Appendix 2

Medway and Swale System Collaboration Priorities

June 2020

Medway and Swale
Integrated Care Partnership

Transforming health and social care in Kent and Medway

Priority Areas for Collaboration:

- Medway and Swale ICP partners having been working together to develop a shared system recovery approach, and have identified 4 key recovery programmes for the system.
- These programmes seek to learn the lessons from the way we have worked together over the last 3 months, resolving seemingly intractable problems through working together at pace and with pragmatic approaches to risk and governance issues.
- They build from the work that our Clinical and Professional Advisory Board had begun pre-COVID to tackle the key health and well-being issues facing the Medway and Swale Health and Care System.
- In light of the CCG's request to identify 3 priority areas for collaboration in 2020/21 Medway and Swale ICP has identified the following:
  - Providing care as close to home as possible for as many people as possible, enabling the system to **Sustain Lower Bed Occupancy Levels**.
  - Maximising the benefits gained through new models adopted to manage the COVID-19 outbreak by **Adopting A Digital Approach** wherever possible.
  - Supporting local with the most complex social and health care needs including the homeless and those with complex mental health and substance abuse issues by **Making a Difference Each Week.**
- These priority areas will be managed through our ICP Recovery Governance mechanism, which is described below.

ICP Strategic Priorities

- ICP Clinical Strategy including:
  - New model of primary care including separation of scheduled and unscheduled primary care
  - Stronger integration of primary and community services
  - Development of primary mental health services and stronger links between physical and mental health services
  - Population health management
  - Understanding and managing the long-term impacts of COVID 19, assessment of the harm which may have occurred during the pandemic due to lower thresholds and risk appetite.
  - Quality and safeguarding, acknowledging the risks and issues pre-COVID and any additional risks and issues which occurred during the pandemic incident management.
  - Understand the new baseline as a result of the impact of Covid-19 and the changes implemented before standing up services and establishing the new business as usual.
- Engagement Plans:
  - Focused on robust communication and engagement with staff, services and the public and other stakeholders
- Robust organisational development plans for all partner organisations and the ICP:
  - Sustaining the changes to support transformation and to function effectively in a ‘New Normal’.
  - Support staff resilience.
  - Impact on LTFM
- Agreement of MoUs that underpin the development of the ICP.
- Robust **management matrix approach** to co-ordinate recovery programmes across the ICP, ensuing we make the best use of available resources.

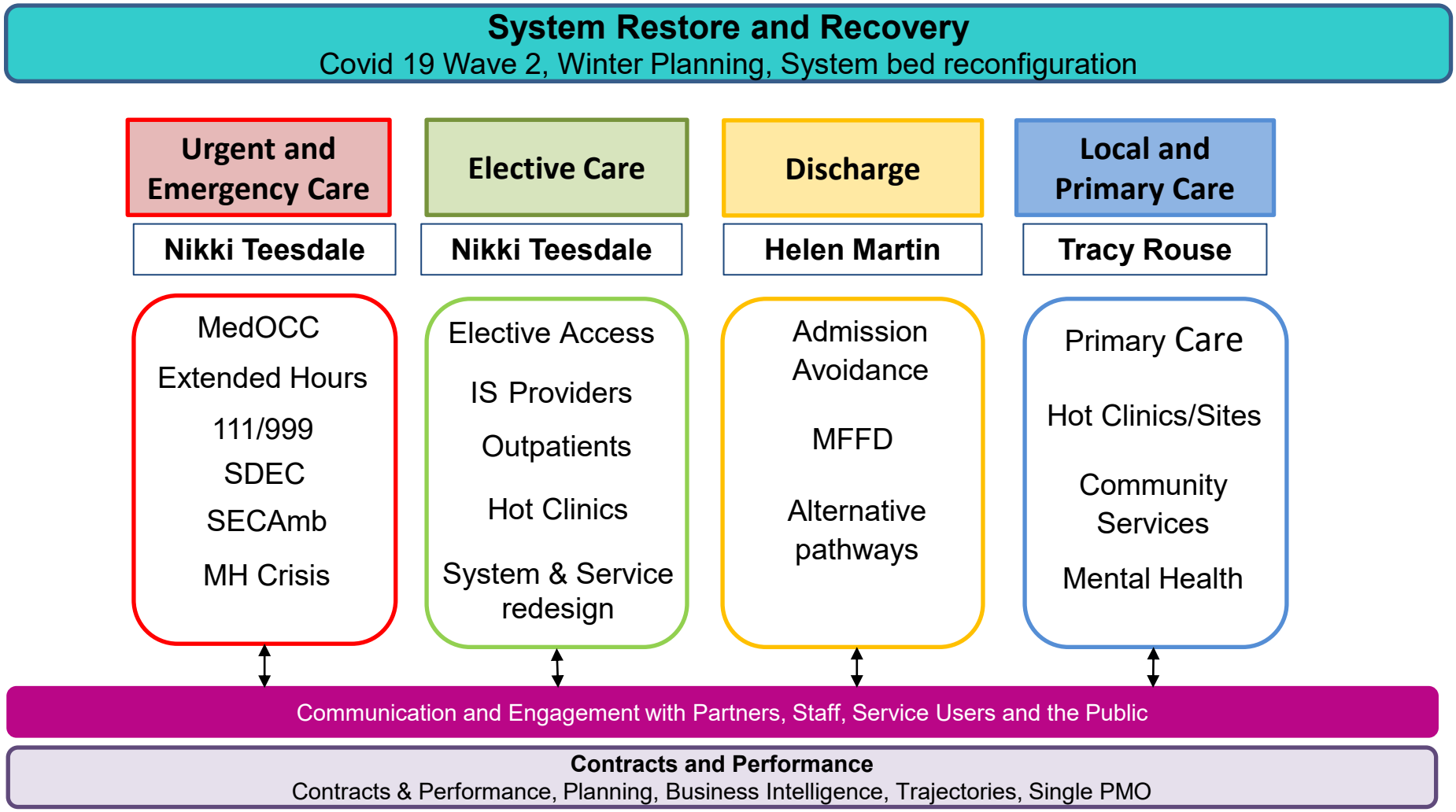
Service Development and Redesign – Our Priorities (1):

- Working with clinicians and professionals; local people; and service users and their carers we have identified the following as priorities for service and pathway development and redesign:
  - Developing a population health management approach, and focusing on the wider determinants of health to reduce health inequalities, and to improve the health and well-being of local people.
  - Developing a sustainable model of primary care that improves access to core primary care services; makes the best use of scare resources; and that builds on the opportunities presented by the development of Primary Care Networks; the update to the GP contract; and the development of new ICP contracts.
  - Continuing to develop and roll-out the Medway and Swale Model and the Buurtzorg Model of neighbourhood nursing which seek to join up local health and care services so that, where appropriate, they can be delivered to close to people's homes.
  - Transforming outpatient services, reducing the need for people to travel to a hospital to access a specialist opinion and reducing waiting times for elective services.
  - Transforming care pathways for people with people with long-term conditions, ensuring that care is provided as close to home as possible; that pathways are easy to navigate and reflect best-practice models; and that patients are supported and encouraged to manage their condition.
  - Improving cancer survival rates for local people by increasing screening uptake and early detection and referral to secondary care services; improving access to diagnostic services; and reducing waiting times for treatment.

Service Development and Redesign – Our Priorities (2):

- Supporting adults and older people with mental health problems and mental illness to live well in their community by improving access to IAPT services for local people with common mental health problems; ensuring that people with severe mental health problems can accesses integrated primary and community mental health services in a timely manner; and that people in a mental health crisis can access 24/7 community-based crisis response services.
- Ensuring that people with severe mental illness are being offered and are able to take up annual physical health checks.
- Reducing the pressure on emergency hospital services by maximising utilisation of alternative urgent care pathways and services that divert patients away from the Emergency Department; ensuring local people can access crisis response services within 2 hours, and re-enablement services within 2 days of referral; and working as a system to ensure that patients are discharged from acute hospital beds in a timely manner
- Ensuring that children and young people in Medway are able to realise their potential; to live healthier, happier lives by ensuring earlier identification of health and development needs and more timely interventions to improve health and academic outcomes; improving outcomes for children with special educational needs; improving access to mental health and emotional well-being services; reducing available A&E attendances; and improving access to end of life services for children and young people.

Recovery Priority Areas



Medway and Swale
Integrated Care Partnership

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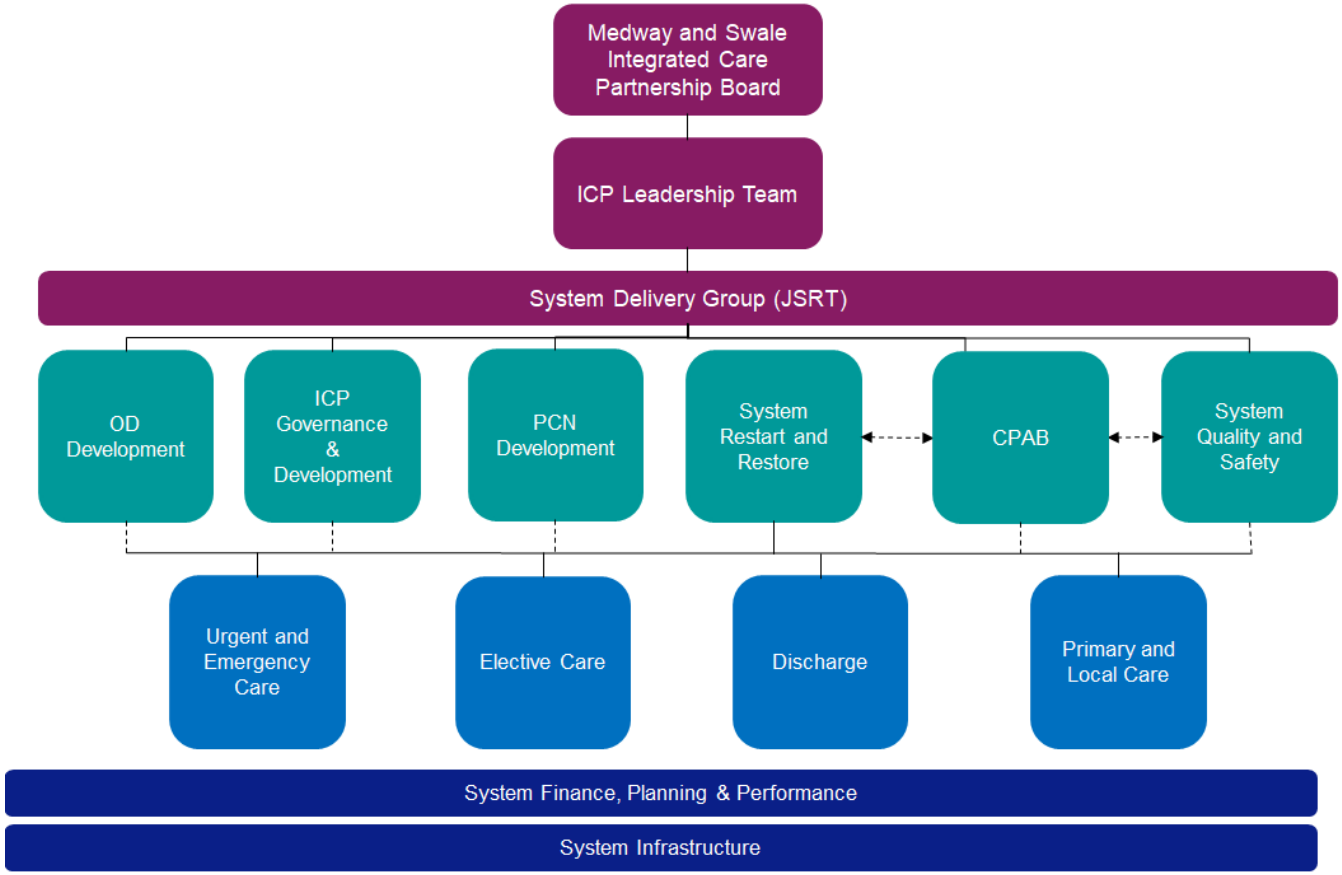
ICP Recovery Governance



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Recovery Approach

- Programme Leads will be supported by matrixed teams including representation from across the health and social care sector in Medway and Swale
- These teams will explore how to integrate current work programmes and build on existing jointly developed projects to embed new ways of working across this system.
- Teams will learn from the rapid changes which were implemented during COVID-19, and ensure we do not revert back to old ways of working where new models are delivering real improvements.
- Programme leads will establish their programmes to promote flexible and agile working, with governance and meeting frequency that is proportionate to the change and outcomes required from the programme.
- Programmes will be supported by the ICP Comms and Engagement Group to ensure effective engagement of key stakeholders in any service/pathway change.
- Each programme area will identify its interdependencies with other programmes, and with other priority service areas including: diagnostics, cancer, rehabilitation, children's health, care homes, learning disabilities, ILRs, support to vulnerable and shielded patients and end of life care.
- Our collaboration priorities fall within the scope of the recovery programmes and will be managed through the agreed matrix management approach over seen by our JPMO.

Sustaining Lower Bed Occupancy:

Recovery Programme	Key Interventions	Outcome Measures
Urgent and Emergency Care	• Improving joint pathways to support patients with mental health needs preventing future emergency admissions. • Wrap around support for frequent attenders at the UEC, linked to ILRs and MDTs. • Increased uptake of Rapid Response Service to avoid admissions.	• Improved mental health and well-being scores and reduction in mental health related illnesses. • Reduction uptake of urgent and emergency care services and NEL admissions. • Improved user satisfaction.
Discharge	• Sustaining MFFD model implemented during COVID. • System-wide bed capacity modelling that can enable the impact of surges in acute demand on community and social care beds and domiciliary services.	• MFFD level remains low. • System can respond to surges in demand for urgent and emergency care.
Local and Primary Care	• Extended use of ILRs and MDTs to support patients with LTC's, particularly for those patients with complex needs post-COVID. • Transition from COVID Care Home Support Programme to Care Home DES. • Continued support to vulnerable and shielded patients to ensure care plans are in place and being delivered; undertaking medications reviews; and supporting people with LTCs to remain well in the community.	• Reduction in NEL attendances and admissions, particularly for Care Home residents. • Post-COVID patients have robust care plans in place, and are confident to manage their health and care needs. • Improved user satisfaction. • Increased confidence in Care Homes to manage residents without hospital admission.

Adopting a Digital Approach:

Recovery Programme	Key Interventions	Outcome Measures
Urgent and Emergency Care	• Continued use of GP online consultations supported by Consultant Connect for urgent advise and guidance. • Consultant Connect for prison health services.	• Improved primary care access. • Reduction in demand for MedOCC and A&E. • Improved patient satisfaction
Discharge	• Use of Consultant Connect for intermediate care and community beds to enable them to support more complex patients.	• Reduced length of stay in acute and community beds • Increased confidence to discharge to community beds. • Improved system flow.
Local and Primary Care	• Expand the use of EFI + to identify , manage and monitor frail and shielded patients. • Enhance the use of Eclipse and EMIS to continue to teach patients and families to undertake safe and appropriate care for patients. • Continue to develop the use of GP on-line consultations.	• Reducing risk of COVID transmission in vulnerable groups. • Improved primary care access and capacity. • Increased levels of self-care. • Improved satisfaction
Elective Care	• Use of Consultant Connect across all specialties to provide targeted on-site outpatient support to prisons. • Increased use of virtual outpatient consultations where physical assessment is not required. • Pilot of Virtual Lucy to support demand management	• Improved health of prison population, with reduced risk of COVID transmission. • Improved user satisfaction. • Reduction in footfall in health care facilities. • Better targeting of available capacity

Making a Difference Each Week:

Recovery Programme	Key Interventions	Outcome Measures
Urgent and Emergency Care, Discharge and Local and Primary Care	• Identifying a service user (or a small cohort of service users) with complex needs whose not currently being met adequately by existing health and care services. • Taking a whole system approach looking at the their physical, mental and social health and care needs. • Working with the service user/group to understand why current services are not meeting their specific needs. • Develop and put in place targeted support that responds to their needs, working with the service user/group and their existing support network. • Actively engage the third sector and wider community wherever possible. • Monitor and adjust support as required. • Consider how these approaches could be scaled or modified to benefit the wider community. • Sharing the learning with existing service and partners to promote the adoption of innovative approaches.	• Improved health outcomes for local people with the highest/most complex health and social needs. • Reduced demand for urgent and emergency health and care services. • Wider community engagement in developing target health and care services. • Better targeting of resources to interventions that deliver health and well-being gains to people with complex needs. • Increased levels of staff satisfaction.