APPENDIX 1

NHS
Medway Clinical Commissioning Group

Medway CCG Operational Plan 2017 to 2019

Transforming health and social care in Kent and Medway

Sustainability and Transformation Plan

Contents

Executive Summary 4
1. Kent and Medway Sustainability and Transformation Plan (STP) 6
2. Finance and QIPP 11
2.1 Quality, Innovation, Productivity and Prevention (QIPP) 12
2.2 Baseline growth assumptions 14
3. Primary Care, Community Services, Prevention, Integration and Coordinated Care 16
3.1. The Medway Model 16
3.2. General Practice and Primary Care 17
3.3. Workforce 25
3.4. Coordination of care 25
3.5. Medicines Management 25
3.6. Prevention 26
3.7. Better Care Fund 31
3.8. Continuing Health Care 33
4. Urgent and Emergency Care 36
4.1. Context 36
4.2. Accident and Emergency Delivery Board (AEDB) 37
4.3. Unscheduled Care Improvement Plan (UCIP) 38
4.4. Contract Management 39
4.5. Frailty and falls 39
4.6. Surge management 39
4.7. Urgent Care Network 39
4.8. Emergency Ambulance Pathways 40
4.9. Constitutional Standard Monitoring and Risk Management 41
5. Planned Care 42
5.1. 18 weeks Referral to Treatment 42
5.2. Planned Care Pathways 43
5.3. Children's Services 45
5.4. Maternity 46
5.5. Constitutional Standard Monitoring and Risk Management 47
6. Cancer 49
6.1. Constitutional Standard Monitoring and Risk Management 51
7. Mental Health 52
7.1. Dementia 52
7.2. Increase Access to Psychological Therapies (IAPT) 55
7.3. Early Intervention to Psychosis (EIP) 56

7.4. Eating Disorder 57
7.5. All Age liaison Psychiatry “core 24/7” 57
7.6. Suicide Prevention....58
7.7. Eliminate out of area placements for non-specialist acute care....59
7.8. Commission effective 24/7 Crisis Resolution Home Treatment Teams as an alternative to acute admissions....59
7.9. Personal Health Budgets 60
7.10. Severe Mental Illness 61
7.11. Local transformation plan 61
7.12. Children and Young People – Improving Access to Psychological Treatment 62
7.13. Perinatal mental health....63
8. Learning Disabilities: Transforming Care 65
9. Improving Quality 68
10. Enablers 74
10.1. Patient Experience and Patient & Public Engagement Strategy (PEPPE)....74
10.2. Partnership Commissioning 74
10.3. Estates transformation....75
10.4. Information and the Local Digital Roadmap (LDR)....76
10.5. MaSCOE....79
10.6. Workforce....80
10.7. Equipment 81

Executive Summary

Medway Clinical Commissioning Group is an active and proactive partner within the Kent and Medway Sustainability and Transformation Plan (K&M STP) and this document sets out the CCG's operational plans for the local implementation of this for the next two years. Both have been created with the strategic challenges below in mind, all of which are facing the broader system at a local and national level.

The CCG committed to developing a strong clinically-led organisation that puts the needs of Medway residents at the heart of its decisions. Our teams work with partners to provide opportunities for people to access services that help them stay healthy. NHS Medway CCG is a membership organisation consisting of GPs from 51 GP practices from across the Medway towns. It is responsible for planning and buying local NHS services, serving a patient population of around 300,000.

The CCG is focussing on improvements in a number of key areas including:

- Ensuring that providers collaborate to provide a wider range of services locally through delivery of the Medway Model and the Kent and Medway Sustainability and Transformation Plan
- Cancer: Preventing Cancer, Early Diagnosis, Improving Cancer treatment and Care, Living with and Beyond Cancer
- Long term support for patients with dementia
- Ensuring that patients are treated within 18 weeks from GP referral
- Ensuring that patients are discharged or admitted from A&E within 4 hours of arrival
- Supporting primary care through the GP Forward View and high impact changes
- Transforming Care for people with learning disabilities
- Improving Access to Psychological Therapies and Early Intervention in Psychosis
- Improving quality of care and the health of the population

This operational plan has been set out in line with the national "must do's" followed by a chapter on enablers. Together these demonstrate how Medway CCG will address the significant challenges to quality, performance and finances within the local health economy.

Medway CCG has developed its Medway Model, a local approach to the K&M STP for local care which builds upon the House of Care approach.

This operational plan is driven by the latest:

- Planning guidance including the '9 Must Dos'
- The 6 clinical priorities with Cancer and Dementia demonstrating the greatest need for improvement
- Delivery of the Medway aspects of the Kent and Medway Sustainability and Transformation Plan
- Constitutional access requirements
- The Key Lines of Enquiry
- The areas of concern highlighted by Right Care (e.g. cancer and respiratory)
- The CCG Improvement and Assessment Framework
- The CCG's Strategic Objectives
- Local service transformation plans
- Joint Strategic Needs Assessment for Medway
- The need for financial balance and the need to meet demand

This operational plan sets out plans for health care in Medway in the following high level domains:

- Primary care, community services, prevention of ill health, integration and coordinated care: how we will deliver our Medway Model; support and commission GP practices; develop local health centres and build local care teams; deliver the GP Forward View, build in primary care resilience and our plans for recommissioning community care.
- Urgent and Emergency Care: how the Medway Model will support a reduction in emergency admissions, ensure that patients have good access to urgent care either at A&E or within a local health centre or GP surgery, and improve the recovery following illness.
- Planned Care: how the CCG will meet the 18 weeks target, ensure that all referrals are made electronically, how the Medway Model will support clinics closer to where people live, how we will deliver the world-class cancer outcomes including early diagnosis and treatment of cancer and how we will deliver the maternity review.
- Mental health: delivering the Mental Health Forward View, ensuring that children and young people have rapid access to the care they need; ensuring that people with dementia are supported to live well; ensuring that people with mental health needs are able to quickly access the care that they need.
- Learning disabilities: how we will work with partners across Kent in Transforming Care for people with learning disabilities.

The plan will be supported by:

- Quality improvements: improving mortality rates; quality assurance and improvements; and partnering with Medway and Swale (MASCOE) to support and drive improvements across the local health economy.
- Workforce: ensuring that our workforce is growing in a way that supports the needs of the services including 7 day access to services.
- Estates: developing local health centres.
- Information: delivering the Local Digital Roadmap as part of the STP; patient information will be accessible by clinicians when they need it; identification of those most in need of support; care records that the patients are part of.
- Partnership working: working with Medway Council; developing our joint commissioning team and ensuring that the Better Care Fund delivers improvements to patients; meeting the needs of the Health & Wellbeing Strategy and the Joint Strategic Needs Assessment.
- Public engagement: putting the patient at the heart of our changes; listening to the patients about how they need to access services; understanding the patient voice in all that we do and developing strategic partnerships with civil society.
- Learning from others: incorporating New Models of Care and learning from others
- Monitoring and response: through national targets, local KPIs and agreed milestones we will ensure that our plans are on target to deliver the changes we need.
- Programme management: ensuring there is robust governance and a Programme Management Office to ensure the plans are delivered.

1. Kent and Medway Sustainability and Transformation Plan (STP)

The Kent and Medway health and social care system is developing its case for change, with an intention to publish this in February 2017. This will outline a range of challenges that are being faced by health and social care that are driving the transformation of care being pursued by the STP (as summarised below).

Theme	Challenges
Health and wellbeing	• **Population growth:** Projected to grow by c5% (≈ 89,000 people) over the next five years, with uneven growth across the patch putting pressures on some parts of the system • **Ageing population:** Largest age group growth is in demographic of 85+ years bringing increased needs for health and social care • **Health inequality:** Range of life expectancies for both men and women related to deprivation exist, with the main causes of death being from preventative interventions and the gap has not closed over the last 10 years • **Housing growth:** Kent and Medway earmarked for significant housing growth, adding to the demand for health and care services
Quality of Care	• **Stresses in the system:** Services close to capacity across the patch with acute occupancy over 90%; a number of providers in special measures; a high ratio of patients to GPs and a number of GPs giving up general medical services (GMS) contracts or retiring • **Delivery of constitutional targets:** Delayed transfer of care, A&E targets, Referral To Treatment, cancer targets, ambulance response times and other services pressures (e.g. stroke) continue to be an ongoing issue • **Workforce issues:** Significant workforce issues around recruitment, rotas and maintaining a viable workforce impacting health and social care
Sustainability	• **Financial sustainability:** 15/16 deficit of £109m forecast to rise to £434m by 20/21 in a 'do nothing' scenario (this excludes social care budget pressures (KCC £45m, Medway Council £7m). • **Clinical sustainability:** Growing reliance on agencies due to workforce issues around unsustainable rotas, recruitment and retention

The challenges outlined above are already being experienced by the CCG as outlined in this document, characterised by an increased demand for services due to changes in the population and increased challenges around delivering constitutional targets and maintaining expenditure within control totals.

The STP is a complex change programme and aims to transform the way we delivery care against four key themes:

	STP Position	Operational Plan Reference
i. Care transformation	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: • Local care (Out-of-hospital care) • Hospital transformation • Mental health • Prevention	 Chapter 3 Chapters 4 & 5 Chapter 7 Chapter 3
ii. Productivity and Modellng	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 • Shared clinical services (e.g. pathology integration) • Procurement and supply chain • Prescribing	 Chapter 2; Chapter 10 Chapters 7 & 8 Chapter 3
iii. Strategic enablers	We need to develop three strategic priorities to enable the delivery of our transformation: • Workforce • Digital • Estates	Chapters 3, 10
iv. System leadership	A critical success factor of this programme will be system leadership and system thinking. We have therefore mobilised dedicated programmes of work to address: • Commissioning transformation - enabling profound shifts in the way we commission care • Communications and engagement - ensuring consistent communications and inclusive engagement	Chapters 3, 10

Local Care

Local care needs to rapidly move from a service provided by a large number of smaller businesses and services, working and governed independently of each other, into consolidated arrangements that support the delivery of integrated and coordinated care, through multispecialty community provider (MCP) type arrangements, and, potentially, into a small number of larger accountable care organisation (ACO) type arrangements that would also hold commissioning budgets. This change will not be undertaken for the sake of the change but because the coming together of existing primary

care with the services already provided outside of hospital will mean patients can remain in their own homes for longer, active 'well-health' management for the population will be the goal.

Our local care model needs to enable to us to potentially care for a significant number of individuals who are currently cared for in the acute sector. These arrangements are also the vehicle that will allow us to integrate health and local authority provision and local commissioning. This potentially enables the development of a wide spectrum of integrated provision arrangements (e.g. therapy led enablement services and nurse-led home care models).

Although working to a similar design across Kent and Medway, implementation of new models of local care will be developed to meet the various needs of local people and the differing workforce constraints across Kent and Medway

Hospital Care

In relation to the hospital workstream of the STP, we are building on the strategic direction outlined in the NHS England Urgent and Emergency Care Review and consolidating services to create emergency hospital centres with specialist services and separate emergency hospital centres. Alongside these we are looking to better separate planned and unplanned activity through the establishment of specialist planned care hospital centres, including the further development of Kent's cancer centre at Maidstone Hospital.

The development of emergency hospital centres with more specialist services will be achieved through the 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. We are also exploring the development of more complex / specialised services in a shared care model with London providers.

The CCG is also working with the STP enabler workstreams, aligned to our own internal priorities as outlined in this plan:

Workforce	**Estates**	**Digital**
Developing a workforce strategy to deliver the transformation required in K&M	*Establishing a single, K&M-wide view of estate held by health and care organisations (including LAs)*	• *Delivering the digital capabilities that are necessary to underpin and facilitate the STP*
Key objectives:	**Key objectives:**	**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	• 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:	• 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

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 associates

optimising asset utilisation and occupancy; overall management of the estate; consolidation of support services; and realisation of surplus assets across the common estate.

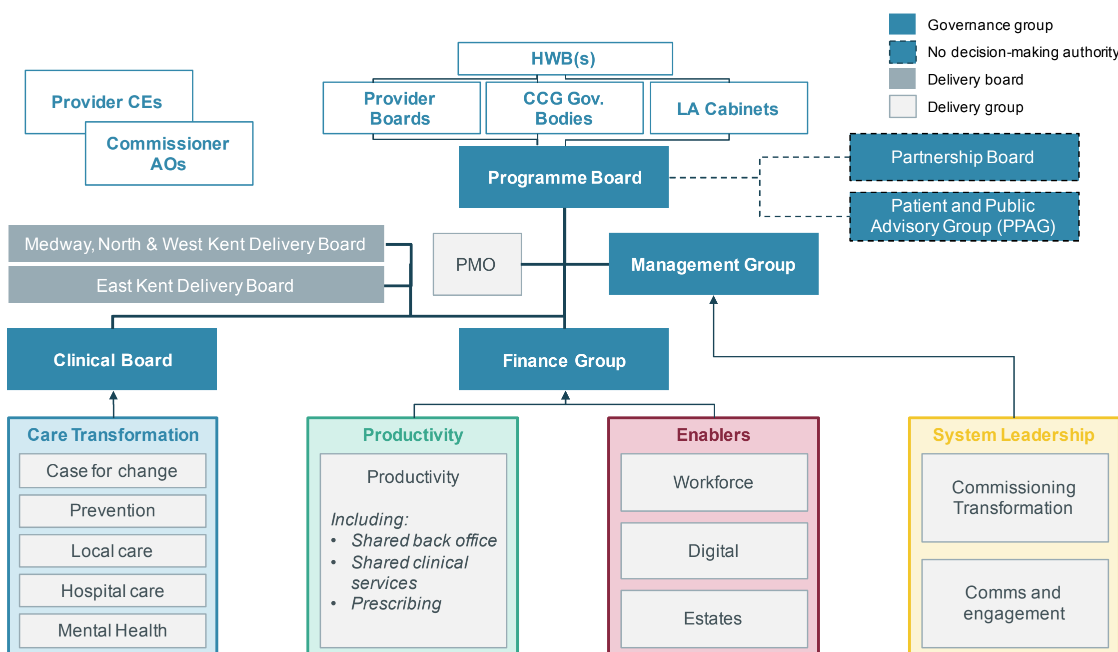
- Redesign and align the estate footprint to support new care models , including the disposal of estates asset and exploring funding models

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

Governance

The Kent and Medway STP has recently bene subject to a formal governance review. This has seen the governance arrangements evolve from those that were initially established across the STP footprint and the following diagram details the overall governance arrangements for the STP:



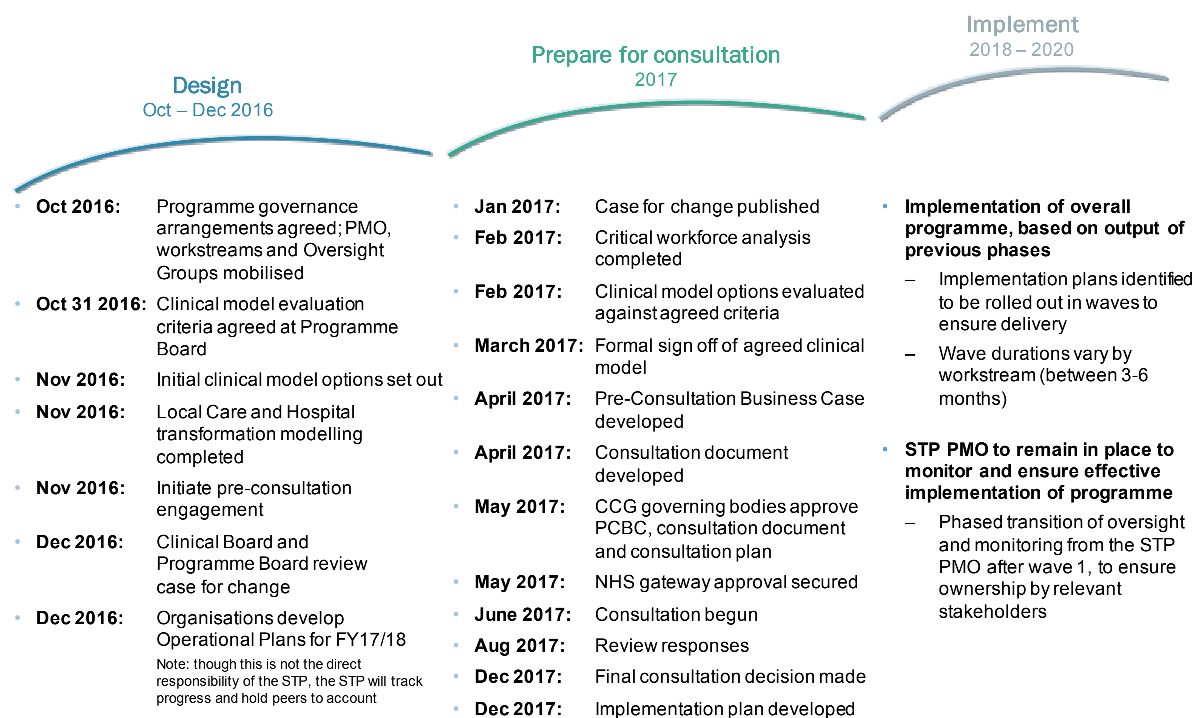
Source: Kent and Medway STP PMO – emerging recommendations following STP Governance Workshop, 17 October 2016

All CCGs are members of the STP Programme Board, which is accountable to the CCG governing bodies and the boards of the NHS provider organisations. In addition, there is a smaller STP Management Group that provides an executive function to support the Programme Board and the CCGs are represented on this through West Kent CCG Accountable Officer. This arrangement is support through a regular meeting of the CCG accountable officers. In addition, CCGs are represented on the STP work streams with a number of these led by CCGs.

Timescales

The high level plan for the STP is shown below. Medway CCG will be ensuring that we meet our requirements and actions to achieve the overall Kent and Medway timescales.

#	Phase	Activity	2016 Oct	Nov	Dec	2017 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1	Mobilise programmes	Come together as leadership group												
		Identify and secure clinical leadership												
		Identify area of focus												
		Establish governance												
		Determine governance arrangements for decision making												
2	Case for change, baseline & eval. criteria	Craft case for change												
		Establish baseline of services and activity by site												
		Determine evaluation criteria												
3	Clinical models and opportunity	Detail clinical models to enable change in activity												
		Assess critical interdependencies between services												
		Set out potential acute opportunity												
4	Evaluate opportunities	Perform analysis to articulate and understand options												
		Review and discuss with relevant clinical group												
		Evaluate options vs. agreed criteria												
5	Engagement throughout	Pre-consultation engagement (patients, public, staff local government, MPs)												
6	Seek approval and launch consultation	Develop pre-consultation business case												
		Develop consultation plan												
		Develop consultation document												
		Secure NHS England gateway approval												
		Hold consultation												
7	Formally consult	Engage with stakeholders and the public												
		Capture feedback												
8	Prepare to implement	Make final decision												
		Plan for implementation												



Source: Kent and Medway STP PMO

What is the evidence of the plan being based on a shared, open-book process to deliver performance and improvement?

Through the governance arrangements outlined in the STP submission, commissioners and providers are working in collaboration. This includes transparency in relation to the position of individual organisations. This has been facilitated through the completion of the STP financial template, which includes information from both commissioners and providers and has been shared with all NHS organisations in Kent and Medway. The completion of the STP financial template was steered and reviewed through the STP finance group, with senior membership from all commissioners (both upper tier local authorities and NHS commissioners) and NHS providers.

Collaborative working also includes STP workshops with all local stakeholders, development of joint QIPPs, early sharing and agreement of commissioning intentions and open book reviews of services.

2. Finance and QIPP

In order to deliver its strategic objectives Medway CCG has developed a two year financial plan which underpins its strategy of sustainable and whole system change to the way care is received by local people as set out in 'Delivering the Five Year Forward View'. It is predicated on meeting the challenge of a changing and more demanding population through greater efficiency and productivity and a move to more self-care with high quality services closer to home and a greater emphasis on prevention.

Medway CCG has its 17-19 plans in line with changes to its resource allocation and revised expenditure plans in line with latest forecast and planned investments.

Medway CCGs plan will also meet the following financial targets and business rules for 2017/19 set out in Delivering the Forward View into action:

- Achieve in year break even
- Set aside 1% of allocation to be used non-recurrently, 0.5% uncommitted at the start of the year
- Set aside a minimum 0.5% contingency

This additional funding will be used to deliver the 9 'Must do's', and investments has been built in the following areas;

- Delivery of Cancer waiting standards
- Delivery of the GP Forward View
- Investment in Mental Health services

The plan assumes price growth of 0.3% on secondary / hospital care, and 0.1% on all other services and non-demographic growth of 0.5%. Demographic growth has been applied at 1% in line with allocation with the exception of the areas set out below where historical levels of growth have been accounted for.

- Mental Health - Spend has been increased by the total percentage growth the CCG has received of 2.7% on programme spend. The schemes to be funded from this additional resource are to deliver the three key areas of IAPT, Psychosis Referrals, and improving dementia diagnosis rates. The CCG will continue to meet the requirements of the Mental Health Investment Standard.
- Secondary / hospital care has had a variable demographic growth applied at the point of delivery level based on year on year forecast trends. These are based on the variables demographic rates are set out below:
    - Outpatients 1.5%
    - Daycases 3.6%
    - Electives -0.3%
    - Non-electives -2.2%
    - A&E attendances 9.1%
- Continuing Health Care - This area has seen significant growth in 14/15 nationally, it is anticipated funding will need to be increased by 3% over the coming year, and this is built into the plan.
- Funded Nursing Care - has been increased by c£800k in line with nationally agreed price increase.
- Prescribing - Horizon scanning has identified additional costs above the growth in demographics. An additional 3% has been included in plans.
- Better Care Fund – has been uplifted in line with national assumptions, although final BCF guidance for 17-19 has yet to be released. For 17/18 by 1.79% and 18/19 by 1.90%

- The impact of Specialist Commissioning and Tariff adjustments to allocations are assumed to be cost neutral.
- Plans include for 16-17 the commissioning budget for Primary care services, which the CCG is in the process of applying for. Additional funding of £3 per head of population (£888k) non-recurrently has been identified for investment in primary care services over 2 years.

The CCG has a QIPP financial target of £11m in 17-18 and £11.25m in 18-19 (3% of total allocation) which forms part of the commissioning intentions for the CCG.

Robust programme management processes have been put in place to mitigate against under delivery or slippage against all QIPP schemes. A PMO function has been introduced within the CCG and a rolling QIPP programme has been introduced to develop and implement QIPP schemes. QIPP delivery is linked to delivery of the STP.

Tariff adjustments are considered to represent a significant risk, with provider costs increasing and CCG allocations being reduced. The impact of this change is assessed at £2.6m and is shown in risks. This is mitigated by use of Contingency and the balance of the Headroom available to CCGs. This however uses all available resources and leaves no further contingency in year.

2.1 Quality, Innovation, Productivity and Prevention (QIPP)

Programme Governance and Delivery

Programmes detailed in the 2017-19 Operating Plan are translated into delivery by means of the Quality, Innovation, Productivity and Prevention (QIPP) programme. The CCG identifies monitors and controls project financials in a cohesive and consistent way and ensures that delivery is lawful, appropriately paced and in line with clinical and patient needs.

The commissioning steps have been incorporated within a Gateway Process (see below), to ensure that project managers have the guidance and support to commission services, whilst the organisation can better monitor and control each project to time, resource and financial expectations. The Gateway Process contains six gateways. Each gateway has a number of mandatory project deliverables, such as Project Initiation Documents (PIDs), Project Plans, Quality & Equality Impact Assessments (Q&EIAs) and Risk Registers. These project deliverables are managed via stage-end boundaries that act as checklists to ensure projects are being delivered in-line with the agreed process.

Regular validation and financial reconciliation

The PMO coordinate a robust validation process and regular financial reconciliation to ensure that all CCG projects are:

- Properly evaluated with coherent milestones
- Correctly calculated and verified by Finance
- Measurable with clearly set out milestones
- Clinically safe; as the scheme is developed it is supported by a Q&EIA owned by the project lead and a Senior Responsible Officer (SRO)

Regular progress reporting

The PMO coordinate a regular progress reporting process for all projects within the CCG via Highlight Reports. This information is then consolidated within programme information packs which are shared with the Senior Responsible Owners (SROs) to ensure they are aware of the status of the delivery of each project.

Risk Management of QIPP Schemes

QIPP schemes are managed as projects. Projects are inherently more risky than business-as-usual because they are introducing change to business operations and therefore introducing an element of uncertainty. In addition projects are unique, often complex, cross divisional and are constrained by finite conditions, therefore an effective risk management process is paramount to the successful delivery of QIPP.

All project risks are described and scored in Risk Registers. The scoring is based on a 5x5 risk matrix for likelihood and impact if the risk was realised. All progress and mitigations are captured within the Risk Register. All risks are described in terms of Cause, Event and Effect to ensure the risk owner focuses on mitigating the cause and not the event.

2017-19 QIPP Summary

Summarised below, by Programme, are details of the proposed initiatives for dealing with this challenge over the next two years.

MCCG Programmes	2017/18 Net Savings £'000	2018/19 Net Savings £'000
Primary Care	2,174	2,100
Prevention,Integration & Coordinated Care	2,976	2,028
Community Services	1,367	1,428
Women, Children & Families	50	50
Planned Care	2,068	1,537
Urgent & Emergency Care	756	210
Finance	256	0
Unidentified	1,353	3,897
Totals	**11,000**	**11,250**

2.2 Baseline growth assumptions

The table below sets out the growth position for the CCG between 2015/16 and 2016/17 compared to the IHAMs tool assumption for 2016/17. Within the CCGs operational plan is a 1% growth assumption for demographics etc.

	OP	DC	EL	A&E	NEL
2015/16 Adjusted	-0.1%	-2.9%	-2.0%	-3.0%	-1.2%
Actual	1.5%	9.3%	5.3%	9.1%	-2.2%
Actual (adjusted for backlog clearance)		5.1%	1.2%		
Actual (adjusted for increased IS capacity)		3.6%	-0.3%		
2016/17 Adjusted	1.5%	3.6%	-0.3%	9.1%	-2.2%
Average 15/16 & 16/17	**0.7%**	**0.4%**	**-1.2%**	**3.1%**	**-1.7%**
IHAM Growth for 2016/17	**4.0%**	**2.2%**	**2.2%**	**2.5%**	**1.9%**

The reported actual growth rate for the CCG included a reduction for known outsourcing by Medway Foundation Trust (MFT). The only two areas of discrepancy to the 1% planning assumption are daycases and Electives.

However the actual activity associated with backlog reduction is harder to quantify as the backlog is also impacted by validations. We have used a further estimated calculation that looks at over performance in the key RTT elective specialties i.e. Orthopaedics, colorectal, gastroenterology and ENT. This adjustment is included in the third row and places Electives at the Medway growth planning figure.

Daycases have been further impacted by increased Choice and particular increased capacity at IS providers. The final adjustment for daycases takes out the increases in activity at KIMS. The residual

3.6% will be the result of other IS providers and Choice to local acutes. We would not expect that growth to continue as the activity is now within baseline and patient flows will have been embedded during 2016/17. Additionally there is the further factor that MFT are treating patients in the urgent care medical model with a pathway to urgent daycase procedure. This cannot be isolated in the data, and so we cannot quantify it, but the impact will be seen in the residual 3.6%.

A&E attendances are reporting a growth of 9.1% in 2016/17 however there is a volatile nature to this service and the CCG does not believe this level of growth will continue, indeed in 2015/16 there was a negative growth of -3%.

2015/16 Growth Rates

A&E: -3%
Daycase: -2.9%
Electives: -2%
NELs: 14.3%. However this was predominantly the impact of the CDU and then subsequent medical model change and so not real growth just a different pathway and recording capture (hence the negative growth in A&E attendances). When we previously removed the CDU type wards the growth came down to a figure that correlated to the A&E attendances at approximately -1.2%.
Outpatients: -0.1%.

While the actual 16/17 growth rates (excluding A&E) are significantly lower that IHAMs, when combined with the 15/16 rates there is a consistent case to suggest that the CCG's growth assumptions are in line with actual underlying trends.

The Growth assumption of 1% is higher than the underlying growth rate by POD which is summarised below, but has been calculated at a lower level, for example outpatients have been calculated as first and follow up level and summarised up.

Medway CCG	**NEL**	**DC**	**EL**	**Outpatients**	**A&E**
IHAM Growth for 2016/17	1.9%	2.2%	2.2%	4.0%	2.5%
Actuals (less outsourcing)	-2.2%	9.3%	5.3%	1.5%	9.1%
Adjusted for Est. Backlog Clearance (MFT)		5.1%	1.2%		
Adjusted for Increased IS Capacity (KIMS)		3.6%	-0.3%		
Avg. Tariff	£ 1,747	£ 703	£ 2,740	£ 95	£ 140
Activity Movement From Generic 1% Growth to Differential Growth	-996	683	-97	1,359	6,798
Financial Impact of Moving to Differential Growth	**-£ 1,740,012**	**£ 480,149**	**-£ 265,780**	**£ 129,105**	**£ 951,720**

The net impact is 1% growth is actually £444k higher than the underlying growth rates, costed at average POD prices. Therefore we believe the overall 1% growth rate that we have allocated in the financial plan is prudent.

3. Primary Care, Community Services, Prevention, Integration and Coordinated Care

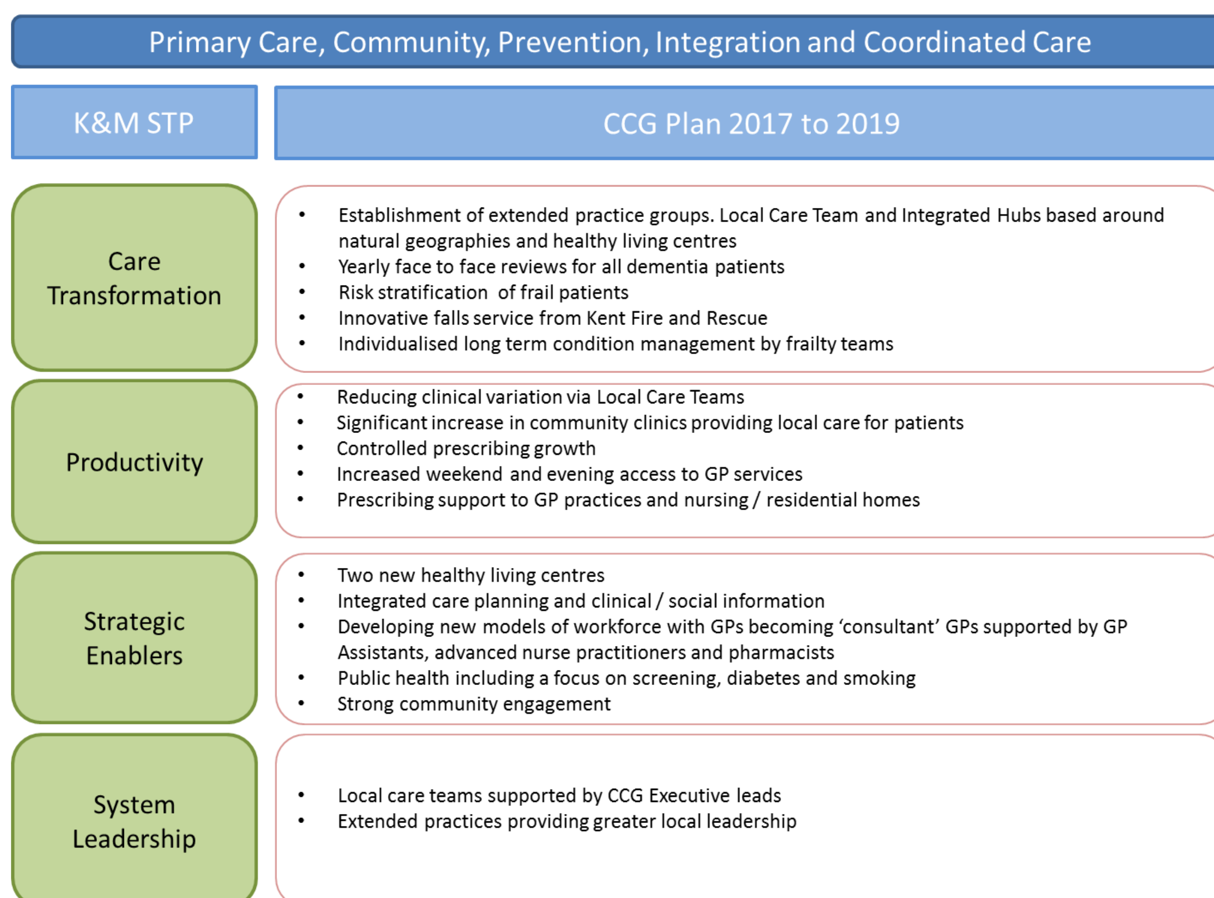


Figure 1: Primary, community, prevention and coordinated care alignment with STP

3.1. The Medway Model

Medway Clinical Commissioning Group (CCG) is an active and proactive partner in the local care system working to improve the care provided to the community we serve.

To do this we are redesigning the health and care system, so that people will need to make fewer trips to hospital and instead obtain the help they need at more specialist clinics provided in local surgeries. This will allow people to have one point of call for family doctors alongside teams of community nurses, social and mental health services, and better access to blood tests, dialysis or even chemotherapy closer to home.

These changes will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that our patients know where they can get urgent help easily and effectively, seven days a week.

Ultimately our aim will be to join up or pool all these budgets, so that we can use the resources more effectively across the Medway area and generate a more thriving community where instead of asking "what's the matter with you?" we enquire "what matters to you?"

The Medway Model is a key response to the K&M STP. The Medway Model is based around the six local geographies, each with a population of between 30,000 and 50,000 and its own unique identity, building groups of extended practices and focusses care in each of these at a strategically placed Healthy Living Centre (HLC):

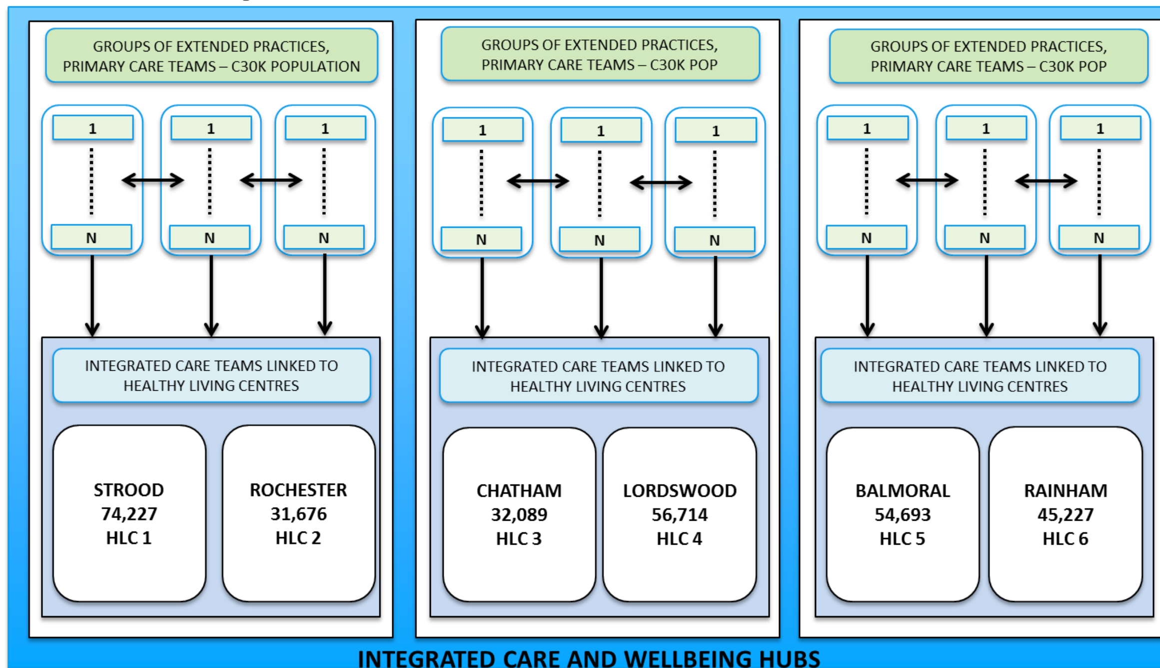


Figure 2: The Medway Model

3.2. General Practice and Primary Care

Strengthening and transforming general practice will play a crucial role in the delivery of STP plans, and already many STP footprints are integrating the aims and more local elements of the GPFV into the system wide plans.

Aligned to the Kent and Medway STP Medway Clinical Commissioning Group (CCG) has been working with Primary Care and its stakeholders to co-design our health and care system.

Our system is being designed to ensure that people will need to make fewer trips to hospital and instead obtain the help they need at more specialist clinics provided in local surgeries. This will allow people to have one point of call for family doctors alongside teams of community nurses, social and mental health services.

These changes will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that our patients know where they can get urgent help easily and effectively, seven days a week.

General Practice (GP) groupings will be at the heart of communities with member practices providing support to patients who need help accessing the services that they need.

Having access to a family doctor is one of the great strengths of the NHS however these services are under increasing strain across the country.

In Medway, as demand has risen, the number of GPs available is not keeping pace with growth and in line with national policy, we are taking action now that will secure and stabilise general practice in the future. By doing this we can assure our communities that the services they expect and deserve, can be provided in a modern and effective way at a time when the NHS is under increasing pressure.

Our patients don't recognise (or need) the traditional partitions between primary, community, mental health and social care and acute services because they make it harder to provide joined-up care that is preventative, high quality and efficient.

The Medway Model dissolves the divides. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model.

General Practice Overview

Practice groupings will be at the heart of community with member practices as the care navigators.

There is an urgent need for GP recruitment in Medway given the basic analysis from SHAPE on the workforce data below

- 38% of the 136 WTE GP's in Medway are over 60 years of age.
- There are 51 GP practices and 22 branch practices in Medway.
- Of these 20 are single handed (based on WTE) and 7 have WTE between 1 and 2.
- Using SHAPE, housing planned over the next five years is 3,370 (excludes Lodge Hill at 5,000 currently with the Secretary of State).
- Using an average population per house hold at 2.4 would increase demand on GPs by 8,088 patients. This excludes the mobility of student and migrant cohorts. Further, average length of consultation is increasing. In 1993 this was 8.4 mins, in 2007 this increased to 11.7 mins. This increase in consultation times was considered to be consequential on greater numbers of older people and those with mental illness visiting surgeries and this trend is expected to continue given the demographic outlined above. If this trend continues at the same rate there will be a 14% increase in GP workload.

We are working with NHSE to ensure that the re-procurement of APMS contracts are aligned to our Medway Model.

GP Forward View

The General Practice Forward View (GPFV) announced actions at national level to reduce pressure and increase resources in general practice. It also announced a three year £30 million national development programme linked with additional investment of £96m (£45m to support the training of reception and clerical staff to play a greater role in navigation of patients and handling clinical paperwork to free up GP time, £6m practice manager development and £45m to support the uptake of online consultation systems.)

This programme will support practices to manage their workload differently, freeing up time – Time for Care – for GPs and improving care for patients. This will help practices implement proven innovations, including online consultations that others have already found useful. These have been expressed as 10 High Impact Actions. In turn, this will help practices lay the foundations for new models of integrated care, and play their part in delivering a sustainable and high quality NHS as part of the STP process in which general practice has a key role.

The CCG will utilise the additional funding of £3 per head of population investment in primary care services to support the implementation of the 10 high impact actions. This will compliment the available central funding for the individual programmes as they are released. Work is underway with the Local Care Teams to establish priorities and required funding.

The GP Forward View five key areas for action to strengthen and modernise primary care are:

1. Investment (detailed below and in Chapter 2)
2. Workforce (detailed below)

3. Workload (detailed below)
4. Infrastructure (covered in Chapter 10)
5. Care redesign (the Medway Model)

The 10 high impact actions to release time for care are set out below with the CCG's approach to achieving them:

1. Active signposting

Patients will be provided with first point of contact which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional. Receptionists acting as care navigators can ensure that patients are booked with the right person first time.

Benefits:

- Improves appointment availability
- Reduces low-value consultations and onward referrals
- Shorter wait to get to see the most appropriate person
- Frees GP time.
- Makes more appropriate use of each team member's skills.
- Reduces internal referrals.

Medway CCG is working NHSE to encourage practices to give patients access to a web portal or mobile app. This can provide a number of services, including booking or cancelling appointments, requesting repeat prescriptions, obtaining test results, submitting patient-derived data (e.g. home blood pressure readings), obtaining self-help advice, viewing education materials and consulting a clinician. The CCG intends to work with their practices to ensure 100% utilisation April 2018.

The CCG will begin the training of practice reception staff to enable them to access information about services, in order to help them direct patients to the most appropriate source of help or advice. This may include services in the community as well as within the practice. This adds value for the patient and may reduce demand for GP appointments.

The CCG will work with the Community Education Providers Network (CEPN) locally to build on work that they have already been undertaking in reception training. This rollout will be complete by September 2017.

2. New consultation types

The CCG will work with local practices to pilot new communication methods for some consultations, such as phone, text messaging, e-consultation, email and in the case of patients with long-term conditions, group consultations.

Benefits :

- Greater convenience, often no longer requiring time off work/caring duties
- Improves availability of appointments
- More opportunities to build knowledge, skills and confidence for self care
- Shorter appointments (e.g. phone consultation average 50% shorter, 66% dealt with entirely on phone)
- More opportunities to support self-care with e-consultations, text message follow-ups and group consultations

The CCG will work with local practices to identify local good practice and pilot news ways of working in practices and across clinical hubs. This work will commence in 2017/18.

3. Reduce DNAs

The CCG will work with the practices to maximise the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment.

Evidence shows that the most effective means of reducing DNAs appear to be rearranging the appointments system to reduce 'just in case' booking ahead by patients - the DNA rate for these can be as high as 25%. We believe that these initiatives will improve patient confidence in the appointments process and subsequently reduce the number of DNAs.

Benefits:

- Improves appointment availability.
- Frees up appointments
- Easier to avoid queues developing, through more accurate matching of capacity with demand.

The CCG is already investing in text messaging software that will support patient reminders, patient appointment and cancellations. Practices will also be encouraged to adopt easy cancellation access via telephone.

Working with practices to increase access will provide patients with the confidence not to book to far in advance and reduce DNA’s. The CCG will roll out and implement the new software to all practices by March 2018.

4. Develop the team

The CCG will work with Health Education England (HEE) and local health care education providers to broaden the available workforce in primary care. This will ensure that the demand is reduced on GPs and the patient sees the most appropriate professional. This may include training a senior nurse to provide a minor illness service, employing a community pharmacist, physicians assistants, medical assistants or providing direct access to physiotherapy, counselling or welfare rights advice. This will also look at the most effective use of paramedics.

Benefits:

- Improves appointment availability
- Reduces low-value consultations and onward referrals
- Shorter wait to get to see the most appropriate person
- Frees up GP time
- Makes more appropriate use of each team member's skills
- Reduces internal referrals
- Improved job satisfaction for administrative staff undertaking enhanced roles

The CCG will benchmark its workforce in Primary Care and begin working with HEE to ensure resources are understood.

Over the next two years. The CCG will work with practices to pilot new roles and rollout best practice. This will include evaluation and rollout of the current Clinical Pharmacist Pilot currently being undertaken in the CCG. The CCG will utilise the central funding once available to agree a recruitment and rollout programme across all practices.

5. Productive work flows

The CCG will work with GP practices to introduce new ways of working. This work will be supported by the service improvement expertise within the Medway and Swale Centre for Organisational Excellence (MASCOE).

This will include reviewing capacity and demand, reviewing practice processes to reduce waste and improve efficiency.

Benefits:

- Improves appointment availability and customer service.
- Reduces errors
- Frees time for staff throughout the practice
- Reduces errors and rework
- Improves appointment availability and patient experience

The CCG will review and pilot news ways of working over the next two years.

6. Personal productivity

The CCG will work with practices to ensure that they access the opportunities to support and develop staff. This will include personal resilience and enhanced skills. These will range from service improvement training to improving information systems and productivity.

Benefits:

- Improved quality of consultations, with more achieved
- Reduced absence of staff
- Frees clinicians to do more in each consultation, with fewer distractions and frustrations
- Improves staff wellbeing and job satisfaction

7. Partnership working

The CCG is working with its member practices to develop 'The Medway Model'

Benefits:

- Access to expanded range of services wrapped around the patient in the community.
- Reduces delays introduced by referrals to different providers.
- Frees GP time, makes best use of the specific expertise of staff in the practice.
- Creates economies of scale and opportunities for new services and organisational models.

8. Social Prescribing

The CCG already commission Care Navigation Services. Primary care can refer to the service that in turn can signpost to non-medical services in the community which increases wellbeing and independence

The CCG will be reviewing and enhancing this service during 2017 to recognise the growing need for social prescribing and that the GP is not always the most appropriate person to meet patients' needs, particularly where someone has social needs.

Benefits:

- Improved quality of life
- Improved ability to live an independent life
- Frees up GP time
- Allows clinicians to do the things that only they can do

9. Support self-care

The CCG will work with Public Health, Primary Care the Voluntary Sector and its Community Provider aligned to the developing Medway Model to create new ways to support people to

play a greater role in their own health and care. This will include care navigation and signposting.

The CCG will work with local community pharmacies to make best use of the minor ailment scheme and advice and guidance in 2017.

The CCG will be working with community providers and specialist teams to increase patient education and self-management of long term conditions.

Benefits:

- Improved ability to live an independent life.
- Frees GP time, allows them to spend more time doing what only they can do.

10. Develop QI expertise

Medway and Swale Centre for Organisational Excellence (MaSCOE) has been created to help improve healthcare systems to deliver sustainable high value outcomes for patients, families and carers by eliminating wasteful practices or processes. Working with partners across Medway MASCOE are committed to working with all our communities in Medway and Swale to create innovative, needs based services that provide patients with healthcare where and when they need it.

MASCOE will use a whole systems approach uses quality improvement (QI) methodology to embed the essential quality improvement capabilities across the system in Medway and Swale.

MASCOE will build local capability in quality improvement and aim to accelerate the delivery of the evolving Sustainable Transformation Plan (STP) supported by our emerging Local Digital Roadmap (LDR).

Benefits:

- Assurance of continuous improvement in patient safety, efficiency and quality of care
- Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care
- Increased staff morale and sense of control

Extended Access

The CCG will be start access improvement funds in 2018/19 and achieve 100% 8-8 coverage from April 2020.

The CCG will commission and fund extra capacity in line with the Medway Model at extended practice level in to ensure that everyone has access to GP services and capacity matches demand. This will include:

- including sufficient routine and same day appointments at evenings weekends
- effective access to other primary care and general practice services including pharmacy, front door at A&E and out of hours support

This will be piloted in one locality in 2017/18 and rolled out across the CCG as funding comes on stream in 2018/19.

Investment

The NHS England allocations for primary care (medical) have been published for the next five years. This sets out that in 2017/18 and 2018/19 there will be an increase in funding for core local primary medical allocations of £231 million and then a further £188 million on top respectively.

In addition to those allocations, other primary care funding is available for specific purposes as part of the £500 million plus sustainability and transformation package announced in the GPFV, as detailed below, as well as specific extra funding to support improvements in access to general practice, and improvements in estates and technology.

The GPFV also assumes that there will continue to be increases in CCG funding to general practice (currently totalling around £1.8 billion in 2015/16) at least equal to, and ideally more than, the increases in CCG core allocations which are 2.14% in 2017/18 and 2.15% in 2018/19.

In line with national requirements the CCG will spend £3 a head as a one off non recurrent investment commencing on 2017/18. This will be allocated over two years in 17/18, 18/19. This funding will come from the NHSE allocations for core funding.

This investment will be targeted at developing the new models of care and to stimulate the implementation of the 10 high impact changes. It will compliment central non-recurring funding also targeting the 10 high impact changes.

Local Care Teams

Local Care Teams (LCTs) have already been developed to enable practices to work together and develop a shared responsibility for building improved services across Medway. By working together they are more likely to improve patient outcomes and support integration (or joining up) of the wider health and social care system.

These Integrated Care Teams (ICTs) are being developed around local natural geographical networks and communities linked to Healthy Living Centres in Strood, Rochester, Chatham, Lordswood, Gillingham and Rainham. Their main purpose is to focus on the health and social care needs of local communities and through their patient participation groups, ensure that patient voices are heard and acted upon. To do this they will need to work better with all providers, civil society, Healthwatch, and other patient representatives.

By placing collaboration at the centre of what we do, Medway primary care will be able to develop services in line with the General Practice Forward View and support the establishment of multispecialty community provider (MCP) contracts.

In addition to the mutual support available through the LCTs, The CCG is working with NHSE on the national programme of support for vulnerable practices.

Groups of Extended Practices and Primary Care Teams

Groups of practices are being encouraged to form alliances and to work together to enable them to access the MCP contracts. It is envisaged that there will be three or four early groups forming with practices joining either with them or as a separate group of practices as services begin to develop in the community.

Integrated Care Teams - 'Integrated Primary Community Services Hubs'

A key element of the Medway CCG emerging strategy is that of creating hub and spoke configurations for service delivery in the community and the promotion of integrated service provision across the five localities. The local Estates Strategy reflects this approach with a focus on utilising the Health Living Centres to achieve this.

The Integrated Primary Community Services Hubs will be developed locally and reflect current and future needs. The exact composition and configuration of these hubs and local teams, will be determined following more detailed discussion with stakeholders and with reference to the emerging Sustainability Transformation Plan.

These multidisciplinary teams will bring together a range of clinical and wider health and social care expertise in a way that facilitates more 'joined up' ways of working, improves access to services and supports primary care across localities in a hub and spoke model.

- There will be greater partnership working across systems, new models of care that are much more closely integrated, shifts in patterns of delivery with much more care provided in community settings and significant developments in primary care to meet growing needs 7 days a week. The scale of the challenge demands a transformational programme of change.
- Focus on public health and prevention
- The Integrated Primary Community Services Hubs will act as central co-ordination points for community and domiciliary based care where a central resource is still required, a need for a place to interact, come together to learn and talk face to face
- For the public community hubs will be visible, providing a clear identity and access to a wider range of primary/community care services, which may include the voluntary sector, mental health services, pharmacy, therapies, urgent care, outreach clinics, etc. These services may be accessed within the hub through face to face contact or through networking, IT and exploiting new technologies to a greater extent.
- A community focus providing facilities to support the local community, e.g. meeting rooms and community cafés
- Provide multi-disciplinary training in dedicated facilities

The new Integrated Primary Community Services Hubs should provide proper space for primary care patients, some outpatient services, community services (including mental health) and encourage voluntary sector users. Where possible all space will be generic and rooms will be used flexibly with shared facilities.

The Hubs will broadly provide:

- Entrance
- Waiting Room
- Reception
- Pharmacy
- Consulting Rooms (interchangeable functions)
- Treatment Rooms (interchangeable functions)
- Administration office space
- Meeting Room (innovation hub)
- Provision of mobile diagnostic facilities (docking space, electricity etc.)
- Physiotherapy suite
- Point of Care Testing
- Community meeting area

Any proposed new Integrated Primary Community Services Hubs will be required to function in ways that enable effective and efficient service provision through: making best use of facilities; ensuring effective networking co-operation and integration; enhancing the accessibility of services and improving the patient experience.

The hub model of working will enable practices to cooperate to achieve the increased access requirement during evenings and weekends.

Community Health Operating Centres

Community Health Operating Centres will be larger population of practices joining over a geographical patch. The larger population basis will provide an opportunity to expand the services provided at Integrated Team Level across a broader population

3.3. Workforce

The Quality and Safety Team monitors provider's workforce strategies and workforce planning to ensure staff staffing levels.

For our primary care providers the Quality and Safety team will:

- Work in partnership with Heath Education Kent, Surrey & Sussex (HEKSS) through the appointed Primary Care Workforce Tutors to develop a coherent and cohesive approach to the education and training of practice staff (other than GPs).
- Support the GP Workforce Tool which will capture the Primary Care workforce data to enable reporting of workforce numbers and skills to help identify risks.
- Support the development and membership of Community Education Provider Networks (CEPN) and Local Action Workforce Board (LAWB), work with providers, educationalists, local authorities, NHSE and HEKSS, to explore and develop of new workforce models and roles which will support the delivery of the STP
- Support the development and facilitate funding streams for the creation of new roles in primary care such as practice based pharmacists, physician associates, nurse prescribers, advanced nurse practitioners and assistant practitioners.

3.4. Coordination of care

Coordination of care is essential to the appropriate management of patient care. The CCG will focus on developing care coordinators within each HLC who will dovetail with the frailty teams to ensure that patients have a single point of contact to signpost and coordinate their care.

The CCG will also be introducing a jointly held and accessed plan of care and care summary for frailty and high risk patients. This information will be available to all clinicians involved in the care of the patient (subject to the patient's consent) and will be developed with the patient to ensure that there is full continuity of care when the care setting changes. This will provide interoperability across providers and systems.

The system will integrate with eReferrals and will provide a seamless and rapid method of electronic referral between care providers and clinicians. This will be further enhanced by electronic order communications for pathology and radiology with Medway FT. This will mean that all clinicians in the hospital and our local GPs will be able to view historic results and if necessary request a further test and then receive the result electronically.

The requirement for electronic discharge notifications to GPs within 24 hours of discharge will be mandated across all providers.

3.5. Medicines Management

The Medicines Optimisation Programme continues to improve the quality of medicines use to ensure safe, cost effective, evidence based and rational prescribing for Medway patients. There is close working with practices and nursing homes to reduce unwarranted variation in prescribing and to reduce medicines waste.

In the period 2017/19 the Medicines Optimisation Programme will continue to maintain patient need and safety at the forefront by prioritising self-care promotion and patient education. Local areas of focus include diabetes, prevention of acute kidney injury and the prescribing of analgesia. The current successful work in nursing homes will be extended to offer support to residential homes.

Ongoing work in nursing homes has highlighted areas for further work. The provision and use of dressings both in and out of nursing homes has been a particular focus. Joint reviews have been conducted with our clinical pharmacists in conjunction with members of the tissue viability team for care homes and practices. This has led to further education on wound care products for GPs, practice staff and community nurses resulting in better management of wounds and a reduction in local spend on wound care products.

The medicines optimisation team are currently working closely with the local dementia support services to ensure appropriate early diagnosis of dementia patients and to reduce inappropriate prescribing in this cohort of patients. In the previous 12 months the Care Homes Pharmacist has discontinued the use of low dose antipsychotics in 43% of total patients reviewed in nursing homes.

In summary:

- Reducing variation and waste through data sharing within Local Care Teams and through education and intervention by pharmacists
- Improving optimisation for patients with diabetes, renal disease and those requiring analgesia through identification and review with GPs
- Extending the nursing home support to residential homes
- Improving prescribing with dementia patients and for patients with polypharmacy through identification and review with GPs
- Controlled local prescribing growth
- Drawing the local average prescribing spend closer to the national average.
- Achieving significant reduction in prescribing costs and quantities for key medicines with a high spend.
- Significant work to increase uptake of the Electronic Prescription Service, repeat dispensing and improved engagement with community pharmacy in Medway.
- Work to improve monitoring of high-risk drugs such as lithium, methotrexate and other disease-modifying drugs, with audits using IT tools and highlighting awareness of the importance of effective monitoring among prescribers.
- Increased patient engagement with the use of medicines.

3.6. Prevention

The NHS England Five Year Forward View, and developing proposals for the Kent & Medway Sustainability and Transformation Plan, emphasise the need to prevent avoidable disease and disability. To be effective, such activities need to be undertaken on a far greater scale than hitherto and to become a routine part of the role of all front line personnel in both health and social care services.

The five main areas for prevention are:

- smoking cessation, because quitting smoking
    - is the most significant thing that a smoker can do to improve their health
    - inhaling second-hand smoke is a significant cause of ill health in children and adults
    - improves the safety and the effectiveness of nearly all treatments of nearly all conditions, including surgical interventions, that is, it reduces risks and improves clinical outcomes

  - in pregnant women, improves growth and development of the unborn baby and reduces the risk of stillbirth and death in the first year of life
- mental health promotion, because
  - half of all lifetime diagnosable mental illnesses begin by the age of 14 years and three-quarters by the mid-20s
  - one-in-four people will experience a severe mental illness at least once in their lifetimes
  - one-in-three GP consultations have a mental health component (making mental ill-health more common than asthma, diabetes, kidney disease, breast cancer and prostate cancer combined)
  - a high proportion of people with long-term physical health problems have concomitant mental health problems which, if not adequately managed, reduces the effectiveness of their treatment
- increasing physical activity as part of everyday life, because being sufficiently physically active
  - has a great benefit in the management of a wide range of long-term conditions
  - has an even more important role in preventing the development of many common diseases and disability
  - is a vital component of slowing the rate of inevitable decline in physical ability to undertake everyday living activities (such as climbing stairs, getting washed and dressed unaided) and reducing the risk of falls and thus increases people's independence;
  - has significant benefits for mental well-being
- establishing and maintaining a healthy weight, because
  - overweight and obesity substantially increases the risk of developing a number of diseases and disability, most significantly diabetes (and complications such as blindness, kidney failure and premature death), but also heart disease; stroke, osteoarthritis, some cancers, among many other things
- drinking alcohol sensibly, because
  - whilst there is no safe lower limit for drinking alcohol, drinking it above recommended limits significantly increases the risk of developing a number of diseases including, but not limited to various types of cancer, liver disease, heart disease, brain damage.

In addition, immunisation is second only to clean drinking water as a way of protecting people's health and is a vital component of reducing the risk of developing avoidable infectious diseases. Protecting our children and others at greater risk of infectious diseases because of age of health problems through immunisation is simple, safe and effective.

The clinical variation programme and steering group including members from public health will further support the uptake of immunisation. The group will use a variety of qualitative and quantitative data including the immunisation dashboard to gain an understanding of variation and agree action to address it.

Improving quality and reducing clinical variation in Medway is one of the enabling strategies that will further strengthen primary care to support the delivery of the primary care and wider system strategy. The CCG will take a holistic approach, using relevant skills and experience from both clinical and managerial resource to work with practices to discuss the data and develop and agree actions to improve that will be jointly monitored.

Screening is also important because it is a simple and safe way of identifying potential health problems at an early stage when they can be more easily remedied or cured. We will work with NHS

England to ensure that screening opportunities are maximised. Screening includes, but is not limited to:

- all aspects of antenatal care
- health checks for children to identify vision, hearing and developmental problems
- tests to detect early changes which, if left untreated, might lead to cancer, for example of the bowel, breast or cervix
- physical health problems in people with either learning disability or dementia
- alcohol misuse
- health checks for adults to identify potential risk for developing long-term conditions such as high blood pressure, diabetes, raised cholesterol, heart disease and stroke caused by atrial fibrillation
- diabetic eye screening
- aortic aneurysm
- identifying the risk of falls.

The clinical variation group will review screening data as part of the programme.

We will continue to encourage and enable people to be healthier in all aspects of their lives at every opportunity, not just when they seek advice from health and care but across public services. And in addition, it is important that we actively encourage and enable people who do not normally seek such services to live healthier lives. We will support our communities to make informed choices about their health and raise awareness about risks associated with lifestyle choices. The CCG are exploring the use of technology to increase the uptake of screening through text messaging via the iplato system.

The CCG will work with NHS England Public Health Commissioning to ensure that screening and immunisation is increased and variation is reduced across the CCG, including in relations to local resilience planning.

The CCG will continue to work with other CCG's, Dartford and Gravesham NHS Trust (as lead local provider) and NHS England Public Health Commissioning on the capacity plans for bowel screening.

Frailty

Drawing on the learning from the Yeovil Vanguard and the information contained within the Kent Integrated Database, the CCG will identify those patients with three or more long term conditions plus those with dementia to ensure that the receive regular reviews of their care to ensure that they maintain their health for as long as possible.

The Yeovil Vanguard has demonstrated a 30% reduction in emergency admissions for their high risk patients that have received enhanced care and reviews from their complex care teams.

The CCG has commenced this enhanced care by commissioning the provision of a consultant geriatrician to provide reviews in health living centres and primary care. This will be built upon and extended to cover all those deemed as complex and high risk to ensure that they receive the very best coordinated care and treatment while reducing the demand for acute emergency beds.

Falls

The CCG is partnering with Kent Fire and Rescue Service to provide home safety visits for patient who have fallen or who are found to be at risk of falling. An identical scheme has been running for the past 4 years in Canterbury, New Zealand where they have reduced the number of fractured necks of

femur by 25%. The CCG will evaluating this with an appropriate academic partner given its potential for significant benefit to patients.

Cancer

Cancer is a major cause of illness, disability and death in the UK. Nationally, the incidence of cancer is increasing, whilst mortality rates have declined largely due to improvements in screening and treatment for cancer. However, in Medway cancer mortality rates have been consistently above the England average, despite incidence rates being similar to England and Right Care identifies this as a key area for improvement for the CCG.

A paper on 'Reducing Cancer Mortality in Medway' was taken to the Medway Health and Wellbeing Board in February 2016. The report provided an overview of cancer in Medway, focusing on lung, breast and colorectal cancer, describing achievements to date and areas for improvement. A recommendation from this report was that a 'detailed, systematic investigation' into cancer in Medway is conducted to explore the possible reasons behind the high mortality rate seen locally and to identify areas for action.

The report takes a detailed look at the burden of cancer in Medway by investigating the prevalence, incidence and mortality for the ten commonest cancers locally. A systematic approach is then taken to analysing the most up to date data available on all areas of the cancer patient pathway, covering:

- Prevalence of risk factors for cancer
- Cancer awareness and campaigns
- Screening
- Routes to diagnosis
- Waiting times for referral, diagnosis and treatment
- Staging at diagnosis
- Patient experience during treatment
- Survival

The focus on each of these areas has been included in the joint action plan with Medway Council. The focus on prevention strategies includes working with the Medway health improvement programmes for smoking cessation, weight management and exercise on referral to ensure public awareness of the risk factors for cancer.

Diabetes:

The CCG will be working with GP practices to highlight and address variation. We are promoting patient structured education that offers practical advice and support around managing their conditions.

Two diabetes specialist nurses will provide support and training to Practices in Medway. Practices identified by the Audit Plus system and as part of the annual National Diabetes Audit with a focus on achievement against the NICE care processes and areas identified by the RightCare programme :

- HbA1c
- Blood Pressure
- Cholesterol
- Serum Creatinine
- Urine Albumin c
- Foot Surveillance
- BMI
- Smoking

100% of Medway practices participated in the National Diabetes Audit in 2015/16. The continued participation will be driven by the delivery of the clinical variation programme.

We will continue to work with partners across primary, secondary and community care to deliver an integrated strategy for Diabetes care and prevention. The strategy development will include input from the South East Clinical Network for Diabetes, Medway Council, Diabetes UK, The Paula Carr Trust and close working with other CCG's across the STP footprint. The focus of the strategy will include:

- Medway FT have adopted an integrated service with a 3 tier model with input from primary care and community care. The Integrated Diabetes Steering Group includes representation from Consultants, Diabetes Specialist Nurses, podiatry nurses, a paediatric nurse and service managers across MFT and Medway Community Healthcare. We will continue to work with the Steering Group on strengthening this model built around the overarching strategy for Diabetic patients in Medway.
- **Screening:** We will work with partners to ensure that diabetic screening service for retinopathy continues to be maximised in line with the Public Health England NHS diabetic eye screening (DES) programme
- **Improving structured patient education:** The demand for structured patient education has increased over the last two years. The current service offers advice and support to assist patients in managing their conditions and describes how making lifestyle changes especially with diet will benefit patients. The CCG will participate in a joint bid across Kent and Medway for the transformation fund to improve the uptake of structured education.
- **Improving foot care:** We have conducted a needs analysis on foot care against the NICE guidance and will be looking into addressing the gaps in conjunction with the plans for the reconfiguration of Vascular services.
- **Local action on obesity linked to diabetes prevention:** We will continue working with Public Health and building on the work of the Diabetes Prevention Programme with Medway Council.
- **Patient information:** We will continue to work with The Paula Carr Trust on promoting the use of information packs for newly diagnosed patients and utilising the technology available on the Map of Medicine system.
- **Hypoglycaemia pathway:** This project in conjunction with the Kent Surrey Sussex Academic Health Science Network introduces a pathway between SECAmb and GPs to provide notification to GPs following response to hypo episodes that do not result in a conveyance to hospital. By providing a notification to the patients registered GP the pathway enables GPs to undertake a follow up with the patient, within a locally agreed timescale, to assess the event and patients concerns, and implement hypo avoidance plans. These plans can then support reduction in the reoccurrence of hypos by helping patients to self-manage their diabetes and avoid further complications that could potentially result in hospital attendance.
- **Cross cutting programmes:** We will work closely with the Medicines Optimisation Team and Medway Council Community Paediatric Health Team on the cross cutting priorities for Diabetes.

Ratio of Recorded COPD prevalence to expected prevalence

We know that in Medway there is variation in the identification of patients COPD. The CCG has been working with practices to ensure that all patients with COPD receive a diagnosis and appropriate management. This work will continue as part of wider efforts to address clinical variation in primary

care. We are also working with GPs, Medway NHS Foundation Trust and Medway Community Healthcare to improve management and support of COPD patients outside of hospital as part of the wider development for Respiratory pathways and MaSCOE programme. Right Care identifies this as a key area for improvement for the CCG.

Smoking:

Whilst smoking prevention remains the overall responsibility of Medway Council's Public Health Team, we recognise the responsibility of the CCG in supporting health partners to make every contact count in identifying smoking status and signposting patients to services who can help them quit. The effectiveness of brief interventions in primary care is well evidenced, and we will continue to develop ways in which we can use technology to make this a straightforward process for Health Professionals in Medway. We will also identify and support GP practices or other providers who require more help in this area.

Immunisations and vaccinations

We will work with Public Health England, Medway Public Health and local GPs to increase the uptake of immunisations and vaccinations across Medway for all groups that require them, including flu vaccine for the older population and health workers and the childhood immunisations. Medway Public Health is able to track progress on childhood immunisations which will inform actions to be taken as necessary.

Measurement of progress

The CCG and Medway Public Health have developed a range of measures to track progress towards the achievement of our joint ambitions.

3.7. Better Care Fund

Context

Medway CCG and Medway Council have very close working relationships including a jointly managed partnership commissioning team. One key area of responsibility of this team is the management of the Better Care Fund.

The Better Care Fund (BCF) has been fully operational since April 2015. 2016/17 has been a very productive period so far with the introduction of the new Medway Integrated Community Equipment Service (MICES), the trial of Home First, the commissioning of the Intermediate Care and Reablement Service (IC&RS) which includes the learning from the Home First trial and which went live from 1 October 2016 and the focus on DToC as part of the new National Conditions

Key Thematic areas of challenge

The following have been identified as those issues on which measurable progress will bring about an easier-flowing journey for service users:

1. Continuing to focus on reducing non-elective admissions across the system initially driven by the three ECIP work-streams (admission avoidance, internal flow, discharge)
2. Ensuring the NHS number is utilised as the main patient identifier across all parts of the system from 1 April 2016
3. Ensuring developments in interoperability are synchronised across the Medway system

4. Understand what seven day working looks like across the Medway system and being assured that initiatives are contributing to the system as a whole
5. Continued development of the IC&RS to extend to "pathway three"
6. Focussing on moving away from a bed-based economy
7. Agreeing what the integration of adult social care and health looks like in Medway and how it will be achieved

One Year Plan

The existing Section 75 agreement covering the governance and all joint working will be reviewed and agreed through the existing Joint Commissioning Management Group (JCMG).

BCF Forward Plan 2017 / 18 – 18/19		
Priority	**Action**	**Timescale**
Continuing to focus on reducing non-elective admissions across the system initially driven by the three ECIP work-streams	Capturing the impact of the various initiatives aimed at reducing / preventing admissions.	Quarterly reporting via stocktake
Ensuring the NHS number is utilised as the main patient identifier across all parts of the system from 1 April 2016	Working across the system to embed the use of the NHS number as the single patient identifier.	Mandatory for Adult Social Care (ASC) on Framework-I from 01.04.16 Quarterly reporting via stocktake and to JCMG.
Ensuring developments in interoperability are synchronised across the Medway system	Supporting those developing systems to understand and account for issues of interoperability and ensure a whole-system view.	Quarterly reporting via stocktake and to JCMG
Understand what seven day working looks like across the Medway system and being assured that initiatives are contributing to the system as a whole	Working closely especially with the Acute sector and Primary Care to establish direction of travel and ensure it is accurately recorded and messages communicated in a clear and cohesive fashion.	Quarterly reporting via stocktake and to JCMG
Focussing on embedding Home to Assess and Intermediate Care as the two main facets of the Acute – Community interface	Supporting leads for the various facets of these inter-linked initiatives to ensure understanding and maximum impact is clear and coherent across the system. Participate in ECIP working groups to cross-fertilise information and ensure it is accurately captured and potential impacts clearly thought through. Participate in specific work-streams to ensure clarity of purpose and response	Standing item at JCMG Quarterly reporting via stocktake.

BCF Forward Plan 2017 / 18 – 18/19		
Priority	**Action**	**Timescale**
	across the system as a whole.	
Developing a DToC programme with multi-disciplinary ownership	Understand a relevant measure through which to articulate progress on DToC; creation of a system plan. Continue weekly validation and highlighting of pinch-points. Address specific challenges with those who can influence change in those areas of operation.	Weekly validation Quarterly reporting via stocktake and to JCMG.
Agreeing what the integration of adult social care and health looks like in Medway and how it will be achieved	Supporting creative thinking across the system to create a vision and appetite for necessary change. Creation of a vision document for NHS England.	Vision document
Monitoring financial progress of BCF	Working across the system to gather and record detailed intelligence relating to BCF-related spend; identify where decommissioning / recommissioning will provide a better patient experience and offer a more cohesive service.	Standing item for JCMG Quarterly reporting via stocktake

3.8. Continuing Health Care

Background and Context (Adult)
NHS Continuing Healthcare refers to a package of on-going care for adults that is arranged and funded solely by the NHS where the person has a 'primary health need'. Eligibility is determined through a nationally prescribed eligibility process and takes place at the interface of health and social care. Funding responsibilities are determined following assessment recognising that health and social care systems are underpinned by a number of different legal frameworks and funding systems. NHS healthcare is free at the point of delivery but social care is subject to means testing and charges may apply. If an individual's health needs change, responsibility for funding their care and support may also change, as may their requirement to financially contribute to their ongoing care.

Service Delivery

CCGs are required to ensure that there is a fair and efficient process and a good quality assessment to reflect an individual's needs and that there are no delays in assessment or decision making. The CCG will:

- Ensure complete compliance with its statutory duty associated with NHS Continuing Healthcare by undertaking eligibility assessments jointly with Social Services, other members of the multidisciplinary team and involving the patients and/or their family.
- Regularly review patients and modify plans based on changing need.
- Apply robust and auditable decision-making so CCGs are compliant with all legal requirements, allocating NHS funding appropriately.
- Secure best value for money for individual care and support packages including residential, domiciliary and personal health budgets (PHBs).
- Regularly review care packages and placements to ensure they meet identified health need and continue to deliver value for money.
- Ensure that patients remain in specialist placements for no longer than their optimum time.
- Step patients down from specialist services to more appropriate local services as their condition improves.
- Undertake partnership working for multi-disciplinary assessments to identify patient health and social care needs.
- Provide expertise in the individual case management of all patients.
- Provide comprehensive training and advice to service providers.
- Manage dispute resolution processes with other statutory bodies.
- Manage complaints and appeals, including NHS England (NHSE) Independent Review and review by the Health Services Ombudsman.
- Undertake clinical quality monitoring of service providers.

Improved Access

Patients in acute hospitals become quickly deconditioned losing muscle strength rapidly; this can result in the loss of independence and increases the risk for the need for long term care. It is therefore vitally important to ensure delays in discharge are eliminated, whilst still complying fully with the statutory duty. The National Framework recognises this is a complex process and allows CCGs 28 days to complete the process from referral to decision. Clearly this could have significant impact on the health and independence of the person if that process means that they have to remain in hospital. The CCG's aim is that no patient will be assessed for NHS Continuing Healthcare in the hospital environment. To do this the "Discharge to Assess" model is being led and developed by NHS Medway CCG and Medway Council Integrated Commissioning Teams based on the principle that a patient will never be admitted to hospital to never see their home again. "Home First" will allow patients to go home cared for by health and social care to allow assessments, including those for NHS Continuing Healthcare, to be carried out in the home environment. The aim is to keep people at home for as long as possible.

It is recognised that not all patients with complex, intense or unpredictable health needs can appropriately be cared for at home. Currently the CCG and Social Services rapidly assess patients in hospital and a NHS Continuing Healthcare decision is made directly at the bedside reducing the time from positive Checklist Tool referral to decision from 28 days to between 5-7 days.

The CCG and Medway Council Integrated commissioning team are also developing the same principle for patients who, due to the level and complexity of their on-going care needs will require a placement on discharge from hospital to ensure that patients can be transferred in a timely manner to an alternative care location and their longer term needs and eligibility for NHS Continuing Healthcare services assessed and established in a more suitable care environment.

Children and Young People's Continuing Care (physical health and mental health)

Children and young people (CYP) with complex health needs which cannot be met by universal or specialist services may be eligible for a Children's' Continuing Care package. Medway CCG and Medway Council work within a partnership commissioning model and follow the National Framework for CYP continuing care. The framework offers guidance and outlines a typical process and states that this is led by a CYP health assessor:

- Assessment and evidence gathering which includes preferences of the CYP and their family, holistic assessment of the CYP's needs, collation of reports and risk assessments from the multi-disciplinary team including education and completion of a CYP specific Decision Support Tool.
- A forum at which all the above are presented to a multi-agency team to consider the evidence, the recommendation of the CYP assessor and to determine if the CYP is eligible for CYP continuing care. The CCG holds regular forum and invites both social care and education colleagues.
- Development of a care package, this may be jointly with a social care package or as a PHB.
- The framework suggests that from referral to decision making takes 6 weeks. Arrangement of provision is guided by individual needs which includes a range of factors for example a specialist skill set or a change of school.

All CYP are entitled to education and to support the education process CYP with complex health needs will require health care within their education setting. The Children & Families Act, 2014, stipulates that CYP with additional needs will have an Education Health and Care Plan – this one plan outlines education health and social care needs, outcomes and the support to be provided. The Special Education Needs department contribute to the Medway multi-agency panel and will present cases of CYP with complex health needs to facilitate those more specialist placements which may include residential school in addition to prescribed health support required within a day school.

CYP with care packages are reviewed and presented to the multiagency panel. If health needs change or at the family's request the review can be brought forward.

4. Urgent and Emergency Care

4.1. Context

The A&E at Medway FT has struggled against the requirement of the 4 hour target to discharge or admit 95% of patients within 4 hours of arrival. An Unscheduled Care Improvement Plan and a Remedial Action Plan are in place and the Trust has been supported by the Emergency Care Improvement Programme (ECIP). The CCG plans will ensure that the 4 hour target is achieved during 2017/18 and 2018/19.

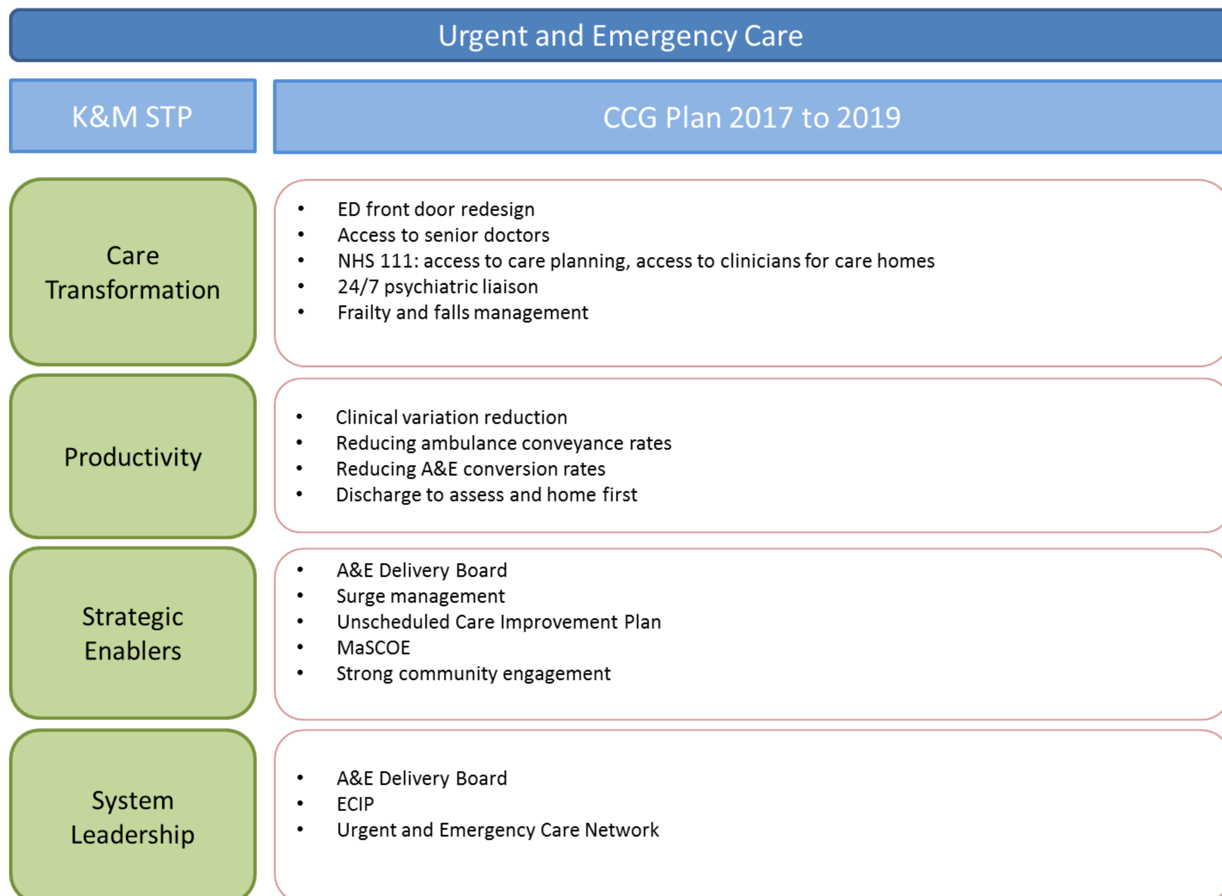


Figure 3: Urgent and emergency care alignment with STP

The STP identifies a need to reduce urgent care costs by 4% against a 2015/16 baseline which equates to a 16% reduction after demographic growth is applied. The CCG has reduced non-elective admissions by 3% so far in 16/17 – the highest reduction in the South of England but recognises there is still a significant challenge.

The CCG has aligned key schemes in the UCIP against this reduction as shown in the waterfall diagram below:

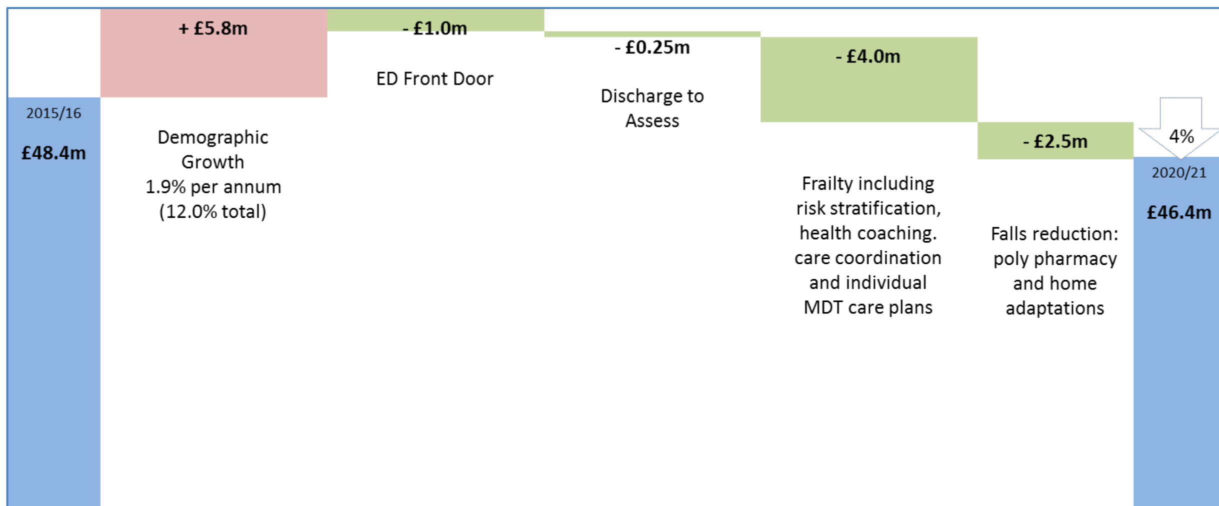


Figure 4: The five year urgent and emergency care challenge

The four A&E priority standards are:

- Timely consultant review: All emergency admissions have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital.
- Improved access to diagnostics: Hospital inpatients have scheduled 7 day access to diagnostic services. Consultant-directed diagnostic tests and reporting available 7 days a week: within 1 hour for critical patients; within 12 hours for urgent patients; and, within 24 hours for non-urgent patients.
- Consultant directed interventions: Hospital inpatients must have timely 24 hour access, 7 days a week, to consultant-directed interventions.
- Ongoing review in high dependency areas: All high dependency patients (including acute medical unit, surgical assessment units and intensive care unit) seen and reviewed by a consultant twice daily, unless it is determined by a senior decision-maker

The 7 day services standards due for Nov 2017 are those for all urgent network specialist services: vascular surgery, stroke, major trauma, STEMI heart attack and children's critical care. Guidance is not yet available but once published the urgent care network will follow up through the respective clinical networks to ensure achievement. In addition, MFT are a Major Trauma Centre and are part of the SELKAM Trauma Network and a recent Peer Review assessed the 4 priority standards and no major concerns were identified. Other areas such as STEMI are managed on a Kent and Medway basis (or wider).

The wider seven day services in hospital is a national policy imperative intended to improve flow in hospital, and hence increase patient safety, experience and also efficiency. Our local acute trust has plans for meeting the requirements in their Service Delivery Improvement Plan (SDIP). This is being managed through the contractual process.

4.2. Accident and Emergency Delivery Board (AEDB)

The AEDB, supported by the Senior Operational Group, will continue to be responsible for the improvements to urgent and emergency care for the CCG. The AEDB is chaired by Medway FT's CEO but jointly owned as a delivery board by all main partners involved in urgent and emergency care including Medway Council, South East Coast Ambulance Service and Medway Community Health.

The Senior Operational Group provides the operational delivery for the Board and this is led by the CCG. This Group focusses on delivering the jointly agreed Unscheduled Care Improvement Plan and Winter Plan.

4.3. Unscheduled Care Improvement Plan (UCIP)

Whole system efforts are also being developed to support a sustained recovery of A&E performance through a range of projects involving whole system collaboration which are being monitored ultimately through the A&E Delivery Board but driven by the Senior Operational Group

The UCIP was developed drawing on local and national knowledge bases including ECIP and the 5 elements of the A&E baseline assessment and focuses on these areas:

- Attendance Avoidance:
  - NHS 111: Continuous review to ensure DOS is up to date; access to care planning to recognised pathways for specific patients; calls from care homes to have clinician access; reprocurement of 111 and OOH GP services in line with contractual requirements.
  - Front Door redesign: continue the diversion of 23% of A&E attenders to on-site primary care service; maximisation of ambulatory care pathways.
  - Primary care interventions: reducing variation in primary care; frailty and falls projects; development of LCTs; increased access to primary care in evenings and weekends.
  - Development of telephony access to senior doctors for all major specialities between 8am-8pm (adaptable to demand profile). The pathway continues to be developed with plans in place to improve response times as specialities are not consistently 'always' available.
  - Ambulance service: Continuous review to ensure DOS is up to date to ensure alternative pathways are used and conveyance rates are minimised; access to care planning to recognised pathways for specific patients; eliminate hand over delays.
  - Community Services changes: consolidate Integrated Care Home Team; expand the Community Geriatrician service; complete the End of Life review; increase the scope of the frequent user programme.
  - Mental Health provision: continue the 24/7 psychiatric liaison service in A&E; introduce street triage.
- Flow:
  - Admission avoidance: consolidate the Home First and Rapid Response
  - Work with Medway FT to support their internal flow improvements including Internal Professional Standards and SAFER flow bundle
  - Ambulatory Emergency Care Services are in place with ongoing development to provide the service 12 hours a day 7 days a week complemented by GAU, SAU and Chest Pain Units.
- Discharges:
  - Introduce a multi-agency care plan and referral system
  - Ensure that Delayed Transfers of Care are maintained below 3.5%. Ensure that there is executive ownership in provider and commissioner organisations.
  - Continue Home First and Rapid Response
  - Trusted assessor arrangements to minimise handover delays
  - Increase continuing health care screenings and assessments so that 90% are conducted outside of the acute setting
  - Ensure choice at discharge policy is in force that reflects national guidance.
- Enablers:
  - Ensure winter planning process is effective and agreed by all parties

- Implement escalation processes including the use of SHREWD and new definitions of escalation.
- Promote the Health Help Now app.

4.4. Contract Management

The CCG will continue to work collaboratively with providers to ensure that patients get the best quality care when and where they need it. The improvements required will be supported by the levers available within the contracts when necessary.

4.5. Frailty and falls

Following the successful pilot of the Integrated Care Home Team the CCG approved funding for the substantive model and also support of the model to be extended across residential homes. This has been achieved through negotiations with the current provider in order to utilise existing available resource with the aim to achieve better integration across community teams (i.e. community geriatrician, dementia support services, falls prevention) reducing duplication across the system, supporting communication and promoting better patient outcomes.

4.6. Surge management

A North Kent wide escalation and surge management plan has been developed across Medway, Swale and DGS CCGs. The whole system has worked collaboratively enabling the development of a single plan, ensuring a cohesive and consistent approach to managing surge and escalation. This has included further development of provider escalation indicators and trigger values in the SHREWD system to provide real-time visibility of the system status as a whole.

4.7. Urgent Care Network

The 7 day services standards due for Nov 2017 are those for all urgent network specialist services - vascular surgery, stroke, major trauma, heart attacks and children's critical care. Guidance is not yet available. Once published the urgent care network will follow up through the respective clinical networks to ensure achievement.

The redesign of stroke services is being led by Dartford, Gravesham and Swanley CCG and Vascular services are managed by the NHS England South East regional team and both are within the STP plans and are likely to take longer than November 2017.

STEMI heart attack management is led by The Kent Cardiac Network and delivered by East Kent Hospitals Trust on behalf of all Kent and Medway CCGs.

The Urgent and Emergency Care Network (UECN) delivery plan sets out the milestones for the key elements of the review. Further work is required on the areas where guidance is not yet available.

The Integrated Urgent Care review and redesign programme can be broken down into two components – telephony and face to face access to urgent care. Telephony includes NHS 111 and GP speak to, with face to face components including all GP out of hours, 24/7 navigation to primary care face to face appointments at Medway Foundation Trust (MFT) and Gillingham Walk in Centre (WIC). Although Emergency Services within the A&E departments are not part of this review, they should be positively affected by the programme, as patients attending these departments that do not require this level of expertise should be directed and treated elsewhere within the urgent care system. To provide economies of scale currently North Kent CCGs have agreed to pursue procurement of a single 111 service across North Kent, that is functionally integrated with three local urgent care models across Medway, Dartford and Swale. Central to this will be the development of a 'clinical hub' or Integrated Clinical Advice Service (ICAS) that will provide clinical advice to patients contacting NHS

111 or 999 and out of hours calls, and provide clinical support to clinicians, such as ambulance staff and emergency technicians so no decision is made in isolation. Timescales for delivery of Integrated Urgent Care aim for the new model to be in place by 1st April 2019.

A strategic review of workforce planning is due to take place under the STP which will link into the UECN as one of the clinical strategic oversight groups. The UECN is currently supporting CCG's to review data and patient pathway activity to support Integrated Urgent Care modelling and to identify what level of clinical skill mix will be require to help develop and deliver the model proposed.

4.8. Emergency Ambulance Pathways

South East Coast Ambulance provides the emergency ambulance service for Medway CCG residents. Although they are currently struggling to achieve key access targets and a Unified Recovery Plan is in place led by Swale CCG on behalf of Medway CCG, SECAmb currently have the second lowest rate for conveyance to hospital.

A number of projects are being progressed by the CCG and providers with the aim to support further reductions in conveyances to A&E, these include:

By June 2017:

- Optimise the use of the SECAmb/MedOCC pathway
- Review of the acceptance criteria for transport of patients to available Minor Injuries Units in Sittingbourne, Sheppey and Gravesend to optimise use of this pathway where appropriate
- Substantive model for the Integrated Care Home Team in place across nursing homes and the expansion of the team across residential homes. This project will explore the expansion of direct telephone access to Out of Hours GP across residential homes and direct admission to SAU and Lister Ward for the Advanced Nurse Practitioners working within the Integrated Care Home Team.
- Focus across End of Life care to increase the number of patients recorded on the My Wishes Register to support patients to die in their place of choice avoiding conveyance to hospital.

March 2017 – March 2018:

- Dispatch on Disposition (DoD) acceptance criteria with varying hours of availability. A demand management plan is in place to allow flex of capacity at times of peak demand.
- Further actions to be progressed by SECAmb to support an increase in the number of ambulance service interventions to ensure the most clinically appropriate resource is allocated to a 999 call first time include the confirmation of the acceptance to moving to 240 DoD within an agreed timeframe, confirmation of NHSE Readiness Checklist activities, submission on T-times and call and dispatch processes for NHSE and confirmation of ambulance trust agreement to provide monthly data returns.
- An existing process of clinical review of green ambulance dispositions already exists within KMSS NHS 111. An initial report has been development to review the performance of this provision and in May 52% of ambulance dispositions were changed to an alternative disposition. Further work is currently underway to fully understand the reasons for these changes with feedback to be provided to commissioners.

4.9. Constitutional Standard Monitoring and Risk Management

Monitoring of the A&E 4 hour target is managed on a live basis through the use of SHREWD and additionally daily reports are provided to the CCG. Performance is reported and discussed at the CCG's operational commissioning meeting 'Touchdown' each week and reported to the Quality, Finance and Performance sub-committee of the Governing Body as well as the Governing Body itself every month.

Risk management of constitutional standards is exercised at the Governing Body level through the Assurance Framework. This in turn references the Commissioning Risk Register which contains the key risks and mitigations. The Commissioning Risk Register is managed proactively through the operational 'Touchdown' meeting and reported to the Commissioning Committee, a sub-committee of the Governing Body.

In line with the CCG specific risk management, the AEDB and SOG provide a further layer of granularity of risk management for the A&E 4 hour standard. The Remedial Action Plan and Urgent Care Improvement Plan contain the specific plans that are designed to improve performance and therefore mitigate against breaches of the standard.

Operationally, risk mitigations are contained within the health economy escalation plan which is reviewed yearly.

Specific operational plans to reduce risk have been set out in the actions in sections 4.1 to 4.8 above as well as in the escalation plan which is triggered at times of pressure.

5. Planned Care

5.1. 18 weeks Referral to Treatment

Capacity challenges at the main provider for the CCG – Medway NHS Foundation Trust (MFT) – have led to a large increase in the number of Medway patients waiting more than 18 weeks for elective treatment. The impact is particularly significant in the specialities of orthopaedics, ENT and dermatology. Reporting against the 18 week target has been suspended at MFT for most of 2016/17 while the quality of the data was corrected but is due to restart in November 2016. The data currently show that backlog reduction is in line with the improvement trajectory agreed with NHS Improvement but still remains below the national requirement of 92% of people waiting under 18 weeks from referral by their GP.

The CCG has focused on expanding alternative secondary care provision to alleviate demand on MFT and ensure that they can reduce their backlog to increase performance to 92% by March 2017.

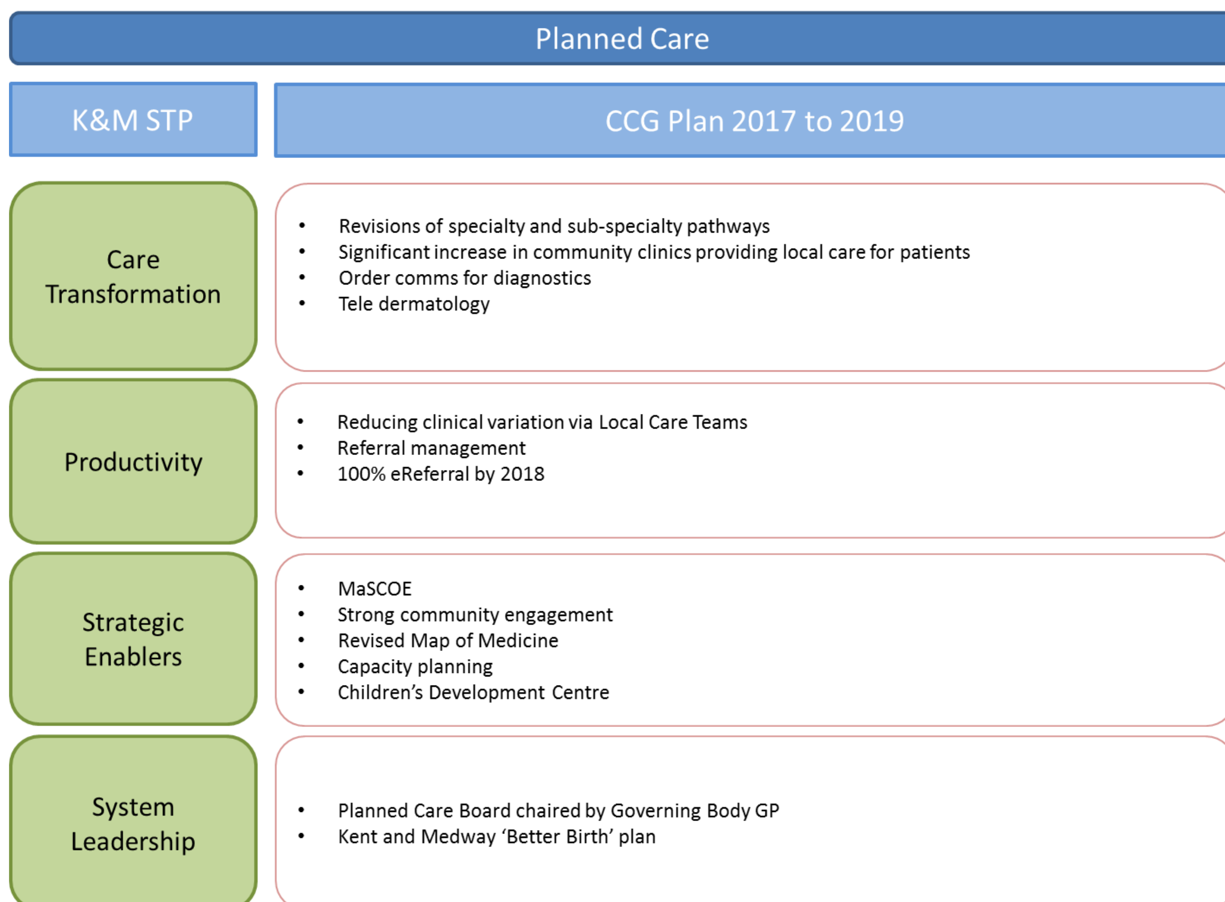


Figure 5: Planned care alignment with the STP

The STP identifies a need to reduce outpatient costs by 7% compared to the 2015/16 baseline, i.e. by 17% after demographic growth is applied. This will be achieved by a combination of referral management (better pathways and processes), community clinics and improved efficiencies of follow up care.

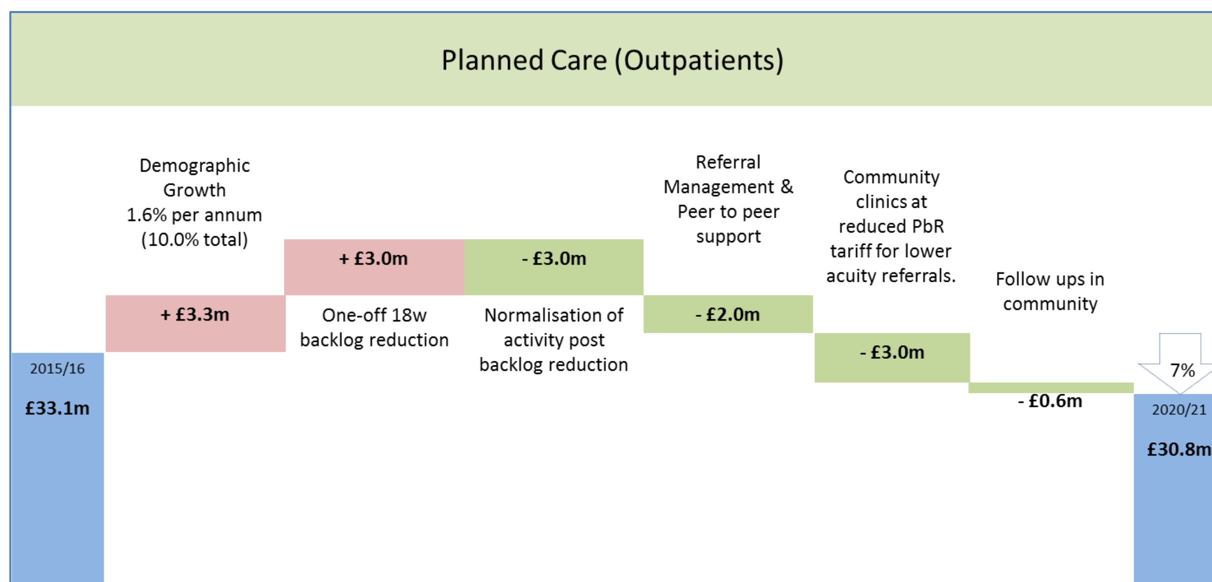


Figure 6: The five year planned care challenge (savings are net of investments)

The CCG will ensure that all secondary care referrals are made electronically by March 2018. The CCG will work with GPs and providers to ensure that the Map of Medicine and referral systems are aligned and that all clinics are published. As specialties become able to receive electronic referrals, we wil work with GPs and providers to ensure that paper referrals are ceased in favour of electronic ones.

5.2. Planned Care Pathways

The two year plan will focus on improving the pathways for a range of specialties to ensure that patients access timely and appropriate care. The CCG will work with clinicians to revise the Map of Medicine tool to ensure that it reflects the agreed pathways and referral requirements utilising electronic referral via the e-Referral system.
The pathway developments are supported by the Planned Care Programme Board held jointly between Medway CCG, Medway NHS Foundation Trust and Medway Community Healthcare. Each high priority specialty has a Task and Finish Group to identify pathway developments.

The pathway development includes a focus on the areas within the NHS England Demand Management Good Practice Guide (August 2016):

- **Ophthalmology:** The introduction of a community ophthalmology service which includes minor eye conditions services (MECS), repeat intra-ocular pressure service, post-operative cataracts and stable glaucoma monitoring across North Kent. The aim is to reduce demand on secondary care and provide improved access to local community services from Q1 17/18.
- **Dermatology:** A reduction in secondary care demand linked to pathway redesign including a new pilot GP service and Tele-Dermatology (linked to finding alternatives to outpatient appointments) from Q1 17/18.
- **Orthopaedics (MSK):** The redesign of musculoskeletal pathways to include robust referral management utilising e-Referral, referral templates, triage, integrated pathways and shared decision making as described in the Good Practice Guide. The programme is linked to the areas of opportunity identified in the Right Care programme related to day case activity. This commences in Q2 17/18.
- **Cardiology:** The redesign of cardiology pathways utilising an audit undertaken by MFT which identified gaps in service provision for a cohort of patients that could be seen in a community setting. The design of cardiology pathways will include referral management centred on triage, direct access to diagnostics, signposting to community settings and linked to the Right Care programme data on pathways for atrial fibrillation. This commences in Q1 17/18.

- **Respiratory:** The respiratory project aim is to redesign respiratory pathways in Medway to facilitate implementation of best practice aligned to the Right Care areas, demand management good practice related to alternatives to outpatient attendances in secondary care by identifying gaps in community service provision, exploring new workforce roles and the increased use of technology. This commences in Q1 17/18.
- **Urology:** The revision of pathways for lower urinary tract symptoms and PSA follow up in order to reduce secondary care demand and ensure efficient management of follow up appointments in line with good practice related to the management of follow up appointments. This commences in Q1 17/18.
- **Gastroenterology:** The redesign of a number of gastroenterology pathways in order to reduce demand on secondary care attendances including endoscopy. The pathway redesign is linked to the Right Care programme quality improvement area in ensuring there is achievement against the six week target for endoscopy. The CCG will continue to work with its providers to ensure sustainability against the 6 week target for gastroscopy which has been achieved in quarter three of 2016/17.
- **ENT:** The introduction of 23 pathways for common ENT conditions, a new GP with Special Interest service including the provision of microsuction and review of all ENT follow up appointments within secondary care linked to good practice for the management and monitoring of follow up appointments. This commences in Q1 17/18.
- **Allergy:** The redesign of the allergy service following the end of the service at Medway NHS Foundation Trust. The aim will be to identify pathways suitable for management within primary care, explore advice and guidance with a new secondary care provider and identify pathways which could be seen by other specialty areas. This commences in Q1 17/18.

The planned care work is supported by the CCG Choice Policy developed in line with the Department of Health 2015/16 Choice Framework which will assist patients understanding the choice agenda.

To achieve reductions in the 18w backlog outsourcing to the independent sector (IS) in a number of specialties through 2016/17 has been achieved through directly commissioned services and via sub-contracts. Medway CCG has been working with GPs through the National Insights Team to ensure patient choice at referral is enhanced within the CCG and that is conducted with the best knowledge of pathways and waiting times. The CCG currently contracts with a range of IS providers including Spire Alexander, Will Adams (Care UK) and BMI Somerfield. All these contracts are being maintained into 2017/18 to 2018/19 with the CCG always requesting to understand the availability of specialties with additional capacity which can support MFT in its backlog reduction either through outsourcing or direct referral.

The pathway development and achievement against 18 weeks is further supported by the development by Medway NHS Foundation Trust regarding dynamic outcome forms which are designed to help improve patient experience, shorten waiting times, increase clinic utilisation, redesign better pathways, improve data quality and increase workforce efficiency.

The forms will lead to the following benefits:

- Clinicians will be informed about each patient's individual pathway whilst the patient attends their appointment
- outcomes that are inconsistent with the pathway will be greyed out on the form
- reduced admin by including the demographics and clinic details onto the outcome form

The feedback so far has included:

- staff are more informed to make decisions about when to schedule the next appointment / investigation / admission
- staff are more informed to make decisions about whether the patient should be discharged back to primary care
- greater awareness of the end-to-end service from the patient perspective
- identification of patients who are struggling to keep their appointments
- staff feel informed to appropriately discharge patients that repeatedly do not attend (DNA)
- staff are more informed to make appropriate decisions about which outcome to record

5.3. Children's Services

Community Paediatric Health Services

Detailed needs analysis has recently been undertaken and commissioners have reviewed of a range of paediatric services throughout the previous financial year. The outcomes of this work has formed the basis for short-term service development improvement plans and longer term commissioning intentions, including how the CCG commissions services that are currently provided within the current distinct service areas:

- Community Paediatric Outpatient Service
- Community Paediatric Administrative Support Service
- Children's Community Nursing Service
- Special School Nursing Service
- Community Learning Disability Nursing Service
- Special Needs Nursery
- Looked After Children Nursing Service
- Paediatric Speech and Language Therapy
- Paediatric Neurodevelopmental Physiotherapy
- Paediatric Musculoskeletal Physiotherapy
- Paediatric Occupational Therapy

Alongside this, Medway's Public Health directorate now has commissioning responsibility for services for children and young people aged 0-19 linked to the Healthy Child Programme; this includes health visiting and school nursing services.

Two-year plan

We aim to use the coming period to commission community-based children's health services that are integrated in their delivery, focused on outcomes and which enable multidisciplinary working to be embedded to improve system efficiency and the level of service that is provided.

Using the available funding to create an integrated service that is focused on core outcomes, with strong links to the progressive universal services that will be commissioned by Medway Public Health Directorate, and with a focus on family support and building resilience will help to improve the service offer for children, young people and their families, and will help to reduce areas of duplication – for example multiple assessment and review processes.

A renewed focus will be given to transition between children and adults services. This will include clear transition for children and young people that have Special Educational Needs and Disabilities.

After a number of years without a Child Development Centre (CDC), a new CDC is currently being developed. It is envisaged that this will facilitate key elements of multidisciplinary working that is currently not routinely present within the system; this will be supplemented by more localised delivery points, aligned where possible to the emerging model of Integrated Care and Well Being Hubs, to provide additional advice and support. This will include the development of shared care for children and young people with ADHD.

In addition, a new way of working to specifically support children and families where there is challenging behaviour will be developed within the next two years. This will improve service provision and outcomes for this specific group and help to generate system efficiencies through reduction of the use of expensive specialist placements.

Acute Paediatric Health Services

Medway Foundation Trust provides acute paediatric services in Medway. During this year, work relating to the high volume pathways of diabetes, epilepsy and asthma has been reviewed to better understand the service that is provided and to identify areas for improvement across the system.

Two-year plan

We aim to reduce epilepsy, diabetes and asthma admissions and attendances at ED for children in Medway, and will work with partners from across the health care system to ensure that this is achieved. The initial focus of this work relates to asthma; numbers of admissions are greater in this area, and Medway is now an outlier to the national average for attendances at ED.

We aim to embed early identification and diagnosis, and empower children, young people and their families to manage their conditions more effectively.

Where possible, specialist provision will be developed through the emerging model of Integrated Care and Well Being Hubs in Medway, to ensure that patients have access to specialist advice close to home; we will run tests for change to ensure that the transition towards this model is undertaken as effectively as possible.

5.4. Maternity

MFT provides the full range of antenatal, delivery and postnatal maternity services in Medway and has the lead Level Three Neonatal Unit in Kent. There are approximately 3,650 births per year for Medway residents.

The maternity specification ensures the provider delivers services in a way that reflect the national context for local planning of maternity services, as set out in the relevant NICE Guidelines and NICE Quality Standards. The 2015 CQC inspection saw maternity services rated as 'Good'.

The recommendations of the national maternity review, Better Births, have been issued and CCG Improvement and Assessment Framework metrics indicate that CCGs and providers should come together in Local Maternity Systems (LMS) to design and deliver maternity services improvements in line with the recommendations. An initial meeting of the LMS took place in December 2016 comprising commissioners and providers across Kent and Medway. The CCG will develop a better births implementation plan in conjunction with the LMS during quarters one and two of 2017/18 including themes that are agreed across the area and learning from the better birth pilot areas.

While the quality of care at Medway FT has been rated as 'Good' by the CQC, maternity has been identified as 'needing improvement' in the six clinical priority areas due to a high rate of still births

and neonatal deaths and a high rate of smoking at time of delivery. The rate of still births and neonatal deaths has reduced significantly in more recent data back to previous levels; the high rate was felt to be a result of random variation.

Two Year Plan

CCG commissioners from across Kent and Medway have reviewed the recommendations from the national maternity review, published in February 2016 and these will be taken into account in the development of our maternity commissioning plans. The key recommendations are:

- Personalised care – centred on the woman, her baby and her family. This includes having a genuine choice over where and how she gives birth; development of personalised care plans setting out decisions about her care; the use of personal maternity budgets.
- Continuity of care – women having access to the same team of midwifes throughout pregnancy, birth and the postnatal period.
- Safer care – developing a culture of learning and continuous improvement; good quality data and robust referral pathways ensuring access to the right care, particularly specialist care, when needed.
- Better postnatal and perinatal mental health care – to address historical underfunding in this area and reduce the number of postnatal maternal deaths associated with mental health needs. A workforce training plan will be developed to support this.
- A continued effort to support women to stop smoking preferably before or but especially during pregnancy.

Commissioners from across Kent and Medway are working with the CCG and provider partners across the STP area, with the support of the NHSE Regional Team, to develop a Kent and Medway Better Births implementation plan. Kent and Medway submitted a bid in September 2016 to become a National Maternity Review Early Adopter site which was unsuccessful; feedback from NHSE was positive and will form a key component of how we implement the recommendations of the maternity review across the Kent and Medway footprint.

A Local Maternity System is being formally established and will be coterminous with the STP footprint; discussions between maternity commissioners, providers, colleagues from Public Health, and colleagues from NHS England has identified that as an area, we will aim to move at pace to identify key priorities for development and to implement change. The LMS is currently in a formative stage; once agreement has been reached as to the direction of travel and areas of focus, clear trajectories for change and milestones will be developed. Feedback from maternity choice and pioneer pilots and Better Births early adopter sites will be pivotal in helping to guide the work of the LMS, and the LMS will work in partnership with NHSE and the Maternity Strategic Clinical Network to help identify and implement agreed changes.

5.5. Constitutional Standard Monitoring and Risk Management

Monitoring of the 18 week target is provided to the CCG by Medway Foundation Trust each week. Performance is reported and discussed weekly at the CCG's operational commissioning meeting 'Touchdown' and reported to the Quality, Finance and Performance sub-committee of the Governing Body every month as well as the Governing Body itself.

Risk management of constitutional standards is exercised at the Governing Body level through the Assurance Framework. This in turn references the Commissioning Risk Register which contains the key risks and mitigations. The Commissioning Risk Register is managed proactively through the operational 'Touchdown' meeting and reported to the Commissioning Committee, a sub-committee of the Governing Body.

In line with the CCG specific risk management, the Planned Care Board and specialty task and finish groups provide a further layer of granularity of risk management for the 18 week standard.

In addition to the actions in 5.2 the Remedial Action Plan contains the further detail on the plans that are designed to improve performance and therefore mitigate against breaches of the standard.

6. Cancer

Context

Medway CCG has identified cancer as having the greatest need for improvement against the six clinical priority areas. Specifically, early detection of cancers and the one year survival rates for lung cancer are seen as needing improvement. This improvement needs to be made alongside adherence to the nation target, e.g. treatment within 62 days of referral.

The prevalence of smoking and obesity is higher in Medway than the England average, but alcohol consumption is at a similar level to the rest of the country. Over time the incidence of all cancers among people aged under 75 has increased in Medway, as in England. Each year in Medway, there are more than 320 deaths due to cancers in people aged under 75. However, the completeness of cancer staging has improved: 2013 saw a rise from the previous year with 5.3% of lung cancer, 16.7% of bowel cancer and 10.1% of breast cancer recorded as un-staged.

Cancer	
K&M STP	CCG Plan 2017 to 2019
Care Transformation	• Recovery package • Stratified follow ups • Cancer reviews within six months • Macmillan practice nurse facilitator
Productivity	• Right Care • Integrated cancer dashboard
Strategic Enablers	• Smoking cessation programmes • Screening programmes and initiatives • JSNA • NICE referral guidelines • "Achieving World-Class cancer Outcomes" • Strong community engagement
System Leadership	• Planned Care Board chaired by Governing Body GP • Joint Cancer Steering Group • Cancer Network

Figure 7: Cancer alignment with STP

Plans

The CCG has a joint Cancer Steering Group and action plan developed with Medway Council, Macmillan Cancer Support, Cancer Research and Public Health England. The action plan is intended to support and implement plans to achieve world-class cancer outcomes by 2020 across Medway, with focus on the following key areas:

- Preventing Cancer
- Early Diagnosis
- Improving Cancer treatment and Care
- Living with and Beyond Cancer

The action plan which identifies actions to be completed by September 2017 has a key focus on:

- Collaboration in order to support screening programme providers and other stakeholders to improve the uptake and coverage of screening in the eligible populations with consideration given to addressing inequalities including increasing uptake for people with learning disabilities. The approach will include undertaking public focus groups to identify the reasons why patients do not access screening services. The actions will be aligned to the relevant awareness months during the first six months of 2017.
- Ensuring local implementation to support the national Be Clear on Cancer campaigns, and raise awareness of the local priorities including Prostate and Bladder.
- Support the implementation of the NICE referral guidelines (NG12) to reduce the threshold of risk which should trigger an urgent cancer referral to improve early diagnosis.
- Monitoring the integrated cancer dashboard to monitor outcomes in the Medway locality and address areas of improvement to ensure Medway CCG increases compliance to above the national average.
- Reviewing and monitoring the CCG Improvement and Assessment Framework in relation to the Cancer Indicators.
- Ensuring the cancer risk factors including smoking, alcohol, excess weight, diet and physical activity as identified through the Medway Joint Strategic Needs Assessment are addressed in partnership with the Local Authority and the signposting of services are available for health services and patients as set out in section 3.6.
- Supporting and monitoring the implementation of the Recovery Package and develop enhanced support for cancer survivors working closely with patient and voluntary groups.
- Adhering to direction and guidance from the Cancer Clinical Networks following the Awareness and Early Diagnosis, Living with and Beyond Cancer and Cancer CAG meetings.
- Work will continue to implement the recommendations of “Achieving World-Class Cancer Outcomes: A Strategy for the NHS 2015-2020” and areas identified within the NHS RightCare programme

The action plan is linked to the priorities of the Medway Foundation Trust Cancer Board, MFT Cancer Strategy and delivery of the NHS Constitution 62 day cancer standard including securing adequate diagnostic capacity in line with NICE referral guidelines (NG12) and the other NHS Constitution cancer standards. During 2016 we have worked with Medway NHS Foundation Trust on a remedial action plan for Cancer performance which has included the improvements below. These improvements will ensure that risks to the constitutional target are minimised while ensuring that clinicians remain at the forefront of delivery.

- Reviewing and improving tumour-specific operational policies
- Reinstating the Local Implementation Groups (LIGs) for each tumour group
- Development of a Cancer Waiting Times Standard Operating Procedure
- Identifying and monitoring key performance indicators (KPI’s) for key operational processes
- Implementing interfaces between the hospital Patient Administration System (PAS) and the Infoflex Cancer system
- Live recording of Cancer decisions during multidisciplinary team meetings
- Developing tumour site specific improvement plans for skin, urology and colorectal

The challenges with achievement against the 62 day target in 2016 have mainly been related to capacity issues for Dermatology. The planned care programme has identified actions to reduce demand linked to pathway redesign including a new pilot GP service and Tele-Dermatology.

The CCG will work with providers to ensure that the correct capacity is commissioned and provided to meet the constitutional requirements.

We have developed a steering group with Clinical Nurse Specialists, Macmillan GPs and Commissioners with a key focus on:

- Ensuring all elements of the Recovery Package are implemented including:
  - Ensuring a robust holistic needs assessment is undertaken for all patients
  - Building on the existing care plans following diagnosis and strengthening the treatment summaries
  - Ensuring cancer care reviews are completed within six months of treatment supported by the development of the GP clinical system and relevant templates
  - Creating templates for a Health Needs Assessment and Macmillan Holistic Needs assessment on the Infoflex cancer system for use by the Clinical Nurse Specialists (CNS)
  - Developing and agreeing stratified follow up pathways starting with breast cancer patients and rolling out to prostate and colorectal. The learning from the initial roll out of stratified pathways will be applied to the development of all other tumour groups.

During 2016/17 Medway CCG secured funding for a Macmillan Practice Nurse Facilitator (MPNF). This role will support the Macmillan GP and Macmillan Practice Nurse Course during 2016-2019. The facilitator will:

- Enhance training and knowledge across the CCG. The programme will include training practice Health Care Assistants to recognise cancer symptoms linked to reducing the late presentation in A&E
- Formulate frameworks and strategies to ensure patients are provided with cancer care reviews and health promotion in line with the development of the recovery packages and holistic needs assessments
- Empower patients with self-management and recognition of re-accruing symptoms.

These efforts will improve the QOF measurement for Cancer Care.

6.1. Constitutional Standard Monitoring and Risk Management

Monitoring of the cancer targets is provided to the CCG via the providers. Performance is reported and discussed at the CCG's operational commissioning meeting 'Touchdown' weekly and reported to the Quality, Finance and Performance sub-committee of the Governing Body every month as well as the Governing Body itself.

Risk management of constitutional standards is exercised at the Governing Body level through the Board Assurance Framework. This in turn references the Commissioning Risk Register which contains the key risks and mitigations. The Commissioning Risk Register is managed proactively through the operational 'Touchdown' meeting and reported to the Commissioning Committee, a sub-committee of the Governing Body.

As mentioned above the LIGs will provide a further layer of granularity of risk management for the cancer standards.

The Remedial Action Plan contains the specific plans that are designed to improve performance and therefore mitigate against breaches of the standards.

7. Mental Health

Medway CCG works closely with Medway Council to commission and develop many of the services across Medway. An integrated mental health strategy for Medway is being developed with Medway Council, Kent Police and KMPT via the Medway Health and Wellbeing Board. The CCG will continue to meet the requirements of the Mental Health Investment Standard.

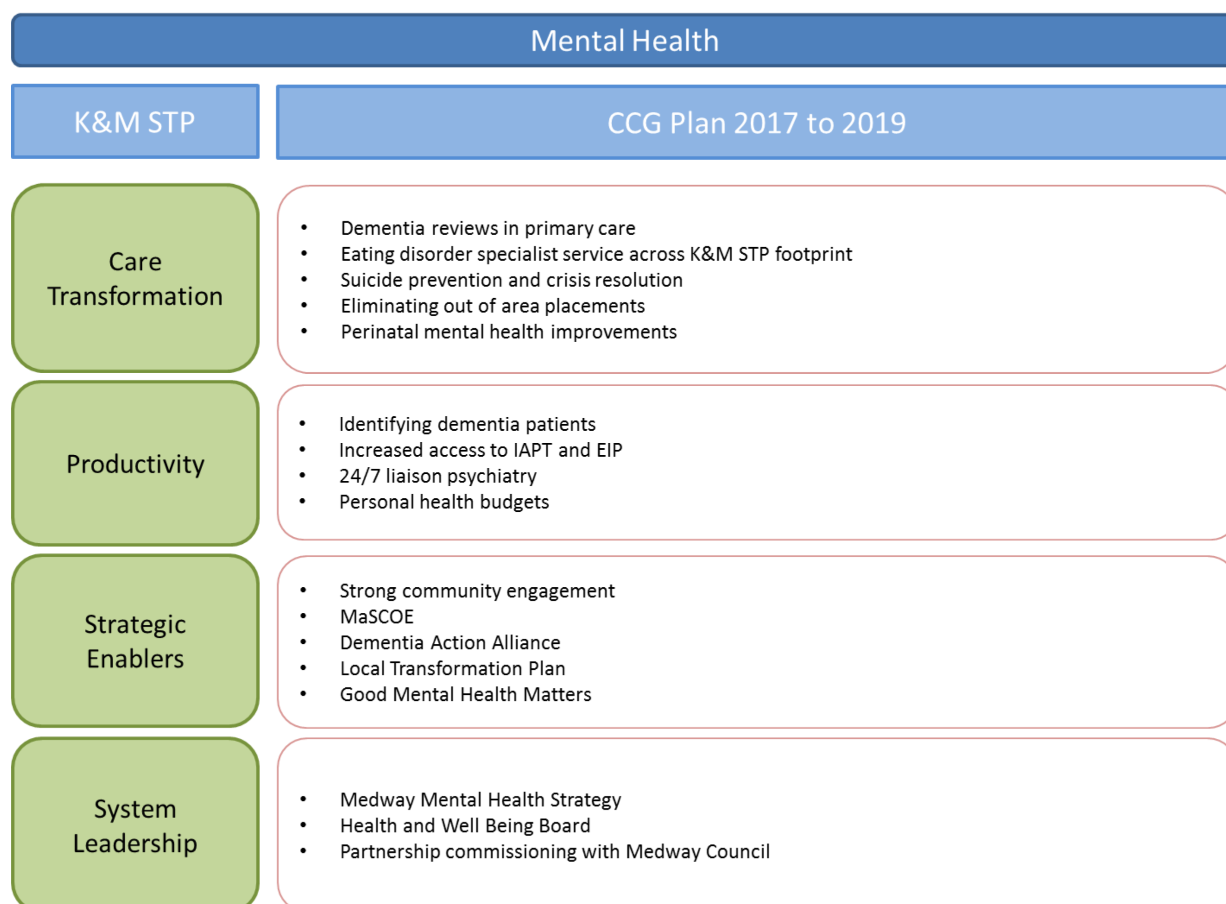


Figure 8: Mental health alignment with STP

7.1. Dementia

In 2015 it was estimated almost 3,000 people in Medway were living with dementia, a considerable increase in this figure is anticipated in future years. Responding to this challenge is a priority, and is highlighted in Medway's Health and Wellbeing Strategy for 2012-2017.

A range of preventative services exist, mainly funded by voluntary contributions, these need to become a core part of the care pathway. A gap analysis undertaken by the CCG and Council has highlighted a number of issues for us to address.

The CCG and the Council work closely to improve the lives of those people with dementia and services are commissioned through the Partnership Commissioning Team, jointly funded and run by the CCG and Council.

The CCG is working to increase the number of over 65 years olds diagnosed with dementia to at least 67% of the estimated prevalence. The CCG has established a working group to improve the Dementia diagnosis. Between January and September 2016 the diagnosis rate increased from 60.3% to 64.2%, resulting in an additional 135 people receiving a diagnosis. The calculation for the prevalence rate for dementia diagnosis will change with effect from 1st April 2017, this will have a negative impact on Medway CCG and result in a reduction of 6% in the diagnosis rate.

In addition to increasing the rate of diagnosis, the CCG will be working with primary care teams to ensure that every patient with a diagnosis of dementia has a documented face to face review every 12 months.

Five-year plan

A number of strategic shifts are required in order to ensure the provision of an effective local service to address rising levels of need and complexity. These include:

- Move commissioning to engaging fully with the market to stimulate a competitive supply, and to finding new ways of contracting for flexible support.
- Transferring resource from assessment to pre and post-diagnostic support.
- Exploring opportunities to transfer pre and post-diagnostic support in secondary care into the community.
- Moving from late assessment to early screening.
- Greater emphasis on supporting people to come to terms with diagnosis and plan for the future.
- Moving from institutional care to extra care housing, with the option for couples to stay together independently and with privacy.
- Re-focussing care and support to be more person-centred, designed around the needs, preferences, strengths, skills and contributions of people with dementia, their families and wider support networks.

Two year plan

- Conducting regular audits using the audit plus tool to identify patients with suspected/possible dementia, patients receiving dementia drugs but no diagnosis of dementia and patients referred to the memory service but with no diagnosis of dementia.
- We will continue to increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral. We have set trajectories in place to ensure improvement is in line with national guidance of 5% each year. We are awaiting further guidance from NHSE as to how the 6 week target will be measured. We are reviewing the pathway for diagnosis to ensure more patients are diagnosed within 6 weeks of referral.
- Ensuring that robust systems are in place to ensure that every patient with a diagnosis of dementia has a yearly face to face review in primary care.
- Focus on personalisation, in particular in relation to rolling out Personal Health Budgets and transforming Dementia Day Services, for instance through key links with Adult Social Care Strategy and Care Act implementation.
- Regular Dementia Friends training sessions to help to raise awareness and tackle misunderstandings.
- Medway Dementia Action Alliance to become self-sustaining by 2017.
- The Joint Dementia Commissioning Plan sets out specific steps to achieve commitment across the system for the design and funding of future care pathways.
- Contacts with key BME community groups will continue to be utilised to develop a more personal approach. This will include further research for groups not yet directly engaged with, for instance LGBT.
- The Integrated Care Home Team which supports nursing homes has been reviewed and a pilot in residential homes will commence.
- An improved partnership with secondary mental health services is in place thanks to liaison with GP-led Local Care Teams. This is part of ongoing work to help GPs identify dementia diagnosis as a priority.

- A strategic review of support services for unpaid carers (including carers of those with dementia) will be completed when re-commissioning will take place. This includes ongoing links with the local branch of the Alzheimer's Society.
- An application by the Dementia Action Alliance (working in partnership with Medway Council and Medway CCG) will be made in December 2016 for Medway to be recognised as a Dementia Friendly Community by the Alzheimer's Society. The impact of and actions achieved by the local Dementia Action Alliance is outlined below.
- A technology pilot has been undertaken, led by a partnership between Medway Telecare Services and Medway Community Libraries, to use GPS technology to enable those with dementia to safely get out and about.
- The pathways involved in dementia care are being mapped and redesigned to develop an integrated care pathway and coherent system of dementia support.
- Dementia advice line for GPs
- Development of a shared care protocol between primary and secondary care for the memory service
- Development of a new referral form for older adult mental health services
- Reviewing the pathway for CT and MRI scans which is currently resulting in long waits for diagnosis
- Improve referral pathways for people receiving a diagnosis of dementia at the acute hospital.
- Identify opportunities for efficiencies/reinvestment through a detailed cost analysis and review of the potential of the Better Care Fund.
- Post diagnostic support test for change approach to be implemented initially in Rainham Healthy Living Centre, working closely with: clinicians, patients, and the voluntary sector. For example, working to develop a drop-in service at the local dementia café.

Dementia Action Alliance

Jointly funded for two years from January 2015 by the local authority and the CCG, the Dementia Action Alliance in Medway has made fantastic progress within 2 years, recruiting a wide range of organisations to become active members and developing a proactive programme of activity to raise awareness of dementia as 'everyone's business'.

Co-chaired by a person who is living with dementia, the Alliance aims to bring organisations together to help reduce isolation and loneliness for people affected by dementia. Health and social care commissioners play an active role within the Dementia Action Alliance, recognising the key contribution of communities and businesses in enabling people with dementia to live actively and well for as long as possible; and supporting people to continue to live meaningful, valued lives in the community. Another key focus is enabling families and carers to maintain and promote their own health and wellbeing, while continuing in their caring role.

7.2. Increase Access to Psychological Therapies (IAPT)

A national programme for improving access to psychological therapies (IAPT) was launched in 2008. The aim of the IAPT service is to provide a universal primary care psychological therapy service for people registered with a GP and suffering with depression and anxiety disorders which is integrated within current physical and mental health services. IAPT aims to relieve distress and transform lives by offering NICE approved interventions such as counselling and cognitive behavioural therapy (CBT) for people suffering with depression and anxiety disorders.

It is estimated nationally that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder and at least 15% of those will enter Primary Care Psychological Therapy Services (PCPTS).

Across Medway the adult population of 18-64 year old is 198,816. Of these, 29,601 (15%) (Mental Health Needs Assessment, 2014), may have common mental health disorders and 4,441 (15%) may enter PCPTS.

The development of the IAPT Service has been undertaken considering the needs of the whole population including prevalence and incidence of common mental health disorders.

5 year vision

Over the next five years Medway CCG will embed the new IAPT service model. We will continue to work with GPs to improve referral into the service much earlier before patients reach crisis point enabling more patients to be seen at step 2. We will work with providers to increase marketing of the IAPT services to improve self-referrals into the service.

Medway CCG will build plans over the next five years to increase access rates into the service to meet the proposed 25% by 2020 and to increase our focus to offer support to those people suffering with long term conditions. We will align our IAPT services with physical settings and ensure IAPT is included in pathways for long term conditions. The ambition for the IAPT service in Medway is to have a high quality, inclusive, IAPT service with a single point of access that is available early on for people in Medway before they reach crisis point. This will support patients early and reduce the need for patients to access secondary mental health services.

Two Year Plan

Following GP and patient feedback the CCG has gone out to procurement for a new IAPT service. The new service will change from an AQP to a lead provider service and will be in place from 1st February 2017. The new service will be called "Medway Talking Therapies" and will have a single front door into the service. This will enable easier access into the service for both GPs and people who are self-referring.

The new service is a lead provider service led by insight who are partnering with Think Action, IESO and DGS Mind. The new service is an open consortium allowing other providers to join if agreed with the CCG. The online therapy offered by IEOS is a new addition to services for Medway.

The CCG used the re-procurement of the service as an opportunity to revise the service specification in line with feedback from GPs, patients and other health care professionals. The new service specification offers additional choice for patients by including additional requirements such as online psychological therapies and provision for patients who previously "fell through the gap" such as supporting people suffering with ADHD or Long Term Conditions

We are working closer with the new provider to increase the use of IAPT service for people suffering with long term conditions and locating services within physical care settings.

The new access targets for mental health include the target that "75% of people with common mental health conditions referred to the IAPT programme will be treated within six weeks of referral with and 95% treated within 18 weeks". Medway CCG is working with providers to ensure we continue to achieve these targets.

The CCG is aiming for:

- 75% of people with "common mental health conditions" referred to IAPT to be treated within 6 weeks and 95% within 18 weeks.
- A 50% recovery rate
- 17/18 - Increase access to IAPT services from 15% of prevalence (4440) to 16.8% of (4973) by quarter 4
- 18/19 increase access to IAPT services to 19% of prevalence (5624) by quarter 4

7.3. Early Intervention to Psychosis (EIP)

Medway CCG is performing well against the new waiting time standard that 50% of patients experiencing a first episode of psychosis commence treatment within two weeks of referral. The EIP service is one service across Kent and Medway and the performance is measured across Kent and Medway. The latest performance figures for August 2016 show that 68% of patients started treatment within two weeks.

The EIP service is currently not fully NICE-complaint.

Five-year plan

The aspiration is to achieve parity of esteem for people with mental health problems and put their care on an equal footing as those with physical health problems.

The EIP services will provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for carers and families. Our vision is to put in place effective and integrated services to address the social and wider needs of people with psychosis to help them live full, hopeful and productive lives.

Two-year plan

With the aim of meeting the standard, the CCG will:

- Link the EIP service into the new single point of access. This will ensure patients having a first episode of psychosis are identified at point of referral and immediately referred into the EIP service.
- As a result, the patient will be allocated a care coordinator and NICE-compliant treatment will begin within two weeks.
- Meet the new access and waiting time standards for EIP from 1st April 16 which are that at least 53% of patient who experiences a first episode of psychosis will start treatment on a NICE compliant care package within two weeks of referral.
- Ensure that the EIP service will see patients from age 14 upwards and patients at risk of mental health state "ARMS"
- Continue to work with the established Kent and Medway wide SDIP group to work towards achievement.
- Ensure that staff within EIP access training provided by Health Education England

- Work with the current provider to work towards fully NICE compliant care.

7.4. Eating Disorder

The new access and waiting time standards for eating disorders state that 95% of patients receive their first treatment within two weeks for an urgent referral and four weeks for a routine referral.

NICE makes recommendations for the identification, treatment and management of a range of eating disorders in primary, secondary and tertiary care for children and young people aged 8 and above. Assessments should be comprehensive and include physical, psychological and social needs and a comprehensive assessment of risk to self. Whole-family approaches are particularly important.

Five-year plan

Medway CCG is working with CCG partners across the STP footprint to procure a new specialist service from 1st September 2017 to provide a full range of NICE-concordant treatments, multidisciplinary treatment and care by qualified staff for service users aged 8 and above, with no upper age limit, to people who have a suspected or diagnosed eating disorder. The service will work in close collaboration with, for example, primary care, GPs, mental health services, general hospitals, specialist eating disorder inpatient services, schools, voluntary sector, and local community based services to ensure good communication across all services involved in the individual's care, to reduce dependence upon the health and social care systems by encouraging improvements in social networks and use of community systems, and to facilitate self-care, personal empowerment and responsibility.

Two-year plan

Funding has been ring-fenced and made available to all CCGs to take forward the Local Transformation Plan (LTP) commitments in respect of eating disorders.

- The Lead Commissioner (West Kent CCG) has set out an in-year Service Development Improvement Plan with incumbent providers (Sussex Partnership NHS Foundation Trust and Kent and Medway Partnership Trust) to work towards achievement of access and waiting times standards through a collaborative project
- Medway has worked with the Kent CCGs to design an all-age pathway for a service from 1st September 2017, this has included service user collaboration and market engagement.
- The new all-age service will be commissioned to deliver within the new access and waiting time targets for eating disorders.
- Procurement for the new eating disorder service has commenced with the new service to be in place from 1st September 2017.
- In-reach programmes into schools through Public Health and the LTP funded SAFE project are supporting children, young people, parents/carers and frontline staff in recognising and understanding eating disorders and how to access appropriate help. This has been supported by the Good Mental Health Matters #GMH campaign

7.5. All Age liaison Psychiatry "core 24/7"

Since 2014, a 24-hour liaison psychiatry service has been provided by Kent and Medway Partnership Trust at Medway Maritime Hospital (MFT). The service is open to anyone aged 18 or over and aims to see patients within two hours at ED to conduct a mental health assessment. It also provides and in

reach service to wards and training for staff in the acute hospital, to increase their knowledge of mental health.

An all-age service staffed by CAMHS nurses and provided by Kent and Sussex Partnership Trust at MFT was opened in December 2015. There is one nurse covering both MFT and DVH sites and the service is operational from 8am-10pm. The service is based on the paediatrics ward and works alongside current liaison services.

Five-year plan

The ambition is to provide a 24-hour "core" all-age liaison service with consultant support. This will be fully integrated within the acute hospital, providing access to patients on wards and allowing more proactive discharge where appropriate. The service will provide support and training to staff and help facilitate joint working. All patients will be screened and if necessary referred within two hours, with the aim of reducing mental health patients' waiting times in ED or on the wards.

Two-year plan

A North Kent working group has been established in relation to the all-age liaison service and working towards achieving a core 24/7 model at MFT. This group includes representation from the adult and children's mental health trusts, the acute trust and commissioners. There is a Service Development Improvement plan in place, the service specification has been signed off and agreed and a gap analysis has been conducted of the current service and the "core 24" service.

The CCG will:

- Use learning from the current model to help to put in place a substantive service for under 18's liaison service using funding from the CYP transformation monies.
- Continue to work on the SDIP
- Identify local need for "core 24" and the various components of "core 24" by conducting a needs analysis
- Apply for additional funding via the A&E boards.
- Consider the most appropriate contracting arrangement for a Core 24 service with all SDIP stakeholders.

7.6. Suicide Prevention

The CCG is an active member of the Kent and Medway suicide prevention steering group. We have developed a local multi-agency suicide prevention plan to help reach the 2020/21 ambition for a 10% reduction in suicide rates.

Some of the actions that have been taken forward include:

- A suicide prevention social marketing campaign called Release the Pressure which has been delivered across Kent consisting of radio and internet advertising, as well as posters in service station toilets, pubs and on buses encouraging men who are feeling under pressure to call a 24/7 helpline. As well as the paid-for advertising, the campaign received significant media attention across TV, radio and newspapers. Early results suggest that the number of calls to the helpline have increased by 20%.
- Our adult mental health trust provider has finalised their internal suicide prevention strategy which includes a new risk assessment framework
- Over the next 2 years we will continue to work closely with Public Health and GPs so we can help more GPs recognise and manage those patients in high risk groups.

7.7. Eliminate out of area placements for non-specialist acute care

The government has set a national ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care by 2020 to 2021. An 'out of area placement' for acute mental health in-patient care happens when a person with assessed acute mental health needs, who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services. This is an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning.

People should be treated as close as possible to home and in a location which helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment.

Two Year Plan

The CCG is working closely with the mental health trust to reduce out of area usage for patients. The mental health trust has given a commitment to reduce out of area usage to zero by 31st December 2016.

We have already seen a significant reduction in the number of Medway patients placed out of area. There is a detailed plan in place which includes a dedicated consultant for complex cases, utilising a range of alternatives to admission and the current stock of beds being correctly managed

The provider is on track and expected to continue to solve the issues and eliminate any future usage of out of area beds although Psychiatric Intensive Care Unit may prove to be a challenge.

Progress against the plan will be to continue to be carefully monitored and we will continue to collect detailed data on the out of area placements including bed type, provider, reason, duration and cost. The CCG will continue with weekly bed calls with the provider and social care to reduce DTOCs and out of area placements

The CCG is working with the mental health provider and social care to establish a closer working relationship and encourage placements and alternative providers.

7.8. Commission effective 24/7 Crisis Resolution Home Treatment Teams as an alternative to acute admissions

The CCG have a 24/7 Crisis and Resolution Treatment Team (CRHT) in place at Medway. In 2016/17 the CCG undertook an evaluation of the core function and focus of CRHT against best practice and national standards. This also included a review of caseload management and quality of crisis plans and home treatment interventions. We also have in place a local CQUIN for CRHT which includes gaining feedback from patients and GPs on the service.

A Service Development Improvement Plan (SDIP) will be agreed for 2017/18 which will consider an increase in capacity in order to meet effective provision of home treatment as an alternative to admission.

This capacity will be enabled by freeing up the team from activities that sit outside the CRHT model such as coordination of section 136 suites and undertaking A&E liaison function out of hours. We will work with the provider to ensure workforce competencies and collaboration with other agencies and carers in order to deliver more episodes of effective home treatment.

Using the current definition for a home treatment episode, a baseline informed on 2016/17 activity will be agreed together with a percentage increase from September 2017 in the number of people home treated and the number of people being discharged from an acute inpatient unit in order to continue their acute care at home.

7.9. Personal Health Budgets

National NHS Planning Guidance sets out the aim of enabling 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000), by 2020. Further to this, the NHS 'Five Year Forward View' states that CCGs must '*lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where the evidence suggests they could benefit'.*

Enabling more patients to benefit from Personal Health Budgets is a major change process for Medway Clinical Commissioning Group, so we will be undertaking a phased approach to this locally. The programme will be implemented as follows:

Year 1 – 2016-2017:

- A full needs analysis will be conducted to identify who could most benefit from personal health budgets between now and 2019/2020, a process which will involve people with lived experience of health services, their families, as well as other people such as NHS staff, social services, and other local organisations.
- More concrete plans will be developed to enable people with learning disabilities and mental health needs and / or autism to access Personal Health Budgets, as part of the wider Transforming Care programme of transformation of the way in which we support people in this group (working closely with Medway Council social services and other partners).
- As explained above, children and young people with additional needs (who have Education, Health and Care Plans) will also be supported to access a Personal Health Budget as part of their EHC Plan, if they, their families, and healthcare professionals feel that they would benefit from this.
- Personal Health Budgets will also be rolled out to patients requiring neuro-rehabilitation services.

Year 2 – 2017/2018:

- Exploration of the possible use of personal health budgets for the purchase of wheelchairs.
- Also explore opportunities to roll out personal health budgets, alongside more person-centred approaches, for people with dementia, mental health needs, neuro-rehabilitation, and continence services (for children and adults).

Year 3 – 2018/19:

- Consideration of the role of personal health budgets in end of life care;
- Further development of personalised approaches for any other groups which may have emerged as priorities from the earlier needs analysis and lessons learned as the programme as developed.

7.10. Severe Mental Illness

The CCG will work closely with the local authority to support people with SMI into paid employment.

We will use the findings from the national audit in quarter 3 of 16/17 to establish a baseline for this service. We will bid for transformation funding through the STP footprint in autumn 2017. The CCG will increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline.

CCGs should commission NICE recommended screening and physical health interventions to cover 30% of the population on the GP register with SMI in 2017/18 and 60% in 2018/19. An audit will be conducted during 2017/18 to establish the baseline.

To achieve the vision described in the “NHS five year forward view”, we will need to adopt more integrated approaches to physical and mental health. We have therefore joined the King’s Fund Learning Network for Integrating Physical and Mental Health Care in 2017. This will bring together senior clinicians and managers across the south east to help them work collectively to overcome common challenges to, and learn from best practice on, integrated approaches to physical and mental health in order to explore innovative models of care from the UK and abroad.

Topics will include:

- Leading new models of care
- Strengthening clinical and service-user leadership
- Team effectiveness in the context of multidisciplinary working
- Supporting the workforce to deliver integrated care.

7.11. Local transformation plan

Background and Context

Our vision is for all children and young people in Medway to enjoy good emotional and mental health and to be supported to develop skills and resilience to help cope with life’s inevitable adversities.

The Medway Local Transformation Plan (LTP) sets out our shared commitment and priorities towards achieving a brighter future for children and young people’s emotional and mental health and wellbeing, regardless of their circumstances. The LTP was developed in response to the report of the Government’s Children and Young People’s Mental Health Taskforce, Future in Mind and in accordance with national Guidance published to CCGs in 2015. Additional recurrent funding has been made available to Medway CCG and partners to take forward the plans and actions within the LTP.

What we have we done this year

We have consulted widely on a Draft Service Model for a new Medway Young Persons’ Wellbeing Service. The case for change was broadly endorsed through the consultation and commissioners are confident that the Final Service Model contains the necessary elements and inter-relationships to bring about service transformation .

Other investment during this interim phase has included:

- The SAFE schools in-reach pilot, extended for the 16/17 academic year, working with 12 Medway secondary schools including input from Medway Council’s Health for Learning team, with courses offered to staff around emotional first aid.

- Development of pastoral support in schools through the Health Education England Innovation Fund and in partnership with the Charlie Waller Memorial Trust.
- The Good Mental Health Matters (#GMH) campaign promoted throughout Medway in the summer of 2016 (focussed at transition age groups at KS3 and KS4).

What will we do in the next two years?

A new 0-25 Medway Young Person's Wellbeing Service contract will be awarded and mobilised. The new service will be provided within the context of the whole continuum of support, requiring potential providers to set out how they will develop strong links throughout the continuum.

Early intervention services will be delivered through joint working and in-reach, thus improving access to support, mutual understanding and communication between specialist mental health practitioners, schools, GPs and Children's Social Care.

Primary mental health workers will be more accessible and better integrated with schools and community based services, to create a more seamless escalation from early intervention services, where necessary.

The inclusion of additional services in the delivery model, specifically: substance misuse support, post abuse support, support dedicated to sexual trauma and recovery, child sexual exploitation, harmful sexualised behaviours and participation in multi disciplinary neurodevelopmental assessment and parental support. This will enable a holistic approach where children and young people have multiple needs and it will reduce duplication

The Good Mental Health Matters # GMH campaign

The Good Mental Health Matters #GMH campaign, funded by Medway and Kent CCGs is designed to promote positive mental health and wellbeing messages to secondary school aged children and young people and their parents/carers, through a multi-channel approach.

A 'Good Mental Health Guide' was delivered to every house Medway and Kent, outlining 7 key steps to Good Mental Health and Wellbeing and information around child behaviour and psychological development and strategies to maintain good mental health. The booklet and website also signpost other resources if parents feel they need further support.

An interactive roadshow visited shopping centres and public spaces across Medway and Kent during the summer holidays as well as 12 schools in the autumn term.

While the majority of participants were children and young people, there were a good number of parents, grandparents and other adults who asked to take part. One parent visited the stand with her 12 year old son; she had received the guide through the post and was waiting to pick her moment to discuss it with him as she had begun to notice some mood changes. She welcomed the opportunity for him to experience the 360 film and an introduction to the topic she wanted to discuss.

Heart FM sponsored the campaign which also included radio adverts and live presenter coverage.

7.12. Children and Young People – Improving Access to Psychological Treatment

The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a service transformation programme delivered by NHS England that aims to improve existing CAMHS working in the community.

The programme works to transform existing services provided by the NHS and partners from Local Authority and Third Sector that together form local area CAMHS Partnerships. The programme aims to create, across staff and services, a culture of full collaboration between child, young person and/or their parent or carer.

What we have done so far

Medway and Kent have joined together to form a local CYP IAPT Partnership as part of the London and Southeast Learning Collaborative. The Partnership currently includes each of the eight Kent and Medway CCGs, Sussex Partnership NHS Foundation Trust (SPFT) as the core incumbent CAMHS provider and Addaction, a third sector provider in Kent. Ten SPFT candidates and two Addaction candidates have been accepted onto training courses in 2016/17. The lead provider and sub-contractors for the Medway and Kent contracts will be required to participate fully, including training and workforce development programmes.

What will we do in the next two years?

- Expand and develop the Kent and Medway CYP IAPT partnership and begin to monitor the impact of training on service delivery and outcomes.
- Embed CYP IAPT within core contract performance and monitoring.
- Work across the Kent and Medway STP footprint to ensure children and young people's mental health services are fully considered within wider workforce development plans .

7.13. Perinatal mental health

The Kent and Medway STP area has been successful in a bid for additional perinatal mental health funding as part of the Perinatal Mental Health Community Services Development Fund. This will enable expansion of the existing MIMHS service in Kent and Medway to meet required national standards in relation to staffing levels, skill mix and equitable access to the service.

Expansion of the team will enable an additional 598 women each year across Kent and Medway to access specialist perinatal mental health services close to home and will provide all service users with more integrated, comprehensive and seamless care in accordance with NICE guidance CG192 and RcPsych CR107 standards.

Kent and Medway CCGs have been successful in a bid for additional funding of £300k for 16/17, £1.1 million for 17/18 and £1.1 million for 18/19 to facilitate the increase in activity. We are working with KMPT to work up the service to increase activity for perinatal services. The successful bid to enhance the current community perinatal mental health services in Kent and Medway will enable the teams to provide training and shadowing opportunities to support workforce development of other new teams across the region. The bid includes a training budget which, alongside continued joint work with health education on addressing local training needs will ensure appropriate staff are recruited and trained for more specialist roles.

A strong foundation of previous successful local innovation and partnership working means the teams will be able to build upon the regular provision of training, supervision and consultancy to midwives, health visitors, social workers, acute hospitals and GPs. The enhancement of the teams will also

enable them to offer training to other professionals to improve early detection and intervention across the perinatal mental health pathway.

8. Learning Disabilities: Transforming Care

Context

Following the investigation into the abuse at Winterbourne View and other similar hospitals, there has been a cross-government commitment to transform care and support for people with a learning disability and/or autism who display behaviour that challenges, including behaviour that can lead to contact with the criminal justice system. This is focused on building up community based capacity and reducing inappropriate hospital admissions, and reducing the length of time spent in hospital when admissions were unavoidable.

We aim to support adults with Learning Disabilities, autism and mental health issues to live independently in their own homes.

The publication of 'Building the Right Support' and the national service model for Transforming Care has led to 48 Transforming Care Partnerships (TCPs) being created to re-shape local services and implement the national service model by 2019. TCPs are based on nationally defined Units of Planning (UoP) with a minimum population threshold of approximately 1 million people. Locally, Kent and Medway have been grouped together to form the Kent and Medway TCP.

Both Medway and Kent wish to maximise the opportunity provided by Transforming Care of improving community services for people with a learning disability and/or autism, behaviour that challenges and those with a mental health condition. Kent County Council and the 7 Kent CCGs have been developing integrated commissioning arrangements for learning disability for some time, and services there have been working together in partnership with an approach that aligns closely with the key principles of the national service model.

Both Local Authority areas are committed to working in Partnership to implement shared Transforming Care ambitions when it is prudent to do so, such as when there is a clear benefit to service users and their families and carers or when there is a clear cost benefit to working together.

What have we done so far?

The Kent and Medway Transforming Care Plan 2016-2019 was submitted to NHS England in May 2016. The plan is currently being refreshed and updated patient trajectories to 2018/19 have been submitted to outline how Kent and Medway will achieve the bed numbers described in the planning assumptions included in Building the Right Support. Inpatient numbers for Kent and Medway are projected to decrease from the current figure of 86 to:

- 81 by 1st April 2017 (57 Spec Comm, 24 CCG)
- 61 by 1st April 2018 (42 Spec Comm, 19 CCG)
- 57 by 1st April 2019 (39 Spec Comm, 18 CCG)

A Medway Integrated Commissioning Board for Learning Disability has been established to provide local governance to the development and implementation of Transforming Care Medway.

Further consultation on learning disability and autism services in Medway is planned to commence in January 2017.

Transformation Fund grants have been awarded to implement the Medway Transforming Care. Grants include a Complex Care Coordinator, additional Adult ASC Support, and two TCP capital grants for a CAMHS Safe Accommodation Scheme, and an Adult ASC Supported Accommodation Scheme.

Medway is an active member of the financial framework working group and is collaborating with key partners to develop a business case for consideration in January 2017.

The key aims of the Transforming Care Plan are:

- A whole system approach to healthcare
    - Care pathways that allow for effective joint working between services
    - Integrated and cohesive commissioning arrangements for all adult learning disability services that build into provider contracts the requirement to deliver the Transforming Care plans
    - Integrated governance arrangements for adult learning disability and disabled children's social services
    - Better quality data and information on those at highest risk to target resources where they will be most effective.
    - Greater involvement of our social care providers as partners in developing and improving standards in the social care market using the Quality in Care Framework

- Improved quality of life through person-centred planning at all stages
    - Defined processes for providers that to identify the required outcomes for individuals
    - Monitoring the outcomes achieved for individuals through robust performance management
    - Greater involvement of individuals and their families in developing person centred packages of support that can effectively meet their assessed needs
    - Regular communication and sharing of information between services and individual practitioners including annual health checks by GPs
    - We will reduce premature mortality by the improved access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.
    - Recommend new and innovative models of care based on individuals' person centred plans
    - New models of care for the assessment and treatment of people who are in crisis as an alternative to the use of specialist learning disability or ASC hospitals

- Improved community provision, reducing reliance on in-patient services.
    - All age care pathway for neuro developmental disorders and associated conditions that dovetails with existing service provision for people with autism
    - Productive partnerships across all sectors including housing and social care providers through participating in the Kent Challenging Behaviour Network.
    - Ensuring there are appropriate resources and capacity in community services for people to provide swift and effective interventions when and where they are needed.
    - Seamless and equitable provision of care to meet the needs of individuals at critical junctures in their life e.g. transition, leaving education.

What will we do in the next two years?

The primary focus is on the reduction of inpatient numbers. Kent and Medway have identified some of the key issues that are contributing to inpatient numbers and a series of meetings to discuss these issues with regional and national NHSE teams and local partners have commenced.

The Kent and Medway Transforming Care Plan will be refreshed regularly to include updated activity plans and service development work.

Further plans include:

- Robust engagement with community and voluntary organisations to further shape plans.
- Working to develop the offer of personal budgets, personal health budgets and integrated personal budgets beyond rights guaranteed in law.
- Liaison with the voluntary sector to consider what additional or different local services can be made available to ensure people with personal budgets have a range of services to choose from.
- Local advocacy services are being actively remodelled and re-procured, this includes investment in non-statutory services for people leaving a hospital setting.
- Medway CCG, supported by the Partnership Commissioning Team, is working to improve the access, uptake and completion of Annual Health Checks (AHCs) for people with a learning disability (LD), so that a minimum target of 75% of people on a GP register are receiving an AHC. In order to achieve this we are currently exploring options with GPs and Community LD teams to promote and improve uptake and completion of AHCs and Health Action Plans (HAP) including:
    - Ensure access to training for healthcare professionals, so that they are competent in undertaking and delivery of AHCs.
    - Development of a 'Charter of Good Practice' for clinicians to use as a guide when completing AHCs.
    - Development and implementation of Easy-Read templates for clinical system providers. In compliance with the Accessible Information Standard - AHC invites and HAPs will be communicated in a way that people with LD can understand.
    - Have a named clinical lead for LD within the CCG
    - Make use of the Audit + tool to run an analysis of take-up of LD health checks by practice and identify outliers which can then be managed as part of the clinical variation work in Local Care Teams.
    - Link up with Public Health who are responsible for commissioning NHS Health Checks i.e. the 40yrs + Health MOT to see how we might be able to work together to promote access to and take-up of the Annual LD Health Checks.
- Continuing to work with partner CCGs to take forward an all-age neurodevelopmental pathway. This will be embedded within commissioning plans for children and adults. Plans for improved pre and post-diagnostic for adults with autistic spectrum disorder are to be included within Medway's Transforming Care Plan as a match-funding bid.
- Detailed consultation and engagement in relation to community paediatric services, including potential remodelling and integration of Learning Disability services as part of a wider 0-19 integrated health provision.
- Medway CCG and partner organisations will participate in the upcoming Learning Disabilities Mortality Review Programme (LeDeR) , which is due to commence in the South East region by February 2017. We are currently working closely with the lead professional who is undertaking this piece of work via NHS England. Annual publication of findings from reviews of deaths will include the annual publication of avoidable death rates, and any actions taken to reduce deaths related to problems in healthcare.

9. Improving Quality

Where providers have been rated as inadequate and placed in special measures the Quality and Safety Team have been integral in driving the implementation of action plans to improve both performance and quality of the provider. This has included the use of contractual levers to address specific quality and safety concerns and working in collaboration with Care Quality Commission (CQC) and NHS Improvement (NHSI) to support implementation of action plans to redress safety issues and mitigate against any future risk to patients. Concerns are escalated via the Quality Surveillance Group (QSG) in addition to other key areas of risk or CCG focus. These principles will also be applied to Primary Care providers.

Quality and safety remain at the heart of the CCG, with patient safety, clinical effectiveness and patient experience linking across all work streams and integral to delivery of the Medway Model. Work has been undertaken to significantly strengthen the involvement of Quality and Safety in all aspects of the CCG during the year with the appointment of a CCG Chief Nurse, joint programme planning and implementation of a Quality Impact Assessment (QIA) process for all CCG programmes. QIAs are undertaken as part of the development and proposal stage of developing business plans and are to be reviewed as projects progress from initial planning through to post implementation. The QIA is designed to identify risk in line with priority quality and safety metrics.

The Quality and Safety team leads on the delivery of statutory, mandatory and national safeguarding functions and development in relation to emerging risk areas and wider changes for the CCG and works to provide assurance across the local health system. The CCG is compliant with all statutory requirements and has full safeguarding staffing in place, this position will be maintained and work to further strengthen assurance across the system will be undertaken this year.

The CCG works with commissioned providers to monitor and assure the quality and safety of services and outcomes, as well as having relationships with other CCGs in order to gain assurance on providers commissioned by other CCGs.

Five-year plan

The Quality and Safety Team have taken an increasingly visible and engaged role working with commissioning team and contracting teams and finance staff within the CCG. Links continue to be significantly strengthened with increased engagement in commissioning programmes, procurement planning and process, pathway redesign and development. Quality and Safety are members of the weekly joint CCG meeting examining all live and planned work streams, ensuring that quality and safety is woven throughout these and that other teams are sighted on and involved in quality and safety risks and concerns and programmes of improvement.

A number of multi-agency partnerships are in place and agreements and actions will continue to be pursued in the medium and longer term, which include:

- Partnership in the Medway Local Safeguarding Children Board, including consideration of the implications of the Wood report and work to implement development in relation to this during 2017. The CCG is a key partner on the main Board and also the Executive Group and takes a lead role in sub groups.
- Partnership in the Kent and Medway Safeguarding Adults Board and Medway Executive Group. This includes close working with Medway council safeguarding staff to ensure a joint approach to dealing with safeguarding concerns impacting health services for both children and vulnerable adults.

- The CCG are multi-agency partners in relation to Operation Willow, Child Sexual Exploitation project, which is planned to run until Q3 2018 and are participating in Multi Agency Sexual Exploitation group arrangements.
- The CCG safeguarding team are partners in the Medway Multi Agency Risk Assessment Conference and have recently undertaken work to secure full provider engagement and GP involvement in this process. Work will be taken forward to ensure that this remains embedded.
- The Quality and Safety team sits on the Medway Community Safety Partnership Statutory Executive Group. Work will continue to link together CCG programmes to work being undertaken by statutory partners such as the Kent Fire and Rescue Service and the Police led SMART project in Gillingham, as well as community projects such as Arches Local in Chatham.

The CCG is currently continuing to take forward both national and local CQUIN schemes with providers for 2016 - 2017. The national schemes for 2017-2019s will be implemented and the CCG will work closely with Swale CCG in relation to STP engagement for MFT.

One-year plan

Improved capacity

Work will be undertaken to develop a Medway CCG specific Quality and Safety Team, moving away from the current shared North Kent arrangements, during 2017. The Medway CCG team will deliver increased capacity to focus on quality locally as well as to take forward wider projects and to support improvement. As part of this work it is planned that a Memorandum of Understanding will support continued cross CCG cooperation, sharing of intelligence and reporting to avoid duplication and ensure depth of knowledge and triangulation of system concerns is maintained.

Clinical Quality Review Meetings are now joint Quality and Performance meetings; this allows a joint approach to dialogue with providers. Work is continuing to refine this approach which is delivering and increased depth of scrutiny and triangulation of impact of both quality and performance concerns on patients.

Data for assurance and improvement

The Quality and Safety team uses quality metrics with providers including key areas of focus such as: patient Safety, including workforce, HCAI, risk management and governance and safeguarding; patient experience including, learning, outcomes and patient and carer experience; clinical effectiveness including, governance, best practice, improvement and development and KPIs. Work is currently underway to further refine metrics to ensure that data from providers supports principles of measurement for improvement and effectively enables triangulation of concern. The data enables key quality and safety information to assist analysis and provide intelligence to direct quality visits, audits and key lines of enquiry. This approach is being extended to work with primary care and a detailed quality focused database is being tested ahead of delegated commissioning of primary care from April 2017.

Working with MFT to gain assurance and enable improvement

Since the 2013 Keogh Review, Medway Foundation Trust has remained in Special Measures and a number of quality and safety concerns have been identified. One approach being taken to support improvement work being undertaken under MaSCOE (Medway and Swale Centre of Excellence) initiative. MaSCOE is supporting the development and implementation of improvement projects with MFT and across the system including supporting a reduction in acute activity and out of hospital care as well as prevention strategies to support maximising people's health and wellbeing and enabling

them to stay well for longer. MaSCOE uses a partnership improvement approach and is being implemented by Medway and Swale CCGs, and MFT in collaboration with HAELO. MaSCOE is also involving system partners such as Medway Council, MCH, SECAmb and KMPT to ensure a joined up approach to projects.

The CCG are also ensuring that a robust approach to improvement is adopted with MFT and the Quality and Safety Team are integral to driving the implementation of action plans to improve both quality and performance at the trust. The CCG are continuing to use contractual levers to address specific quality and safety concerns with MFT where progress has not been robust for quality and safety.

The Quality and Safety Team will continue working closely across the CCG to support Remedial Action Plans in place with MFT, and seek assurance in relation to patient harm, including individual patient reviews to determine whether any harm has occurred building on the clinical review model implemented during this year.

The CCG will continue to work closely with partners including NHS E, NHS Improvement and the CQC via the Quality and Performance Oversight Committee to support improvement at the trust, redress safety issues and mitigate against any future risk to patients. The CCG have worked to streamline engagement with MFT and have a programme of constructive engagement via formal contractual routes and focused monitoring and development meetings which support close dialogue to ensure detailed understanding of risk and ensure improvement.

The CCG Quality and Safety Team will continue to work closely with NHS E Nursing and Quality Team on patient safety issues in relation to regionally focused work on workforce, mixed sex accommodation and handover delays, and in relation to local concerns such as SIs processes and safeguarding at MFT.

Concerns taken forward using contractual measures are escalated via the Quality Surveillance Group (QSG), as well as other key areas of risk and quality focus. Workforce concerns at MFT are a key example of a risk area escalated to QSG. Workforce at MFT remains the CCG’s highest rated quality and safety risk. The Quality and Safety Team are continuing to work to ensure that close engagement is in place with the trust to monitor work undertaken under the workforce action plan and in the developing strategy. Meetings with the Director of Workforce at MFT will continue as well as formal monitoring via workforce metrics and at the Quality and Performance meetings. The Quality and Safety Team are working closely with contract and performance staff at the CCG to ensure that information provides a clear picture of risk in relation to the impact of workforce on patient safety.

Work is continuing with MFT in relation to gaining assurance that Cost Improvement Plans are subject to robust Quality Impact Assessment. This work has supported the development of an improved process and is continuing to focus on risk management elements.

The Quality and Safety Team are continuing to work via a Maternity Patient Safety Improvement Forum (Kent and Medway Maternity Collaborative group), with commissioning staff and with MFT and other providers working across Kent and Medway to implement the Saving Babies Lives Care bundle as well as the Five year Forward view for Maternity Care. This work is also supporting learning lessons from cases to deliver improvement across Kent and Medway. This group will be progressing work to support the implementation of Better Births and are likely to act as a reference group for the Local Maternity System and to support implementation of actions. The group will start planning this work in January 2017 and will support development of plans during quarters one and two of 2017/18

and implementation of actions during the following quarters.**Serious Incidents and learning for complaints and feedback**

The Quality and Safety Team are leading an SI Collaborative work stream and have established the Kent & Medway SI Improvement Forum as a working group with a specific remit for improving reporting and learning from Serious Incidents / Never Events and near misses across Kent & Medway. The forum is supported by the Kent NHS E Area Team as part of the Kent & Medway Patient Safety Network work streams which precede the implementation of a Kent Medway Surrey and Sussex Patient Safety Collaborative. The group is evolving with representation from all CCGs and NHS providers in Kent and Medway as well as GP representation, independent providers and local authority. Regular attendance from national leads in patient safety ensure that up to date information is cascaded at local level with the aim of improving patients care experience.

The Quality and Safety Team continue to co-ordinate the North Kent Serious Incident Operational Group. The panel includes a range of clinical and quality lead representatives. A review of the Serious Incident Operational Group has been undertaken in 2016/17. In addition to reviewing individual incidents at the panel meetings from November 2016 thematic reviews will now be presented by providers and discussed as a collective theme to obtain assurances that focussed work streams are supporting learning throughout the trust. This development will be included to ensure we are: supporting robust provider reporting culture, continuing to improve the quality of investigations and identification of learning, identifying themes and sharing learning to support whole system improvement.

Work will continue with providers to target harm reduction specifically in relation to falls, pressure ulcers and HCAI and to ensure that organisations are learning. As part of the focus on learning the Quality and Safety Team will continue to undertake an annual complaints audit with providers, to ensure appropriate handling of complaints, identification of themes and trends and with a particular focus on evidence of taking forward of learning and outcomes from this. The Quality and Safety Team will continue to work with providers to ensure that patient experience is used to drive improvement, as well as supporting CCG engagement. A patient experience event will be held during the year with a focus on improvements resulting from patient feedback, this will include participation from patient groups.

Mortality and learning from deaths

The CCG will ensure that providers publish a report reviewing deaths, both expected and unexpected, and the learning outcomes and changes made to services as a result of findings. The CCG will do this by including the expectation in the quality metric which is part of the contract.

The Quality and Safety Team are continuing to support a focus on reducing mortality at MFT and monthly mortality calls are in place to examine rebased data. In addition GP clinical involvement with the Trust's monthly overarching Mortality meetings is in place. Mortality review work is identifying areas for clinical improvement and enabled learning to be implemented. GP clinical lead input into the Trust process is informing CCG Governance meetings and includes triangulation against intelligence from SIs as well as improvement programme evaluations such as the Medical Model evaluation which is underway.

The CCG Serious Incident Policy has been updated to ensure that it aligns to the recommendations of the Mazar report. All providers have been requested to undertake a gap analysis against the recommendations highlighted in the Mazar report into unexpected deaths. Action plans have been developed and ongoing monitoring continues to support improvements in the monitoring of

mortality and learning from these deaths. The CCG has also conducted a review against the commissioner recommendations and continues to progress against delivery of improvements.

Quality review visits

A programme of quality visits will continue to be implemented at MFT to facilitate and provide assurance of improvement and investigate areas of concern. These are planned to investigate emerging concerns as well as to test improvement. Within MFT these visits have included: reviews of clinical areas following triangulation of workforce and patient safety data and intelligence, regular ED visits (currently monthly), themed visits following concerns in relation to safeguarding and Serious Incidents, escalation bed areas and mixed sex accommodation. In addition quality visits have been undertaken looking at specific pathways and service areas such as stroke care and paediatric services.

The Quality and Safety Team have supported Medway Community Healthcare's (MCH) cycle of internal Gaining Insight reviews providing reviewers to work alongside MCH's staff. The Gaining Insight reviews use CQC methodology and feed into a programme of learning and improvement which the Quality and Safety Team monitor. The Quality and Safety Team will continue to participate in these reviews, the next phase of which will focus on areas identified as needing improvement.

The Quality and Safety Team have worked closely with West Kent CCG to undertake visits into the Kent Institute of Medicine and Surgery independent provider following concerns raised by CQC. Work with independent providers will continue to be strengthened this year.

The Quality and Safety Team's approach to planning quality visits will continue to be developed this year to broaden engagement by involving subject matter experts such as Medicines Optimisation staff and also strengthening involvement of CCG patient engagement leads and clinical leads. In line with NHS Operational Planning and Contracting Guidance 17 / 19 and NHS Improvement Single oversight Review Framework quality visits over the next year will be planned to review concerns and to support delivery of projects. The Quality and Safety Team will develop a streamlined single framework for review which aligns to the NHS Improvement Single Oversight Framework – (based on CQC model). The team will also ensure that visits are planned in partnership with CCG work programs to support a rounded visit and avoid duplication.

Workforce

The CCG are engaging in the STP workforce group and will ensure the Clinical Board of the STP provides a focus on staffing requirements and the impact on quality. To facilitate this, the CCG Chief Nurse has re-constituted the Kent and Medway Director of Nursing meeting which it is proposed will act as a steering group for nursing and quality representation within the STP.

The Quality and Safety Team monitors provider's workforce strategies and workforce planning to ensure staff staffing levels. The team work with providers to gain assurance that providers submit clear, accurate, timely and detailed workforce data, which includes vacancy rates per speciality and individual staff group, use of bank and agency staff and implementation plans for safer staffing guidance and that staffing levels are adequate to maintain safety an patient care.

The Quality and Safety Team are integral to work underway to plan for delegated co-commissioning and for quality assurance of these services. To mitigate against risk a robust set of quality metrics

have been developed to assist with early identification of patient safety concerns. The team are working collaboratively commissioning colleagues develop processes. CQC are planning to complete their comprehensive inspections of all practices by January 2017 and we are working closely with them to ensure action plans are implemented and risks are addressed.

In relation to primary care workforce the Quality and Safety Team will work in partnership with Heath Education Kent, Surrey & Sussex (HEKSS) through the appointed Primary Care Workforce Tutors (PCWT) to develop a coherent and cohesive approach to the education and training of practice staff (other than GPs). The team will also support the GP Workforce Tool which will capture the Primary Care workforce data to enable reporting of workforce numbers and skills to help identify risks. The team will support the development and membership of Community Education Provider Networks and Local Action Workforce Board, work with providers, educationalists, Medway Council, NHSE and HEKSS, to explore and develop of new workforce models and roles which will support the delivery of the STP. As well as supporting the development of new roles in primary care such as practice based pharmacists, physician associates, nurse prescribers, advanced nurse practitioners and assistant practitioners.

The PCWTs come together with colleagues from across Kent, Surrey and Sussex to share best practice and also to link with other roles and organisations to develop multi-professional education and training around long-term conditions and end of life care. They have pre-registration nurse student placements within the general practice, and worked in collaboration with the universities of Canterbury Christ Church and Greenwich to develop a rolling programme for nurses new to general practice. The PCWTs support the development of the GP workforce tool which allows GP Practices to capture the Primary Care workforce picture. This has enabled reporting of workforce numbers and skills to help identify risks.

The Quality and Safety Team will work with providers in order to move urgent and emergency care to a seven day service by 2020. The Quality and Safety Team will work collaboratively with CCG colleagues and provider organisations in order that mechanisms are in place that support a smooth transition to provide enhanced quality of care to patients that is not dependent on the day of the week that treatment is required.

10. Enablers

10.1. Patient Experience and Patient & Public Engagement Strategy (PEPPE)

The CCG has made a clear commitment to ensuring that patient experience and public perspectives are embedded into all its activities. The strategy provides a clear framework within which these activities can be conducted.

The strategy is accompanied by an implementation plan that reflects key commissioning intentions and strategic developments containing outcomes, targets and relevant timeframes so that the impact of PEPPE can be measured over time.

The strategy enables the CCG to meet its statutory duties and responsibilities in relation to patient and public engagement, ensuring that the commissioning, design, development, delivery and monitoring of healthcare in Medway meet the needs of its population.

By listening to its stakeholders and learning from people's experience of healthcare, the CCG will be able to demonstrate how it understands what really matters to people and acts upon this feedback to improve the services it commissions.

The strategy will:

- Support the implementation of the CCG's 2017/19 Operational Plan by engaging with communities around priorities and commissioning intentions
- Develop and maintain strategic alliances and partnerships working with Healthwatch and the third sector
- Establish a "community chest" to which small community organisations, who can support improved health and care outcomes, can bid
- Seek to gather, analyse and hold community feedback more systematically so that stakeholder views can be used to inform commissioning activities
- Support the ongoing development of Patient Participation Groups (PPGs) across Medway.

The CCG intends to develop and use a range of communication and engagement tools to engage with as many people as possible. A Head of Engagement has been recently appointed who will lead this work going forward.

This approach recognises that there is an important link between the equality, patient experience and patient engagement agendas. It will provide opportunities for different stakeholder groups and individuals to be involved in different ways and at different times. It will build on existing good practice and utilise good practice within the organisation and working with others.

Patient experience intelligence will be managed across and within commissioning teams alongside the work undertaken by the CCG's Quality and Safety Team.

10.2. Partnership Commissioning

The co-terminosity with Medway Council and its Unitary Authority status provide a real advantage in the commissioning of services for Medway CCG. The CCG will continue to develop and embed its partnership commissioning arrangement with Medway Council. Already most children's services, maternity services, intermediate care, dementia care, the Better Care Fund and CAMHS are commissioned by the partnership commissioning team which is funded jointly by Medway CCG and Medway Council and which is accountable to both organisations and pooled budget arrangements are in place.

10.3. Estates transformation

The first draft of the Medway CCG Estates Strategy was submitted to NHSE in December 2015. The strategy was developed with key stakeholders including the Strategic Partnering Board.

Key short term drivers included:

- The publication of the Five Year Forward View in October 2014.
- Development of a Sustainability and Transformation Plan for Medway in line with national planning requirements and timescales
- Medway Hospital Trust under continued special measures.
- Local Health Need – demography, deprivation and service inequality
- Integrated commissioning, the Better Care Fund.
- The CCG will be reviewing its refreshed strategy in line with the timetable for the submission of the 3 – 5 year Sustainability and Transformation Plan.

The Estates Strategy is an enabler to build resilience and growth into the local system. Key to the Primary Care and Estates Strategy is the creation of Community and Primary Care Hubs.

Estates provision will need to ensure that the scale and configuration of space for clinical work as well as the wider team and the supporting activities that are appropriate to accommodate and support the integrated community service hub model.

The scale of the challenges faced by the Medway CCG locality over the coming years demands a transformational approach to service development and provision and a clear vision for the estate required to support and facilitate that transformation. Current primary care estates facilities are generally poor. The current Healthy Living Centres are poorly utilised and have the potential to develop to become Hubs. The vision for future estate is that it:

- Is fit for purpose - functional, accessible, clinically and operationally safe, of high quality, appropriate and up to date and contributes to longer term sustainability by being flexible, affordable and well utilised

- Re-profiles and aligns the physical environment with future needs and responds to growing demand by delivering increased capacity where needed in a range of settings

- Supports and facilitates closer integration at local level, with improved access to a wider range of services and delivers the concept of 'integrated community services hubs' as a physical entity that will act as the focus of local services

- Makes the most of what already exists, redeveloping and reconfiguring facilities where possible but investing in new infrastructure where needed

This will be achieved by the development and use of Healthy Living Centres (HLC's) Rochester, Gillingham, Rainham and Lordswood and the development of two further Hubs.

There is a recognised need for an Integrated Primary Community Services Hubs in Central Chatham and Strood. A Primary Care Transformation (PCTF) PID has been previously successfully submitted for funding to prepare an option appraisal to identify appropriate infrastructure for an Integrated Primary Community Services Hubs for Chatham.

The CCG have successfully progressed to the due diligence stage of the Estates and Transformation Fund for a new Health Living Centre at Clover Street at Chatham. The remaining bids for Lordswood and Cuxton have not been approved. The CCG will be completing the next stage of due diligence by

the end of November prior to moving to Full Business Case. The CCG will review the implications for the other capital projects.

A capital grant of £200,000 has been confirmed to upgrade and reconfiguration of void space in the Rainham Healthy Living Centre has been approved. The space will be upgraded to bookable clinic space to support the Medway Model.

The CCG will work with partners to ensure the appropriate reinvestment of funds released from the sale of local estate.

10.4. Information and the Local Digital Roadmap (LDR)

Clinically led improvement, enabled by new technology, is transforming the delivery of health care and our management of population health. Strategic decisions about clinical transformation and the associated investment in information and digital technology help significant gains in quality, efficiency and population health. Information technology can also provide the route to a model of care that generates new value for patients, professionals and organisations.

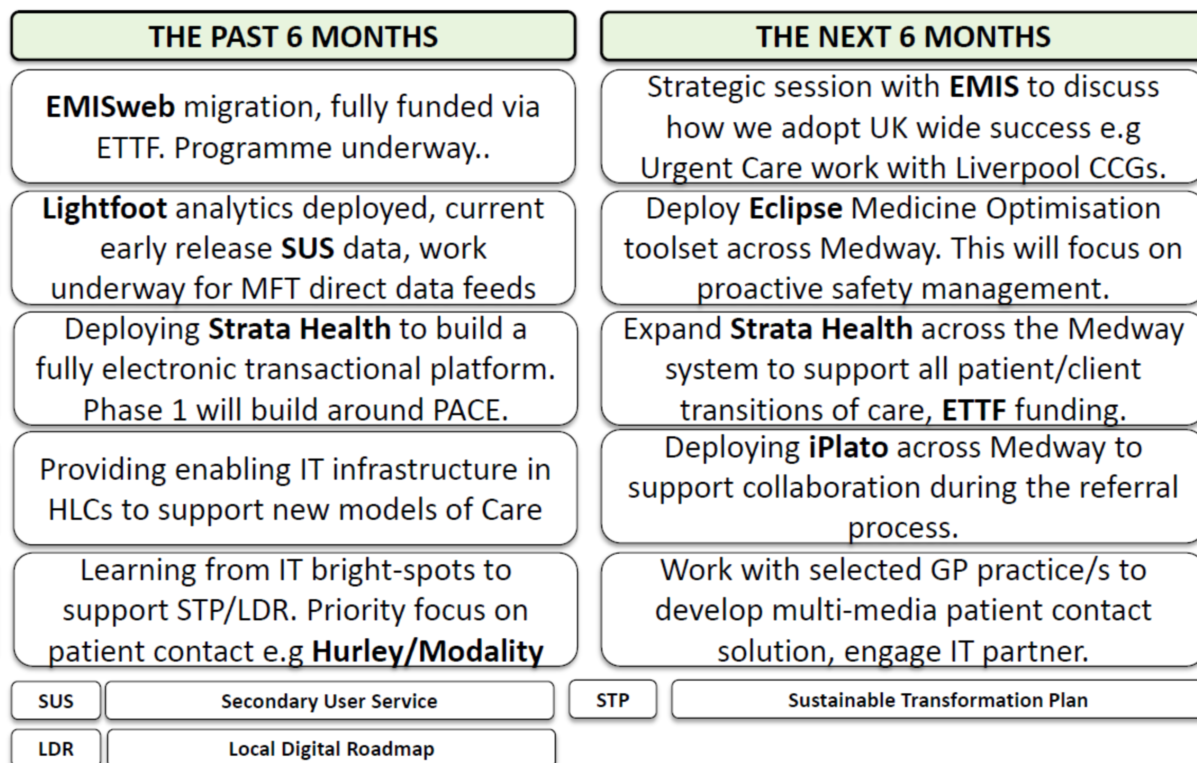


Figure 9 - Current delivery of the LDR

To support this vision the investment in technology across the CCG will deliver a modern, integrated, paperless NHS which revolutionises the way patients access care from home and empowers people to take control of their healthcare needs.

In June 2016, as part of the annual planning process, the CCG submitted our plan - the Local Digital Roadmap - for how their local health and care economies will achieve the ambition of being paper-free at the point of care by 2020. The CCG has engaged with health and care providers across Medway in completion of these plans.

As part of the planning process NHSE have defined a set of universal capabilities that the LDR must deliver:

- GP record sharing in following settings: (A+E/ Urgent Care and Walk-in Centres / 111/ Pharmacies/ Ambulance/ Out Of Hours GP services)

- GP access to clinical system outside principal practice location
- Patient access to clinical record.
- E-Correspondence between clinical/care settings e.g. referrals, admissions, discharges and transfers.
- Diagnostic requesting/results reporting.
- Child Protection information accessible in unscheduled care.
- End of life register & preferences available x-organisations.
- Learning disabilities information & communication preferences available x-organisations.
- Prevention / TECS.

Standardisation of GP systems across primary care

Evidence suggests nationally that CCG organisations operating on a standardised GP system across the primary care estate (Liverpool / Tower Hamlets / Cumbria) have more effective means to work collaboratively and in a more integrated way both federally and with other health and care providers in delivering efficient and cost effective care. With the introduction of a common set of systems there comes the opportunity to review ways of working across practices to ensure that maximum benefit is being achieved from the systems and that best practice is being shared and followed. Medway CCG is encouraging GP federated working as part of the strategic commissioning for:

- Out of hospital OPD clinics within a multi-disciplinary care setting.
- Primary care new service offers .
- Primary care - community care integration model.
- Supporting multi-referral sources and clinical pathways through a standard GP system solution.

This will support the following benefits:

- Ability to establish federated clinical and business system models.
- Technical integration between health and care clinical systems standardised
- Management and support costs for system integration reduced
- Establish common approach to pathway design and referral management processes
- Practices can develop shared administrative functions between EMIS Web practices (such as cross practice appointment booking, document managing, searches and reports).

IT Infrastructure Consolidation:

This will standardise and consolidate on IT infrastructure services supported through a single support and management technology partner. The scope of operational functions encompassed by this development includes:

- Voice & SPA call centres: Increase patient access whilst remaining in control of the system and the allocation of appointments; enabling and supporting patients when the practice is closed to book, cancel, check and change the times of their appointments.
- Active Directory: Permits user to connect their device to access applications at their host locations and also from remote sites.
- Communication and collaborations tools: Provide a common set of communication and collaboration tools across the CCG and GP practices based on the provision of NHS Mail2 core services.

Telehealth / Care

The CCG will continue to work with Medway Council to expand the telehealth offering. This will assist in the early detection of signs and symptoms in patients discharged from acute care and those residing in residential / nursing Homes. Patients identified that had a LTC or required episodic treatments, COPD, Heart Failure, Diabetes, UTIs and generally not feeling well where telecare, including apps, would provide an aid in the management of those conditions and enable patients to remain in the homes and prevent either GP visits and or unnecessary admission to hospital.

We will support the development of demand management for planned care services through the use of e-Referral and other technology including Tele-Dermatology. The use of telecommunication technologies will be explored across all pathways in order to implement the exchange of medical information using audio, visual and data communication which enables diagnosis, consultation and treatment as well as education.

Patient online

The CCG will work with practices and system providers to:

- Expand the use of electronic booking of appointments, access to medical records and repeat prescription services (to commence Q1 17/18)
- Introduce a range of non-face to face consultation methods as alternatives to a GP appointment. This may include phone, text, online consultations, email and even video (to commence Q1 17/18)
- Introduce a text messaging based service to remind patients of appointments (to commence Q1 17/18)
- The CCG will utilise central funding to implement on line consultation systems. Service Specifications are being published by NHSE in December. The CCG will plan to procure and rollout the system by March 2019.

Clinical interfacing systems

The CCG will introduce a jointly held care plan for its most vulnerable patients. These care plans will be developed jointly with the patients and their carers and they will be accessible to all partners locally on the agreement of the patient. This will ensure that patient's needs are understood during transfers of care, for example if the patient attends A&E.

This system will also draw on information from local providers including Medway Council to provide a comprehensive patient record that clinicians will be able to access with the patient's consent. This will improve the quality and responsiveness of care. A full data sharing agreement will be in place to support this.

The CCG will work with secondary care providers, mainly Medway FT, and GPs to ensure that Map of Medicine remains up to date with the latest agreed pathways of care and to ensure that all secondary care referrals from GPs are made electronically by March 2018.

Diagnostic requesting & reporting

Medway NHS Foundation Trust is working towards implementing an electronic order communications solution. This will mean that all clinicians in the hospital and our local GPs will be able to view historic

results and if necessary request a further test and then receive the result electronically. This will mean a change to the way in which our local GPs request and receive tests, starting with Pathology and Radiology. The benefits of this locally are:

- To securely request and receive results of diagnostic tests electronically.
- Improving patient safety and overall experience during healthcare episodes through increased information accuracy and faster access to diagnostic results.

Increased use of technology will reduce the Trust's reliance on paper and manual data entry processes.

Identifying patients at risk

The CCG will work with GPs to help them identify patients needing enhanced levels of care to keep them well for longer. This will building on the model from Yeovil which has shown that patients with three or more long term conditions are those who need the greatest support. This information will help GPs and Local Care Teams support their patients who have the highest needs.

Audit+ will be utilised to identify these patient and also patients who may have dementia but have yet to be formally diagnosed.

Data driven improvements

The CCG will work with providers of quality and business intelligence systems to drive improvements. Clinical variation will be reduced through proactive sharing of data with GPs within the Local Care Teams and utilising the data included within the RightCare data packs. Live activity data will be used to monitor and improve pathway changes.

The CCG will work with local providers to commission a percentage of outcomes in new contracts. This will be accompanied by a robust set of outcome measures that will be reviewed and monitored regularly,

Data Quality Improvement Plans will be used to improve data quality of providers.

10.5. MaSCOE

Medway and Swale Centre for Organisational Excellence (MaSCOE) is taking a whole system approach based on Improvement Science (IS) methodology. We will build local Quality Improvement (QI) capability to accelerate the delivery of the Medway element of the Kent and Medway Sustainable Transformation Plan (STP), supported by an innovative Local Digital Roadmap (LDR).

We will work with our partners across the Medway system to drive out unwarranted waste, harm and variation. We are committed to working with our communities to commission locally on a needs basis, with associated high value outcome delivered in an equitable manner. We will ensure that QI is embedded across our system and will utilise enabling technology and whole system intelligence/analytics to both support and accelerate breakthrough / sustainable innovation.

The initial Medway focus is on three priority areas:-

1. The whole system Frailty Pathway, building on new medical models.
2. The front door at MFT.
3. Outpatients.

There is a strong alignment of all three as in depth analytics have highlighted that delivering Quality Improvement (QI) across the Frailty Pathway will have a large impact on demand at A&E and subsequent flow in MFT. We will be utilising a range of QI tools, but will ensure that we create in an inclusive manner, build innovative driver diagrams that have aims/objectives fully aligned with the Medway operating plan. We will also utilise smart measurement tools in conjunction with PDSA cycles to invest appropriate resource where necessary, realign if required and stop in a timely manner when evidence exists to do so. This will be supported by leading edge analytical toolsets.

We are also building physical infrastructure (Improvement Rooms) in each of our Healthy Living Centres (HLCs) to support our multi-disciplinary teams to create innovative new approaches to deliver the majority of care in our local communities. This is being supported by the new clinical rooms in Rainham HLC to support the spread of our PACE (Proactive Clinic for Elderly) from the successful test of change in the Woodlands GP Health Centre. We envisage this spreading to all our HLCs by during 2017/18.

Initial outcomes from PACE are encouraging and align fully with the new Frailty medical model in MFT. We are also developing a structured education programme to develop GPs with Special Interest (GPwSIs) in Frailty. This will help to address the existing workforce challenge to support those living with Frailty across our communities.

We have partnered with Haelo to benefit from their whole system QI success across Salford. We will also learn from their experience around the delivery of a Proactive Measurement and Monitoring of Safety system within Salford and currently being extended within the new chain of Foundation Trusts and their Integrated Care Organisation (ICO). They are a clear innovator around the use of IT to support the above, currently rated the most digital mature organisation in NHS England. Some of the GP practice innovation has increased capacity to consult by over 20%.

10.6. Workforce

In line with our Constitution, member practices voted on whether or not the CCG should take on delegated responsibility for commissioning primary medical services (GP practices) from NHS England. Member practices voted ‘for’ delegated commissioning and as such the CCG will apply in December 2016 and subject to approval, will formally adopt delegated commissioning from 1 April 2017.

The CCG is satisfied that we will be able to deliver delegated commissioning without any significant workforce challenges. The CCG’s current organisational structure positively aligns with the delivery of delegated commissioning. However, a workforce plan will be devised in order to support implementation.

The CCG intends to use this flexibility to improve services locally and further develop our strong working relationships with practices to enable us all to support effective participation within the sustainability and transformation plan (STP).

Medway Clinical Commissioning Group recognises the importance of succession planning in order to identify and grow talent and to fill business-critical positions in the future. Therefore, in order to ensure business continuity and resilience, a formal succession plan is being devised. Additionally, a bespoke induction process will be implemented for Governing Body members in order to ensure that they are fully equipped to undertake their new role.

10.7. Equipment

Children's wheelchairs

The CCG will invest in children's wheelchair services in order to halve the number of children waiting 18 weeks by Q4 2017/18 and eliminate 18 week waits for wheelchairs by the end of 2018/19.

Medway Integrated Community Equipment Service (MICES)

The mission statement of the provider of 'Right Equipment, Right for you, Right Time' puts the service user at the heart of provision and ensures that their needs are at the forefront of all decisions made about the service. MICES supports the following areas to improve the safety, experience and effectiveness of the service:

- Timely discharge of patients from hospital with the right equipment helps to enable them to regain their independence. Through the Home First programme equipment will be delivered within 4 hours as an urgent delivery, ensuring that service users are not put at risk whilst waiting for equipment to be delivered post discharge.
- This supports the prevention agenda as the application of the right equipment enables individuals to maintain their independence and remain in their own homes for longer. Equipment is also provided to those requiring reablement and intermediate care and supports practitioners in giving service users the tools to be able to improve their health and independence and reduce dependence on long term traditional types of social care.
- Having the right equipment provided to them at the right time will increase the time individuals can remain independent delay the admission of individuals with health and social are needs to residential and nursing homes. Appropriate equipment allows individuals to live a full, independent life in their own homes supports the prevention agenda and increases quality of life for those with long term health and social care needs by giving them the maximum level of control over their own lives.