downside
	20/21 challenge, 'do nothing'	(434)	(434)	(434)
	CCG QIPP	50	50	25
	NHSE QIPP	51	51	25
Care Transformation	Secondary to out-of-hospital care	74	33	10
	Primary Prevention	22	22	11
	RightCare Savings	46	46	23
	Total	**141**	**102**	**44**
Productivity	Cross Organisational Savings	39	39	20
	Delivery of Provider BAU CIP	151	151	75
	Total	**190**	**190**	**95**
Enablers	**TBC**			
System Leadership	Reconfiguration of Commissioners	6	6	3
	Reconfiguration of Providers	6	6	3
	Total	**12**	**12**	**6**
	Service Developments cost more/less than £122m	70	0	(35)
	Variance on 16/17 Position	0	0	(108)
	Ebbsfleet Additional Growth	28	0	0
	Total	**126**	**0**	**(143)**
	Grand Total	**110**	**(29)**	**(382)**

Source: STP financial template

Emerging analytical insights suggest a stretch target, validating the opportunity for our Care Transformation programme to enable financial sustainability

Workstream	Net impact, base case, 2020/21, £M	Key assumptions
Local Care / Hospital Care	156	• Acute activity reductions to match Right Care peer or internal GP top decile level: NEL 13%, A&E 16%, EL 15%, OP 12% • Acute reduction in avoidable inpatient length of stay – Non-elective stays by over-70s limited to 10 days yielding 27% bed day reduction – Elective stays in key specialisms reduced (TBC) yielding a 17% bed day reduction • Aggregate reinvestment rate of 22% to enable new Local Care model, integrating primary, community, social, mental health and acute care • Impact on bed-based community care not yet quantified • Impact beyond activity/LOS reductions enabled by Local Care model not yet quantified
Mental Health	20	• Shift in care delivery model from inpatient admissions to community contacts to match top quartile delivery cost performance among peer CCGs with comparable population complexity • Assuming £375 cost per OBD and £125 cost per contact (NHS Benchmarking national averages) • However, additional cost pressure (not quantified) may exist incremental to assumed financial challenge to deliver the Five Year Forward View for mental health
Prevention	21	• TBC
Total	**197**	

Source: Carnall Farrar analysis

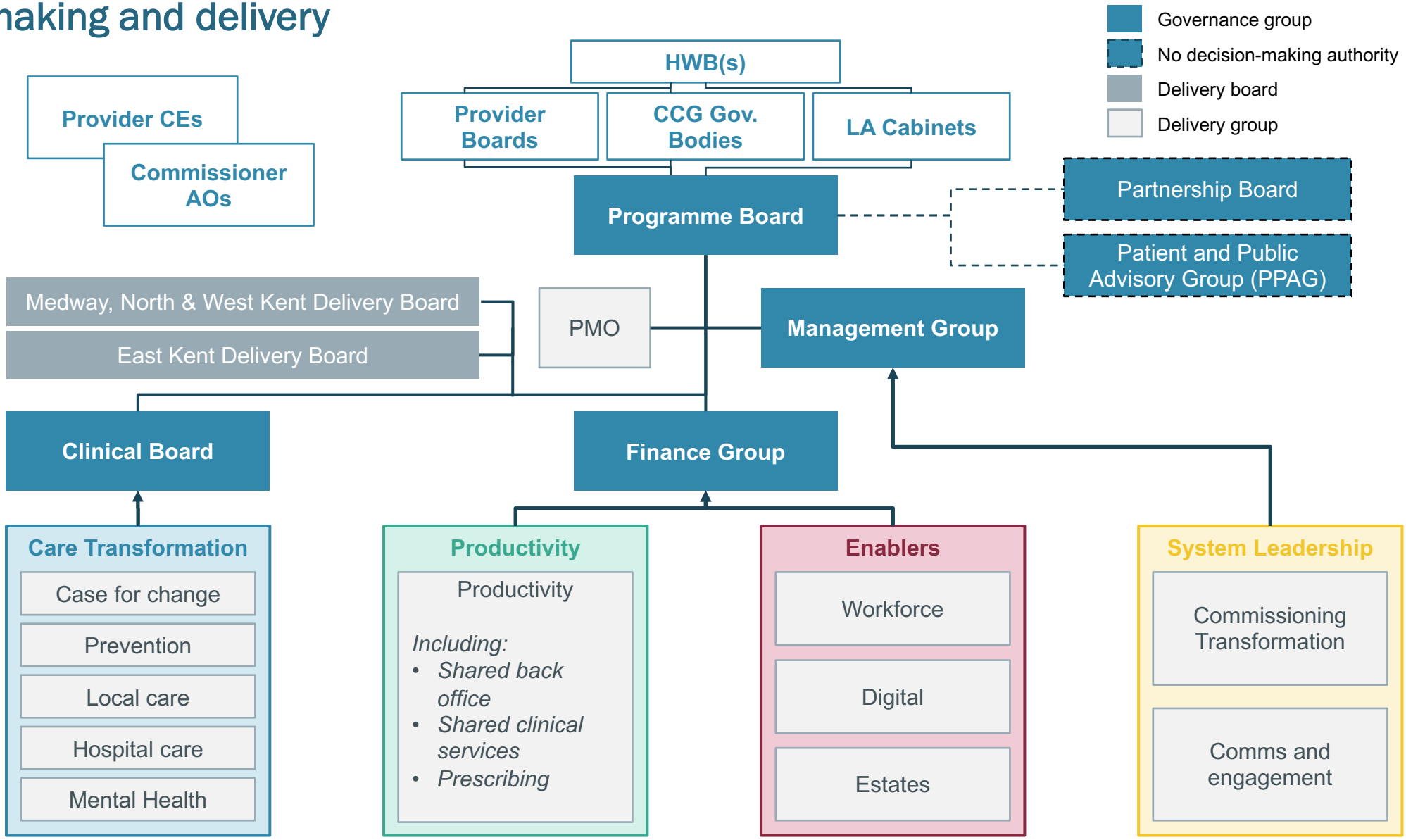
We are moving next to quantify bottom-up the impact of the Kent and Medway local care model which will enable this financial transformation

Position today

	1	2	3
Phases	**Quantify the opportunity to reduce acute activity and spend**	**Develop the new models of local care which will enable the change**	**Translate new models into impact on activity, spend, workforce and capacity**
Key steps	• Develop population segmentation to understand K&M activity and spend • Estimate savings potential: – Benchmarking vs. Right Care peers – Internal GP practice variation – Clinical review	• Engage clinicians to develop Local Care model to support health and wellbeing and prevent acute activity (e.g. MCP, PACS) • Identify acute configuration options by understanding site-level economics and future activity flows	• Specify changes to care package by population segmentation • Quantify changes to activity and resulting workforce and capacity requirements • Develop financial model and compare to baseline to understand net impact
Progress made	• Identified opportunity to reduce activity to match Right Care peers and reduce excessive length of stay among elderly	• Developed local plans for new models of care • Working to develop common Kent and Medway blueprint	• Data analysis underway to quantify new models of care and acute configuration options

Source: Carnall Farrar methodology

We have strengthened our STP governance arrangements to accelerate decision-making and delivery



Source: Kent and Medway STP PMO – emerging recommendations following STP Governance Workshop, 17 October 2016

We have mobilised Oversight Groups to steer and oversee the transformation

	Role	Membership
Programme Board	• Provides collective leadership to drive development and implementation of STP • Ultimately responsible for design and delivery • Ensures programme keeps to time and focus and that it delivers the outcomes required	• **Independent Chair: Ruth Carnall** • Glenn Douglas, STP SRO • Michael Ridgwell, STP Programme Director • CCG AOs • Trust Chief Executives • Chief Executives of KCC and Medway Council • NHSE and NHSI Regional Directors • Chairs of Clinical Board • Chair of Finance Group • Chair of Patient and Public Advisory Group • Comms and engagement lead
Management Group	• Supports Programme Board to ensure efficient and effective oversight of programme • Drives programme delivery to ensure on track • Oversees PMO and work of System Leadership workstreams	• **Chair: Glenn Douglas** • Michael Ridgwell • Ian Ayres (nominated by CCGs) • Matthew Kershaw • Paul Bentley • Helen Greatorex • Ian Sutherland, Medway Council • Kent County Council rep. (TBC) • Phil Cave, Finance Group Chair • Chairs of Clinical Board • Comms and engagement lead
Clinical Board	• Provides clinical leadership to programme • Leads development of strategy's clinical content and oversees work of clinical workstreams • Advises Programme Board on all clinical matters	• **Co-chairs: TBC** • Clinical Chairs of CCGs • Trust Medical Directors • Directors of Public Health • Senior Social Care professionals from Adults' and Children's services • Nursing and Allied Health Professional representatives
Finance Group	• Provides financial leadership and oversees of the Enabler and Productivity workstreams • Provides strategic advice and guidance for STP delivery and development • Ensures the plan makes best use of available resources for K&M population	• **Chair: Phil Cave** • All Chief Finance Officers from CCGs • All NHS and NHS Foundation Trust Finance Directors • NHS England specialised commissioning finance lead • NHSE primary care commissioning finance lead • KCC Finance Lead • MUA Finance Lead

Source: Kent and Medway STP PMO

Our workstreams are mobilising at pace to detail our strategy

R Red A Amber G Green

	Workstream	SRO	Status
Care Transformation	Case for change	• Co-chairs of Clinical Board	G
	Prevention	• Andrew Burnett (Dir. Public Health, MUA) • Andy Scott-Clark (Dir. Public Health, KCC)	G
	Hospital Care	• Glenn Douglas (CE, MTW)	R
	Local care	• Caroline Selkirk (AO, Medway CCG)	R
	Mental Health	• Helen Greatorex (CE, KMPT)	A
Productivity	Provider productivity including shared back office, shared clinical services and prescribing	• Steve Orpin (DoF, MTW)	A
Enablers	Workforce	• Hazel Carpenter (AO, SKC & Thanet CCGs)	R
	Digital	• Susan Acott (CE, DGT)	A
	Estates	• Rebecca Spore (Dir. Of Infrastructure, KCC)	A
System Leadership	Commissioning transformation	• Felicity Cox (NHS England), supported by Ian Ayres as Lead (AO, West Kent CCG)	A
	Communications and engagement	• Michael Ridgwell (STP Programme Director)	A

Mobilisation and next steps

- Each workstream has:
  - An assigned SRO; and
  - completed a Project Initiation Documents (PID)
- Workstreams are at different stages of development as a result of the programme being stood up at pace
- During the next 3 months, all workstreams will undertake a consistent and detailed planning and design process through facilitated workshops – this will ensure consistent planning assurance and governance reporting
- The STP PMO will provide the structures, processes and template materials to enable the workstreams to plan and deliver projects effectively and in a consistent approach
- Workstreams will routinely report to their corresponding Oversight Group

Source: Kent and Medway STP PMO

We are pressing ahead to meet key programme milestones

Design
Oct – Dec 2016

- **Oct 2016:** Programme governance arrangements agreed; PMO, workstreams and Oversight Groups mobilised
- **Oct 31 2016:** Clinical model evaluation criteria agreed at Programme Board
- **Nov 2016:** Initial clinical model options set out
- **Nov 2016:** Local Care and Hospital transformation modelling completed
- **Nov 2016:** Initiate pre-consultation engagement
- **Dec 2016:** Clinical Board and Programme Board review case for change
- **Dec 2016:** Organisations develop Operational Plans for FY17/18

  Note: though this is not the direct responsibility of the STP, the STP will track progress and hold peers to account

Prepare for consultation
2017

- **Jan 2017:** Case for change published
- **Feb 2017:** Critical workforce analysis completed
- **Feb 2017:** Clinical model options evaluated against agreed criteria
- **March 2017:** Formal sign off of agreed clinical model
- **April 2017:** Pre-Consultation Business Case developed
- **April 2017:** Consultation document developed
- **May 2017:** CCG governing bodies approve PCBC, consultation document and consultation plan
- **May 2017:** NHS gateway approval secured
- **June 2017:** Consultation begun
- **Aug 2017:** Review responses
- **Dec 2017:** Final consultation decision made
- **Dec 2017:** Implementation plan developed

Implement
2018 – 2020

- **Implementation of overall programme, based on output of previous phases**
  - Implementation plans identified to be rolled out in waves to ensure delivery
  - Wave durations vary by workstream (between 3-6 months)
- **STP PMO to remain in place to monitor and ensure effective implementation of programme**
  - Phased transition of oversight and monitoring from the STP PMO after wave 1, to ensure ownership by relevant stakeholders

Source: Kent and Medway STP PMO

Development of our case for change is an immediate priority to be overseen by the Clinical Board

Agreed approach by end of 2016

1 Develop the case for change using existing data

Key steps

- **Establish the Clinical Board**: confirm the terms of reference and membership. Convene first Board meeting. Confirm specific contributions required from members. Review and confirm results from analysis in 1:1 discussion with key individuals.
- **Capture and distil an agreed crisp and compelling case for change** in a written prose and brief PowerPoint.

Approach

- Assess existing case for change
- Work with Clinical Board to discuss and seek contributions
- Perform and review targeted analysis
- Synthesise key themes
- Review with the Clinical Board
- Approval by the Clinical Board

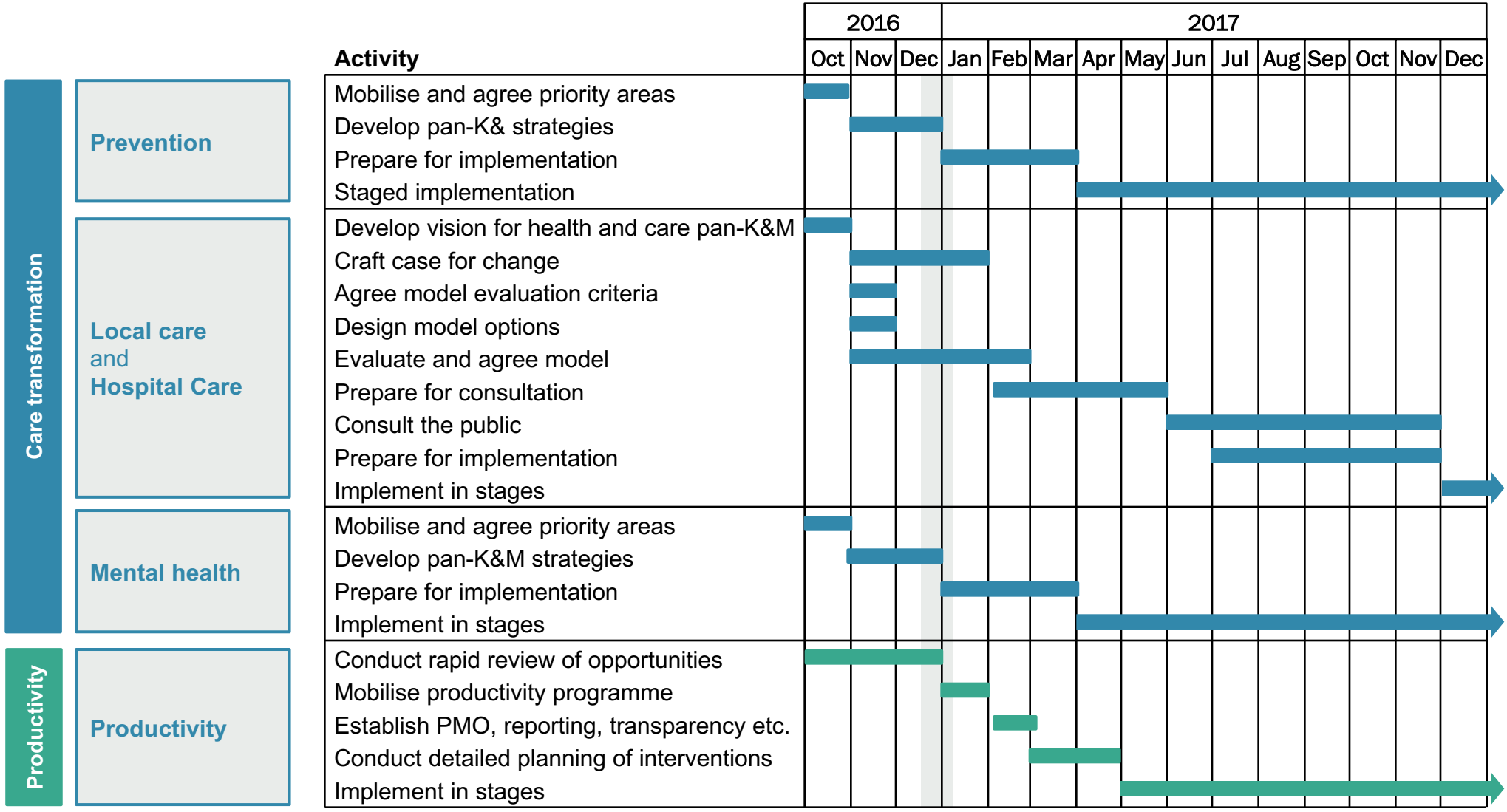
2 Undertake additional data collection

- **Collect and review local, bespoke data** relating to:
  - Self-assessment against quality standards
  - Acuity audit across acute and community hospital beds
  - Drivers of the commissioning and provider deficits
  - Number of lives lost through weekend working
  - Workforce (vacancies, turnover, sickness)
  - Local success stories
  - Utilisation of community hospitals

- Draft data collection instrument
- Meet with Medical Directors to discuss data collection requirements, expected inputs and outputs
- Data collection, analysis and presentation
- Review with key individuals
- Review with the Clinical Board
- Support Medical Directors in their communication to senior colleagues the steps being taken

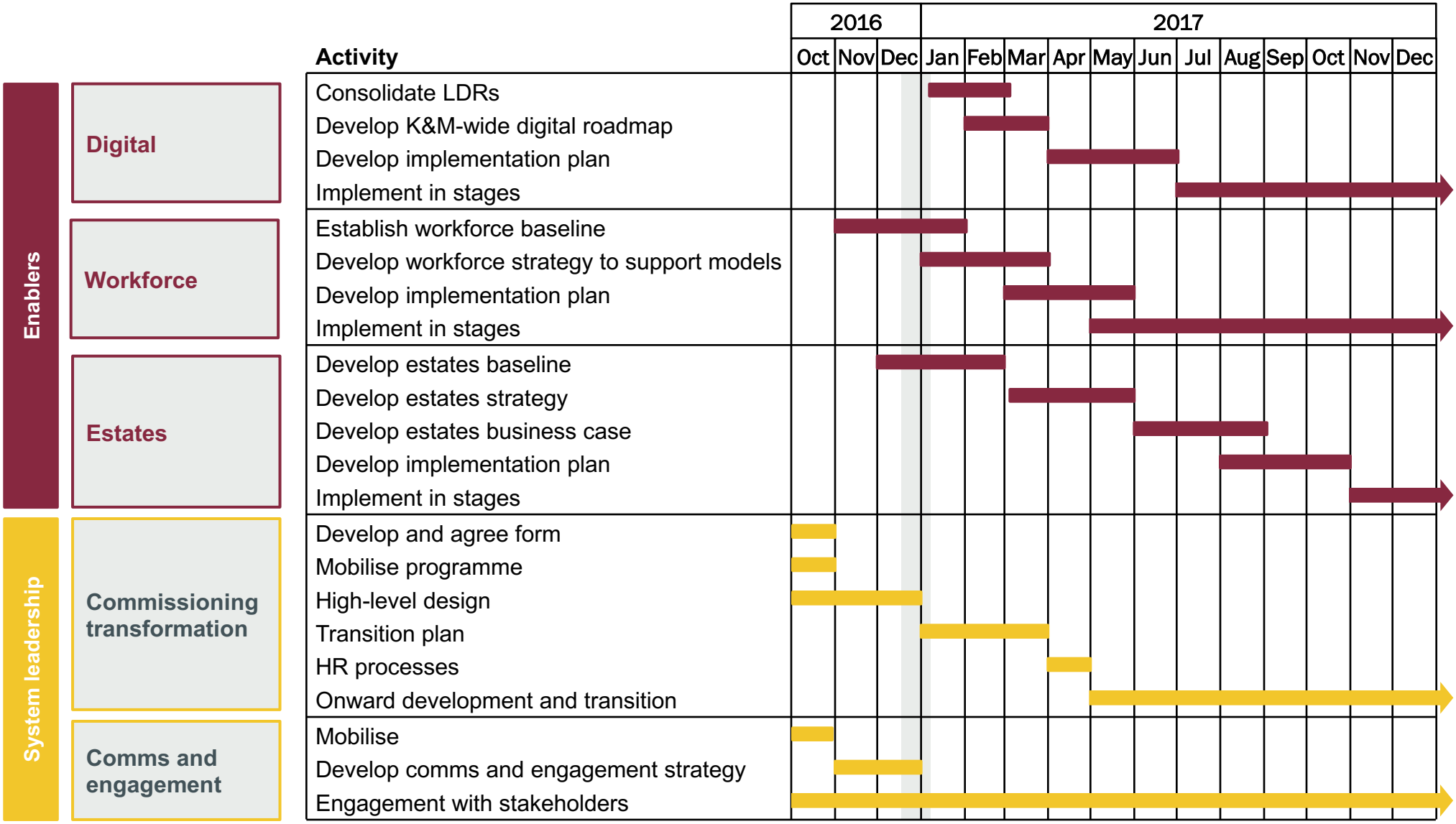
Source: Carnall Farrar engagement plan

K&M STP overarching programme timeline (1 of 2)



Source: Kent and Medway STP PMO

K&M STP overarching programme timeline (2 of 2)



Source: Kent and Medway STP PMO

In the interests of transparency this is submission remains unaltered from the version submitted to NHS England and NHS Improvement on the 21st October 2016 – the following lists changes that have been made to this submission since it's publication

- Slide 9 - footnote on should refer to "do nothing scenario" not "no nothing scenario"
- Slide 11 references 3 HASUs (hyper acute stroke units) and 1to 2 elective orthopaedic centres, the development of these would be subject to public consultation (with regard to the development of orthopaedic centres this is just one example of how the separation of planned and unplanned care could be supported and different approaches are being considered in different areas and would be subject to consultation if required)
- Slide 15 should say Ashford Rural 6-day service not Herne Bay 7-day service
- Slide 21 references that in East Kent the options modelled include an "as is" model, alongside an option that sees the closure of one site and the creation of a single site option; these represent a number of the options alongside a range of other options representing varying degrees of potential change that have been modelled
- Slide 25 should indicate that the open dialogue intervention will be used across diagnoses (rather than the first episode of psychosis as it currently reads)
- Slide 28 reference KEM – this should refer to Kent and Medway
- Slide 36 references KCC and Medway Council chief executives would sit on the programme board this should indicate that senior officer representation, chair of health and wellbeing boards and directors of public health from the two councils would sit on the group.

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