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thanet district council

QEQM HOSPITAL CABINET ADVISORY GROUP

13 DECEMBER 2016

A meeting of the QEQM Hospital Cabinet Advisory Group will be held at **11.15 am on Tuesday, 13 December 2016** in the Austen Room, Council Offices, Cecil Street, Margate, Kent.

Membership:

Councillor Game (Chairman); Councillors: Wells, L Fairbrass, J Fairbrass, Falcon, I Gregory, Grove and Matterface

A G E N D A

Item No	Subject

1. **DECLARATIONS OF INTEREST**

   To receive any declarations of interest. Members are advised to consider the advice contained within the Declaration of Interest form attached at the back of this agenda. If a Member declares an interest, they should complete that form and hand it to the officer clerking the meeting and then take the prescribed course of action.

2. **APOLOGIES FOR ABSENCE**

3. **MINUTES OF PREVIOUS MEETING** (Pages 1 - 4)

   To approve the Minutes of the QEQM Hospital Cabinet Advisory Group meeting held on 21 April 2016, copy attached.

4. **CAG TO DRAFT COUNCIL RESPONSES TO THE EKHUFT & PARTNER AGENCIES PUBLIC CONSULTATION** (Pages 5 - 112)

   Covering report to follow.

Declaration of Interests Form

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QEQM HOSPITAL CABINET ADVISORY GROUP

Minutes of the meeting held on 21 April 2016 at 7.30 pm in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Councillor Lesley Ann Game (Chairman); Councillors Ashbee, J Fairbrass, L Fairbrass, Falcon, I Gregory, Matterface and Wells

In Attendance: Hazel Carpenter

1. ELECTION OF CHAIRMAN

Councillor Wells proposed, Councillor Matterface seconded and Members agreed that Councillor Game be the Chairman of the QEQM Hospital Cabinet Advisory Group.

Councillor Game in the Chair.

2. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Glenn Coleman-Cooke who was substituted by Councillor Jeremy Fairbrass.

Councillor Wells, Leader of the Council advised the meeting that after his appointment to the Cabinet Advisory Group, Councillor Coleman-Cooke became an employee of the East Kent Hospital University Foundation Trust (EKHUFT). He therefore would have had to declare a pecuniary interest at all meetings of the advisory group and leave the meeting room. Councillor Jeremy Fairbrass was now his replacement moving forward.

3. DECLARATIONS OF INTEREST

There were no declarations made at the meeting.

4. SUSTAINABLE TRANSFORMATION PLAN PROCESS - REORGANISATION OF EKHUFT

Hazel Carpenter, Accountable Officer for Thanet CCG and South Kent Coast CCG led discussion with a PowerPoint presentation, which is hereby attached as Annex 1 to this minute item. She explained that the Clinical Commissioning Group (CCG) was a grouping of General Practitioners from whom one GP is elected chairman to lead the group. They hold a National Health Services (NHS) budget for Thanet which was currently at £200 million per year. This budget excludes services like primary care or specialist services where cases are usually referred to London.

The Thanet CCG was currently working with three other CCGs in the South East Kent to develop approaches for future integrated working. EKHUFT has been discussing proposals for a health service strategy for the future. However the Trust cannot go it alone. There is a need for a more holistic approach moving forward that would involve engaging the various CCGs who hold the legal obligation to consult in cases where new health delivery strategies are being proposed.

Case for Change

Hazel Carpenter said that there was a rising demand for care in a situation where service provision was fragmented and there was a need reconsider how health services can be provided in a seamless way to enhance the patient experience. Care Quality Commission (CQC) performance results show poor performance. Whilst the constitutional performance targets for A&E are a four hour wait for 95% of the people, QEQM

Hospital's A&E results are more likely to be under 70% in some weeks. There was shortage of specialist skills in the NHS and locum staff are being used to fill in the gaps, and this was not sustainable in the long run.

There were inequalities in health standards. For example, in Thanet life expectancy goes down 17 years as one moves from one area to another. There was therefore a case for addressing these issues through a holistic re-organisation of health service delivery. Chief Executives and Medical Directors of all major health organisations (Ambulance Services, NHS, Social Care Services etc), Kent County Council, four clinical Commissioning Groups Chairs meet as a Strategic Board chaired by Sarah Philips to come up with a model for integrated working which is sustainable and closes the current gap of quality, affordability and inequalities.
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The Board is building a case for change through understanding the various needs and gaps at local level (Thanet level), sub-district level and county level. They are looking at some work streams which are:

a) Maternity and Paediatrics;
b) Mental health care;
c) Urgency and Emergency care;
d) Prevention and self care;
e) Learning disabilities;
f) Long term conditions and frailty;
g) Planned care and Specialist care;
h) End of life care

The Board is looking at what the best should be like for each of these services and developing a model for integrated care. In the process the board is developing a Kent Integrated Data set that allows for the analysis flow across health and social care. This facility is new and unique nationally.

Time Scale
Originally the governance arrangements were scheduled to be in place by Easter. These arrangements would enable Thanet CCG to make a decision on this matter. By end of April – early May clinical models need to have been described and set out. Stakeholders and the public will be engaged in the process. A Patient Panel will be set up to keep patients informed of the progress.

By June 2016 there should be a Plan to take to public consultation. The intention is to have one service, one team and one budget.

After the presentation by Hazel Carpenter, Members asked questions that she responded to. She said that although the end of life care budget in the slides reflected 0%, that budget is covered for within the hospital budget, community budget and primary care budget. There was a general shortage of GPs nationwide, but plans are being worked out to address the problem.

Doctors do not have the right contacts that would incentivise them or the right staff to work with. At a national level an additional £60,000 for each GP is to be allocated. This includes attempts to bring together GPs to work together as a group of surgeries. For example in Thanet, four localities (Margate, Broadstairs Ramsgate and Quakes Locality) have come together and are to receive CCG allocated funding to incentivise them working together.

Hazel Carpenter said that there will be criteria for the public consultation for the changes in services across east Kent. This included looking at safe service, same service standards, access to services by the local community (including non health seeking

community) Clinical outcomes are critical in the proposals for a new model of working and service change. The GP members and managers are very clear about that and aware of that requirement. However some very specialist services need concentrating to ensure the right number of patients are being seen and specialist skills can be brought together in safe clinical rotas.

With regards to patients being referred to William Harvey for certain appointments and not at QEQM Hospital, GPs can see the patient information on how many individuals would take an earlier appointment at William Harvey rather than sit back and wait for a longer waiting time appointment at QEQM Hospital. These issues will be taken into consideration when working out the new model.

Speaking under Council Procedure Rule 20.1, one Member asked what the CCG was doing to address the issue of low morale in the NHS, recruit and retain staff, improving moral and tackling agency spend (and reduce the financial gap). Early change management programme would need to be used to fully engage NHS staff right from an early stage of the change process.

Hazel Carpenter said the Board was already looking at ways of promoting and developing opportunities to work in those health sectors and support the work of the NHS without encouraging employees leaving some organisations in great numbers.

Members observed that if the Cabinet Advisory Group waited for the public consultation in order to feed into the process might be too late as some significant decisions would have been made. There is a need for the sub group to look at the right points to influence the change process. Hazel Carpenter said that she welcomed the input from the Council. She said that there was no likelihood of the A& E Department being moved away from QEQM Hospital. The Chairman said that it was good news that the department would not be closing down.

GPs across Thanet are currently working on an initiative that would set up the Thanet Hub which will based in QEQM Hospital, which will be at front door and the A&E would then be moved to an area within the QEQM Hospital behind the Hub.

Hazel Carpenter said that after the closure of the GP surgery in Garlinge, all the patients will receive notification letters advising them where they have been allocated a registration with another GP. She also said that the NHS has got an internal recruitment agency and it was worth noting that 70% of recruitment is passed on between NHS organisations.

With regards to shortage of consultants at the A& E, Hazel Carpenter advised the meeting that plans were being drawn up to address this across the Trust. She urged Members to write to the CCG and NHS to raise these clinical concerns. A new medical model is being implemented to enable consultants to attend A& E within the expected best practice time scales.

Members received and noted the presentation. The Chairman also thanked Hazel Carpenter for her presentation.

5. AGREE TERMS OF REFERENCE OF THE QEQM HOSPITAL CABINET ADVISORY GROUP

Madeline Homer introduced the item for discussion and referred members to the draft terms of reference in Annex 1 to the sub group report. The Leader said that it was important to get timing for the intervention by Council right to influence the decision. This would call for getting the information from the Thanet CCG at the appropriate time.

Councillor Wells proposed, Councillor Matterface seconded and Members agreed that the following be the amended terms of reference of the QEQM Hospital Cabinet Advisory Group:

1. Consider or shadow the proposed re-organisation of East Kent health services through the work of the East Kent Strategy Board;

2. In the event of a public consultation relating to the provision of health services at QEQM Hospital in Margate, prepare a draft Thanet District Council response to the consultation;

3. Prepare a final report for consideration by Cabinet.

The amended terms of reference will need to be approved by Cabinet.

Madeline Homer said that there was need to clarify how the public consultation process will be conducted and the role of the Thanet Health & Wellbeing Board in this process. In response to a suggestion to increase the membership size of the advisory group, Councillor Wells indicated that the size was appropriate for the time being and any Members who wanted to take part in the discussions of the sub group could attend meetings and speak under Council Procedure Rule 20.1.

Meeting concluded: 8.40 pm

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

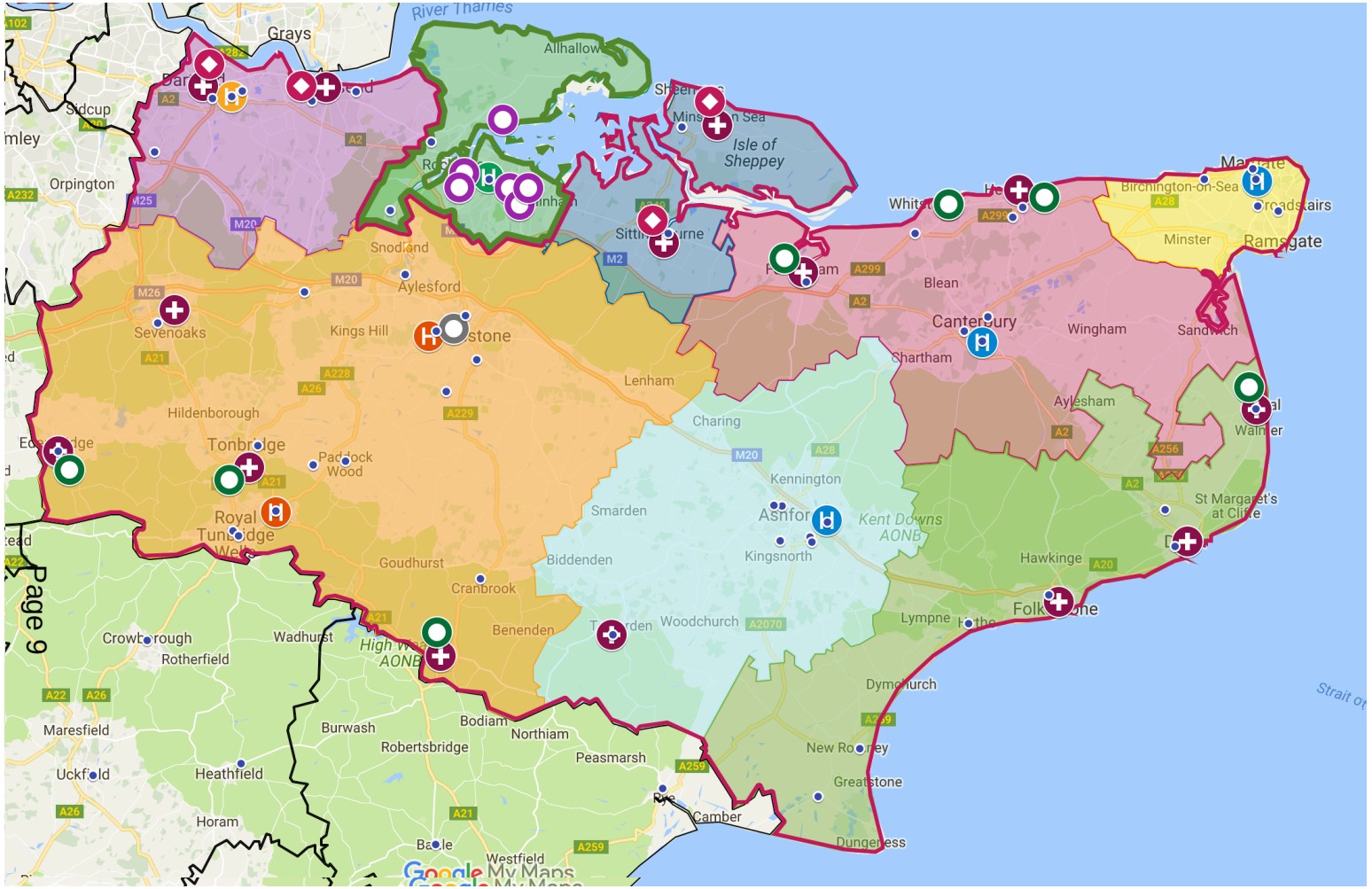
Executive summary (2/2)

- 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



- H D&G NHS Trust
- H EKHU NHS FT
- H Medway NHS FT
- H 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

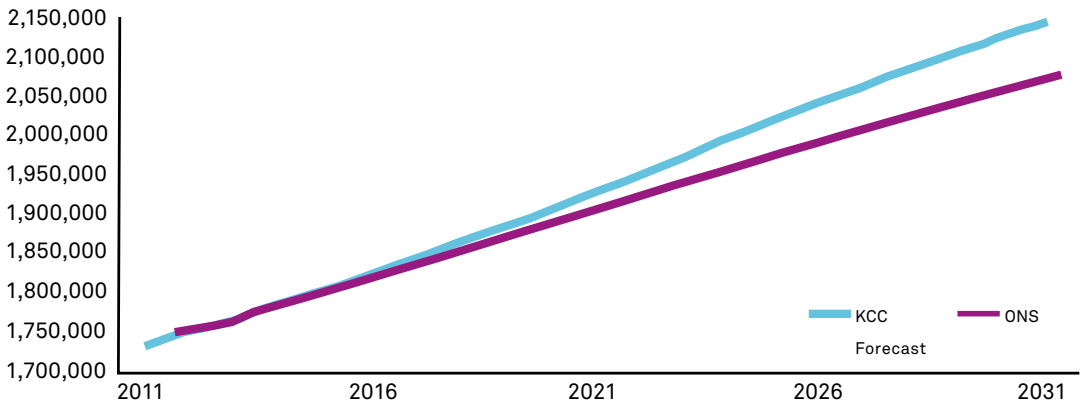
- We are **£109m 'in the red'** and this will rise to **£486m by 20/21** across health and social care if we do nothing.
- Our **workforce is aging** and we have difficulty recruiting in some areas. This means that **senior doctors and nurses are not available** all the time.

- 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

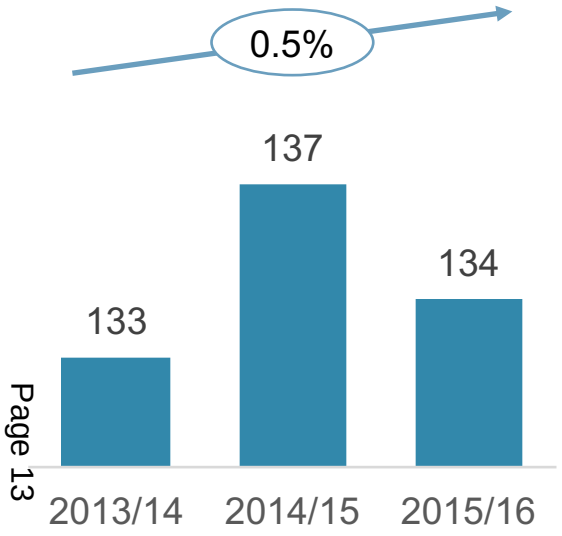
Source: KMGIF, DGS CCG, DGT

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

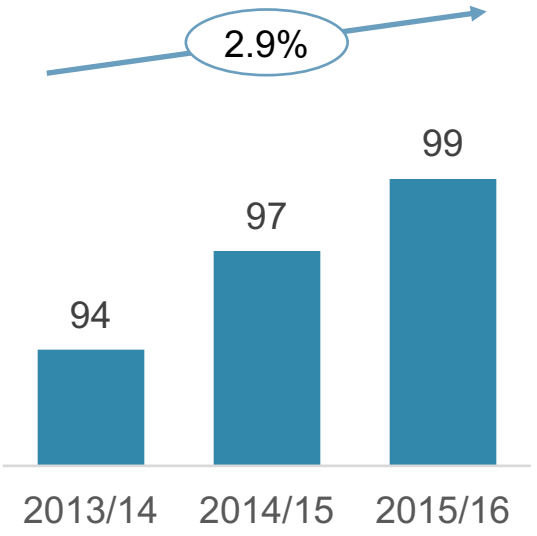
Example: Acute activity per 1,000 population, Kent and Medway

- CAGR, %

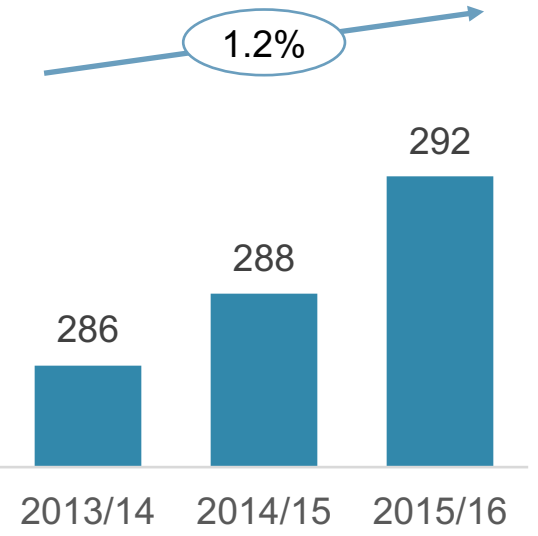
Elective



Non-elective



Outpatient

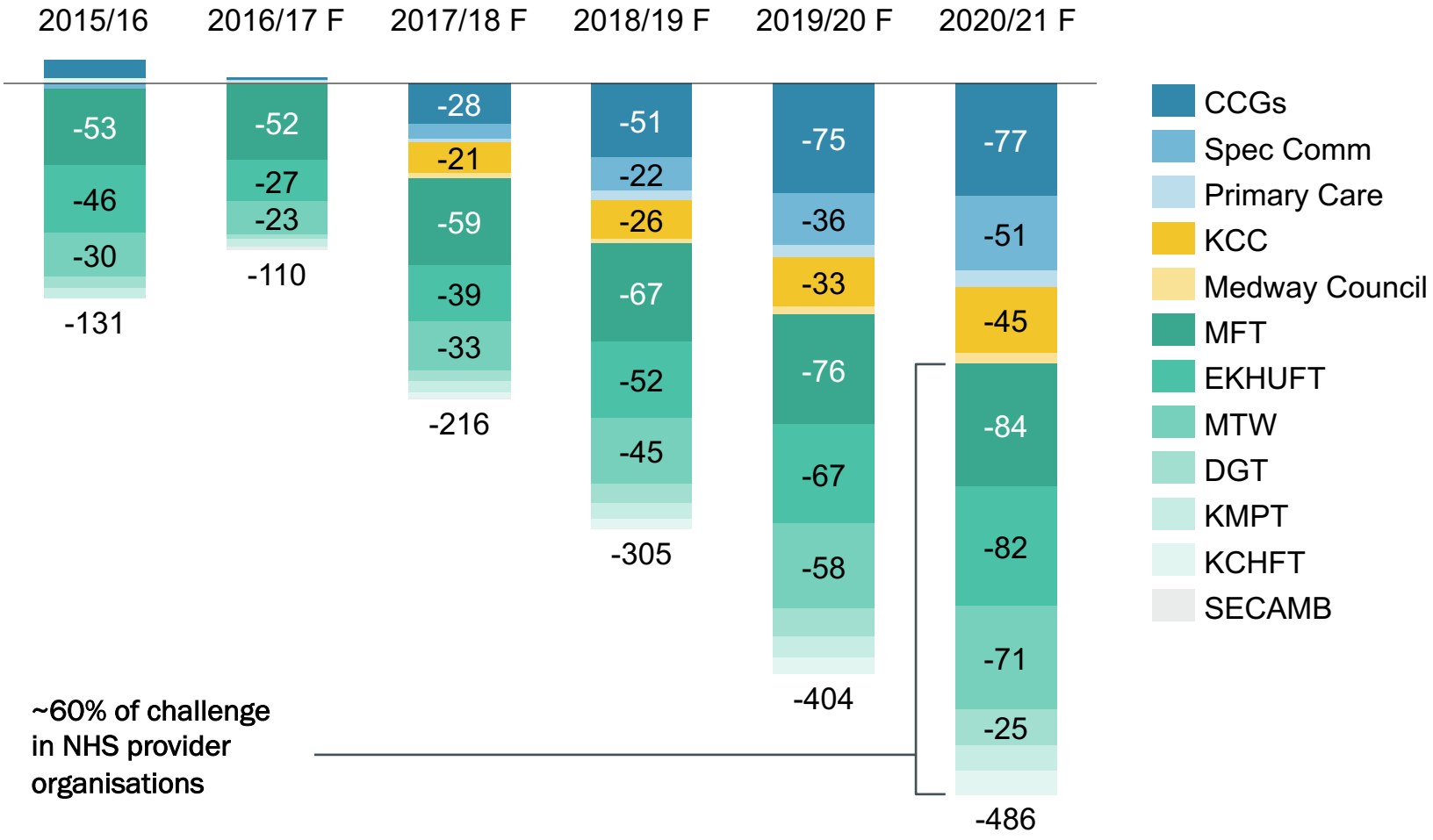


Notes: 1 Right Care peers for each K&M CCG selected and peer activity data aggregated, weighting by population
Source: MAR Data, Carnall Farrar analysis

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

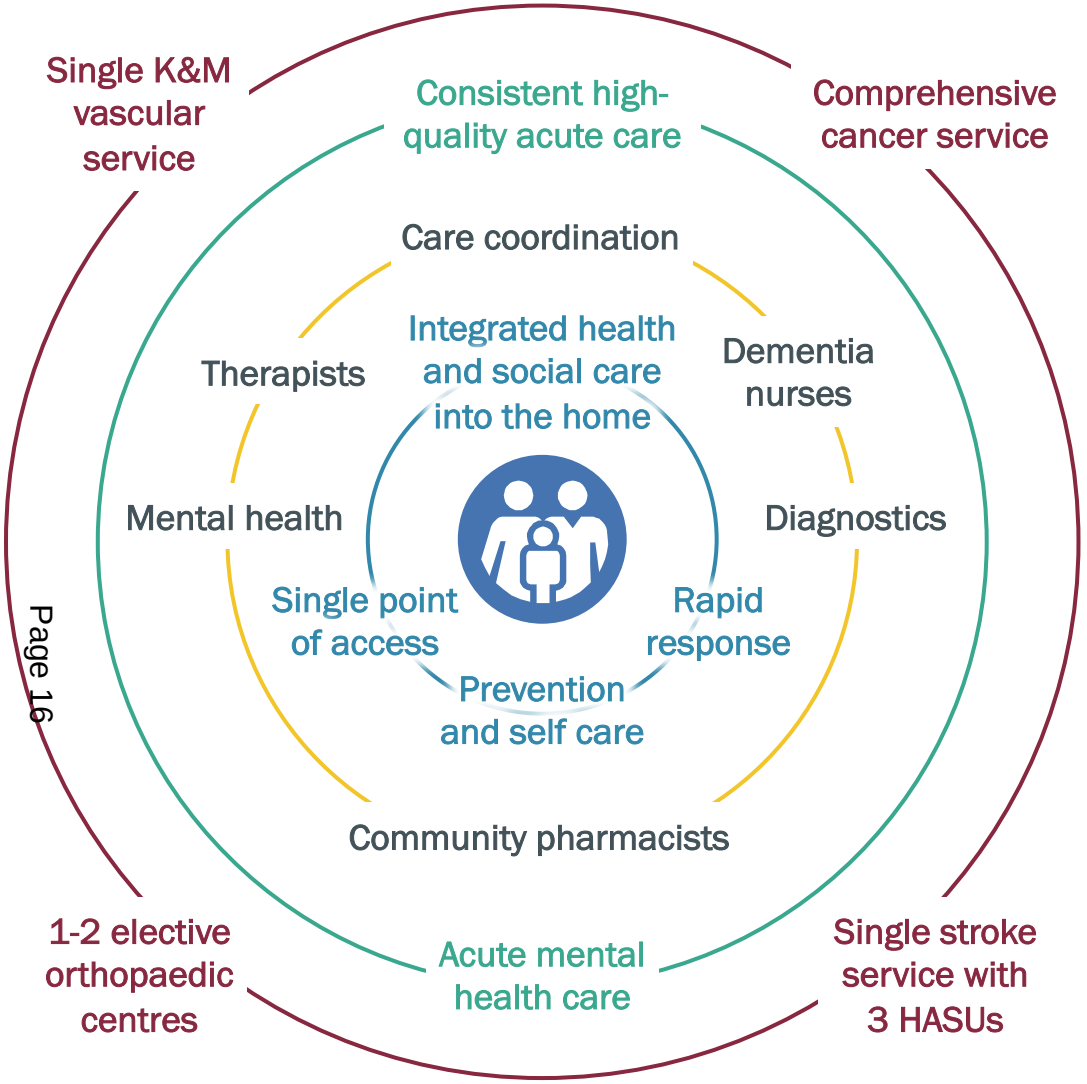
A critical success factor of this programme will be system leadership and system thinking. We have mobilised dedicated programmes of work to address:

- **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

MCP / PACS models[1]

Accountable Care Organisations

Our aspirations

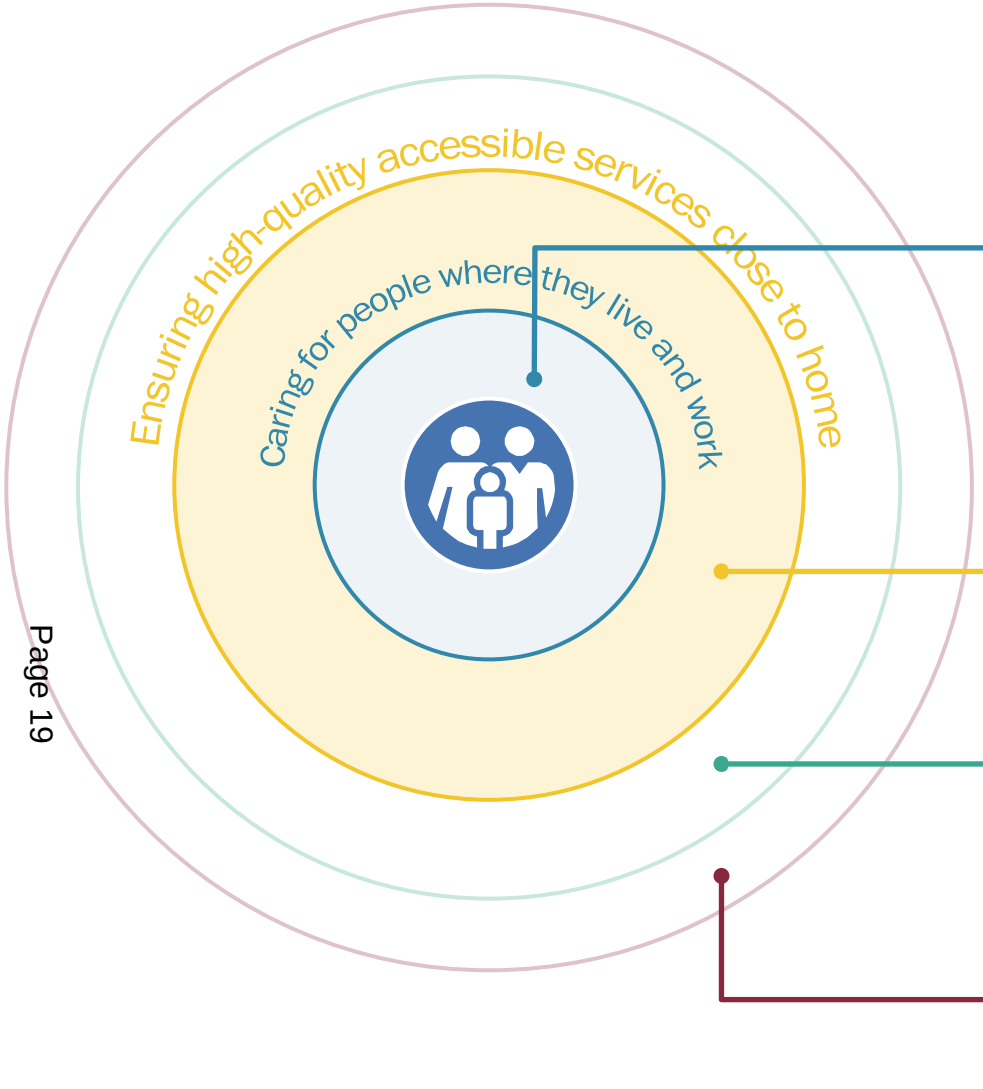
- Identify patients' healthcare needs and provide integrated treatment which encompasses all of them
- Empower patients through person centered, proactive support
- Ensure increased patient participation in their own care
- Enable proactive care that supports improving and promoting health and wellbeing, 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

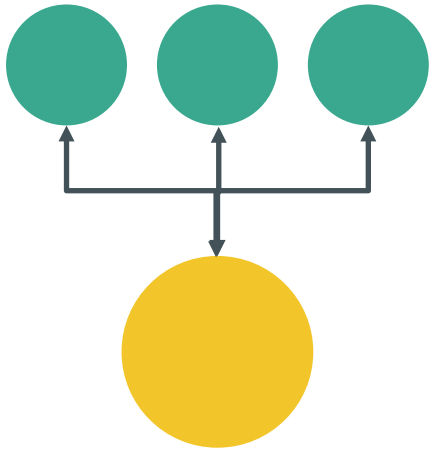
- Activity

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

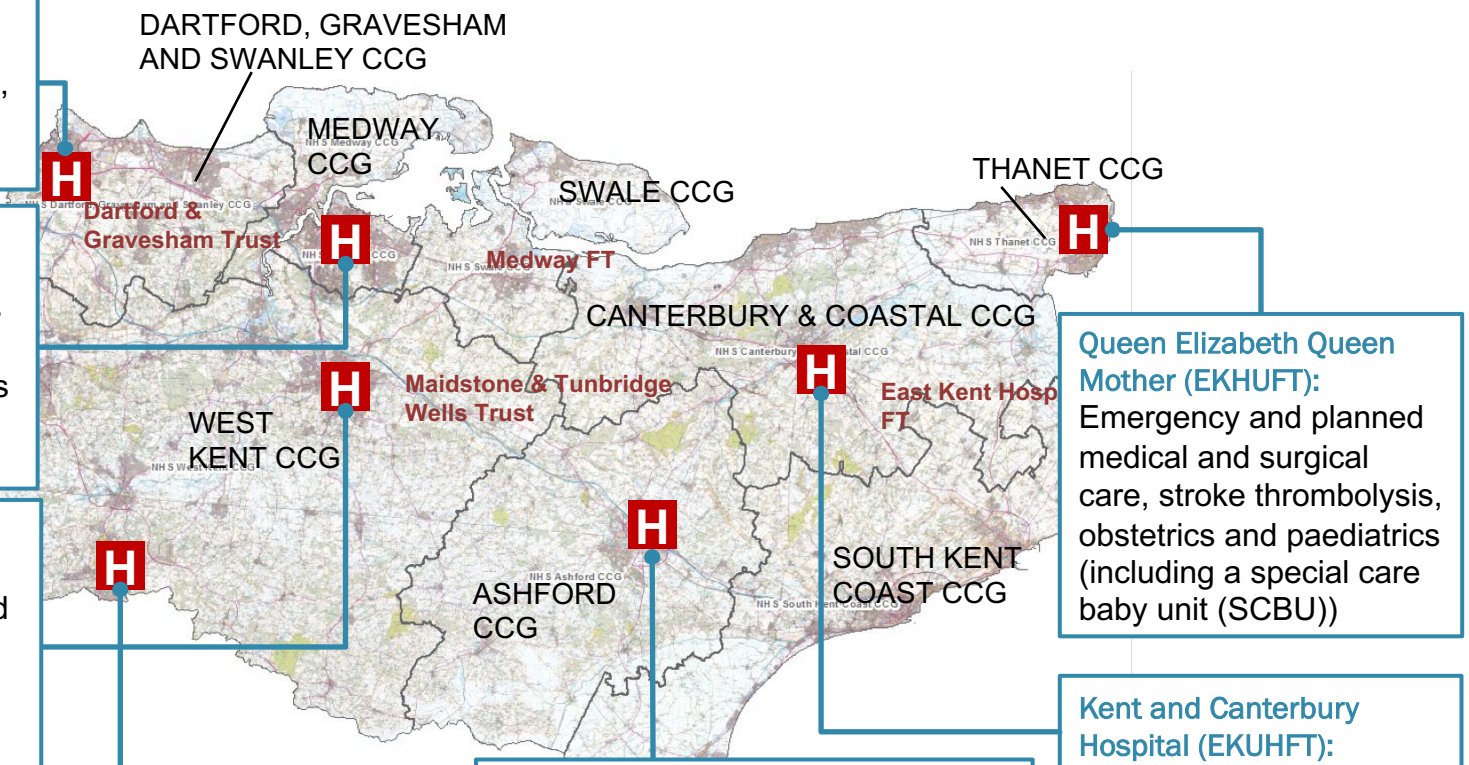
Our Acute Care model is partially consolidated, but is still largely based on historic dispersal of services

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

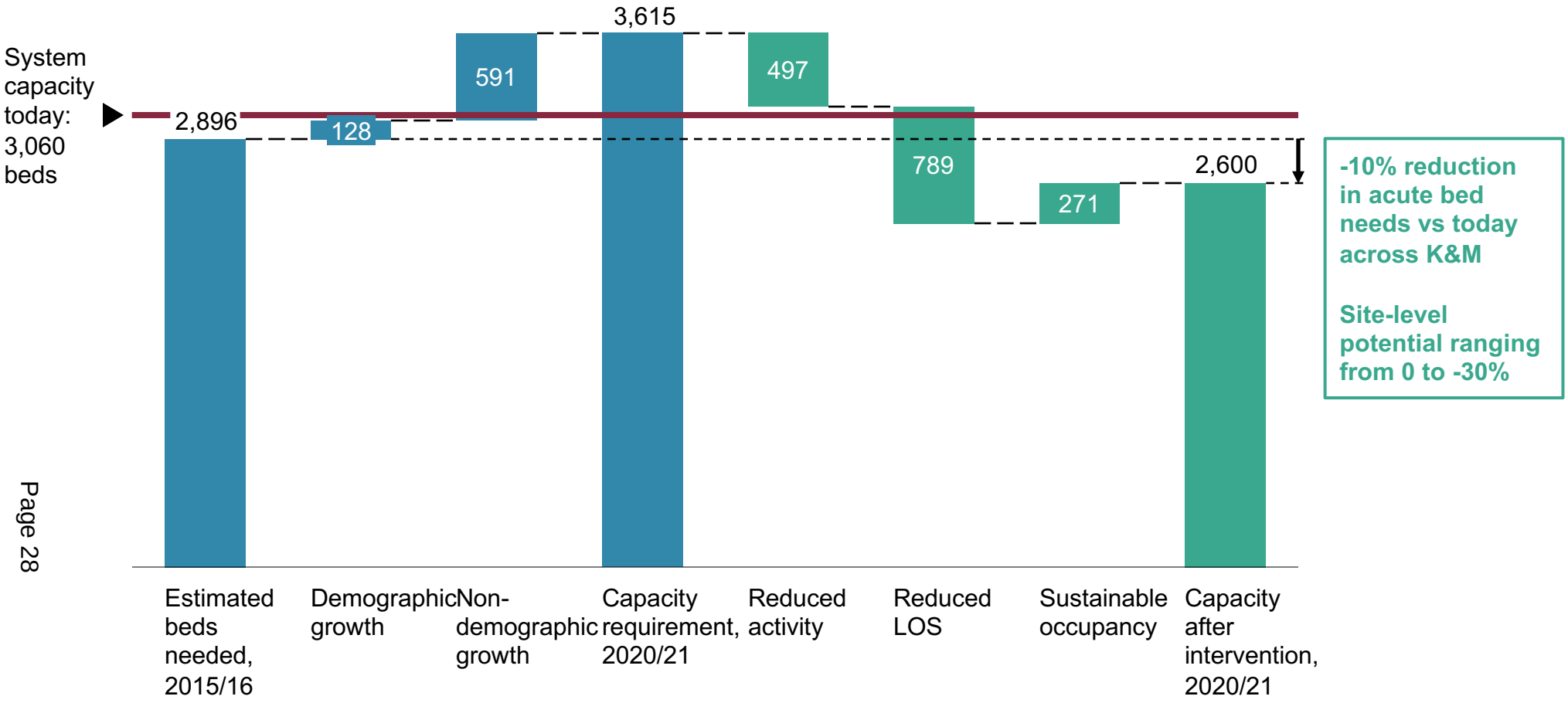
	Key enablers	Opportunity	System savings, 2020/21, £ Millions: Gross	Net[5]
1 **Avoid emergency admissions through more proactive and coordinated care**	• Care coordinators • Rapid response	• Internal and external activity benchmarking[1] suggests opportunity to reduce acute activity: – Non-elective: -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

Phases	1 Programme mobilisation and developing our vision	2 Understanding baseline for activity, cost and spend	3 Developing our evaluation criteria	4 Identify and analyse opportunities	5 Prepare for consultation	6 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

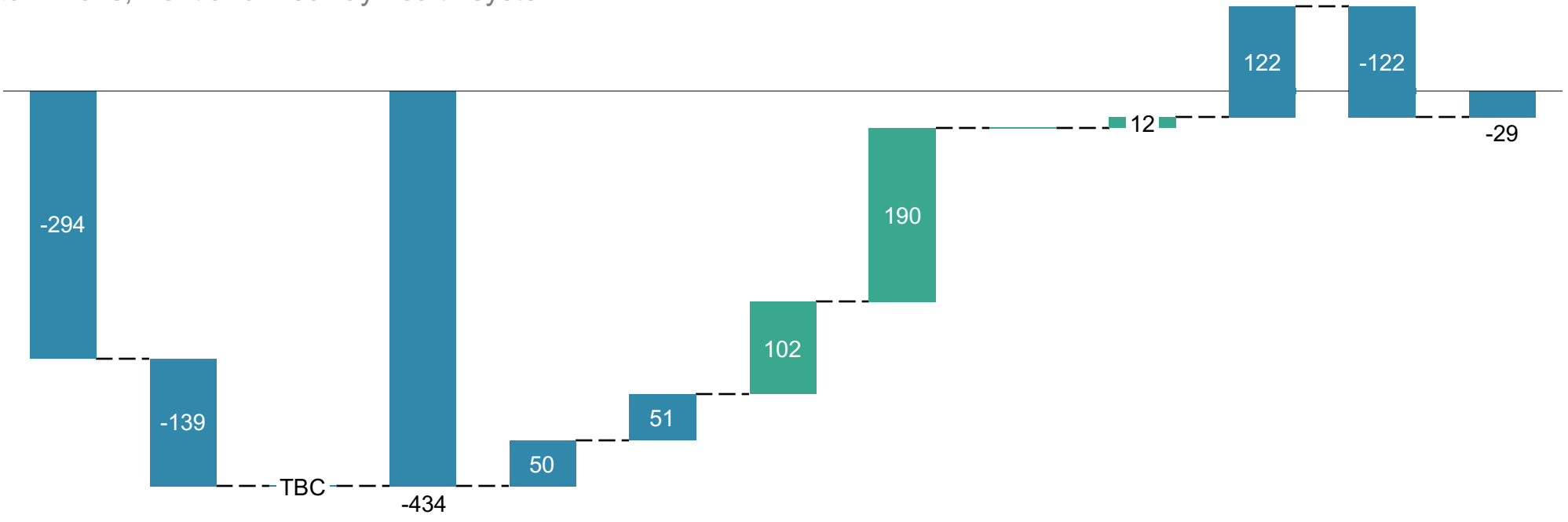
- Understand new contracting models to allow ACOs as lead providers to be commissioned to provide appropriate outcomes for defined populations with minimal transactional bureaucracy
- Understand evolution of CCGs and NHSE commissioning and impacts on form and function of CCGs

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.

Page 96

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
Care Transformation	Secondary to out-of-hospital care	74	33	10
	Primary Prevention	22	22	11
	RightCare Savings	46	46	23
	Total	**141**	**102**	**44**
Productivity	Cross Organisational Savings	39	39	20
	Delivery of Provider BAU CIP	151	151	75
	Total	**190**	**190**	**95**
Enablers	**TBC**			
System Leadership	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)**

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**	

Source: Carnall Farrar analysis

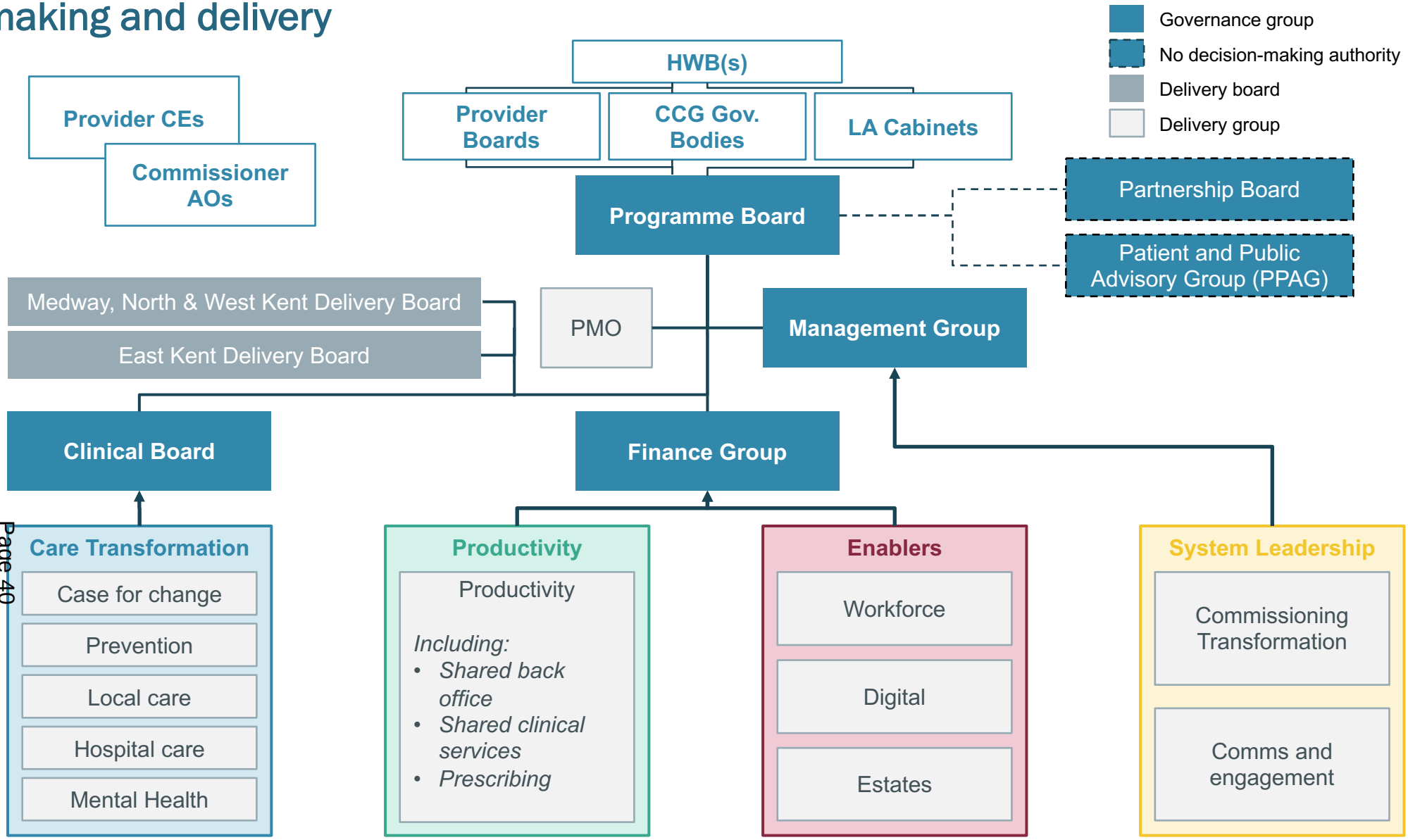
We are moving next to quantify bottom-up the impact of the Kent and Medway local care model which will enable this financial transformation

Position today

	1	2	3
Phases	**Quantify the opportunity to reduce acute activity and spend**	**Develop the new models of local care which will enable the change**	**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

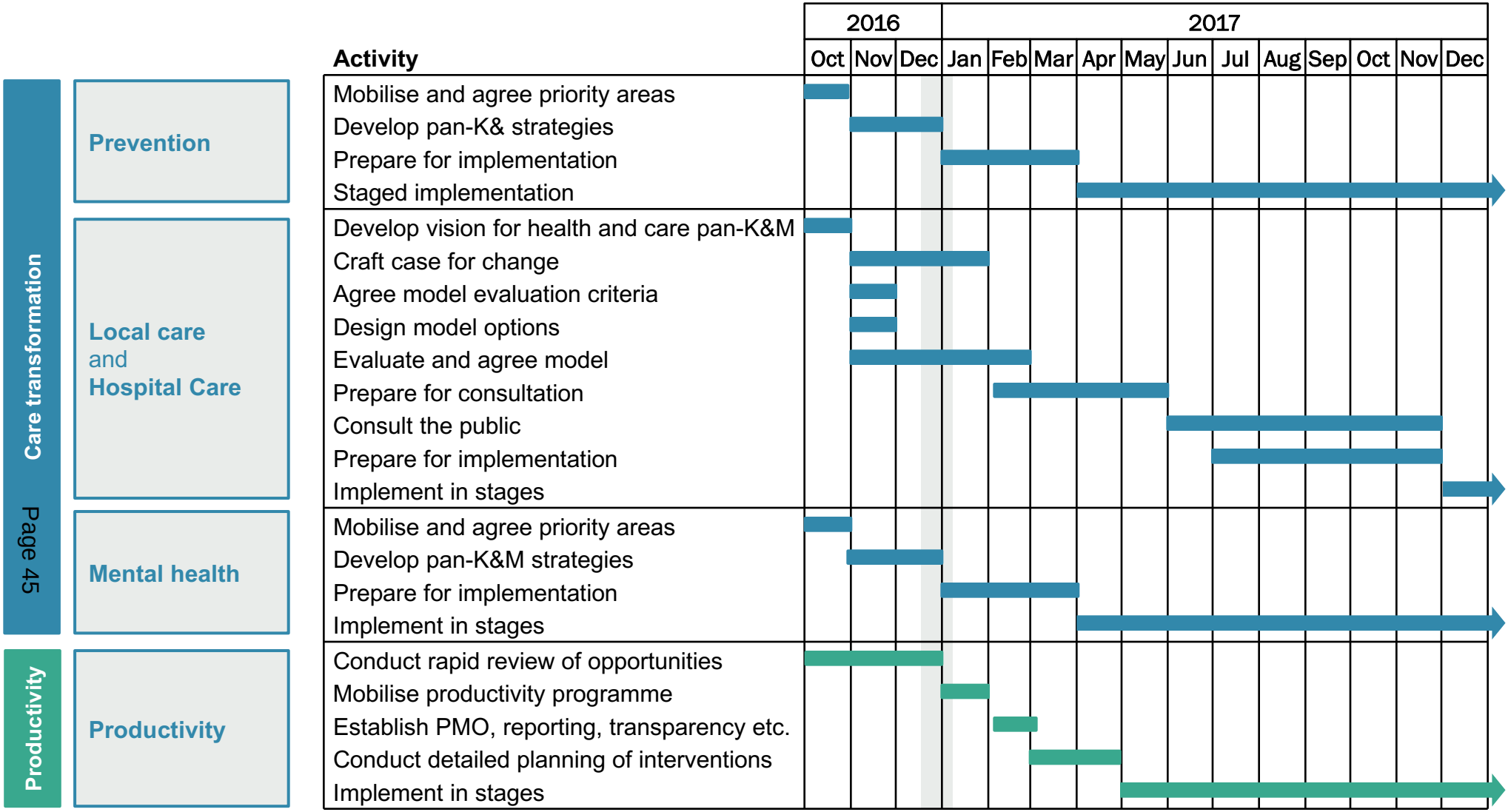
2 Undertake additional data collection

- **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

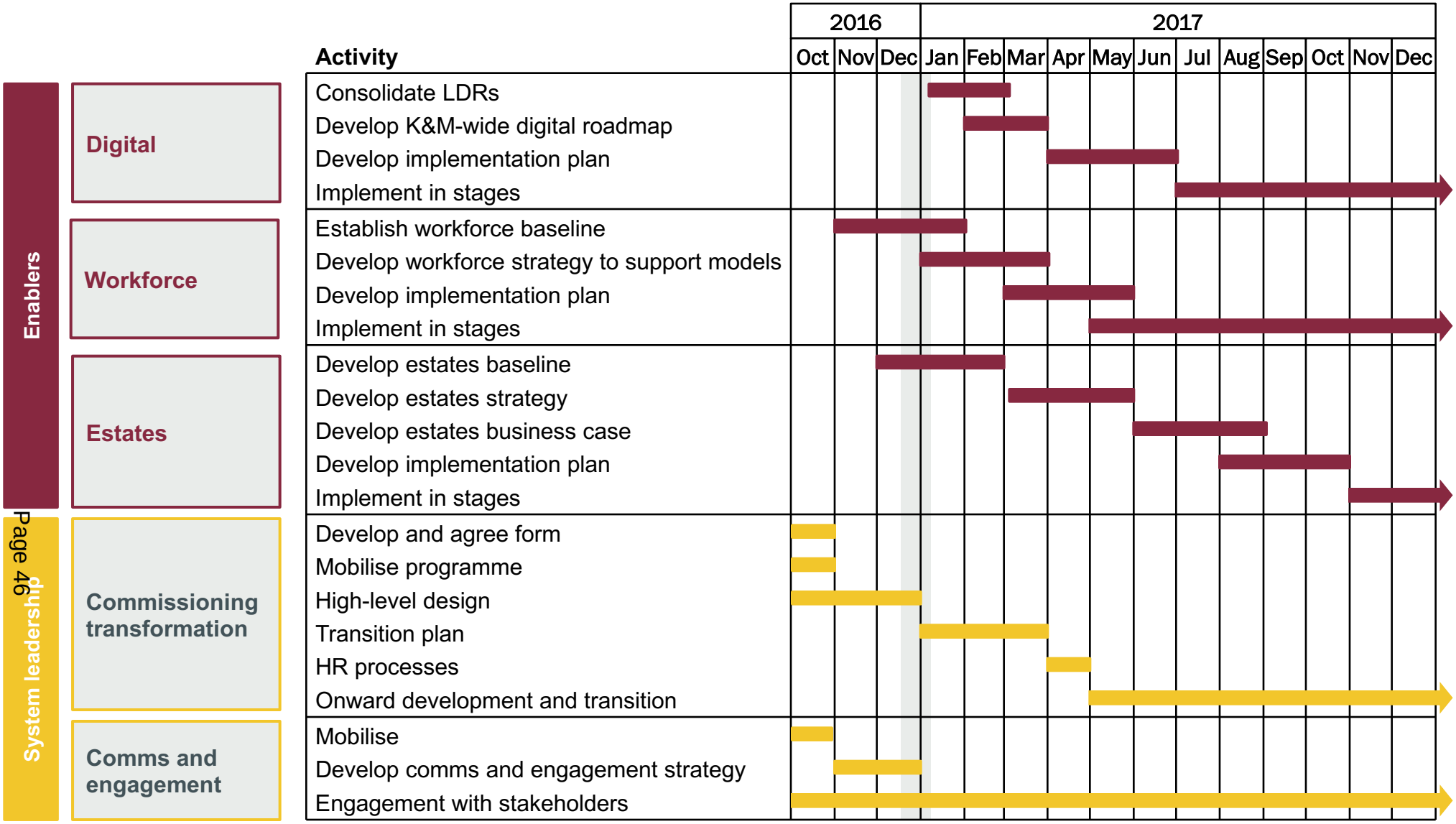
Source: Carnall Farrar engagement plan

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.

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FIVE YEAR FORWARD VIEW

October 2014

CONTENTS

FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.

Targeted prevention. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

NHS support to help people get and stay in employment. Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural

areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

The NHS as a local employer. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: A new deal for primary care

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- *Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.*
- *Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.*
- *Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours

inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the

forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

New care model - specialised care

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

New care model - modern maternity services

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

New care model – enhanced health in care homes

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of

models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

How will we support the co-design and implementation of these new care models?

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several

hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of 'special measures'.

We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage

recruitment and retention in parts of the country and in occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health

professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with

partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate

use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

Demand

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

Efficiency

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation


CareQuality
Commission


NHS
Health Education England


Monitor
Making the health sector
work for patients


NHS
England


Public Health
England


tda
Trust
Development
Authority
Quality. Delivery. Sustainability.

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How can local health and social care services better support health and wellbeing in Kent and Medway

The NHS, social care and public health in Kent and Medway are working together to plan how we will transform health and social care 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 to health and social care over the next five years.

We have identified key priorities within the plan:

1) Prevention – everyone has a part to play

2) Local care – the care you can get out of hospital

3) Hospital care – when you need it

By answering this survey you will help us to identify what needs to change and to shape local services in your area.

Please don't feel obliged to answer all the questions, especially if you haven't used that service, but we are grateful for any information you can provide.

The survey will run from 13 October 2016 until 23 December 2016.

Your answers will be invaluable in helping us design services for your area that are really suited to the community.

Please reply in a personal capacity. If you would like to respond on behalf of a group that you represent, please email secsu.engagement@nhs.net so this can be organised.
All responses will be confidential, and the results anonymised and collated in a report for the commissioners and their partners. Thank you for your time, your views are very important to us and will help inform our plans.

Please tell us a little bit about your general health and how we can help you to take care of yourself and support you to stay fit and well:

1. Where is your home located? (please enter first part of your post code); for example, TN23

2. Which of the activities below do you do to stay healthy? Please tick those that you do regularly

☐ I eat at least five portions of fruit and vegetables a day

☐ I exercise or am active until I am slightly out of breath for at least 150 minutes a week

☐ I carry heavy shopping, dig the garden, work out with weights or do other things that keep my muscles strong

☐ I don't smoke tobacco/cigarettes

☐ I choose plain water or unsweetened drinks instead of fizzy or sugary drinks

☐ I limit sugary, fatty and salty snacks and foods

☐ I know my BMI - Body Mass Index - and maintain a healthy weight

☐ I keep to recommended daily alcohol consumption limits

☐ I get a good night's sleep

☐ I spend social time with other people and do activities I enjoy

☐ I talk about my feelings and ask for help when I need it

☐ Other (please specify)

3. What is the one change you would like to make to improve your general health and wellbeing?

4. What is the biggest barrier stopping you making that change?

5. What would most help you to make that change?

- [ ] Join a group
- [ ] One to one support (such as a health trainer)
- [ ] Information
- [ ] Low cost exercise activities
- [ ] Recommended smartphone apps
- [ ] Other (please explain below)

6. Do you know which services are available in your area to help you with health improvement - such as diet, or exercise or managing weight, stopping smoking?

- ○ Yes
- ○ No
- ○ I am not sure
- ○ Please tell us which condition(s), if applicable

7. What is the best way to tell you about health improvement services which are available in your area? Please tick those which are most likely to help

- [ ] Adverts on screens in waiting rooms in GP practices or hospital clinics
- [ ] Health focused website and app
- [ ] Paid-for promotions on Facebook

- [ ] Posts on Facebook shared by your friends
- [ ] Posters and leaflets in shops and community venues
- [ ] Posters and leaflets in GP practice, pharmacies and hospitals
- [ ] Leaflets put through your door
- [ ] Articles in council magazines
- [ ] Articles or adverts in local papers or magazines
- [ ] Text messages from your GP practice
- [ ] Emails from your GP practice or other service providers
- [ ] Articles or adverts on websites that you use a lot
- [ ] A leaflet given to you by staff treating or caring for you

Other (please specify)

8. Many people live with and manage one or more long-term health conditions such as: heart problems, lung disease (COPD) and diabetes.

If you have a long term health condition, how confident do you feel that you can watch out for and manage changes to your health condition at home, with advice and support from a health professional?

- ○ Very confident - I know my body and have been managing my health for years
- ○ Quite confident - I know who to ask for advice and I already know what to do for some issues or problems
- ○ Not very confident - I worry things will get worse quickly and I won't know what to do
- ○ Not at all confident - I want to be seen by a health professional, I would panic on my own
- ○ Don't know - I 've not thought about it or been asked about it before

Next

Improving local care

More joined up care

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.

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 for their physical and mental health given by professionals who talk and work together

· to tell their story once and have one point of contact

· to be able to access the right help when they are in crisis.

The aim is for you to be supported by people working together as a single team which treats your physical and mental health needs, seven days a week.

To do this, we need to change not only the way we work with you, but the ways that we work together and, in some cases, where we work.

We would like to hear from you about how local health and social care services are working, and how services could improve.

Please take a few moments to answer the following questions about ALL or ANY health and social care services. If you have never used one of the services you can skip that question and go to the next one.

9. If health and social care services could be available at times when your usual GP practice is closed, when would you be most likely to need them? Please use the star rating to indicate which sessions you are likely to use - using the most stars for the one you will most use.

	one star	two star	three star	four star	five star
Weekday evenings after 5p.m. and before 10 p.m.	○ Weekday evenings after 5p.m. and before 10 p.m. one star	○ Weekday evenings after 5p.m. and before 10 p.m. two star	○ Weekday evenings after 5p.m. and before 10 p.m. three star	○ Weekday evenings after 5p.m. and before 10 p.m. four star	○ Weekday evenings after 5p.m. and before 10 p.m. five star
Week days over night	○ Week days over night one star	○ Week days over night two star	○ Week days over night three star	○ Week days over night four star	○ Week days over night five star
Saturday mornings between 9 a.m. and 1 p.m.	○ Saturday mornings between 9 a.m. and 1 p.m. one star	○ Saturday mornings between 9 a.m. and 1 p.m. two star	○ Saturday mornings between 9 a.m. and 1 p.m. three star	○ Saturday mornings between 9 a.m. and 1 p.m. four star	○ Saturday mornings between 9 a.m. and 1 p.m. five star
Saturdays 9 a.m. to 5 p.m.	○ Saturdays 9 a.m. to 5 p.m. one star	○ Saturdays 9 a.m. to 5 p.m. two star	○ Saturdays 9 a.m. to 5 p.m. three star	○ Saturdays 9 a.m. to 5 p.m. four star	○ Saturdays 9 a.m. to 5 p.m. five star
Saturdays 8 a.m. to 8 p.m.	○ Saturdays 8 a.m. to 8 p.m. one star	○ Saturdays 8 a.m. to 8 p.m. two star	○ Saturdays 8 a.m. to 8 p.m. three star	○ Saturdays 8 a.m. to 8 p.m. four star	○ Saturdays 8 a.m. to 8 p.m. five star
Sundays 9 a.m. to 1 .p.m.	○ Sundays 9 a.m. to 1 .p.m. one star	○ Sundays 9 a.m. to 1 .p.m. two star	○ Sundays 9 a.m. to 1 .p.m. three star	○ Sundays 9 a.m. to 1 .p.m. four star	○ Sundays 9 a.m. to 1 .p.m. five star
Sundays 9 a.m. to 5 p.m.	○ Sundays 9 a.m. to 5 p.m. one star	○ Sundays 9 a.m. to 5 p.m. two star	○ Sundays 9 a.m. to 5 p.m. three star	○ Sundays 9 a.m. to 5 p.m. four star	○ Sundays 9 a.m. to 5 p.m. five star
Weekends overnight	○ Weekends overnight one star	○ Weekends overnight two star	○ Weekends overnight three star	○ Weekends overnight four star	○ Weekends overnight five star

Other (please specify)

10. If health and social care services could be contacted at times when your GP practice is closed, how would you prefer to contact them? Please use the star system to show which you would prefer to use (most stars) down to the one you at least likely to use (one star).

	one star	two star	three star	four star	five stars
By telephone to a single number	By telephone to a single number one star	By telephone to a single number two star	By telephone to a single number three star	By telephone to a single number four star	By telephone to a single number five stars
By email	By email one star	By email two star	By email three star	By email four star	By email five stars
By text message	By text message one star	By text message two star	By text message three star	By text message four star	By text message five stars
Via a web site	Via a web site one star	Via a web site two star	Via a web site three star	Via a web site four star	Via a web site five stars
Via a mobile phone app	Via a mobile phone app one star	Via a mobile phone app two star	Via a mobile phone app three star	Via a mobile phone app four star	Via a mobile phone app five stars
All of the above	All of the above one star	All of the above two star	All of the above three star	All of the above four star	All of the above five stars

11. We want to use technology to provide a faster more efficient service to our patients and their families. Which of these new additional services would you be happy to use? Please tick as many as you would like.

- A call back from a health professional
- A video call, SKYPE - or similar system, with a health professional in your home
- A video call, SKYPE or similar system, from a health professional whilst at your GP practice for example if a hospital consultant could talk to you and your GP at the same time to give advice on follow up treatment rather than going to a hospital appointment
- Messaging via a web site,

- ☐ Messaging via a mobile phone app
- ☐ All of the above

12. Please tell us what sort of assistance you would be happy to use via the technology linked health services listed above?

- ☐ Follow up after treatment
- ☐ Monitoring
- ☐ Specialist or second opinion on images (such as x-rays, scans, MRI) sent to another health professional
- ☐ Health screening
- ☐ Check ups
- ☐ All of the above

13. A modern approach to health and social care services requires the best technology so everyone treating or caring for you can (with your consent) see your record. Technology can also help you access health and care services more quickly and easily.

Which of the methods listed below would you use?

- ☐ A single, joint patient record that can be viewed and updated by all those providing that person's care
- ☐ A computer system that lets people book all their health appointments online
- ☐ Secure online access to your medical records
- ☐ Ability to book appointments and view your medical records via a smartphone app
- ☐ Electronic discharge letters and notifications
- ☐ Electronic test results
- ☐ Electronic referrals

14. Although the NHS and social care have secure systems and strict rules on how we protect your data, do you have any concerns about the increased use of technology? Yes / No. If yes, please explain

15. If you had access to 'social prescribing' – when a volunteer or professional links people to alternative sources of support in the community - which of the activities listed below would you be most likely to join?

- ☐ A walking group led by a volunteer
- ☐ Exercise classes led by a health or care profession
- ☐ Exercise classes led by a volunteer
- ☐ A peer support group organised by a voluntary sector organisation or charity
- ☐ A peer support group organised by staff at your GP practice or other health or care staff
- ☐ A weight loss or weight management programme
- ☐ Healthy eating, cooking and meal planning activities
- ☐ Community gardening or allotment activities
- ☐ Art and craft sessions
- ☐ A community choir or other voice-based music group
- ☐ Life story or local history group or memory café
- ☐ None
- ☐ Other (please add your answer below)

Page2 / 7 29% of survey complete.
Prev Next

Improving local care

16. Below are some services that could be included as part of single teams providing health and social care of different types. For each service select a score on the scale from 0 to 4, 0 being it's a bad idea and 4 being it's a great idea

	0	1	2	3	4
Home-birthing support	☐ Home-birthing support 0	☐ Home-birthing support 1	☐ Home-birthing support 2	☐ Home-birthing support 3	☐ Home-birthing support 4
Care coordinators or personal care managers	☐ Care coordinators or personal care managers 0	☐ Care coordinators or personal care managers 1	☐ Care coordinators or personal care managers 2	☐ Care coordinators or personal care managers 3	☐ Care coordinators or personal care managers 4
Personal assistant employer support and advice	☐ Personal assistant employer support and advice 0	☐ Personal assistant employer support and advice 1	☐ Personal assistant employer support and advice 2	☐ Personal assistant employer support and advice 3	☐ Personal assistant employer support and advice 4
Personal budget support	☐ Personal budget support 0	☐ Personal budget support 1	☐ Personal budget support 2	☐ Personal budget support 3	☐ Personal budget support 4
Carer support and advice services	☐ Carer support and advice services 0	☐ Carer support and advice services 1	☐ Carer support and advice services 2	☐ Carer support and advice services 3	☐ Carer support and advice services 4
End of life care support	☐ End of life care support 0	☐ End of life care support 1	☐ End of life care support 2	☐ End of life care support 3	☐ End of life care support 4
Hearing loss support, advice services and clinics	☐ Hearing loss support, advice services and clinics 0	☐ Hearing loss support, advice services and clinics 1	☐ Hearing loss support, advice services and clinics 2	☐ Hearing loss support, advice services and clinics 3	☐ Hearing loss support, advice services and clinics 4
Medication advice and medicines use reviews	☐ Medication advice and medicines use reviews 0	☐ Medication advice and medicines use reviews 1	☐ Medication advice and medicines use reviews 2	☐ Medication advice and medicines use reviews 3	☐ Medication advice and medicines use reviews 4
Cancer survivor	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer

	0	1	2	3	4
support	survivor support 0	survivor support 1	survivor support 2	survivor support 3	survivor support 4
Support for parents of children with additional physical and mental health needs	☐ Support for parents of children with additional physical and mental health needs 0	☐ Support for parents of children with additional physical and mental health needs 1	☐ Support for parents of children with additional physical and mental health needs 2	☐ Support for parents of children with additional physical and mental health needs 3	☐ Support for parents of children with additional physical and mental health needs 4

17. These are some ideas that have been suggested nationally or internationally. Which, if any, of these ideas do you think might help you and people you know to lead healthier lives?

☐ A neighbourhood social care bank or cooperative society where people can offer to swap or exchange care services with their neighbours

☐ 'National volunteering service' where younger people volunteer to care for others in exchange for reduced higher education tuition fees or fast track access to apprenticeships and public sector posts

☐ Professional care brokers who match those who need care one-to-one with local volunteers

☐ Priority planning approval for housing developments that are dementia friendly, accessible and include intergenerational communal living space and amenities and on-site care provision

☐ Help to buy, shared ownership for younger adults sharing or sub-letting their home to lone, isolated and vulnerable elderly people

☐ Local restrictions on alcohol sales, restricted outlets and personal use purchase limits, restricted opening hours and licensing hours

☐ Combined, single site day services for children under 5 and older adults

18. Are there any innovative ideas that you think might help you and people you know to lead healthier lives?

19. Community and GP practice nurses have a wide range of skills that are absolutely essential to giving people local care and treatment. Please take a moment to read through the list of these services then tick up to five that you think are most important for your area.

- ☐ Provide care and treatment for people with long term conditions, working with a team of professionals who care for people with complicated health issues and conditions
- ☐ Plan and support care at home or close to home for people at the end of their lives, including giving medicines
- ☐ Provide intravenous therapy (drips) and device care
- ☐ Train patients and their carers in self management such as to take or give medicines themselves
- ☐ Care for wounds including assessments, prescribing care and referrals to specialist services
- ☐ Provide care at clinics including specialised nursing for certain conditions
- ☐ Recognise and treat urinary tract (water) infections when patients are housebound
- ☐ Provide nursing care with GPs so that the most vulnerable patients avoid going to hospital
- ☐ Prescribe continence products (pads etc) and manage referral to specialist services
- ☐ Provide health checks and flu jabs for housebound people
- ☐ Recognise and support patients with complex, complicated and or long term conditions
- ☐ Be a constant point of contact for patients on their list.
- ☐ Be notified when patients on their list go in to hospital and be involved when they come out
- ☐ Be able to admit patients into community hospitals and respite care.
- ☐ Make referrals to specialist respiratory (lungs and breathing) / heart failure teams.
- ☐ Support for patients and carers living with dementia
- ☐ Provide an assessment of mental health and referral to the appropriate service

20. If you have direct experience of COMMUNITY NURSE OR GP PRACTICE NURSE services please tell us in the boxes below what works well, and what needs to improve?

What works well?

What could be improved?

21. Adult social care helps people live their lives comfortably, particularly those people who require extra practical and physical help, and to stay connected in their community.

Adult social care aims to help individuals to improve or maintain their wellbeing and live as independently as possible.

Do you or does somebody that you care for receive any of the social care services listed below? Please tick any that you receive.

- ☐ Help or support with personal hygiene (such as bathing and being dressed)
- ☐ Help or support with access to nutrition (such as delivery of meals)
- ☐ Help or support to make use of the home safely
- ☐ Somebody to support you to access work or training, or attend day activities and venues outside your home
- ☐ Benefit advice, help and support.
- ☐ Support with housing.
- ☐ Support with accessing employment services

22. Do you or somebody that you care for pay for [self-fund] any of these social care services ? Please tick any that you make a contribution towards or pay for in full

- ☐ Help or support with personal hygiene (such as bathing and being dressed)
- ☐ Help or support with access to nutrition (such as delivery of meals)
- ☐ Help or support to make use of the home safely
- ☐ Somebody to support you to access work or training, or attend day activities and venues outside your home

23. If you or somebody that you care for have used social care services please tell us in the boxes below what works well and what needs to improve

What works well? _____

What could be improved? _____

24. Please take a moment to read through the list of MENTAL HEALTH AND DEMENTIA CARE services. Please choose up to three that, in your opinion, are the most essential for us to provide?

- ☐ Work together in a multidisciplinary team so that all patients' medical needs are treated at the same time
- ☐ Provide support and early help to known and new patients with mental health needs
- ☐ Work with patients to manage their mental health and wellbeing, and crisis situations
- ☐ Be a constant point of contact for patients on their list
- ☐ Quick access to specialist teams (eating disorders, drug and alcohol services)
- ☐ Set boundaries with the person using services and their family/carer, focusing on choices and independence.
- ☐ Support patients with medication including requesting an urgent review of any medication that they take to help their mental health
- ☐ Access to a wide range of support services including leisure, employment and other non-NHS services
- ☐ Recognise physical illness and refer to colleagues in multidisciplinary teams
- ☐ Provide support for people in a mental health crisis.
- ☐ Support the early identification and diagnosis of dementia
- ☐ Work with people who have dementia and their carers to manage their health and wellbeing.

25. If you or somebody that you care for have used MENTAL HEALTH or DEMENTIA CARE services please tell us in the boxes below what works well and what needs to improve.

What works well? _____

What could be improved? _____

Page3 / 7 43% of survey complete.

Prev Next

Improving local care

Making the most of our resources

We know that GP Practices and our community hospitals can play an even stronger role at the heart of our NHS - with more joined-up services linking hospitals, GP practices and social care more closely to deliver better health outcomes for patients, with more personalised care.

We want to make the most of the resources the NHS has in terms of staff, services and facilities. We will still refer patients to our bigger hospitals or clinical specialists when necessary, but there is much more that can now be done locally, given the advances in medical practice.

We may be able to offer a greater range of services locally, and we may need to modernise some of our facilities, but by working more effectively together we can provide a better service for patients and improve their experience of health care locally.

26. Do you think it would be a good idea if GP practices shared facilities with other community-based health and social care services?

- ○ Yes
- ○ No
- ○ Not sure
- ○ If yes, which services do you think they should be?

27. As part of the Kent and Medway plan, we want to make better use of public buildings and share space where possible, introducing health and social care services alongside others, for example regular opportunities to have health checks in your library or children's centre. Please share your ideas for how we could do this.

How do you think better use could be made of our community [cottage] hospitals? For example for healthy living services and access to social care?

Improving local care

Please tell us a little about you

Please tell us a little about you, this information is for monitoring purposes and will not be shared with any third parties, all results will be anonymised. We are very grateful for your taking the time to complete the survey and would appreciate understanding a little more about who responded.

28. Are you male or female?

- Male
- Female

29. What is your age?

- 17 or younger
- 18-20
- 21-29
- 30-39
- 40-49
- 50-59
- 60 or older

30. What is your ethnicity please choose from the list below

- English/ Welsh/ Scottish/ Northern Irish/ British
- Irish
- Gypsy or Traveller
- Any other white background
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed/multiple ethnic group backgrounds
- Indian
- Pakistani
- Bangladeshi
- Chinese

- Any other Asian back ground
- African
- Caribean
- Any other Black /African / Caribean background
- Arab
- Any other ethnic group (please state)

Page5 / 7 71% of survey complete.
Prev Next

Improving local care

Thank you for taking the time to complete the survey

Thank you for taking the time to complete the survey, your comments and information will help inform our plans and provide the insight we need into our patient's experience of current services, so we can plan how to improve them.

31. If you would like to be further involved in this work, please give us your name and contact details in the box below. ***Please note this information will be kept confidential and will not be linked to your survey answers, or used to contact you about anything else.***

Page6 / 7 86% of survey complete.
Prev Next

Improving local care

Thanks for sharing your thoughts.

We will consider all feedback we receive and will take account of it as we draw up plans for improved health and social care services for the future.

Visit the website of your local clinical commissioning group (see below) for more information about how you can get involved. Many CCGs have health networks which you can join to get a regular update. CCGs will be working in partnership with local authorities, NHS hospitals and other providers of care, including the voluntary and community sector, to find out what local people think, so that information can shape the plan.

www.ashfordccg.nhs.uk: Ashford 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

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THANET DISTRICT COUNCIL DECLARATION OF INTEREST FORM

Do I have a Disclosable Pecuniary Interest and if so what action should I take?

Your Disclosable Pecuniary Interests (DPI) are those interests that are, or should be, listed on your Register of Interest Form.

If you are at a meeting and the subject relating to one of your DPIs is to be discussed, in so far as you are aware of the DPI, you **must** declare the existence **and** explain the nature of the DPI during the declarations of interest agenda item, at the commencement of the item under discussion, or when the interest has become apparent

Once you have declared that you have a DPI (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote on the matter;
2. Withdraw from the meeting room during the consideration of the matter;
3. Not seek to improperly influence the decision on the matter.

Do I have a significant interest and if so what action should I take?

A significant interest is an interest (other than a DPI or an interest in an Authority Function) which:

1. Affects the financial position of yourself and/or an associated person; or
   Relates to the determination of your application for any approval, consent, licence, permission or registration made by, or on your behalf of, you and/or an associated person;
2. And which, in either case, a member of the public with knowledge of the relevant facts would reasonably regard as being so significant that it is likely to prejudice your judgment of the public interest.

An associated person is defined as:

- A family member or any other person with whom you have a close association, including your spouse, civil partner, or somebody with whom you are living as a husband or wife, or as if you are civil partners; or
- Any person or body who employs or has appointed such persons, any firm in which they are a partner, or any company of which they are directors; or
- Any person or body in whom such persons have a beneficial interest in a class of securities exceeding the nominal value of £25,000;
- Any body of which you are in a position of general control or management and to which you are appointed or nominated by the Authority; or
- any body in respect of which you are in a position of general control or management and which:
  - exercises functions of a public nature; or
  - is directed to charitable purposes; or
  - has as its principal purpose or one of its principal purposes the influence of public opinion or policy (including any political party or trade union)

An Authority Function is defined as: -

- Housing - where you are a tenant of the Council provided that those functions do not relate particularly to your tenancy or lease; or
- Any allowance, payment or indemnity given to members of the Council;
- Any ceremonial honour given to members of the Council
- Setting the Council Tax or a precept under the Local Government Finance Act 1992

If you are at a meeting and you think that you have a significant interest then you **must** declare the existence **and** nature of the significant interest at the commencement of the

matter, or when the interest has become apparent, or the declarations of interest agenda item.

Once you have declared that you have a significant interest (unless you have been granted a dispensation by the Standards Committee or the Monitoring Officer, for which you will have applied to the Monitoring Officer prior to the meeting) you **must:-**

1. Not speak or vote (unless the public have speaking rights, or you are present to make representations, answer questions or to give evidence relating to the business being discussed in which case you can speak only)
2. Withdraw from the meeting during consideration of the matter or immediately after speaking.
3. Not seek to improperly influence the decision.

Gifts, Benefits and Hospitality

Councillors must declare at meetings any gift, benefit or hospitality with an estimated value (or cumulative value if a series of gifts etc.) of £25 or more. You **must,** at the commencement of the meeting or when the interest becomes apparent, disclose the existence and nature of the gift, benefit or hospitality, the identity of the donor and how the business under consideration relates to that person or body. However you can stay in the meeting unless it constitutes a significant interest, in which case it should be declared as outlined above.

What if I am unsure?

If you are in any doubt, Members are strongly advised to seek advice from the Monitoring Officer or the Committee Services Manager well in advance of the meeting.

DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS, SIGNIFICANT INTERESTS AND GIFTS, BENEFITS AND HOSPITALITY

MEETING……...

DATE…… **AGENDA ITEM** ……

DISCRETIONARY PECUNIARY INTEREST ☐

SIGNIFICANT INTEREST ☐

GIFTS, BENEFITS AND HOSPITALITY ☐

THE NATURE OF THE INTEREST, GIFT, BENEFITS OR HOSPITALITY:

……

……

……

NAME (PRINT): ……

SIGNATURE: ……

Please detach and hand this form to the Democratic Services Officer when you are asked to declare any interests.