HEALTH AND ADULT SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE
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VARIATION IN PROVISION OF HEALTH SERVICE – IMPROVING OUTPATIENT SERVICE IN MEDWAY AND SWALE IN LINE WITH THE MEDWAY MODEL AND COMMUNITY SERVICE REDESIGN

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Summary

This report updates the Committee on improving the outpatient services across Medway and Swale. This is in line with the Medway Model and community service redesign which will enable care to be delivered closer to people's homes. The improvement programme will be bringing services together, this will enable health and care staff to work more closely together and develop services that focus on the needs of the patients.

This report from NHS Medway Clinical Commissioning Group (CCG) updates the Committee on the progress of the programme since the previous paper on the Community Service Redesign and the Medway model that was sent to the Committee in January 2019 and the papers related to Improving Outpatient Services sent to the Committee in March 2019 and June 2019.

At the March meeting, the Committee deemed that the proposal to reconfigure the delivery of outpatient services does represent a substantial development of, or variation to, the health service in Medway.

Following the update presented to the June meeting, the Committee requested that a further update report be provided on progress and to demonstrate how the programme supports whole system working across Medway.

1. Budget and Policy Framework

1.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

2. Background

2.1 The current outpatient model within the NHS across England has been described as "obsolete". In the past ten years, the number of outpatient appointments has doubled, meaning the CCGs need to address services to ensure that patient needs are being met locally. Further, the system needs to support the NHS Long Term Plan objective that over the next five years patient care changes will result in a reduction by one-third of face-to-face outpatient visits.

2.2 The Medway NHS Foundation Trust (MFT) serves a catchment of around 400,000 patients from across Medway and Swale. In 2017/2018, the Trust had 325,000 outpatient attendances, with a cost to local CCG's of £32m.

2.3 A multi-faceted approach – the Outpatient Improvement Programme – is being implemented to jointly develop a Medway and Swale integrated approach with strategic partners. This will enable change to bring patient and system benefits. It is acknowledged by the sponsors that this will be a long term programme of change, initially planned for 2 years, with an overarching design principle of clinicians, managers and patients working collaboratively to define and design end to end pathways. The approach has been designed from a patient-centric position with a modern, technologically enabled approach to the delivery of current outpatient care, and then to meet the emerging and changing health needs of the Medway and Swale, acknowledging population demographics and long term conditions. Communications and Engagement teams have been gaining patient and clinical feedback and views to support the development of the pathway improvements, and this will continue throughout the programme.

2.4 The programme is supported by identified clinicians from primary, secondary and community organisations, to maximise the opportunity to transform pathways to include best practice, reflect national guidance, digital and innovative approaches, seamlessly from primary care, through to secondary care then back to primary care as appropriate.

2.5 The programme supports the aim within the NHS Long Term Plan (January 2019) to reduce variation across the health system by incorporating local findings from the "Getting it Right First Time" (GIRFT), "Model Hospital" and "NHS Right Care" programmes. The Medway and Swale Outpatient Development programme is a pilot for Whole System Partnership (WSP) working, by modelling support for

demand and capacity planning based on care needs of local populations and then supporting development proposals. WSP have attended whole system workshops and respiratory task and finish groups, with initial modelling outcomes shared in early September. Further modelling for additional specialties is planned from October.

2.6 This report provides an update on the progress of the Outpatients Improvement Programme to date. The main activities undertaken to date have been:

- Phase 1 initial patient and provider **engagement workshops** undertaken for neurology, respiratory, cardiology, urology and clinical haematology outpatient services. Excellent engagement to date with very positive feedback from patients.
- **Task and Finish Groups** established for four of these specialties (respiratory, cardiology, urology & neurology), with consistent clinical representation from system partners. Clear actions agreed and implemented.
- Comprehensive and clinically led **end to end pathway reviews** completed for 3 specialties (respiratory, cardiology & urology), identifying opportunities to streamline pathways and embed best practice to improve patient care. Updated pathways shared with Primary Care via their clinical systems from 1st September.
- Phase 2 for the 4 specialties above is underway, developing initiatives identified in Phase 1. Scoping for further specialties to include in the programme commencing in Quarter 3.
- Advice and guidance support for Primary Care via **Consultant Connect** pilot commenced in August. Results to inform business case for full implementation from 2020.
- **Key Performance Indicators** for programme agreed.
- **Risk Register** for the programme in place and monitoring on-going.
- **Monthly Outpatients Steering Group** meetings being held with system partners to monitor progress and escalate issues resulting from task and finish groups and address issues that affect the delivery of the whole programme.
- **Communications and engagement plan** prepared and agreed. An external engagement company has been commissioned to support communication and engagement activities and this has started with patient engagement sessions and patient and staff survey development is underway.
- Medway Foundation Trust (MFT) has introduced their **STAR programme** which is an internal improvement programme that reflects and supports the objectives of the Outpatient Improvement Programme. Medway CCG is invited to be part of this programme, demonstrating improved system working.
- Improved engagement across providers to support work to date and in future of the programme.

3. Methodology

3.1 The programme plan started in Quarter 1 2019/20, to be implemented over a 2 year period (until March 2021.) This overarching plan is underpinned by specialty level project plans, each with key milestones identified for delivery.

3.2 From a review of examples of initiatives implemented in other areas a number of possible ways to reduce consultant face to face appointments and make more effective and efficient use of clinical resources, especially consultants has been identified and included in the overarching programme Project Initiation Document (PID). This has recently been updated to reflect programme delivery to date and will be shared at the October Programme Steering Group.

3.3 During the first phase of the programme six specialties were identified: rheumatology, neurology, respiratory, cardiology, urology and clinical haematology. The first phase is nearing completion with the establishment of clinically-led Task and Finish groups conducting end to end reviews of the referral criteria, existing pathways and patterns of activity. The reviews have identified gaps in current pathways so the reviews have introduced improvements along the whole pathway with input from both patients and clinicians from across the system. The aim was to identify ways to make the best use of clinical resources available to deliver the right care in the right place at the right time to meet patient needs and focus on more holistic care approaches. The updated pathways have been loaded onto the Primary Care clinical system, DXS, for GPs to refer to.

3.4 The task and finish groups had 3 months to complete clinical pathway reviews and commence implementation of any changes identified. Further task and finish groups will be established for a further 3 month period for each specialty to focus on areas for improvement and gaps in services identified from the initial groups and the pathway reviews. Phase 2 is planned to commence from Quarter 3.

3.5 Additional specialties to be added to the programme early in Quarter 3 and include Ear, Nose and Throat, gastroenterology, gynaecology, trauma and orthopaedics and paediatrics and scoping is underway to review focus areas but the same approach will be adopted with via task and finish groups and end to end clinical pathway reviews as a first step.

3.6 Embracing technology to support self-management and remote monitoring is being explored to support new models of care aiming to release clinical time to deliver care more appropriately to meet clinical needs, when monitoring indicates this to be required. This supports the aim within Chapter 5 of the NHS Long Term Plan, of digitally-enabled care becoming mainstream across the NHS.

3.7 Other technology options being actively considered include a virtual clinic approach which can provide clinicians and patients a flexible approach to managing outpatient consultation, reducing clinical time and improving patient experience with no travelling or waiting times incurred. Virtual consultations can be offered through telephone consultations, video-conferencing e.g. Skype. This work is linked to the digital innovations being considered for Primary Care to reduce face to face patient consultations and the Outpatients Programme is sighted on Local Care initiatives to avoid duplication and make best use of resources.

3.8 Engagement and communications plans developed will ensure all stakeholders remain informed and engaged at each stage of the programme, in particular engaging with frontline staff and clinicians who are leading the improvement programme and involving people who use services and those who deliver them in setting priorities and establishing criteria for improvement. There overarching programme communications and engagement plan will also ensure that the CCGs and Trust remain compliant with their legislative duties around involvement and engagement.

4. Programme Progress

4.1 Patient Engagement

5 patient engagement workshops have been held for respiratory, cardiology, neurology, urology and clinical haematology specialties. These all followed a similar format and were well attended by a range of patients, carers, and clinicians from a range of services and voluntary sector organisations. The scope of the discussion focused on sharing patients' experiences of current services and what is good about the current service, what are the current issues and what would a good outpatient service look like for them.

4.1.1 Patients, clinicians and staff from a range of providers and areas told us that many things are currently working well within current outpatient services:

- Highly professional and dedicated staff often working collaboratively.
- Support from voluntary groups and patient led support groups such as the prostate support group and Breatheasy.
- Self- management programmes and education. For respiratory patients in particular referrals to exercise such as gyms, swimming/exercise classes, singing groups/classes were highly valuable for patients.
- Patients being listened to and treated holistically.
- For some conditions having a 'rescue pack' at home for immediate action when the condition worsens.
- In some areas timely follow up and prompt appointments.

4.1.2 Participants identified a number of themes for areas for improvement that were repeated across the range of specialities:

- Waiting times for initial appointments, follow up and for tests and test results.
- Administrative capacity at the Trust – in some areas very confused appointment systems.
- Referrals – can be too confusing, take too long, are inappropriate and the patient is passed around and left without information.
- Lack of joined up working between GPs, community services and hospital services – including consultant feedback to GPs and communication to community and voluntary sector partners.

- Lack of support out of hours or when a crisis or sudden worsening of a condition occurs. Having a number to call or a support service may prevent frightening and worrying exacerbation and decline in a condition.
- Problems within primary care – waiting too long to see a GP.
- A lack of emphasis on patients taking control of their own conditions and on person centred individual care.
- Inequity across the services – for instance it was suggested that patients in Swale and some parts of Medway are disadvantaged, also that not all outpatient services are meeting the same standards of care.
- Better, consistent, equitable patient information**,** written and verbal: at point of diagnosis; follow-up; to promote self-care and to know what to do/where to go, if the condition changes/worsens**.**

4.1.3 These areas reflected the initial scoping of the programme and have been considered by the task and finish groups when reviewing pathways to aim to improve in these areas.

4.2 Task and Finish Groups

4.2.1 For 4 of the 6 specialties identified there have been clinically led task and finish groups established – respiratory, cardiology, neurology and urology. They have each met 3 times to date. Initially there were issues with identifying the appropriate clinicians and service managers to attend from acute and community services so the groups did not meet as soon as was originally intended. A clinical haematology task and finish group has not been established yet as the patient engagement workshops did not happen until the end of July, due to the more complex nature of these conditions a more tailored approach to the engagement was undertaken.

4.2.2 Clinical end to end pathway reviews have been the main focus of the task and finish groups established for 4 phase 1 specialties – cardiology, respiratory, urology and neurology. Several existing and new pathways have been reviewed, updated and uploaded to the GP clinical system DXS and communications with primary care have been planned and implemented to raise awareness of alternatives and changes made within the new pathways, such as community services, and updated referral forms and criteria. Close monitoring of the accessing of these pathways and subsequent impact on referral activity is underway.

4.2.3 GP education and socialization is a key next step to support the effectiveness of the new pathways and a specific outpatients-focused primary care training session is planned for the October Protected Learning Time (PLT) meeting. MFT and MCH clinicians will facilitate a workshop-type event to encourage interaction and discussion around the pathways to improve system-wide understanding and develop relationships. Information is also being shared via GP Bulletin and via Local Care Teams.

4.2.4 The scope of the task and finish groups is now to be reviewed to determine the next focus area and the appropriate membership of the group to address this. For each specialty there have been areas for improvement identified that include clinical triage processes, community service provision to support secondary care and technology options to reach some patient groups. Patient engagement at future task and finish groups is anticipated where services are being redesigned to best meet patient needs.

4.3 Governance and Monitoring

4.3.1 The whole programme oversight is provided by the Outpatient Transformation Steering Group that is chaired by the Associate Director for Secondary Care Commissioning and has senior and executive representation from all providers involved in the programme. These meetings are being held monthly and issues are escalated to the Transformation Board. The main issues to date have been engagement from clinicians and service managers and with appropriate escalation via the Steering Group this has been addressed and the situation has improved.

4.3.2 Project Initiation Documents (PID) have been prepared and signed off at the Strategic Improvement Board at Medway CCG for the overarching Programme and for each individual specialty. The PIDs have been supported with Combined Impact Assessments (CIA) that have also been agreed. Finance and activity forecasts have been included in the PIDs and agreed by the CCG finance team. Monitoring of implementation and achievement of the activity changes expected will commence from quarter 3, now that pathway changes have been implemented. The overarching PID for the programme has been updated and will be shared with the October Steering Group for sign-off.

5. Specific Programme Areas

5.1 Advice and Guidance

5.1.1 Outpatient services are often the first point of contact that most patients have with secondary care. However, getting things right at the referral stage of the pathway can have significant benefits in terms of patient safety, quality and cost further downstream and impact on the requirement for traditional outpatient services. This can take many forms and can be useful at many stages along any pathway.

5.1.2 Currently there are no formal advice and guidance arrangements between primary and secondary care providers. This is thought to be having a significant impact on the numbers of referrals being made into secondary care as a significant number of patients could be managed in primary care with appropriate specialist advice on treatment plans and/or diagnostic tests to undertake prior to referral.

5.1.3 One option identified to address this is a service provided by Consultant Connect which is an advice and guidance telephone solution to enable a direct call between a primary care clinician and specialty based consultant. The

solution has been implemented in >50 CCG areas. It works through a GP calling Consultant Connect, and choosing a specialty. The call loops through the specialty's rota of local and/or national consultants and the GP is put through to the first consultant to answer. The conversation is recorded and call data is tracked. The outcome of the call is rated by both the consultant and GP as to whether the referral avoided a referral or admission.

5.1.4 The service reduces unnecessary referrals and requires no additional clinical sessions and provides GP's with an opportunity for case-based learning. North Essex CCG estimate that 8-10 admissions per week have been avoided and from the calls received to the service 74% resulted in referrals being avoided.

5.1.5 From 19th August 2019 a pilot of Consultant Connect commenced, initially with Urology consultants at MFT. This has been expanded to include paediatric consultants from MFT and the national network of consultants for 8 other specialties is available to answer calls from mid-September. The intention is to expand the local consultants on the system to support local pathways. There are extensive communications underway with primary care to support the system, including live demonstrations at Protected Learning Times, GP Bulletin updates and practice visits.

5.1.6 Consultant Connect will be closely monitoring the uptake and usage of the system at practice level so that practices not accessing the system can be identified and training offered. The monitoring process also allows GPs to leave feedback on their experience of using the system, which will be valuable information to understand how the system is being utilised and any improvements needed.

5.1.7 After the initial 4 month trial a full evaluation of the impact on referral activity and GP and consultant experience will be undertaken to determine next steps, including adding additional specialties and expanding to include Swale GPs as well, and inform the business case to move to a full service in 2020.

5.2 Triage

5.2.1 Following on from the Task and Finish Group meetings held to date it has been discussed for several specialties that the establishment of a Triage and/or Clinical Assessment Service (CAS) would be of benefit to ensure that patients are being referred to the most appropriate service to meet their needs, whether in an acute or community setting.

5.2.2 For example, from a clinical audit conducted in Neurology of 100 GP referrals it was identified that up to 70% of patients awaiting neurology consultant appointments could be directed to another more clinically appropriate service, such as neuro-physiotherapy in the community, if a triage service was in place.

5.2.3 The intention is to conduct similar referral audits within respiratory, cardiology and urology to determine the scale of potential redirection of referrals and develop a model and business case to establish a triage services for range of specialties, that could be delivered in a range of ways. The overarching aims of this are to:

- Reduce Referral to Treatment Times (RTT).
- Reduce waiting lists.
- Ensure that only the appropriate patients are seen by a specialist consultant.
- Make effective use of other specialists such as Clinical Nurse Specialists and specialist Community Services, including GPs with Extended Responsibility (GPwER).
- Improve patient experience – patients will be seen in a more timely manner and by the correct clinician

5.3 STAR Programme

5.3.1 Further to the opportunities identified by the task and finish group work to date a work-stream has developed, led by Medway Foundation Trust (MFT), called the STAR (Service Transformation & Access Review) programme and this is a project that supports the aims and objectives of the overarching Outpatient Transformation Programme.

5.3.2 The STAR programme focuses on key internal processes within MFT that impact on how outpatient services are managed and delivered. The vision statements for the project are:

- Patients who need to be seen by a specialist in hospital will be seen as quickly as possible.
- It will be an expectation that patients will have a brilliant customer experience when they interact with the hospital.
- To help our staff, we will root out and eliminate waste and duplication from our internal processes.
- We will modernise our services using new technologies and embrace the opportunities in virtual clinics and telehealth
- Through smarter clinical pathways, we will make effective use of generalist and specialist staff at the right times.

5.3.3 The main areas identified which offer opportunities for improvement as part of this project are:

- Booking utilisation
- Did Not Attends (DNA)
- New to follow-up ratios
- Administration and diagnostic processes

5.3.4 There is a Clinical Council Listening Session planned as well to capture views on current outpatient delivery and views of what outpatient care could look like in the future. Feedback will be used to inform further programme developments.

5.3.5 The expectation of improvements in these focus areas will be of benefit to patients, staff and improve Trust systems, impacting on performance of RTT.

5.3.6 This programme is also about implementing and managing change within the organisation and for the system. It requires a change in mind set with consultants and service managers across all specialties to reduce activity within secondary care, as this has not been the approach adopted in the past. In order for lasting change to be achieved behaviour needs to alter, for example not pulling patients back in for follow-ups that are not needed and directing patients back to primary care and community services for ongoing condition management.

6. Specialty Focus Areas

Below are the specific details of the next focus areas for each specialty area:

6.1 Urology

6.1.1 The PSA pathway for Prostate Cancer diagnosis and monitoring was discussed at the Cancer Alliance meeting on 22nd August and will be raised at the next Tumor Site Specific Group meeting for Urology in October. The suggestion is to adopt the Essex pathway under a local agreement which requests GPs to follow criteria of undertaking two tests prior to referral as well as other lifestyle factors that could influence a false positive result. This, if adopted in Kent and Medway, will impact positively on patient experience as many patients will not need the invasive biopsy and CT that currently follows from a referral on 2 week wait following 1 positive PSA result. This could also generate system savings by reducing the demand for these tests and free up capacity of the current workforce to only be seeing those patients identified as requiring the intervention.

6.1.2 The impact of the above changes will be that Primary Care will have guidelines to follow which they do not currently have at the moment; prevent inappropriate referrals into MFT; reduce overall referrals, and in conjunction with Consultant Connect, reduce RTT which will improve the overall wait for patients and improve patient experience.

6.1.3 The next steps for the task and finish group will be to look at non-complex activity such as catheter management and how this could be managed within the community setting. Work to implement a virtual clinic for follow ups is also underway that will be primarily look at PSA follow up appointments to inform the patient when their test result is within the normal range, linked to the work above. Work is currently underway to scope the estimated activity reduction as these appointments are currently carried out face to face.

6.2 Neurology

6.2.1 The project has progressed and the task and finish groups identified the need for a Clinical Assessment Service (CAS) to triage and assess symptom-based criteria to cover all Neurology referrals currently going to MFT. An initial audit of referrals demonstrated that potentially up to 70% of referrals into secondary care neurology services could be redirected to alternative community services, including neuro-physiotherapy. The CAS model is currently being scoped with a view to a pilot beginning in October. This is anticipated to be provided as an extension to the

current MSK Triage service and is expected to have a positive impact on the current waiting times for an appointment with a secondary care neurologist by reducing inappropriate referrals and redirecting patients that can be managed by alternative services such as the neuro-physiotherapy service to ensure that patients reach the correct clinician in the system as quickly as possible. A clinical pathway for this service is being drafted.

6.2.2 Pathway review continues for all neurological conditions, including referral criteria and forms. The timeline for uploading new condition specific pathways depends on the expected timescale for the introduction of a triage/CAS, to ensure all changes are aligned.

6.3 Respiratory

6.3.1 It was identified during the pathway review process that there was a gap with no current pathways for Asthma and Chronic Cough available to primary care. A group of clinicians have taken the time to design and introduce these new pathways in line with the latest Asthma British Thoracic Society and NICE guidance. These pathways have been socialised via the GP bulletin and will be shared visually with GP's at their October Protected Learning Time meeting.

6.3.2 A Respiratory consultant at MFT has also identified the need to review the acute discharge pathway, and the subsequent outpatient appointments generated, and this is currently under clinical review.

6.3.3 There is an audit planned to review 100 referrals to identify issues within the current referral process in September. Solutions to these issues could impact on the waiting times in a positive way as patients would be directed to the most appropriate service for their needs, which could be provided in the community. This links with MFT's STAR programme and other triage initiatives already identified.

6.3.4 Spirometry provision is also under review with the current service provider and the contract has been extended until 30th April 2020, whilst options for the most appropriate delivery of this service in future are being considered.

6.3.5 The Home Oxygen Service pathway still requires a review and this will be worked up by the task and finish group in October.

6.4 Cardiology

6.4.1 There are further clinical pathways reviews underway for Heart Murmur and Palpitations and these will be issued in September. The impact on referral activity will be closely monitored, as will the DXS access of these new pathways at a practice level to determine utilization levels.

6.4.2 There is an audit planned for September which will review 100 referrals and subsequent impact on outpatient activity. The findings gathered will inform the need for a CAS/Triage service. Initial clinical triage internally by MFT consultants

is expected to commence during September and results from this will inform future triage models.

6.4.3 Cardiology advice and guidance is available from the national platform but local consultant rotas for Consultant Connect are being developed.

6.4.4 Specific issues have also been identified with the interpretation of ECGs – both those taken in the community and in the acute trust. The Consultant Connect platform allows for the sharing of images, including ECG results, so a way of virtual review is being considered to reduce consultant referrals for ECG interpretation.

6.5 Rheumatology

6.5.1 There is not currently a task and finish group in place for rheumatology. The intention from MFT is for this service to move it into the community. This has been stalled due to confirmation of clinical room requirements from MFT across Medway. However, recently the service from Darent Valley Hospital has been moved into the community in the DGS area. Outcomes from this move have been asked to be shared from DGS CCG and further meetings with MFT are planned to discuss next steps and progress this move.

6.6 Phase 2 Specialties

6.6.1 Specialty focused Project Initiation Documents and project plans will be developed early in Quarter 3 and scoping has commenced. The phase 2 specialties are: Ear, Nose and Throat, gastroenterology, gynaecology, trauma and orthopaedics and paediatrics.

6.6.2 The task and finish group approach taken with other specialties will be replicated for all phase 2 specialties. As with the phase 1 specialties it is expected that triage options will need to be considered, alongside clinical end to end pathway reviews to ensure that the appropriate information is available to primary care to direct patients to the most appropriate service to meet their needs in the timeliest manner.

7. Education in Primary Care

7.1 Clinical staffs across all specialties from Secondary Care and current Community providers have agreed to provide targeted education sessions to GPs and Practice Nurses. The mechanism to deliver this training needs to be determined but suggestions include informal “curry nights”, practice nurse sessions and engagement at Primary Care Networks, as they become established. This will upskill Primary Care as well as develop relationships to encourage the use of tools such as Consultant Connect which will impact on reducing referrals into the acute and ensure that Primary Care are aware of services provided in the community. The Outpatients Transformation Programme has a workshop planned at the October Protected Learning Time to promote the new pathways available for primary care and encourage clinical discussion. Regular updates are included in

the weekly GP Bulletins to share the latest information in relation to the programme.

8. Risk management

8.1 The Outpatient Improvement Programme has been included in the CCG's performance risk register. The initial risks identified and being mitigated and monitored are below. The risk rating for all these identified risks has been reduced due to the actions taken.

Risk	**Description**	**Action to avoid or mitigate risk**
1. Financial Risk	There is a financial risk to the CCG for non-delivery.	This has been mitigated in part by ensuring adequate resource is available for the programme. Clear measurement of activity changes implemented.
2. Stakeholder engagement	There is a risk of poor engagement from clinicians / stakeholders. In addition, the current service is not sustainable and not fit for purpose.	Stakeholder engagement has improved since programme commenced, with executive support and internal communication channels.
3. Patient Experience & expectation	Patients often have duplication of care, unnecessary appointments and long waiting times for follow up. This does not lead to a positive patient experience; this will continue if the project does not deliver.	Patient engagement plan has been developed and is being implemented to time frames agreed.
4. Workforce	Workforce capacity and capability to deliver alterative models of care, as they are developed.	Ongoing monitoring of workforce requirements linking with provider workforce leads to identify gaps and options to deliver. Workforce steering group re-instated.

5.IT Inter-operability	Ability to share patient records and care plans across organisations to ensure consistency of care and avoid duplication from patients perspective	Link to Digital Roadmap planning and STP-wide IT strategy.

9. Communication and Engagement

9.1 To support the Outpatients Transformation Programme a specific communications and engagement plan has been developed and agreed by the programme Steering Group. The main aims and timeframes of the plan are:

- Review of existing patient experience data concerning outpatient services and data collection methods, July – September 2019
- User and staff surveys – baseline and follow up, September 2019 and March 2020
- Targeted staff engagement sessions, September – November 2019
- Task and finish groups – mapping pathways of care, September – November 2019
- Community based focus groups – equalities and diversity focus, October – December 2019
- Co-design themed workshops, November 2019 – February 2020
- One-to-one Interviews and patient case studies, October – December 2019
- Patient Scrutiny Panel, Feb- March 2020.

9.2 An external specialist engagement company has been contracted to provide additional specialist support in the delivery of the above. They have facilitated the previous patient engagement workshops and been involved in the overall programme scoping.

10. Conclusion

10.1 The changes in referral management processes being implemented are not just about improving patient experience and appropriate use of specialist care providers. By taking out inappropriate referrals and reducing activity it is intended to free up consultant time so that current backlogs of waiting patients can be addressed. This will be monitored by the dashboards that have been developed.

10.2 Once this is achieved and waiting times are reduced then it is expected that activity can be pulled back to MFT from independent sector providers. The intention is also to allow consultants to focus on seeing the most complex patients which will add appeal to their workloads improving job satisfaction and boosting moral.

10.3 The longer term aim is that consultant job plans can be reviewed to develop changes in the way services can be delivered in future. For example by having

capacity to consider implementation of specialist investigation services and HOT clinics, allowing rapid access for patients when their needs are at their most urgent. Improved job satisfaction, different ways of working and innovative ideas will also make Medway/Swale a more attractive place to work and support recruitment initiatives into specialist areas, where there are currently difficulties in recruiting.

10.4 The areas covered within this report demonstrate how the programme is making progress and highlights the intended impact of the changes currently underway.

11. Financial implications

11.1 There are no financial implications to Medway Council directly arising from the contents of this report.

12. Legal implications

12.1 Provision for health scrutiny is made in the Local Authority (Public Health, Health and wellbeing Boards and Health Scrutiny) Regulations 2013 and includes a requirement on relevant NHS bodies and health service providers (including Public Health) to consult with local authorities about any proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment. Where more than one local authority has to be consulted under these provisions those local authorities must convene a Joint Overview and Scrutiny Committee for the purposes of the consultation and only that Committee may comment.

12.2 The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. The circumstances in which a report to the Secretary of State is permitted are where the local authority is not satisfied that consultation with the local authority on the proposed substantial health service development or variation has been adequate, in relation to content or time allowed, or where the authority considers that the proposal would not be in the interests of the health service in its area.

12.3 Revised guidance for health service Commissioners on the NHS England assurance process for service changes was published in March 2018:

https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

12.4 The guidance states that broadly speaking, service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services

available and/or the geographical location from which services are delivered. It also says that any proposed changes should be aligned to Sustainability and Transformation Partnership (STP) Plans.

12.5 The NHS England guidance acknowledges that the terms “substantial development” and “substantial variation” are not defined in the legislation. Instead commissioners and providers are encouraged to work with local authorities to determine whether the change proposed is substantial thereby triggering a statutory requirement to consult with Overview and Scrutiny. The Council has developed a template to assist the Committee in determining whether a proposed change is substantial. At the meeting in March 2019, where the completed template was considered, the Committee deemed that the proposal does represent a substantial development of, or variation to, the health service in Medway.

12.6 The NHS England guidance also states that public consultation, by commissioners and providers is usually required when the requirement to consult a local authority is triggered under the regulations because the proposal under consideration would involve a substantial change to NHS services. However, public consultation may not be required in every case, sometimes public engagement and involvement will be sufficient. The guidance says a decision around this should be made alongside the local authority. At its June 2019 meeting, the Committee noted and supported proposed patient engagement activity as part of the programme for improving the outpatient service in Medway and Swale. This followed CCG advice that consultation would be too prescriptive and that engagement would better enable a full range of feedback to be taken into account.

13. Recommendations

13.1 The Committee is asked to consider and comment on the report.

Lead officer contact

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Appendices

None.

Background Papers

None.