Appendix 1

NHS
Kent and Medway

NHS Kent and Medway Integrated Care Board

Community Services Transformation Ambitions

Our ambition is to transform and improve NHS community services provision for people across Kent and Medway.

August 2024

Together, we can

www.kentandmedwayicb.nhs.uk

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Foreword

As an integrated care board, we are a health leader in Kent and Medway's Integrated Care System which wants to be transformational in the way we develop service models, both now and in the future.

It is imperative that our patients, clients and service users are cared for in the right place, at the right time and by the right person.

That's why I am delighted to welcome you to our prospectus for adult and children's community services. It sets out our intention to redesign community services and details our vision for transformation of the community health sector across Kent & Medway.

It is widely recognised that as healthcare modernises, and with the increasing use of technology, as well as a growing and ageing population, care outside of hospitals will be the focus for providing care for our populations moving forward.

Kent and Medway is ideally placed to be a national lead for our community services to deliver care through the integration of patient pathways, development of best practice and a workforce dedicated to deliver care closer to home.

This community service prospectus is a key strand in NHS Kent and Medway's Operational Plan and our Shared Delivery Plan

Our partners and ourselves want to see transformation of services across all aspects of community healthcare, including measurable improved patient outcomes with reduced waiting times, enhanced quality of care and improved patient experience.

It is essential these aspirations are brought about through collaboration, partnerships, patient engagement and the implementation of new models of care at pace.

It is with great anticipation that I await to see how you feel your organisation can support and deliver our vision for the transformation of community services across Kent & Medway.

Paul Bentley
Chief Executive
NHS Kent and Medway

1. Introduction

This document sets out our intention to transform the provision of services outside of hospital for the population of Kent and Medway. These ambitions will cover all four Health and Care Partnership (HCP) areas:

- Dartford, Gravesham and Swanley
- East Kent
- Medway and Swale
- West Kent

We have provided the key features we believe should feature in a new model of care as part of the transformation of these services, as well as key considerations, principles, and broad transformational outcomes.

1.1 Strategy

The ICS developed an interim strategy for Kent and Medway in 2022, with a final version published in April 2024. Broadly, there are six outcomes in the strategy, which you can see in this infographic.

Read the full strategy here: CS56370_Care_Strategy-final-accessible_v3.pdf (kmhealthandcare.uk)

We are aware that in parts of our community, there is variation and inequality in terms of access to services and delivery, as well as the potential for duplication, fragmentation and a lack of consistency and efficiency. Our aim through this transformation project is to eliminate the variation and reduce inequalities by providing equitable services across all four HCPs.

1.2 Transformation Principles

Ourselves and our provider partners will need to demonstrate the following principles in the delivery of transformation:

- To deliver a patient centred approach that empowers patients, families and carers, and addresses people's needs.
- To focus on integrating services into local neighbourhoods, operating without duplication and fragmentation of provision, whilst maintaining national standards of quality and safety, and supporting the 'Green Agenda' by utilising existing resources including estates and IT.
- To work in partnership with the community, social services, and the voluntary sector, redesigning major pathways to integrate acute and community care, increasing care outside of a hospital setting.
- To increase personalised care, support, or treatment in a holistic approach outside of a hospital setting that includes physical and mental health.
- To improve public health and reduce health inequalities by investing in prevention and health promotion. This will address the social, economic, and environmental determinants of health in the community.
- To develop workforce models that ensure a flexible, responsive, and sustainable workforce. These will be based on national skills and competencies for community working without increasing the workload on General Practice.
- To improve technology, data sharing and information so that quality and efficiency of services are enhanced.

In addition, it will be expected that the transformation programme aligns to the Fuller Stocktake Report (2022)[1] in regard to the creation of Integrated Neighbourhood Teams to bring together formerly siloed teams and enhance care for entire populations and other national guidance as set out below.

We know our residents and patients are at the heart of all our work and as such, we will be looking for our future provider/s to co-design services with our current and potential service users, as well as other stakeholders from across the ICS.

2. Adult Services

2.1 Challenges

The Kent and Medway population is currently circa 1.9 million people and is forecast to increase by about 25% by 2031.

In Kent and Medway, people in more affluent areas live longer than those living in more deprived areas. Kent is varied in its demographic - Tunbridge Wells has been shown to be its least deprived area, while south Thanet is the most deprived. Coastal towns, of which Kent and Medway has many, are often areas of poorer health (increases seen in long term conditions (LTCs) such as COPD and CHD) and high deprivation. Medway contains some of the most deprived neighbourhoods in England; these are in Gillingham and Chatham.

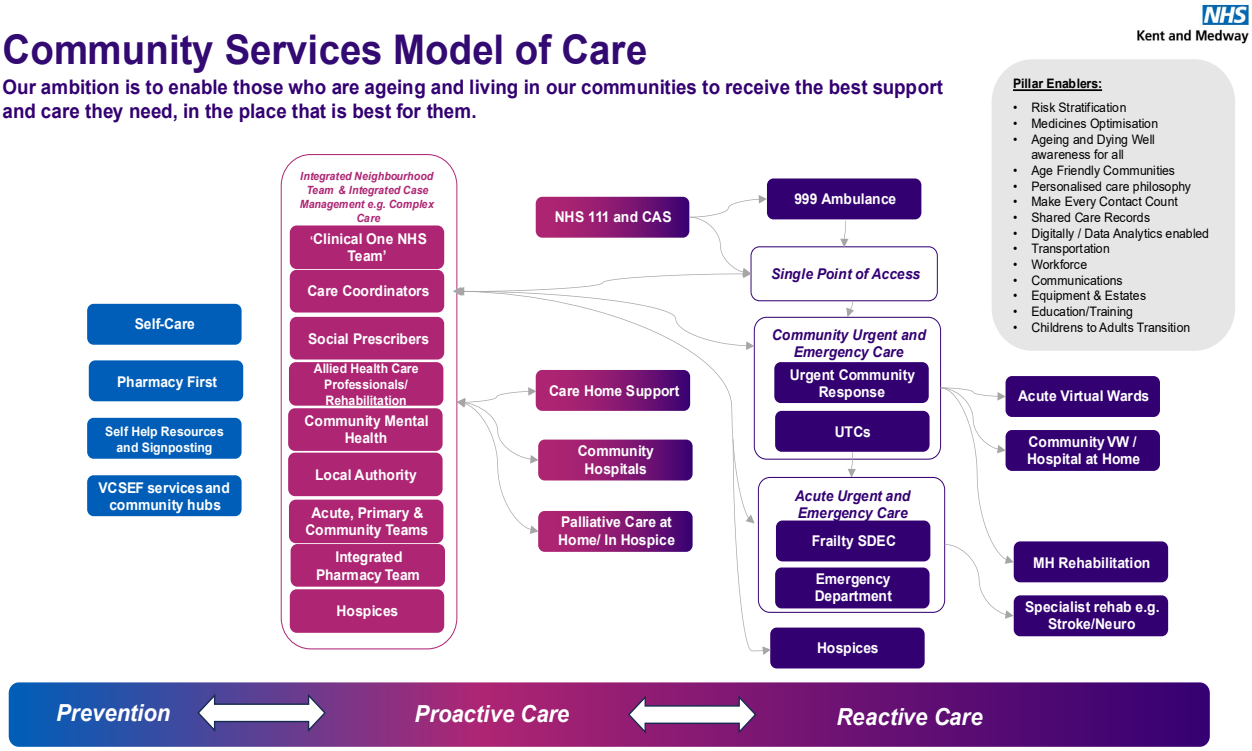
[1] Fuller Stocktake Report (2022) Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)

As with many areas of the UK, Kent & Medway has an ageing population, however life expectancy is significantly shorter for some groups of people, including homeless people, people with learning disabilities and people with severe mental illness, compared to the general population. We also are seeing an increase in people having two or more LTCs with 60% of people aged 75+ now having two or more co-morbidities in Kent.

The Armed Forces community includes serving personnel (Regular and Reservists), former service personnel and their family and carers. In Kent and Medway, this community is about 8-10% of our population and is a group that frequently experiences health inequalities and poorer access to healthcare as a result of developing more complex needs during or following their service.

2.2 New Model of Care

A new model of care for how Adults community health services are delivered in the context of the Kent and Medway health and care system will be co-designed with the public and providers to ensure integrated, fit for purpose, and VFM services are developed. An initial draft model is shown below.



Associated outcomes and measures will need to be developed – see **Appendix** for examples.

2.3 Transformational Service Areas

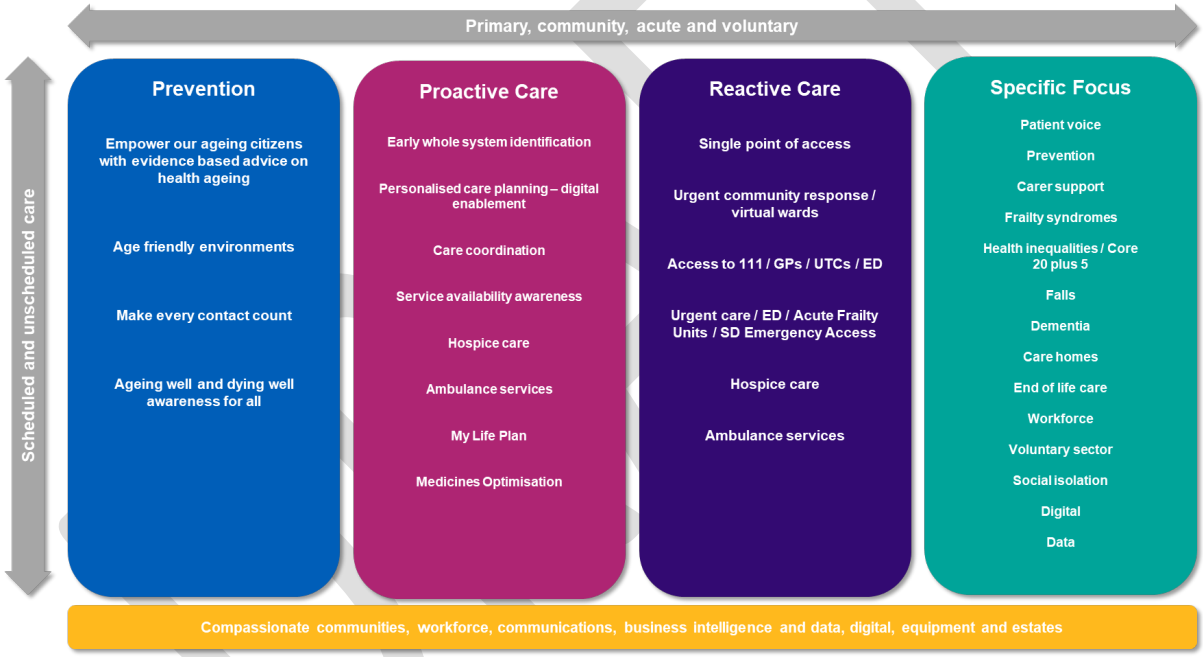
2.3.1 Ageing Well

Our ambition is to enable those who are ageing and living in our communities to receive the best support and care they need, in the place that is best for them.

There is a collective agreement to move to a different model of care where:

- We will be guided by the voice of our ageing communities.
- Ageing and dying is not just a medical matter, but a societal matter, and we will support all involved in Kent & Medway.
- People age well and stay well so they can enjoy the best quality of life for as long as possible.
- When people do need healthcare, we move to an out-of-hospital model, delivering services in the community and at home as much as possible with a single front door
- As people reach the latter stages of life, it becomes normal to have an end of life plan so people are supported to die at home if that is their wish.

Implementation of the ageing well strategy and models of care to ensure our communities have the best possible health care to age well and sustain health living. This includes integration and adaption of the World Health organisation model for healthy ageing communities.



Kent & Medway Ageing Well Model-Our Ageing Well Pillars

This work will be led by the joint NHS and LA Ageing Well Board chaired by an ICB Clinical Lead.

Key Milestone / Deliverable:

- Year 1: We will have agreed an **implementation plan** for the ageing well strategy for Kent and Medway which you will have participated in creating and be integral to delivering.

Further Reading:

NHS England » Ageing well and supporting people living with frailty
NHS Long Term Plan » Ageing well
WHO's work on the UN Decade of Healthy Ageing (2021-2030)
Enhanced health in care homes: NHS Kent and Medway (icb.nhs.uk)

2.3.2 Community Nursing

Development of an **integrated neighbourhood model** with primary, community and social care colleagues.
Implementation will be supported by an agreed workforce plan, and a nursing and care skills development model based on national standards of care, enabled by a new training and development skills centre (see below).

This work will be led by the Integrated Neighbourhood Teams Committee, supported by the Kent and Medway Health and Care Academy.

Key Milestones:

- Year 1: An integrated neighbourhood model encompassing primary, community and social care.
- Year 2: A recruitment and retention plan for care, allied health and nursing workforce across out of hospital care.
- Year 2: Implementation of joint nursing and care teams in Neighbourhoods based on the agreed competency model.

Further Reading:
NHS England » Community nursing contribution
Putting neighbourhoods at the heart of integrated care - NHS Providers
Oustanding-Models-of-District-Nursing.pdf (qni.org.uk)

2.3.3 Community Out-Patients Appointments

All community out-patients to transition to EROS (Electronic Referral Optimisation System) processes and systems. OPA communication to be in line with the national validation standard, including the same waiting list management tools to be developed across community waiting times including patient portal, two-way text messaging, advice and guidance, and Patient Tracking List (PTL) management to reduce long waiters. Deployment of the elective care DNA management protocol will also be required. NHSE's new 'Faster Data Flows' to be used.

This work will be overseen by the Elective Care Programme Board, Chair to be a nominated Provider CEO/SRO from Kent & Medway.

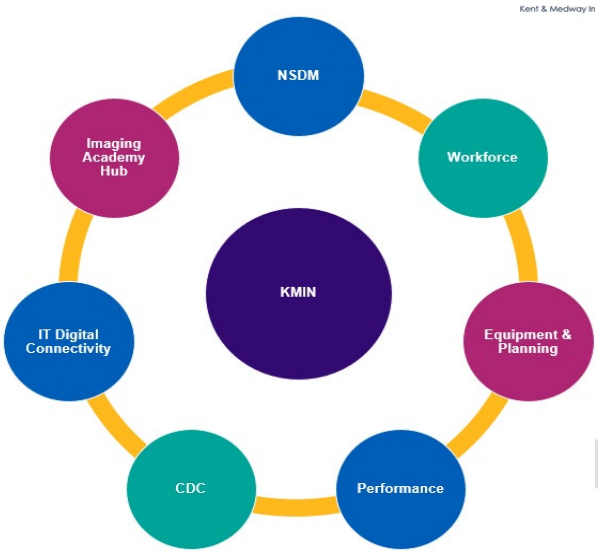
Key Milestones:

- Year 1: NHSE's new 'Faster Data Flows' to be used (in line with implementation timetable).
- Year 1: All community OPD will be on one dashboard, have been validated via the national validation standard and implemented the elective care DNA management protocol.
- Year 2: All community OPD will be on the EROS system, using shared PTL protocol and Kent and Medway access policy.

Further Reading:
Can we reduce waiting lists in community and mental health trusts? - News & Insights (thepsc.co.uk)
What matters when waiting? – involving the public in NHS waiting list prioritisation | The Strategy Unit (strategyunitwm.nhs.uk)

2.3.4 Diagnostics

Integration of our diagnostic investigations will be essential to development of seamless community pathways. Integration and alignment of phlebotomy, screening, and CDC capacity to our community services is key to developing full and robust patient pathways.



Kent & Medway Imaging Network

This work will be overseen by the Diagnostic Board and chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestones:

- Year 1: An implementation plan will be agreed for mapping health inequalities across neighbourhoods to help inform areas of need.
- Year 1: Further to the development of PTL for endoscopy involving mutual aid across Trusts, to be widened to cover other relevant diagnostics modalities.
- Year 2: Systems will be in place to support primary, community and secondary care in appropriate and timely ordering of imaging; iRefer-CDS risk stratification tool will be fully rolled out and integrated with EROS; GP order comms will further improve this by electronic ordering of imaging.
- Year 2: All localities will have live operational CDC sites to support capacity in the community.

Further Reading:

NHS England » NHS to introduce 'one stop shops' in the community for life saving checks
Why do diagnostics matter? | The King's Fund (kingsfund.org.uk)
What are diagnostics, and how are diagnostics services performing? | The King's Fund (kingsfund.org.uk)
Diagnostics: a major priority for the NHS - PMC (nih.gov)

2.3.5 Elective Community Hubs

The introduction of elective community hubs, which bring together elective care in the community at scale. This will include endoscopy provision, surgical capacity hubs in the community, same day emergency care and coordination's hubs for long term conditions. Within the first 12 months, a 'blueprint' will be agreed for the development of provision across Kent and Medway in Neighbourhoods.

This work will be led by the Primary Care Team working with the Elective Care Board, Diagnostic Board and Community Collaboratives alongside HCPs. A task and finish group chaired by the ICB CDO will be set up to oversee the implementation of the centres.

Key Milestones:

- Year 1: A blueprint for all HCP areas and integration of Pharmacy, Ophthalmology and Dentistry (POD) will be co-developed.
- Year 2: The provider will have collaborated to co-design with the ICB an estates plan to utilise current resources and estate for endoscopy hubs, elective community hubs and include pharmacy, podiatry and optometry**.**

Further Reading:

The multispecialty community provider (MCP) emerging care model and contract framework (england.nhs.uk)
NHS England » Hundreds of thousands more patients to benefit from major NHS surgical capacity boost
Strategies to reduce waiting times for elective care | The King's Fund (kingsfund.org.uk)
NHS England » NHS and social care hub helps people at risk stay well and out of hospital

2.3.6 End of Life Care (EoLC)

Delivery aligned with our ambitions in terms of the integration of community teams for EoLC is crucial to achieve the best outcomes for patients and families during end of life.

The implementation of a single integrated system for EoLC including early identification, personalisation and co-ordination of 24/7 out of hospital capacity will be key to support access to care and achieving what matters to people at end of life.

Principles of EoLC

This work will be overseen by the End-of-Life Committee and chaired by an ICB Clinical Lead.

Key Milestone:

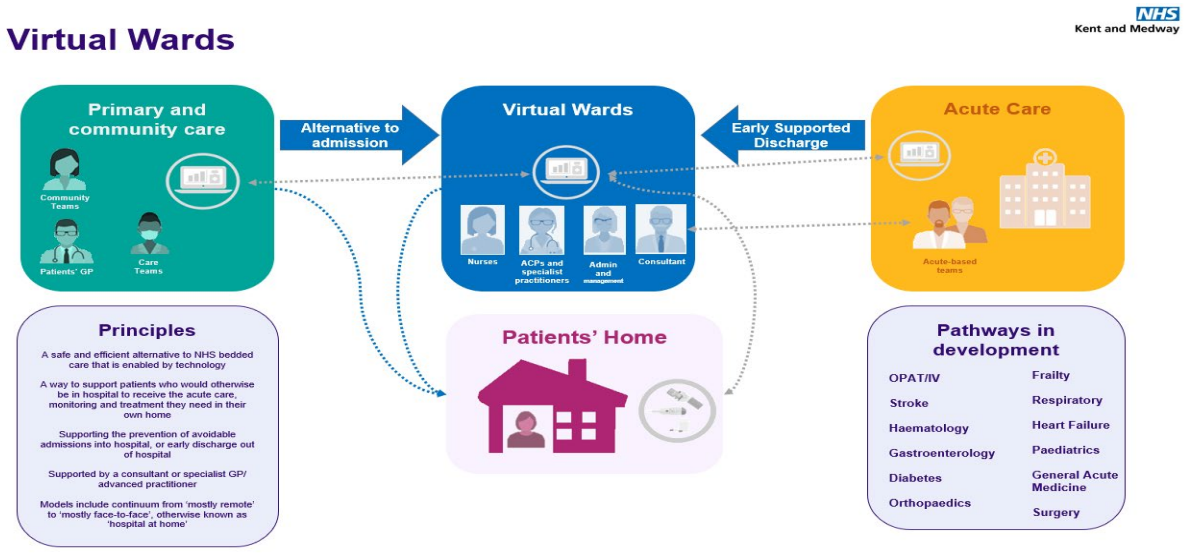
- Year 1: A single integrated end of life service.

Further Reading:

Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf (england.nhs.uk)
What end of life care involves - NHS (www.nhs.uk)
Dying Matters | Hospice UK

2.3.7 Frailty

An agreed frailty model that maintains patients in their normal place of residence will be implemented at scale. This will include frailty out of hospital hubs, virtual ward capacity and rapid equipment deployment. The new model of care for ageing well will be embedded in the frailty model with focus on prevention, reduction in social isolation, enabling communities to care for older people and an increase in respect and recognition for care of older people.



Kent & Medway Virtual Ward Model

This work will be led by the Frailty Steering Committee, chaired by an ICB Clinical Lead.

Key Milestones:

- Year 1: Virtual ward frailty capacity across all of Kent and Medway and integrated frailty teams within community and acute, with an agreed costed workforce plan.
- Year 2: A system-wide frailty service which can scale to demand predictions.

Further Reading:

B1207-ii-guidance-note-frailty-virtual-ward.pdf (england.nhs.uk)
NHS Long Term Plan » Ageing well
Social isolation - Oxford Health NHS Foundation Trust
What is the value of an older person's life? | Discover | Age UK

2.3.8 Integrated Specialist Services

All specialist consultant services which can be integrated should be integrated, a review of this will be undertaken via the acute collaborative. Integrated Stroke service, integrated Dermatology service and integrated Rheumatology service will be the focus for the first year of transformation.

This work will be overseen by the Elective Care Board-Pathway Team and chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestone:

- Year 2: Integrated pathways will be in place for Stroke, Dermatology and Rheumatology.

Further Reading:
NHS England » What are integrated care systems?
NHS England » National Stroke Service Model: Integrated Stroke Delivery Networks
Transforming dermatology services in the East of England - Technology for the NHS - NHS Transformation Directorate
Rheumatology pathway - Rheumatology digital playbook - NHS Transformation Directorate (england.nhs.uk)

2.3.9 Intermediate Care

We will implement a new intermediate care model which transfers patients from acute within 24/48 hours of the clinical ready for discharge decision.

The new model will include redesigning Integrated Discharge Teams (IDT) into Transfer of Care Hubs, increasing domiciliary care capacity (to work in conjunction with services commissioned by LA's), home care support at scale, and voluntary sector integration and development.

This work will be overseen by the Social Care, Primary Care and Community Care Collaborative which will be chaired by a nominated provider CEO/SRO from Kent & Medway.

Key Milestones:
- Year 1: An agreed Transfer of Care Hub model and have implemented new integrated discharge teams on all acute and community sites.
- Year 2: A new intermediate care model which delivers at scale home care and domiciliary care.

Further Reading:
Understanding intermediate care, including reablement | Quick guides to social care topics | Social care | NICE Communities | About | NICE
Multi-disciplinary / multi-agency discharge teams | Local Government Association
NHS England » Voluntary, community and social enterprise sector partnerships

2.3.10 Rehabilitation

A new model for rehabilitation will be developed which places the patient at the centre of an MDT which facilitates rapid rehabilitation against agreed rehabilitation goals.

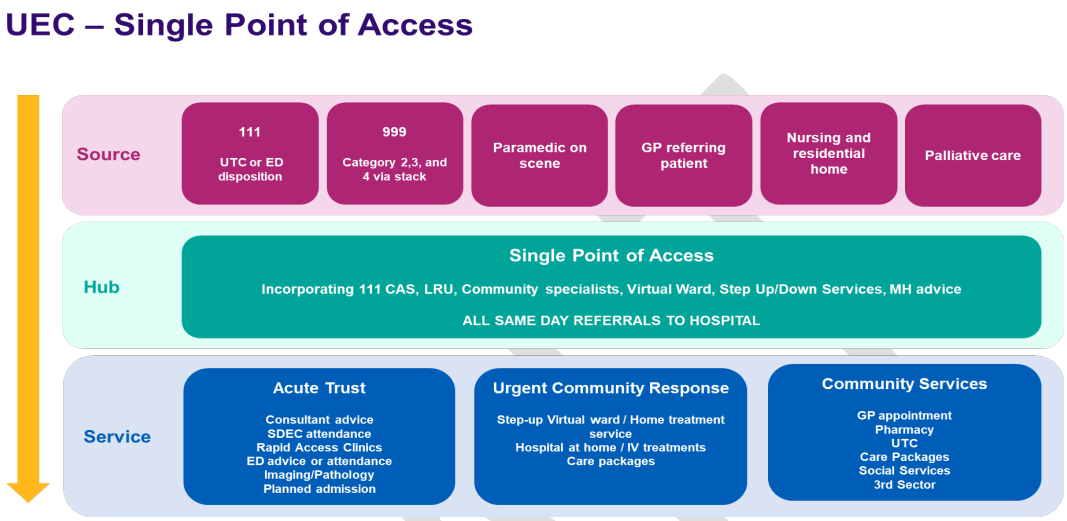
This work will be overseen by the Social care, Primary care and Community collaborative, chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestones:
- Year 1: A new model of care will be agreed for rehabilitation.
- Year 2: Implementation of the new model with improvements in patients in acute and community hospitals being discharged to pathways zero, one, two and three.

Further Reading:
Goal Setting in Rehabilitation - Physiopedia (physio-pedia.com)
Commissioning guidance for rehabilitation (england.nhs.uk)
Layout 1 (england.nhs.uk)

2.3.11 Single Point of Access - Out of hospital Urgent Care

A single urgent care system, coordinated via an urgent care hub, will be implemented to ensure patients are provided with care out of hospital as much as possible. This includes primary care streaming for urgent appointments, community treatment centres, frailty hubs/assessment centres, virtual ward and 2-hour community response and other out of hospital services to prevent acute hospital admission. Overnight services will be incorporated into this single urgent care system to ensure services out of hospital 24/7.



Kent UEC SPoA Model

This work will be overseen by the UEC Board and chaired by a nominated Provider CEO/SRO from Kent & Medway.

Key Milestones / Deliverables:

- Year 1: The provider(s) will have collaborated with the ICB to develop an out-of-hospital urgent care hub coordinating urgent care and managing patients' pathways to the relevant services.
- Year 2: A Kent and Medway urgent care system that can flex and scale over the next 8 years to meet our patient demand.

Further Reading:

NHS England » NHS and social care hub helps people at risk stay well and out of hospital
NHS England » Urgent treatment centres
Transforming urgent and emergency care (nice.org.uk)
Re-envisioning urgent and emergency care | NHS Confederation

3. Children's Services

3.1 Challenges

There are some unique and significant challenges in meeting the needs of children and young people (CYP) across Kent and Medway. These challenges include but are not limited to, the geographical placement of support and care services, a diverse county of children and young people and growing demand of children and young people with complex needs. Kent also has areas of deprivation and poverty, and childhood deprivation is associated with higher rates of neurodevelopmental and mental disorders in adulthood.

Children differ from adults in at least 4 important ways:

- developmental change
- dependency on parents and carers
- differential epidemiology (e.g., different health, illness and disabilities)
- demographic patterns.

Children's use of health services is different to other age groups, for example, the rate of acute, short stay hospital admissions is higher and rising. Children may need to be transitioned from paediatric to adult services and have constantly changing needs in relation to their developmental stage and age.

Education is especially important, rather than social care, and there is a greater dependence on the family than social care, compared to adults. There is an opportunity to prevent physical and mental ill health in adult life by improving the health of CYP.

Despite the challenges, we are highly ambitious and aim to support our children, young people, and their families by transforming services to ensure they meet the needs of the individual, are of high quality, responsive and meet national standards and guidance.

NHS Kent and Medway aspires to work with partners who share our ambition and consider they have the right capacities and capabilities to respond to the challenges ahead. We wish to ensure that services have clear pathways, are aligned, and maximise efficiencies whilst improving outcomes. Our ambition is that provider(s) should work in partnership with Education, Social Care and the Voluntary Sector.

This approach has been informed by Joint commissioning approach for SEND (kent.gov.uk) developed in collaboration with Kent County Council, which sets out our commitment to working jointly to improve the outcomes of all children and young people.

3.2 Transformation Principles for CYP Services (excluding CYP Mental Health Services)

Vision Statement

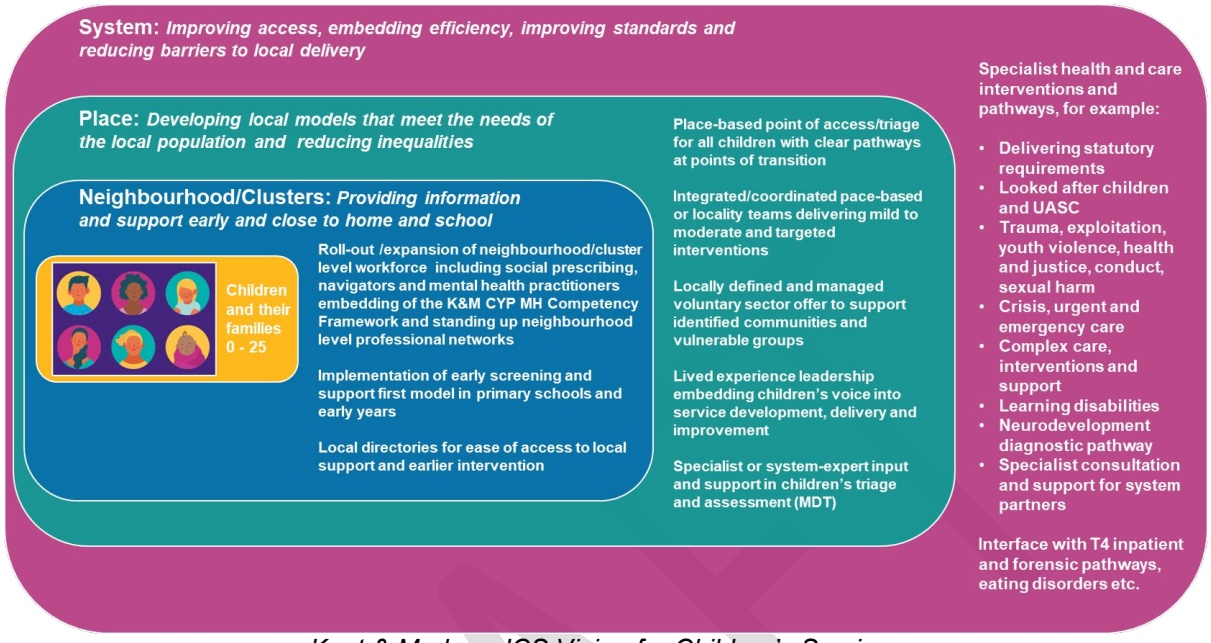
Support children and young people to achieve; through living healthy, safe lives in which they feel seen and included.

Principle	Principle Focus Areas
Quality of Care: As part of the NHS Kent and Medway's strategy to give Children and Young People (CYP) the best start in life, services will ensure that all CYP have the conditions and support they need to be healthy, resilient and ambitious about their future. Every child should have access to high quality, evidenced based services designed to reduce the impact of illness on the child and their parents, caregivers and families.	1. The right provision, at the right time, in the right place 2. Evidence based practice 3. Positive behaviour support 4. Service improvement and user engagement

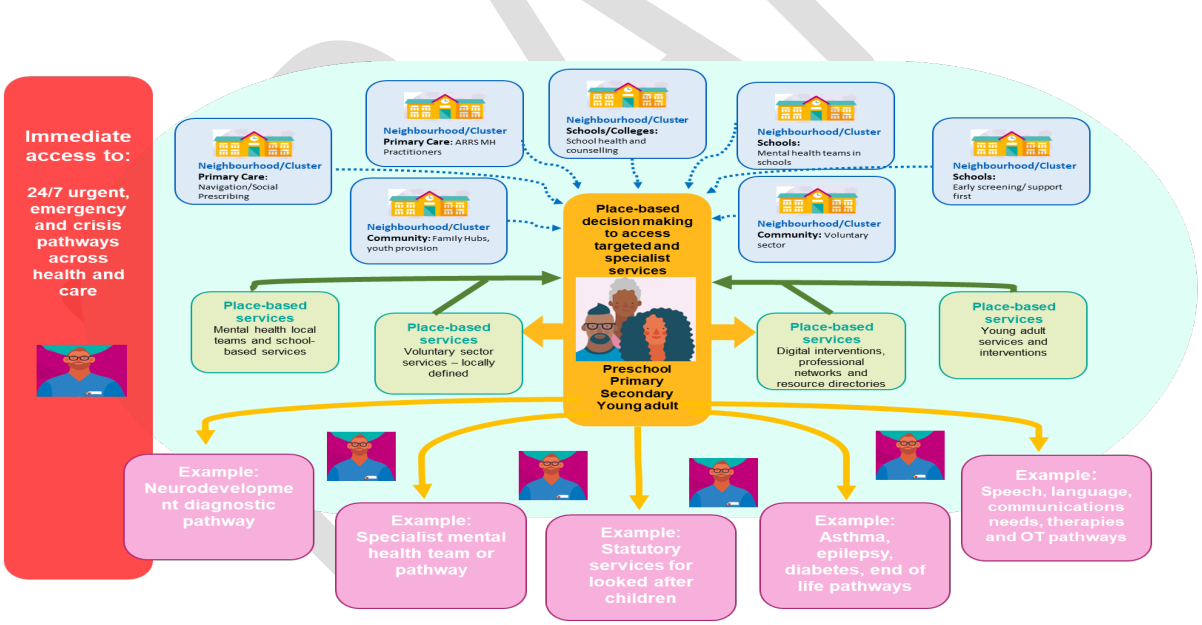
	5. Innovation and Technology
Addressing Health Inequalities: Health inequities will be addressed by providing equitable care based on need. CYP will receive the right care, in the right place, at the right time. Central to our approach is a commitment to eliminating disparities in access to healthcare and treatment outcomes. We will focus on identifying the barriers faced by different groups of children and young people and implementing targeted initiatives to overcome these challenges. In this way, we ensure equitable care for all populations, promoting a healthier future for every child.	1. Social prescribing 2. Supporting diversity 3. Supporting inclusion 4. CYPCore20PLUS5 Programme 5. Social value 6. Population health management
Personalised Care: CYP and their families will be at the heart of decision making and the health outcomes that matter most to them will take priority. The aim is to enhance their overall experience through facilities and interactions that promote comfort, confidence and wellbeing.	1. Early identification and response to increased need 2. Family centred care 3. Creating a clinical management plan for the child that meets their individual needs. 4. Development of shared service pathways
Transition: Move towards 0–25 year-old service models for those with Special Educational Needs and Disabilities (SEND) that provides person-centred and age-appropriate care for mental and physical health needs, with a planned transition to adult services according to health need.	1. Effective and appropriate transitions 2. Partnership Working 3. Preparation for adulthood
Leadership & Accountability: There should be clear leadership and accountability and all organisations will work in partnership to achieve agreed outcomes for CYP and families. This will include collaboration and coproduction in service transformation. There is a commitment to continually improving the skills and abilities of our healthcare professionals. By investing in ongoing training and development, the aim is to equip professionals with the latest knowledge and tools they need to provide high quality care.	1. Flexibility and change 2. Partnership working 3. Workforce management and leadership 4. Achieving the best skill mix 5. Workforce competencies 6. Move from Outputs to Outcomes 7. Development of shared service pathways 8. Advocating for the child and family.

3.3 New Model of Care

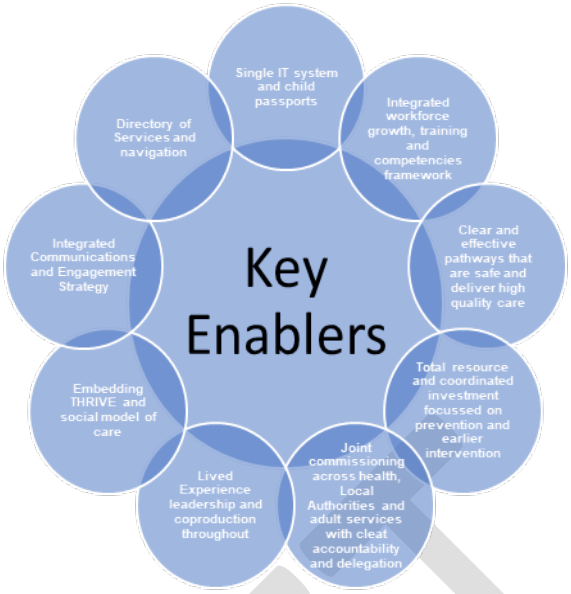
A new model of care for how Children's services are delivered are needed and co-design is needed to ensure that an integrated children's model of care is developed, for example, the diagrams below show the ICS vision for how services will align.



Kent & Medway ICS Vision for Children's Services



Kent & Medway ICS integrated model of care for Children's Services



Key Enablers identified for Kent & Medway Children's Services

3.4 Transformational Service Areas

It is our ambition to implement the new model of care which demonstrates the following outcomes:

3.4.1.Integration

A holistic model will be in place which covers primary, acute, and community CYP care through seamless pathways, reducing duplication and handovers and families repeating their stories.

- This will enhance opportunities to join up with existing Transformation programmes, including Long Term Conditions, requirements of CYP Core2PLUS5 Programme, Public Health and School Nursing, a new model of care for the Neurodevelopmental Support Pathway, transformation of the CYP Mental health service, and expansion of virtual wards.
- Review and address local inequalities in health provision resulting from historic commissioning arrangements.

Key Milestones:

- By end of year 2, the provider will have collaborated with the ICB and wider system partners to develop a plan for a seamless CYP pathway across health and social care services.
- By end of year 3, there will be an alignment of services with a single shared record (supported by the ICS Digital Strategy).

3.4.2. Locality

- Where clinically appropriate, all services will be based as close as possible to CYP place of residence or education setting, delivered through a single integrated model demonstrating involvement from primary, secondary, and community care.

- There will be equity of access to services for all CYP and reduced organisational and professional boundaries.
- Where appropriate, CYP with long term conditions will be seen as part of a multi-disciplinary clinic.

Key Milestones:

- By end of year 2, the provider(s) will have collaborated with the ICB to develop a plan to deliver Multi-Disciplinary Team (MDT) clinics for identified services at neighbourhood level.
- By end of year 2, integrated pathways will be in place between primary, community, and secondary care, for CYP with long term conditions.

3.4.3 CYP Elective Community Care

- Following CYP elective care treatment, community services will develop effective transfer arrangements with Acute Paediatric Services for CYP to be cared for in the community, as appropriate.

Key Milestones:

- By end of year 2, providers will have collaborated with the ICB to provide feedback concerning the development of Kent and Medway surgical hubs schemes designed to benefit CYP and adults.
- By end of year 2, providers will have collaborated with the ICB to provide feedback concerning non-complex elective activity in non-specialist centres (utilising existing estates) where capacity allows, with day case rates a minimum of 95% with a top-level target of 98%.

3.4.4 Looked After Children

- Services for Looked after children will be standardised across Kent and Medway, with a single IT system and dashboard. This will clearly reflect performance against statutory timescales and allow early identification of capacity and demand issues.

Key Milestones:

- By end of year 2, clinical templates and electronic records for looked after children will be standardised across Kent and Medway.
- By end of year 3, there will be a single IT system and reporting dashboard for looked after children.

3.4.5 Therapies

- Services for children with Special Educational Needs and Disabilities (SEND) in Kent will meet the requirements of the Accelerated Progress Plan (APP), developed in collaboration with system partners.
- SEND services for CYP in Medway will meet the requirements of the Medway Local Area Plan (LAP), in partnership with the wider Kent and Medway system.
- A plan will be developed to Implement the Balanced System Approach for Speech, Language and Communication Needs across Kent and Medway and to consider application of the approach across all therapy services.
- A plan will be developed to reduce waiting times. NHS England (NHSE) data from January 2022 estimates that over 900,000 children and adults are waiting for care

in the community. There are significant wait times for speech and language therapy, community paediatrics, occupational therapy, physiotherapy and neuro-developmental assessments for those with suspected autism and attention deficit hyperactive disorder.
- Develop a plan for multidisciplinary integrated care, which allows for a co-ordinated approach to gathering information and guidance, as well as input from a wide range of professionals.

Key Milestones:
- By end of year 1, waiting times will be reported on a new CYP dashboard.
- By end of year 1, providers will have collaborated with the ICB to meet the requirements of the APP and LAP to reduce waiting times.

3.4.6 CYP Community Nursing
- There will be a clear shift to a community based, integrated health and social care model with a focus on admission avoidance, early discharge and greater support for families and carers for CYP with complex needs in the home and other community settings. This will include community in-reach support into acute hospitals where appropriate.
- There will be a clear plan to develop and extend the role of nurse prescribers.
- There will be a clear plan to minimise the impact of illness on children, young people, and their families and to manage transition effectively.
- A demand and capacity study will be undertaken, to review the impact of growth in demand as seriously ill children live for longer with multiple complex health conditions.

Key Milestones:
- By end of year 2, providers will have collaborated with the ICB to develop a clear plan to address capacity and demand issues.
- By end of year 2, providers will have collaborated with the ICB to develop a plan to extend the role of nurse prescribers.

3.5 Interdependencies
In addition to the areas listed above, significant transformation work is underway across the following pathways, which will impact on the transformation of CYP community services. It is therefore expected that all partners will work collaboratively where interdependencies exist. The following list provides examples of interdependencies but is not exhaustive.

- Public Health Services, including Nursing.
- Local Authority therapy services.
- Children's Emotional Wellbeing and Mental Health Services.
- Neurodevelopmental Pathway.
- All Age eating Disorder Services.
- Acute Paediatric Services.
- Local Authority owned children's facilities i.e. Multi-Agency Specialist Hub units and Residential Short Break centres.

- Local CYP Hospices.
- Voluntary Care Sector Organisations.
- Local Family Hubs and Start for Life programmes.
- Education Settings and identified settings where CYP may not be in formal education.
- Integrated Neighbourhood Teams delivered in primary care.

4 Transformation Enablers – Adult and Children's Services

4.1 IT / Digital

Digital transformation will enable the fulfilment of the goals outlined within the ICS strategy and the corresponding CYP and Adult services strategies and models of care. Modern integrated digital tools will be utilised that:

- provides a seamless digital front door for patients and carers that enables self-care options (where appropriate), access to their records and ability to manage referrals and appointment bookings to improve patient experience
- supports health and care professionals' delivery more effective and efficient safe and high-quality care
- provides a directory of services that is readily available, maintained, and easy to navigate for patients and professionals
- keeps patient flows and the capture of high-quality consistent data at the heart of all design and integrations
- are interoperable to support seamless transfer of information between organisations and across care pathways.

The ICB's ambition is to rationalise the numbers of systems to reduce complexity and risk and where possible converge on single IT systems that are compliant with NHS cyber and data standards.

Standardisation will be a key tenet within all future digital developments to reduce errors and delays in the provision of care and allow for the better use of data and reporting, with Faster Data Flows (FDF) being utilised for reporting on one standardised dashboard.

Faster Data Flows will also ensure that Providers are able to meet all mandatory local and national requirements for data submissions. For patients and their carers, data flows will be bi-directional with two-way text messaging, advice and guidance being utilised to reduce long wait times and waste within the system.

Key Milestones:
A connected health and care system means that information can flow safely and seamlessly between IT systems, care providers and settings. The insights generated from it can help to tailor services to the needs of populations, enable more targeted care and reduce unnecessary interventions.

Therefore, the provider will:

- work with the ICB to digitise services, connect them to support integration and, through these foundations, enable service transformation.

- adopt digital tools to address our long term health improvement goals.
- set out plans to adopt new technologies and innovation including providing a single digital front door to services for citizens and support for self-care within the first year of service operation.

Further Reading
FutureNHS Collaboration Platform - FutureNHS Collaboration Platform
Community Services Data Set Directions 2020 - NHS England Digital
https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/secretary-of-state-directions/community-services-data-set-directions-2020

4.2 Patient and Community Involvement

People who use services, families and local communities will be involved in the transformation of community health services across Kent and Medway from the start of this programme. There will be an emphasis on reaching into communities who are less likely to get involved, and who may have been poorly served by community services. Patient experience will be reviewed regularly and will be used to improve services.

We expect partners to develop an approach to involving people with lived experience and also communities in the transformation – particularly those who are currently underserved by community healthcare services and the Core 20 + communities building on existing evidence of patient experience and will involve a robust series of listening exercises which offer multiple accessible ways to get involved. All partners will be expected to show how they have taken account of people's views in the transformation to demonstrate how engagement and involvement has made a difference. We recognise that Healthwatch Kent and Healthwatch Medway and community and voluntary sector organisations across Kent and Medway play a key part in engaging with communities and they will be partners in involving people.

An ongoing approach to involvement and engagement will take place with further decisions about developing services continuing to involve people, patients and communities.

The present systems of gathering information about patient experience will be reviewed to gain live and strategic patient views and opinions which will be used to improve services. This may include reviewing service information and accessibility to ensure that it is as simple as possible to access information on self-care, community services and acute care.

The community redesigned services will review and increase information on self-care to enable patients to take responsibility for their health and well-being, as well as the extension of Personal Health Budgets.

CYP

Children and young people will be involved in the transformation of services in collaboration with our partners incorporating the work already started with "Blue Lozenge" to listen to the views of children and young people. We will explore the use of communication channels that are commonly used by CYP on social media platforms.

A new steering committee will be established to review present patient information and engagement methods, this will include seeking external support from leading experts in engagement and public communication. This will be chaired by an independent member of the public or patient representative, such as Healthwatch.

Key Milestone:

- We will have reviewed the current communication and engagement methods and made recommendations to implement a new communications and engagement model.

Further Reading:

Understanding integration: how to listen to and learn from people and communities | The King's Fund (kingsfund.org.uk)
ppp-involving-people-health-care-guidance.pdf (england.nhs.uk)
People in control of their own health and care | The King's Fund (kingsfund.org.uk)
PersonCentredCareMadeSimple.pdf (health.org.uk)

4.3 Skills Development

Building on the work of the Kent and Medway Health and Care Academy, we will build a collaborative model for education and careers, co-designed between education providers and employers. It will enable a robust pipeline of local workforce, maximising the use of apprenticeships and direct routes into health and care employment.

The academy will also support providers to drive forward their role as Anchor Institutions, creating employment programmes to address long term and youth unemployment, increase employment opportunities for individuals with learning disabilities and neurodiversity, carers, our armed forces community, and widen participation from underrepresented groups.

It will lead the development of innovative workforce models aimed at meeting long-term challenges around recruitment and retention, resulting in a highly trained and competent workforce.

Organisations will work together to complete workforce planning, developing workforce plans that drive new models of care and address local population needs.

The intention will be within the first 6 months for the Health and Care Academy sub-group to have developed a work plan to implement community nursing skills, role development and recruitment.

Key Deliverables:

- An agreed model for community skills development will be in place.
- An agreed short-, medium- and long-term recruitment and retention plan will be in place.

Further Reading:

Training Hubs | Health Education England (hee.nhs.uk)

5. Summary

Kent and Medway wants to work in partnership to transform the way we develop service models, both now and in the future.

It is imperative that our patients, clients and service users are cared for in the right place, by the right person and at the right time – first time.

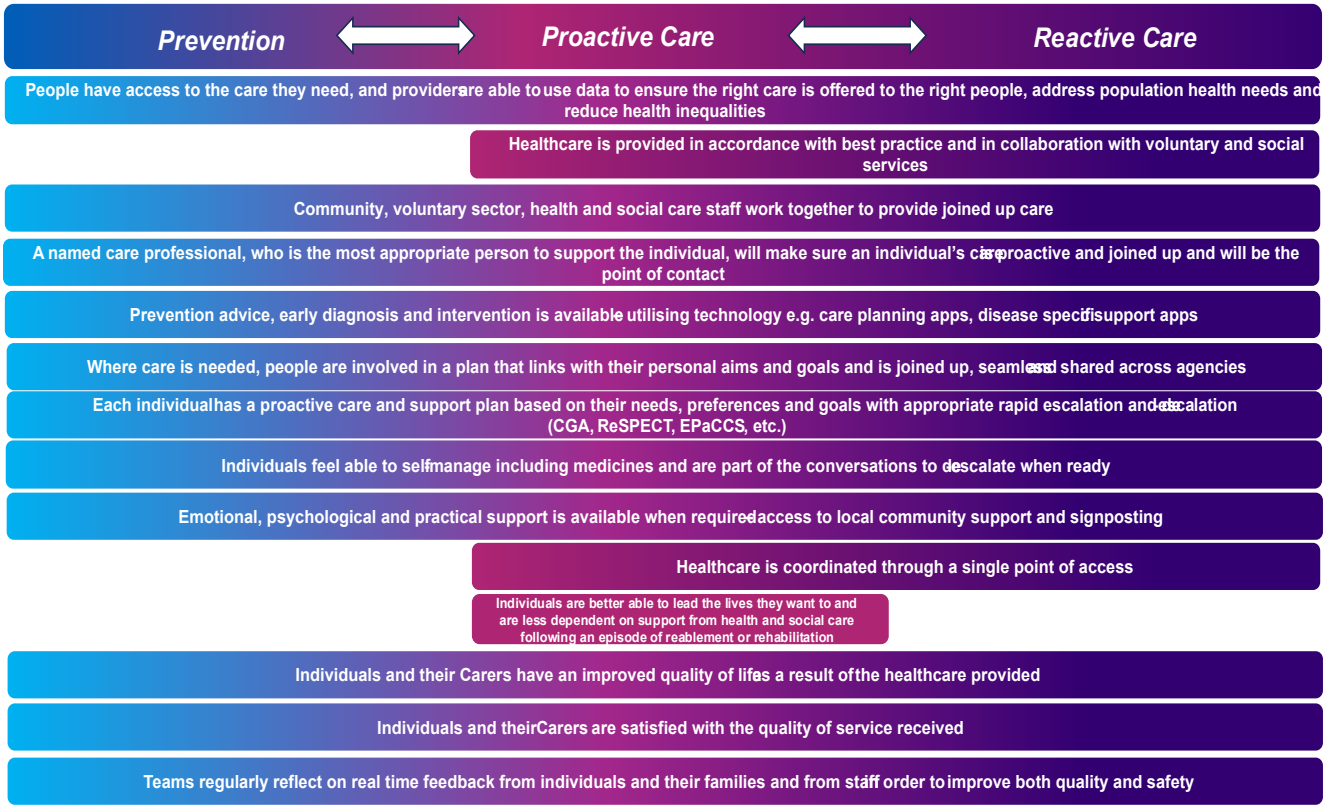
Our Ambitions will inform service transformation planning, with milestones and deliverables confirmed through the costed Service Development Improvement Plans (SDIP) for the initial years of the contract, ahead of on-going transformation work throughout the contract lifecycle.

This work will be supported by a Community Improvement Committee whose role will include the regular review of service specifications, to reflect the changes from the implementation of our Ambitions, ensuring redesigned community services – adults and CYP - are fit for the future.

Appendix

Adult Services – Outcomes and Measures Examples

Community Services Outcomes



Community Services Measures