HEALTH AND WELLBEING BOARD

2 SEPTEMBER 2021

MEDWAY AND SWALE LOCAL CARE PLAN

Report from: Martin Riley, Managing Director MCH CIC - SROs Medway and Swale ICP

Author: Donna Rowell, Director of ICP Transformation, Medway and Swale ICP

Summary

Updates have previously been provided to both the Health and Wellbeing Board (HWB) and the Health and Adult Social Care Overview and Scrutiny Committee (HASC) on the development of the Medway and Swale Integrated Care Partnership (ICP). This document sets out the priorities for the ICP and focuses on the proposed Local Care plan which incorporates primary care.

1. Budget and policy framework

1.1. No decision is required for the council's policy and budget framework; in the development of the overarching ICP Delivery Plan for 2021 of which the Local Care Plan is one element, the plan incorporates both Health and Social Care priorities.

2. Background

2.1. As the ICP has continued to develop, key priorities have been collectively agreed which will form the roadmap for the ICP. These priorities not only include clinical priorities but set out principles of how different organisations will work together and the governance framework required to enable this to happen. To accomplish this the ICP is mid-way through an organisational development review which will define these principles to enable a culture of collaborative working.

2.2. In terms of the immediate priorities to be included in the roadmap are:

- Population Health Management, as a tool;
- Elective Recovery following the COVID-19 pandemic;
- Diabetes;
- Respiratory;
- Out of hospital urgent emergency care, which focuses on reducing emergency demands on the Hospital front door;
- Discharge, which will create flow within the acute;

- Access to primary care, including addressing members' concerns on access to GP appointments raised at the Board meeting on 17 June, which is the focus of this paper.

3. Local Care Plan

3.1. Local Care Plan overview

3.1.1 The purpose of the Local Care Plan is to set out the Medway and Swale ICP objectives and aims to support the enhancement of primary care across Medway and Swale. This plan will form the beginnings of a strategy which will set out the priorities and ambitions for the next 3 years.

3.1.2 Although the focus is the development of a primary care strategy it is important to understand the wider context and ambition of local care across Medway and Swale of which primary care is an important component. It is for this reason that the first part of this plan sets the vision and ambition of local care and how this will contribute to an overall strategy. In developing the full Local Care strategy, the ICP will engage local people and key stakeholders.

3.1.3 Prior to the COVID-19 pandemic Primary Care, Community providers, the Acute Providers, Local Authorities and other local providers and wider stakeholders had started discussions with a view to the co-design of the ongoing Local Care programme. This will continue to evolve and move towards co-production to ensure the feedback from users of the services will shape the services within our local health and care system.

3.2 Ambition of Local Care

3.2.1 Within 3 years local care will be delivered by health care teams that operate across primary and community care settings, known as neighbourhood teams, responding to the specific needs of their "neighbourhood". The teams may be employed by different organisations or practices however operating collaboratively as integrated multi-disciplinary teams around their primary care network. Each team will be placed in the geographical areas across Medway and Swale, in order to deliver improved patient outcomes.

3.2.2 There will be aspects of community and primary care services that cannot be operated this way, but these should be 'ruled out' by exception. The underpinning principles of this plan are:

- to provide the best care services for our local population on a sustainable basis;
- to put 'place' ahead of individual organisations goals;
- to support primary and community care to deliver services that meet the needs of patients;
- to have greater control on shaping the future of primary care services in Medway and Swale;
- be an active partner to the delivery of the priorities for the Medway and Swale ICP;

- to address the variations in our population wide determinants of health to improve the health of our populations and reduce premature mortality, using population health management as an enabler;
- to link to the ICP digital strategy recognising that digital solutions are a key enabler to future delivery of service;
- to use the collective skills, experience and knowledge of clinicians and patients with long term conditions to transform and develop whole system change to disease management and empower patients.

3.3 Strategic approach

3.3.1 To support the development of this plan, the expectations for delivery are:

- Putting the patient's population health improvements at the heart of our decision-making.
- To develop our local care teams for today and the future, to meet the demands of people on primary and community care.
- To support the development of clinical leadership across the sector as a whole.
- Contribute to the innovative and creative approaches to provide effective, efficient and safe services to meet patient need.
- Flourish through the opportunities of integrated and collaborative working with system partners.
- Commission by clear patient outcomes.
- Design a governance framework and financial flows that allows multiple providers to collaborate and teams to operate as integrated multi-disciplinary teams (where possible) to improve patient outcomes.

3.4 Integrated Successful Projects

3.4.1 Despite the impact of the COVID-19 Pandemic, significant progress has been made in the development of the Primary Care Networks in Medway and Swale. The PCNs in conjunction with the Medway and Swale ICP and community providers has successfully launched new services and programmes in response to the COVID-19 pandemic to support primary care and managing patients in the community, as well as actively supporting primary care in the delivery of the COVID-19 vaccination programme.

3.4.2 Successful launch of:

- COVID HOT clinics in primary care.
- COVID @Home Pulse Oximetry Service for remote monitoring of patients tested positive for COVID to enable the early detection of silent hypoxia and escalate for treatment and intervention; as well as monitor patients who have been discharged from the acute on an early supported discharge pathway following their COVID inpatient stay in the acute.
- Adopted a collaborative system approach for the rollout of the COVID vaccinations for Housebound patients in the Medway PCNs and on discharge from the community wards for the 1st and 2nd vaccination.

- The formation of an ICP Vaccinations Group, with system partners to proactively plan the rollout of the 3rd COVID vaccination and flu vaccination for our housebound patients;
- Championing the Community Mental Health Framework Transformation as the pilot area for Kent and Medway CCG.

3.5 Current Position

3.5.1 Despite the positive steps taken with restore and recovery post the COVID-19 pandemic; there were a range of conditions highlighting variation within the Medway and Swale PCNs through the Joint Strategic Needs Analysis (JSNA) completed at PCN level. These include:

- Our smoking prevalence in people aged over 18 is 4% higher than the England average.
- The percentage of adults classified as overweight or obese is 4% higher than the England average
- An estimated 12% fewer people over 65 suffering with dementia are diagnosed in Medway compared with the England average.
- Compared with the England average 7% more women in Medway and Swale smoke at the time of giving birth; and breastfeeding initiation is 6% lower than the England average, with Swale being 12% lower.
- Depression prevalence is 2% higher in Medway and Swale that the England average.
- There is a higher rate of suicide, particularly for men, in Medway and Swale than the England average.
- 8% more people die from cancer under the age of 75 compared to the England average; and our one-year cancer survival rates are 5% lower than the England average.
- 23% more people than the England average have an unplanned admission for a chronic condition that could be managed out of hospital.
- Many younger patients (aged 45-65 years old) have multiple long-term conditions comparable with the over 65s – and they are using a disproportionate amount of health compared to our health economy peers.

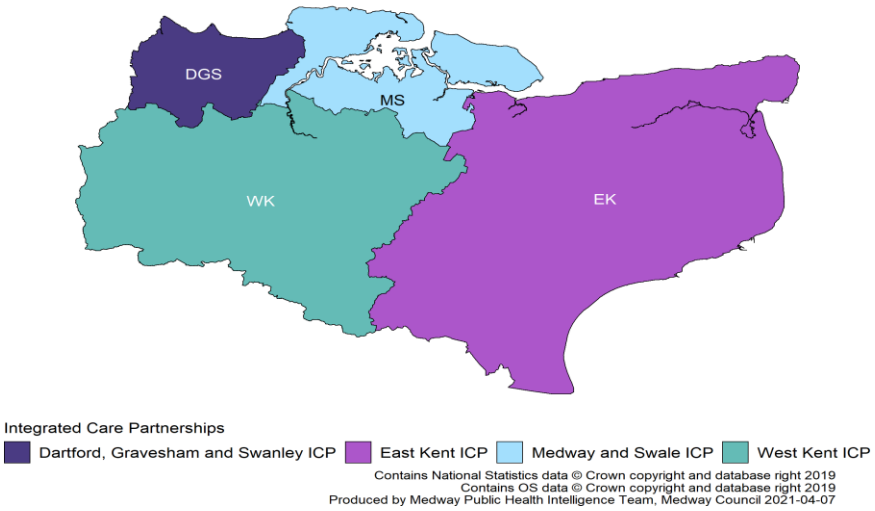
3.5.2 This puts pressure on primary care services as well as the wider providers within the Medway and Swale ICP. Collaboratively as system partners it is imperative that we work together to address the impacts of the challenges of our local population's health.

3.6 Primary Care Structure

3.6.1 Medway and Swale PCNs are within the Medway and Swale ICP which is located with the North patch of the Kent and Medway Integrated Care System (ICS), and is one of four ICPs.

3.6.2 The nine PCNs collectively deliver primary care services to a population of total population of 410,256; Medway has a population of 294,352 and Swale's population is 115,904 and Medway and Swale have some of the highest

levels of deprivation in the UK with some wards being in the 10 per cent most deprived areas in the country.



3.7 Primary Care Networks

3.7.1 Medway and Swale PCNs are within the Medway and Swale ICP which is located with the North patch of the Kent and Medway Integrated Care System (ICS), and is one of four ICPs. The nine PCNs collectively deliver primary care services to a population of total population of 410,256; Medway has a population of 294,352 and Swale's population is 115,904 and Medway and Swale have some of the highest levels of deprivation in the UK with some wards being in the 10 per cent most deprived areas in the country.

3.7.2 The Medway and Swale ICP and PCNs are supported by two Local Authorities; Medway Council and Kent County Council. Within the Medway and Swale ICP consists of nine Primary Care Networks across which is made up of 54 GP practices

Medway PCNs
Gillingham (6 Practices)
Medway Central (6 Practices)
Peninsula (3 Practices)
Rainham (9 Practices)
Medway South (7 Practices)
Rochester (4 Practices)
Strood (5 Practices)

Swale PCNs
Sheppey (6 Practices)
Sittingbourne (8 Practices)

3.8 Priorities for Local Care

3.8.1 In Medway and Swale health and social care partners are committed to delivering a new model of local care; building on the successes of the Medway Model as well as shared learning across Medway and Swale to develop the new model of integrated health and care services. Delivering care and providing access to services through multi-disciplinaries teams forming neighbourhood teams is key to providing physical and mental health care closer to where people live (including nursing and residential care home) and is a collective commitment of the health and care system across Medway

and Swale to fundamentally transform how and where we will support people to keep well and live well.

3.8.2 The outline of the model has been built on conversations held to date with local people, clinicians and stakeholders about the care they need and has the service user at its very centre; however, the intention will be to strengthen the engagement and understanding the views of people with lived experience of the services in order to transform and strengthen the local care model.

3.8.3 Through the data collated it has shown that our frail population start from middle age due to multi-comorbidities and long-term conditions and not limited to the older aged person; therefore, our local care intentions and transformation programme is being managed through a frailty programme.

3.8.4 The frailty programme is multi-faceted with focus on in and out of hospital care bringing clinicians together from primary, secondary and community care, social care, mental health and other sectors together to develop a model for delivery at PCN level.

3.8.5 The table below sets out the proposed model:

Frailty Patients	
Interventions include: • ILRs / MDTs • End of Life Care • Early identification of frailty • Befriending • Signposting • Care Navigation • Care Homes • Carer's Health Checks • Blue Light Scheme	**Delivered by Neighbourhood Teams including:** • GPs • Urgent Response (Medway) • Rapid Response (Swale) • Care Navigators • Community Nurses • Mental Health roles • ARRS

Local Care Model

3.9 Priorities for Primary Care

3.9.1 There are a number of fundamental elements to ensure that primary care is supported to provide sustainable, high quality, accessible care.

3.9.2 Following one of the most challenging and unprecedented times in health care due to the COVID-19 pandemic, primary care services require support to re-establish themselves as an accessible component for delivering services to patients. However, it should be recognised that the workforce is exhausted and fatigued, and therefore, developing local care is imperative to allow patients to access the right service at the right time to meet their needs.

3.9.3 Recognising that primary care is the access point for the majority of patients it is critical that the limited capacity and resources are organised to be efficient

as possible. A key element is the methods used for accessing services and aligning patients to services and clinicians to meet their presenting needs at the time they need the care.

3.9.4 This strategy will focus on nine key priorities that all support improved access to primary care:

3.10 Priority one: Improved Access

3.10.1 Recently, focus has been placed on the additional capacity provided through GP Improved Access and the Extended Access. Although previously these have been two different national agenda's, from September the Extended Access and Improved Access will be merged into a new model. It is anticipated that there will be core deliverables which will transfer into the new Extended Access directive due to be published September 2021.

3.10.2 The current GP Improved Access has been delivered by MPA Ltd and an assessment by GP Surgery and at PCN level has been undertaken to review the capacity and demands on this extra capacity. It has been identified there are large inequities regarding the usage of this service by some practices within PCNs, with some having not having used it at all.

In anticipation of the guidance, an options appraisal is being developed which explores how additional primary care capacity can be provided to patients through improved and extended access, as well as through home visiting.

3.11 Priority two: Delivering effective out of hospital care

3.11.1 Delivering out of hospital care was one of the key priorities set out in the NHS Long Term Plan. New models of care were trialled as proofs of concepts during the COVID-19 pandemic; for example, the Falls Response Car which successfully saw 72% non-admission to the acute for all patients who were attended to by the Falls Response Car where patients/carers had called emergency services following a patient fall. This proof of concept took place in Medway however a business case has been completed to request the full commissioning of a Falls Response Car which cover the breadth of Medway and Swale and support patients staying in the community with wrap around support and reducing the need to be conveyed to hospital as an emergency. More novel ideas need to happen to support primary, community and acute

services to support patients in an out of hospital model and are being considered collectively through the urgent and emergency care transformation programme.

3.11.2 Additional areas for review and development of plans include:

- Supporting the Local Care priorities
- Integrating mental health with physical health
- Workforce development
- Working collaboratively to deliver a multi-partner, clinically driven urgent community hub involving the acute; ambulance trust, MCH, CCG and primary care accessing the most appropriate service the first time for the patients presenting needs.
- Community Crisis Response within 2hrs
- Care Homes – digitilisation, training, visiting (video and F2F visits)
- GP alignment to care homes
- Multi-disciplinary care team working
- Appointment mapping will now give us clearer data.

3.12 Priority three: Planning for surge and escalation

3.12.1 When the last two waves of the COVID-19 pandemic took hold, there was very little time to proactively put measures in place to support primary care; however as further waves of the pandemic happen, including the annual winter pressures on the system, its important that primary care have plans in place which can be rapidly deployed in the event of surge escalation. Therefore, as a priority, a Primary Care Continuity Plan to respond to periods of surge needs to be defined at pace, working with and learning with system partners how everyone's plans can be deployed collaboratively and not putting unwarranted pressure on any one part of the local system.

3.12.2 Consideration will need to be given to the Primary Care Plans on the following areas and consider how plans at PCN level could provide the overarching plan to putting in place a planned approach to an emergency situation:

- identifying the resources required;
- establish a primary care Opel status and the step changes required to maintain flow and response to increased demands;
- ongoing continuation with vaccination rollout, including flu vaccinations, during periods of higher demands;
- consider how the CO@H service could be deployed to provide remote monitoring to support patients at risk in primary care;
- whether services may need to stop in primary care to support surge management;
- automation of metrics to highlight the pressures in primary care so other providers in health and social care can provide mutual aid;
- consider the impacts of any secondary care shift of workload on primary care;

- deployment of hot hubs to provide increased capacity taking into consideration:
  - Resource allocation
  - Location
  - Digital needs
  - Rota's
  - Key supplies including; PPE
- patient engagement and awareness;
- a consistent approach across the PCNs to minimise variation in service.
- effective comms including how primary care include messages about surgeries are not closed and are still handling emergencies (baby immunisations/cancer only).

3.13 Priority four: Appointing Additional Roles Reimbursement Scheme

3.13.1 The Additional Roles Reimbursement Scheme (ARRS) is a national scheme providing funding for an additional 26000 roles to be created to add to multidisciplinary teams.

3.13.2 Locally we are working collaboratively with all nine PCNs across the ICP to ensure that we maximise this opportunity looking at how we can appoint at PCN level and explore how we can:

- learn from one another on how to successfully recruit into the roles;
- use the ICP to support with the recruitment and interview process to establish matrix working;
- consider pooling resources to create capacity where there is a scarcity in available professions;
- possibility of collaborative appointments of ARRS roles;
- how pooling of clinical staff could align with PCNs;
- being creative in the naming and types of roles based on skills required to deliver functions and services;
- ensuring the staff appointed into the roles have comprehensive induction which includes working with the wider teams;
- consider embracing the neighbourhood team philosophy, function and benefits at PCN level;
- utilise the Training Hubs to support PCN workforce development.

3.13.3 The ARRS roles include the employment of the following roles to support primary care:

- Physician Associates
- Pharmacy Technicians
- Care Co-ordinators
- Podiatrists
- First contact physiotherapists
- Mental Health Nurses in conjunction with Kent and Medway Partnership Trust (KMPT).

3.14 Priority five: Effective comms and engagement

3.14.1 A priority for the ongoing development of the Medway and Swale local care plan is advanced engagement of service users to truly develop a co-produced and monitored model which meets the local needs identified.

3.14.2 The approach will see developments in:

- provider relationships;
- patient relationships;
- embedding the voluntary sector in the creation of services and accessing hard to reach communities to gain their views;
- working PPGs;
- reviewing what worked well during the pandemic and the positive feedback received from patients; learning from the concern's patients have raised;
- communication to increase the populations awareness of services being provided within primary and community care;
- targeted approach to the encourage the uptake of screening and vaccinations;
- the creation of a centralised Medway and Swale community-based Patient Liaison Service to support patients and primary care acting as a liaison between the GP practice, patient and secondary care.

3.15 Priority six: Adopting Digital Solutions

3.15.1 As identified in the Long Term Plan, virtually all areas in the modern day have embraced innovation and technology and this includes healthcare. During the COVID-19 pandemic a number of changes were put in place to support patients adopting a digital approach and lessons learnt from this should continue to be explored when transforming services ensuring digital approaches are considered as well as recognising there are still some patients who do not or cannot use digital technologies and therefore cannot be disadvantaged.

3.15.2 One of the key drivers set out in the Long Term Plan is to use digital technologies to release administration burden on clinicians so they are released to provide more direct care to patients. To take this agenda forward key considerations will include:

- cleansing of primary care IT systems;
- establish and stabilise the IT infrastructure at PCN level;
- complete the implementation of Consultant Connect connecting primary and community clinicians with secondary care clinicians in local specialties providing the advice and guidance for elective and emergency concerns;
- E-consult electronic system;
- virtual primary care booking hub;
- phone lines – managing contracts, approach and standardisation;
- the roll out of the APEX and ARDENS IT tools across multiple PCNs standardising the approach towards data gathering and clinical templates;

- effective use of IT in in providing virtual appointments, prescriptions and facilitating communication with the patient (iPlato, AccuRx, EConsult);
- utilising population health management data to inform priorities;
- Data Sharing Agreements to support risk stratification;
- use of automated processes to generate reporting.

3.16 Priority seven: Access to estates to provide new services

3.16.1 In order to support the delivery of new services and coordinated care, there will be a requirement for estates which are fit for purpose within the locality in order to achieve the provision of care closer to home. Following the establishment of the baseline needs of estates; we will work collaboratively to address the needs to deliver the local and primary care plan.

3.16.2 This will be managed through:

- primary care leads working collaboratively with practices to provide a unified voice about the estates needs for their PCN.
- GPs acting as Advocates at both ICP & ICS levels;
- collectively creating an estates strategy without compromising other services and demonstrating the requirements of primary care.
- identifying a GP Estates Lead to work with the local authorities to proactively promote the health care/primary care needs with new housing developments.

3.17 Priority eight: New financial models and flows to support change

3.17.1 Exploring new financial models to underpin the changes to services, redesign and transformation is key in taking the ICP forward. In order to enable this, the ICP system partners will work closely with the ICS and other sources to develop new contract and financial models to enable us to:

- explore the realignment of funding from secondary care/ICS to support practices with the increased demands as a result of long waiting times.
- It is likely that the long waiting lists and times will have an impact on primary care therefore explore putting in place different services to provide support for patients experiencing with long waiting times.
- Working collectively with other system partners to address whole system change to manage long term conditions. In this transformation programme we will be looking at the clinical pathways, service provision, patient adherence to treatment plans, self-management techniques, remote monitoring with underpinning contracting and financial flows to enable the sustainable change. We are starting with the establishment of a new diabetes model which is underpinned by organisational development. Once this model has been developed it will be used to support the development of other long-term conditions (LTCs) for example; respiratory as well as any other LTCs identified through the population health management analytics.

3.18 Priority nine: Sustainable workforce

3.18.1 In order to provide primary care services on a sustainable basis, an understanding of the current position and the workforce needs for the future is vital.

3.18.2 Analysis of the number of clinical professionals in post, age profile and gaps will be undertaken to define the position and needs for the present and the next 3-5 years. Other considerations will include:

- a review the resource across M&S – GPs, nurses, Physio, pharmacists, paramedics;
- determine the number of GPs heading towards retirement age now and over the next five years;
- explore developing new recruitment contracts to allow greater flexibility with time being spent in the GP practice, an urgent hub and supporting ICP/PCN development;
- provision of OD and Leadership skills for clinical leads;
- establish succession planning for CD roles to grow our own future leaders;
- appointing all ARRS roles to provide the additional clinical workforce required in primary care;
- creating workforce and services working collaboratively and not competing against one another for the scarce resources.

4. Risk management

4.1 The table below provides an initial view of the key risks associated with the Medway and Swale ICP local care plan and the mitigating actions.

Risk	Description	Action to avoid or mitigate risk
Unprecedented Pressures on Primary Care	Primary care is under significant pressures since the COVID-19 pandemic and may not have the capacity to lead on changes being considered.	Use the collective knowledge of the PCN Clinical Directors and other health care clinicians to support patients' timely access to primary and community-based care. Explore the collective skills of the wider clinical professionals to provide patients with improved access.
Provision of out of hospital urgent and emergency care	Need to explore new models of UEC to be dynamic in our collective approach to UEC in the community	A number of innovations have been undertaken which have had a positive impacts, consideration is being given to a new community UEC hub which will enable co-located coordination to support emergency services, local

Risk	Description	Action to avoid or mitigate risk
		care services and primary care.
Timely creation of a primary care Opel status for emergency planning	Opel status is traditionally used to establish system pressures, this has not previously been defined for primary care.	Through a networked approach establish whether other health care systems in England have introduced an Opel method to determine the thresholds, actions and triggers for primary care.
Unable to appoint to the ARRS roles	It is recognised that there is an increasing problem in the recruitment of key professionals impacted also by the competitive rates offered in London for similar roles.	Work collaboratively to recruit across the PCNs and not inadvertently cause unwarranted risk to recruiting to other PCNS. Be creative with the roles required and consider new roles based on the skills required rather than typical role names.
Adopting a digital approach	Challenges in adopting new digital approaches when the system is in recovery following the pandemic. Affordability of new systems and ensuring interoperability with existing platforms to reduce duplication of data entry.	Appointing a GP digital lead to act as an advocate for primary care on the ICP Digital Board to help progress the digital needs for local and primary care. Effective scoping of new digital solutions to assess interoperability and affordability on a short and longer timeframe. Engagement and alignment with the ICS Digital vision and plans
New contract and finance models	Challenges in the timely development of new contract and financial models in readiness for the new financial year 2022/23	Consider the new contract models possible in the Finance and Contract meetings using collective knowledge and skills in this field to support the development of new models. Use the diabetes transformation programme as the first model to develop new contract and financial flows.

5. Financial implications

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

6. Legal implications

6.1 There are no legal implications to Medway Council arising directly from the recommendations of this report.

7. Recommendation

7.1 The Health and Wellbeing Board is asked to note this report.

Lead officer contact

Donna Rowell, Director of ICP Transformation, Medway and Swale ICP
Donna.Rowell2@nhs.net

Appendices

None

Background papers

None