AGENDA

COMMUNITIES, HOUSING AND ENVIRONMENT COMMITTEE MEETING

Date: Tuesday 13 December 2016
Time: 6.30 pm
Venue: Town Hall, High Street, Maidstone

Membership:

Councillors Barned, M Burton, Joy, D Mortimer (Vice-Chairman), Perry, Mrs Ring (Chairman), Mrs Robertson, Webb and Webster

Page No.

1. Apologies for Absence
2. Notification of Substitute Members
3. Urgent Items
4. Notification of Visiting Members

Continued Over/:

Issued on Monday 5 December 2016

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact Caroline Matthews on 01622 602743**. To find out more about the work of the Committee, please visit www.maidstone.gov.uk

Alison Broom

Alison Broom, Chief Executive, Maidstone Borough Council, Maidstone House, King Street, Maidstone Kent ME15 6JQ

5. Disclosures by Members and Officers

6. Disclosures of Lobbying

7. To consider whether any items should be taken in private because of the possible disclosure of exempt information.

8. Minutes of the Meeting Held on 15 November 2016 — 1 - 6

9. Presentation of Petitions (if any)

10. Questions and answer session for members of the public (if any)

11. Committee Work Programme — 7 - 8

12. Report of the Licensing Committee held on 29 September 2016 - Draft Licensing Compliance and Enforcement Policy — 9 - 17

13. Report of the Head of Environment and Public Realm - Pest Control Arrangements — 18 - 25

14. Report of the Head of Housing and Community Services - Temporary Accommodation Strategy — 26 - 33

15. Report of the Head of Housing and Community Services - Kent and Medway Health and Social Care Sustainability and Transformation Plan (Draft) — 34 - 121

PART II

To move that the public be excluded for the items set out in Part II of the Agenda because of the likely disclosure of exempt information for the reasons specified having applied the Public Interest Test.

		Head of Schedule 12 A and Brief Description	
16.	Exempt Appendix to the Report of the Head of Housing and Community Services - Temporary Accommodation Strategy	Paragraph 3 – Info re Financial/business affairs	122 - 124

PUBLIC SPEAKING

In order to book a slot to speak at this meeting of the Communities, Housing and Environment Committee, please contact Caroline Matthews on 01622 602743 or by email on carolinematthews@maidstone.gov.uk by 5 pm one clear working day before the meeting. If asking a question, you will need to provide the full text in writing. If making a statement, you will need to tell us which agenda item you wish to speak on. Please note that slots will be allocated on a first come, first served basis.

MAIDSTONE BOROUGH COUNCIL

COMMUNITIES, HOUSING AND ENVIRONMENT COMMITTEE

MINUTES OF THE MEETING HELD ON TUESDAY 15 NOVEMBER 2016

Present: **Councillor Mrs Ring (Chairman), and Councillors Barned, Mrs Blackmore, M Burton, Joy, D Mortimer, Mrs Robertson, Webb and Webster**

Also Present: **Councillor Mrs Gooch**

92. APOLOGIES FOR ABSENCE

It was noted that apologies had been received from Councillor Perry.

93. NOTIFICATION OF SUBSTITUTE MEMBERS

It was noted that Councillor Mrs Blackmore was substituting for Councillor Perry.

94. URGENT ITEMS

There were no urgent items.

95. NOTIFICATION OF VISITING MEMBERS

It was noted that Councillor Mrs Gooch indicated her wish to speak on Agenda Item 14 – Review of CCTV – Findings and Options.

96. DISCLOSURES BY MEMBERS AND OFFICERS

There were no disclosures by Members and Officers.

97. DISCLOSURES OF LOBBYING

There were no disclosures of lobbying.

98. EXEMPT ITEMS

RESOLVED: That all items be taken in public as proposed.

99. MINUTES OF THE MEETING HELD ON 18 OCTOBER 2016

RESOLVED: That the Minutes of the meeting held on 18 October 2016 be approved as a correct record and signed subject to the following changes:-

Minute 82 – Report of the Head of Environment and Public Realm – Community Toilet Scheme:-

Under 'During the debate, the following comments were made by Members', a bullet point should be added:-

- That Officers would circulate a copy of the Agreement to all Members of the Committee

In addition, the voting for this item should read:-

For: 5 Against: 4 Abstentions: 0

100. PRESENTATION OF PETITIONS (IF ANY)

There were no petitions.

101. QUESTIONS AND ANSWER SESSION FOR MEMBERS OF THE PUBLIC (IF ANY)

There were no questions from members of the public.

102. COMMITTEE WORK PROGRAMME

It was noted that the Air Quality Working Group would be having their first meeting on 22 November 2016. Therefore it was agreed that a report would come to the February Committee meeting on their findings.

The Crime and Disorder Committee would meet prior to the normal Communities, Housing and Environment Committee meeting in December.

RESOLVED: That the work programme be noted.

103. REPORT OF THE DIRECTOR OF FINANCE AND BUSINESS IMPROVEMENT - SECOND QUARTER BUDGET MONITORING 2016/17

The Committee considered the report of the Director of Finance and Business Improvement which related to the Second Quarter Budget Monitoring 2016/17.

Members noted that the report provided an overview of the revenue budget and outturn for the second quarter of 2016/17. It also highlighted significant variances against the budget.

The Chief Accountant advised that a major contributor to the overspend on the budget was the temporary accommodation. Members were advised that the report coming to the December Committee would set out how the Council intended to tackle this issue.

Members were made aware that increased controls had been introduced across the Council, and would be closely monitored by the Corporate Leadership Team, in the following areas:-

- Recruitment
- Temporary Staff
- Discretionary Spending
- Contractual commitments

In response to enquiries from Members, Officers advised:-

- That the grounds maintenance section carried out work for Parishes but were looking to generate income undertaking more external work

- That the street cleansing overspend occurred mainly as a result of a lack of resources. A second review of the operation would take place in April/May next year.

RESOLVED: That the revenue position at the end of the second quarter and the actions being taken or proposed to improve the position where significant variances have been identified be noted.

104. REPORT OF THE HEAD OF POLICY AND COMMUNICATIONS - STRATEGIC PLAN PERFORMANCE UPDATE QUARTER TWO

The Committee considered the report of the Head of Policy and Communications on the Strategic Plan Performance Update Quarter 2 2016/17.

Members noted that 82% of the Key Performance Indicators (KPIs) for this Committee were on target for Quarter 2.

The Policy and Information Manager highlighted the areas where performance was on or above target.

In response to questions from Members, the Policy and Information Manager advised that:-

- All KPIs were reviewed on a regular basis and if it was considered that they should be amended or deleted, this would come back to the Committee for decision

- In terms of flytipping, Quarter 2 showed an expected increase from Quarter 1 due to a seasonal increase. This had been borne out by a 200% increase in construction and demolition waste and a 150% increase in garden waste.

- The Parish Liaison Officer's post was only funded for a year which would finish in December and it was noted that most of the objectives had been achieved.

RESOLVED:

1) That the summary of performance for Quarter 2 of 2016/17 for Key Performance Indicators (KPIs) and corporate strategies and plans be noted;

2) That the progress of strategic plan action plan at Appendix III to the report of the Head of Policy and Communications be noted;

3) That where complete data is not currently available, this be noted; and

4) That the performance of Key Performance Indicators from Quarter 1 of 2016/17 for which data was not available at Policy and Resources Committee on 26 July 2016 be noted.

105. REPORT OF THE HEAD OF HOUSING AND COMMUNITIES - REVIEW OF CCTV - FINDINGS AND OPTIONS

The Committee considered the report of the Head of Housing and Communities which summarised the findings from the review of CCTV funding carried out June – October 2016 and recommended what options should be developed in more detail to be reported back to the February Committee meeting.

It was noted that the CCTV operation costs the Council in the region of £340,000 a year, the operation of the 95 static cameras are monitored 24/7 and maintained by Medway Council at a cost to the Council of £315,000. The Council also operates 28 mobile cameras which are administered by a PCSO, the Council pays half of the salary of the postholder. The cost of the mobile CCTV service was in the region of £25,000.

Officers advised that at present Medway Council maintain the CCTV system on behalf of the Council as part of a partnership agreement with Medway, Swale and Gravesham Councils. The CCTV partnership agreement expires on 31 March 2017 and discussions had been held with the other councils and the provider with a view to extending the partnership agreement for 12 months and the consideration of what level of service is required.

Members' attention was drawn to the key findings of the review set out in the report. The review found that CCTV by itself was not particularly effective in preventing crime and disorder, although it was more effective when used with other interventions.

It was noted that Kent Police and the Police Crime Commissioner had made it clear that they would not be able to contribute towards the annual ongoing revenue cost of CCTV.

Councillor Mrs Gooch addressed the Committee as a Visiting Member and as the Council's representative at the Kent and Medway Police and Crime Panel. She advised that in attending the Panel she had taken the opportunity to ask the Police Crime Commissioner (PCC) what impact it

would have on the police service in their investigation of crime if the Council reduced its CCTV operation.

In his response the PCC stated that in reviewing the CCTV operation Councils should be mindful to consider the value that each camera provided in terms of how often it had been used for evidence gathering. He added that both he and the Police valued it and it was an example of where there should be collaborative working on non-statutory services to ensure that the best is being done by the public.

He did confirm that he could not commit any funding for the CCTV operation and neither could the Police. However he did suggest that the Council may be able to get funding from the Safer Maidstone Partnership.

In response to comments from Members, it was noted that:-

- The data provided by Medway is the same kind of data the Council received when the service was carried out in-house.

- A review of the cameras was carried out in 2014 and a number were de-commissioned. A regular review would continue to be carried out.

- There is a duplication of CCTV within the town centre where businesses are putting in their own equipment and the Police and our own Enforcement teams are now wearing body worn cameras.

- The Council would investigate the use of new technologies as part of the review.

- An option for local businesses to purchase the existing hardware may be an alternative to de-commissioning some of the cameras.

- Detailed site maps would be produced with the next report on where the CCTV cameras are currently situated.

- In terms of the Urban Blue Bus, their views would be taken into account as part of the stakeholder engagement.

During the discussion Councillor Mrs Blackmore proposed and Councillor Webster seconded that Recommendation 3 be amended to:

3) That the options be agreed for the use of CCTV funding to be developed further and a final recommendation to be made to this Committee in February 2017:-

   * **review** the CCTV service – considering reduced camera numbers and reduced hours of active monitoring of the static CCTV cameras and mobile cameras

   * explore other funding or commercial opportunities

* better use of new technology

The motion was lost.

Voting: For: 4 Against: 0 Abstentions: 5

RESOLVED:

1) That the intention be noted to re-negotiate the service provided by Medway and extend the CCTV partnership agreement for one year to 31 March 2018;

2) That it be noted that a review of the current provision and siting of static cameras would be carried out to ensure the Council complies with the Surveillance Camera Code of Practice 2013; and

3) That the options be agreed for the use of CCTV funding to be developed further and a final recommendation to be made to this Committee in February 2017:-

   * reduce the CCTV service – considering reduced camera numbers and reduced hours of active monitoring of the static CCTV cameras and mobile cameras

   * explore other funding or commercial opportunities

   * better use of new technology

   Voting: For: 5 Against: 0 Abstentions: 4

106. DURATION OF MEETING

6.30 p.m. to 8.45 p.m.

COMMUNITIES, HOUSING AND ENVIRONMENT COMMITTEE – COMMITTEE WORK PROGRAMME

Issue	Date	Comments
Pest Control Arrangements	December	
Temporary Accommodation Strategy	December	
Draft Kent and Medway Health and Social Care Sustainability and Transformation Plan (draft)	December	
Parish Charter Update	January	
Safer Maidstone Partnership	January	Crime and Disorder Committee
Fees and Charges – MTFS	January	
Strategic Plan 2015-20 Refresh	January	
MBC Lottery	January	
Medium Term Financial Strategy and Budget Proposals	January	
Service Level Agreements & Grant Review	January	
Dog Waste Bins – Review	January	
Parish Charter Update	January	
Temporary Accommodation Policy	February	
Homelessness Update Quarter 3	February	
Strategic Plan Performance Update Q3	February	
Third Quarter Budget Monitoring 2016/17	February	
Commercial Waste Feasibility Report	February	
Air Quality Management Areas	February	
CCTV Options	February	
Review of Waste Strategy	April	
Homelessness Performance Quarter 4	April	
Taxi Rank Policy	April	

Issue	Date	Comments
To be confirmed		
Budget Monitoring Q4		
Strategic Plan Performance Update Q4		
Maidstone Housing Strategy 2016-20 Update		
Licensing Partnership Update		
Allocation Housing Scheme		
Air Quality (Low Emissions) Working Group	22 November	
Members Briefings/Development Sessions		
Planning and Housing Act Workshop	Early 2017	

MAIDSTONE BOROUGH COUNCIL

COMMUNITIES, HOUSING AND ENVIRONMENT COMMITTEE

13 DECEMBER 2016

REPORT OF THE LICENSING COMMITTEE HELD ON 29 SEPTEMBER 2016

Draft Licensing Compliance and Enforcement Policy

Issue for Decision

To adopt the revised Licensing Compliance and Enforcement Policy.

Recommendation Made

That the draft Licensing Compliance and Enforcement Policy attached as appendix A be adopted.

Reasons for Recommendation

On 29 September 2016 the Licensing Committee considered a report which provided an update on the draft Licensing Compliance and Enforcement Policy (appendix A). It was explained that the service specific policy would help to ensure that consistency could be applied across the Licensing Partnership through the harmonisation of policies.

It is best practice to be transparent and concise in how we, as the Licensing Authority, achieve compliance and enforcement. It is important to review our policy, including our approach to compliance and enforcement matters to reflect change over time, changes in resources and to reflect changes in legislation in order to maintain public confidence and continue to achieve public safety and prevent offences being committed under the various Acts.

A Compliance and Enforcement Policy enables clarity on the position of licence holders, what is expected of them, steps the Licensing Authority would expect them to take to rectify an issue and steps we may take to resolve an issue in relation to non-compliance and offences under various Acts.

The draft Policy at appendix A if adopted will also act as new guidance to Members of the Licensing Committee/Sub-Committee when making decisions on the status of a licence. The guidance will outline actions that are reasonable and proportionate to ensure decisions are fair, in the public interest and proportionate and that any decision taken is defensible.

Alternatives Considered and Why Not Recommended

Members could decide to retain the existing umbrella policy in isolation. This is not recommended as it would not fulfil the needs of the Licensing Partnership to enable greater harmonisation of policies and consistency of approach or be service specific.

Background Documents

None

Maidstone Borough Council Licensing Compliance and Enforcement Policy

CONTENTS

1. INTRODUCTION

1.1. Maidstone Borough Council (MBC) is responsible for licensing and registering a range of functions within its district in the interests of public safety and protection. This policy sets out how we as the Licensing Authority achieve compliance and enforcement.

1.2. We define compliance as how licence holders meet the standards required of them and define enforcement as meaning taking action in relation to unlicensed activities.

These functions include:

(a) hackney carriage and private hire drivers and vehicles and private hire operators;
(b) alcohol, entertainment and late night refreshment;
(c) charity collections;
(d) sex establishments;
(e) gambling premises, permits and lottery registrations;
(f) scrap metal dealers and collectors.
(g) street trading

1.3. This Licensing Compliance and Enforcement Policy seeks to cover all relevant licensing functions and all related topics.

1.4. Maidstone Borough Council as the Licensing Authority puts into effect and ensures compliance with a range of legislation in the public interest. Furthermore, the Council has a duty to uphold and achieve compliance relating to the policies adopted by the

Licensing Authority and conditions and requirements that may be imposed on licence holders or those that engage in licensable activities for the benefit of public safety. The Licensing Authority supports the corporate vision that the borough should remain a prosperous, safe and healthy place where people want and are able to live and work, and whereby culture, tourism, employment and self-sufficiency of local communities is encouraged.

1.5. Compliance and enforcement is important to maintain integrity and confidence in the various licensing regimes, and to prevent anyone obtaining an unfair advantage through unlicensed activities.

1.6. The Licensing Authority seeks to uphold the legislation and prevent offences occurring under the various Acts. The seriousness of these offences is reflected in the maximum penalty on conviction in the Magistrates' Court which for some offences may result in imprisonment and/or an unlimited fine.

1.7. In developing this policy, the Licensing Authority has had regard to the Human Rights Act 1998, the statutory Regulators' Code issued under the Legislative and Regulatory Reform Act 2006, the Regulatory Enforcement and Sanctions Act 2008, the Code for Crown Prosecutors and the Equalities Act 2010.

2. AIM OF THIS POLICY

2.1. This policy is intended to reinforce the aims and uphold the objectives of the published guidance to all relevant legislation (as shown in appendix A) by promoting effective practice and the Regulators' Code ensuring proportionate, consistent and targeted regulator activity, whilst developing a transparent and effective dialogue and understanding between regulators and those we regulate.

2.2. This policy is intended to protect individuals, organisations, the community and the environment from harm and to assist as practically as possible in preventing further crime and disorder and to change the behaviour of perpetrators. This policy also aims to eradicate any financial gain or benefit which may be the consequence of non-compliance and to protect those affected by non-compliance. The Licensing Authority in adopting this Policy aims to be responsive and consider what is appropriate in the circumstances, be proportionate to the nature of the offence and the harm caused and to deter future non-compliance.

3. IMPLEMENTATION OF POLICY

3.1. All enforcement powers are delegated to the Head of Housing and Community Services who may instruct the Head of Legal Partnership to the Council to commence legal proceedings where appropriate. However, Officers have delegated authority to determine licences and undertake investigations as may be appropriate under the Council's Constitution and the various Acts. Officers may where appropriate present a case to the Licensing Sub-Committee to determine enforcement action.

3.2. Any appeal to an Officer's decision or Licensing Sub-Committee decision may be to the appropriate Court.

3.3. This policy was adopted by the Communities Housing and Environment Committee on XXX and came into immediate effect. It will be reviewed in 2021, unless legislative or

other changes make it appropriate to do so before this period. Policies and procedures may change from time to time as they may be reviewed on a regular basis in the light of changes in legislation, case-law or best practice.

3.4. New Councillors elected to serve on the Licensing Committee will receive training on the policy and the relevant Committees will be kept informed about any future updates.

3.5. The Licensing Authority has a duty under the Crime and Disorder Act 1998 to take all reasonable measures to prevent crime and disorder within the Borough. Consequently, the Licensing Authority will share information where relevant about applicants, licence-holders and unlicensed people or organisations with other agencies as appropriate. For example, the Council's Fraud team, the Police, HM Revenue and Customs, Home Office Immigration Enforcement, Trading Standards or the Department for Work and Pensions.

3.6. This list may be revised from time to time and we may share information with other agencies as required with due regard to data protection legislation.

3.7. All enforcement decisions will be fair, independent and objective. They will not be influenced by any of the protected characteristics under the Equalities Act 2010 for example, age, ethnicity, national origin, gender, religious or political belief, disabilities or sexual orientation.

3.8. Due regard will be taken when dealing with juveniles or other vulnerable people. Each case will be determined on its own merits taking into consideration the requirements of the governing legislation, relevant guidance, Council Policies and relevant sources of evidence. Policies the Council will consider within its decision making process may include the Statement of Licensing Policy Licensing Act 2003, Statement of Licensing Principles for the Gambling Act 2005, Hackney Carriage and Private Hire Licensing Policy, Street Trading Policy, Sex Establishments Policy, Scrap Metal Policy, Charitable Collections Policy. This list is not exhaustive and may change from time to time given legislative or procedural changes.

3.9. In some cases where the Council does not have powers to intervene as the Licensing Authority, the Council may refer the intelligence or complaint to the appropriate organisation. Where the Council do have powers to intervene, the first approach wherever possible will be to attempt an informal resolution. Officers will use the resources at their disposal, intelligence and evidence presented and gathered to determine objectively using their discretion whether an informal resolution is possible. Informal resolutions will unlikely be adopted for repeat offenders. This will involve clearly identifying the nature of any actual or potential legislative breach and giving the perpetrator the opportunity to remedy it.

3.10. Decisions will be consistent, proportionate and will aim to uphold public confidence. They will balance the rights of licence holders, applicants and perpetrators with maintaining public confidence and safety. The Council will also make clear the difference between statutory requirements or advice, or guidance about what is desirable or good practice which is not compulsory.

3.11. The Licensing Authority may publicise the results of prosecutions when it is in the public interest to do so, or in the interests of the Authority.

3.12. The Licensing Authority will maintain the confidentiality of complaints and sources of complaints as far as reasonably possible. Should a prosecution be pursued, the Court or other relevant parties may be required to be provided with these details. We will only release personal information in accordance with legal requirements or the Data Protection Act 1998.

4. PRINCIPLES OF OPERATION

4.1. The Licensing Authority aims to continue to promote the spirit of co-operation that exists between the relevant agencies and to recognise the benefits to be derived from developing close working relationships.

4.2. The Licensing Authority will seek to enhance the understanding of the advantages and opportunities which joint activity can bring to effective enforcement and community safety and promote the legitimate exchange of information and operational cooperation.

5. LIAISION ARRANGEMENTS

5.1. There will be regular contact and liaison with the responsible authorities and other government bodies or individuals or organisations where appropriate to:

- Provide access to appropriate sources of information;
- Provide a consistent approach to communication, operations and investigations;
- Encourage early contact and liaison in specific cases;
- Allow for advice or guidance to be given in relation to a specific case;
- Ensure that any national or regional campaigns or investigations are considered;
- Enable relevant officers to be kept informed of the progress of cases that are being investigated;
- Ensure that information and intelligence being passed between the agencies is in accordance with the Information Sharing Agreement between the Licensing Authority and other Council and Police departments.

Officers will seek to:

- Ensure the effective exchange of information between the agencies;
- Consider the need for joint visits;
- Implement co-ordinated actions as necessary;
- Co-ordinate the supply of evidence and information to any other agency taking formal action;
- Work together where practicable, to promote stated objectives;
- Discuss and liaise in the event of uncertainty over lead roles.

6. EFFECTIVE PRACTICE

6.1. The Council will ensure that it will carry out the work undertaken in accordance with the legislation, government guidance and all reasonable aspects of effective practice. In doing so the Council will:

- Focus primarily on premises/activities that are determined by consultation between relevant parties to be a high risk of contravening the legislation and the objectives of the legislation;

- Ensure all guidance and information is in a clear, accessible and concise format, using media appropriate to the business;

- Ensure that service delivery is provided in a non-discriminatory manner;

- Highlight those matters that are legal requirements to separate them from matters that are recommendations or good practice;

- Provide information in a timely manner and where required, advise recipients of their legal rights in such matters;

- Ensure, wherever possible, that responsible persons do not undertake work that is unnecessary in terms of duplication with other legislation and has regard to cost/benefit; available technology; consistency in application with enforcement action proportionate to risk in each case;

- Deal with the public, licensees and businesses in a fair and honest way;

- Provide a courteous, efficient responsive and helpful service, responding promptly and appropriately to service requests and complaints;

- Attend Court in support of partner agencies where it is agreed that evidence/ information will be of mutual assistance having due regard to liability.

7. RISK RATING OF LICENSED PREMISES

7.1. All licensed premises will be risk assessed. This assessment takes into consideration the type of premises, range of licensable activities, history of complaints, competency of the current management and other factors which may change from time to time. The Licensing Authority will base its regulatory activity on risk, prioritising high risk and problem premises and activities.

7.2. All premises will be scheduled for inspections based upon their level of risk. This schedule may change from time to time subject to management changes or complaints arising from premises.

8. COMPLIANCE

8.1. In respect of licensed premises such as those under the Licensing Act 2003, Gambling Act 2005, Scrap Metal Dealers Act 2013, Sex Establishment Licences under the amended Schedule 3 of the Local Government (Miscellaneous Provisions) Act 1982 and Operator licences under the Local Government (Miscellaneous Provisions) Act 1976, routine visits/inspections may be made on the basis of risk assessments, as well as intelligence led operations.

8.2. In respect of licensed vehicles, the relevant compliance tests are required to be passed and vehicles will be inspected as a result of complaints or intelligence received. The Authority has the right to inspect a licensed private hire or hackney carriage vehicle whenever they deem it appropriate to do so. A sample of vehicles will be tested monthly. Checks will also be carried out on drivers of licensed vehicles each month and as a result of complaints or intelligence from other authorities.

8.3. When inspecting premises, the Authority will draw the appropriate authority's attention to any contraventions of any relevant legislation which are found to exist and will record the information gathered from all visits and act upon it in order to achieve compliance.

8.4. Non-compliance with the relevant legislation may lead to the appropriate proportionate enforcement action, taking into consideration the frequency of the breach, a risk to public safety or whether it is in the public interest to do so amongst other factors.

9. ENFORCEMENT

9.1. Enforcement action must be proportionate to the offence and the circumstance of the offence and balanced against risks, costs and resources available to the Authority. Proportionate action concerns judging the extent to which perpetrators have gone to in order to comply with the law and the extent to which the breach was intended, for instance deliberate misuse of licensed activities or premises and vehicles and so forth. Also assessed is the extent to which the breach could have been avoided, for instance previous knowledge of the requirements through advice or warnings.

Circumstances may include (but not exclusively) the following:

- Previous licensing history/character;
- Previous interventions from the Authority and other agencies;
- Change of premises ownership/management;
- Seriousness of the offence and impact on risk to public safety.

9.2. An informal warning for example is unlikely to be a suitable disposal for a significant infringement that led to or could have potentially led to serious injury. Likewise, a prosecution is generally unsuitable for a minor administrative type of breach or technical oversight.

Enforcement action may include the following:

- No further action;
- Verbal warning;
- Written warning;
- Simple caution;
- Prosecution;
- Other legal action.

9.3. The Authority may undertake informal advisory visits and meetings, mediation where possible, education, awareness-raising and advice. The Authority may also use direct

observations, test purchasing, joint investigations with other agencies and roadside vehicle checks for licensed vehicles and scrap metal dealers. The Authority will also conduct proactive and reactive visits.

9.4. The Authority, where possible, will give an early indication to all relevant parties of our progress and our intended course of action. The Authority will liaise with those parties as necessary to ensure a co-ordinated and thorough approach. The Authority will consider other actions as required bearing in mind alternative approaches to dealing with the situation that have been previously attempted and/or deemed to be inappropriate.

9.5. The Authority will explain the need for enforcement action in writing and verbally as far as reasonably practicable and why the action is necessary and when it must be carried out by. The Authority recognises that it may not be always possible to liaise with the relevant parties immediately if action is needed urgently to protect public health, safety or the environment or preserve evidence.

9.6. If the Authority receives information that may lead to formal enforcement action it will notify the source of the complaint as soon as practicably possible of any intended enforcement action, unless this will impede an investigation or pose a safety risk.

9.7. The Authority has the right to request to interview those whom they suspect of unlicensed activity, or breaches under the various licensing legislations. These interviews may be informal, formal recorded interviews or interviews conducted under the Police and Criminal Evidence Act (PACE). Whilst attendance may not be compulsory, it would be in the interests of the individual or organisation being investigated to attend. Actions may be considered should they abstain from attending.

10. REVIEW OF THIS POLICY

10.1. Maidstone Borough Council shall periodically review this Policy, at least once every five years, to ensure that it maintains a suitably responsive and practical arrangement for all licensing functions and that enforcement and compliance measures remain reasonable and proportionate to the matters to which it pertains, and in line with the resources at the Council's disposal.

Communities, Housing and Environment Committee	**13 December 2016**
Is the final decision on the recommendations in this report to be made at this meeting?	**Yes**

Pest Control Arrangements

Final Decision-Maker	Communities, Housing and Environment Committee
Lead Head of Service	Head of Environment and Public Realm
Lead Officer and Report Author	Martyn Jeynes, Environmental Enforcement Manager
Classification	Public
Wards affected	All

This report makes the following recommendations to this Committee:

1. To approve the appointment of Goodwin Pest Management as Pest Control Service provider from 1 January 2017 for an initial period of three years (with an option to extend for up to a further two years).

This report relates to the following corporate priorities:

- Keeping Maidstone Borough an attractive place for all – provides a vetted, value for money service that enables the local authority, residents, businesses and land owners to utilise a service that controls vermin and other nuisance pests.
- Securing a successful economy for Maidstone Borough - provides a vetted, value for money service that employees local people.

Timetable	
Meeting	***Date***
Corporate Leadership Team	6th December 2016
Committee (Communities, Housing and Environment Committee)	13th December 2016

Pest Control Arrangements

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Council's current pest control service contract expires on 31 December 2016. Maidstone Borough Council (MBC) carried out a tender process on behalf of Swale and Maidstone Councils, which was evaluated both on quality and price.

1.2 The primary purpose of this contract is to provide a range of pest treatments for residents and businesses within Swale. The contract also provides evidential reports to support pest control enforcement by Environment Officers. Other functions have used the service to provide pest treatments in public open spaces and Council property.

1.3 This report summarises the procurement process and its results, and seeks Committee approval of the recommended contractor.

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2. INTRODUCTION AND BACKGROUND

2.1 Since moving away from employing our own directly employed Pest Control Officer in the early 2000s, the Council has provided a pest control service utilising the skill and expertise of a private sector company. The Council initially reduced its overheads by paying a smaller fee to a local company to provide Pest Control at set prices, determined by the local authority, to residents and businesses via a dedicated pest control telephone line. This has previously been promoted online or through communication with the appropriate departments in the authority such as Environmental Health.

2.2 This should not be confused with the local authority's statutory duties in regards to investigating public health nuisances, such as vermin and infestations, which are undertaken by officers within the Environmental Enforcement team. Nor should it be confused with the Council's responsibilities as a land owner to keep its land free from vermin or nuisance pests such as wasps and birds.

2.3 In 2008/09, whilst retendering for the service, a bid was received from a different local company who offered to pay the council to provide its Pest Control Service. They were willing to pay for the benefit of being the recommended provider because of the level of business expected and potential repeat business that the initial contacts would provide.

2.4 This provided the Council with a contribution towards the management overheads for providing residents' with advice about pest nuisance and investigating complaints regarding issues originating from neighbouring properties or land.

2.5 In 2011 Maidstone Borough Council (MBC), Ashford Borough Council (ABC) and Swale Borough Council (SBC) put together a joint tender specification, identifying the individual service requirements of each authority. This included ensuring that the company utilised safe working processes, best practice and innovative pest control solutions, as well as a customer focussed service in line with the values of each local authority and at a price controlled by the local authority.

2.6 As a result of the process a 3 year contract with option to extend for up to 2 years was awarded to the most suitable company. This is due to end at the beginning of January 2017 and therefore a new tendering exercise was initiated. This process was limited to Swale and Maidstone Borough Councils as Ashford had taken the decision to withdraw from the service.

2.7 The charges will continue to be set as part of the Council's fees and charges process to ensure they are considered reasonable and are in line with other providers offering a similar standard of service. It is accepted that residents will be able to find cheaper alternatives to this service, either through carrying out the work themselves or using smaller independent companies. However the purpose of this arrangement is to give residents' reassurance over the companies working practices and an avenue of complaint should they be dissatisfied with the outcome of the work.

2.8 The quality aspect of the tenders was evaluated by Alister Andrews, Environment Response Manager, SBC; Martyn Jeynes, Environment Enforcement Manager, MBC; and Kevin Metland, Technical Officer, MBC.

2.9 The quality of service to the customer was expected to be of a high standard with all of these providers as they were required to have membership of the British Pest Control Association. However the 'quality' component measured the added value for the councils, such as performance measurement, auditable and easily accessible systems, environmental and social value and the potential to grow the business.

2.10 The outcomes of the assessment exercise are set out in Table 1 below.

Table 1: Scores from assessment panel.

Organisation	Price Score	Quality Weighted Score	Total Score
Company A (Goodwin Pest Management)	60	20.3	80.3
Company B	57	22.1	79.1
Company C	35.7	21.3	57
Company D	27.7	26.6	54.3
Company E	2.3	20.9	23.2
Company F	0 (unable to score due to limited information)	19.2	19.2

2.11 Company A and Company B were originally very close on their overall assessment scores. On the recommendation of the MBC Procurement Team both companies were interviewed by the evaluation panel to clarify points within their submissions. As a result Goodwin Pest Management was found to have submitted the most economically advantageous tender.

2.12 Goodwin Pest Management is located in Kent, with the owner and some employees living in both Swale and Maidstone. They employ local staff and encourage apprenticeships. They are also committed to local community events. The new contract is also estimated to generate approx. £12K pa for the Council.

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3. AVAILABLE OPTIONS

3.1 The tender process has determined that Goodwin Pest Control, a local pest control company is willing to pay MBC a guaranteed income of £36k over 3 years in order to provide Pest Control in partnership with the local authority.

3.2 One option is not to award the contract and withdraw the service. This is not recommended as the contract provides a valued service to residents. The service provider supports frontline teams with evidential reports for enforcement, and provide pest treatments on council land and property.

3.3 Another alternative is to award the contract to one of the other companies that tendered. This is not recommended as Goodwin Pest Management scored the highest total in the formal tender assessment exercise.

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4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 The procurement process has determined that Goodwin Pest Control offers the most economically advantageous tender whilst providing a pest control service which has been vetted to ensure:

- The price paid by the customer is controlled and competitive within the sector
- The company utilises safe working processes, best practice and innovative pest control solutions
- Customer satisfaction and other values are in line with the values of with those of Maidstone Borough Council
- Added value will provided in regard to the provision of Pest Control to property services and parks and open spaces and environmental enforcement in relation to the services they each provide.

4.2 The results of the procurement process were reported to the Director of Finance and Business Improvement, explaining the process and how the result had been determined. Under his delegated authority the Acceptance of Tender was duly signed. Goodwin have been made aware the contract remains subject to the report of this decision and are already prepared to go live on 3rd January 2017 should the preferred option be agreed.

4.3 Since 2009 the budget for Pest Control, which is used for Management and Administration charges and CIPFA reporting has had an income target set against it to cover those budgetary requirements. This is primarily the work undertaken by Technical Officers in the Environmental Enforcement team investigating pest related service requests. Should the committee decide not to implement this option there will be a budget shortfall of £12,000 pa.

5. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

5.1 Complaints have been minimal for the service, with more detailed customer satisfaction reports being a requirement for the new contractor.

6. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

6.1 Once agreed the formal handover of the contract provision will begin. This will include ensuring the council communication is redirected to the new provider.

6.2 It has been agreed to investigate the possibility of including a message on the telephone system to ensure customers are aware the service is provided by a third party company and to quote an agreed reference to ensure they benefit from the agreed rates provided by the tendered service.

6.3 The new pest control contract will be operational from 3 January 2017.

7. CROSS-CUTTING ISSUES AND IMPLICATIONS

Issue	Implications	Sign-off
Impact on Corporate Priorities	Keeping Maidstone Borough an attractive place for all – provides a vetted, value for money service that enables the local authority, residents, businesses and land owners to utilise a service that controls vermin and other nuisance pests.	Head of Environment and Public Realm

	Securing a successful economy for Maidstone Borough - provides a vetted, value for money service that employees local people. The tender document submitted by Goodwin Pest Management demonstrates a strong commitment to social, economic and environmental matters. The company employs local staff and encourages apprenticeships. They are also committed to local community events.	
Risk Management	The successful contractor has all of the necessary qualifications - this was a key part of the selection criteria. The contract ensures that contractors are fully competent, particularly in the area of health and safety. Goodwin Pest Management's competence is evidenced through their membership of the British Pest Control Association (BPCA).	Head of Environment and Public Realm
Financial	The total value of the contract for the five years is estimated at £135K. Anticipated annual income from the pest control service contract is £12K pa. This is paid to the Council from the contractor as a result of undertaking pest treatments in line with council fees and charges. Goodwin Pest Management will also redistribute 25% of gross income over £100K pa to MBC and SBC (previous income was approximately £67,600 p/a). There are no TUPE implications identified by our outgoing service providers.	Section 151 Officer & Finance Team
Staffing	None identified.	Head of Environment and Public Realm
Legal and Statutory including	The contract will be the standard Council contract using the Council's current Terms and Conditions.	Team Leader (Contracts and Commissioning)

Human Rights Act	The Council has a statutory duty to investigate pest issues, but not to provide a pest control service. However, the provision of the service assists officers with delivering our statutory duties, as well as generating additional income. There are no consequences arising from the recommendation that adversely affect or interfere with individuals' rights and freedoms as set out in the Human Rights Act 1998.	
Equality Impact Needs Assessment	No detrimental impact on the protected characteristics of individuals identified.	Equalities and Corporate Policy Officer
Environmental/Sustainable Development	The service is provided by the contractor, and reliability and experience were considered in the tender process. Regular contractor meetings will ensure that service delivery and performance are reviewed regularly. Goodwin Pest Management has the necessary accreditations.	Head of Environment and Public Realm
Community Safety	By having a qualified pest technician on hand we are able to target more complex pest enforcement issues quickly and effectively.	Head of Environment and Public Realm
Procurement	The Council's Contract Standing Orders, Commissioning framework, Procurement Strategy, relevant EU Procurement Directives, and the Public Contract Regulations 2015 have all been adhered to.	Head of Environment and Public Realm [Section 151 Officer]
Asset Management	As a land owner the use of a vetted pest control provider and regular contracts meetings will ensure value for money in regards to our duties as a land owner.	Head of Environment and Public Realm

8. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

None

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9. BACKGROUND PAPERS

None

Communities, Housing & Environment Committee	**13 December 2016**
Is the final decision on the recommendations in this report to be made at this meeting?	**Yes**

Temporary Accommodation Strategy

Final Decision-Maker	Communities, Housing & Environment Committee
Lead Head of Service	John Littlemore
Lead Officer and Report Author	John Littlemore
Classification	Public
Wards affected	All

This report makes the following recommendations to this Committee:

1. The Committee adopts the approach to the acquisition and use of Temporary Accommodation outlined within this report.
2. The Committee endorses the approach of direct lettings for homeless households owed the main homelessness duty.
3. The Committee agrees in principle to acquiring through purchase or lease 13 additional units of temporary accommodation to be agreed on a case by case basis.
4. The Committee agrees to increase the amount offered to landlords as part of the Homefinder Scheme in order to secure at least 50 units of private rented accommodation per year.
5. The Committee notes the financial implications contained within the exempt appendix.

This report relates to the following corporate priorities:

- Keeping Maidstone Borough an attractive place for all
- Securing a successful economy for Maidstone Borough

Timetable	
Meeting	***Date***
Communities, Housing & Environment Committee	13 December 2016

Temporary Accommodation Strategy

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Council is faced with unprecedented levels of homelessness that has resulted in an increase in the use of temporary accommodation. This report provides a framework to minimise the use of temporary accommodation and where the provision of TA cannot be avoided, to provide the most cost efficient form of TA.

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2. INTRODUCTION AND BACKGROUND

2.1 The Council's primary objective and key priority within the Housing Strategy is to prevent homelessness. This report is not intended to cover the prevention of homelessness nor the Council's strategic approach to housing matters and reference is made to Maidstone Borough Council's overarching housing documents such as the Housing Strategy; Homelessness Strategy; and Allocation Scheme.

2.2 Additional resources are being deployed to assist in the task of tackling the use of TA and the Council has submitted bids for funds under the recently announced government grant to provide additional services to prevent homelessness and tackle street homelessness.

2.3 At the same time pressure is being exerted on the Kent housing market by external influences such as the placement of homeless households by the London housing authorities. This has evolved from individual leases being acquired by these authorities to whole-scale acquisitions of new housing developments. At the same time the Cameron led government removed all grant support for new-build affordable rented accommodation, further exacerbating the lack of affordable housing. Cross authority lobbying in conjunction with Kent County Council is continuing in order to achieve a change in direction and/or support with regard to these issues.

2.4 Unfortunately not all instances of homelessness can be avoided and as there is insufficient affordable housing to provide homes for all those who become homeless the Council is forced into the position of having to provide TA. Homelessness legislation sets out when the Council is under a duty to provide accommodation.

2.5 In 2010/2011 the Council made 80 homelessness decisions and at the current pace of applications the Council is due to make in excess of 700 decisions in 2016/17. In 2013/14 the Council accommodated 206 households in temporary accommodation for 11,942 nights; this increased to 501 households accommodated for 20,065 nights in 2015/16. As a result of the increase the Council is now accommodating over 100 households in TA. This report sets out how the Council will minimise the use and length of stay of TA for homeless households.

2.6 During 2015/16 over 630 homelessness decisions were issued and during that period 50% of applicants were placed into TA. About half of the 315 requiring TA were eventually owed the main housing duty. The length of stay varied considerably between those applicants who were owed the main housing duty and those who were not.

Bedroom size	Main duty accepted (days)	Negative decisions (days)
One	98	45
Two	80	56
Three	199	49
Four	290	61

2.7 In both main duty and negative decision cases the average time taken to reach a decision and issue it to the applicant was under the 33 working days recommended in the Homelessness Code of Guidance. This suggests that the extended time spent in TA by those owed the main duty is connected with the supply of suitable permanent housing.

2.8 Homelessness decisions during the first two quarters of 2016/17 reached 357 and confirm the trend in demand for homelessness resources remains on an upward trajectory. Based on previous historical data and anticipating demand based on the current level of demand it is anticipated that the Council will accommodate around 350 households during the year.

2.9 The approach outlined in this report is written using current assumptions as at December 2016 and data available at that time. It is intended that the calculation used as the basis within the report can be scaled up or down depending on future demand for the service and the number of TA units required adjusted accordingly.

2.10 The TA strategy is dependent on two critical factors - homelessness decisions being made and issued within 30 days and the availability of accommodation to move applicants from TA. The process of receiving, determining and completing homeless applications can be viewed as a series of steps:

Step 1. Investigation

In order to minimise the length of time that people will spend in TA whilst enquiries are on-going the Housing Service will prioritise staff resources towards the rapid and robust completion of enquiries. The aim being to issue decisions in less than 30 days.

2.11 This will result in two groups of people: those people who receive a negative decision and are not owed a duty to secure accommodation long-term but the Council is required to provide a further period of TA whilst they find their own accommodation.

2.12 The average length of stay for households following the issuance of a negative homelessness decision is 28 days. Therefore the Council estimates

it will require 30 units in order to accommodate 175 applicants for an average period of 60 days over the year.

This can be expressed as a number of TA units: 60/365 x 175 = 30 units (rounded up)

2.13 The target figure for the average length of stay for those households who are owed the main homelessness is 30 days, with permanent housing being secured either through an offer of Part 6 accommodation with a housing association or a private rented sector nomination. Therefore the Council estimates it will require 15 units of TA for a total period of 30 days for this cohort of applicant.

This can be expressed as a number of TA units: 30/365 x 175 = 15 (rounded up)

2.14 Step 2. Supply of TA

In addition to the units in current ownership and about to be leased on long-term arrangements the Council will acquire sufficient units of TA to provide for both sets of clients. The most cost effective way to provide good quality accommodation is either to own or rent on a long-lease. In order to provide some contingency it has been calculated that the Council will require in the region of 50 units of TA based on 700 homeless decisions during the year.

Property. Current	Ownership	Type & size	Bed spaces
Aylesbury House	MBC	Shared rooms	12
Magnolia House	MBC	Self-contained 1 bedroom flats 2 bedroom flats	 4 4
Star House	Leased	Self-contained 1 bedroom flats 2 bedroom flat 3 bedroom flat	 4 1 1
Sub Total			**26**
Pipeline	Ownership	Type & size	Bed spaces
Marsham Street	Leased	Shared	6
Square Hill	MBC	Shared	5
Required	Ownership	Type & size	Bed Spaces
	Owned/Leased	Self-contained 2 bedroom flats	13
Total units required			**50**

2.15 The Council currently owns and leases 26 units with a further 11 units due to be available early in the New Year. This leaves a shortfall of around 13 units, which should mainly be family sized accommodation in order to provide a portfolio of TA that matches demand. The most cost effective way

of achieving these units is through purchasing and retaining units such as Magnolia House.

2.16 Step 3. Ending the placement in TA
To be able to achieve a net reduction in the use and length of time spent in TA there will need to be a rapid turnaround following the positive decision to move the applicant out of TA and into their new home. The intention is that on day 31 those owed the main housing duty will be quickly moved into settled housing e.g. a qualifying offer in the private rented sector or with a housing association.

2.17 Actions that will enable the quick movement of applicants includes negotiating with our local housing associations to increase the number of households owed the main housing duty that are offered suitable permanent tenancies. The current Allocation Scheme permits the Council to employ 'direct allocations' to homeless households. During 2015/16 homeless households made up less than 20% of all those housed via housing associations and the intention is to improve this percentage and speed up the process by matching households to suitable vacancies.

2.18 The Council has met with Golding Homes, the largest provider of existing affordable homes in the Borough, and meetings have been diarised to swiftly conclude discussion as to how the new approach of increased direct nominations will be put into practice. Early indications are that Golding Homes will be looking to the Council to provide some form of underwriting and a proposal is set out the attached Appendix A. Similar conversations are due to take place with the other major providers within the Borough.

2.19 The Council's Homefinder Scheme enables the Council to acquire access to the private rented sector and end the homeless duty in through what is termed as a 'qualifying offer of accommodation'. Since 2015 the Council has ended its housing duty to 42 cases through the private rented sector. The current scheme makes a single payment of £2,500, which secures access to the accommodation for a period of 2 years.

2.20 A review of the current Home Finder scheme has identified that whilst the scheme works well for obtaining 1 bedroom property, it is not so attractive to landlords with family sized accommodation. In order to increase the availability of family sized homes, especially 3 bedroom units, within the private rented sector the financial offer under Home Finder will be adjusted to reflect the market requirements.

2.21 Additional staff resources required to boost the availability of this type of housing will be assigned from within existing resources. This will enable increased capacity for the acquisition of property without additional cost; it is acknowledged that this will have a detrimental impact on the delivery of other services provided by the team but reflects the need to take steps to reduce the use of TA and its associated costs.

3. Associated risks

3.1 There are a number of associated risks contained within the approach suggested within the report and document attached. These include:

i. Vacant accommodation not being readily available on day 31 for those owed the main housing duty, causing existing TA to 'silt up' with applicants, resulting in a requirement for additional TA units.

ii. Housing associations refuse to permit vacant units to be let by direct allocations to homeless persons resulting in a lack of accommodation being readily available.

iii. An increase in complaints and requests for review of decisions resulting in staff resources being distracted from the decision making or ending TA part of the process.

iv. As more vacant properties will be allocated to homeless households applicants waiting on the housing register change tactic believing the quickest way to be provided with housing is to make a homelessness application resulting in an increase in homelessness approaches and greater pressure on TA numbers.

v. The implementation of Universal Credit in the pilot areas has evidenced greater delays in processing claims than had been anticipated. If these delays carry through into the national roll out of Universal Credit this could adversely affect the income expected through rents and negatively affect the net spend.

vi. The general housing market fails to restart resulting in greater numbers of homeless households than was anticipated, requiring more units of TA.

3.2 In order to moderate against these risks the adopted approach will be monitored regularly to maintain alertness to changes in approaches and impact on the use of TA. A report will be provided quarterly to the Communities, Housing & Environment Committee on homelessness activity including the impact of the implementation of this approach. In addition the Council can lobby through various routes including attendance at the Homelessness Working Group chaired by the Minister for Local Government on improvements or exemptions around Universal Credit for applicants in TA.

4. Financial Implications

4.1 The financial implications are contained within the attached Appendix A.

4.2 If the council were not to tackle the use of TA it is projected that the net cost for 2017/18 based on current trends would be expenditure of £852,000, which is £406,000 in excess of the current budget. It is projected that the successful implementation of this strategy would reduce the net spend to £312,000 in 2018/19 , providing cost avoidance of £540,000 and a saving in relation to current budgets of £134,000 in 2018/19. For the purposes of budget setting this has been rounded down and a saving of £100,000 has been assumed in 2018/19.

5. AVAILABLE OPTIONS

5.1 The Council could choose not to adopt the approach set out in this report but to do so would leave the Council subjected to the current prevailing demands on service without a way of managing its exposure.

5.2 By adopting an approach that includes the following, the Council is better placed to maintain a degree of control over the use and acquisition of TA;

- minimising the time spent to determine applications
- sourcing good quality, affordable TA
- moving applicants once the decision is completed out of TA through increased nominations to housing associations and use of the private rented sector

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6. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

6.1 Option 5.2 is recommended for the reasons stated above.

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7. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

7.1 None required.

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8. CROSS-CUTTING ISSUES AND IMPLICATIONS

Issue	Implications	Sign-off
Impact on Corporate Priorities		Head of Housing & Community Services
Risk Management	Contained within the report above	Head of Housing & Community Services
Financial	Contained within the report	Section 151 Officer & Finance Team
Staffing	Exiting staff resources will be temporarily moved within the Service to enable TA to be tackled without increasing revenue costs through staffing.	Head of Housing & Community Services
Legal		[Legal Team]

Equality Impact Needs Assessment		[Policy & Information Manager]
Environmental/Sustainable Development		[Head of Service or Manager]
Community Safety		[Head of Service or Manager]
Human Rights Act		[Head of Service or Manager]
Procurement		[Head of Service & Section 151 Officer]
Asset Management		[Head of Service & Manager]

9. REPORT APPENDICES

Exempt Appendix - Financial Implications

10. BACKGROUND PAPERS

Communities, Housing & Environment Committee	**13th December 2016**
Is the final decision on the recommendations in this report to be made at this meeting?	**Yes**

Kent and Medway Health and Social Care Sustainability and Transformation Plan (STP)

Final Decision-Maker	Communities, Housing & Environment Committee
Lead Head of Service	John Littlemore, Head of Housing and Community Services
Lead Officer and Report Author	Paul Clarke, Healthy Lifestyle Commissioning Officer
Classification	Public
Wards affected	Borough

This report makes the following recommendations to this Committee:

1. The Committee notes the progress made on the Sustainability and Transformation Plan (STP) reflected in this report
2. The Committee agrees that the council responds to the online survey and in addition writes to the STP team to provide a more comprehensive response in line with the issues set out under sections 2.14 and 2.15 of this report.

This report relates to the following corporate priorities:

- **Keeping Maidstone Borough an attractive place for all:** The Kent and Medway Health and Social Care STP developed by NHS, social care and public health leaders encourages good health and wellbeing for residents across the region by preventing ill health, intervening earlier and having excellent care wherever it is delivered.

- **Securing a successful economy for Maidstone:** Prevention of ill health through good health and wellbeing and improved self-care are key aims of the STP which are supported by all of MBC's action areas which focus on the wider determinants of health including ensuring there are good leisure and cultural attractions, securing improvements to the transport infrastructure, promoting a range of employment opportunities and skills required and planning for sufficient homes to meet our Borough's needs.

Timetable	
Meeting	***Date***
Communities Housing and Environment Committee	13th December 2016

Kent and Medway Health and Social Care Sustainability and Transformation Plan (STP)

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to update the Communities Housing and Environment Committee on the draft Kent and Medway Health and Social Care STP. The report identifies any gaps in the STP, the implications of the proposed changes in terms of the impact for Maidstone Borough residents and how best the council can contribute.

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2. INTRODUCTION AND BACKGROUND

2.1 Across Kent and Medway, health and social care have £3.4billion in funding but overspent by £141million in 2014/15. Without change, there could be a gap in funding of £486million by 2020/21.

2.2 Successful delivery of the vision set out in the initial STP will mean an expected balanced budget by 2020/21 with the exception of £29million, which is the expected annual cost of the health services required by the expanded population of the new town at Ebbsfleet. Additional funds will be sought for this.

2.3 Currently in Kent and Medway (See Appendices for further information):

- 4,000 people die early as a result of diseases which are mostly preventable.
- 240,000 people over 50 are living with long-term disability, largely as the result of health conditions. Often this could be avoided or delayed if people were more active or made other lifestyle changes.
- Around one in four people who are in hospital beds at any given time could be at home or cared for elsewhere. (This varies depending on area). For older people this negatively impacts on their recovery - 10 days in hospital (whether it is an acute (main) or community hospital) leads to the equivalent of 10 years' ageing in the muscles of people over 80.
- Population projected to grow by 5% (≈ 89,000 people) over the next five years, with uneven growth across the patch putting pressures on some parts of the system.
- Significant housing growth e.g. Ebbsfleet and Maidstone, requires planning in order to meet the additional demand for health and care services.

2.4 As part of the initial draft Sustainability and Transformation Plan, the Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting.

2.5 The main priority is to work with clinicians and the public to transform Local Care through the integration of primary, community, mental health and social care and re-orientate some elements of traditional acute hospital care into the community. This allows patients to get joined-up care that considers the individual holistically.

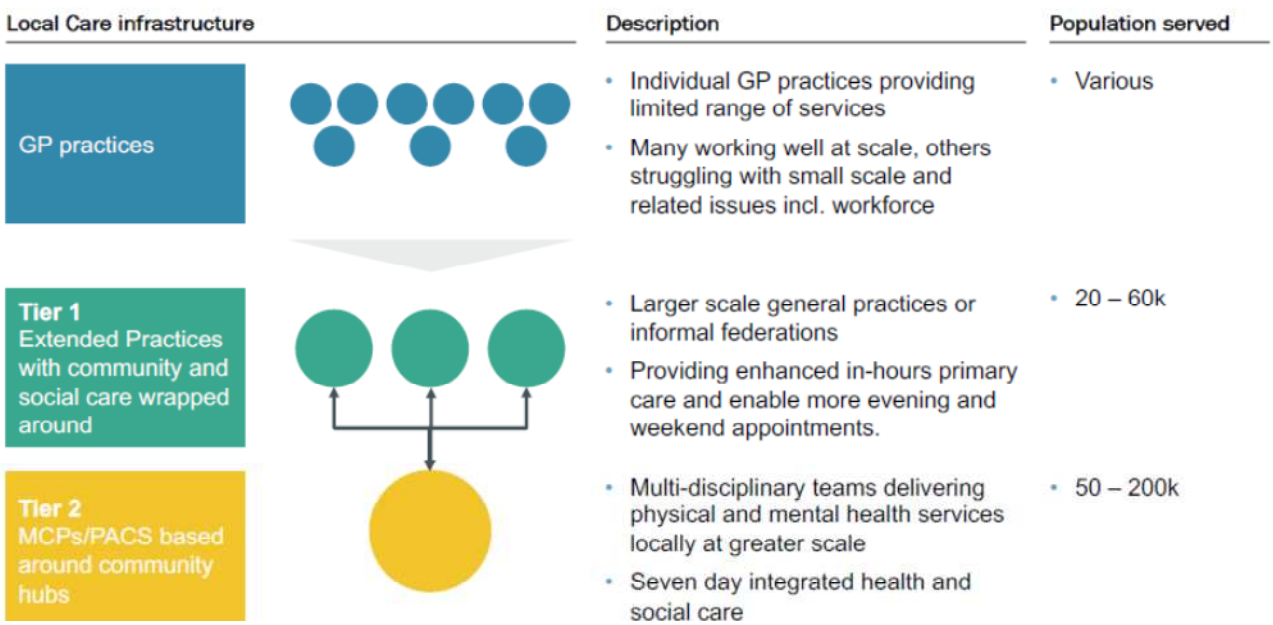
2.6 The STP is aiming to transform services to deliver proactive care, and ensure that support is focused on improving and promoting health and wellbeing, rather than care and support that is solely reactive to ill-health and disease.

2.7 Core to the model is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate the independent sector to deliver the right care, in the right place, at the right time.

2.8 The transformation plan will aim at bringing a shift in where and how care is delivered. It builds on conversations held with local people about the care they want and need and has the patient at its heart:

2.8.1 The first priority is developing **Local Care**, building on local innovative models that are delivering new models of care, which brings primary care general practices into stronger clusters, and then aggregating clusters into multispecialty community provider (MCP) type arrangements, and, potentially, into a small number of larger accountable care organisation (ACO) type arrangements that hold capitated budgets.

We are delivering Local Care by scaling up primary care into clusters and hub-based Multi-speciality Care Provider models



Our local implementation of the Kent and Medway model varies to meet the needs of our populations

Summary of Local Care models across Kent and Medway

	Ashford	Canterbury & Coastal	DG&S	Medway	Thanet	Swale	South Kent Coastal	West Kent
Population	129,000	220,000	261,000	295,000	144,000	110,000	202,000	479,000
No. GP practices	14	21	34	53	17	19	30	62
Average list size	9,200	10,500	7,700	5,600	8,500	5,800	6,700	7,700
Extended practices	3	5	TBC	9	4	TBC	4	9
Population	30 – 60 k	30 – 60 k	20 – 40k	30 k	30 – 60 k	20 – 40k	30 – 60 k	TBC
Hubs (virtual / physical)	1	1	5	3	1	2	1	3 – 5
Population	129,000	220,000	50 k	100 k	144,000	50 k	202,000	TBC
Chair	Navin Kumta	Sarah Phillips	Elizabeth Lunt	Peter Green	Tony Martin	Fiona Armstrong	Jonathan Bryant	Bob Bowes
AO	Simon Perks	Simon Perks	Patricia Davies	Caroline Selkirk	Hazel Carpenter	Patricia Davies	Hazel Carpenter	Ian Ayres

2.8.2 Local Care will enable services to operate at a scale where it will be possible to bring together primary, community, mental health and social care to develop integrated services in the home and in the community.

2.8.3 This model will manage demand for acute services, enabling significant reductions in acute activity and length of stay which amount to £160m of net system savings by 2020/21 and relieve pressures on the availability of hospital beds. Reducing the number of beds in main hospitals by 10 percent.

2.8.4 This means there is a commitment to a Kent and Medway-wide strategy for **Hospital Care**, which will provide high-quality specialist services at scale and also consider opportunities to optimise services and estate footprints as the landscape of care provision becomes more local.

2.8.5 Work is ongoing to surface potential opportunities and evaluate them ahead of public consultation from June 2017

2.9 The STP aims to maximise value of one public estate by:

- Releasing capacity that is surplus to needs from reduction in beds and release of unnecessary estate and invest in housing and community facilities.
- Maximising colocation of professionals in hubs to facilitate multidisciplinary working, extended hours and extended range of services available to patients.
- Make use of flexibilities from Local Authority to invest in one public estate.

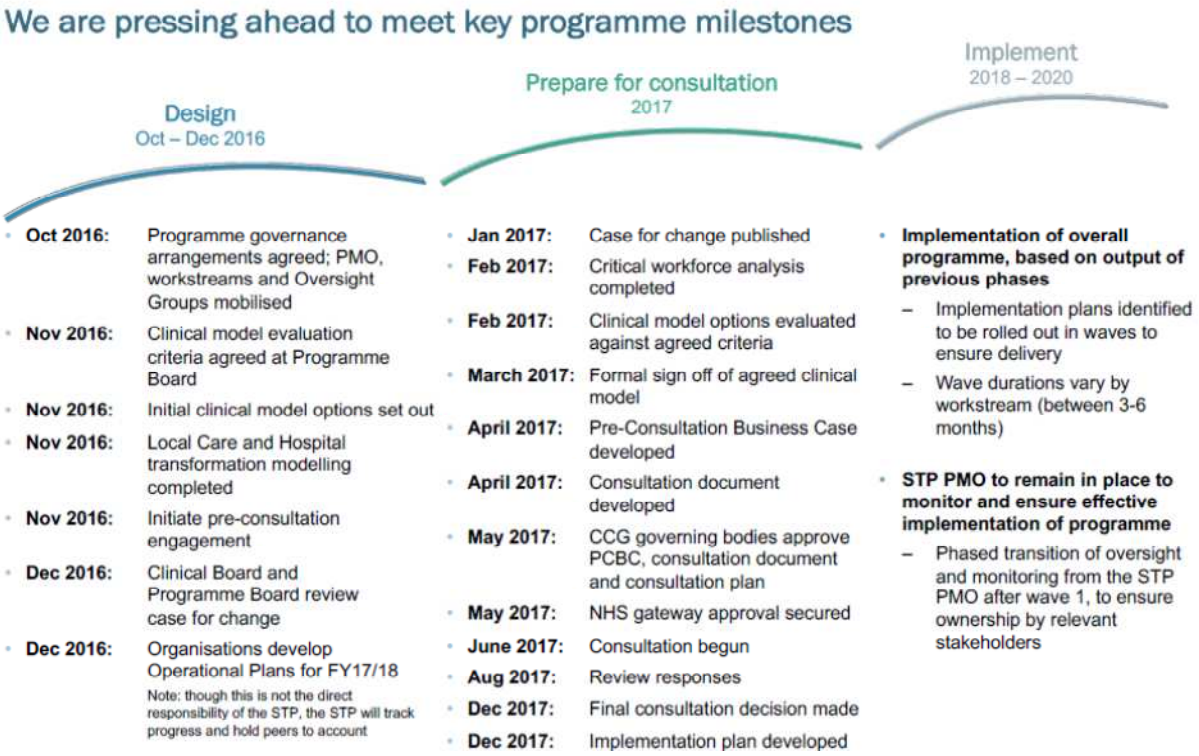
2.10 The STP aims for a radical transformation in the population's health and wellbeing, the quality of care, and the sustainability of the system by targeting interventions in four areas:

- **Care Transformation:** Preventing ill health, intervening earlier, local care, hospital care and mental health
- **Productivity:** Maximising synergies and efficiencies in shared services, procurement and prescribing
- **Enablers:** Investing in estates, digital infrastructure and the workforce needed to underpin a high-performing system
- **System Leadership:** Developing the commissioner and provider structures which will unlock greater scale and impact

2.11 The STP enlists the whole Kent and Medway community in improving health and wellbeing so people stay well, look after each other and use services only when they need to. The aims of the prevention programme include:

- Treating both physical and mental health issues at the same time and effectively
- Concentrating prevention activities on key areas; obesity and physical activity, reducing alcohol-related harm, preventing and stopping smoking
- Deliver workplace health initiatives, aimed at improving the health of staff delivering services.

2.12 Timeline of STP:



2.13 Implications of the proposed changes on our community:

2.13.1 People will be able to access more services in their community and at home, with more support for frail elderly people and people with complex needs, including those reaching the end of their lives whenever possible to maximise their quality of life. Health and social care teams will support people at home, providing care, treatment

and support around-the–clock, including in crisis and will be based in GP practices and hubs.

2.13.2 There will be a reduction in the number of hospital beds.

2.13.3 People will be encouraged to take charge of their own health and wellbeing, avoiding preventable illnesses, and being experts on their own health, knowing when they can manage and when they need to contact a professional. It is unclear what systems and training will be in place to take this approach effectively.

2.13.4 Some services which are currently delivered through individual GP surgeries will be moved into an extended practice or hub. Individual GP practices will provide a limited range of services from what they currently deliver. In West Kent there are currently 62 GP practices which will go to 9 extended practices with 3-5 hubs.

2.13.5 People will be supported to leave hospital as soon as they are medically fit.

2.13.6 Health and social care professionals will come together to work as a single team for a local area and will be able to access records 24 hours a day (with client consent).

2.13.7 Patient experience to be improved through digital initiatives such as;

- Health and care professionals having immediate access to all relevant information about a patients care, treatment diagnostics and previous history, for all patients across Kent
- Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway
- Patients can access their medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question, to virtual consultations, online assessments and diagnostic systems, and advice on apps to monitor own health. There are no details as to how and if those who are unable to access the digital resources will be supported. This is important when considering health inequalities.

2.13.8 Increased services to prevent and manage long-term health conditions such as diabetes and lung disease.

2.13.9 It is intended that every part of Kent and Medway will have access to more specialist and out of hours service, provided by a hub which includes services around:

- Outpatient appointments with a GP who specialises in treating a particular health problem, a highly trained nurse or a consultant – either in person or via phone or computer.
- Minor injuries units where clinicians can see and treat a range of conditions, such as suspected fractures of arms and lower legs,

sprains and strains, wound infections, minor burns, bites and stings.
- Mental health screening and assessment.
- Dementia diagnosis
- End of life care
- Social care.

2.13.10 Mental health will be an integral part of local care. There will be several specific schemes to improve care including:

- A single phone number for people in Kent and Medway in a mental health crisis.
- Reducing to zero the number of people placed in private mental health beds out of county.
- Bringing back to Kent and Medway as many people as possible placed out-of-area for specialist care.
- Improving interventions for people experiencing psychosis for the first time.
- Improving care for children and young people with mental health and emotional wellbeing issues.

2.13.11 There are plans to develop a Kent and Medway Medical School for both undergraduate and post-graduate education.

2.14 Gaps within the STP:

2.14.1 Whilst reducing health inequalities is an aim of the STP there is no detail as to how this will be implemented. Proportional universalism should be applied where Health and Social Care services are focused more in areas of greater health inequality.

2.14.2 Whilst reducing health inequalities is an aim of the STP there is no detail as to how this will be implemented. There is no detail as to whether this means that proportional universalism will be applied where Health and Social Care services are focused more in areas of greater health inequality.

2.14.3 District/Borough Councils have not been involved so far in the development of STP, which is remise for a number of key reasons:

- The vision of the STP is to improve health and wellbeing for the population, reducing their need for health and care services. However the transformation focus is still almost entirely on health and social care services which is unlikely to decrease the burden of use but risks moving people into other parts of the system. Health is primarily determined by factors other than health care such as the environment in which people live and good quality employment. District and Borough councils are in a good position to influence many of these factors through their key functions and in their wider role supporting communities and influencing other bodies.
- The importance district councils have in place shaping, active travel, access to leisure facilities and green spaces, access to a

clean and safe environment, environmental enforcement, quality housing and regeneration and employment.

- The effect the STP will have on our residents and communities.
- To shift the focus of STP towards primary prevention more than secondary and tertiary.
- There will be an increase of tier 2 weight management programmes from 2,348 across Kent and Medway to 10,000. This is still a small number and other strategies/areas of focus are needed to reduce obesity and the burden on health and social care. In Kent alone (excluding Medway) there are 771,476 people aged 16+ estimated to be overweight or obese which is 64.6% of the adult population (Kent 'Healthy Weight' JSNA Chapter Summary Update 2014/15). To significantly reduce the pressure on health and social care a whole system response to obesity is required which includes transport, the built environment, housing leisure, licensing and a range of other key drivers. Many of these factors are beyond the reach of health and social care but not district/borough councils.

2.14.4 There is no mention of the wider determinants of health or place shaping both of which are key in determining the health of the population.

2.14.5 The focus on prevention includes increasing awareness, uptake and capacity of health improvement services including weight management, stop smoking and some community services (social prescribing). More detail is required:

- Will the increase in capacity of tier 2 weight management programmes (from 2,348 to 10,000 a year across Kent and Medway) mean more funding will be available? Particularly as many of the programmes such as those in Maidstone have often run at capacity.
- Will community programmes which will be signposted through the social prescribing agenda be able to support an increase in capacity without additional resources? If capacity is reached and there are long waiting lists, how will people's expectations and motivations be managed?

2.14.6 Behaviour change is an important element within the STP. There is no detail as to whether training will be in place for NHS and the wider workforce to deliver and ensure behaviour change techniques are used correctly. Changing behaviour of an individual or a group is a skill. This is particularly important as signposting may not always be appropriate given the limited capacity of health improvement services and that shifting patient responsibility for their own health is a key aim.

2.14.7 There is little explanation on how and if the STP will link in and help shape the new Kent Adult Lifestyle Service.

2.14.8 There is a need to understand what incentives organisations who can support the objectives of the STP will gain from this given the

cost benefits will be seen within Health and Social care and not within their own organisations.

2.14.9 More information is needed on the workplace health initiatives that will be delivered. Are these going to build upon the Kent Healthy Business Awards which have already been a success in Maidstone and if so will there be more resources?

2.15 How the council can best contribute to the STP to bring about positive changes for our community

2.15.1 Prevention of ill health and self-care are key aims of the STP. Health is primarily determined by factors other than health care such as the environment in which people live and employment. The council can play the key role in primary prevention ensuring all our actions have a positive effect on health through tackling the wider determinants of health (Planning, Parks and Leisure, Economic Development, Licensing, Community Safety, Housing, Environmental Health etc.) which are primarily beyond the reach of health and social care. We also have a key role in place-shaping.

2.15.2 The Borough Council could also support specific parts of the STP through its various services and functions including:

- Supporting Hospital Discharge, particularly Housing Services and Homeless Prevention.
- Supporting to reduce attendances at Accident and Emergency departments, and emergency admissions to hospital beds. Through Community Safety Unit (CSU)(e.g. urban blue bus), Housing services etc.
- Support workplace health initiatives through the Kent Healthy Business Awards and Regeneration and Economic Development Service. We are in a key position to support the STP through this given the success in Maidstone of the Kent Healthy Business Awards and also the key connections and influence we have with local businesses through the Regeneration and Economic Development Service.
- Communications to provide health messages to the general public.
- Planning to support STP around Health and Social Care one public estate particularly around investing in housing and community facilities. Development of new services in community locations will mean the council will need to be involved.
- Health Improvement Services currently delivered by council.

Given the financial constraints facing the Council, any such support would be dependent on the availability of additional funding.

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3. AVAILABLE OPTIONS

3.1 The Committee can choose not to act at all as Maidstone Borough Council does not have a statutory responsibility for Health. However, this would

mean the Council foregoing the opportunity to influence the formation of the local STP which will have an impact on the health, care and wellbeing of our residents and communities.

3.2 To consider the progress made on the STP reflected in this report and send a council response to the STP team via the online survey before the 23rd of December 2016.

3.3 To complete option 3.2 but recognise the limited scope of the online survey to provide a full and comprehensive response on behalf of the council. Therefore in addition to provide a formal comprehensive response on behalf of Maidstone Borough Council to be agreed with the Chairman and Vice Chairman of the CHE Committee.

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4. PREFERRED OPTION AND REASONS FOR RECOMMENDATIONS

4.1 The preferred option is contained in paragraph 3.3, as this proposal will allow the council to provide a comprehensive response to the STP team.

4.2 A more formal response will enable the council to demonstrate the importance of being in a position to influence factors which determine our residents' health, many of which are beyond the reach of the NHS and Social Care and that the council should therefore be involved as a key partner in the formation of the STP. This will ensure better outcomes for our residents and in the long-term reduce the financial burden on services.

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5. CONSULTATION RESULTS AND PREVIOUS COMMITTEE FEEDBACK

5.1 There has been no consultation specifically on the STP. Consultations have taken place to demonstrate the importance of borough council's involvement in the public health on the following dates:

- Wider Leadership Team Workshop: Tuesday 13th September 2016. Following this session, Heads of Service were requested to nominate a health champion for their area.
- Members Workshop: Monday 17th October 2016.

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6. NEXT STEPS: COMMUNICATION AND IMPLEMENTATION OF THE DECISION

6.1 Following the decision of the Committee, should the recommendations be accepted a letter will be drafted based on the assessments within this report and signed off by the Chair and Vice Chair of the CHE Committee to go to the STP team.

6.2 There will be a Council response to the online survey before the 23rd of December based on the assessments within this report.

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7. CROSS-CUTTING ISSUES AND IMPLICATIONS

Issue	Implications	Sign-off
Impact on Corporate Priorities	The STP contributes to the delivery of the Strategic Plan priorities: Keeping Maidstone an attractive place for all and Securing a successful economy for the Maidstone Borough.	Head of Housing and Community Services
Risk Management	Not being involved in the health agenda would carry the risk that the Council is unable to influence matters relating to the health and wellbeing of its communities.	Head of Housing and Community Services
Financial	There are no direct financial implications involved relating to this report. However, this may change should the council become involved in the formulation and then delivery of the STP.	Section 151 Officer and Finance Team
Staffing	There are no staffing implications involved relating to this report.	Head of HR Shared Service
Legal	There are no legal implications identified in this report.	Interim Deputy Head of Legal Partnership
Equality Impact Needs Assessment	None	Policy & Information Manager
Environmental/Sustainable Development	None.	
Community Safety	None.	
Human Rights Act	None.	
Procurement	None	
Asset Management	None	

8. REPORT APPENDICES

The following documents are to be published with this report and form part of the report:

- Appendix 1: Letter from health and social care leaders across the NHS https://gallery.mailchimp.com/02839480f06ca808cd31129a4/files/STP_covering_letter_23_November_2016.pdf
- Appendix 2: Transforming health and social care in Kent and Medway: Summary version https://gallery.mailchimp.com/02839480f06ca808cd31129a4/files/Transforming_health_and_social_care_in_Kent_and_Medway_updated_Nov_2016.pdf
- Appendix 3: The Sustainability and Transformation Plan in Full https://gallery.mailchimp.com/02839480f06ca808cd31129a4/files/20161021_Kent_and_Medway_STP_draft_as_submitted_ii.pdf
- Appendix 4: Sustainability and Transformation Plan summary slides https://gallery.mailchimp.com/02839480f06ca808cd31129a4/files/Summary_slides_20161122.pdf

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Transforming health and social care in Kent and Medway

Letter to Kent Health Overview and Scrutiny Committee; Medway Health and Adult Social Care Overview and Scrutiny Committee; Kent Health and Wellbeing Board; Medway Health and Wellbeing Board; all Kent and Medway MPs; Healthwatch Kent; Healthwatch Medway; GPs; NHS staff in Kent and Medway; Kent County Council members and staff; Medway Council councillors and staff; NHS Health Network members; Patient Participation Group chairs and members; service user forums; foundation trust members; voluntary and community sector; Local Medical Committee, Local Pharmaceutical Committee, Local Dental Committee, Local Optometric Committee; district and borough council leaders, chief executives, members and staff; town councils; parish councils; independent providers.

23 November 2016

Dear colleague

Transforming health and social care in Kent and Medway

We are pleased to share with you our draft Health and Social Care Sustainability and Transformation Plan (STP) which sets out our thinking on how services need to change over the next five years to achieve the right care for people for decades to come.

It has been developed by NHS, social care and public health leaders in Kent and Medway. It is the first time we have all worked together in this way and it gives us a unique opportunity to bring about positive and genuine improvement in health and social care delivery over the next five years.

People in Kent and Medway need safe, high quality, integrated and sustainable health and social care services that meet their needs now and into the future.

Our draft plan builds on conversations held over several years with local people about the care they want and need, and has the patient at its heart.

However, it is work in progress - we are not putting forward concrete proposals at this stage. Instead, we are sharing our ambition for the future and our thinking on where we need to focus. We want better health and wellbeing for Kent and Medway, better standards of care and better use of staff and funds to meet the changing needs of local people.

Currently, in Kent and Medway:

- 4,000 people die early as the result of diseases which are mostly preventable
- 240,000 people over 50 are living with long-term disability, largely as the result of health conditions. Often this could be avoided or delayed if people were more active or made other lifestyle changes
- around one in four people in our hospital beds at any given time could be at home or cared for elsewhere. (This varies depending on area.). For older people this impacts on their recovery - 10 days in hospital (whether it is an acute (main) or community hospital) leads to the equivalent of 10 years' ageing in the muscles of people over 80.

To help people make the most of their lives, we want to:

- prevent ill health
- intervene earlier
- have excellent care wherever it is delivered.

Working like this will also enable us to make better use of staff and funds to secure the long-term future of health and care services.

Across Kent and Medway, health and social care have £3.4billion in funding but overspent by £141million last year. Without change, we would be looking at a gap of £486million in our budgets by 2020/21.

Successful delivery of the vision set out in our initial Sustainability and Transformation Plan will mean we expect to be in balance by 2020/21 apart from £29million, which is the expected annual cost of the health services required by the population of the new town at Ebbsfleet. We will be bidding for additional funds for this.

Our pledge to the people of Kent and Medway

We want to get this right, and we need local people's views to help us do that.

So we will use all the means at our disposal to involve patients, carers, the public and health and care professionals, at every stage.

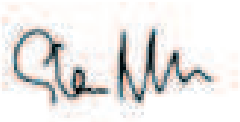
At this stage we would request that you encourage as many people as possible to:

- complete our survey which can be found at https://www.surveymonkey.co.uk/r/KandMstp
- join their GP patient participation group, clinical commissioning group Health Network or become a member of an NHS trust to be kept informed
- read the STP or the summary, *Transforming health and social care in Kent and Medway,* which sets out the key points in simpler terms
- further distribute this information so that it reaches as many people as possible in Kent and Medway.

Further information, including a glossary, and questions and answers, will be on our websites from 3pm today, 23 November 2016.

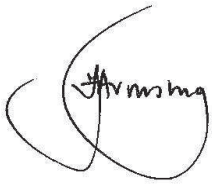
In the New Year along with more detailed information about the STP, we will publish a timetable for engaging with the public in Kent and Medway in 2017. We look forward to working with you to deliver safe, high quality, integrated and sustainable health and social care services that meet the needs of the people of Kent and Medway for the future.

Yours sincerely



Glenn Douglas, Senior Responsible Officer for the Kent and Medway Health and Social Sustainability and Transformation Plan and Chief Executive of Maidstone and Tunbridge Wells NHS Trust

Susan Acott
Chief Executive
Dartford and Gravesham NHS Trust

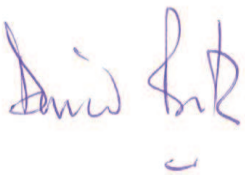


Dr Fiona Armstrong
Clinical Chair
NHS Swale Clinical Commissioning Group

Ian Ayres
Accountable Officer
NHS West Kent Clinical Commissioning Group

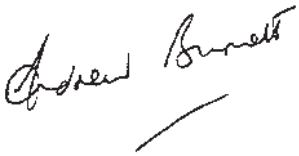
Paul Bentley
Chief Executive
Kent Community Health NHS Foundation Trust

Dr Bob Bowes
Clinical Chair
NHS West Kent Clinical Commissioning Group



David Brake
Chair
Medway Health and Wellbeing Board

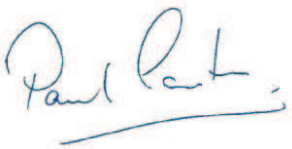
Dr Jonathan Bryant
Clinical Chair
NHS South Kent Coast Clinical Commissioning Group



Dr Andrew Burnett
Interim Director for Public Health
Medway

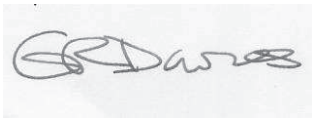
Transforming health and social care in Kent and Medway

Hazel Carpenter
Accountable Officer
NHS South Kent Coast and NHS Thanet Clinical Commissioning Groups



Paul Carter CBE
Leader
Kent County Council

Andrew Scott-Clark
Director for Public Health
Kent



Geraint Davies
Acting Chief Executive
South East Coast Ambulance Service NHS Foundation Trust

Patricia Davies
Accountable Officer
NHS Dartford, Gravesham and Swanley and NHS Swale Clinical Commissioning Groups

Lesley Dwyer
Chief Executive
Medway NHS Foundation Trust

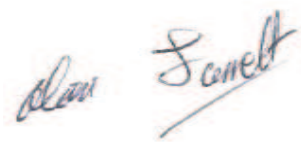
Steve Emerton
Delivery Director
Specialised Commissioning
NHS England South East

Dr Peter Green
Clinical Chair
NHS Medway Clinical Commissioning Group

Roger Gough
Chair
Kent Health and Wellbeing Board

Helen Greatorex
Chief Executive
Kent and Medway NHS and Social Care Partnership

Andrew Ireland
Corporate Director of Social Care, Health and Wellbeing
Kent County Council



Alan Jarrett
Leader
Medway Council

Bart Johnson
Chief Executive
Virgin Care

Matthew Kershaw
Chief Executive
East Kent Hospitals
University NHS
Foundation Trust

Dr Navin Kumta
Clinical Chair
NHS Ashford Clinical
Commissioning Group

Dr Elizabeth Lunt
Clinical Chair
NHS Dartford,
Gravesham and Swanley
Clinical Commissioning
Group

Dr Tony Martin
Clinical Chair
NHS Thanet Clinical
Commissioning Group

Simon Perks
Accountable Officer
NHS Canterbury and
Coastal Clinical
Commissioning Group
and NHS Ashford
Clinical Commissioning
Group

Dr Sarah Phillips
Clinical Chair
NHS Canterbury and
Coastal Clinical
Commissioning Group

Martin Riley
Managing Director
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Caroline Selkirk
Accountable Officer
NHS Medway Clinical
Commissioning Group

Philippa Spicer
Director
Health Education Kent
Surrey Sussex

Ian Sutherland
Interim Director
Children and Adult
Services
Medway Council

Transforming health and social care

in Kent and Medway

Updated November 2016

What's this about?

People in Kent and Medway need safe, high quality, integrated and sustainable health and social care services that meet their needs now and into the future. So the NHS, social care and public health in Kent and Medway are working together to plan how we will transform our services to meet the changing needs of local people. It is the first time we have all worked together in this way and it gives us a unique opportunity to bring about positive and genuine improvement in health and social care delivery over the next five years.

We need your help with this. Please see the end of this leaflet for details of how you can help shape services for the future.

How will our plan benefit you as someone who lives in Kent and Medway?

You can expect to see:

- **joined-up services** to treat and care for you at home and support you to leave hospital as soon as you're medically fit to leave: "your own bed is the best bed"
- **health and social care professionals** coming together to work as a single team for your local area, able to access your records 24 hours a day (with your consent)
- **a modern approach** to health and social care services using the best technology, from booking your appointment online to virtual (but secure) consultations, online assessment and diagnostic systems, and advice on apps to monitor your health
- **timely appointments** with the right professional
- **care for you as a whole**, for both your physical and mental health
- **regular monitoring** if you have complex health conditions affecting your physical or mental health, or both
- **more support** from voluntary and charitable organisations which already play such an important part in our communities
- **better access** to health improvement advice and services to help you improve and manage your own health and so reduce your risk of serious illness
- **"social prescribing"** - information to help you access relevant support from voluntary, charitable and local community groups or services
- **quality hospital care** when you need it – and more care, treatment and support out of hospital when you don't.

Currently, in Kent and Medway:

- **4,000 people** a year die early as the result of diseases which are mostly preventable[1]
- **240,000 people** over 50 are living with long-term disability which could potentially be avoided or delayed[2]
- around **one in four people** in our hospital beds at any given time could be at home or cared for elsewhere. (This varies by area.) For older people this impacts on their recovery - 10 days in hospital (whether it is a main or community hospital) leads to the equivalent of 10 years' ageing in the muscles of people over 80.[3]

To help people make the most of their lives, we want to:

- prevent ill health
- help people with treatment and advice earlier
- have excellent care wherever it is delivered.

Working like this will also enable us to make better use of staff and funds to secure the long-term future of health and care services.

1 such as lung cancer, heart disease and type 2 diabetes.

2 the disability is largely as a result of health conditions which can often be avoided or delayed by lifestyle changes, such as being more active in everyday life.

3 this comes from a study by Kortebein P, Symons TB, Ferrando A, et al. (2008): Functional impact of 10 days of bed rest in healthy older adults.

So what is the plan?

We – the leaders of all the NHS organisations in Kent and Medway, and Kent County Council and Medway Council which plan and pay for public health and social care – have developed a draft Health and Social Care Sustainability and Transformation Plan (STP). It is based on what people have told us they want from services over recent years, and detailed work carried out by health and social care professionals to assess what will best meet people's needs. It sets out how we think services need to change over the next five years to achieve the right care for people for decades to come and to improve people's health and wellbeing.

It is a work in progress because we need to engage with you, the people who live and work in Kent and Medway, including frontline health and care professionals, so we can get it right.

The plan will provide:

Better health and wellbeing

We want to:

- create services which are able to meet the needs of our changing population, as people age, and more people move into Kent and Medway
- reduce health inequalities (unfair differences in health and life expectancy that people experience in some parts of the county) and death rates from preventable conditions
- increase services to prevent and manage long-term health conditions such as diabetes and lung disease.

Better standards of care

We want to:

- make sure people are cared for in the right place and get high quality, accessible social care across Kent and Medway
- reduce attendances at Accident and Emergency departments, and emergency admissions to hospital beds
- make sure local providers of health and social care deliver high quality services, which meet nationally recognised clinical quality standards.

Better use of staff and funds

We want to:

- attract, retain and grow a talented workforce – and use them to the best effect
- consolidate some of our specialist clinical staff and equipment so they can work more effectively across a wide population as expert teams
- work within the budget we have for health and social care across Kent and Medway.

Across this area, the NHS and social care have £3.4billion in funding but overspent by £141million last year. Without change, we would be looking at a gap of £486million in our budgets by 2020/21.

We have identified key priorities for the transformation of care:

1. **Prevention of ill-health**
2. **Local care**
3. **Hospital care**
4. **Mental health**

Prevention
everyone has a part to play

A number of the health problems people face in Kent and Medway are preventable, and sometimes small changes can make a big difference. We are enlisting the whole Kent and Medway community in improving health and wellbeing so people stay well, look after each other, and use services only when they need to.

Our prevention programme will:

- treat both physical and mental health issues at the same time and effectively
- concentrate prevention activities on key areas – obesity and physical activity, reducing alcohol-related harm, preventing and stopping smoking
- deliver workplace health initiatives, aimed at improving the health of staff delivering services.

Local care
better access to care and support in people's own communities

GPs, nurses, therapists, social care workers, mental health staff and urgent care staff in Kent and Medway are already looking at how they can work together across towns and rural areas so that you can get the care you need at home and in your community wherever possible, reducing the need for you to go to hospital.

People with long-term health problems and disabilities have told us they want:

- to have all their needs and what works for them taken into account
- co-ordinated support given by professionals who talk and work together
- to tell their story once and have easy, co-ordinated, access to services.

The aim is for you to be supported by a single team of health and social care professionals, with GP leadership, which treats your physical and mental health needs, seven days a week. And helps you take control if you have a long-term health problem, so you are expert at managing your own health.

The table on the next page shows the number of teams (called extended practices) each area expects to have: three in the Ashford area, five in the Canterbury and Coastal area, and so on. GP practices within these teams will work together, to share expertise and to enable them to provide a range of different services for people seven days a week. Community, mental health, social care and other staff will be "wrapped around" the practices to form "place-based" teams, focused on working together to care for the patients in that place.

This integrated approach will enable GPs, nurses, therapists and others to spend more time on looking after frail patients, people with complex needs including mental health needs, and patients at the end of their lives.

We also intend for every part of Kent and Medway to have access to more specialist and out of hours services, provided by a hub.

The services provided could be:

- outpatient appointments with a GP who specialises in treating a particular health problem, a highly trained nurse or a consultant – either in person or via your phone or your computer
- minor injuries units where clinicians can see and treat a range of conditions, such as suspected fractures of arms and lower legs, sprains and strains, wound infections, minor burns, bites and stings
- mental health screening and assessment
- dementia diagnosis
- end of life care
- social care.

	Ashford	Canterbury & Coastal	DG&S	Medway	Thanet	Swale	South Kent Coast	West Kent
Population	129,000	220,000	261,000	295,000	144,000	110,000	202,000	479,000
No. GP practices	14	21	34	53	17	19	30	62
Average list size	9,200	10,500	7,700	5,600	8,500	5,800	6,700	7,700
Extended practices	3	5	TBC	9	4	TBC	4	9
Population	30-60k	30-60k	20-40k	30k	30-60k	20-40k	30-60k	TBC
Hubs	1	1	5	3	1	2	1	3-5
Population	129,000	220,000	50k	100k	144,000	50k	202,000	TBC

Note 1: "hub" is used in two ways – in east Kent, it means the organisation that will purchase and provide the full range of local care (irrespective of where that care is provided). In the rest of Kent and Medway, it means the building from which more specialist and out of hours services will be provided, such as a community hospital.

Note 2: This table sets out emerging ideas. TBC means there is not yet a view of how many teams there will be in a CCG area, or how many people each team or hub will serve.

Next steps on local care

We want to:

- enable all health and social care professionals to be able to access your health records in one place, 24 hours a day when they need to (with your consent)
- use anonymous information from the whole of Kent and Medway health and social care, looking at it for the first time as a whole, to improve planning and care delivery
- work towards pooling of budgets and staff from different organisations and break down barriers to integrated health and social care, and community-based and hospital care
- maximise co-location of staff and the best use of our buildings.

3 Hospital care
in a community, mental health or acute (main) hospital

We will provide hospital care when it is needed and ensure it is of the best possible quality, whether it is in a community, mental health or acute (main) hospital. At the moment, around 25 per cent of the beds in our main hospitals (this varies by area) are occupied by people who could be better treated in their homes or local communities. Our plan is to make sure local care facilities and support are in place so we can reduce the total number of beds in our main hospitals by 10 per cent and reorganise the way services are provided. By doing this we believe people will get the best possible care and we will be able to reduce some of the high costs associated with hospital-based care. We will use the same money to strengthen access to care and support in people's own communities.

Stroke and vascular reviews

Someone who has just had a stroke needs treatment in a highly specialist stroke unit where they get rapid access to first class diagnostics, specialist assessment and intervention, seven days a week. This saves lives and reduces disability.

Reviews of stroke services in Kent and Medway and vascular procedures (for artery and vein problems) are already underway and will continue as part of our plan. We expect to carry out a public consultation next summer. More information about the reviews is available on the clinical commissioning group (CCG) websites – details are at the end of this leaflet.

Separating planned and unplanned care

We are also exploring the idea of creating specialist centres for planned surgery such as hip and knee replacements to separate these services from emergency care. Experience from other parts of the country shows this can significantly improve care for patients, including speeding up how quickly they get the operation they need, and reducing the risk of cancellations because of surgeons being called away to operate on emergency patients.

Enhancing recovery

We are learning from each other and from best practice round the country – particularly a programme known as NHS RightCare – about how we can reduce complications from surgery or other planned treatment so you get a better result, needing less time in hospital, and less follow-up.

Next steps on hospital care

East Kent health and social care leaders have been working together as the East Kent Strategy Board since September 2015, to determine how best to provide health and social care services to the population of east Kent. This programme, which is now part of the Kent and Medway STP, has carried out engagement with local people, councils, MPs and other stakeholders, and frontline professionals.

Building on this work, we have looked at a number of options and, making sure we enhance local care closer to people's homes as described above, we now want to explore the creation in east Kent of:

- one emergency hospital centre with specialist services, including planned care
- one emergency hospital centre, including planned care
- one planned care hospital centre focusing on planned inpatient orthopaedic surgery or treatment, supported by rehabilitation services, and a GP-led urgent care centre
- all supported by strong local care (the care and support people can get in their own communities).

The main hospitals in east Kent already work in different ways. For example, there are Accident and Emergency departments at the hospitals in Margate and Ashford, and an Urgent Care Centre at Canterbury; acute general surgery is based at Margate and Ashford, and some of the hospitals provide a service for the whole of Kent and Medway, for example, specialist cardiology at Ashford.

In the rest of Kent and Medway, Medway NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust have agreed to complete by the end of 2016:

- a strategy for development of acute (main) hospital services
- a strategy for planned care.

Without merger or acquisition, Dartford and Gravesham NHS Trust and Guy's and St Thomas' NHS Foundation Trust are working together to develop a model of care locally that will improve outcomes for patients, meet the challenges of increased demand and reduce costs. They have been selected to work together as a pilot site called the Foundation Healthcare Group, sharing information, knowledge and building new networks to enhance care in a way that can be replicated elsewhere.

4 Mental health
just as important as physical health

Mental health will be an integral part of local care. In addition we have several specific schemes to improve care including:

- a single phone number for people in Kent and Medway in a mental health crisis
- reducing to zero the number of people placed in private mental health beds out of county
- bringing back to Kent and Medway as many people as possible placed out-of-area for specialist care
- improving interventions for people experiencing psychosis for the first time
- improving care for children and young people with mental health and emotional wellbeing issues.

Greater efficiency through smarter working

In addition, we are looking to become more efficient by sharing services. These include a shared pathology service (which tests blood and cells) and looking at how we can make better use of our buildings by sharing space. And we want to develop computer systems that all parts of the health and social care network can use (your consent will be sought if this involves looking at your records).

The organisations which commission (plan and purchase care) are also planning to develop arrangements that enable health and social care commissioning at a strategic level across Kent and Medway.

How will the STP help us do better with the resources we have?

The draft STP maps out how, by improving care for patients, being more efficient and providing higher quality services, we can make better use of our staff and money so we can meet rising demand.

If we do nothing, patients will not get the best care, people's health and wellbeing will not improve, and we will be looking at a hole of £486million in our budgets by 2020/21.

We intend to invest millions more every year in local care to enable the improvements to people's care outlined above. We believe this will release around £165million currently spent on hospital care, though this is still work in progress and forms part of the work we want to engage on with you.

Commissioners and providers will continue to manage services in the most cost-effective way. For the NHS, this means continuing with our routine cost improvement programmes and our drive to improve quality, innovation, productivity and prevention. By working in new and different ways, we think we can reduce costs by £292million.

We expect to be in balance by 2020/21 apart from £29million, which is the expected annual cost of the health services required by the population of the new town at Ebbsfleet. We will be bidding for additional funds for this.

Background information

Our plan for Kent and Medway builds on good work already undertaken. To find out more, visit

- **www.eastkent.nhs.uk** to read Better health and care in east Kent: time to change
- **www.westkentmappingthefuture.nhs.uk**
- **http://consultations.kent.gov.uk/consult.ti/adultsstrategy/consultationHome**

Have your say

The STP will bring about a profound shift in where and how we deliver care. Our draft plan builds on conversations held with local people over several years about the care they want and need, and has the patient at its heart.

A Clinical Board, which includes local GPs, hospital doctors and senior social care practitioners, is overseeing development of the plans for prevention, local care, hospital care and mental health. They will ensure these plans are underpinned by professionals' knowledge and expertise.

We are also setting up formal groups – including a Partnership Board and a Patient and Public Advisory Group – to test and discuss the programme with us. We expect to produce a more detailed case for change early next year.

We recognise that people's needs are different across Kent and Medway. Our proposals for the future, which will be based on the thinking outlined in this document, will take this into account.

That's why it is so important that you have your say at every stage, to shape the services available to you.

In the New Year, along with more detailed information about the STP, we will publish a timetable for engaging with the public in Kent and Medway in 2017. In the meantime, we ask you to help us shape our ideas and plans by filling in this survey, which closes on 23 December 2016:
www.surveymonkey.co.uk/r/KandMstp

You can also access the survey via the website of your local clinical commissioning group (see below) where you will also find more information about how you can get involved. Many CCGs have health networks which you can join to get a regular update.

www.ashfordccg.nhs.uk Ashford, Tenterden and rural area

www.canterburycoastalccg.nhs.uk Canterbury, Faversham, Herne Bay, Sandwich and Ash, Whitstable

www.dartfordgraveshamswanleyccg.nhs.uk the boroughs of Dartford and Gravesham and the northern part of Sevenoaks district including Swanley town

www.medwayccg.nhs.uk Medway Council area

www.southkentcoastccg.nhs.uk Deal, Dover and the district of Shepway, including Folkestone and Romney Marsh

www.swaleccg.nhs.uk Sittingbourne, Sheppey and surrounding villages

www.thanetccg.nhs.uk the district of Thanet

www.westkentccg.nhs.uk the boroughs of Maidstone, Tonbridge and Malling and Tunbridge Wells, and the southern part of Sevenoaks district

Kent and Medway STP

Update

Case for change: overview

Health and wellbeing

- **Population growth**: Projected to grow by c5% (≈ 89,000 people) over the next five years, with uneven growth across the patch putting pressures on some parts of the system
- **Ageing population**: Largest age group growth is in demographic of 85+ years bringing increased needs for health and social care
- **Health inequality**: Range of life expectancies for both men and women related to deprivation exist, with the main causes of death being from preventative interventions and the gap has not closed over the last 10 years
- **Housing growth**: Kent and Medway earmarked for significant housing growth e.g. Ebbsfleet, adding to the demand for health and care services

Quality of care

- **Stresses in the system**: Services close to capacity across the patch with acute occupancy in the 90s; EKHUFT, SECamb and MFT in special measures; a high ratio of patients to GPs and a number of GPs giving up general medical services (GMS) contracts or retiring
- **Delivery of constitutional targets:** Delayed transfer of care, A&E targets, Referral To Treatment, cancer targets, ambulance response times and other services pressures (e.g. stroke) continue to be an ongoing issue
- **Workforce issues**: Significant workforce issues around recruitment, rotas and maintaining a viable workforce impacting health and social care

Sustainability

- **Financial sustainability**: 15/16 deficit of £109m forecast to rise to £434m by 20/21 in a 'do nothing' scenario (this excludes social care budget pressures (KCC £45m, Medway Council £7m).
- **Clinical sustainability**: Growing reliance on agencies due to workforce issues around unsustainable rotas, recruitment and retention

Transformation: four themes

Care Transformation

We are transforming our care for patients, moving to a model which prevents ill health, intervenes earlier, and delivers excellent, integrated care closer to home.

This clinical transformation will be delivered on four key fronts:

- **Local care (Out-of-hospital care)**
- **Hospital transformation**
- **Mental health**
- **Prevention**

Productivity and modelling

We will undertake a programme to identify, quantify and deliver savings through collaborative provider productivity addressing the following areas:

- **CIPs and QIPP delivery**
- **Shared back office** and corporate services (e.g., Finance, Payroll, HR, Legal)
- **Shared clinical services** (e.g. Pathology integration)
- **Procurement** and supply chain
- **Prescribing**

Enablers

We need to develop three strategic priorities to enable the delivery of our transformation:

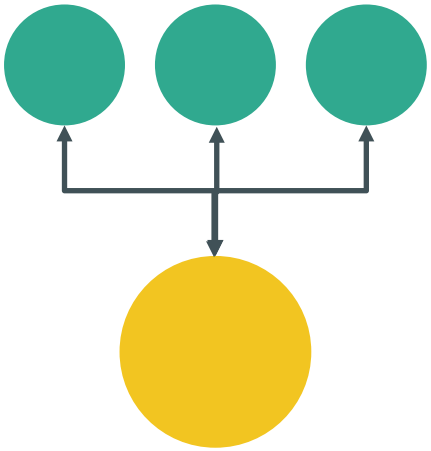
- **Workforce**
- **Digital**
- **Estates:** Achieving 'One Public Estate' by working across health organisations and local authorities to find efficiencies, deliver new models of care, and develop innovative ways of financing a step change in our estate footprint

System Leadership

A critical success factor of this programme will be system leadership and system thinking. We have therefore mobilised dedicated programmes of work to address:

- **Commissioning transformation:** Enabling profound shifts in the way we commission care
- **Communications and engagement:** Ensuring consistent communications and inclusive engagement

We are delivering Local Care by scaling up primary care into clusters and hub-based Multi-speciality Care Provider models

Local Care infrastructure		Description	Population served
GP practices		• Individual GP practices providing limited range of services • Many working well at scale, others struggling with small scale and related issues incl. workforce	• Various
Tier 1 Extended Practices with community and social care wrapped around		• Larger scale general practices or informal federations • Providing enhanced in-hours primary care and enable more evening and weekend appointments.	• 20 – 60k
Tier 2 MCPs/PACS based around community hubs		• Multi-disciplinary teams delivering physical and mental health services locally at greater scale • Seven day integrated health and social care	• 50 – 200k

Our local implementation of the Kent and Medway model varies to meet the needs of our populations

Summary of Local Care models across Kent and Medway

	Ashford	Canterbury & Coastal	DG&S	Medway	Thanet	Swale	South Kent Coastal	West Kent
Population	129,000	220,000	261,000	295,000	144,000	110,000	202,000	479,000
No. GP practices	14	21	34	53	17	19	30	62
Average list size	9,200	10,500	7,700	5,600	8,500	5,800	6,700	7,700
Extended practices	3	5	TBC	9	4	TBC	4	9
Population	30 – 60 k	30 – 60 k	20 – 40k	30 k	30 – 60 k	20 – 40k	30 – 60 k	TBC
Hubs (virtual / physical)	1	1	5	3	1	2	1	3 – 5
Population	129,000	220,000	50 k	100 k	144,000	50 k	202,000	TBC
Chair	Navin Kumta	Sarah Phillips	Elizabeth Lunt	Peter Green	Tony Martin	Fiona Armstrong	Jonathan Bryant	Bob Bowes
AO	Simon Perks	Simon Perks	Patricia Davies	Caroline Selkirk	Hazel Carpenter	Patricia Davies	Hazel Carpenter	Ian Ayres

Notes: Whitstable Vanguard represents 4 of the 5 hubs in Canterbury and Coast CCG. Ashford, Canterbury & Coastal, South Kent Coast and Thanet have no extended practices; practices grouped directly into hubs.
Source: CCG returns, September 2016

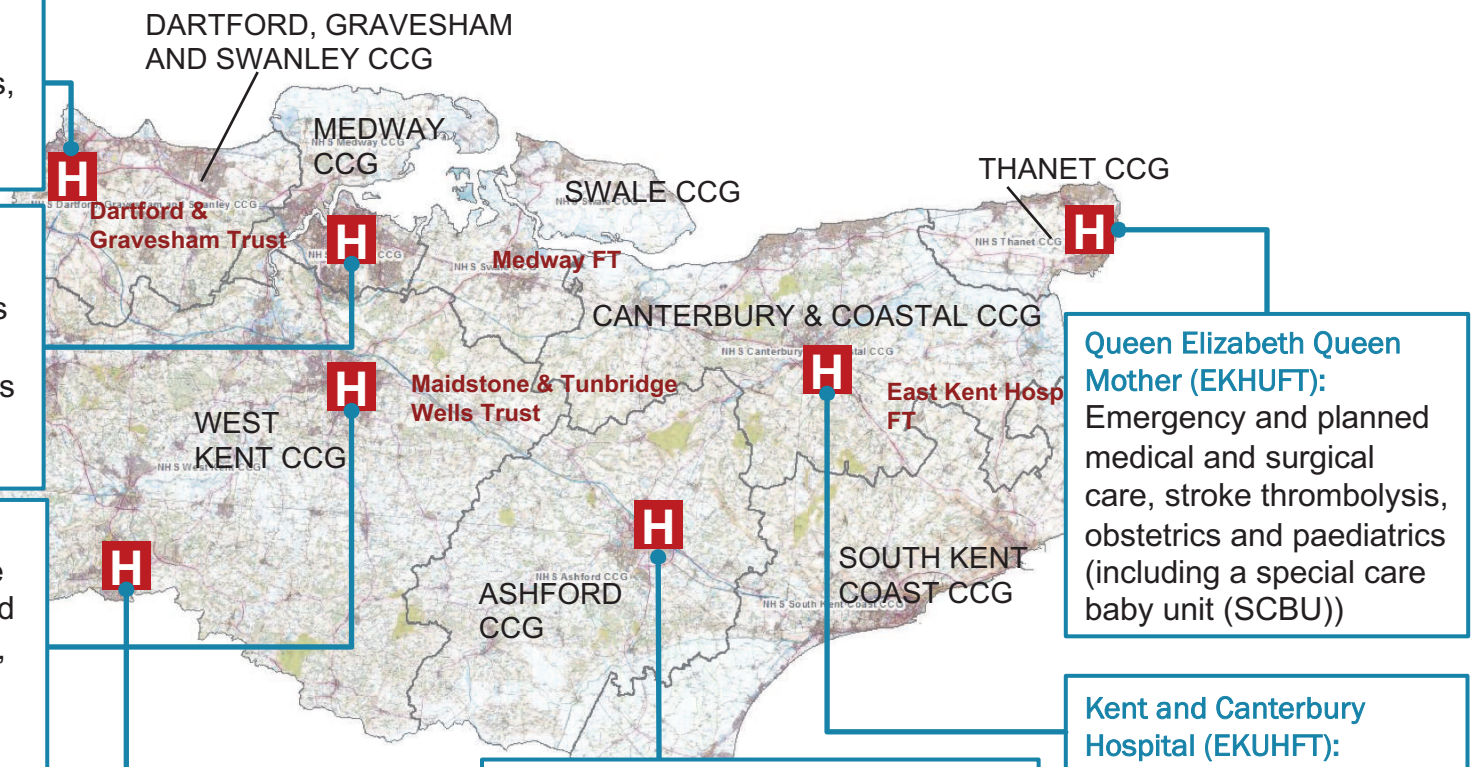
Our Acute Care model is partially consolidated, but is still largely based on historic dispersal of services

Darent Valley Hospital (DGT):
Emergency and planned medical and surgical care, plus stroke thrombolysis, obstetrics and paediatrics (including a special care baby unit (SCBU))

Medway Maritime Hospital (MFT):
Emergency and planned medical and surgical care, some specialist services (e.g. vascular, stroke thrombolysis, trauma unit), obstetrics and paediatrics (including a neonatal intensive care unit (NICU))

Maidstone Hospital (MTW):
Emergency and planned medical care (with midwife led birth centre), planned surgical care (no emergency surgery), including cancer centre, stroke thrombolysis, and ambulatory paediatrics

Tunbridge Wells Hospital (MTW):
Emergency and planned medical and surgical care, plus trauma unit, stroke thrombolysis, obstetrics and paediatrics (including a neonatal intensive care unit (NICU))



Queen Elizabeth Queen Mother (EKHUFT):
Emergency and planned medical and surgical care, stroke thrombolysis, obstetrics and paediatrics (including a special care baby unit (SCBU))

Kent and Canterbury Hospital (EKUHFT):
Emergency medical care (through acute medical take but no A&E) and some specialist provision, e.g. emergency / planned vascular, but no routine emergency surgery

William Harvey Hospital (EKUHFT):
Emergency and planned medical and surgical care, plus emergency primary percutaneous coronary intervention (pPCI), trauma unit, stroke thrombolysis, obstetrics and paediatrics (including a neonatal intensive care unit (NICU))

Progress has been made in the re-design of acute services across Kent and Medway

K&M strategic priorities: Consolidation of emergency and elective services

- Further develop our accident and emergency centre to create emergency hospital centres with specialist services and separate emergency hospital centres;
- Establishment of specialist planned care hospital centres;
- Further consolidation and co-location of specialist services such as primary percutaneous coronary intervention; vascular, renal, head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology in patient services;
- Further development of Kent's cancer centre;
- 10 clinical standards for urgent care being met;
- Exploration of more complex / specialised services in a shared care model between London and local providers;
- Development of new and innovative models of care.

East Kent

- EKHUFT has modelled the shift in activity and capital requirements for a range of acute configuration options
- EKHUFT's plans are based on improvements to local care which will mean 300 acute beds will be no longer needed
- EK's initial thinking sees the creation of one emergency hospital centre with more specialised services[1] and a trauma unit serving east Kent
- This site will be supported by a further emergency hospital centre and a planned care hospital, supported by rehabilitation services and a primary care led urgent care centre
- Emerging model has potential to deliver over £90m efficiencies in EKHUFT and deliver sustainable services that deliver high quality care

Medway, North Kent and West Kent

- The boards of MFT and MTW have agreed to a short process to complete primary objectives by the end of 2016:
  - The development of a single draft document setting out the strategic direction of acute services
  - The identification of opportunities for consolidation and greater efficiency in back office services
  - A coherent shared strategy for planned care (e.g. hip and knee replacements) potentially taking the shape of a single shared centre
- A collaboration between DGT and GSTT to develop a Foundation Healthcare Group model

Note: [1] Including primary percutaneous coronary intervention (pPCI), vascular, renal head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology specialist in patient services

Our Mental Health programme will delivery parity of esteem, promote health and wellbeing, integrate physical and mental health services and improve crisis care

Our vision

We will ensure that our Mental Health provision delivers parity of esteem for any individual with a mental health condition

Our vision is to ensure that within Kent and Medway we create an environment where mental health is everyone's business, where every health and social care contact counts where we all work together to encourage and support children, their parents, young people and adults of all ages with a mental health problem or at risk of developing one to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.

Local Care:

- Promoting wellbeing and reducing poor health
- Delivering integrated physical and mental health services

1. **Live well service**
2. **Open Dialogue Pilot**
3. **Encompass MCP Vanguard**
4. **Single point of access**
5. **Complex needs**

Acute Care:

- Delivering improved care for people and their carers when in a crisis

1. **Improved patient flow**
2. **Therapeutic staffing and peer support**
3. **Liaison Psychiatry**
4. **Personality disorder pathway**
5. **Single point of access**

We are enlisting the whole Kent and Medway community in improving health and wellbeing through our prevention programme

Our vision

- Improve health and wellbeing for our population, reducing their need for health and care services
- We aim to make this vision the responsibility of all health and social care services, employers and the public
- We will achieve this by:
  - delivering workplace health initiatives, aimed at improving the health of staff delivering services;
  - industrialising clinical treatments related to lifestyle behaviours and treat these conditions as clinical diseases;
  - treating both physical and mental health issues concurrently and effectively; and
  - concentrating prevention activitiesin four key areas

Our prevention priorities

- **Obesity and Physical Activity**: 'Let's Get Moving' physical activity pathway in primary care at scale across Kent and Medway. Increase capacity in Tier 2 Weight Management Programmes from 2,348 to 10,000
- **Smoking Cessation and Prevention**: Acute trusts becoming smoke-free with trained advisors, tailored support for the young and youth workers, pregnant and maternal smokers and people with mental health conditions.
- **Workplace Health**: Working with employers on lifestyle interventions and smoking and alcohol misuse, providing training programmes for improved mental health and wellbeing in the workplace
- **Reduce Alcohol-Related Harms in the Population**: 'Blue Light initiative' addressing change-resistant drinkers. 'Identification and Brief Advice' (IBA) in hospitals ('Healthier Hospitals initiative') and screening in GPs. Alcohol health messaging to the general population

We have mobilised Enabler groups to deliver our transformation

Workforce

Developing a workforce strategy to deliver the transformation required in K&M

Key objectives:

- Develop a fit for purpose infrastructure for workforce scheduling and planning assurance across K&M, particularly to support new care models
- Undertake an Organisational Design (OD) programme of work to ensure system leadership and talent management is in place to support the STP
- Analyse demand and projection of supply to support safe service and rota arrangements
- Develop a Kent and Medway Medical School for both undergraduate and post-graduate education
- Increase supply and develop specific roles in K&M proactively e.g. paramedic practitioners; dementia care workforce; pharmacy in community and primary care, physicians assistants

Estates

Establishing a single, K&M-wide view of estate held by health and care organisations (including LAs)

Key objectives:

- Establish a Kent and Medway-wide view of estate held by health and care organisations and develop a long-term estates plan to enable the required transformation
- Establish and maintain the baseline metrics for the estate, covering: land ownership, running costs, condition, suitability and occupancy
- Implement an estate efficiency savings programme through: optimising asset utilisation and occupancy; overall management of the estate; consolidation of support services; and realisation of surplus assets across the common estate.
- Redesign and align the estate footprint to support new care models , including the disposal of estates asset and exploring funding models

Digital

Delivering the digital capabilities that are necessary to underpin and facilitate the STP

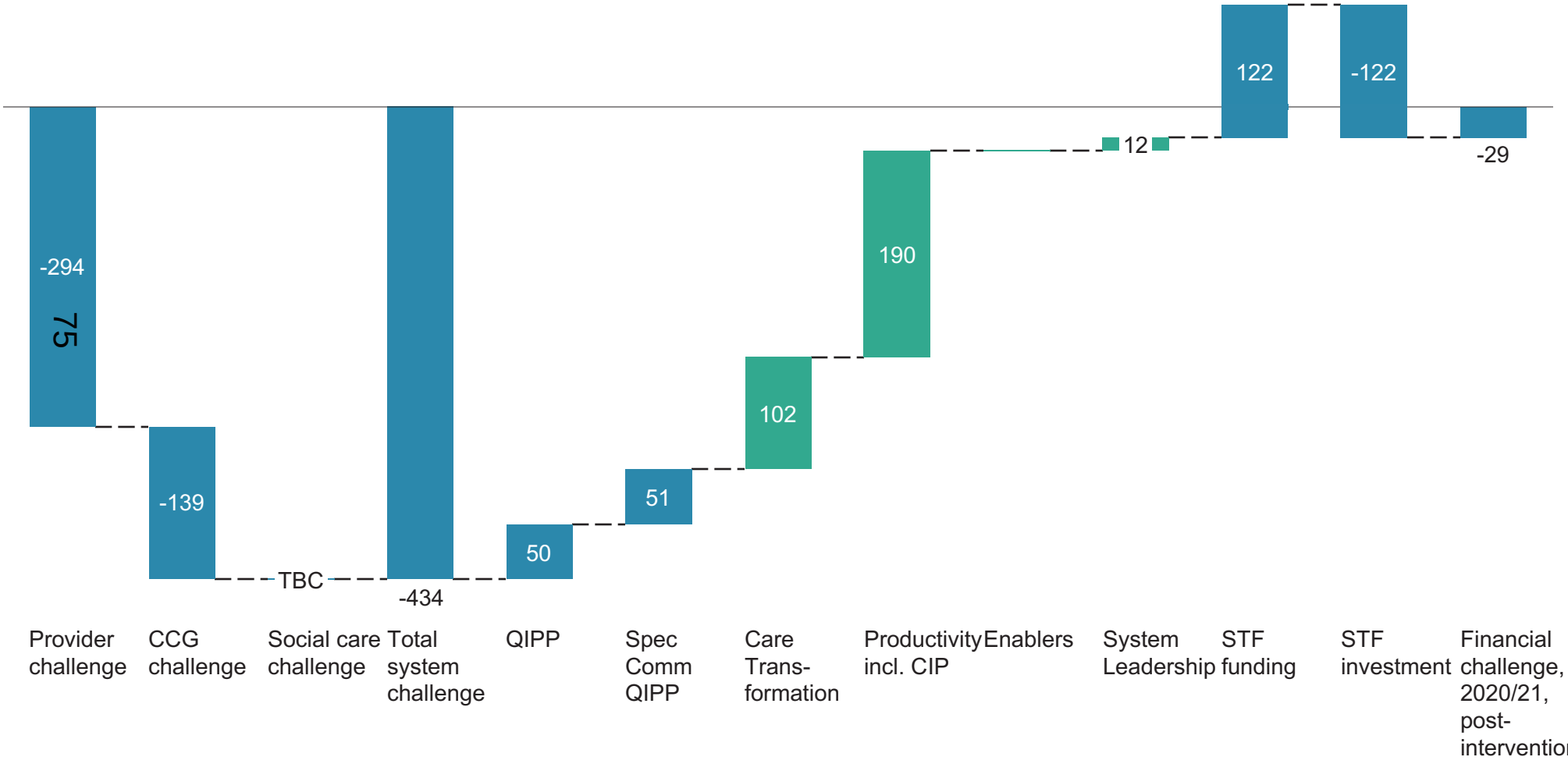
Key objectives:

- Provide all STP workstreams with the Information Management and Technology capabilities necessary to deliver the transformation required
- Design and deliver a universal care record across K&M
- Ensure universal clinical access – facilitating effective and efficient care so that patients can get the right care in the right place by professionals with the right information the first time
- Establish universal transactional services and shared management information systems
- Improve communications and networking of clinical and non-clinical services across K&M
- Facilitate self care by harnessing technology such as wearable devices and patient-centric monitoring

Source: Kent & Medway STP PMO

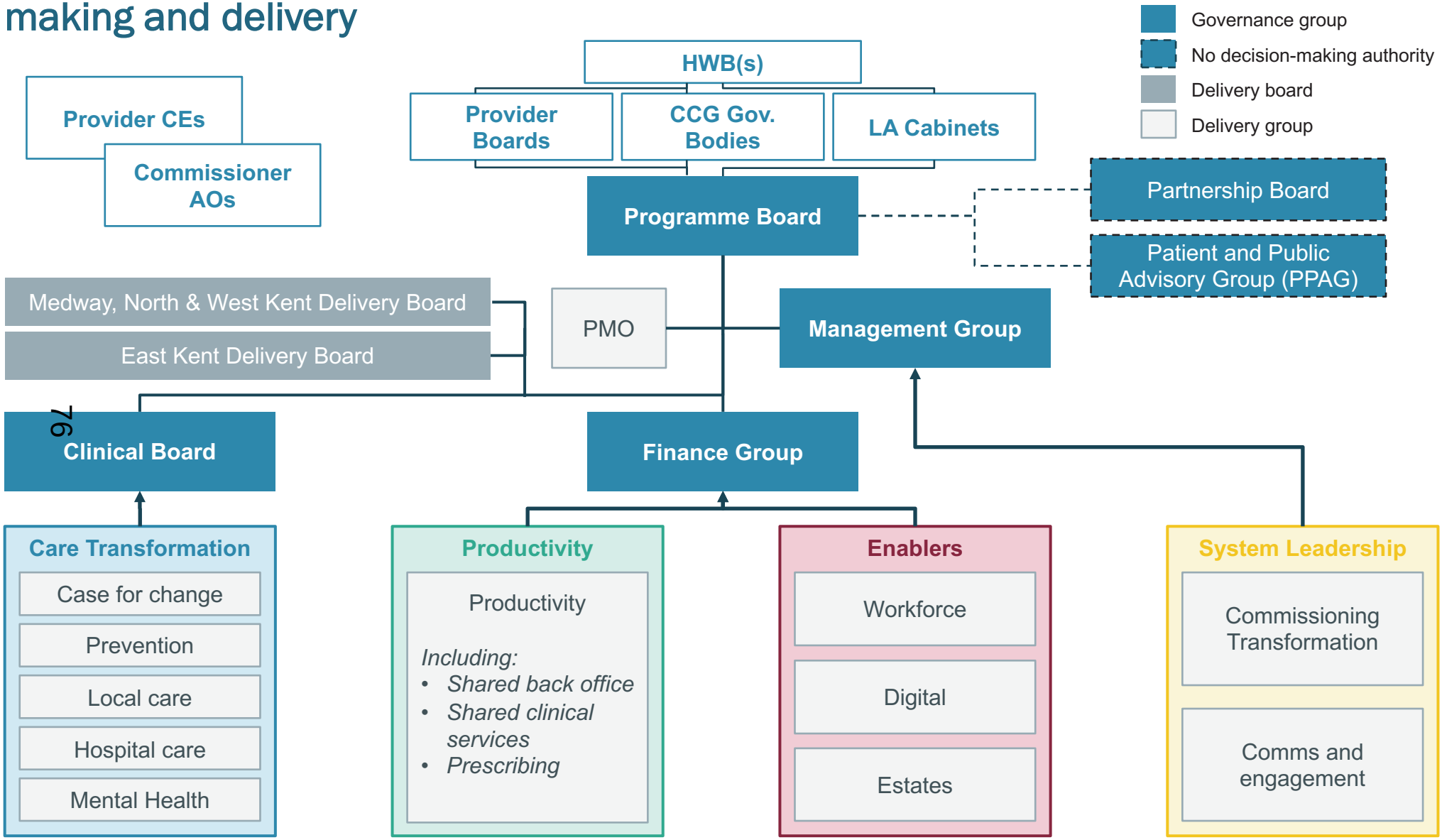
Our financial plan brings the system close to balance

£ Millions, Kent and Medway health system



These figures exclude the social care budget pressure of £52m by full-year 2020/21 (KCC £45m, Medway Council £7m).

We have strengthened our STP governance arrangements to accelerate decision-making and delivery



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

Incorporating existing work programmes: East Kent Strategy Board

EKSB's role to date

- Established Sept 2015. Collaboration of local health and social care leaders to focus on transformation and service re-design
- Ambition: make health and social care services safe, high quality and affordable for the long-term – same as STP guiding principle. EKSB work *is* the STP content for east Kent
- Significant and wide-ranging work programme looking at all aspects of health and social care economy
- Case for change developed and published Aug 2016.

Shift to STP governance

- EKSB work to merge with STP programme – single coherent plan and consistent approach across Kent and Medway
- EKSB becomes East Kent Delivery Board within STP programme governance, but local CCGs remain decision-making bodies
- A single programme approach will help deliver one, consistent 'model of care' for local (out of hospital) and specialist hospital-based services across Kent and Medway, and shared strategies for 'enablers' such as finance, workforce, IT etc
- Ability to maximise improvements at scale (specialist services such as stroke).

Future focus

- Develop clinically and financially sustainable local service proposals within Kent and Medway strategy framework.
  - drive development and delivery of service proposals that meet local residents needs and reflect principles/approach for Kent and Medway
  - develop, review and agree models of care with local clinical leadership and widespread clinical engagement – test and share across Kent and Medway
  - foster local ownership of proposed changes and drive comms and engagement about proposals
  - ensure East Kent commissioners make final decisions about local changes.

We are pressing ahead to meet key programme milestones

Design
Oct – Dec 2016

- **Oct 2016:** Programme governance arrangements agreed; PMO, workstreams and Oversight Groups mobilised
- **Nov 2016:** Clinical model evaluation criteria agreed at Programme Board
- **Nov 2016:** Initial clinical model options set out
- **Nov 2016:** Local Care and Hospital transformation modelling completed
- **Nov 2016:** Initiate pre-consultation engagement
- **Dec 2016:** Clinical Board and Programme Board review case for change
- **Dec 2016:** Organisations develop Operational Plans for FY17/18

  Note: though this is not the direct responsibility of the STP, the STP will track progress and hold peers to account

Prepare for consultation
2017

- **Jan 2017:** Case for change published
- **Feb 2017:** Critical workforce analysis completed
- **Feb 2017:** Clinical model options evaluated against agreed criteria
- **March 2017:** Formal sign off of agreed clinical model
- **April 2017:** Pre-Consultation Business Case developed
- **April 2017:** Consultation document developed
- **May 2017:** CCG governing bodies approve PCBC, consultation document and consultation plan
- **May 2017:** NHS gateway approval secured
- **June 2017:** Consultation begun
- **Aug 2017:** Review responses
- **Dec 2017:** Final consultation decision made
- **Dec 2017:** Implementation plan developed

Implement
2018 – 2020

- **Implementation of overall programme, based on output of previous phases**
  - Implementation plans identified to be rolled out in waves to ensure delivery
  - Wave durations vary by workstream (between 3-6 months)
- **STP PMO to remain in place to monitor and ensure effective implementation of programme**
  - Phased transition of oversight and monitoring from the STP PMO after wave 1, to ensure ownership by relevant stakeholders

Source: Kent and Medway STP PMO

Transforming health and social care in Kent and Medway

Sustainability and Transformation Plan

21st October 2016
Work in progress

Transforming Health and Social Care in Kent and Medway

Kent and Medway, like other parts of England, have the challenge of balancing significantly increasing demand, the need to improve quality of care and improve access all within the financial constraints of taxpayer affordability over the next five years. Health and social care, with partners, have come together to develop this Sustainability and Transformation Plan. We have a track record of working well together and, increasingly, of integrating our approach to benefit our population by achieving more seamless care, and workforce and financial efficiencies.

This is an exciting opportunity to change the way we deliver prevention and care to our population. We are working in new ways to meet people's needs and aspirations, ensuring an increased quality of support by a flexible NHS and social care provision.

Our main priority is to work with clinicians and the public to transform Local Care through the integration of primary, community, mental health and social care and re-orientate some elements of traditional acute hospital care into the community. This allows patients to get joined-up care that considers the individual holistically – something patients have clearly and consistently told us they want.

We believe the way to achieve this is to enhance primary care by wrapping community services around a grouping of GP practices, to support the communities they serve, and to commission and manage higher-acuity and other out-of-hospital services at scale, so that we are able to:

– meet rising demand, including providing better care for the frail elderly, end of life patients, and other people with complex needs, who are very clear that they want more joined-up care;

– deliver prevention interventions at scale, improve the health of our population, and reduce reliance on institutional care; done well this will:

– enable us to take forward the development of acute hospital care (through reducing the number of patients supported in acute hospitals and supporting these individuals in the community).

Clinical evidence tells us that many patients, particularly the elderly frail, who are currently supported in an acute hospital are better cared for in other settings. Changing the setting of care for these individuals will be truly transformational. We know it is possible to deliver this change and already have local examples to build upon where this new approach is being delivered (such as the Encompass Vanguard comprising 16 practices (170,000 patients) in east Kent who are operating as a multi-specialty community provider (MCP), providing a wide range of primary care and community services).

We also need to focus more on preventing ill-health and promoting good health and our Local Care model needs to deliver population-level outcomes through delivery at scale. This is needed to support individuals in leading healthy lives, as well as reduce demand and costly clinical interventions. We also need a disproportionate focus on the populations where health outcomes are the poorest.

In response to this, acute care will need to change to improve patient experience and outcomes; achieve a more sustainable workforce infrastructure; and make best use of our estate, reducing our environmental impact and releasing savings. We want to continue to create centres of acute clinical expertise that see a greater separation between planned and unplanned care. This would end the current pattern of much-needed surgery being delayed because of pressure on beds for non-elective patients. Through this we will deliver referral to treatment time (RTT) targets; improve workforce rotas, retention and morale; and release significant savings, alongside investment in Local Care.

This is an ambitious plan of work and we are committed to progressing it for the benefits of the people we serve.

Glenn Douglas
Senior Responsible Officer
Kent and Medway Sustainability and Transformation Plan

Executive summary (1/2)

- The Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting
- More than that, the system will transform services to deliver proactive care, and ensure that support is focused on improving and promoting health and wellbeing, rather than care and support that is solely reactive to ill health and disease
- Core to the model is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and where appropriate the independent sector to deliver the right care, in the right place, at the right time
- Our transformation plan will bring a profound shift in where and how we deliver care. It builds on conversations held with local people about the care they want and need and has the patient at its heart:
  - Our first priority is developing **Local Care**, building on local innovative models that are delivering new models of care, which brings primary care general practices into stronger clusters, and then aggregating clusters into multispecialty community provider (MCP) type arrangements, and, potentially, into a small number of larger accountable care organisation (ACO) type arrangements that hold capitated budgets
  - Local Care will enable services to operate at a scale where it will be possible to bring together primary, community, mental health and social care to develop truly integrated services in the home and in the community
  - This model will manage demand for acute services, enabling significant reductions in acute activity and length of stay which amount to ~£160m of net system savings by 2020/21 and relieve pressure on our bed base
  - We have also therefore committed to a Kent and Medway-wide strategy for **Hospital Care**, which will both ensure provision of high-quality specialist services at scale and also consider opportunities to optimise our service and estate footprint as the landscape of care provision becomes more local
  - Work is ongoing to surface potential opportunities and evaluate them ahead of public consultation from June 2017

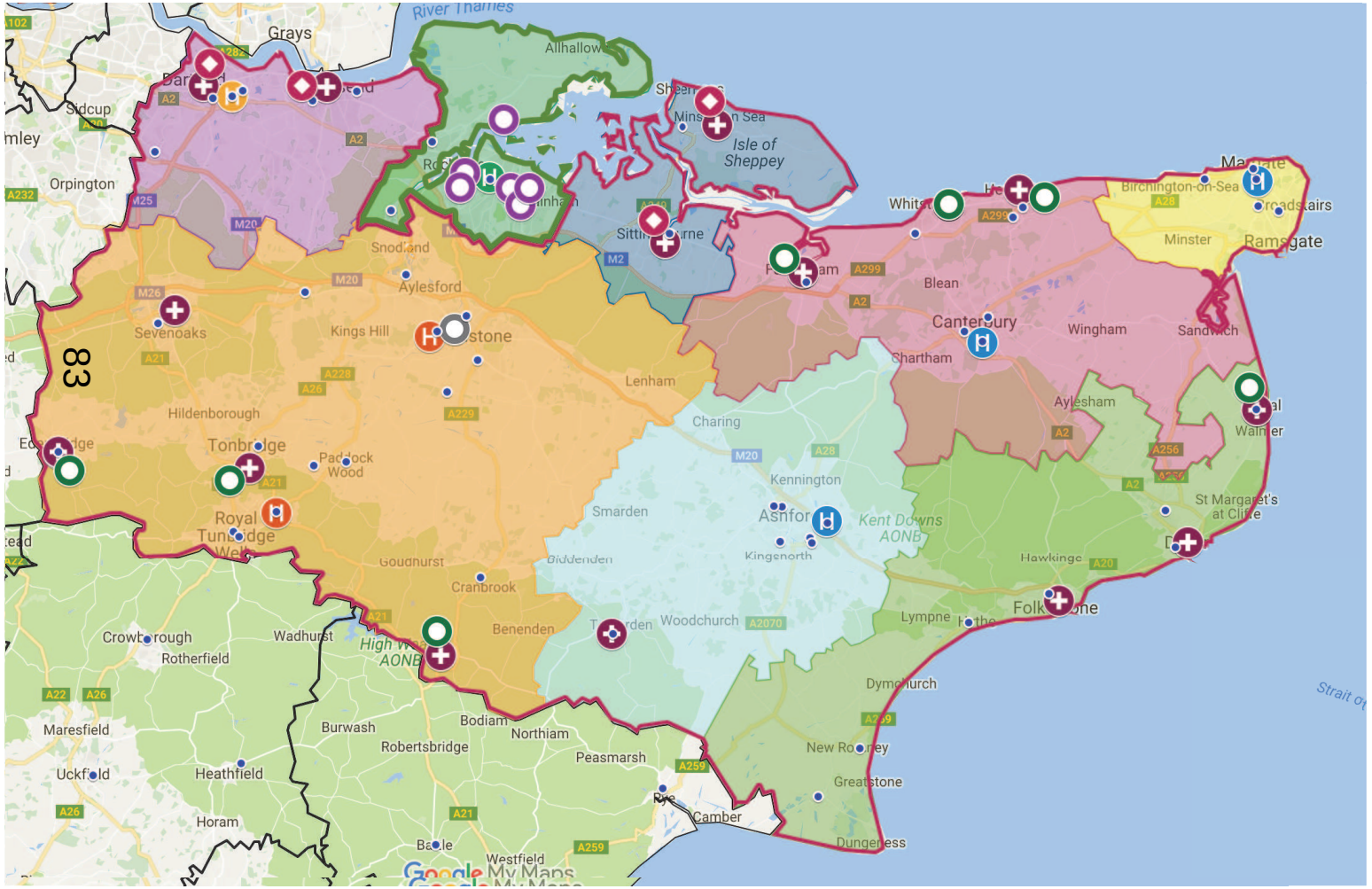
Executive summary (2/2)

- Over the last year we have built the new working relationships and launched the discussions which enable us to work at a greater scale and level of impact than before.
- In recent months we have made dramatic improvements in our STP, moving from a fragmented and unsustainable programme to one which has a truly transformational ambition, engages health and social care leaders from across the footprint, has robust governance oversight, and brings the system back towards sustainability.
- Our plan aims for a radical transformation in our population's health and wellbeing, the quality of our care, and the sustainability of our system by targeting interventions in four key areas:

Care Transformation	Preventing ill health, intervening earlier and bringing excellent care closer to home
Productivity	Maximising synergies and efficiencies in shared services, procurement and prescribing
Enablers	Investing in estates, digital infrastructure and the workforce needed to underpin a high-performing system
System Leadership	Developing the commissioner and provider structures which will unlock greater scale and impact

- Our financial strategy now directs the system back to sustainability, closing a £486m do-nothing financial challenge (including social care pressures) to a remaining £29m challenge in 2020/21. The remaining £29m challenge is associated to financial pressures that arise as a result of the Ebbsfleet Health New Town Development.
- Working with health and social care professionals, patients and the public, we are continuing to develop our plan and design the transformation programme which will deliver it
- We anticipate that some elements of the core transformation will influence 2017/18 operational planning and that a first wave of holistic transformation will launch in 2018

We are eight CCGs, 7 NHS providers and two local authorities, joining together with other partners, to transform health and care in Kent & Medway



- D&G NHS Trust
- EKHU NHS FT
- Medway NHS FT
- MTW NHS Trust
- Kent community hospitals
- Kent and Medway NHS and Social Care Partnership Trust
- Medway Community Healthcare services
- Kent Community Healthcare Foundation NHS Trust
- Virgin Health
- South East Coast Ambulance Service NHS Foundation Trust

Local Authorities:

- Kent County Council
- Medway Council

Since June we have made great strides in strengthening our change programme and raising our joint ambition

	Previous position	How we are strengthening the programme
Programme development	• Programme lacked a robust and active set of workstreams aligned with strategic priorities • No PMO to drive progress	✓ Workstreams mobilising around core priorities, with SROs now all in place and PIDs being completed ✓ PMO established with interim external support
Financial sustainability	• Plan did not balance, leaving a £196m NHS gap before STF allocation	✓ Analytical work undertaken across Kent and Medway has indicated significantly higher potential to transform the way we deliver health and care ✓ Our financial framework is now close to balance
System leadership and relationships	• Two-speed programme with little strategic work completed across Kent and Medway • Insufficient governance	✓ Commitment from leaders across the STP footprint to work together and drive further, faster ✓ Alignment around joint consultation timeline ✓ Strengthened governance arrangements in place
Communication	• Varying levels of communication with wider stakeholders beyond senior system leaders	✓ Consensus across all organisations around STP ✓ STP rationale and benefits communicated to staff, public, stakeholders and media in letter signed by leaders ✓ Comprehensive communications and engagement plan in place to March 2017 (incl. key stakeholders and timing)

We believe that health and care in Kent and Medway needs to change

Health and wellbeing

Case for change

- Our population is expected to **grow by 90,000 people** (5%) over the next five years; 20,000 of these people are in the new town in Ebbsfleet. Growth in the number of over 65s is **over 4 times greater** than those under 65; an aging population means **increasing demand for health and social care**.
- There are **health inequalities** across Kent & Medway; in Thanet, one of the most deprived areas of the county, a woman living in the best ward for life expectancy can expect to live **almost 22 years longer** than a woman in the worst. The main causes of early death are **often preventable**.
- Over **500,000 local people live with long-term health conditions**, many of which are preventable. And many of these people have multiple long-term health conditions, dementia or mental ill health.

Our ambition

- Create services which are able to meet the needs of our changing population
- Reduce health inequalities and reduce death rates from preventable conditions
- More measures in the community to prevent and manage long-term health conditions

Quality of care

- There are many people who are **in hospital beds who could be cared for nearer to home.** Being in a hospital bed **for too long is damaging for patients** and increases the risk of them ending up in a care home.
- We are **struggling to meet performance targets** for cancer, dementia and A&E. This means people are not seen as quickly as they should be.
- Many of our local hospitals are in ‘special measures’ because **of financial or quality pressures** and numerous local nursing and residential homes are **rated ‘inadequate’ or ‘requires improvement’**.

- Make sure people are cared for in clinically appropriate settings
- Deliver high quality and accessible social care across Kent and Medway
- Reduce attendance at A&E and onward admission at hospitals
- Support the sustainability of local providers

Sustainability

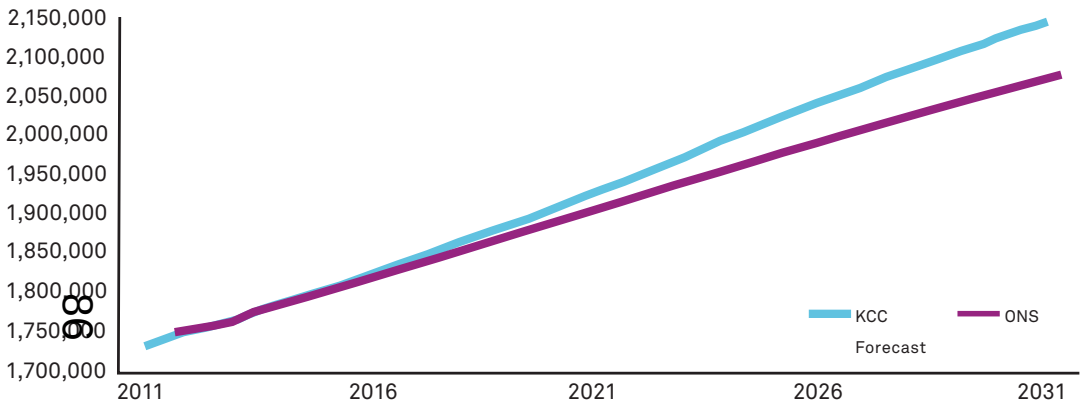
- We are **£109m ‘in the red’** and this will rise to **£486m by 20/21** across health and social care if we do nothing.
- Our **workforce is aging** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time.

- Achieve financial balance for health and social care across Kent and Medway
- To attract, retain and grow a talented workforce

Kent and Medway population is set to grow rapidly, faster than ONS projections

Housing developments will bring a higher population than ONS projections

Population growth forecast, Kent, KCC estimate vs. ONS



- Kent and Medway has planned significant housing growth (aimed at commuters and new families)
- The Kent and Medway Growth and Infrastructure Framework (KMGIF) has projected 188,200 new homes and 414,000 more people incremental to ONS projections
- Expected that the new population will place pressure on paediatric and maternity care especially

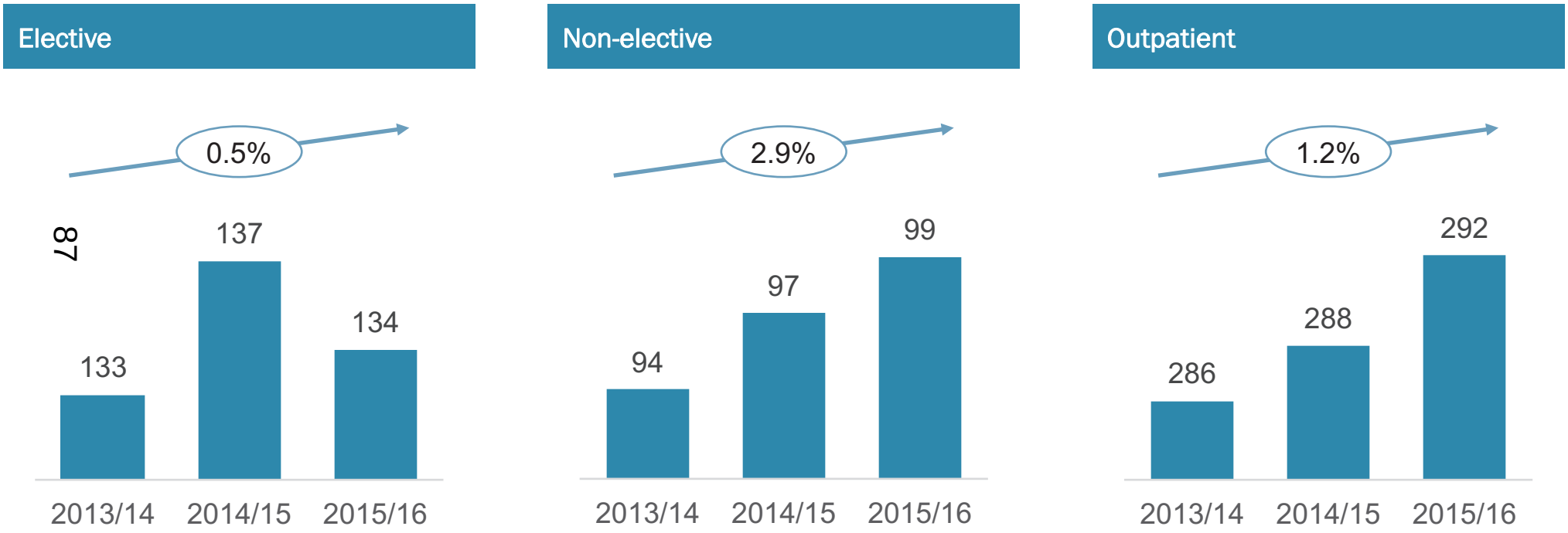
Ebbsfleet Health Garden City brings an additional pressure

- Ebbsfleet Healthy Garden City and wider local housing developments will grow Dartford, Gravesham and Swanley CCG population especially
- Population expected to grow by 21,000 by 2020/21
- Work by local NHS organisations suggests £28m health care commissioner pressure and £75m provider capital needs

Source: KMGIF, DGS CCG, DGT

The rate at which our growing population uses services is also rising, placing further pressure on services

Example: Acute activity per 1,000 population, Kent and Medway

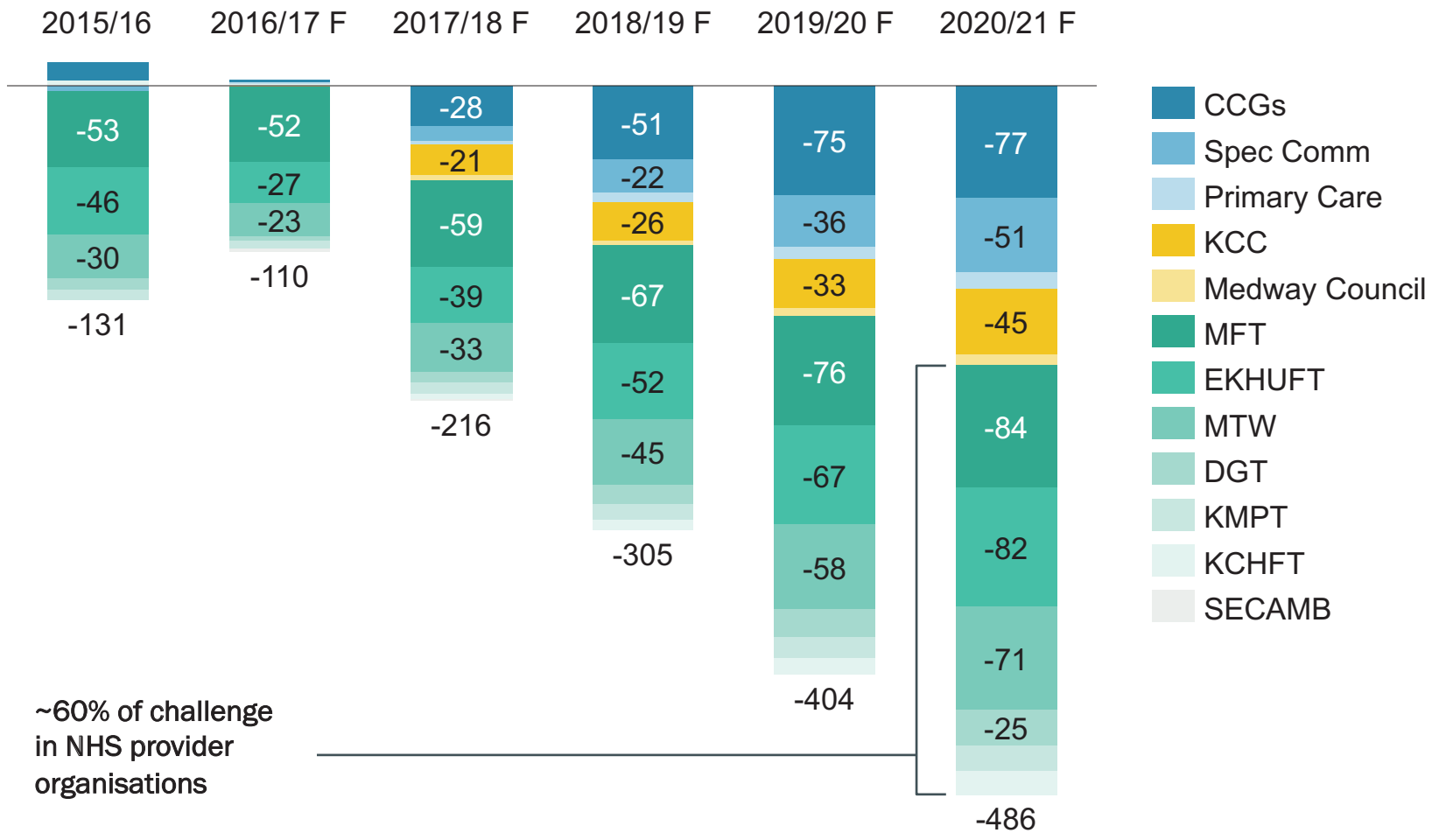


Notes: 1 Right Care peers for each K&M CCG selected and peer activity data aggregated, weighting by population
Source: MAR Data, Carnall Farrar analysis

Increasing demand is set to widen a £110m system deficit in 2016/17 into a £486m financial challenge by 2020/21 if nothing is done

£ Millions, health and social care system surplus/deficit, assuming ONS population growth

Kent & Medway system financial position, split by organisation



Note: 'No nothing' scenario is hypothetical; local authorities in particular confirm their statutory obligation and commitment not to run a deficit
Source: Kent and Medway STP Finance Group

We are pursuing transformation around four themes to tackle these challenges

Care Transformation

We are transforming our care for patients, moving to a model which prevents ill health, intervenes earlier, and delivers excellent, integrated care closer to home.

This clinical transformation will be delivered on four key fronts:

- **Prevention**: Enlisting public services, employers and the public to support health and wellbeing, with efforts to tackle the future burden of cardio-vascular disease and diabetes
- **Local care**: A new model of care closer to home for integrated primary, acute, community, mental health and social care
- **Hospital transformation:** Optimal capacity and quality of specialised, general acute, community and mental health beds
- **Mental health**: Bringing parity of esteem, integrating physical and mental health services, and supporting people to live fuller lives

Productivity

We can achieve more collectively than we can as individual organisations.

This applies most immediately for Providers in Kent & Medway as they look to realise efficiencies and productivity improvements in non-clinical settings.

Learning the lessons from the Carter Review, we will undertake a programme to identify, quantify and deliver savings through collaborative provider productivity addressing the following areas:

- **CIPs and QIPP delivery**
- **Shared back office** and corporate services (e.g., Finance, Payroll, HR, Legal)
- **Shared clinical services** (e.g. Pathology integration)
- **Procurement** and supply chain
- **Prescribing**

Enablers

We need to develop three strategic priorities to enable the delivery of our transformation:

- **Workforce:** Transforming our ability to recruit, inspire and retain the skilled health and care workers we need to deliver high-quality services – including partnership with local universities to develop a medical school
- **Digital:** Unifying four local digital roadmaps within a single Kent and Medway digital framework, which both informs and is informed by the strategic clinical models we are implementing
- **Estates:** Achieving 'One Public Estate' by working across health organisations and local authorities to find efficiencies, deliver new models of care, and develop innovative ways of financing a step change in our estate footprint

System Leadership

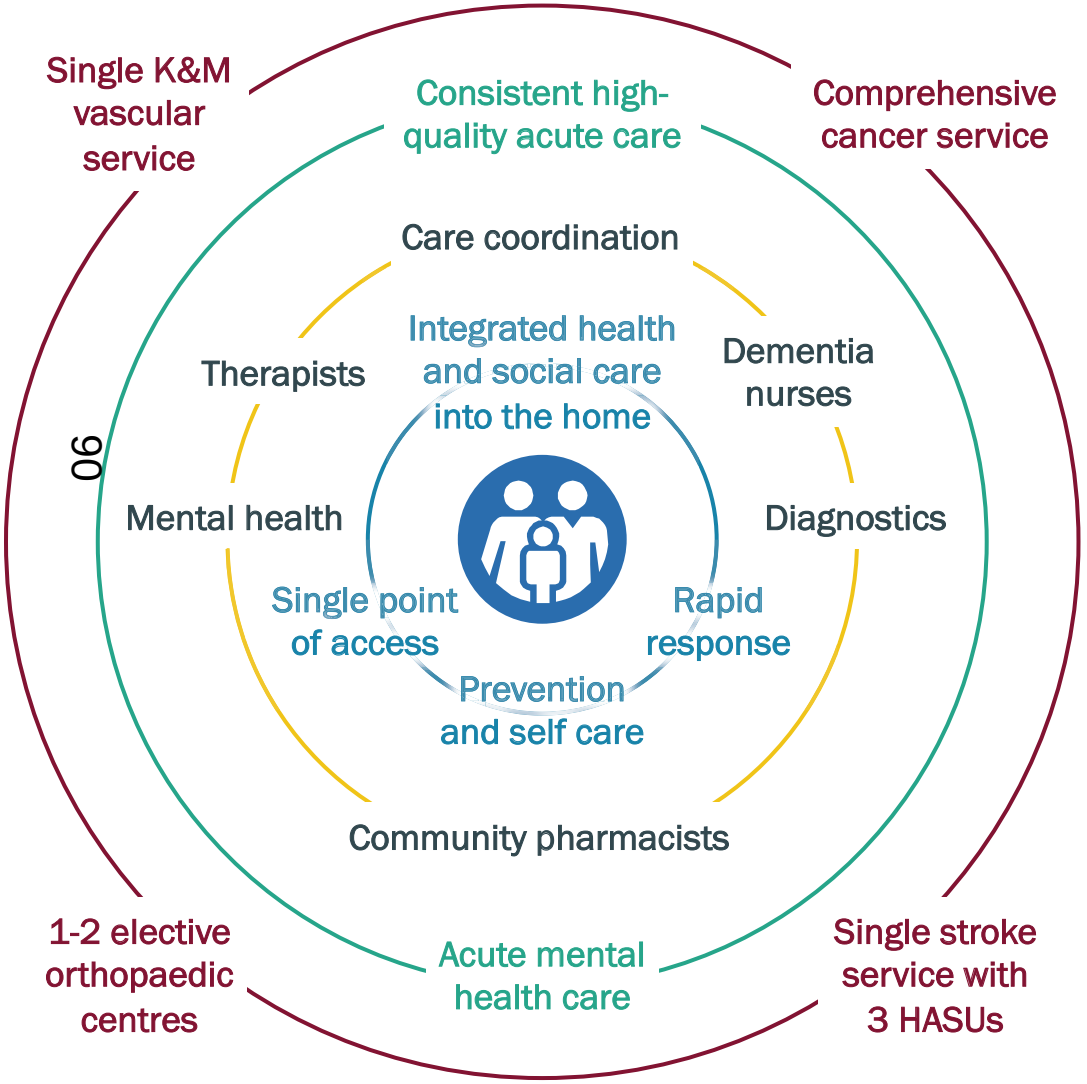
A critical success factor of this programme will be system leadership and system thinking. We have mobilised dedicated programmes of work to address:

- **Commissioning transformation:** Enabling plans for the future to be shaped by health and social care professionals, the public, patients, carers and stakeholders in an open and honest way, and responding to concerns
- **Communications and engagement:** Ensuring consistent communications and inclusive engagement which inform and include all key stakeholders in the design and development of the STP

We are currently designing a workstream to consider provider organisational form and develop the strategy to sustaining innovative provider models of care, including Accountable Care Organisations (ACOs).

Our vision for care has the patient at its core

Kent and Medway Future Care Model



How health and care services will work for patients

- Your own bed is the best bed: only the most seriously injured or ill will ever spend more than a few days in an acute hospital due to their need to be under the care of a consultant
- Teams will support frail older people and people with complex needs, including those reaching the end of their lives at home whenever possible to maximise their quality of life
- Health and social care teams will support people at home, providing care, treatment and support round-the-clock, including in a crisis – and will be based in GP practices and community hubs
- People in Kent and Medway will take good care of themselves and of each other – taking charge of their health and wellbeing, avoiding preventable illnesses, and being experts on their own health, knowing when they can manage and when they need to contact a professional
- People will have planned surgery under conditions that maximise their recovery, including improved health before their operation

We are enlisting the whole Kent and Medway community in improving health and wellbeing through our prevention programme

Our vision

- Improve health and wellbeing for our population, reducing their need for health and care services
- We aim to make this vision the responsibility of all health and social care services, employers and the public
- We will achieve this by:
  - delivering workplace health initiatives, aimed at improving the health of staff delivering services;
  - industrialising clinical treatments related to lifestyle behaviours and treat these conditions as clinical diseases;
  - treating both physical and mental health issues concurrently and effectively; and
  - concentrating prevention activities in four key areas

Our prevention priorities

- **Obesity and Physical Activity**: 'Let's Get Moving' physical activity pathway in primary care at scale across Kent and Medway. Increase capacity in Tier 2 Weight Management Programmes from 2,348 to 10,000
- **Smoking Cessation and Prevention**: Acute trusts becoming smoke-free with trained advisors, tailored support for the young and youth workers, pregnant and maternal smokers and people with mental health conditions.
- **Workplace Health**: Working with employers on lifestyle interventions and smoking and alcohol misuse, providing training programmes for improved mental health and wellbeing in the workplace
- **Reduce Alcohol-Related Harms in the Population**: 'Blue Light initiative' addressing change-resistant drinkers. 'Identification and Brief Advice' (IBA) in hospitals ('Healthier Hospitals initiative') and screening in GPs. Alcohol health messaging to the general population

Local Care aims to improve health, support independence and reduce reliance on hospitals through transformational, integrated health and social care

Our journey

Encompass Vanguard

92

MCP / PACS models[1]

Accountable Care Organisations

Our aspirations

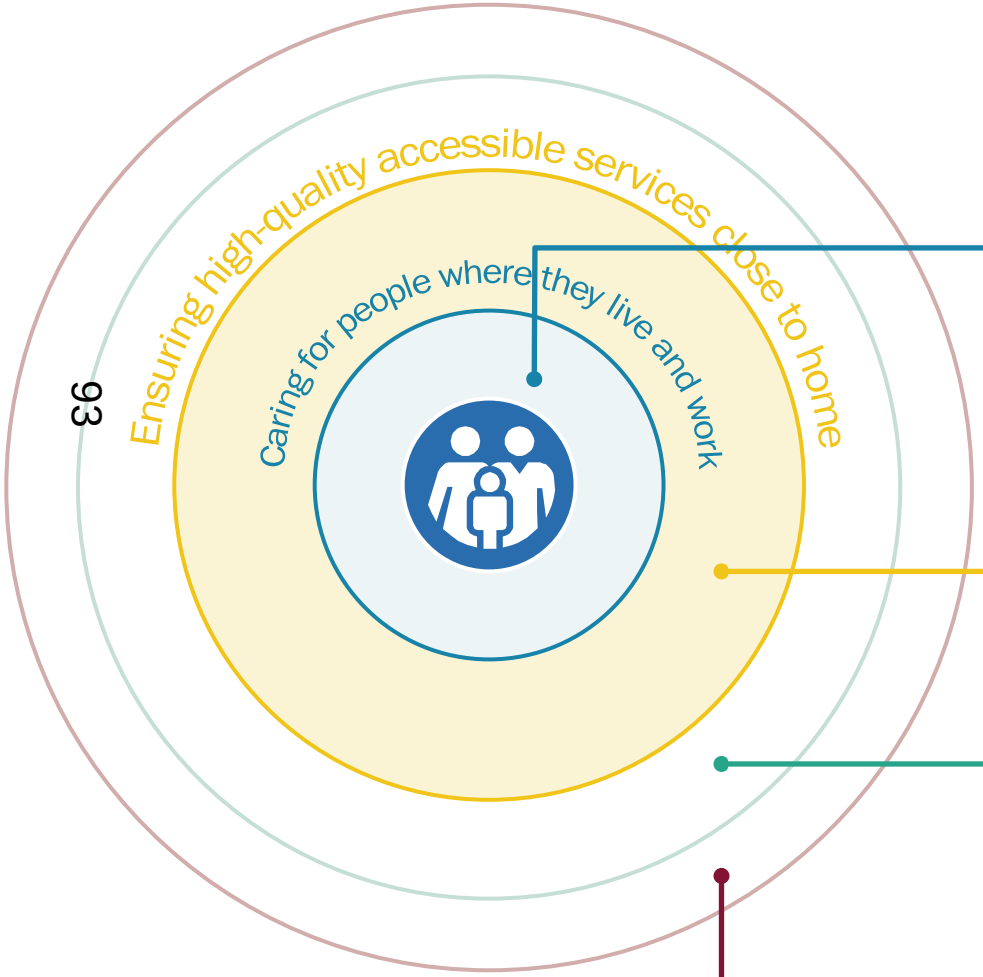
- Identify patients' healthcare needs and provide integrated treatment which encompasses all of them
- Empower patients through person centered, proactive support
- Ensure increased patient participation in their own care
- Enable proactive care that supports improving and promoting health and wellbeing, supporting patients ability to live independently
- Facilitate clear signposting to the most relevant service that is driven by a 'community first' philosophy
- Utilise coordinated statutory, voluntary and where appropriate the independent sector services including: primary, community, secondary, social care, mental health and voluntary services that are wrapped around defined GP populations
- Provide a range of out of hospital services through Local Care hubs (incl. community hospitals) facilitating increased local accessibility
- Enable innovation in coordinated care provision

How we will deliver our vision

- Proactive identification
- Personalised care packages
- Self care and prevention strategies
- Multi Disciplinary Teams
- Integrated Care pathways
- Urgent and Community care
- Diagnostic and same day services

Note: 1 Multispecialty Community Providers and Primary and Acute Care Systems

Our Local Care model will be delivered across Kent and Medway through a series of strategic interventions both close to home and beyond



Key interventions

1. Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours
2. Bring integrated health and social care into the home
3. Provide rapid response service to get a community nurse to home within 2 hours and avoid ambulance or admission
4. Provide single point of access to secure any community and social care package
5. Care coordination, planning and management around GP practices and community services
6. Access to expert opinion without referral for outpatient appointment, including making use of GPSI and advanced nurse and therapist roles
7. Facilitation of transitions of care incl. discharge planning
8. Mental health liaison

Innovative interventions are also being developed and delivered locally to meet population needs

Selection of local interventions

Swale integrated care teams

Integrated care teams made up of community nurses and social care practitioners have been introduced and attached to **General Practice clusters**. Further supported by the successful procurement of adult community services, this has allowed us to move at pace to integrated new models of care (done jointly with DGS).

Dartford, Gravesham and Swanley new town

Having successfully won **healthy new town status** following a competitive process linked to the North Kent and specifically Ebbsfleet Garden City Development, significant focus is on reduction of health inequalities through new models of care.

Dartford, Gravesham and Swanley integrated commissioning

DGS has established an **integrated commissioning team** jointly with Kent Council Council for children's, Learning Disabilities and Mental Health services, including joint governance arrangements and full time posts.

Medway and Swale collaboration

Medway and Swale CCG, MFT and Medway Council have collectively created a **whole system improvement collaborative** called MASCOE to drive key components of delivery within the new models of care.

Herne Bay 7-day access

7-day access to a range of urgent and outreach services, including diagnostics have resulted in better patient experience and reduced acute admissions and A&E attendances.

Thanet IACO

The vision for integrated health and social care in Thanet is being delivered via a MCP operating as an **Integrated Accountable Care Organisation** (IACO). The IACO has just won National Association of Primary Care provider development of the year.

Encompass Vanguard CHOCs

Community Hub Operating Centres (CHOCs) have developed an Integrated Case Management (ICM) model to deliver community based integrated assessment, care planning and service delivery for people who are at risk of hospital admission.

Encompass Vanguard social prescribing

The **Encompass MCP Vanguard** has partnered with Red Zebra Community Solutions and now uses a web-based tool for NHS professionals and **social prescribing** services in the community to refer people to a range of local, non-clinical support. This has resulted in improved social, emotional or practical wellbeing for patients.

Canterbury and Coastal paramedics

Paramedic practitioners attached to General practices doing visits with the GP EPR. This has resulted in faster response rates, better patient satisfaction and a reduction in inappropriate admissions to hospitals. A similar initiative has been subsequently developed in Swale.

South Kent Coast

SKC are undertaking a Rheumatology pilot, delivering **rheumatology care closer to home**, supporting self-care, increasing capacity and primary care skill/knowledge. Potential savings of 30% against tariff. Ongoing work to replicate in cardiology and respiratory care.

Source: Kent and Medway CCGs

Growing our Local Care model will enable a change in care setting and drive large reductions in acute activity

Increased activity *from integrated care initiatives*

Drives

Large reductions *in acute activity (and small reductions system-wide)*

Community care

- Intermediate care beds managed by GPs
- Step up/step down
- Rapid response
- Reablement

Primary care

- GP/nurse contacts
- Care coordination
- Case management
- Access to specialist opinion
- Geriatrician in community

Mental health

- Liaison/RAID
- Early intervention
- Home treatment/Recovery

Acute

- Reduction in long LOS through
  a) better process
  b) changes in decision making
  c) new models
- A&E attendances and emergency admissions

Social care

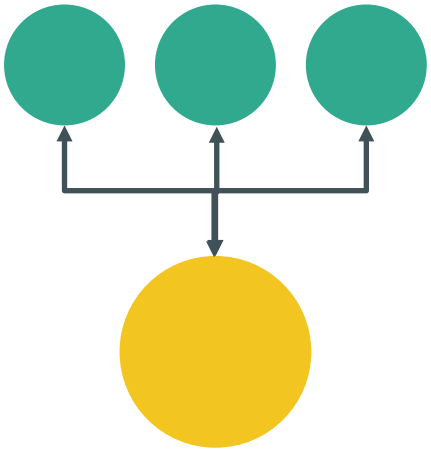
- Activity

Mental health

- Bed days

Source: Kent and Medway Local Care workstream; CCG presentation to HWBB

We are delivering Local Care by scaling up primary care into clusters and hub-based Multispeciality Care Provider models

Local Care infrastructure		Description	Population served
GP practices		• Individual GP practices providing limited range of services • Many working well at scale, others struggling with small scale and related issues incl. workforce	• Various
Tier 1 Extended Practices with community and social care wrapped around		• Larger scale general practices or informal federations • Providing enhanced in-hours primary care and enable more evening and weekend appointments.	• 20 – 60k
Tier 2 MCPs/PACS based around community hubs		• Multi-disciplinary teams delivering physical and mental health services locally at greater scale • Seven day integrated health and social care	• 50 – 200k

Our local implementation of the Kent and Medway model varies to meet the needs of our populations

Summary of Local Care models across Kent and Medway

	Ashford	Canterbury & Coastal	DG&S	Medway	Thanet	Swale	South Kent Coastal	West Kent
Population	129,000	220,000	261,000	295,000	144,000	110,000	202,000	479,000
No. GP practices	14	21	34	53	17	19	30	62
Average list size	9,200	10,500	7,700	5,600	8,500	5,800	6,700	7,700
Extended practices	3	5	TBC	9	4	TBC	4	9
Population	30 – 60 k	30 – 60 k	20 – 40k	30 k	30 – 60 k	20 – 40k	30 – 60 k	TBC
Hubs	1	1	5	3	1	2	1	3 – 5
Population	129,000	220,000	50 k	100 k	144,000	50 k	202,000	TBC
Chair	Navin Kumta	Sarah Phillips	Elizabeth Lunt	Peter Green	Tony Martin	Fiona Armstrong	Jonathan Bryant	Bob Bowes
AO	Simon Perks	Simon Perks	Patricia Davies	Caroline Selkirk	Hazel Carpenter	Patricia Davies	Hazel Carpenter	Ian Ayres

Notes: Whitstable Vanguard represents 4 of the 5 hubs in Canterbury and Coast CCG. Ashford, Canterbury & Coastal, South Kent Coast and Thanet have no extended practices; practices grouped directly into hubs.
Source: CCG returns, September 2016

We are investing in key initiatives which will enable our Local Care transformation and improve the way we commission and deliver health and care

	Our vision
1 **Pursue single shared record**	• Provide health and care professionals with immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history for all patients across Kent and Medway
2 **Industrialise the Kent Integrated Dataset**	• Enable information flow to support targeting, care delivery, planning, performance and payment by leveraging the unique KID dataset
3 **Develop capitated payment models**	• Enable the pooling of resource across health and social care • Breakdown silos to allow delivery of integrated care • Facilitate the development of accountable care organisations that support delivery of our vision
4 **Maximise value of one public estate**	• Release capacity that is surplus to needs from reduction in beds and release of unneccessary estate and invest in housing and community facilities • Maximise colocation of professionals in hubs to faciliate multidisciplinary working, extended hours and extended range of services available to patients • Make use of flexibilities from Local Authority to invest in one public estate
5 **Commissioning transformation**	• Develop single strategic commissioning across Kent and Medway to create the capability and capacity to drive the update of new information and payment models and secure the release of value from the estate

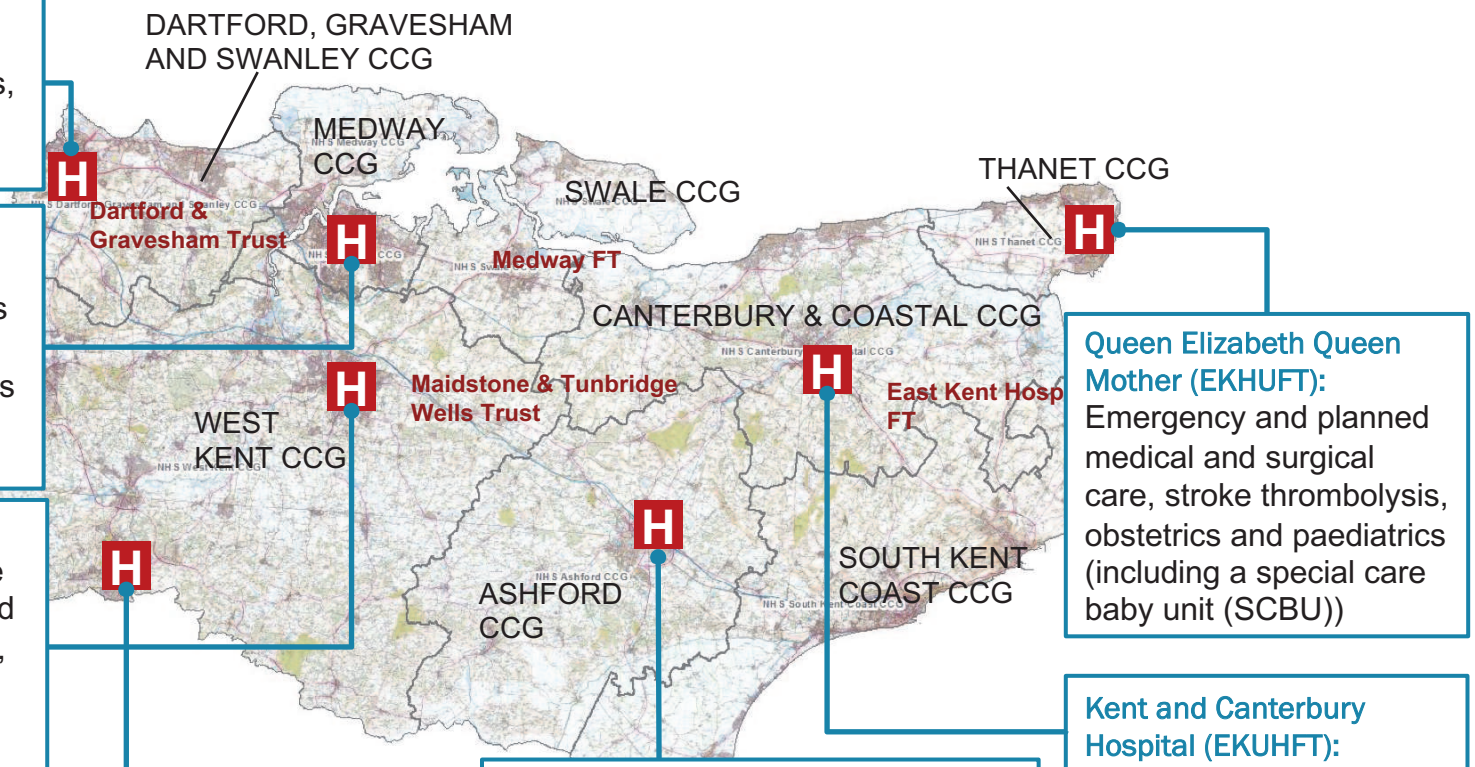
Our Acute Care model is partially consolidated, but is still largely based on historic dispersal of services

Darent Valley Hospital (DGT):
Emergency and planned medical and surgical care, plus stroke thrombolysis, obstetrics and paediatrics (including a special care baby unit (SCBU))

Medway Maritime Hospital (MFT):
Emergency and planned medical and surgical care, some specialist services (e.g. vascular, stroke thrombolysis, trauma unit), obstetrics and paediatrics (including a neonatal intensive care unit (NICU))

Maidstone Hospital (MTW):
Emergency and planned medical care (with midwife led birth centre), planned surgical care (no emergency surgery), including cancer centre, stroke thrombolysis, and ambulatory paediatrics

Tunbridge Wells Hospital (MTW):
Emergency and planned medical and surgical care, plus trauma unit, stroke thrombolysis, obstetrics and paediatrics (including a neonatal intensive care unit (NICU))



Queen Elizabeth Queen Mother (EKHUFT):
Emergency and planned medical and surgical care, stroke thrombolysis, obstetrics and paediatrics (including a special care baby unit (SCBU))

Kent and Canterbury Hospital (EKUHFT):
Emergency medical care (through acute medical take but no A&E) and some specialist provision, e.g. emergency / planned vascular, but no routine emergency surgery

William Harvey Hospital (EKUHFT):
Emergency and planned medical and surgical care, plus emergency primary percutaneous coronary intervention (pPCI), trauma unit, stroke thrombolysis, obstetrics and paediatrics (including a neonatal intensive care unit (NICU))

Progress has been made in the re-design of acute services across Kent and Medway

K&M strategic priorities: Consolidation of emergency and elective services

- Creation of emergency hospital centres with specialist services and separate emergency hospital centres;
- Establishment of specialist planned care hospital centres;
- Further consolidation and co-location of specialist services such as pPCI; vascular, renal, head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology in patient services;
- Further development of Kent's cancer centre;
- 10 clinical standards for urgent care being met;
- Exploration of more complex services in a shared care model between London and local providers;
- Development of new and innovative models of care;
- Agreement to widespread shared service arrangements with appropriate specialist service providers

East Kent

- EKHUFT has modelled the shift in activity and capital requirements for a range of acute configuration options, together with a significant and safe shift to local care models with potential activity savings worth at least 300 acute beds
- These options include the "as is" model, alongside an option that sees the closure of one site and the creation of a single site option
- EK's initial thinking sees the creation of one emergency hospital centre with specialist services[1] and a trauma unit for a natural catchment of over 1.5m
- This site will be supported by a further emergency hospital centre and a planned care hospital, supported by rehabilitation services and a primary care led urgent care centre
- Emerging model has potential to deliver over £90m efficiencies in EKHUFT

Medway, North Kent and West Kent

- The boards of MFT and MTW have agreed to a short process to complete primary objectives by the end of 2016:
  - The development of a single draft document setting out the strategic direction of acute services
  - The identification of opportunities for consolidation and greater efficiency in back office services
  - A coherent shared strategy for planned care, most likely taking the shape of a single shared centre
- A collaboration between DGT and GSTT to develop a Foundation Healthcare Group model

Note: [1] Including pPCI; vascular, renal head and neck; urology; hyper-acute stroke; haemat-oncology and gynae-oncology specialist in patient services

Investment in our Local Care model should enable ~£210m gross spend reduction in the acute sector by 2020/21

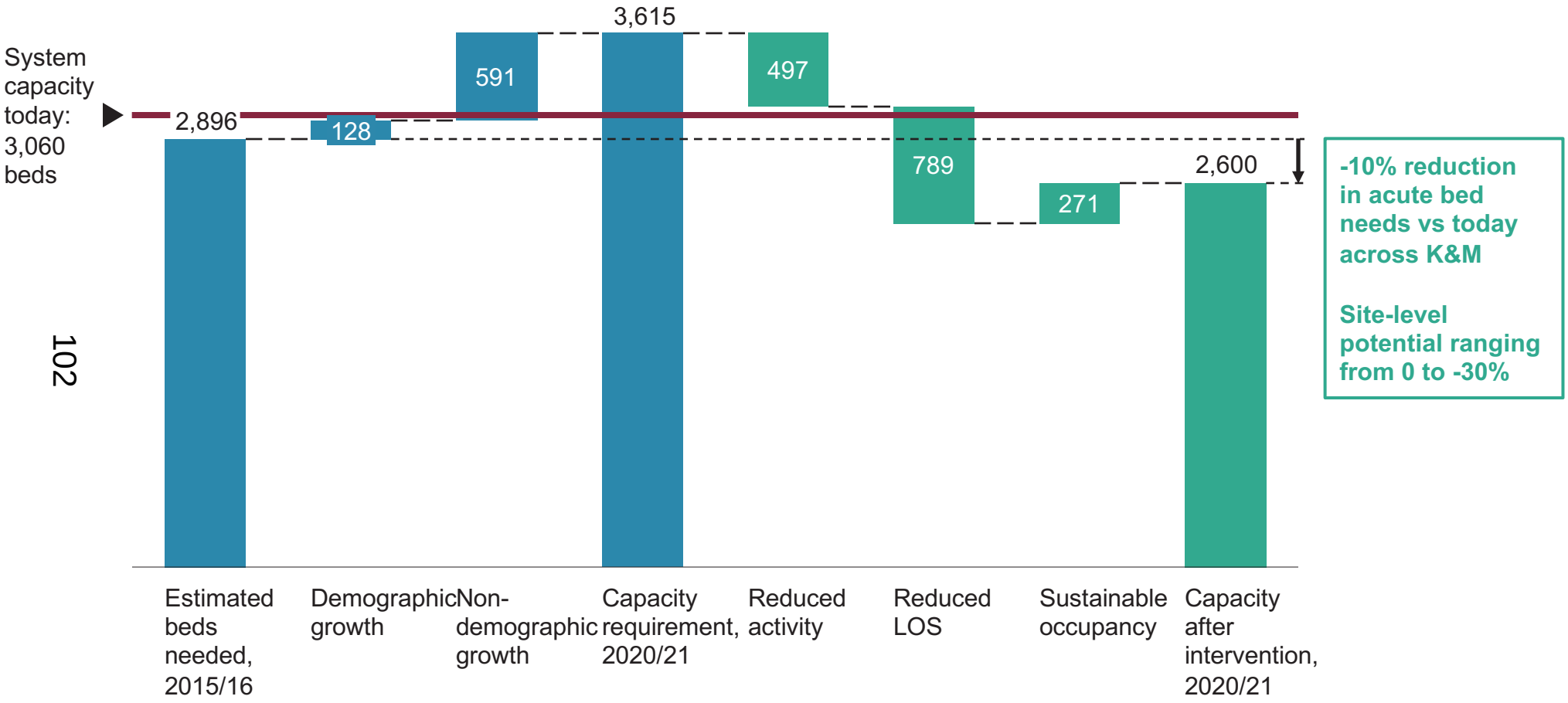
	Key enablers	Opportunity	System savings, 2020/21, £ Millions: Gross	Net[5]
1 **Avoid emergency admissions through more proactive and coordinated care**	• Care coordinators • Rapid response	• Internal and external activity benchmarking[1] suggests opportunity to reduce acute activity: – Non-elective: -13% – A&E: -16%	71	46
2 **Reduce avoidable non-elective inpatient length of stay**	• Effective discharge planning • Rapid response • Domiciliary care package • Single point of assessment	• Significant numbers of elderly patients in beds who are medically fit for discharge • Limiting non-elective stays by over-70s to 10 days would yield a ~27% bed day reduction[2]	64	48
3 **Optimise elective pathway**	• MDT clinic • Preoperative assessment • Consultant level feedback • Effective planning for discharge	• Activity benchmarking[1] suggests opportunity to reduce elective volume by ~14% • Limiting 3-9 day elective stays to 3 days would yield a ~17% bed day reduction[3]	53	49
4 **Optimise outpatient pathway**	• Expert first point of contact • Qualified referrals • Diagnostic protocols • Non-medical support and education	• Internal and external activity benchmarking[1] suggests opportunity to reduce outpatient activity by ~12%	26	22
		Total	**214**	**165**

Notes: 1 Internal benchmarking between GP practices and external benchmarking vs. Right Care peers of each Kent and Medway CCG 2 258k bed days, 830 beds vs. 2020/21 position after admission avoidance intervention. 3 16k bed days, 53 beds. Further potential to increase theatre throughput. 4 Not quantified
5 Reinvestment rates for activity reduction: NEL: 35%, EL: 5%, AE: 35%, OP: 35% first and 5% for follow-up; 25% for length of stay reduction

Source: Commissioner and Provider Data Returns, 2015/16 MAR Data, STP submission template, Carnall Farrar analysis

Improved Local Care could relieve pressure on acute capacity

Acute bed requirements to support elective and non-elective activity



Note: Assumed occupancy rates: DGT: 99%, MTW: 94%, MFT: 99%, EKHUFT: 91%. 'Sustainable occupancy' lever estimates the impact of reducing acute bed occupancy levels to 85% across the Kent and Medway system.

Source: Kent and Medway provider length of stay data; NHSE KH03 occupancy data, 2015/16; Carnall Farrar analysis

Work is ongoing to surface potential opportunities to improve the financial and clinical sustainability of hospital-based care

Current focus of our work

	1	2	3	4	5	6
Phases	**Programme mobilisation and developing our vision**	**Understanding baseline for activity, cost and spend**	**Developing our evaluation criteria**	**Identify and analyse opportunities**	**Prepare for consultation**	**Consult and agree final opportunities**
Key steps	• Identify area of focus • Establish governance • Mobilise programme • Articulate and capture vision that clinicians have for how services are delivered in key areas	• Establish a clear case for change • Establish activity spend and capacity baseline • Develop and quantify change options • Assess estate and quantify capacity implications	• Develop a set of standards that are: – Guided by clinical evidence from literature – Clearly measure-able – Supported by clinical leaders • Consider co-dependencies	• Describe clinical models that are internally coherent and distinct, informed by vision, standards and co-dependencies • Perform analysis to understand impact of opportunities • Assess models against criteria	• Develop consultation plan and document • Develop PCBC and review by gateway process • Secure NHSE Gateway approval • Clinical Board and CCG governing bodies review and approve PCBC	• Engage with stakeholders and the public • Capture feedback including answers to the consultation questionnaire and more quantitative feedback • Make final decision • Plan for any implementation
Progress made	• Programme mobilised • Vision created with stakeholder buy in	• Case for change in progress • Analysis underway	• By end of November 2016	• By end of November 2016	• By April/May 2016	• June – September 2017

Our Mental Health programme will delivery parity of esteem, promote health and wellbeing, integrate physical and mental health services and improve crisis care

Our vision

We will ensure that our Mental Health provision delivers parity of esteem for any individual with a mental health condition

Our vision is to ensure that within Kent and Medway we create an environment where mental health is everyone's business, where every health and social care contact counts where we all work together to encourage and support children, their parents, young people and adults of all ages with a mental health problem or at risk of developing one to live in their own community, to experience care closer to or at home and to stay out of hospital and lead a meaningful life.

Local Care:

- Promoting wellbeing and reducing poor health
- Delivering integrated physical and mental health services

1. **Live well service**: Cross-sector partnership to strengthen wellbeing by increasing access to wellbeing navigators and community link works and investing in training
2. **Open Dialogue Pilot:** Investing in holistic family intervention in first episode of psychosis to reduce admission by training more staff and peers in the approach
3. **Encompass MCP Vanguard:** Ensure MH professionals are an integral part of the model, with integrated care plans for individuals with LTC and MH comorbidity
4. **Single point of access:** Dedicated, clinically-led MH screening, assessment and signposting 24/7 linked to NHS 111, SECAMB, acute and primary care
5. **Complex needs:** Reviewing patients with complex needs in out-of-area specialist placements and seeking to repatriate; refining out-of-area placement process

Acute Care:

- Delivering improved care for people and their carers when in a crisis

1. **Improved patient flow**: Reach zero private beds by December 2016, implement alternative models of care to prevent admission and actively manage DToCs
2. **Therapeutic staffing and peer support:** Implementation of Therapeutic Staffing model on acute wards, with reduced LOS and use of temporary staff
3. **Liaison Psychiatry:** Implement Core 24 model in all acute EDs by 2018 and partner w. acute providers for Medically Unexplained Symptoms outpatient service
4. **Personality disorder pathway:** Implement NICE-compliant pathway ensuring effective prevention, community-based treatment and acute crisis response
5. **Single point of access:** Linked point of access, also providing tele-triage psychiatric assessments for people presenting in crisis

We are undertaking an ambitious programme to deliver efficiencies and productivity improvements through collaboration

Where are we today?

- Significant opportunities exist to design and deliver efficient and effective non-clinical services collaboratively
- In the first instance, we are focusing on the opportunity to consolidate corporate services between NHS provider organisations to both improve quality whilst driving down cost
- Furthermore, we will explore opportunities with local authorities where collaboration would make sense: predominantly in IT, estates and facilities, but potentially other areas in addition
- The services in scope of the initial wave of redesign programme are:
  - Finance
  - HR
  - Procurement
  - Legal services
  - IM&T
  - Estates & facilities
  - Governance & risk

What are our plans for the future?

- Our vision for the future of corporate services in Kent and Medway:
  - Tasks and resources are not duplicated between individual organisations
  - Standardisation of approach and process enables economies of scale to be delivered
  - Outsourcing of services is chosen where it provides the best route for service delivery at scale
  - Alternative methods and approaches are considered and where individual organisations work collaboratively for the greater benefit of all, balancing issues of sovereignty with issues of cost and efficiency
- The corporate services consolidation project has been incorporated in the STP financial plan with a target saving of **£39m by 2021**
- We intend to therefore undertake a larger-scale productivity programme to deliver collaborative savings in **networked clinical services, shared clinical support services and collaborative prescribing** as well as shared corporate services/back office

What are our design principles?

- In each area a consistent process will be followed to design a new shared model:
  1. Conduct a rapid review to understand the opportunity
  2. Complete a full benchmark to assess potential savings
  3. Define the collaborative strategy and identify the key initiatives through a hypothesis-driven approach
  4. Define the most appropriate sourcing strategy, e.g. in house/outsource
  5. Define the target operating model for the services
  6. Transition: establish the shared service, including organisation, people, process and technology
  7. Establish service and operating level arrangements
  8. Define supplier management arrangements:
     - A. Sourcing; scenario planning and options analysis
     - B. Procurement strategy including competitive dialogue and managing the procurement process

Source: Kent and Medway STP Productivity workstream

We have mobilised Enabler groups to deliver our transformation

Workforce

Developing a workforce strategy to deliver the transformation required in K&M

Key objectives:

- Develop a fit for purpose infrastructure for workforce scheduling and planning assurance across K&M, particularly to support new care models
- Undertake an Organisational Design (OD) programme of work to ensure system leadership and talent management is in place to support the STP
- Analyse demand and projection of supply to support potential safe service and rota arrangements in K&M
- Develop a K&M Medical School for both undergraduate and post-graduate education
- Increase supply and develop specific roles in K&M proactively e.g. paramedic practitioners; dementia care workforce; pharmacy in community and primary care, physicians assistants

Estates

Establishing a single, K&M-wide view of estate held by health and care organisations (including LAs)

Key objectives:

- Establish a K&M-wide view of estate held by health and care organisations and develop a long-term estates plan to enable the transformation required in K&M
- Establish and maintain the baseline metrics for the estate, covering: land ownership, running costs, condition, suitability and occupancy
- Implement an estate efficiency savings programme through: optimising asset utilisation and occupancy; overall management of the estate; consolidation of support services; and realisation of surplus assets across the common estate.
- Redesign and align the estate footprint to support new care models , including the disposal of estates asset and exploring funding models

Digital

Delivering the digital capabilities that are necessary to underpin and facilitate the STP

Key objectives:

- Provide all STP workstreams with the Information Management and Technology capabilities necessary to deliver the transformation required
- Design and deliver a universal care record across K&M
- Ensure universal clinical access – facilitating effective and efficient care so that patients can get the right care in the right place by professionals with the right information the first time
- Establish universal transactional services and shared management information systems
- Improve communications and networking of clinical and non-clinical services across K&M
- Facilitate self care by harnessing technology such as wearable devices and patient-centric monitoring

Source: Kent & Medway STP PMO

We are innovating how patients experience care through digital initiatives

	Our vision	Progress across Kent and Medway
Universal patient record	• Health and care professionals have immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history, for all patients across Kent; with each digital footprint area determining their own delivery approach.	• West Kent currently implementing a solution across major providers; other areas working to identify preferred solution.
Universal clinical access	• Health and care professionals can operate in the same way independent of their geographic location	• No firm plans yet across KEM, although discussions are taking place with potential providers.
Universal transactional services	• Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway	• Across KEM there are plans to expand the use of eRS.
Shared management information	• Health and care professionals have the management information they require to run an efficient and effective service for patients e.g. details of bed occupancy and compliance with targets.	• Most provider organisations in Kent have deployed Shrewd to gather KPIs. • Core business intelligence under procurement jointly by KEM CCGs
Online patient services	• Patients can access their medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question	• Patients access GP records provided through the GP system in most parts of KEM. Ongoing work to develop online patient portals
Expert systems	• Health and care professionals and patients have access to knowledge bases to support the care processes	• Limited community wide expert systems exist. • Needs further definition to develop requirements
Personal digital healthcare	• Patients can use personal technology to support their healthcare e.g. a device can automatically send data to alert their GP. This can be collated and used to inform population health management	• Limited facilities in place at present and needs further definition

Source: Kent and Medway STP PMO

We are pursuing ACO arrangements and strategic commissioning and have agreed a series of next steps for our Commissioning Transformation workstream

Future of commissioning

ACOs and strategic commissioning

- Pursuing the potential for commissioning to move into new care models operating in ACO-type arrangements
- Strategic commissioning will need to be undertaken at a greater scale, across a wider geography, with focus on:
  - Defining and measuring outcomes
  - Putting in place capitated budgets
  - Appropriate incentives for providers to deliver outcomes
  - Longer-term contracts extending over five to ten years

Benefits

- Reduce transaction costs and free up resources to invest in improving health and care.
- Generate opportunities to bring together the current dispersed approach to enabling infrastructure
- Support streamlining of back office overheads to ensure that resources are focused on front line delivery.
- Drive integration of health and social care at all levels and support new care models to be implemented at pace and scale

Impacts to consider

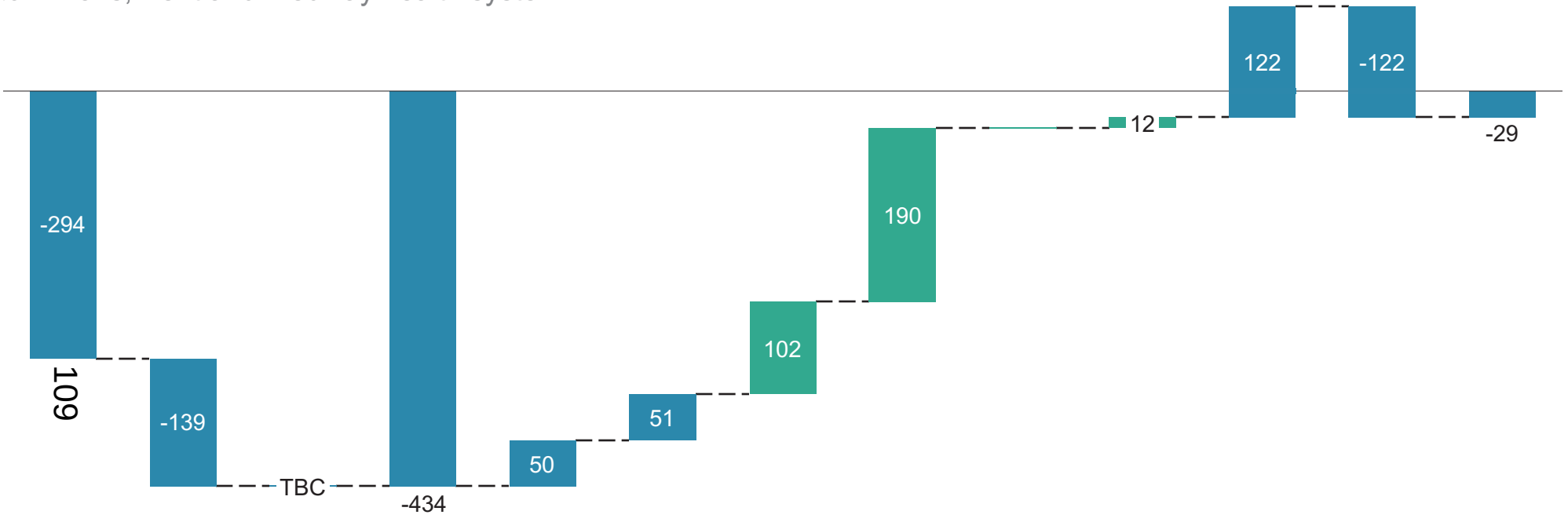
- Understand new contracting models to allow ACOs as lead providers to be commissioned to provide appropriate outcomes for defined populations with minimal transactional bureaucracy
- Understand evolution of CCGs and NHSE commissioning and impacts on form and function of CCGs

Next steps

- Reset the K&M leadership coalition for change (executives, practitioners and politicians)
- Develop and agree a more compelling case for change across K&M with absolute buy-in from all organisations
- Develop transformation plan to address the case for change which binds K&M together – story + numbers
- Clarify what model(s) are to be pursued for ACO/MCP/PACS and what will deliver
- Develop options and decide scale and subsidiarity
  - What to do at K&M and different levels?
  - What to do locally and what to aggregate up?
- Resourcing plan of money and people to deliver plans – put forward best people to drive. Build on existing success and deprioritise other things.

Our financial plan brings the system close to balance

£ Millions, Kent and Medway health system



- Assumed 100% investment of STF funding to deliver transformational change and service developments
- Further work required to refine this need.

- Outstanding gap relates to £29m funding for Ebbsfleet growth by 20/21
- Also a capital implication of £75m.

Notes: 1 Includes 7 day services, GP forward view, increased capacity for CAHMS and eating disorders, implementing mental health task force and cancer task force, maternity review, digital road maps, investment in prevention.

Source: STP financial template

STP NHS financial submission

Healthcare financial forecast, 'do nothing'						
£m	15/16	16/17	17/18	18/19	19/20	20/21
Commissioner						
Income	2,850	2,937	3,019	3,102	3,190	3,327
Spend						
Secondary Care	1,631	1,652	1,704	1,751	1,801	1,867
Admin	39	40	41	41	42	43
Other	525	559	590	619	650	683
Primary Medical Care	221	228	239	249	259	273
Specialised	424	455	487	521	558	601
NR Spend - Transformation	0	0	0	0	0	0
Total	2,841	2,934	3,060	3,182	3,310	3,467
Commisioner Surplus (Deficit)	**9**	**3**	**(41)**	**(80)**	**(120)**	**(139)**
Provider						
Income (inc Non-Footprint)	1,888	1,940	1,996	2,043	2,114	2,190
Spend						
Pay	1,263	1,280	1,329	1,377	1,438	1,502
Non-Pay	765	773	818	862	922	982
NR Spend- Transformation	0	0	0	0	0	0
Total	**2,028**	**2,053**	**2,147**	**2,239**	**2,359**	**2,484**
Provider Surplus (Deficit)	**(140)**	**(112)**	**(151)**	**(195)**	**(246)**	**(294)**
Indicative STF Allocation 2020/21	0	0	0	0	0	0
Footprint Surplus (Deficit)	**(131)**	**(109)**	**(191)**	**(276)**	**(365)**	**(434)**

Impact of interventions						
15/16	16/17	17/18	18/19	19/20	20/21
0	0	0	0	0	0
0	0	0	0	0	0
0	0	(25)	(79)	(110)	(147)
0	0	0	(5)	(6)	(6)
0	0	(8)	(10)	(12)	(12)
0	0	0	0	0	0
0	0	(10)	(22)	(36)	(51)
0	0	0	0	0	61
0	0	(43)	(117)	(163)	(216)
0	**0**	**43**	**117**	**163**	**216**
0	0	(24)	(75)	(103)	(137)
0	0	0	0	0	0
0	0	(48)	(114)	(174)	(232)
0	0	(22)	(48)	(70)	(93)
0	0	0	0	0	61
0	**0**	**(70)**	**(162)**	**(244)**	**(264)**
0	**0**	**46**	**87**	**141**	**127**
0	0	34	34	0	122
0	**0**	**89**	**204**	**304**	**343**

'Do something', base case					
15/16	16/17	17/18	18/19	19/20	20/21
2,850	2,937	3,019	3,102	3,190	3,327
1,631	1,652	1,679	1,671	1,690	1,719
39	40	41	36	37	37
525	559	582	609	638	671
221	228	239	249	259	273
424	455	477	499	522	550
0	0	0	0	0	61
2,841	2,934	3,017	3,064	3,147	3,311
9	**3**	**2**	**37**	**43**	**16**
1,888	1,940	1,972	1,968	2,011	2,053
1,263	1,280	1,281	1,263	1,263	1,271
765	773	796	814	852	888
					61
2,028	**2,053**	**2,077**	**2,077**	**2,116**	**2,220**
(140)	**(112)**	**(105)**	**(108)**	**(105)**	**(167)**
0	0	34	34	0	122
(131)	**(109)**	**(68)**	**(38)**	**(62)**	**(29)**

Capital implications are being assessed and outline capital requirements are detailed in the financial return. Lack of access to capital is potentially a significant barrier to change (including to support transformation but also to support smaller schemes to enable operational delivery, e.g. endoscopy). It is inevitable that transformation of the care model will require a re-profiling of estate and we are working with KCC, who are leading on estates for the STP, to identify innovative solutions. As part of this we are looking to work with NHS I, NHS E and NHS Property Services to develop a business case to reinvest receipts from disposals to enable transformation.

Source: STP financial template

Sensitivity analysis on STP financial submission

Health system impact, £ Millions

	Upside	Base case	Downside
20/21 challenge, 'do nothing'	(434)	(434)	(434)
CCG QIPP	50	50	25
NHSE QIPP	51	51	25
Secondary to out-of-hospital care	74	33	10
Primary Prevention	22	22	11
RightCare Savings	46	46	23
Total	**141**	**102**	**44**
Cross Organisational Savings	39	39	20
Delivery of Provider BAU CIP	151	151	75
Total	**190**	**190**	**95**
TBC			
Reconfiguration of Commissioners	6	6	3
Reconfiguration of Providers	6	6	3
Total	**12**	**12**	**6**
Service Developments cost more/less than £122m	70	0	(35)
Variance on 16/17 Position	0	0	(108)
Ebbsfleet Additional Growth	28	0	0
Total	**126**	**0**	**(143)**
Grand Total	**110**	**(29)**	**(382)**

Care Transformation

Productivity

Enablers

System Leadership

111

Source: STP financial template

Emerging analytical insights suggest a stretch target, validating the opportunity for our Care Transformation programme to enable financial sustainability

Workstream	Net impact, base case, 2020/21, £M	Key assumptions
Local Care / Hospital Care	156	• Acute activity reductions to match Right Care peer or internal GP top decile level: NEL 13%, A&E 16%, EL 15%, OP 12% • Acute reduction in avoidable inpatient length of stay – Non-elective stays by over-70s limited to 10 days yielding 27% bed day reduction – Elective stays in key specialisms reduced (TBC) yielding a 17% bed day reduction • Aggregate reinvestment rate of 22% to enable new Local Care model, integrating primary, community, social, mental health and acute care • Impact on bed-based community care not yet quantified • Impact beyond activity/LOS reductions enabled by Local Care model not yet quantified
Mental Health	20	• Shift in care delivery model from inpatient admissions to community contacts to match top quartile delivery cost performance among peer CCGs with comparable population complexity • Assuming £375 cost per OBD and £125 cost per contact (NHS Benchmarking national averages) • However, additional cost pressure (not quantified) may exist incremental to assumed financial challenge to deliver the Five Year Forward View for mental health
Prevention	21	• TBC
Total	**197**	

112

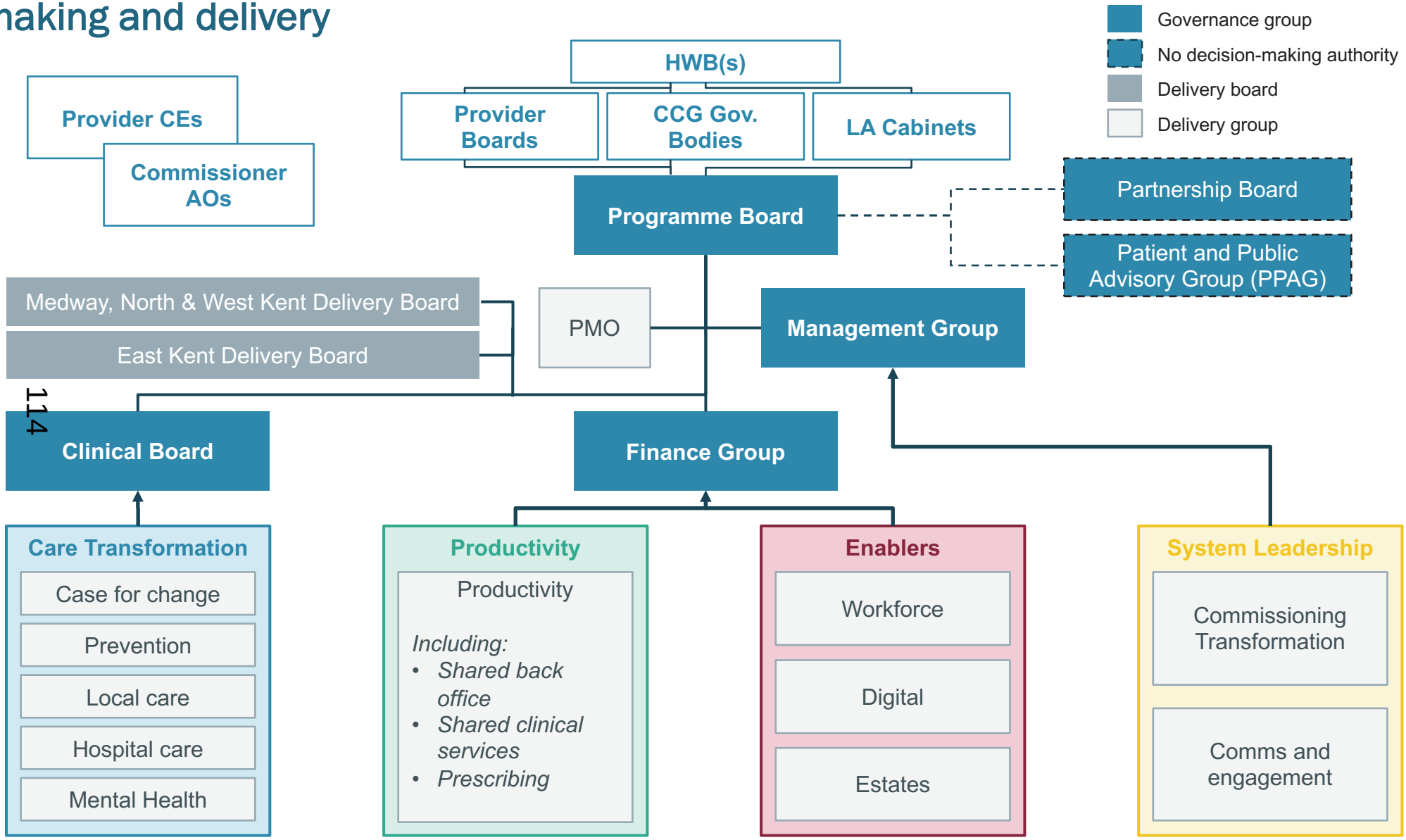
Source: Carnall Farrar analysis

We are moving next to quantify bottom-up the impact of the Kent and Medway local care model which will enable this financial transformation

Phases	1 Quantify the opportunity to reduce acute activity and spend	2 Develop the new models of local care which will enable the change	3 Translate new models into impact on activity, spend, workforce and capacity
Key steps	• Develop population segmentation to understand K&M activity and spend • Estimate savings potential: – Benchmarking vs. Right Care peers – Internal GP practice variation – Clinical review	• Engage clinicians to develop Local Care model to support health and wellbeing and prevent acute activity (e.g. MCP, PACS) • Identify acute configuration options by understanding site-level economics and future activity flows	• Specify changes to care package by population segmentation • Quantify changes to activity and resulting workforce and capacity requirements • Develop financial model and compare to baseline to understand net impact
Progress made	• Identified opportunity to reduce activity to match Right Care peers and reduce excessive length of stay among elderly	• Developed local plans for new models of care • Working to develop common Kent and Medway blueprint	• Data analysis underway to quantify new models of care and acute configuration options

Source: Carnall Farrar methodology

We have strengthened our STP governance arrangements to accelerate decision-making and delivery



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

We have mobilised Oversight Groups to steer and oversee the transformation

	Role	Membership
Programme Board	• Provides collective leadership to drive development and implementation of STP • Ultimately responsible for design and delivery • Ensures programme keeps to time and focus and that it delivers the outcomes required	• **Independent Chair: Ruth Carnall** • Glenn Douglas, STP SRO • Michael Ridgwell, STP Programme Director • CCG AOs • Trust Chief Executives • Chief Executives of KCC and Medway Council • NHSE and NHSI Regional Directors • Chairs of Clinical Board • Chair of Finance Group • Chair of Patient and Public Advisory Group • Comms and engagement lead
Management Group	• Supports Programme Board to ensure efficient and effective oversight of programme • Drives programme delivery to ensure on track • Oversees PMO and work of System Leadership workstreams	• **Chair: Glenn Douglas** • Michael Ridgwell • Ian Ayres (nominated by CCGs) • Matthew Kershaw • Paul Bentley • Helen Greatorex • Ian Sutherland, Medway Council • Kent County Council rep. (TBC) • Phil Cave, Finance Group Chair • Chairs of Clinical Board • Comms and engagement lead
Clinical Board	• Provides clinical leadership to programme • Leads development of strategy's clinical content and oversees work of clinical workstreams • Advises Programme Board on all clinical matters	• **Co-chairs: TBC** • Clinical Chairs of CCGs • Trust Medical Directors • Directors of Public Health • Senior Social Care professionals from Adults' and Children's services • Nursing and Allied Health Professional representatives
Finance Group	• Provides financial leadership and oversees of the Enabler and Productivity workstreams • Provides strategic advice and guidance for STP delivery and development • Ensures the plan makes best use of available resources for K&M population	• **Chair: Phil Cave** • All Chief Finance Officers from CCGs • All NHS and NHS Foundation Trust Finance Directors • NHS England specialised commissioning finance lead • NHSE primary care commissioning finance lead • KCC Finance Lead • MUA Finance Lead

Source: Kent and Medway STP PMO

Our workstreams are mobilising at pace to detail our strategy

R Red A Amber G Green

	Workstream	SRO	Status
Care Transformation	Case for change	• Co-chairs of Clinical Board	G
	Prevention	• Andrew Burnett (Dir. Public Health, MUA) • Andy Scott-Clark (Dir. Public Health, KCC)	G
	Hospital Care	• Glenn Douglas (CE, MTW)	R
	Local care	• Caroline Selkirk (AO, Medway CCG)	R
	Mental Health	• Helen Greatorex (CE, KMPT)	A
Productivity	Provider productivity including shared back office, shared clinical services and prescribing	• Steve Orpin (DoF, MTW)	A
Enablers	Workforce	• Hazel Carpenter (AO, SKC & Thanet CCGs)	R
	Digital	• Susan Acott (CE, DGT)	A
	Estates	• Rebecca Spore (Dir. Of Infrastructure, KCC)	A
System Leadership	Commissioning transformation	• Felicity Cox (NHS England), supported by Ian Ayres as Lead (AO, West Kent CCG)	A
	Communications and engagement	• Michael Ridgwell (STP Programme Director)	A

Mobilisation and next steps

- Each workstream has:
  - An assigned SRO; and
  - completed a Project Initiation Documents (PID)
- Workstreams are at different stages of development as a result of the programme being stood up at pace
- During the next 3 months, all workstreams will undertake a consistent and detailed planning and design process through facilitated workshops – this will ensure consistent planning assurance and governance reporting
- The STP PMO will provide the structures, processes and template materials to enable the workstreams to plan and deliver projects effectively and in a consistent approach
- Workstreams will routinely report to their corresponding Oversight Group

Source: Kent and Medway STP PMO

We are pressing ahead to meet key programme milestones

Design
Oct – Dec 2016

- **Oct 2016:** Programme governance arrangements agreed; PMO, workstreams and Oversight Groups mobilised
- **Oct 31 2016:** Clinical model evaluation criteria agreed at Programme Board
- **Nov 2016:** Initial clinical model options set out
- **Nov 2016:** Local Care and Hospital transformation modelling completed
- **Nov 2016:** Initiate pre-consultation engagement
- **Dec 2016:** Clinical Board and Programme Board review case for change
- **Dec 2016:** Organisations develop Operational Plans for FY17/18

  Note: though this is not the direct responsibility of the STP, the STP will track progress and hold peers to account

Prepare for consultation
2017

- **Jan 2017:** Case for change published
- **Feb 2017:** Critical workforce analysis completed
- **Feb 2017:** Clinical model options evaluated against agreed criteria
- **March 2017:** Formal sign off of agreed clinical model
- **April 2017:** Pre-Consultation Business Case developed
- **April 2017:** Consultation document developed
- **May 2017:** CCG governing bodies approve PCBC, consultation document and consultation plan
- **May 2017:** NHS gateway approval secured
- **June 2017:** Consultation begun
- **Aug 2017:** Review responses
- **Dec 2017:** Final consultation decision made
- **Dec 2017:** Implementation plan developed

Implement
2018 – 2020

- **Implementation of overall programme, based on output of previous phases**
  - Implementation plans identified to be rolled out in waves to ensure delivery
  - Wave durations vary by workstream (between 3-6 months)
- **STP PMO to remain in place to monitor and ensure effective implementation of programme**
  - Phased transition of oversight and monitoring from the STP PMO after wave 1, to ensure ownership by relevant stakeholders

Source: Kent and Medway STP PMO

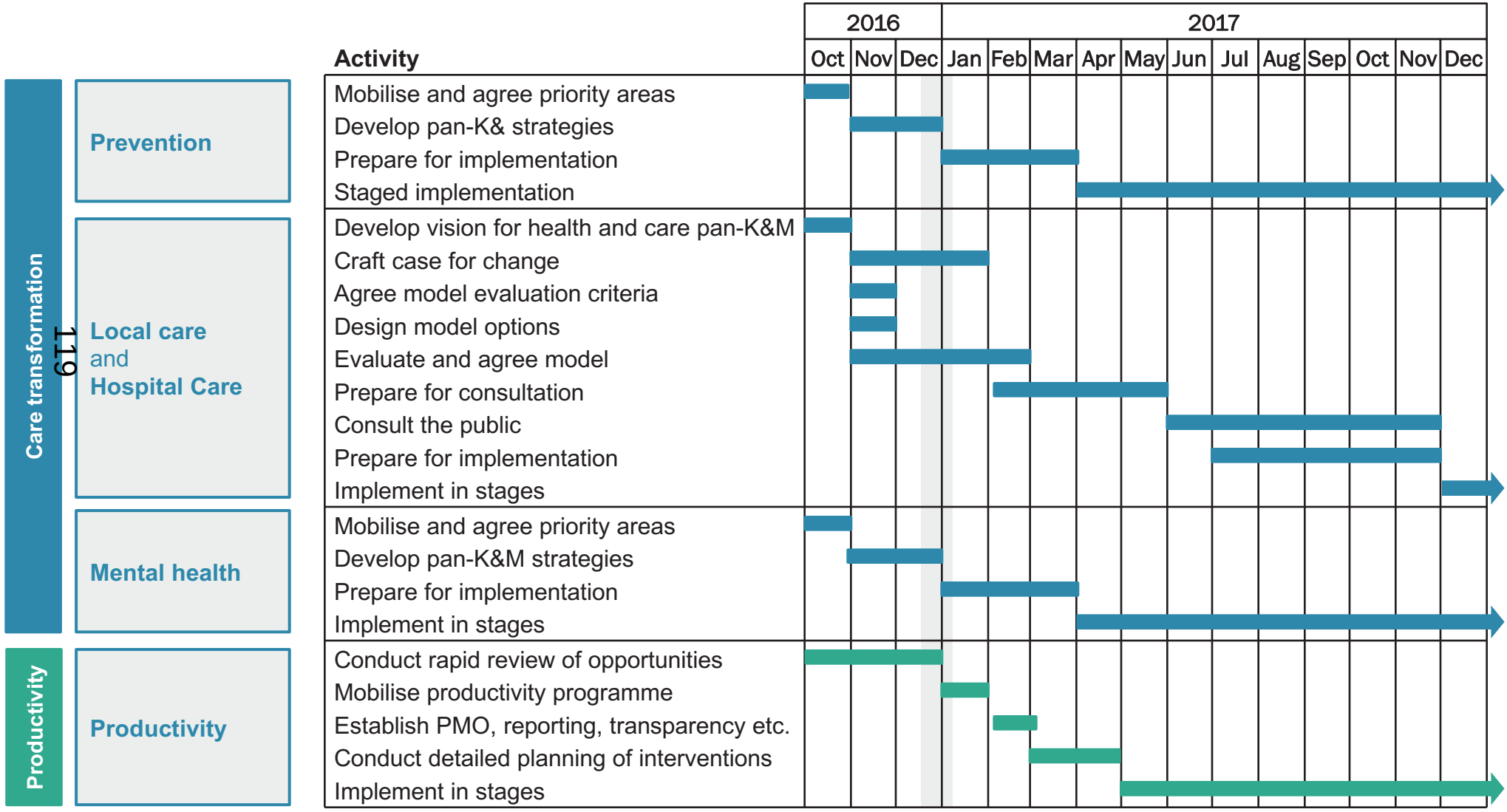
Development of our case for change is an immediate priority to be overseen by the Clinical Board

Agreed approach by end of 2016

	Key steps	Approach
1 Develop the case for change using existing data	• **Establish the Clinical Board**: confirm the terms of reference and membership. Convene first Board meeting. Confirm specific contributions required from members. Review and confirm results from analysis in 1:1 discussion with key individuals. • **Capture and distil an agreed crisp and compelling case for change** in a written prose and brief PowerPoint.	• Assess existing case for change • Work with Clinical Board to discuss and seek contributions • Perform and review targeted analysis • Synthesise key themes • Review with the Clinical Board • Approval by the Clinical Board
2 Undertake additional data collection	• **Collect and review local, bespoke data** relating to: – Self-assessment against quality standards – Acuity audit across acute and community hospital beds – Drivers of the commissioning and provider deficits – Number of lives lost through weekend working – Workforce (vacancies, turnover, sickness) – Local success stories – Utilisation of community hospitals	• Draft data collection instrument • Meet with Medical Directors to discuss data collection requirements, expected inputs and outputs • Data collection, analysis and presentation • Review with key individuals • Review with the Clinical Board • Support Medical Directors in their communication to senior colleagues the steps being taken

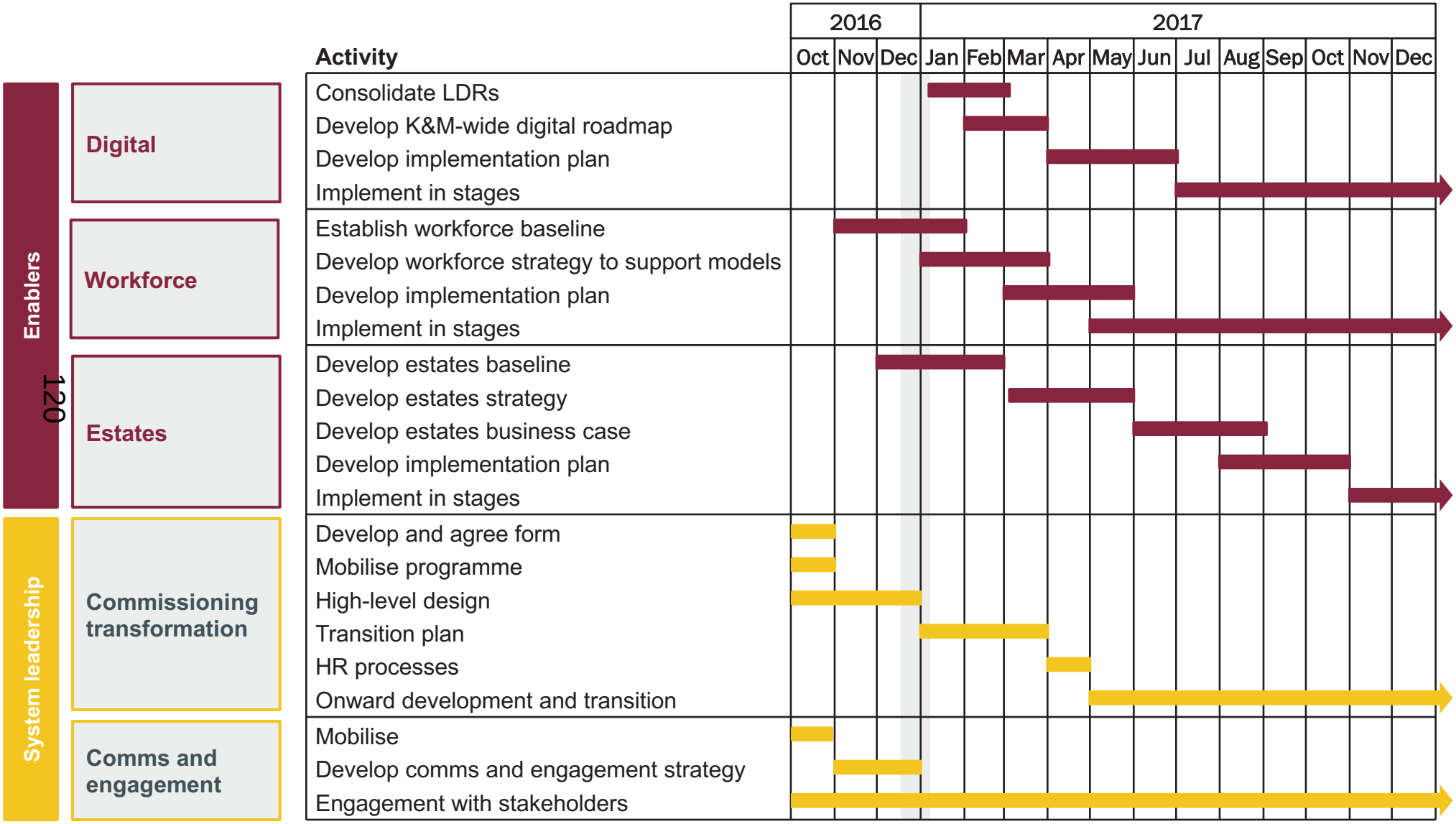
Source: Carnall Farrar engagement plan

K&M STP overarching programme timeline (1 of 2)



Source: Kent and Medway STP PMO

K&M STP overarching programme timeline (2 of 2)



Source: Kent and Medway STP PMO

In the interests of transparency this is submission remains unaltered from the version submitted to NHS England and NHS Improvement on the 21st October 2016 – the following lists changes that have been made to this submission since it's publication

- Slide 9 - footnote on should refer to "do nothing scenario" not "no nothing scenario"
- Slide 11 references 3 HASUs (hyper acute stroke units) and 1to 2 elective orthopaedic centres, the development of these would be subject to public consultation (with regard to the development of orthopaedic centres this is just one example of how the separation of planned and unplanned care could be supported and different approaches are being considered in different areas and would be subject to consultation if required)
- Slide 15 should say Ashford Rural 6-day service not Herne Bay 7-day service
- Slide 21 references that in East Kent the options modelled include an "as is" model, alongside an option that sees the closure of one site and the creation of a single site option; these represent a number of the options alongside a range of other options representing varying degrees of potential change that have been modelled
- Slide 25 should indicate that the open dialogue intervention will be used across diagnoses (rather than the first episode of psychosis as it currently reads)
- Slide 28 reference KEM – this should refer to Kent and Medway
- Slide 36 references KCC and Medway Council chief executives would sit on the programme board this should indicate that senior officer representation, chair of health and wellbeing boards and directors of public health from the two councils would sit on the group.

Document is Restricted