AGENDA

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

Tuesday, 25th June, 2019, at 2.00 pm Ask for: **Ann Hunter**

Darent Room - Sessions House Telephone **03000 416287**

Tea/Coffee will be available 15 minutes before the start of the meeting in the meeting room

Membership

Dr J Allingham, Mr I Ayres, Mrs C Bell, Cllr David Brake, Dr B Bowes, Mr P B Carter, CBE, Cllr Doe, Mr G Douglas, Mr M Dunkley CBE, Mr R W Gough, P Graham, Cllr A Jarrett, E Lyons-Backhouse, Mr Chris McKenzie, Mr P J Oakford, Cllr M Potter, Mr M Scott, Mr A Scott-Clark, Ms C Selkirk, Ms P Southern, Dr R Stewart, Mr I Sutherland and Mr J Williams

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1. Apologies and Substitutes

2. Declarations of Interest by Members in items on the agenda for this meeting

To receive any declarations of interest by Members in items on the agenda for the meeting

3. Minutes of Meeting held on 19 March 2019 (Pages 3 - 16)

4. Progress on Prevention Strategy for Kent and Medway (Pages 17 - 44)

5. Progress on Local Care including the Local Care Implementation Board (Pages 45 - 104)

6. Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities (Pages 105 - 128)

7. Work Programme (Pages 129 - 130)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Monday, 17 June 2019

Medway Council

Meeting of Kent and Medway Joint Health and Wellbeing Board

Tuesday, 19 March 2019

4.10pm to 6.15pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present:	Councillor David Brake, Portfolio Holder for Adults' Services, Medway Council (Chairman) Councillor Sarah Aldridge, Swale Borough Council, Cabinet Member for Health and Wellbeing Dr Bob Bowes, Chairman of the Strategic Commissioner Steering Group Glenn Douglas, Accountable Officer for the eight CCGs in Kent and Medway and Chief Executive of the Kent and Medway STP Mr Graham Gibbens, Cabinet Member for Adult Social Care and Public Health, Kent County Council Mr Roger Gough, Cabinet Member for Children, Young People and Education, Kent County Council Penny Graham, Heathwatch Kent Mr Peter Oakford, Deputy Leader and Cabinet Member for Finance and Traded Services, Kent County Council (Vice-Chairman) Eunice Lyons-Backhouse, Healthwatch Medway CIC Representative Councillor Martin Potter, Portfolio Holder for Educational Attainment and Improvement, Medway Council Caroline Selkirk, Managing Director of Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs Penny Southern, Corporate Director Adult Social Care and Health, Kent County Council Dr Robert Stewart, Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation James Williams, Director of Public Health, Medway Council
Substitutes:	Dr Allison Duggal, Consultant in Public Health, Kent County Council (Substitute for Andrew Scott-Clark)

In Attendance:

Sharon Akuma, Legal Services, Medway Council
Cathy Bellman, Kent and Medway STP Local Care Lead
Rebecca Bradd, STP Workforce Programme Director
Steve Chevis, Health Improvement Manager, Medway Council
Karen Cook, Policy And Relationships Adviser (Health), Kent County Council
Lisa Keslake, Programme Director – Long Term Plan
Jade Milnes, Democratic Services Officer, Medway Council
Jessica Mookherjee, Public Health Consultant, Kent County Council
Dr John M Ribchester, Chair, Encompass MCP

900 Chairman's Announcements

The Chairman welcomed Dr Bob Bowes, Chairman of the Strategic Commissioner Steering Group to his first meeting of the Joint Board following his appointment in December 2018.

The Chairman recommended that agenda item 10 (An Overview of the Encompass MCP Vanguard) be considered as the first substantive item on the agenda to enable the Chair, Encompass MCP to attend another meeting. This was agreed.

He explained that this meeting was the final meeting of the 2018/19 municipal year and thanked Members and officers for their contribution to the work of the Joint Board. The Vice-Chairman also expressed his gratitude.

901 Apologies for absence

Apologies for absence were received from Councillors Alan Jarrett (Leader, Medway Council) Howard Doe (Deputy Leader of Medway Council and Portfolio Holder for Housing and Community Services), Mr Paul Carter, CBE (Leader of Kent County Council and Cabinet Member for Health Reform) and Tony Searles (Sevenoaks District Council), Dr John Allingham (Kent Local Medical Committee, Ian Ayres (Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs), Matt Dunkley, CBE (Corporate Director for Children, Young People and Education, Kent County Council), Chris McKenzie (Assistant Director of Adult Social Care for Medway Council), Matthew Scott (Kent Police and Crime Commissioner) Andrew Scott-Clark (Director of Public Health, Kent County Council), and Ian Sutherland (Director of People – Children and Adults Services, Medway Council).

902 Record of Meeting

The record of the meeting held on 14 December 2018 was agreed and signed by the Chairman as correct.

903 Declaration of Disclosable Pecuniary Interests and other interests

Disclosable pecuniary interests

There were none.

Other interests

Councillor Martin Potter disclosed that he was a member of the Kent and Medway STP Non-Executive Director Oversight Group.

904 Urgent matters by reason of special circumstances

There were none.

905 Reducing Alcohol Consumption Deep Dive

Discussion:

The Director of Public Health for Medway introduced the report which provided a deep dive into reducing alcohol consumption, alcohol related harm to adults and treatment of alcohol use disorder across Kent and Medway. He explained that the impact of substance misuse was far reaching and had wider societal impacts, in addition to impacts to the person who consumed the alcohol and their families.

The Health Improvement Manager, Medway Council drew the Joint Board's attention to key trends in relation to alcohol consumption and its impact. These were provided in detail within section 2 of the report. He explained that the evidence and data showed a good picture across Kent and Medway. For example, the data showed that with respect to alcohol related hospital admissions, both Kent and Medway had fewer admissions than the England average, in addition, the years of life lost due to alcohol were less than the England average. With respect to the measure, successful completion of alcohol treatment, both Kent and Medway had a higher percentage of successful completions than the England average.

Referring to areas where further intervention was required it was noted that there was a variation across districts where harms were generally more marked in disadvantaged communities. In addition, further work was required to support individuals with co-occurring conditions for example problematic substance use was one of the most common co-morbid conditions among people with a major mental illness.

It was considered that a whole system approach was required to reduce alcohol consumption. Factors relevant to this aim and existing interventions were highlighted to the Joint Board and were set out in section 3 of the report.

Members raised a number of points and questions, including:

Licencing – In response to a question concerning the relationship between licensed premises opening hours and the impact on alcohol consumption, the Joint Board was advised that negative issues tended to occur after premises closed, therefore staggered closing hours in a locality could cause difficulties for the Police.

Children and young people – In response to a question concerning encouraging children and young people away from alcohol, the Joint Board was advised that there was a declining trend in alcohol consumption amongst young people in comparison to adults who had more disposable income to purchase alcohol. It was recognised that action needed to be taken to prevent access and harm to children and young people from substance misuse.

Type of drinking – Clarification was sought on factors influencing the relationship between the type of drinking (lower risk drinking to severe dependence and complex drinking) and the number of alcohol units consumed. It was noted that severity of likely harms could be very different, even if the same amount of alcohol was consumed. In response, it was explained that individuals in more disadvantaged communities might experience greater harms than others drinking the same amount of alcohol because there was a greater availability of poor quality alcohol and higher levels of stress (cortisol) within these communities, which might influence the harm experienced. It was added a number of chemicals had been found in poor quality/ cheap drinks which were more likely to cause liver damage.

Decision:

The Kent and Medway Joint Health and Wellbeing Board considered the report and provided their support for:

a) promotion of collaborative working between organisations (including Public Health, Licensing, Police, Trading Standards, Planning and Regeneration) to limit availability and minimise the social impact of High Strength / Low Cost Alcohol.

b) a call for the Co-Occurring (Dual Diagnosis) protocols between Substance Misuse Treatment Services, Mental Health Services and Primary Care to be updated, reissued and a mechanism be put in place to measure their use.

906 Sustainability and Transformation Partnership (STP) Local Care Update

Discussion:

The STP Local Care Lead summarised amendments made to the governance arrangements for Local Care. This included the establishment of a new, smaller strategic Local Care Board which was comprised of senior leaders from key organisations involved in the commissioning and delivery of Local Care

services across the Kent and Medway health and social care system. This Board had two key functions which were to hold the CCG footprint Local Care Boards to account and to help create the conditions for success.

She explained that the existing Local Care Implementation Board (LCIB) would not be disbanded, as this Board had been invaluable in bringing together a wide range of organisations. However, it was noted that the focus of LCIB would be amended. It was considered that this outgoing Board would become a "learn and share" forum and would include additional members to focus on: progress across Kent and Medway; learning from other areas nationally and internationally and; ideas and examples of innovation. It was noted that the first event for this forum would be on 22 May 2019.

The Joint Board was reminded of the outcomes of the Local Care deep dives which were explained in detail in Appendix B of the report and had been circulated to the Joint Board following their meeting in December 2018. The Joint Board's attention was also drawn to the progress on the Local Care Delivery Framework set out in section 4 of the report. This Framework would be shaped by the outcome of the deep dives. It was anticipated that the first populated dashboard would be completed in July 2019.

Members raised a number of points and questions, including:

Workforce - In response to questions concerning the workforce challenges outlined on page 65 of the agenda, Appendix B to the report, the Joint Board was advised that recruitment and retention of the Kent and Medway workforce was considered to be very important. Challenges were being addressed in two ways. Firstly, by adapting the existing workforce by working differently, for example capacity had been released by forming Multi-Disciplinary Teams (MDTs) which had reduced duplication of efforts. Secondly, there was a long term ambition to attract new staff into the area.

With respect to the specific challenge of making it easier for staff to rotate across organisations i.e. a passport or secondment, the Joint Board was advised that this may help with recruitment and retention of staff. In particular, prospective employees had requested an opportunity to develop a portfolio careers and gain experience in different organisations and health sectors. Kent and Medway could be a trailblazer in this regard.

Funding for Local Care - The Joint Board was assured that funding was in place to support Local Care. This was demonstrated as part of the Local Care deep dives. In addition, within the NHS Long Term Plan, £4.5billion had been committed to primary and community care. The first tranche of this funding had been realised, with CCGs receiving an uplift of circa 3% on their budgets. It was explained that this money was ring-fenced for use within primary and community care only.

Estates – In response to questions concerning feedback from the Local Care deep dives regarding the need for a flexible housing stock to attract key workers, it was recognised that collaborative working between Local Authorities

and the NHS could yield new opportunities. It was explained to the Joint Board that the NHS were under an obligation to review their estate and release property specifically for building housing. There was a national and local target for identifying surplus accommodation to be put towards the housing stock.

The Joint Board was advised that most of the property across Kent and Medway was owned by individual Trusts, therefore the Trust would have first call on income generated by the estate. Some properties were owned by NHS Property Services and in this instance the money from these property disposals would be held centrally by the NHS.

It was noted that any money released would, in part, help fund any NHS committed funding, such as the circa 3% uplift for primary and community care committed in the NHS Long Term Plan. However, it was added that the Secretary of State for Health and Social Care had recently announced that properties under the responsibility of NHS Property Services could be transferred to local systems, provided there was a business case do so. This would benefit the local area and provide much more flexibility to make the best use of the estate.

It was explained that a Kent and Medway Estates Strategy was being developed. It was suggested that the results of this Strategy could be shared with Joint Board Members.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the content of this report, in particular:

- the update provided on the implementation and progress of the new Local Care Board and the proposed Kent and Medway wide Local Care/ Primary Care Network 'Learn and share' forums;

- the outputs from the Local care 'Deep Dives', set out at Appendix B of the report and details provided on how the outputs are informing the Local Care work programme and other workstreams;

- the approach to monitoring progress and agreeing a Local Care Delivery Framework, as set out in section 4 of the report; and

- the difference between the Delivery Framework and the Kent and Medway overall population 'Outcomes Framework' which will be influenced by Local Care.

b) supported a collaborative approach between the NHS and Local Authorities to effectively utilise their estates portfolio to support the provision of accommodation for key workers.

907 STP Workforce Transformation Plan

Discussion:

The Kent and Medway STP Workforce Programme Director presented the report which set out, at Appendix 1, the STP Workforce Transformation Plan. The report was accompanied by a presentation. It was explained to the Joint Board that the Plan focussed on the commitment to work together to prioritise actions that it was considered would have the biggest impact on addressing Kent and Medway's Workforce challenges. The overarching ambition was to promote Kent and Medway as a great place to live, work and learn. There were three aims supporting this ambition, which were:

- Workforce to work together across health and social care, enjoy their work, learn in their jobs and be empowered, engaged and developed to be good at what they do;
- Employers to work together to attract and retain the right supply of health and social care workforce through talented and capable leadership and the offer of attractive, flexible and interesting careers; and
- Population to have the skills and support to help them manage their own health and care with confidence and, where needed, with the right support to achieve their health, social and community outcomes and goals.

There were also five key strategic priorities supported by a number of actions which were explained to the Joint Board. The five priority areas were:

- Promoting Kent and Medway as a place to work;
- Maximising supply of health and care workforce;
- Developing lifelong careers;
- Developing systems leaders and culture; and
- Supporting workforce wellbeing, addressing workload and supporting inclusion to support retention of the workforce.

The Joint Board was advised that in Kent and Medway circa. 83,800 FTE individuals were employed in over 350 careers across health and social care organisations. In Kent and Medway, the workforce supply had decreased for most workforce groups and was behind the national average. However, it was noted that work had already been undertaken to address recruitment and retention. Some examples included, launching the 'Take a Different View' website to attract perspective employees, upskilling the workforce in the community to maximise the workforce supply, implementation of the Esther Model and implementation of specific retention programmes such as the First Five, Last Five programmes.

The Joint Board's attention was drawn to key workforce actions in 2019/20 across the Local Care, Primary Care, Stroke, Mental Health, Cancer and Prevention workstreams. It was explained that the Plan was accompanied by a draft detailed implementation plan and delivery dashboard that would be agreed and monitored through the Workforce Board.

The Plan was agreed by the STP Programme Board having been considered by the Workforce Board and the Clinical and Professional Board. It was added that the STP Programme Board emphasised the importance of including performance indicators to monitor progress in implementation.

Members raised a number of points and questions, including:

Promotion of Kent and Medway - In recognition of the steps taken so far to support recruitment and retention, Members stressed the importance of positivity in promoting Kent and Medway as a great place to live, learn and work. It was considered that Kent and Medway was also a great place to enjoy and this aspect should also be promoted.

Workforce growth - Referring to examples of workforce growth set out on page 81 of the agenda, a Member expressed concern that nationally there had been growth in the workforce of a number of staffing groups but a decline locally. For example, nationally, the number of Mental Health Therapists had increased by 83% from 2015 to 2017 but in Kent and Medway growth declined by 47%. He recognised, however, that there were a number of actions in place to support recruitment and retention.

London effect - In response to a question regarding retaining professionals who had completed their training in Kent and Medway, it was considered that traditionally each locality had focussed on what an organisation could offer rather than the system. The more the local system could work together on the attraction offer, the greater the pull to relocate and remain in Kent and Medway would be. Other actions considered important were: targeting specific points of attraction to the relevant cohort of perspective employees i.e. millennials, individuals nearing retirement etc., improving the accommodation offer, including key worker housing, promoting Multi-Disciplinary Team working and enabling cross organisational development.

Schools and education - Members expressed support for undertaking further work with the local education sector to encourage young people to pursue careers in health and social care. However, concern was expressed regarding the shortage of science teachers to support young people in accessing these careers. It was considered that over time the medical school could be a catalyst for transformation in Kent and Medway and provide opportunities to access a range of careers on offer in the health service. It was noted that the Dean of the Medical School had visited a number of local schools to reaffirm the opportunities available.

It was noted that there was an aspiration to widen participation and encourage young people from the locality to join the Medical School. It was suggested that this might reverse the trend of individuals training in Kent and Medway and then locating elsewhere. There was an aspiration to develop satellite sites which would further enhance opportunities to learn and encourage retention.

It was added that Medway Council had recently launched its Skills Strategy. A key element of the Strategy was a skills mapping exercise and supporting

further work with education partners. A Member offered his support in sharing information in this regard.

Decision:

The Kent and Medway Joint Health and Wellbeing Board received and supported the STP Workforce Transformation Plan.

908 Kent and Medway Transformation - Update on Integrated Care Systems and Kent and Medway System Commissioner

Discussion:

The Chairman of the Strategic Commissioner Steering Group (Clinical Chair, West Kent CCG), introduced the update on Integrated Care Systems and the Kent and Medway System Commissioner. In doing so, he reflected on the general financial position of the NHS and the four main areas for improvement set out within the Case on Change.

He drew the Joint Board's attention to section 3 of the report which explained the proposed changes to commissioner and provider models in response to the need to deliver local care, improve prevention, invest in mental health services and support providers to deliver clinically and financially sustainable services. Figure 1 was highlighted to the Joint Board which described in detail the Kent and Medway Integrated Care System architecture including Integrated Care Partnerships and Primary Care Networks.

It was noted that at present, only the CGGs had a statutory basis, all other Boards were partnerships. It was recognised that this was challenging, particularly in decision making. As a result, it was proposed that there would be a single CCG, subject to the approval of member practices, and an application would be submitted to NHS England for consideration in June 2019 for implementation in April 2020. It was considered that whilst the timeline was challenging it would encourage pace in delivery.

The Joint Board's attention was also drawn to Appendix 1 of the report which at the request of the Board set out details of the role of the Kent and Medway CCGs in emergency planning. The Joint Board was assured that the NHS had made the necessary preparations to respond to the known issues in relation Britain's EU Exit.

A Member commended the Kent and Medway STP and partners for their professional approach and their efforts in reviewing and recommending system improvements, working toward financial sustainability, to the benefit of local people. It was recognised that there would be a role for the local authorities of Kent and Medway to scrutinise the proposals.

Decision:

The Kent and Medway Joint Health and Wellbeing Board noted the update.

909 NHS Long Term Plan Update

Discussion:

The Programme Director, Long Term Plan, provided the Joint Board with an overview of the NHS Long Term Plan and the response required from the Kent and Medway Sustainability and Transformation Partnership (STP). The report was accompanied by a presentation.

It was noted that the NHS Long Term Plan aligned with the existing focus areas of the Kent and Medway STP and was considered to be a framework for bringing together the existing workstream areas.

The key messages of significant note from a system perspective were drawn to the attention of the Joint Board. These included:

- All systems to become Integrated Care Systems (ICSs) by 2021;
- An increased 'duty to collaborate' and greater integration between the NHS and local authorities covering social care, prevention, population health and public health;
- Development of a system oversight approach i.e. the Integrated Care System would be overseen and regulated as a system as well as individual organisations. It was noted that there would be an integration index which would reflect public opinion as to whether services feel joined up, personalised and anticipatory;

It was explained that in response to the NHS Long Term Plan, the STP was required to develop and implement its own Five Year Plan. This would be a continuation of work that had already been undertaken by the Partnership and whilst there was, currently, no template for these Plans, the STP would set out how it would deliver against all of the NHS Long Term Plan themes. It was explained that the NHS Long Term Plan also required the STP to refresh its strategic planning for the five year period, including development of five year financials for the system from 2019/20 to 2023/24 and five year system priorities in terms of system and care transformation.

At present the workstream leads were undertaking a diagnostic assessment of the extent to which each STP workstream/programme was aligned with the NHS Long Term Plan content and whether any further actions or initiatives were required. The headline findings from this assessments would be shared with a number of forums including the STP Clinical and Professional Board, Programme Board and the Joint Board as required.

It was noted that there were a number of existing strands of work which would support the STPs' response to the NHS Long Term Plan, including refreshing the Kent and Medway Case for Change, the Kent and Medway outcomes dashboard and creation of two new strategies, the Primary Care Strategy and Children's Strategy.

In response to a question concerning how Healthwatch could assist with contributing the public voice to the way forward and assist with public

engagement, the Joint Board was advised that a Communications and Engagement Strategy and Plan would be developed in collaboration with Healthwatch and other partners between now and autumn when the Five Year Plan would be published. It was added that initial thoughts were that engagement should focus on some of the themes identified in the NHS Long Term Plan and it was considered that there were exciting opportunities to engage on topics such as primary care, children's services and metal health.

A Member highlighted to the Joint Board that there were circa. 500 expectations/performance outcomes/targets set out in the NHS Long Term Plan spanning the 2, 5, and 10 year period. Referring to past experience, he cautioned that achieving these expectations might result in a need for spending which exceeded annual 3.4% budget uplift.

Decision:

The Kent and Medway Joint Health and Wellbeing Board noted the update on the NHS Long Term Plan.

910 An Overview of the Encompass MCP Vanguard

Discussion:

The Chair, Encompass MCP presented the Joint Board with a presentation on the work and legacy of the Encompass Multi-Speciality Community Provider (MCP) Vanguard. It was explained to the Joint Board that following a successful bid securing 3 years of funding, the Vanguard was established and was comprised of 14 GP practices representing circa. 180,000 patients. The Vanguard operated across 5 community hubs and brought together: health, social care, the voluntary sector and the community to work together at scale, as an integrated system of care, around the patients' health needs, offering hub level services to populations of circa. 50,000 people (with the exception of Sandwich and Ash which had a smaller population density).

One of the foremost achievements of the Vanguard was the development of Multi-Disciplinary Teams (MDTs). These MDTs drew expertise from a range of professionals, which could be tailored to suit the local area and in some instances included the Police, Fire and Rescue and Housing Services. MDTs worked together across the footprint of the Hubs to create anticipatory care plans for the individuals within the Vanguard.

The Joint Board was advised that there were four strands to the work of the Vanguard centred around the GP Practice, these were:

1. Routine, Prevention and Proactive Care
2. Emergency and Reactive Care
3. Acute Care
4. Tertiary Care

It was explained that the Vanguard considered four population cohorts ranging from the individuals that were considered to be the most vulnerable and frail

with multiple co-morbities to those that were generally well. The Vanguard initially concentrated on the cohort which was considered to be most vulnerable and frail who had the most need and expended the most resource (analysis showed that this cohort represented circa. 6% of the population but utilised 80% of the total expenditure on emergency admissions across the whole population in the Vanguard).

It was explained that in total there were 12 workstreams which were set out for the Joint Board in a Directory of Services. Some of the focus areas included:

1. **Health condition management** which involved moving some services, historically provided within a hospital setting, into the community, extending the roles of GPs and other health care professionals. Fast access to services within the community avoided attendance at A&E.
2. **Supported self care** which aimed to support people to make healthier lifestyle choices to avoid preventable diseases. This included social prescribing undertaken in collaboration with Red Zebra, providing a single point of access for GPs to enable them to signpost individuals to one or more voluntary organisations who could provide further support. The Vanguard also developed Health Trainers (Lifestyle Coaches), an initiative in schools to keep children active and lastly, the Vanguard developed a Waitless App which provided real time data on Minor Injury Units (MIUs) and A&E departments in east Kent.

With respect to achievements made over the three years, the Joint Board was advised patient experience had improved and there had been a reduction in short stay admissions by 33.1%, a reduction in A&E minor attendance by 6.4%, a reduction in emergency admissions by 8.2% and in relation to a specific project, a reduction in Catheter related admissions by 22.6%. Overall it was forecast that this represented a £3.4m net saving.

With respect to next steps, it was explained that the CCG had continued to support the funding of the 12 workstreams of the Vanguard. The Vanguard had also helped define the model for Local Care across Kent and Medway. Referring to the emerging national health system model, it was noted that there was a plan for each of the 8 CCG localities, within Primary Care Networks, for Local Care which had been developed across Health, Care and the Voluntary Sector to build on the model of the Vanguard.

Local Care Deliverables for 2019/20 included:

- Delivery of all the elements of the MDT model for frail and elderly, embedding all components i.e. urgent and emergency care, Home First, care navigation and end of life care;
- Embedding mental health into the MDT model, including dementia support; development of a a menu of services needed to support people, from wellbeing to severe mental illness
- Developing the MDT approach for children and young people with complex conditions;
- Upscaling of care navigation / social prescribing; and

- Providing support for carers, including developing the next stages of the Carers App.

Members raised a number of questions, including:

Estates - In response to a question concerning the experience of the Vanguard finding suitable and affordable properties, the Joint Board was advised that it was a challenge to obtain a property stock correct for this new model of care. It was considered that the Estuary View Medical Centre in Whitstable was an exemplar facility which could be reproduced, subject to funding availability.

Services for children and young people - With respect to a question concerning services for young people, it was explained that the Vanguard introduced the daily mile within some schools. As a result of this intervention, the fitness of children increased, obesity reduced and concentration levels increased within the school environment. The Chair, Encompass MCP, added that he would support further learning within schools on subjects such as First Aid and CPR. In addition, it was considered that schools were an important community resource and should be open outside of school hours for purpose of increasing access to physical activity.

Financial savings - Clarification was sought on the realisable savings made as a result of the Vanguard. It was explained that a £3.4million saving was made on the cohort of the population within the Vanguard. It was added that real savings could be achieved if the model was upscaled which would allow for the hospital bed stock to be reduced.

Social isolation - With respect to a question on social isolation, the Joint Board was advised that circa. 80% of the patients referred into the social care programme were people suffering with social isolation. These individuals were supported by voluntary sector through Red Zebra Service.

Mental Health - A Member supported the aim of health condition management in ensuring that mental health was given the same level of importance as physical health.

Decision:

The Kent and Medway Joint Health and Wellbeing Board thanked the Chair, MCP Encompass for his presentation and noted the overview of the Encompass MCP Vanguard.

911 Work Programme

Discussion:

The Democratic Services Officer at Medway Council introduced the work programme report and drew the Joint Board's attention to the recommended amendments to the work programme set out at paragraphs 2.3 to 2.4 of the report.

A Member requested that following consideration by the Joint Board of the NHS Long Term Plan (agenda item 9), the Joint Board be presented with an update report on the Kent and Medway response to the NHS Long Term Plan and the Five Year Plan once it was completed.

Decision:

The Kent and Medway Joint Health and Wellbeing Board agreed the work programme attached at Appendix 1, subject to the following amendments:

a) that the report on the Kent and Medway STP workstream, Workforce, be presented to the Joint Board every six months;

b) the addition of a report on the Kent Medical School to the Joint Board's work programme, with a date to be determined;

c) the addition of an update report on the Kent and Medway response to the Long Term Plan and the final Five Year Plan to the Joint Board's work programme.

Chairman

Date:

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
25 JUNE 2019
PHYSICAL ACTIVITY DEEP DIVE

Report from: James Williams, Director of Public Health for Medway Council

Andrew Scott-Clark, Director of Public Health for Kent County Council

Author: Allison Duggal, Deputy Director of Public Health, Kent County Council

Scott Elliott, Head of Health and Wellbeing Services, Medway Council

Summary
This report presents a deep dive into the current position with respect to physical activity across the Kent and Medway STP footprint. The report is based on the evidence-based principles set out in 'Everybody active every day'[i]. The report sets out the work being carried out across Kent and Medway to increase the level of physical activity and concludes by highlighting some areas for discussion and consideration to elicit enhanced impact.

1. Background

1.1. Being physically active is important for physical health, mental health and wellbeing. Regular physical activity can safeguard against some of the diseases that are currently on the increase and which are affecting people at an earlier age, for example cancer, diabetes, obesity, hypertension and depression[ii]. Persuading inactive people (less than 30 minutes exercise per week) to become more active could prevent one in ten cases of stroke and heart disease in the UK.

1.2. Physical inactivity is estimated to be responsible for one in six deaths in the UK and to cost the NHS £0.9 billion and the UK economy £7.4 billion.

1.3. Our population is around 20% less active than it was in the 1960s and if this trend continues, we will be 35% less active by 2030.

1.4. The current situation across Kent and Medway with respect to physical activity and physical inactivity are both set out in Appendix 1.

1.5. A review of evidence, including a return-on-investment analysis demonstrated the economic benefits of investing in physical activity. This has demonstrated that there are not only economic benefits in terms of health,

but also wider social benefits such as social care, regeneration, travel and transport, business and economic productivity, crime and education.

1.6. This report uses the four headings from 'Everybody active, every day'[iii] to provide an overview of the initiatives that are currently in place across Kent and Medway, and what further steps can be taken. 'Everybody active, every day' is a national, evidence-based approach to support all sectors to embed physical activity into the fabric of daily life and make it an easy, cost-effective and 'normal' choice in every community in England. To make active lifestyles a reality for all, the framework's four areas for action are:

- **Active society - creating a social movement**: change the social 'norm' to make physical activity the expectation
- **Moving professionals – activating a network of expertise**: develop expertise and leadership within professionals and volunteers
- **Active environments – creating the right spaces**: create environments to support active lives
- **Moving at scale – scaling up interactions that make us active**: identify and up-scale successful programmes nationwide

1.7. Public Health England co-produced the framework with over 1,000 national and local leaders in physical activity and is calling for action from providers and commissioners in: health, social care, transportation, planning, education, sport and leisure, culture, the voluntary and community sector, as well as public and private employers. 'Everybody active, every day' is part of the cross-government 'Moving More, Living More' campaign for a more active nation as part of the 2012 Olympic and Paralympic Games legacy.

2. Advice and analysis

2.1. Active Society: creating a social movement

2.1.1. We know that people in Kent and Medway are not as active as we would want. For example, the Active Lives Survey demonstrated that 24% of people in Kent were inactive (less than 30 minutes per week of moderate intensity activity) and an additional 13% do not reach the Chief Medical Officer's recommendations of 150 minutes of moderate intensity activity per week. The same is true of young people; an Active Lives Survey for Children and Young People was introduced by Sport England via schools in 2017-18. This showed that nearly 60% of young people do not meet the Chief Medical Officer's guidelines of 60 minutes activity per day.

2.1.2. A culture change is required so that being active every day is the social norm in every community and generation. This requires sustained activity at every level of society, mobilising diverse stakeholders for visible leadership in the public, private and third sector.

2.1.3. A recent evidence review on 'Physical activity for general health benefits in disabled adults'[iv] for the UK Chief Medical Officers' update of the physical activity guidelines set out evidence for the effectiveness of physical activity to improve disabled adults' health. The benefits of physical activity for disabled adults are in line with those for the rest of the population and any suggestion that physical activity is inherently harmful for this group should be dispelled.

2.1.4. The World Health Organisation Guidelines[v] on physical activity, sedentary behaviour and sleep for children aged 0-5 years old published in May 2019 set out specific recommendations for time spent on each of these behaviours. For the greatest health benefits, infants and young children should meet these guidelines within a 24-hour period. The report also stated that replacing restrained or sedentary screen time with an increased amount of moderate to vigorous activity, while maintaining sufficient sleep, can provide additional health benefits.

2.1.5. Kent County Council and Medway Council currently promote a range of services, programmes and campaigns that aim to encourage people to be more active. A Better Medway, One You Kent, Explore Kent and Medway Sport are just some examples of local authority lead campaigns that aim to support people to find an activity that they want to do and encourage them to make it a regular part of their lives.

2.1.6. Local authorities cannot achieve a shift in social norms alone, but there are a wide range of public, private, voluntary and academic sector partners that also promote individual activities and the need for people to be active. This includes the promotion of a wide range of sport and exercise providers, free health walks, promotional activities within primary care settings and much more.

2.1.7. The Public Health England (PHE) Physical Activity Clinical Champions programme has a network of healthcare professions who provide practical peer to peer training. This network of 40 healthcare professionals has already delivered training to over 20,000 practising healthcare professionals[vi].

2.1.8. Social media channels are increasingly being used by all these different sector partners to reach their target audience and promote physical activity and their own services. Kent County Council and Medway Council promote national campaigns such as One You, Change 4 Life, Couch to 5k and This Girl Can in addition to their own local campaigns.

2.1.9. The existing activity needs to continue with existing and new partners taking more action building on existing work. Social norms can only shift if we can change attitudes radically. The message is that being active is not just fulfilling and fun but can also be an easy choice, and this needs to be a linking thread that unites the public sector with the voice of charities, local residents and community leaders. It is a message that can be woven into the policies, commissioning and planning decisions made every day across Kent and Medway.

2.1.10. The promotion of physical activity also needs to be targeted to those that stand to gain the most from moving more. Public Health England data suggests that 20% and 22.5% of Kent and Medway residents respectively, are sedentary. These individuals who do less than 30 minutes of activity per week, should be the primary target audience of new promotions.

2.2. **Moving Professionals: activating networks of expertise**

2.2.1. Supporting individuals to become more active requires expertise and leadership amongst the professionals and volunteers who already engage individuals on a daily basis through a 'Making Every Contact Count' (MECC) approach.

2.2.2. Across Kent County and Medway, workers who work in public-facing roles such as housing officers have access to training to develop skills for Making Every Contact Count. These include opportunities to train on Solutions Focussed Brief Therapy (SFBT), Motivational Interviewing Technique (MIT) and Cognitive Behavioural Therapy (CBT). Both authorities have secured funding from the Local Workforce Action Board of the STP to commission this training.

2.2.3. Both Kent and Medway have a Champions programme, where partners can receive training to help them become Public Health Champions. These are well attended and there is a thriving network of Champions across Kent and Medway.

2.2.4. Kent County Council has a Sport and Physical Activity Service, which is a small service aiming to promote involvement in a wide range of physical activity opportunities, including sport. The service has combined its limited resources with those from Sport England and acts as the Active Partnership for Kent (Kent Sport). The current focus is on encouraging the least active and under-represented groups to become more active. This includes projects such as physical activity sessions for people living with early onset dementia; Active at Work, a workplace health programme helping people build activity into their day using e.g. fitness trackers, and the Kent School Games (see Appendix 3)

2.2.5. Medway Sport performs a similar function across Medway, providing a wide range of leisure and sporting activities for residents to participate in. This includes mass participation events for the whole family, targeted exercise programmes, free swimming and other activities. The team work collaboratively with Medway Public Health team, who coordinate a large-scale walking for health programme, cycling and Nordic Walking groups.

2.2.6. Explore Kent works alongside Kent Sport and other countryside operators and organisations, such as Public Rights of Way, Country Parks and Countryside Management Partnerships to promote outdoor activities.

2.2.7. Another local project is Walk to Win, which used Mosaic to target people living in areas of deprivation in Thanet with a multimedia campaign of radio adverts, print and bus posters. People were encouraged to take regular health exercise accessing the coast and countryside around them and 2,500 people collected free pedometers and 600 people took up the Walk to Win challenge.

2.3. **Active environments: creating the right spaces**

2.3.1. Getting everybody active every day requires spaces – indoors and outdoors – that make daily physical activity the easy, efficient and cost-

effective choice for all regardless of age, disability and other personal characteristics.

2.3.2. The way land is used in communities has an immense impact on the public's health. Although it is the quality and not just the quantity of public parks and spaces that encourages people to be active, evidence shows just having ease of access to open space makes a crucial difference. Building more physical activity into daily routines – the commute, walking the dog, the journey to the shops, school or workplace – involves creating the kinds of environments that support active living.

2.3.3. Medway Council Public Health Team are working closely with Planning Policy officers to fully embed activity into the new local plan. Creating a health and wellbeing golden thread through the policy, will enable every opportunity for planners to create spaces that allow people to be physically active. The team also work collaboratively with a wide range of officer groups such as contributing to the Cycling Strategy group, chaired by the deputy leader of Medway Council.

2.3.4. Kent Public Health team is working with the NHS Healthy New Towns Programme to embed learning from the programme on community development and working with planners to make new developments healthier places to live.

2.4. **Moving at scale: scaling up interactions that make us active**

2.4.1. The Moving at Scale domain highlighted the need to better identify and scale-up what works to achieve population scale change. It consists of three main strands: increasing understanding of the evidence in a UK context; improving awareness and skills in evaluation and collaboration between researchers, commissioners, providers and practitioners to implement what works at scale.

2.4.2. Appendix 2 and Appendix 3 gives an indication of some of the interventions currently in place across Kent and Medway to increase physical activity. There are considerably more that take place that are not captured. Understanding the existing assets and what is currently in place is an important step to increasing the volume and quality of interventions. Many of these known activities have target audiences, and it is important that all groups across society have some targeted interventions and participate in some activities.

2.4.3. Monitoring the effectiveness of these interventions is important so that the programmes which deliver the best results, can be scaled up. To make everybody active every day a reality we need to monitor progress and measure the impact at a population, organisational, programme and individual level.

3. Discussion

3.1. Members of the Kent and Medway Joint Health and Wellbeing Board are asked to discuss and consider their views on the following challenges arising from the implementation of the 'Everybody active, everyday' framework for actionvii across Kent and Medway.

- **Active Society - creating a social movement:** In order to create the social movement necessary to increase physical activity across Kent and Medway, promotion and awareness raising of the key messages is imperative. Members of the Kent and Medway Joint Health and Wellbeing Board are asked to discuss how they can best lend their support to the dissemination of these messages across the Kent and Medway STP footprint and more specifically to target groups.

- **Moving professionals – activating a network of expertise:** Members of the Kent and Medway Joint Health and Wellbeing Board are asked to discuss and consider how it can be ensured that MECC becomes a fundamental part of the development of Integrated Care Partnerships (ICPs). So that MECC in relation to physical activity becomes embedded in mandatory training and conversations relating to physical and mental health and wellbeing.

- **Active environments - creating the right spaces:** Members of the Kent and Medway Joint Health and Wellbeing Board are asked to discuss and consider how the learning from 'Healthy Towns' is made sustainable for implementation in other areas of the Kent and Medway STP footprint. Similarly, how can the learning from active travel schemes be scaled up across the county and the infrastructure developed to support this?

- **Moving at scale - scaling up interactions that make us active:** Members of the Kent and Medway Joint Health and Wellbeing Board are asked to discuss and consider how social prescribing might be scaled up across the Kent and Medway STP footprint. There is scope to use the 'Connect Well' portal to share all known social prescribing opportunities more widely across Kent and Medway. The portal has scope to link to opportunities across the majority of existing Kent and Medway platforms therefore providing much wider accessibility. Promoting active travel at scale also provides opportunities to improve air quality at scale across the STP footprint.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
High levels of inactivity amongst the population of Kent and Medway (Physical health)	The residents of Kent and Medway have levels of inactivity above the recommended levels. This puts them at a much higher risk of disease for example CVD and stroke.	A range of campaigns and associated interventions to encourage residents to increase their levels of activity	C2
High levels of inactivity amongst the population of Kent and Medway (Mental health)	The residents of Kent and Medway have levels of inactivity above the recommended levels. This lack of physical activity has an associated impact on their levels of mental health.	A range of campaigns and interventions highlighting the importance of physical activity to well being and good mental health.	C2
High levels of inactivity amongst the population of Kent and Medway (Economic)	The residents of Kent and Medway have levels of inactivity above the recommended levels. The associated increased risk of non-communicable disease results in an increased financial cost to the health service and productivity loss for the economy.	A range of campaigns and interventions encourage residents of Kent and Medway to increase their physical activity and therefore reduce their risk of non-communicable disease.	C2

5. Financial implications

5.1. There are no financial implications arising directly from this report

6. Legal implications

6.1. The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012

6.2. The Joint Board operates to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the Sustainability and Transformation Partnership. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may consider and seek to influence the work of the STP focusing on prevention, local care and wellbeing across Kent and Medway.

6.3. The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

7. Recommendations

7.1. Members of the Joint Health and Wellbeing Board are asked to support:

7.1.1. The dissemination of key messages relating to the importance of physical activity

7.1.2. Embedding physical activity 'Making Every Contact Count Training' as a mandatory element of training for health professionals

7.1.3. Scaling up of learning from 'Healthy Towns' and active travel schemes to bring sustainable change in the development of new infrastructure

7.1.4. Development of active travel schemes

Lead officer contact

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Acknowledgements

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Helen Page, Interim Head of Countryside and Community Development, Kent Country Council
Elise Rendall, Physical Activity Manager, Kent County Council

Appendices

Appendix 1: Joint Health and Wellbeing Board Dashboard – Physical activity and inactivity
Appendix 2: Physical activity interventions: Medway Council
Appendix 3: Physical activity interventions: Kent County Council

Background papers

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/748126/Physical_activity_for_general_health_benefits_in_disabled_adults.pdf [Accessed 29 April 2019]

Appendix 1
Joint Health and Wellbeing Board Dashboards – Physical activity and physical inactivity

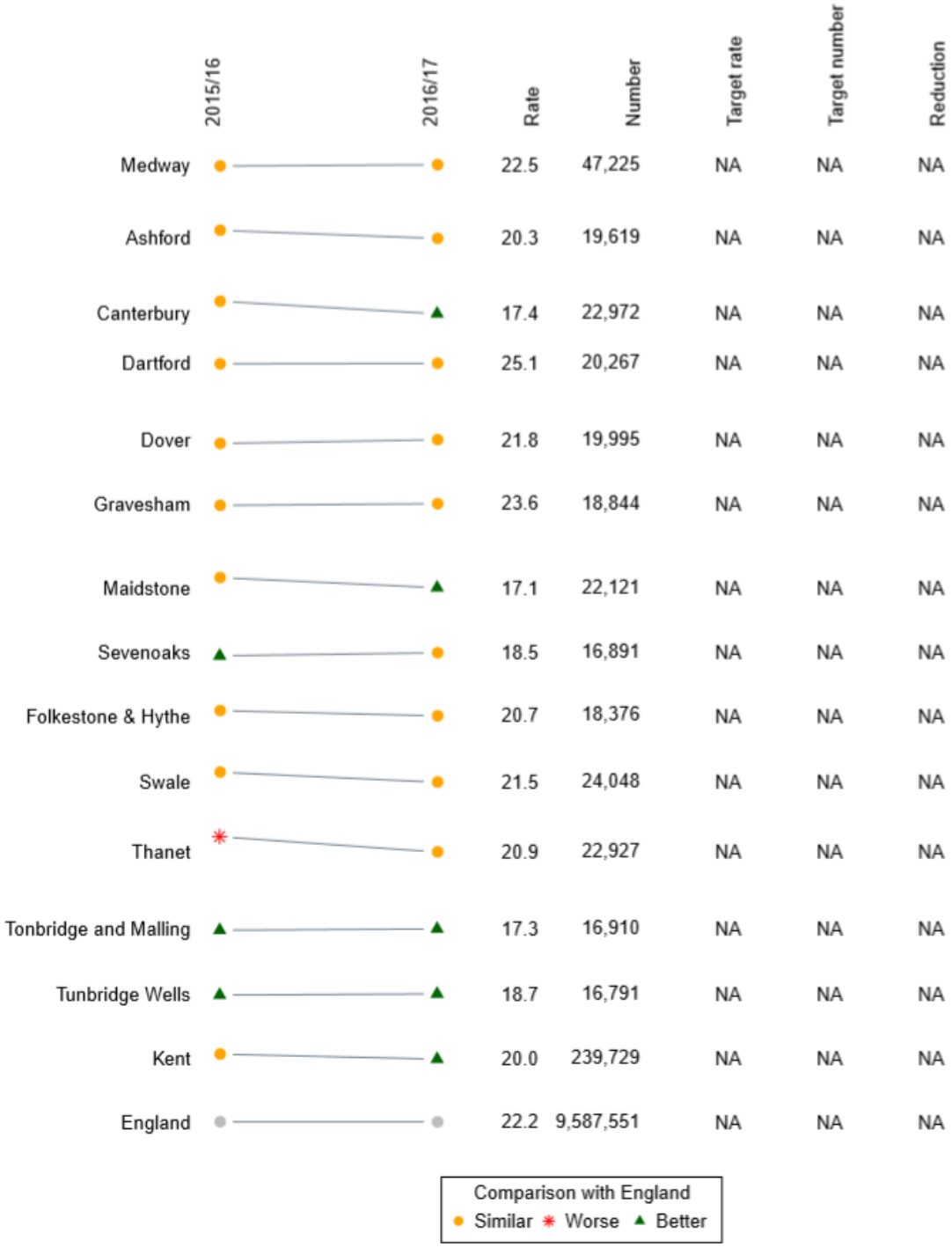
Physically active adults (%)

The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 19 and over.

Produced by Medway Public Health Intelligence Team (2019-04-25)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Physically inactive adults (%)

The number of respondents aged 19 and over, with valid responses to questions on physical activity, doing less than 30 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 19 and over.



	Rate	Number	Target rate	Target number	Reduction
Medway	22.5	47,225	NA	NA	NA
Ashford	20.3	19,619	NA	NA	NA
Canterbury	17.4	22,972	NA	NA	NA
Dartford	25.1	20,267	NA	NA	NA
Dover	21.8	19,995	NA	NA	NA
Gravesham	23.6	18,844	NA	NA	NA
Maidstone	17.1	22,121	NA	NA	NA
Sevenoaks	18.5	16,891	NA	NA	NA
Folkestone & Hythe	20.7	18,376	NA	NA	NA
Swale	21.5	24,048	NA	NA	NA
Thanet	20.9	22,927	NA	NA	NA
Tonbridge and Malling	17.3	16,910	NA	NA	NA
Tunbridge Wells	18.7	16,791	NA	NA	NA
Kent	20.0	239,729	NA	NA	NA
England	22.2	9,587,551	NA	NA	NA

Comparison with England
Similar Worse Better

Produced by Medway Public Health Intelligence Team (2019-04-25)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Appendix 2
Physical activity interventions: Medway Council

Intervention	When started	Target audience
1-1 cycling instruction for adults	2014	Adults who cannot ride a bike
A Better Medway Champions	2013	All local residents
ABM training of professionals	2013	All children and adults
Active Medway Cycling Groups	2012	Adults who are not confident cycling
Active retirement association exercise sessions	unknown	Older adults
Medway Cycling Festival	2014	Adults and children interested in cycling or starting to cycle
Big Splash	2014	Families
Bike ability training for children within schools	2010	Children wanting to improve cycling skills
Cardiac rehabilitation exercise classes	2000	adults recovering from CHD
Change for Life local promotion	2008	Families
Disability Sports Taster Day	2011	Disabled residents and able-bodied individuals willing to try disability sports
Free swimming for under 16s and over 60s	2010	Over 65s and under 16s
Green gyms in parks	2008	All residents
Greenacre School Sports Partnerships	2008	Children
Medway cycling routes	unknown	Cyclists
Medway exercise referral programme	2010	Adults with a long-term health condition
Medway Festival of Sport	2013	All Medway residents
Medway greenspaces, parks and play areas	unknown	All residents
Medway Health Walks	2008	Older adults
Medway Leisure centres and young people's gym	2011	Under 16s
Medway Mile	2006	Families
Medway Mini Youth Games	1999	Years 4,5 and 6
Medway Sports clubs and disability sports clubs	2004	Sports clubs
Medway walking routes	unknown	All residents
Nordic Walking groups	2016	People interested in walking

Passport to leisure discount scheme	2008	Adults with low income
Pulmonary rehabilitation exercise classes	2005	Adults recovering from pulmonary conditions
Safer journeys projects to promote walk to school initiatives and of other sustainable modes of travel	2008	Children and parents
Sports volunteering opportunities	2005	14 years plus
Workplace health initiative	2008	Adults within workplaces
Great Lines Park run	2016	People interested in running
Daily Mile	2017	Primary school
Man vs Fat	2018	Overweight men

Appendix 3
Physical activity interventions: Kent County Council

The Kent County Council's Sport and Physical Activity Service is a small discretionary service, which aims to promote involvement in a wide range of physical activity opportunities, including sport. The Kent County Council's Sport and Physical Activity Service is a discretionary service which aims to promote involvement in a wide range of physical activity including sport. It has combined some resources with those from Sport England and also acts as the County Sports Partnership for Kent (Kent Sport).
Explore Kent works alongside Kent Sport and other countryside operators and organisations to promote activity in the outdoors:

- providing promotion of low barrier to entry physical activity (predominantly walking and cycling, access to green space, conservation volunteering, activities etc).
- working on behalf of a range of partners in the countryside sector (including Country Parks, Countryside Management Partnerships, Public Rights of Way, Kent Nature Partnership, and other private providers) to promote physical activity outdoors including walking and cycling.
- Promoting getting outdoors and active for the benefit of health and has a significant potential to engage audiences particularly across digital channels as demonstrated by the following statistics:
  - 60,000 walking and cycling guide downloads per year from ExploreKent.org
  - 47,000 website page views per month
  - 19,700 Twitter followers
  - 5,500 Facebook likes
  - 6,000 + Subscribers to quarterly e-newsletter
  - Explore Kent has a healthy place-based approach and has worked with local communities (where funding is available) to promote active lifestyles.
  - Previously working with partners to establish the Active Ramsgate project to promote active, healthy and sustainable tourism over a 3-year period. This was funded by Ramsgate Town Council.
  - Currently working with Cycle Friendly Deal to promote cycling and walking in the Deal area as well as providing 'We Love Walking and Cycling Training' for businesses.
  - Having discussions about potential packs for residents in the Ebbsfleet Heathy Garden City development.
  - Healthy Place making and shaping is central to what Explore Kent does.

Town Cycling and Walking Maps - Explore Kent is working with KCC's Transport Innovation Team on a Step Ahead of the Rest (StAR) Programme[viii] and Department for Transport funded project to produce and promote town cycling and walking maps to encourage people to walk and cycle for the good of their health as well as the environment.

Examples of work being undertaken to encourage wider take-up of physical activity across Kent

Physical Activity sessions for people living with young onset Dementia [ix]	Alzheimer's Society Kent and Medway had seen a sharp increase in the number of people under 65 who were coming through to the Dementia Support Service frustrated at the lack of specific provision for their age group. A group of service users worked in a co-productive way to mutually produce an

	age appropriate physical activity service/activity to meet their needs.
Kent's Sporting Memories project	Two-year project developing reminiscence activities that improve mental and physical well-being of older people (50+), in particular, those experiencing social isolation and loneliness and those living with dementia through tapping into their passion, knowledge and love of sport.
Active at work	Workplace health programme to help workplaces to encourage and support employees to become more active and build activity into their day. Programme includes an activity tracker, champion training and business games. There is also a focus on encouraging Active Travel, through a partnership with the Sustainable Transport team
Kent School Games	Established in Kent since 2008 as an Olympic and Paralympic legacy programme. The School Games provides opportunities for primary and secondary aged pupils and there is a strong programme for young people with special educational needs or a disability. The programme of activities has developed to focus on attracting young people of all ages and abilities rather than high level competition.
The Daily Mile	Leading on delivery of the roll out of the Daily Mile initiative across Kent. The Daily Mile is a free activity available to all primary schools which sees children run for 15 minutes a day in order to improve their physical, emotional, social and mental health.
Mental Health	Kent Sport's Mental Health Action Plan has been used as a case study by Sport & Recreation Alliance as part of their Mental Health Charter best practices. The plan includes: raising awareness and promotion of positive messages/stories, working with MIND and Street Games to deliver training for professionals & volunteers, and developing partnerships and building relations with local mental health projects & organisations Kent Sport has also supported a group called Primal Roots, which provides activity in the outdoors for people with mental health challenges as a result of issues such as addiction or homelessness.
Parkinson's	Awarded a small grant to deliver boxing activity for people with Parkinson's in Medway.
Everyday Active	Aimed at encouraging activity amongst less active people. The campaign will develop over the next two years and aims to provide resources and examples/case studies/video clips (including Dementia, Cancer, Walking Football, Breeze, Paracise), to assist health professionals to provide support for people who could benefit from being more physically active but don't have the confidence or information in order to be able to start. Consultation is due to commence in targeted

	areas with partners and the public in order to design the campaign based on local feedback and need.
Get Out Get Active (GOGA) project in Thanet	An externally funded programme supporting disabled and non-disabled people to take part in fun and inclusive activities together.
Housing Association work	Working with agencies such as Golding Homes, Optivo, West Kent / Moat Housing to provide a programme of activities for young people within local disadvantaged communities.
Leisure Trust pilots	Projects in Ashford, Swale and Thanet working with leisure facility staff to attract new audiences. This work includes staff training and review of marketing and promotional materials, which can be off-putting for individuals who are less active and do not use leisure facilities.
Running project and Parkruns	After a highly successful Running project that has now ceased due to funding, a number of Parkruns and junior Parkruns, have been supported to become established in the county.
Activity specific projects	Just Bowl project – a project funded through the Bowls Development Alliance to develop opportunities through adapted equipment in care homes
Kent Cycling Partnership	A joint initiative between Kent Sport, KCC Transport, Explore Kent and British Cycling promoting recreational cycling opportunities across Kent.
Physical Activity and Older People innovation grants	6 pilot projects were selected to receive funding to contribute to wider health and social outcomes by creating opportunities for older people aged 55+ (and their carers) to become more physically active, using a range of different recreational, leisure and appropriate sports activities.
Satellite Clubs	A countywide project aimed at 14-19-year olds who are less likely to be part of a formal sports club or activity to become active in less formal clubs based largely in educational and wider community settings
Open Active	A national initiative being promoted locally to encourage sport, leisure and activity providers to 'open' their opportunity data, so that it can become more widely accessible and easier to find. This will support health professionals to be able to signpost individuals to appropriate activity.

[i] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

[ii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

[iii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

[iv] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/748126/Physical_activity_for_general_health_benefits_in_disabled_adults.pdf [Accessed 29 April 2019]

[v] file:///C:/Users/jacqui.moore/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/I05EULO4/sedentary%20behaviour%20children%20(002).pdf[Accessed 2 May 2019]

[vi] https://publichealthmatters.blog.gov.uk/2018/10/10/increasing-physical-activity-in-every-level-of-society/ [Accessed 25 April 2019]

[vii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

[viii] https://www.kent.gov.uk/about-the-council/strategies-and-policies/transport-and-highways-policies/transport-and-highways-funding/step-ahead-of-the-rest

[ix] http://www.activepartnerships.org/impact/physical-activity-sessions-people-living-young-onset-dementia

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

25 JUNE 2019

LEARNING DISABILITY ANNUAL HEALTH CHECKS

Report from:	James Williams, Director of Public Health for Medway Council
	Andrew Scott-Clark, Director of Public Health for Kent County Council
Author:	Samantha Bennett, Consultant in Public Health, Kent County Council
	Lorraine Foster, Partnership Commissioning Programme Lead, Medway Council

Summary

This report presents an overview of the health inequalities experienced by local people with learning disabilities. In Kent and Medway, it is known that only a quarter of people with a learning disability are on a GP learning disability register, meaning they miss out on extra support which could improve their health. In addition, only 41.7% and 40.8% of people on the register in Kent and Medway respectively in 2017/18 received a learning disability (LD) health check, which aims to provide holistic support and intervention to improve health outcomes. Work is underway in Kent and Medway to improve uptake. Specific opportunities are available to improve the health and wellbeing of people with learning disabilities in prison and to make use of the summary care record (SCR).

1. Budget and policy framework

1.1. LD annual health checks are delivered by general practice through a directly enhanced service (DES) commissioned by the NHS. GP Practices do not have to sign up to delivering the LD health checks. Practices are remunerated for the LD annual health checks they provide. Every person aged 14 and over on a learning disability register, is eligible for this service.

1.2. NHS England has set a target for GPs and Clinical Commissioning Groups (CCGs) to increase the access to the LD annual health checks, so that by 2020 75% of people on a GP learning disability register in England should have received a check. The recently published NHS Long Term Plan (2019) has also committed to piloting a specific health check for people with autism[i].

2. Background

2.1. People with a learning disability have worse physical and mental health than people without learning disabilities. It has been found, on average, that the life expectancy of women with a learning disability is 18 years shorter than women without a learning disability. For men, the difference is 14 years shorter[ii]. In particular, people with a learning disability experience greater levels of multi morbidity, epilepsy and mental health issues. In Kent 18% of persons with learning disabilities have two or more other long term[iii] conditions. There is also evidence of greater inequities in access to care.

3. Advice and analysis

3.1. The learning disability annual health check

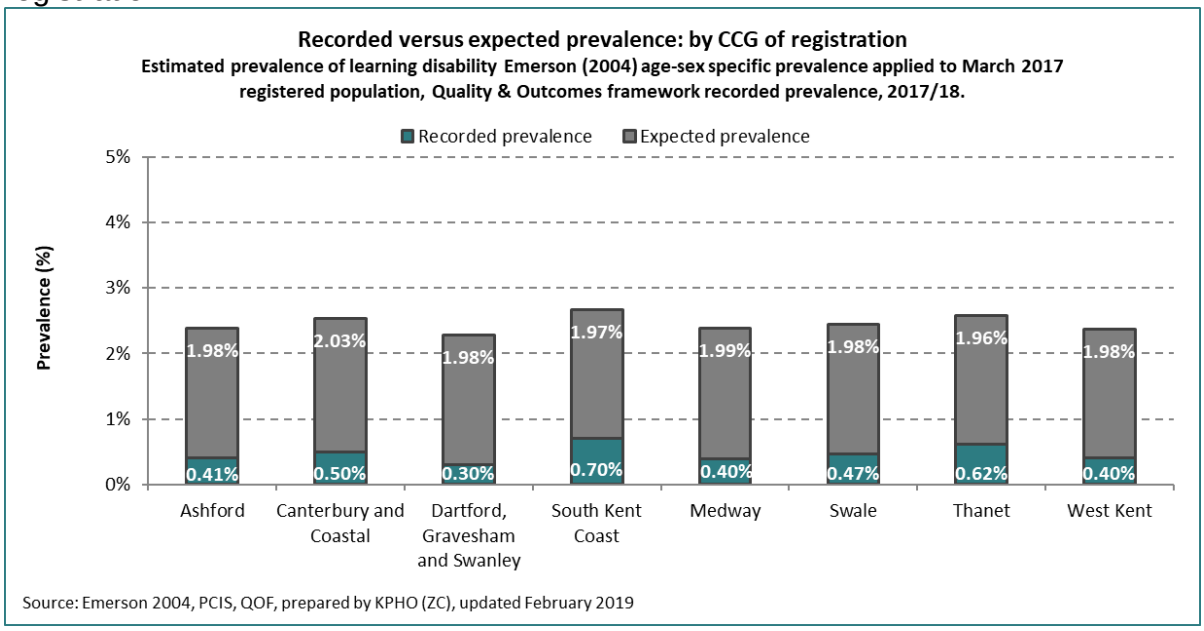
3.1.1. The LD annual health check is one tool to help mitigate the health inequalities experienced by people with a learning disability. They have been available since 2008. The LD annual health check is a holistic review of a person's health and wellbeing in its broadest sense, considering any particular diseases, medication, lifestyle and access to preventative healthcare including screening and immunisations. It also helps build a relationship between the practice and the person with a learning disability. Following the LD health check, a health check action plan should be produced.

3.1.2. In Kent and Medway, the recorded prevalence of learning disabilities varies by CCG area, ranging from 0.3% in Dartford, Gravesham and Swanley to 0.7% in South Kent Coast. The recorded prevalence is far below the expected prevalence of learning disabilities, resulting in 24,000 people with learning disabilities in Kent alone not being present on a GP register who should be. Figure 1 presents a comparison of expected and recorded prevalence of learning disability by CCG area. This under-recording presents a challenge as it means that in most areas less than a quarter of people with learning disabilities are on a register and therefore eligible for an annual LD health check.

3.1.3. Further analysis in Kent has found that older people with learning disabilities are most likely to receive an annual LD health check. A focus on deprivation found that the uptake of LD health checks in 2017/18 was most likely in the most deprived areas.

3.1.4. There is evidence that LD health checks have a positive impact on the health of people with learning disabilities, including detecting unmet health needs, taking[iv] a preventative approach to health, increasing referrals to secondary care[v] and reducing preventable emergency admissions. Local analysis for Kent has identified that the rate of non-elective hospital admissions was lower for people with learning disabilities who had received a LD health check. It was also found that for those people with learning disabilities who did have a non-elective admission, the cost of the admission was lower for people who had the LD health check compared to those who had not.

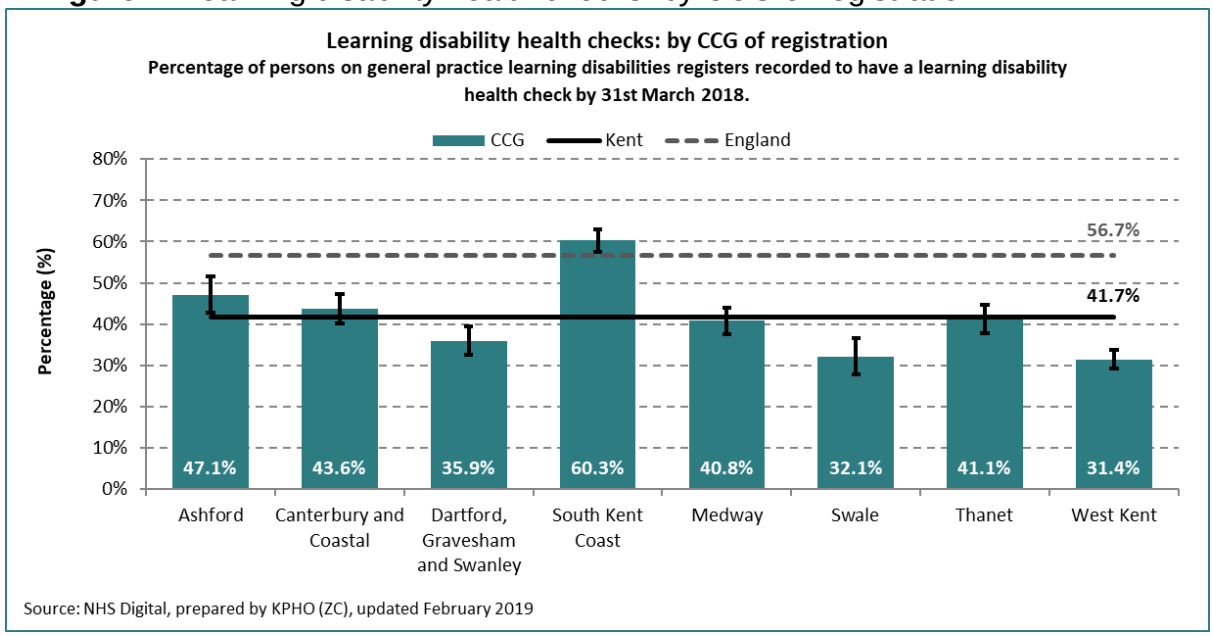
Figure 1: Recorded versus expected prevalence of learning disabilities: by CCG of registration



3.1.5. The Learning Disabilities Mortality Review (LeDeR Programme) Annual report[vi] cites that more than a third of deaths in people with learning disabilities were potentially amenable to health care interventions. LeDeR is providing evidence in action that the restriction to good quality healthcare is directly restricting people's right to life as people with learning disabilities die younger. Delivery of good quality LD annual health checks in Primary Care are one way that equality of access to good healthcare can be achieved.

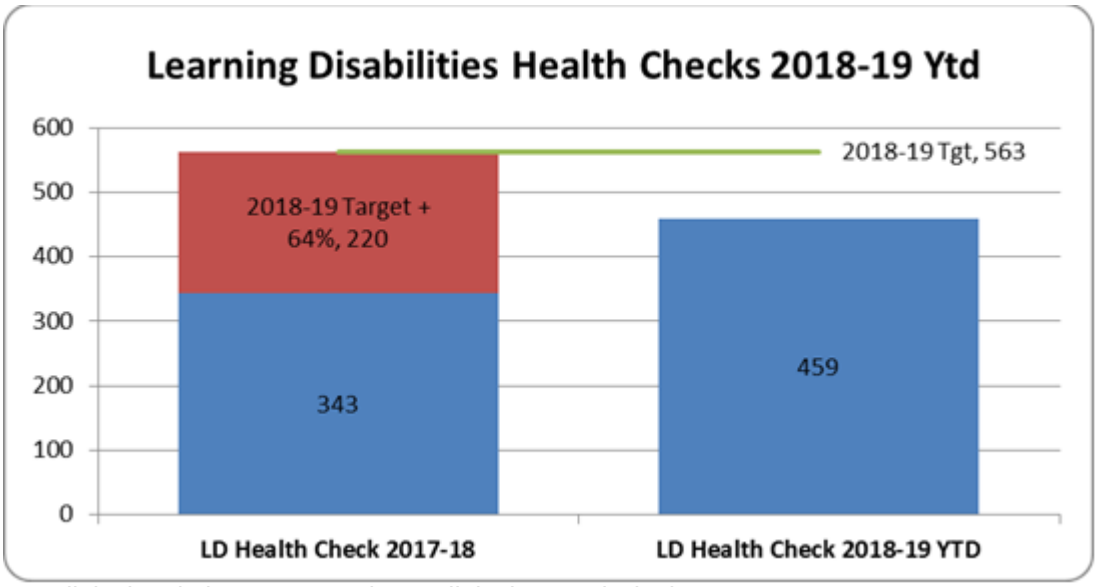
3.1.6. In Kent the coverage of the learning disability annual health checks is 41.7%, the figure is similar in Medway at 40.8%. This is lower than the England average of 56.7%. Figure 2 presents the variation in coverage of the LD health check, uptake ranges from 31.4% in West Kent to 60.3% in South Kent Coast CCG.

Figure 2: Learning disability health checks: by CCG of registration



3.1.7. The Clinical Variation (CV) Team at Medway Clinical Commissioning Group have been working with General Practice (GP) managers to identify learning disability patients that have not completed a health check within the past twelve months. This has resulted in a total of 459 LD health checks being completed for the period April 2018 to March 2019. This is an increase of 116 health checks (34%) compared to the total number of checks completed in 2017-18. The CV team will continue to work with GP managers during 2019-20 to further increase LD health check uptake, which is currently 40%, to 49% which will bring Medway in line with National uptake. Figure 3 shows the comparative number of LD health checks for 2017/18 and 2018/19.

Figure 3: Learning disability health checks 2018-19 Year to date



Source: Clinical variation team, Medway Clinical Commissioning Group 2019

3.1.8. Further analysis has been undertaken to look at the uptake of health services designed to prevent ill health. Table 1 presents the summary data. The uptake of the seasonal flu immunisation and colorectal screening is similar for those people registered with a learning disability compared to the general population. However, far fewer eligible women with a learning disability are accessing cervical and breast screening services than the general population, in Kent there is a 41.9% gap in uptake for cervical screening, in Medway the figure is 43.7%.

Table 1: Uptake of Preventative Interventions by people with Learning Disabilities

Intervention	England, Kent, Medway-General Population	England LD	Kent LD	Medway LD	CCG Range
Seasonal Flu Immunisation	48.9%, 45.0%, 45.5%	44.7%	42.1%	34.4%	32.3% DGS to 49.4% South Kent Coast
Cervical Screening	71.4%, 74.4%, 73.4%	31.2%	32.5%	29.7%	29.7% Medway to 37.9% Canterbury and Coastal
Breast Screening	74.9%,76.9%, 76.2%	52.5%	47.2%	29.8%	29.1% South Kent Coast To 65.1% Swale
Colorectal Screening	59.0%, 60.6%, 56.9%	77.8%	69.0%	56.5%	53.2% South Kent Coast To 91.7% Thanet

3.1.9. Across Kent and Medway, a programme is being planned by NHS England to increase the uptake of cervical screening in eligible women with a learning disability. This will build on initiatives developed in other parts of the country to ensure that people with learning disabilities are supported and receive information in the appropriate way, to make an informed decision about having screening, undergoing the screening itself and receiving the results.

3.1.10. In Kent, the Learning Disability Nursing Team have been working to increase the uptake of breast screening. The GP link nurses identify those women with a learning disability in the practices being targeted by the next round of screening. The women are offered support and information in an accessible format.

3.2. **LD Annual Health Reviews and the NHS Plan**

3.2.1. In addressing health inequalities for people with learning disabilities the new NHS Plan (2019) has outlined a number of actions that all health and social care economies will need to address[vii]. Amongst these actions is the requirement to:

> *" Increase the uptake of annual health checks in primary care by patients with a learning disability to 75%, and the piloting of health checks for patients with autism a significant proportion of whom will also have a learning disability"*

3.2.2. Work is currently underway across Kent and Medway to drive up the number of individuals who take up LD annual health reviews (paragraph 3.1.6). Initial findings are that this approach is increasing numbers, however there is a risk that if this initiative is confined to one local area that

improvements in the uptake of annual health reviews will not be seen across the patch.

3.3. **Summary Care Records**

3.3.1. Summary Care Records (SCR) are an electronic record of important patient information, created from GP medical records. They can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care. SCRs can be accessed through the NHS Spine web portal and as such can provide at a minimum important information in relation to current medication, allergies and patient demographic details. The patient can also choose to include additional important information such as long term conditions or significant medical history.

3.3.2. For individuals with learning disabilities and their carers this tool that can be utilised to provide significant information at a time of distress like an A&E visit when remembering all the details may prove challenging. It also ensures that clinical staff can provide safer care that is not delayed as the relevant information is at hand. Often the LD annual health check facilitates the development or refresh of a SCR and as such highlights the importance of the completion of LD annual health checks.

3.4. **LD Annual Health Reviews and the Criminal Justice System**

3.4.1. The House of Commons Health and Social Care Select Committee Report – Prison Health (2018) identifies that prisoners with learning disabilities form a significant part of the prison population[viii] Report authors identified that prison can give an opportunity to identify those with a learning disability that may have previously gone undiagnosed. As such prison health services needed to be adequately equipped to undertake assessment, diagnosis and provide support for people with learning disabilities.

3.4.2. In addition, the report recommends that a memorandum of understanding exists with each local authority to address the provision of social care. In this way it is felt that health inequalities amongst people with learning disabilities in the criminal justice system can be systematically addressed.

3.4.3. The provision of the LD annual health check sits at the heart of addressing health inequalities for people with learning disabilities (LD). In 2015*, 'Equal Access, Equal Care; Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities'* was published, outlining the changes and standards for prison healthcare settings to ensure prison healthcare services are on par with services delivered to people with LD in the community[ix] The guidance states that "the mental health team will also work with the primary care team in the development of learning disability registers that will enable an LD annual health check and health action plan to be completed".

3.4.4. In carrying out the services the Provider procured by health commissioners and prison governors is "exercising public functions" and as such must pay due regard to the Public Sector Equality Duty under section 149(1) of the Equality Act 2010 to deliver the Services accordingly[x]. In addition, 'parity of esteem' is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care

Act 2012 and as such applies to everyone who has a learning disability and a mental health condition[xi].

3.4.5. **"**The Transforming Care Model Service Specifications: Supporting implementation of the service model" document states that "community support is reliant on interdependencies across the local geography to ensure that needs of the population as a whole are met, either by providing the intervention directly or by supporting colleagues to provide interventions as needed"[xii]. These interdependencies include links with mainstream services in the community, which can support the various needs that the person has.

3.4.6. It is within this policy context that challenges exist across Kent and Medway in ensuring that people with LD, including those within the criminal justice system or who have been released from prison, have access to annual LD health reviews and the development of health action plans. Although the Model Service Specification gives direction as to what provision should look like these directions are not prescriptive and direct readers towards the provision of localised services based on assessed need. With 7 prisons and 1 secure training centre within the Kent and Medway boundaries this is an issue that requires further consideration and discussion, particularly for those who are released into the local community.

3.5. **Challenge**

3.5.1. Members of the Kent and Medway Joint Health and Wellbeing Board are asked to discuss and give their views on how partner organisations can support in the following areas:

- Increasing the uptake of LD annual health checks
- Increasing the use of summary care records for people with learning disabilities.
- How it can be ensured that people with LD including those within the criminal justice system or who have been released from prison have access to LD annual health reviews and the development of health action plans.
- To increase the registration of people with learning disabilities.
- To increase the uptake of preventative interventions by people with learning disabilities.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
No increase in annual health reviews	Annual health reviews amongst people with learning disabilities in Medway do not increase and as such deaths from avoidable causes continue	Continue to support GP practices to increase the number of people with learning disabilities on their LD registers Continue to support GP practices to increase the number of annual health reviews for people with learning disabilities Deliver a targeted social media campaign in Medway to increase the knowledge and awareness of annual health reviews amongst people with learning disabilities and their carers	C2
No increase in the production of summary care records for people with learning disabilities	Clinical teams' access to up to date and relevant clinical information particularly at times of urgency or distress remains limited and impacts negatively on their ability to assess, diagnose and treat people with learning disabilities appropriately. This continues to lead to deaths from avoidable causes	As above Deliver a social media campaign in Medway to increase the knowledge and awareness of the purpose of summary care records amongst people with learning disabilities and clinical professionals across the board	C2
No links are made with prison health services to support the delivery and uptake of annual health reviews for prisoners and as such deaths from avoidable causes continue	Access and uptake of LD annual health checks for prisoners is unknown and as such the individual and wider societal benefits derived from the annual health checks is unrealised	Risk is that mainstream services in the community continue to have limited contact with prison health services and as such the health and welfare of the learning disability prison population continues to be unknown and as such unsupported by mainstream services. Agreement needs to be gained across health and social care that work needs to be undertaken with prison services to support the delivery and uptake of annual health checks.	C2

5. Financial implications

5.1 There are no financial implications arising directly from this report.

6. Legal implications

6.1 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012

6.2 The Joint Board operates to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the Sustainability and Transformation Partnership. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may consider and seek to influence the work of the STP focusing on prevention, local care and wellbeing across Kent and Medway.

6.3 The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

7. Recommendation

7.1 Members of the Kent and Medway Joint Health and Wellbeing Board are asked to support with raising the profile and increasing the uptake of LD annual health checks.

Lead officer contact

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Appendices

There are no appendices

Background papers

[i] NHS England (2019) The NHS Long Term Plan Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf. Accessed [2 April 2019]

[ii] NHS Digital (2019) *Health and Care of People with Learning Disabilities , Experimental Statistics: 2017 to 2018 [PAS]*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2017-to-2018. Accessed [20 March 2019]

[iii] Heslop et al (2013) *Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD)* Available at: https://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf. Accessed [20 March 2019]

[iv] Robertson, J, Hatton, C, Emerson, E & Baines, S (2014), 'The impact of health checks for people with intellectual disabilities: an updated systematic review of evidence' *Research in Developmental Disabilities*, vol. 35, no. 10, pp. 2450-2462. Available at: https://doi.org/10.1016/j.ridd.2014.06.007 Accessed [20.03.2019].

[v] Buszewicz M, Welch C, Horsfall L, Nazareth I, Osborn D at el. (2014) *Assessment of an incentivised scheme to provide annual health checks in primary care for adults with intellectual disability: a longitudinal cohort study.* The Lancet Psychiatry; 1(7): 522-530 Available at: http://dx.doi.org/10.1016/S2215-0366(14)00079-0. Accessed [20 March 2019]

[vi]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/739560/government-response-to-leder-programme-2nd-annual-report.pdf [Accessed 26 April 2019]

[vii] https://www.england.nhs.uk/long-term-plan/

[viii] https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/prison-healthcare-inquiry-17-19/

[ix] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf

[x]https://www.legislation.gov.uk/ukpga/2010/15/contents

[xi] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[xii] https://www.england.nhs.uk/publication/transforming-care-service-model-specification-january-2017/

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

25 JUNE 2019

NHS HEALTH CHECK: OVER 75 ELIGIBILITY

Report from:	James Williams, Director of Public Health for Medway Council
	Andrew Scott-Clark, Director of Public Health for Kent County Council
Author:	Andrew Scott-Clark, Director of Public Health, Kent County Council

Summary

At the December Meeting of the Joint Kent and Medway Health and Wellbeing Board a query was raised as to why the Local Authority commissioned the NHS Health Checks Program stopped at 74.

This paper clarifies the basis for the NHS Health Check Program and describes what arrangements are in place for people over the age of 75.

1. Legislative framework

1.1. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 sets out the requirement for Local Authorities in relation to Health Check Assessments.

1.2. Paragraph 4 (2) describes an eligible person in the Local Authority's area who is aged from 40 to 74 years.

1.3. Additionally, eligibility also relates to the offer of a health checks assessment once every five years and goes on to rule out those people already diagnosed with any of the following:

- Coronary Heart Disease
- Chronic Kidney Disease
- Diabetes
- Hypertension
- Arterial Fibrillation
- Transient ischemic attacks
- Hypercholesterolaemia
- Heart Failure
- Peripheral artery disease

- Stroke
- A person on a lipid lowering drug
- A person having already been assessed as having a 20% or higher risk of having a cardiovascular event during the ten years following the check

1.4 Thus the statutory duty of the Local Authority is quite clear in regard to the age limits of the program.

2. Over 74 Check

2.1. People of the age of 75 are not included in the NHS Health Check as they have a named accountable G.P. One of the responsibilities of the accountable G.P is to provide a health check on request where an examination hasn't been performed in the preceding twelve months.

2.2 Thus annual health checks are already available to the >75 age cohort under General Medical Services.

3. Conclusion

3.1. Local Authorities have the statutory duty to invite the eligible population aged between 40 and 74 years and every five years for an NHS Health Check

3.2 People over 75 can request annual assessments already under existing general medical services.

3.3 There is provision therefore for people over 75 years.

Contacts

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Appendices

There are no appendices

Background papers

KENT AND MEDWAY

JOINT HEALTH AND WELLBEING BOARD

25 JUNE 2019

SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) LOCAL CARE UPDATE

Report from: Caroline Selkirk, Managing Director East Kent Clinical Commissioning Group (CCG),

Ian Ayres, Managing Director Medway and North West Kent Clinical Commissioning Groups (CCGs)

Author: Cathy Bellman, STP Local Care Lead

Summary

As requested at the 19 March meeting of this Joint Board, this report will provide an update on;

- delivery plans and outcomes framework
- alignment with Primary Care Strategy and
- approach to a framework for consistency, quality and reporting.

(Please see attached, the Local Care update paper, which went to the Sustainability and Transformation Partnership (STP) Programme Board on the 4 June 2019).

1. Budget and Policy Framework

1.1 The Kent and Medway Sustainability and Transformation Plan outlines the intention of the Kent and Medway health and care system 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.

1.2 Additionally, the Kent and Medway Case for Change identified the priority to develop more and better local care services. There are a number of workstreams within the Sustainability and Transformation Partnership, one of which is a dedicated Local Care workstream to deliver the Plan.

2. Governance

The attached Local Care update paper has been to the following meetings of the Kent and Medway Sustainability and Transformation Partnership before coming to this joint Board;

- Local Care Board, 5 April 2019

- Finance Group, 3 May 2019
- Clinical and Professional Board, 16 May 2019
- Programme Board, 4 June 2019.

Feedback resulted in the following recommendations;

a) A need for more ambition around the numbers going through the MDTs
b) A consistent approach to modelling
c) Consistency of implementation ,
d) Consistency of financial reporting for Local Care investment and return on investment and
e) Greater emphasis on describing a Kent and Medway approach to 'shift and save' with financial planning transparency across Health and Social Care.

3. Risk management

3.1 The Local Care Implementation Board has regularly reviewed the overarching Local Care risk register. Going forward the risk register will be reviewed on an ongoing basis by the Local Care Board. As system level plans are developed the risk register will be updated. Moving forward Local Care reporting will be on a shared programme management system (Aspyre), being implemented across the Sustainability and Transformation Partnership; this will allow alignment of planning, reporting and risk management across all workstreams.

4. Financial implications

4.1 As set out in previous reports to this Joint Board, the investment has been identified for Local Care in 2018/19, with clear timelines for identifying the key deliverables in 2019/20 and beyond. The investment case is being refreshed for 2019/20 alongside the response to the NHS Long Term Plan. As mentioned in the attached paper there is work underway which will provide consistency for financial reporting on investment and return on investment for Local Care.

4.2 There are no financial implications arising directly from this report i.e. notwithstanding the discussions happening elsewhere, this is an update report and there are no requests for resources.

5. Legal implications

5.1 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012.

5.2 The Joint Board operates to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of

the Sustainability and Transformation Partnership Plan. In accordance with the terms of reference of the Kent and Medway Joint Health and Wellbeing Board, the Joint Board may consider and seek to influence the work of the STP focusing on prevention, local care and wellbeing across Kent and Medway.

5.3 The Joint Board is advisory and may make recommendations to the Kent and Medway Health and Wellbeing Boards.

6. **Summary**

The attached paper provides an update for Local Care development across Kent and Medway on;

- System improvement priorities and the impact - delivery plans for 2019/20 and outcomes framework
- How the development of Local Care fits in with the Primary Care Strategy and development of the Primary Care Networks
- Local Care 'State of Readiness' - Maturity Matrix Re-run (Deep Dive)
- Multi-disciplinary team activity and addressing consistency across K&M
- Approach to achieving consistency in reporting for investment and modelling, and
- The 'bottom up' development of a 'Standards Framework' which will support Multi-Disciplinary Teams/Primary Care Network development.

7. Recommendations

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to note the content of this report, in particular is asked to:

a) Support having a framework to assist the development of the MDT/PCNs
b) Endorse the approach to achieving consistency in the delivery of Local Care across K&M; cohort modelling, reporting on inputs/outputs (delivery and financial savings).

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Appendix A - Full Version of Local Care system improvement priorities and the impact in 19/20
Appendix B - Full evaluation results of the Local Care 'Maturity Matrix' re-run, January 2019
Appendix C - Local Care multi-disciplinary team framework for Primary Care Networks (draft).

Background papers
Agenda and minutes of Kent and Medway Joint Board Meeting –19 March 2019

https://democracy.medway.gov.uk/ieListDocuments.aspx?MId=4249

Transforming health and social care in Kent and Medway

Local Care Update
Kent and Medway Joint Health and Wellbeing Board

25 June 2019

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

The Following Provides An Update On Local Care Delivery:

1. **Our system improvement priorities and the impact - delivery plans for 2019/20 and outcomes framework**
2. **How the development of Local Care fits in with the Primary Care Strategy and development of the Primary Care Networks**
3. **Local Care 'State of Readiness' - Maturity Matrix Re-run (Deep Dive)**
4. **MDT activity and addressing consistency across K&M**
5. **Investment and modelling**
6. **MDT Framework to support Multi-Disciplinary Teams (MDTs)/ Primary Care Network (PCN) Development**

We would welcome discussion on the;

- Information presented
- The approach to achieving consistency in the delivery of Local Care across K&M; cohort modelling, reporting on inputs and outputs (delivery and financial savings) and framework to support the development of the MDT/PCNs

1. Our system improvement priorities and the impact in 19/20 (Full details in appendix 1)

Our delivery priorities during 19/20 are:

- Fully functioning Multi-disciplinary Teams (MDTs) supporting **Primary Care Networks**
- By 2020 - developed models of care to deliver **all 8 elements of the model** (including rapid response, falls prevention, reactive discharge planning and reablement)
- To have increased the number of individuals with an integrated case management **'care plan'**
- To have embedded the **dementia pathway** within the 'Dorothy Model'
- Begin working on an MDT **model for Children** with complex needs, adults with Learning Disabilities and Autism
- To ensure **community navigation and social prescribing** are embedded as part of the model and are being delivered at scale
- Build on the 2018/19 support offer **for paid and unpaid carers,**
- Build on **local care workforce actions** already underway as part of the 19/20 deliverables identified in the STP Workforce Transformation Plan

The Local Care Delivery Framework has been agreed

By the end of 19/20, we will track

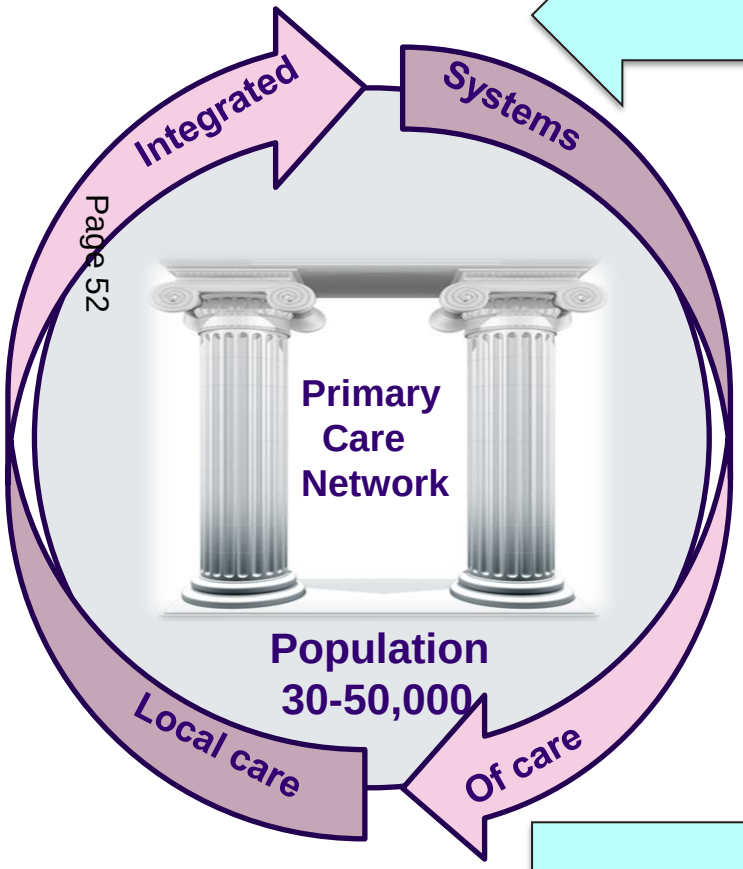
- Number through MDTs
- Anticipatory care plans in place
- A reduction in falling in frail adults
- A reduction in A&E admissions associated with falls, UTIs, catheter related issues and from care homes
- An increase in the uptake of social prescribing opportunities for high need groups
- Increased numbers going home after admission
- Reduction in admissions to long term care
- Reduction in LOS
- Reduction in non-elective admissions
- Nos people still independent 90 days after they received reablement
- Increase in dementia diagnosis rate

- Carers rate the Help4Cares app positively
- Agreed strategy for an MDT model for children with complex needs (linked to children's strategy)
- Begin to develop and MDT approach for adults with Learning Disabilities and Autism

Expansion of the model: Local Care supporting the development of Primary Care Networks (PCNs)

Increasing Numbers in Local Care Services

Admission Avoidance



Routine, Prevention and Proactive Care –Integrated Case Management (ICM patient centred approach for admission avoidance, anticipatory care planning.

Emergency and Reactive Care – ICM approach for admission avoidance, rapid/ emergency response to avoid hospital admission to keep people well at home.

Acute Care
- When intervention is essential. Working across organisations for repatriation at the earliest opportunity.

Tertiary Care
- For highly specialist intervention. Repatriation at the earliest opportunity.

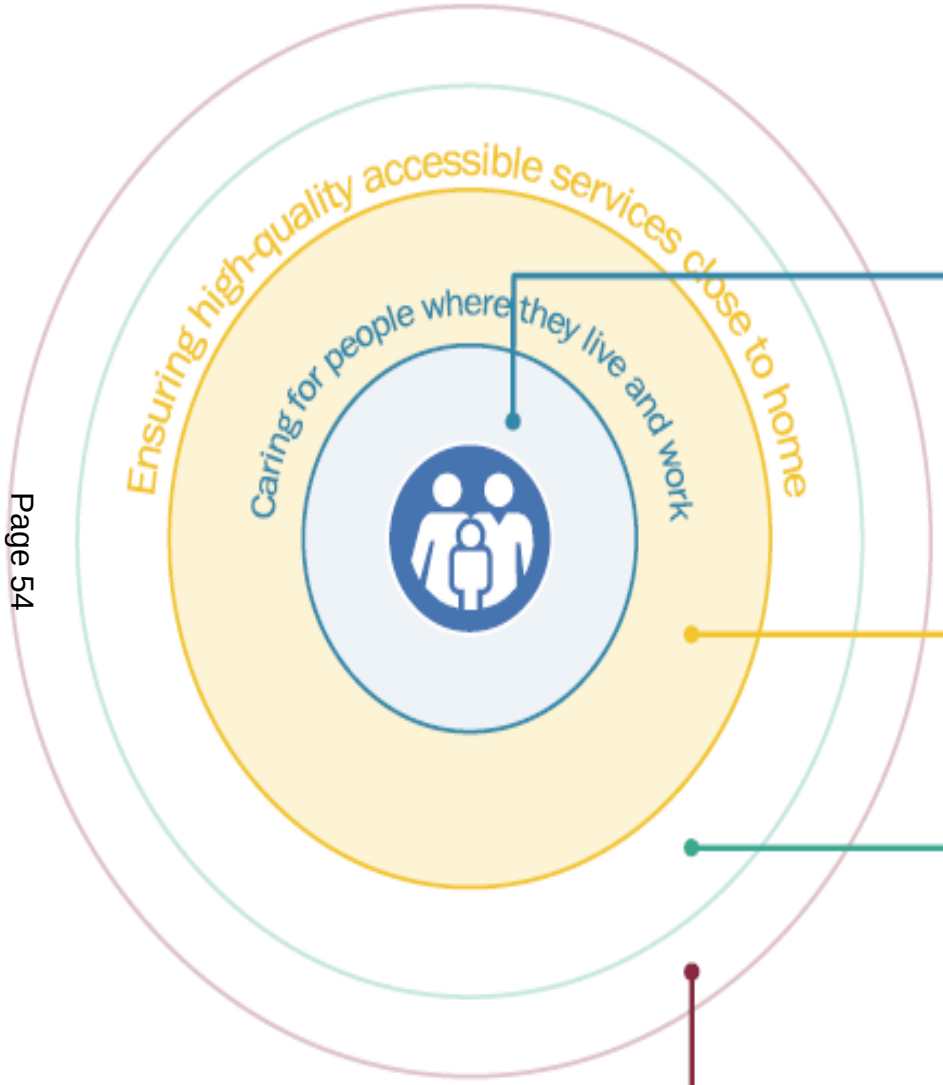
Level of Acuity

2. Local Care Implementation Readiness Assessment

- Originally run in the autumn of 2017.
- The **domains** have been **kept the same** to enable comparison.
- Originally completed, at CCG level **; however for this run east Kent was assessed as a collective of 4 CCGs, giving an amalgamated score,** leading to a slightly conservative score as have erred on the lowest scores within that area
- The focus has been on the **8 interventions of the 'Dorothy Model';** (Adults and Older People with Complex Needs).

  Some localities are making changes to services for other parts of the population, therefore the survey includes the following sections for **other population groups:**
  - Urgent and elective care demand management for mostly healthy and those with LTCs who do not have complex needs
  - Younger adults with complex needs
- Allows local areas to **self- assess current status** relating to the current maturity of Local Care models.

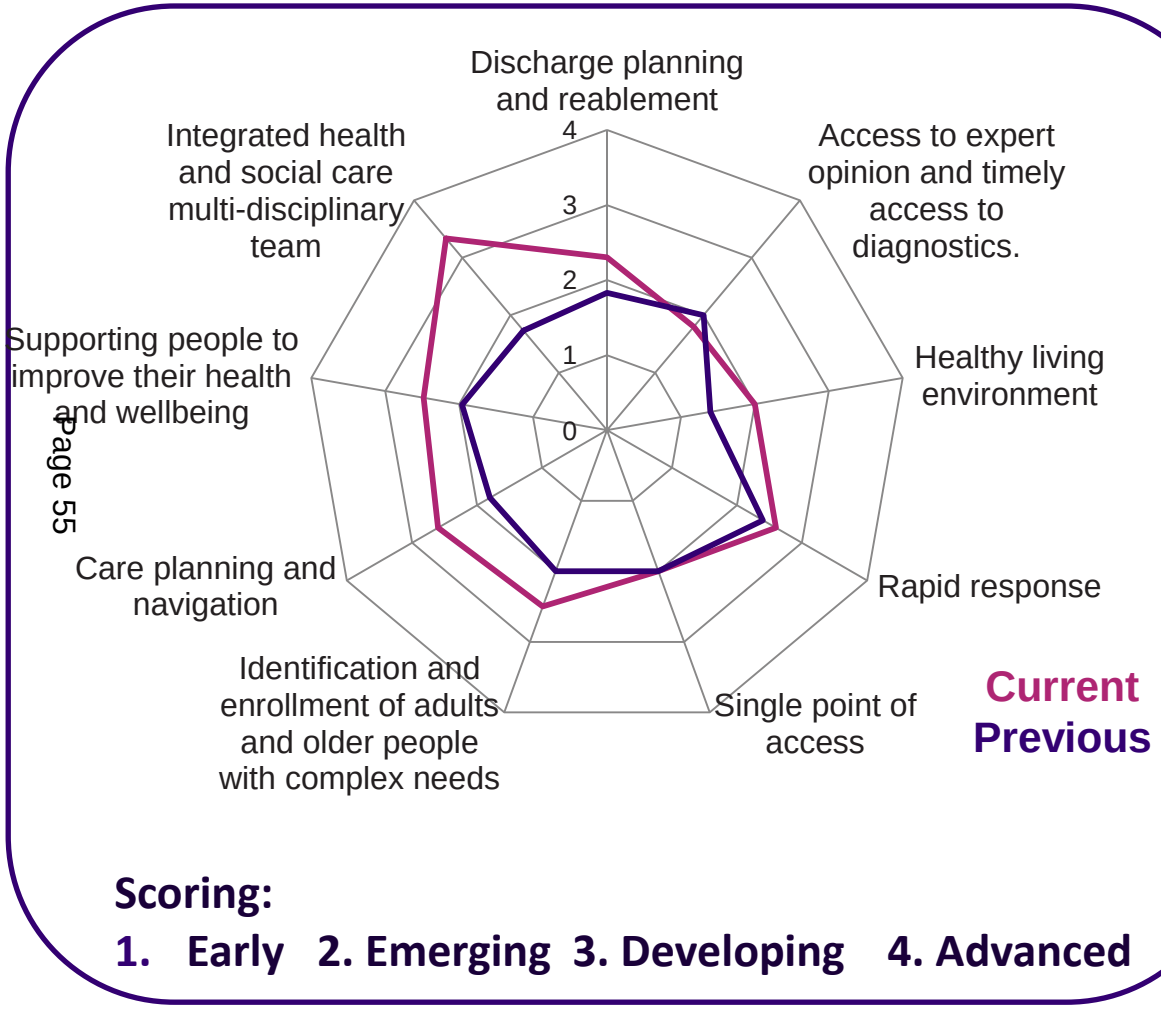
The 8 interventions for Dorothy – a reminder



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

Kent & Medway - Adoption of care model for frail elderly and other people with complex needs (2018/19 investment of £32m)



Scoring:

1. Early 2. Emerging 3. Developing 4. Advanced

***(Detailed evaluation results in appendix 2)**

Commentary:

- There is less variation between CCGs than previously.
- East Kent has pockets of greater maturity which have been hidden by combining the CCGs into one return (see next slide for explanation)

On the 4 point scale we remain at *emerging*.

*(**Note:** scoring system requires significant changes to move between levels and in some areas we may not want to progress to the highest score)*

Least mature domains are:

- Discharge and reablement
- Access to expert opinion
- Healthy living environment
- Single point of access

East Kent position

***Please note this assessment was at an amalgamated east Kent position which may at first glance look as if there has been less progress this year with implementation across this locality.**
This **is not the case** and can be explained as follows;

- The roll out of the model across in east Kent happened a different points with each CCG area focusing on different aspects of the model depending on local need (see below some examples below from other CCGs across east Kent).

- East Kent hosted **Encompass NHS Vanguard** developed the model for multi-disciplinary team working and integrated case management for frail and elderly, which is being adopted across all areas

- **Thanet Acute Response Team (ART**) - developed an integrated team which provides a range of clinical and personal care support for patients who have healthcare needs which previously would have been met by admission to Hospital. It is being used as the blue-print for services across east Kent

- **Ashford – have made improvements in Primary Care for End of Life planning;** enabling patients/relatives/carers and health professional to discuss advanced care plans

- **East Kent CCGs have been awarded Digital Accelerator status. This will include delivery on 3 unscheduled care initiatives –**
  - Digital First Primary Care – Hub and Spoke Model
  - Digital Enabled Acute Response Team linking in with Care Homes and Urgent Treatment Centres
  - Aligning with Digital Right Care Right Time

- **South Kent Coast – have built on the status of east Kent as a digital accelerator site;** SKC are using the Medical Interoperability Gateway **(MIG)** to support transferable patient data in real time, which supports the multi-disciplinary team in decision making.

MDT Activity Gap between planned numbers and potential cohort size

	Total population	*EK method	CF Tier 3	2019/20 Planned MDT volumes	2018/19 Actuals	2018/19
EK	712,423	12,220	9,831	12,703	c4,000	24% below planned activity
Medway	300,395	4,863	3,197	2,282	c130	As planned
DGS	270,809	3,429	3,876	1,872	Small numbers	
Swale	113,961	1,840	1,509	1,181	Small numbers	
WK	491,608	7,591	6,896	1,840	c1,000	22% below planned activity

EK Method
- All highest risk band
- Second risk band and 3 highest eFI bands
- Third risk band and highest eFI band
- Fourth risk band highest eFI band

Scaled up to whole population from those practices flowing to the KID

CF Method
- **Tier 3** = Age 70+ with dementia, Age 70+ with 3+ LTCs and at least two AE appearances/NEL admissions per year, End of life patients

***Cohort Modelling:**
- **West Kent using Whole Systems partnership**
- **East Kent using Ernst and Young**

Local Care Cohort Modelling, Investment and Return on Investment

This was discussed at the **STP Finance Group 3 May 2019** with the following recommendations;

- Needs to be more ambition around the **numbers going through the MDTs –** each CCG FD to take back
- Need for a **consistent approach to modelling** – east Kent using Ernst and Young, Medway and North west Kent using Whole Systems Partnership.
- Need for consistency of financial reporting for Local Care, investment and return on investment; greater emphasis on describing a K&M approach to 'shift and save' with financial planning transparency across Health and Social Care.

Agreement from the group:

Finance Director support for Local Care (Ivor Duffy, east Kent CCGs and Gordon Flack, KCHFT), to help review the above and provide a steer for colleagues across K&M.

Workshop planned for 10 June 2019.

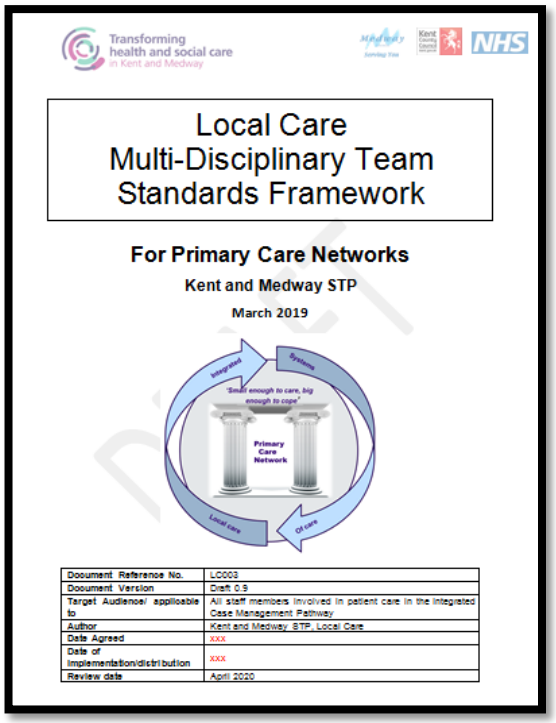
(This was endorsed by the Clinical and Professional Board 16 May 2019)

How are we ensuring consistency in quality and sharing of good practice?

Stakeholders across Kent and Medway have been involved in a bottom up approach to the development of a **Local care MDT Framework, for Primary Care Networks.**

21 indicators of effectiveness have been identified and refined by colleagues during the development process

(See appendix 3 for draft document – N.B. social care input still to be added)


Transforming health and social care in Kent and Medway

NHS

Local Care
Multi-Disciplinary Team
Standards Framework

For Primary Care Networks

Kent and Medway STP

March 2019

Document Reference No.	LC003
Document Version	Draft 0.9
Target Audience/ applicable to	All staff members involved in patient care in the integrated Case Management Pathway
Author	Kent and Medway STP, Local Care
Date Agreed	xxx
Date of implementation/distribution	xxx
Review date	April 2020


Transforming health and social care in Kent and Medway

Wednesday, 22 May
9.30am to 4.30pm
Great Danes Hotel, Maidstone ME17 1RE.

Save the date...

Kent and Medway
Learn and share conference
Small enough to care, big enough to cope

The Kent and Medway Sustainability and Transformation Partnership (STP) is supporting NHS and social care organisations to change and improve the services we provide to people across the county.

We are holding a conference for front-line NHS, care and volunteer colleagues, who are key to making this positive change happen, to learn and share best practice of how integrated care is working across Kent and Medway.

We will also update you on the development of primary care networks and how we are responding to the NHS Long Term Plan.

To book your place, email: designandlearningcentre@kent.gov.uk

Design and Learning Centre
Medway Serving You
NHS
Kent County Council

22 May – 'Learn and Share' Conference;

- over 40 health, care and voluntary sector organisations from across Kent and Medway attended
- 30 speakers, sharing success and learning across 13 different subject areas
- Panel Q&A with senior leaders across the system
- Focus on the NHS Long Term Plan and future direction of travel.

Appendix A. Full Version of LC system improvement priorities and the impact in 19/20

Local Care

The K& M 'Case for Change '(2016) revealed the need for better Local Care Services, identifying that;

- 30% of patients in acute hospital beds are better looked after in an alternative location of care
- 12% of admissions through A&E are avoidable through more consistent decision making at the front door, or better health and social care provision in the community
- 25% of community hospital patients would be better cared for at home or in a community setting.

Across K&M we have developed ,and agreed ,a consistent neighbourhood based, patient centred approach, to providing multi-disciplinary, cross organisational support for people with complex needs around Primary Care Networks (the 8 core elements of the model for those adults with complex needs).

Our sub-systems are at different stages of implementation, reflecting different starting places, for example in Whitstable the model is well advanced following the Encompass NHS Vanguard work, whereas North Kent are in the first stages of developing multi-disciplinary teams focused on high need groups.

Our delivery priorities during 19/20 are:

- For all areas to have fully functioning Multi-disciplinary teams (MDTs) supporting Primary Care Networks
- By 2020 to have developed models of care to deliver all 8 elements of the model (including rapid response, falls prevention, reactive discharge planning and reablement)
- To have increased the number of individuals with an integrated case management 'care plan'
- To have embedded the dementia pathway within the 'Dorothy Model'
- Begin working on an MDT **model for Children** with complex needs, adults with Learning Disabilities and Autism
- To ensure care navigation and social prescribing are embedded as part of the model and are being delivered at scale
- Build on the 2018/19 support offer for paid and unpaid carers, by expanding the development of the 'Help4Carers'App; facilitate events with key stakeholders to identify levels of support and links with care navigation / social prescribing, directory of services , training(stage 2-3 of development).
- ***Build on local care workforce actions already underway as part of the 19/20 deliverables identified in the STP Workforce Transformation Plan***

By the end of 19/20, we will:

- Reach the following volumes of adults with complex needs with multi-disciplinary team working:
  - For Medway: 2282.
  - For North Kent: 3,053
  - For West Kent: 1,840
  - For East Kent: 12,703
- Deliver the following outcomes for the above groups by end of 19/20:
  - Anticipatory care plans in place
  - A reduction in falling in frail adults
  - A reduction in A&E admissions associated with falls, UTIs, catheter related issues and from care homes
  - An increase in the uptake of social prescribing opportunities for high need groups
  - Increased numbers going home after admission
  - Reduction in admissions to long term care
  - Reduction in LOS
  - Reduction in non-elective admissions
  - Nos people still independent 90 days after they received reablement
  - Increase in dementia diagnosis rate
- Carers rate the Help4Cares app positively
- Agreed strategy for an MDT model for children with complex needs (linked to children's strategy)
- Begin to develop and MDT approach for adults with Learning Disabilities and Autism

Transforming health and social care in Kent and Medway

*Appendix B:
The section is for information only and contains the full evaluation results of the 'Maturity Matrix' re-run January 2019

Local Care Maturity Matrix

Second Run January 2019

Purpose of this document

This document summarises the results of the Local Care Maturity Matrix Survey which was completed in January 2019 by the CCG Local Care Leads.

The results of the Maturity Matrix serve two main purposes:

1 To support local areas in their ongoing implementation of Local Care

- The Maturity Matrix enables local areas to self- assess their current status on a number of key dimensions relating to the current maturity of Local Care models
- The results will inform local implementation planning

2 To enable the STP to obtain a helicopter view of the readiness and implementation status for Local Care

- This latter purpose will in turn support the central STP team to:
  - Develop packages of support and facilitation to local areas
  - Engage with NHS national bodies about the K&M journey for Local Care and its impact on the system's financial and operational performance

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Introduction to the Local Care Implementation Maturity Matrix

- The Maturity Matrix was originally run in the autumn of 2017.
- The domains and associated questions have been kept the same to enable comparison.
- The first run was intended to be run at cluster/hub (now PCN) level but there was very little variation within each CCG
- This run has been completed at CCG level and for the whole of East Kent
- Running at the East Kent level has led to a slightly conservative score as we have erred on the lowest scores within that area
- The initial focus of the STP has been the care model for Adults and Older People with Complex Needs, the survey concentrates on this group of people. However, as localities are making changes to services for other parts of the population, the survey includes the following sections for other population groups:
  - Urgent and elective care demand management for mostly healthy and those with LTCs who do not have complex needs
  - Other population groups
- The matrix allows local areas to self- assess current status on a number of dimensions relating to the current maturity of Local Care models

Introduction to the Local Care Maturity Matrix

Structure

The survey includes 54 questions grouped into six domains:

Adoption of local care models

1. Adults and older people with complex needs
2. Mostly healthy people, without complex needs
3. Other population groups (children with complex needs)

Maturity of enabling factors for local care

4. Level of joint working
5. Other enablers (e.g. workforce, estates etc.)

Impact

6. Adults and older people with complex needs

Scoring:

1. Early
2. Emerging
3. Developing
4. Advanced

The survey included 54 questions, grouped into the following six domains:

Domain	High level question	Mid-level question
1 **Adults and older people with complex needs - "Dorothy model"**	Adoption of care model	• Identification and enrollment of adults and older people • Care planning and navigation • Integrated health and social care multi-disciplinary team • Supporting people to improve their health and wellbeing • Healthy living environment • Single point of access • Rapid response • Discharge planning and reablement • Access to expert opinion and timely access to diagnostics
2 **Mostly healthy & those with LTCs but un-complex needs**	Adoption of care models	• Urgent care • Elective care
3 **Other population groups**	Adoption of care models	• Adults with a single long term condition (e.g. diabetes, COPD) • Children with complex conditions • Other population groups

The survey included 54 questions, grouped into the following six domains (cont.):

Domains	High level	Mid-level question
4 Joint working	Joint working	• Scale of primary care collaboration • Current extent to which health and social care organisations are working together
5 Maturity of the enabling factors	Enablers	• Leadership • Culture • Communications • Engagement • Governance and performance management • Workforce training and recruitment • Workforce/organisational development • Information/Digital • Process - clinical • Process - non-clinical • Money flow (commissioning, contracting and payment) • Estates
6 Impact	Impact of Care Model for Adults and Older People with Complex Needs	• Patient outcomes • Patient experience • Staff experience • Activity transformation

Table of contents

From the data collected so far we are drawing the following conclusions

- There is less variation between the CCGs' maturity
- Enablers remains the least developed domain
- The Adoption of the model for older people with complex needs model is the most mature domain but with areas of concern centred on:
  - Discharge and reablement
  - Access to expert opinion
  - Healthy living environment
  - Single point of access (work to be completed on what is meant by this)

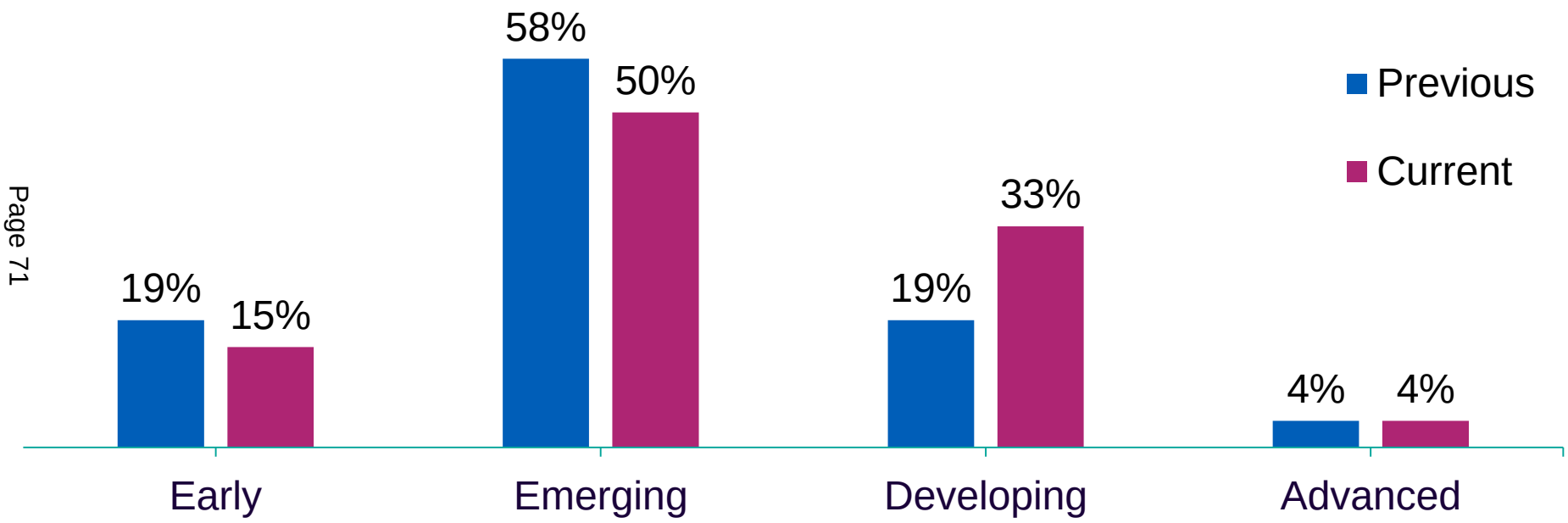
Overview of average scores by CCG

CCG	Previous score	Current score	Owner
West Kent	2.1	2.4	Rachel Parris
DGS	1.7	2.2	Debbie Stock
Swale	1.7	2.2	Debbie Stock
Medway	2.0	2.2	Tracy Rouse
East Kent	2.0	2.2	Oena Windibank

Commentary

- There is less variation between CCGs than previously.
- East Kent has pockets of greater maturity which have been hidden by combining the CCGs into one return

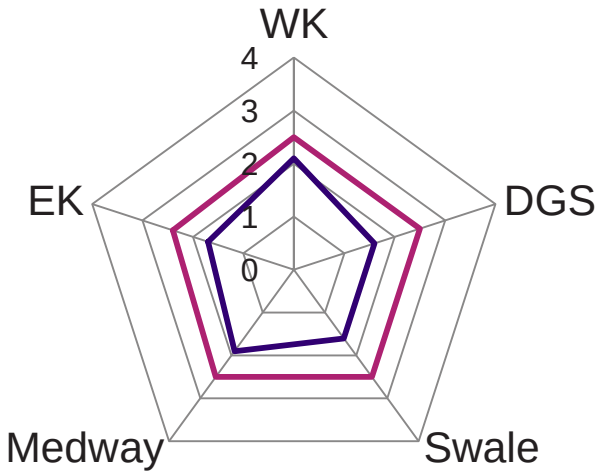
At Kent and Medway level, the average score for all questions domain is 2.2 up from 2.0 but remains *emerging*



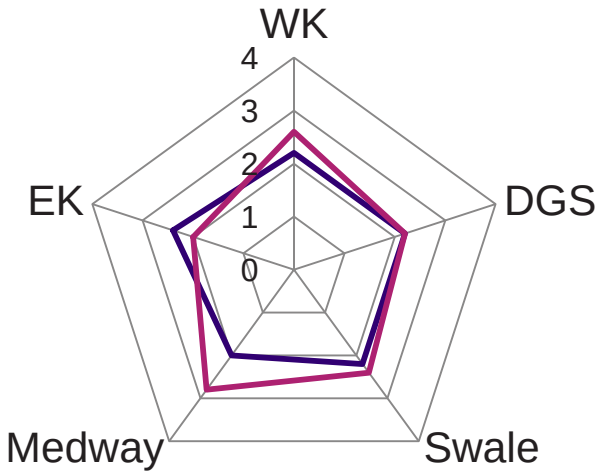
- *Emerging* is remains the most frequent score
- *Developing* is now the second most frequently chosen score

Domains by CCG - Adoption of the model

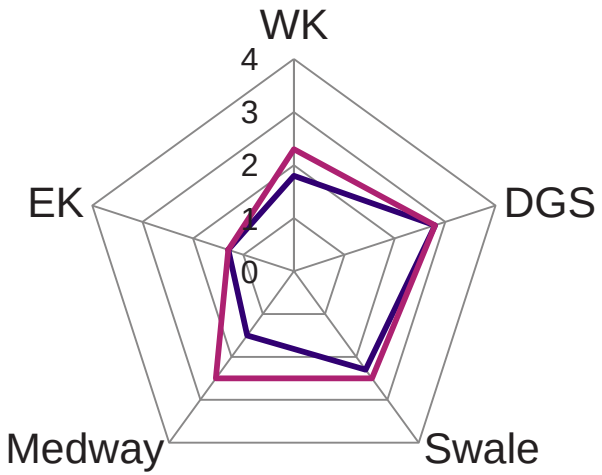
Eight interventions of the adults and older people with complex needs model



The mostly healthy and those with LTCs who do not have complex needs



Other population segments

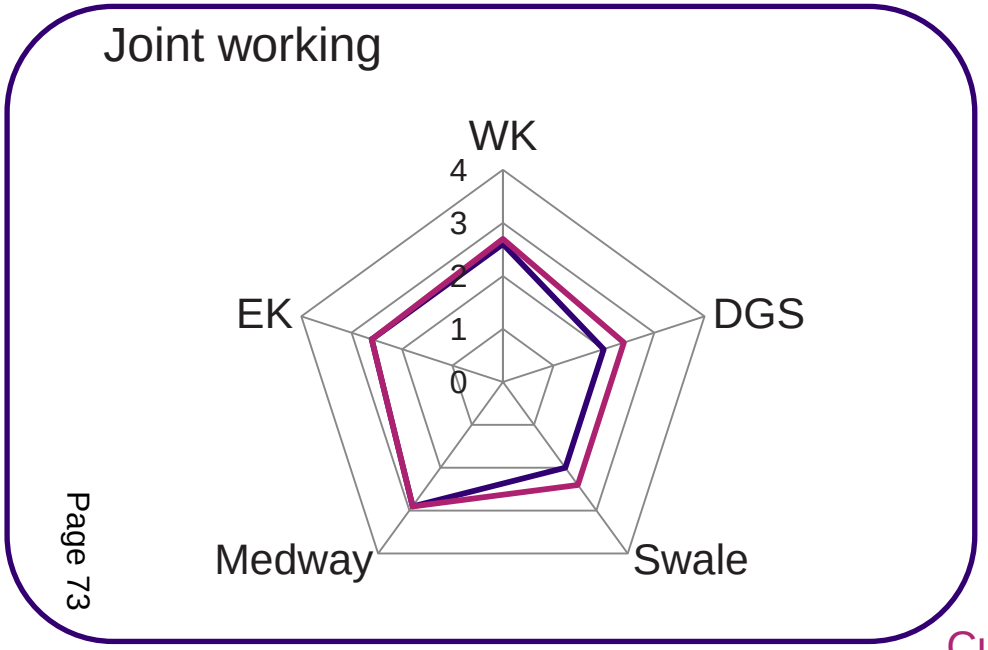


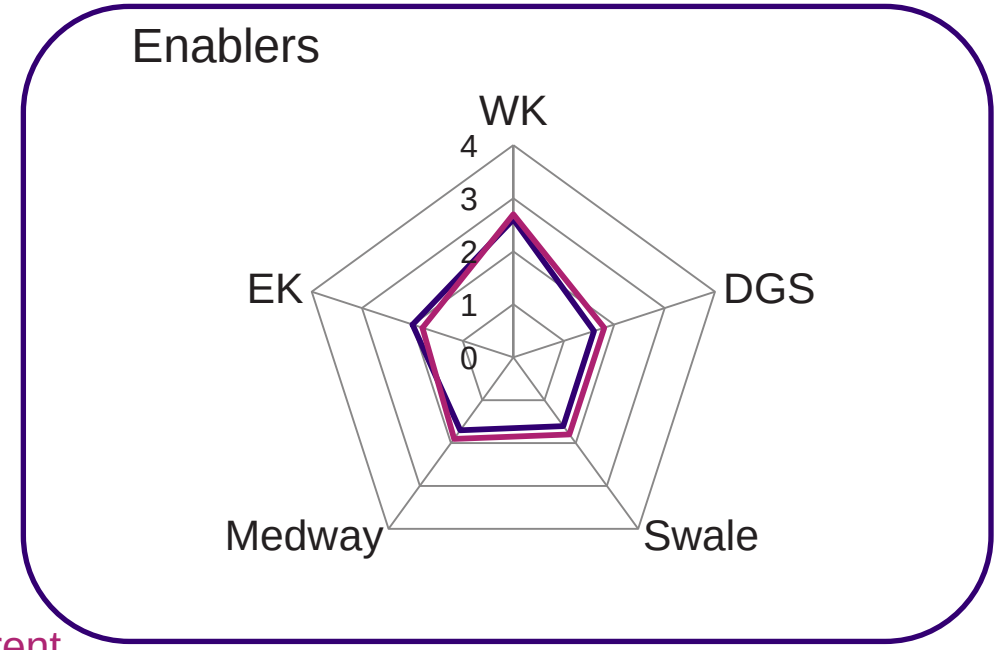
Current
Previous

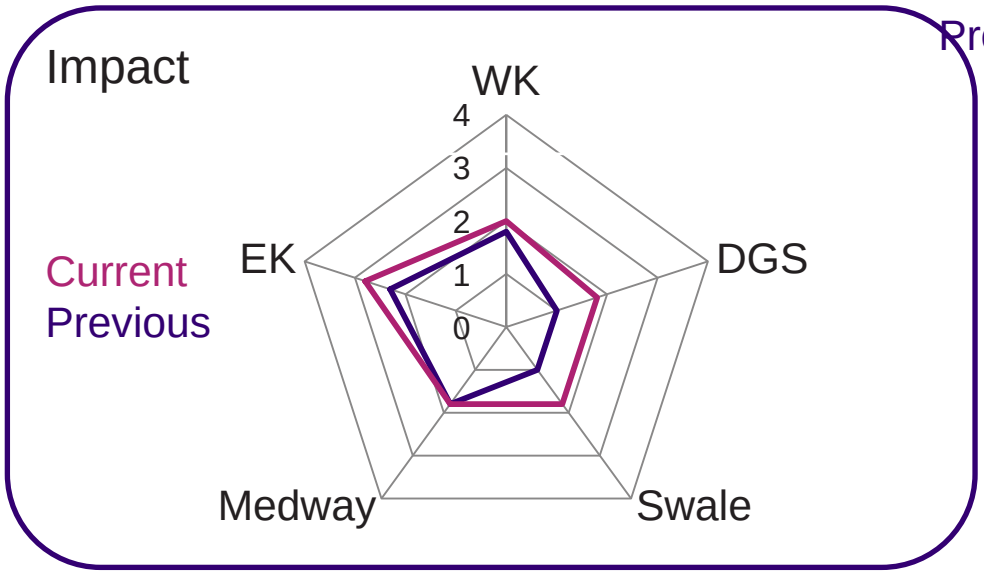
Commentary

- Most movement for those with complex needs reflecting current focus of local care
- Medway's scores reflect the targeting of a wider cohort than the frail elderly

Domains by CCG







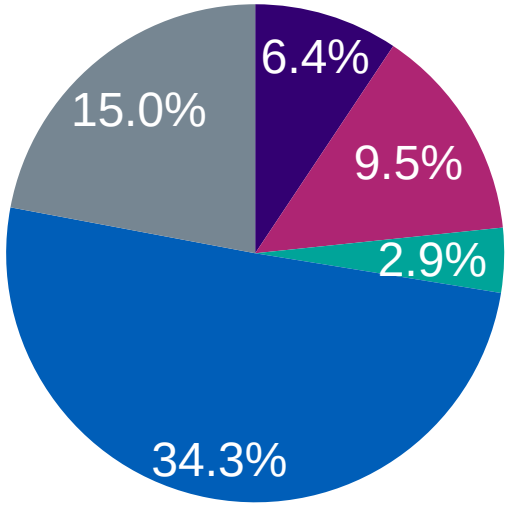
Current
Previous

Commentary

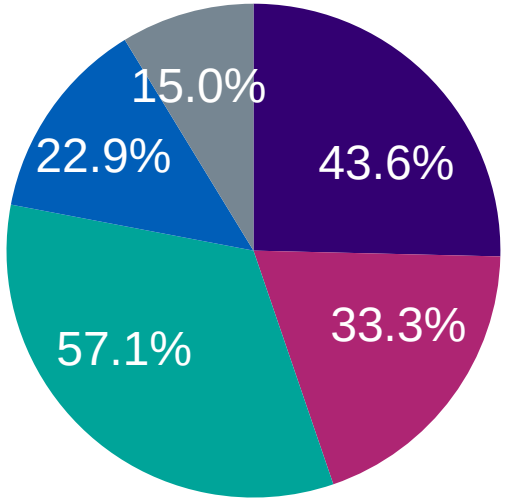
- Less movement in these domains
- Question: Is this leading to slower progress in the other domains?
- Development of the Local Care Delivery Framework will increase maturity in this domain

What are the most and least mature domains?

Scored as *Early*



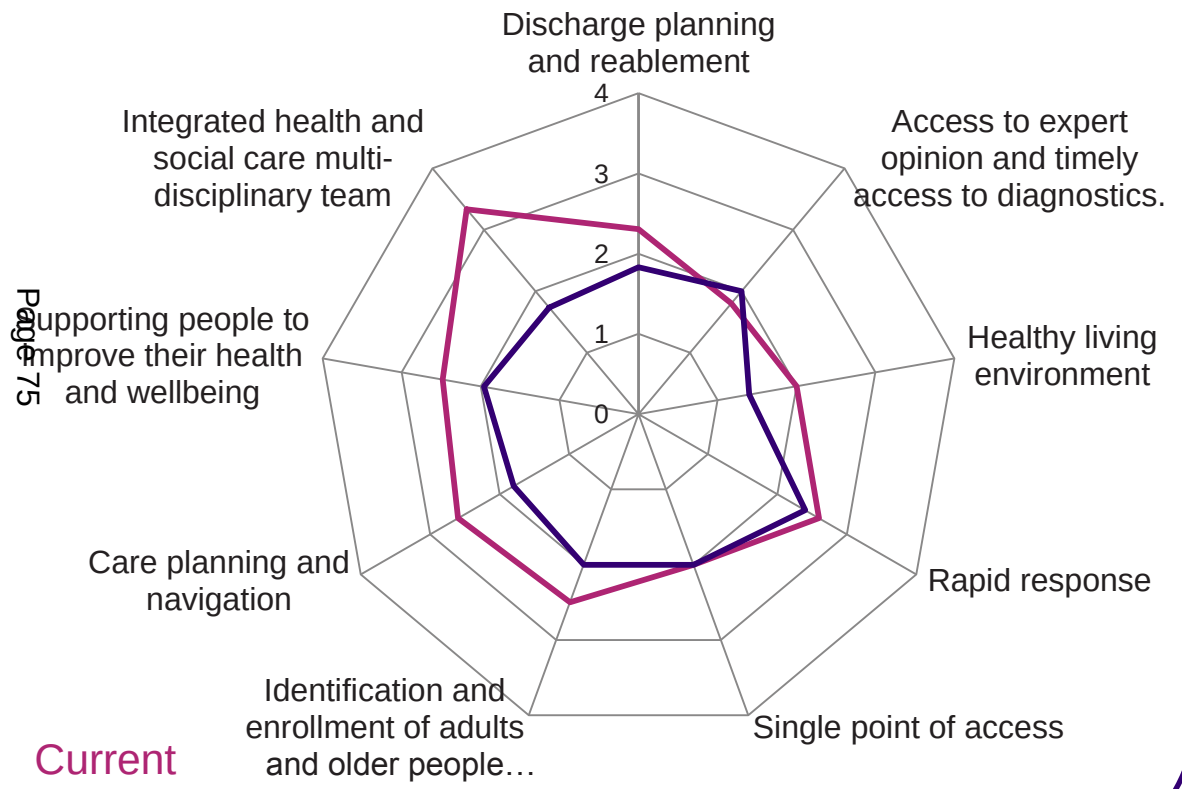
Scored as *Developing* or *Advanced*



Commentary

- The *Enablers* domain has been rated as the least mature
- The local care delivery framework will increase the maturity of the *Impact* domain
- *Scale* mostly covers the very basics of PCN groupings and so overstates readiness of this domain

Kent & Medway - Adoption of care model for frail elderly and other people with complex needs

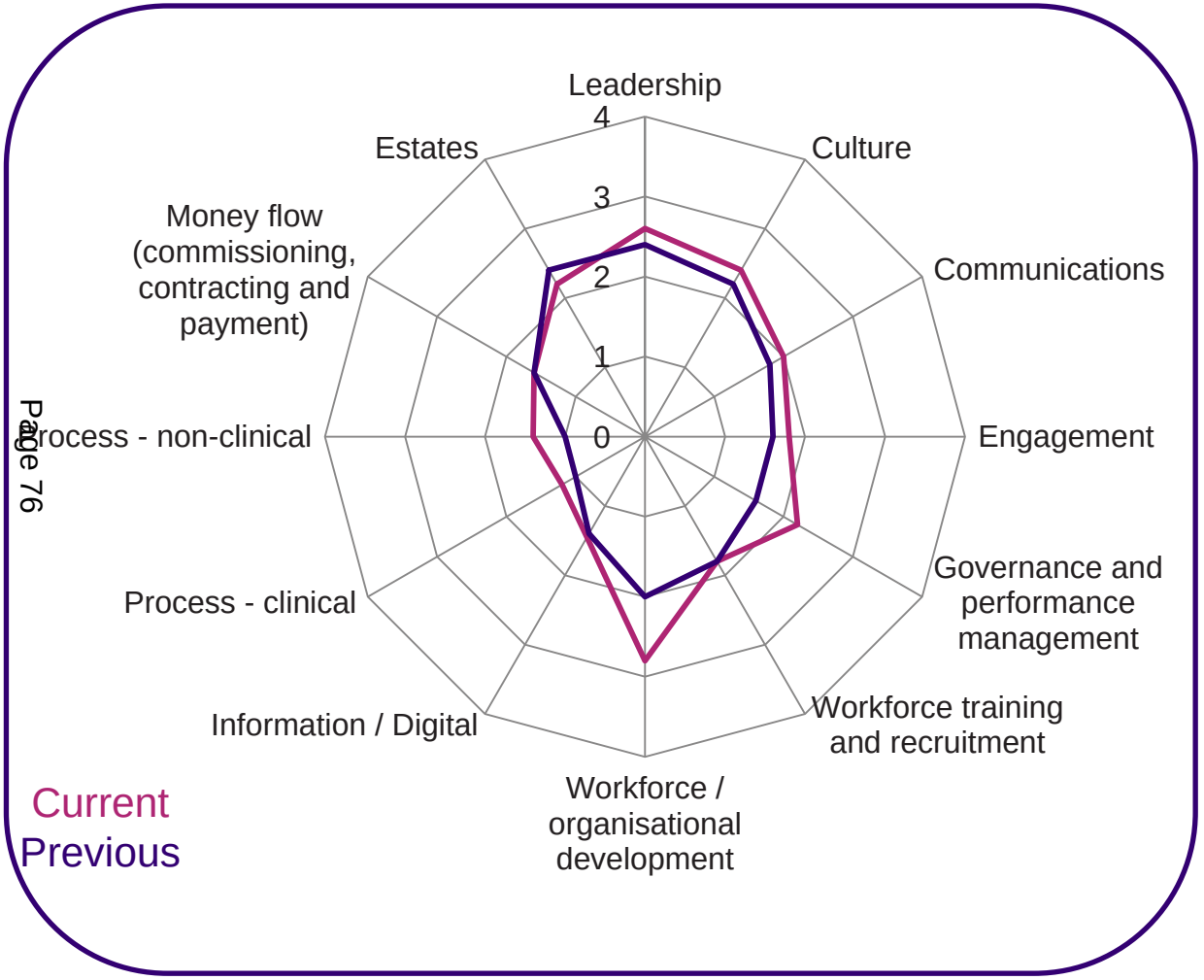


Commentary

Least mature domains are:

- Discharge and reablement
- Access to expert opinion
- Healthy living environment
- Single point of access

Enablers



Commentary

Least mature domains are:

- Information / Digital
- Process - clinical
- Process - non-clinical
- Communications
- Money flow (commissioning, contracting and payment)
- Engagement
- Workforce training and recruitment
- Estates

Lowest scores in the *enabling* domain by CCG

Enabler	CCGs scoring as *Early*	Number of CCGs
Information / Digital	All	5
Process - clinical	WK, DGS, Swale, Medway	4
Process - non-clinical	WK, Medway, EK	3
Communications	DGS, Swale, Medway	3
Money flow (commissioning, contracting and payment)	DGS, Swale, EK	3
Engagement	DGS, Swale	2
Workforce training and recruitment	WK	1
Estates	EK	1

Commentary

Digital comprises – information sharing, access to intranet, telecare/remote consultation.

Recommendations

The following areas are the least developed:

- Discharge planning and reablement
- Healthy living environment
- Access to expert opinion
- Data sharing/shared records
- Single point of access build on 111

Is the board content that these should be the areas of focus?

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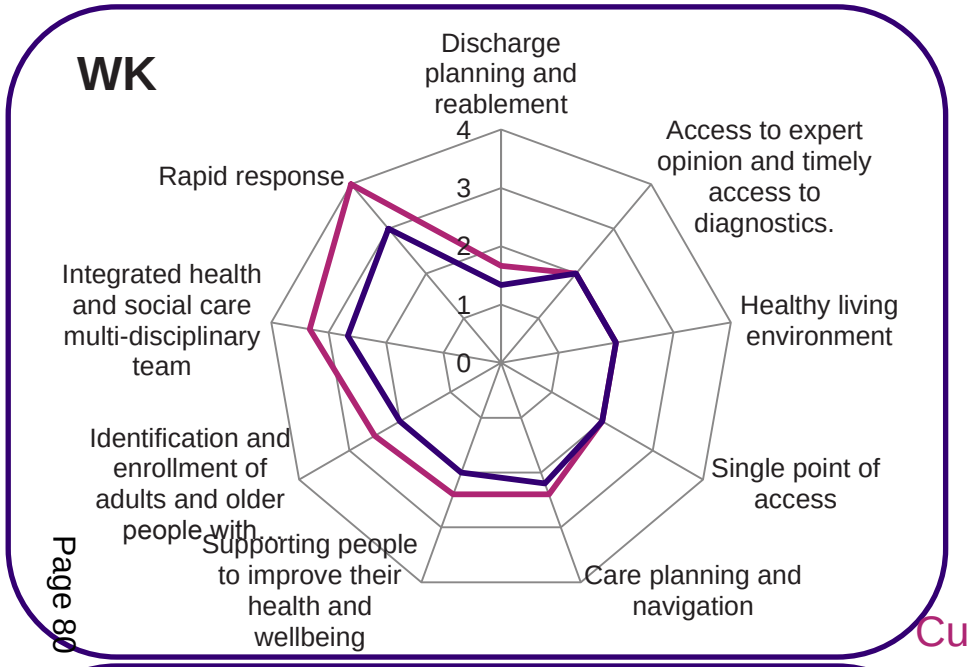
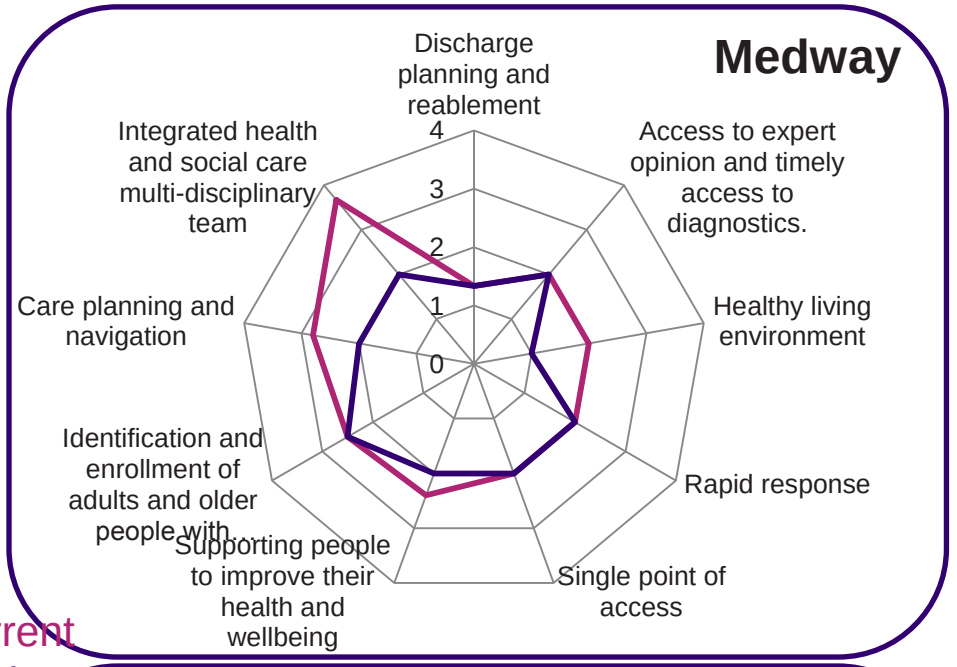
Adoption of eight interventions (Dorothy)





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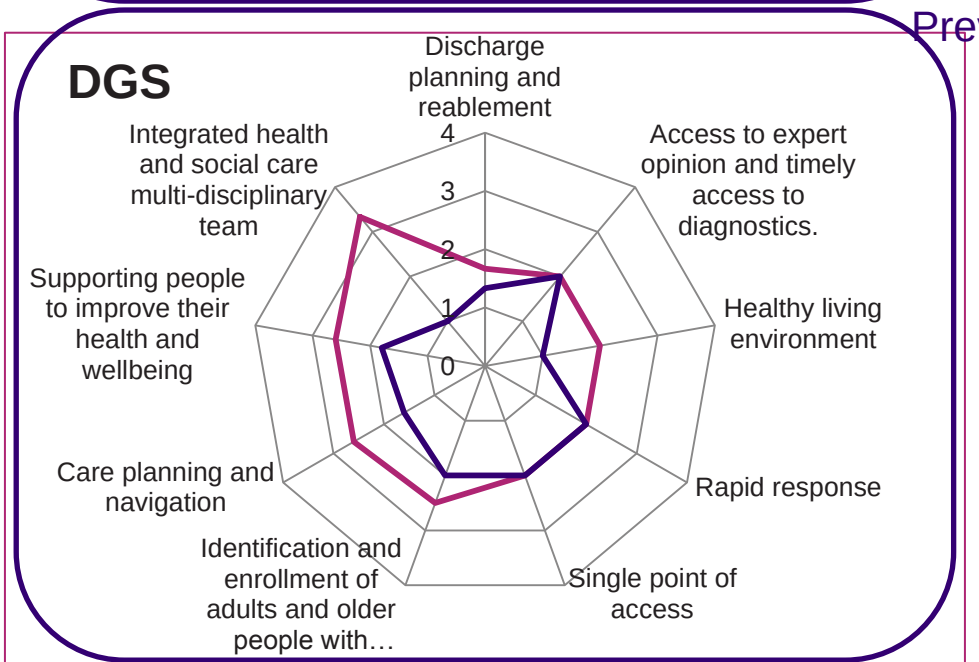
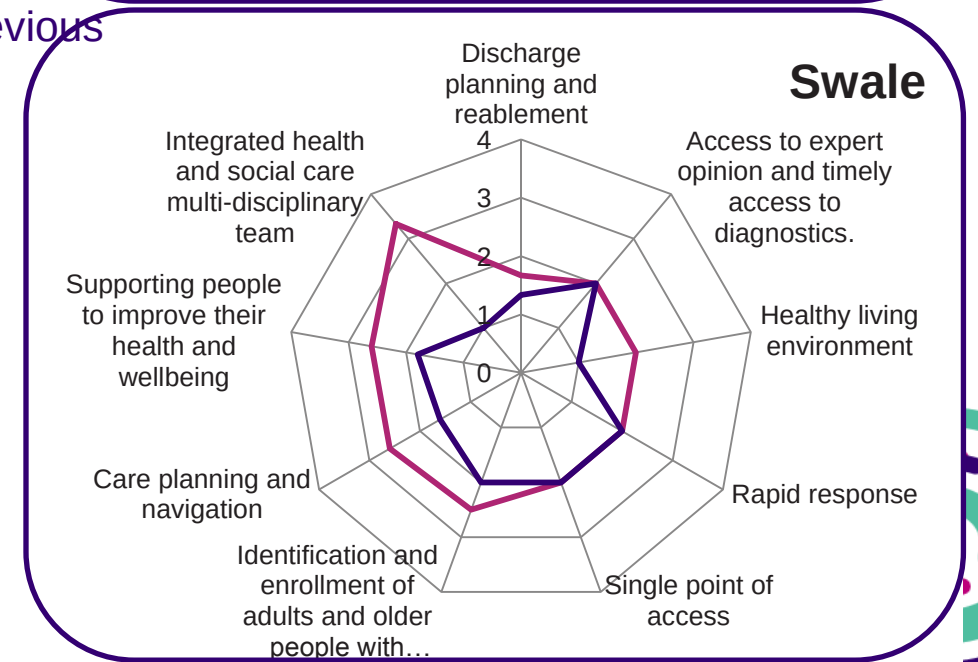
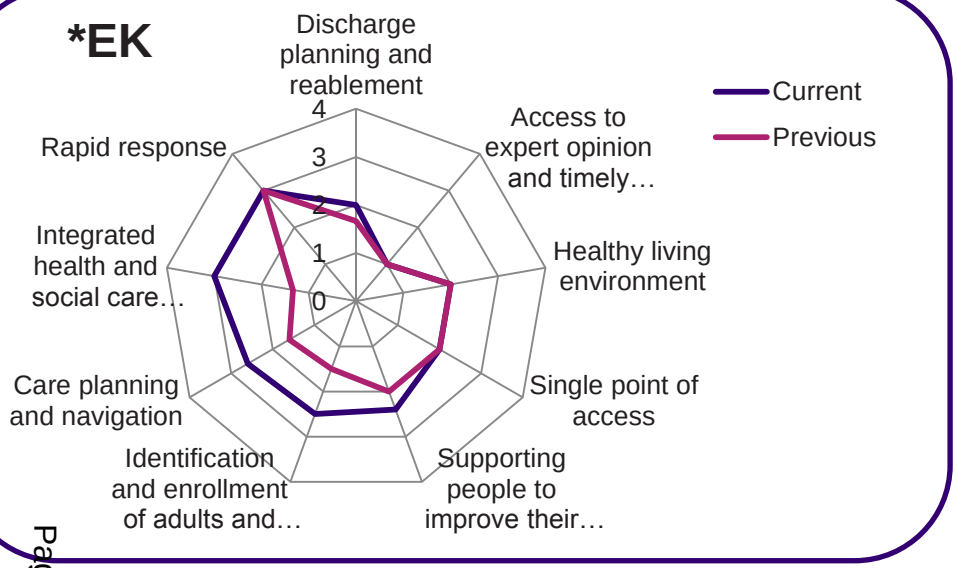




Adoption of eight interventions (Dorothy)



***Please note this assessment was at an amalgamated east Kent position which may at first glance look as if there has been less progress this year with implementation across this locality.**

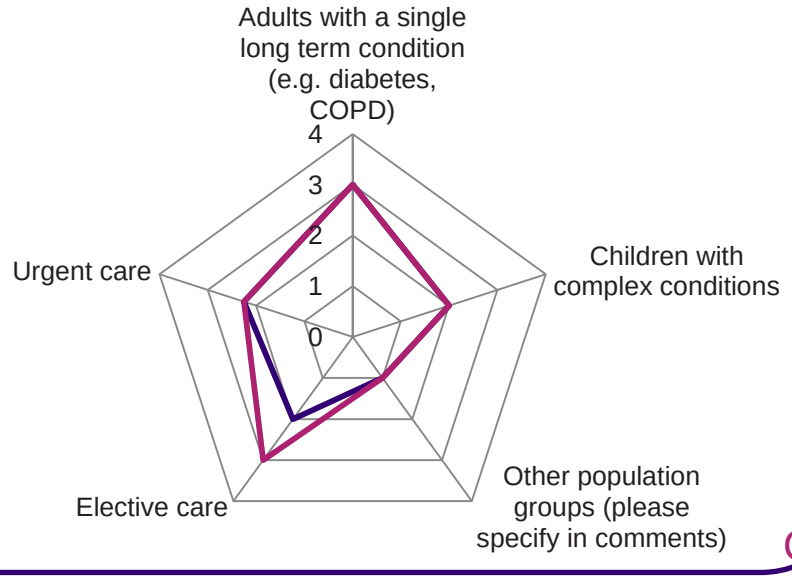
This **is not the case** and can be explained as follows;

- The roll out of the model across in east Kent happened a different points with each CCG area focusing on different aspects of the model depending on local need (see below some examples below from other CCGs across east Kent).

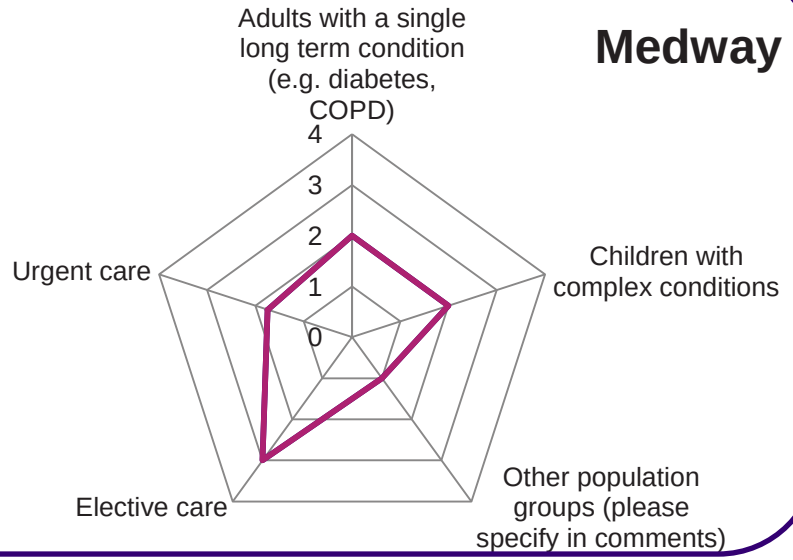
- East Kent hosted **Encompass NHS Vanguard** developed the model for multi-disciplinary team working and integrated case management for frail and elderly, which is being adopted across all areas
- **Thanet Acute Response Team (ART**) - developed an integrated team which provides a range of clinical and personal care support for patients who have healthcare needs which previously would have been met by admission to Hospital. It is being used as the blue-print for services across east Kent
- **Ashford – have made improvements in Primary Care for End of Life planning;** enabling patients/relatives/carers and health professional to discuss advanced care plans
- **East Kent CCGs have been awarded Digital Accelerator status and will deliver on 3 unscheduled care initiatives**
  - Digital First Primary Care – Hub and Spoke Model
  - Digital Enabled Acute Response Team linking in with Care Homes and Urgent Treatment Centres
  - Aligning with Digital Right Care Right Time
- **South Kent Coast – have built on the status of east Kent as a digital accelerator site;** SKC are using the Medical Interoperability Gateway **(MIG)** to support transferable patient data in real time, which supports the multi-disciplinary team in decision making.

Adoption of local care models for those who are mostly healthy/without complex needs and other groups

WK



Medway



Current
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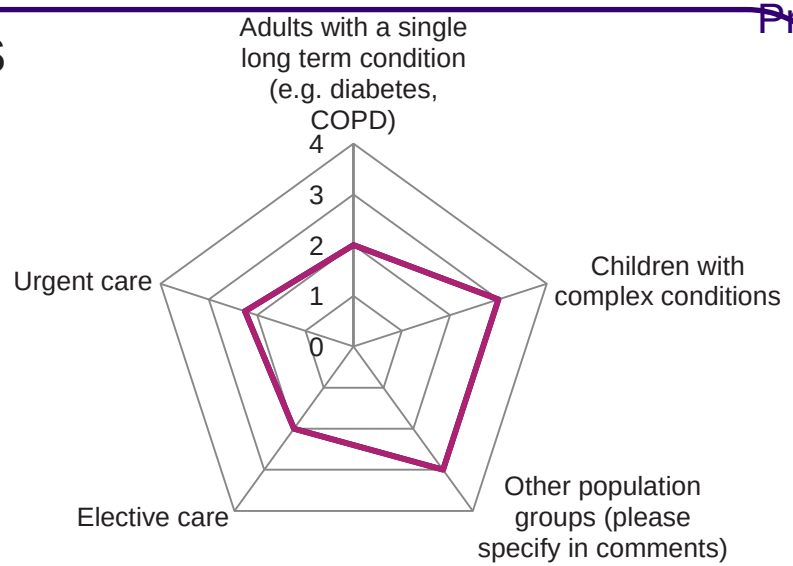
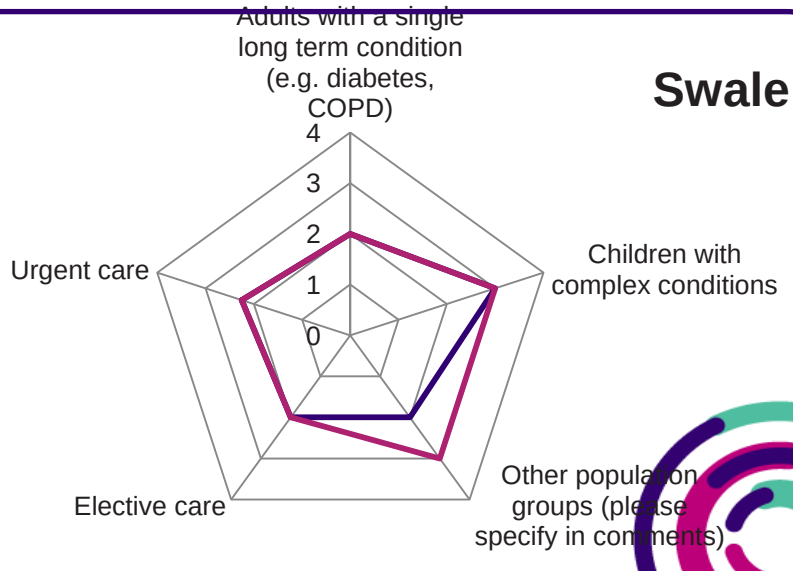
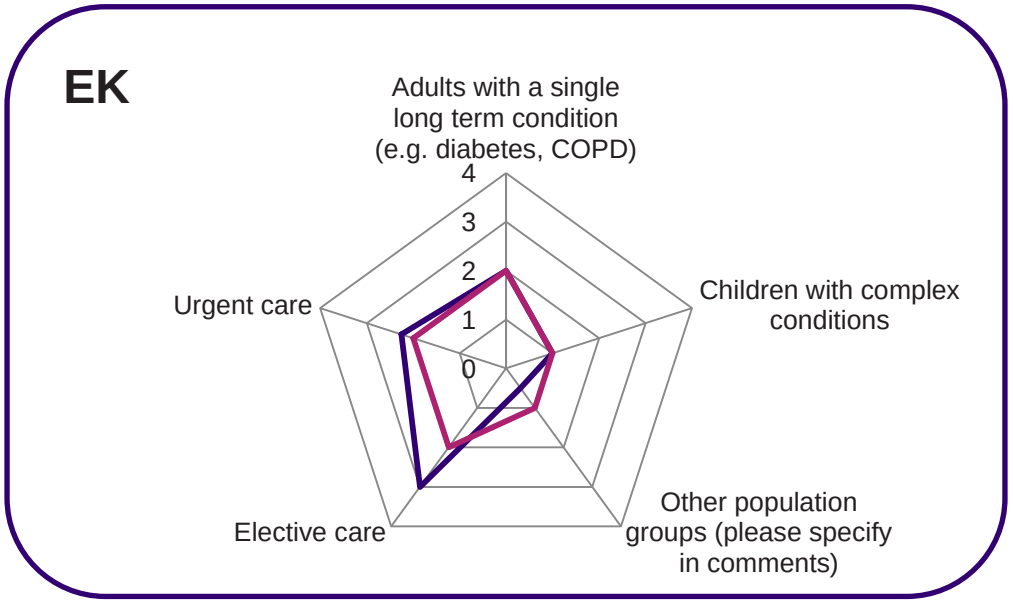
DGS



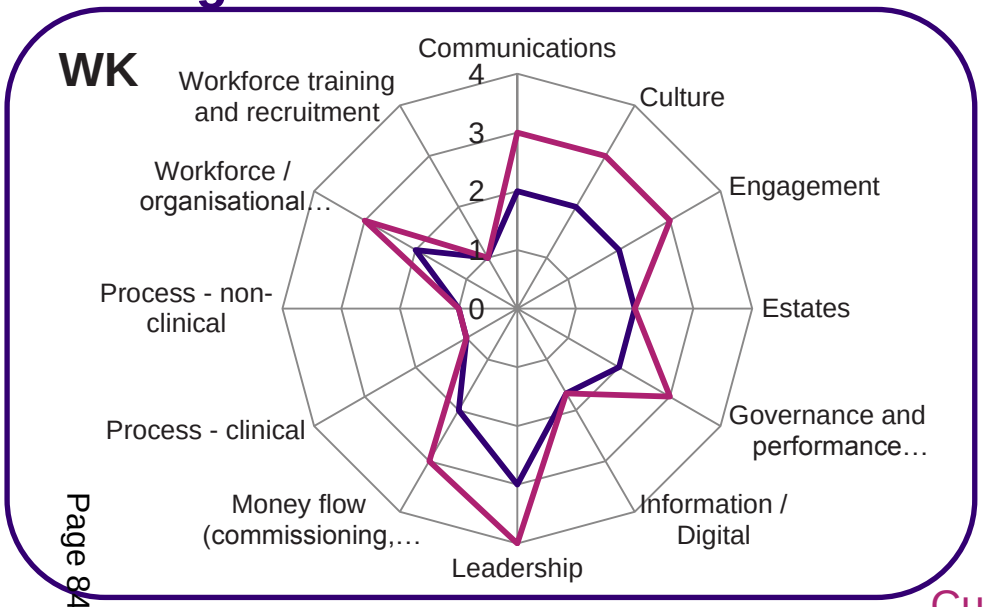
Swale

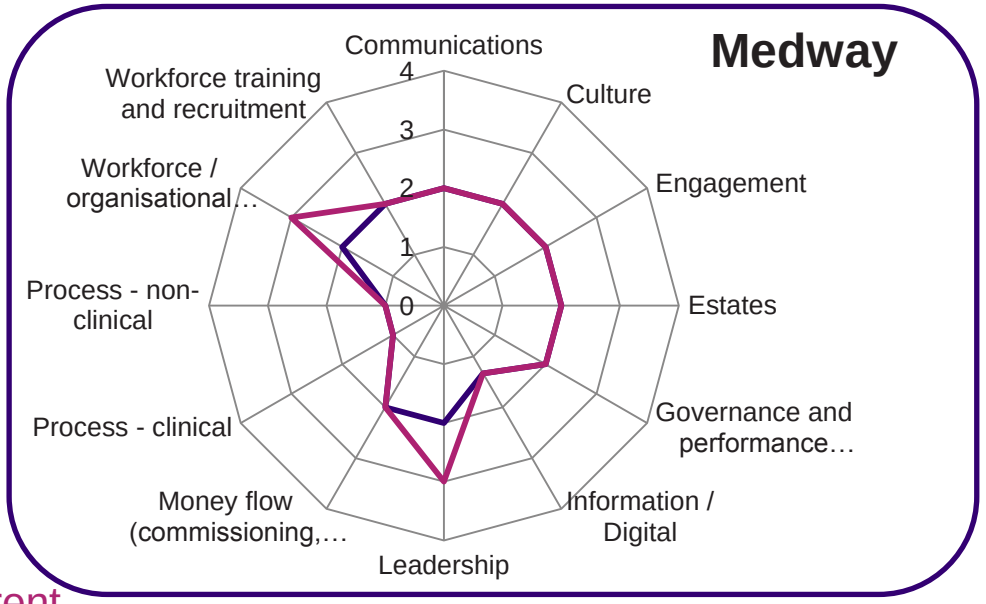


Adoption of local care models for those who are mostly healthy/without complex needs and other groups



Enabling





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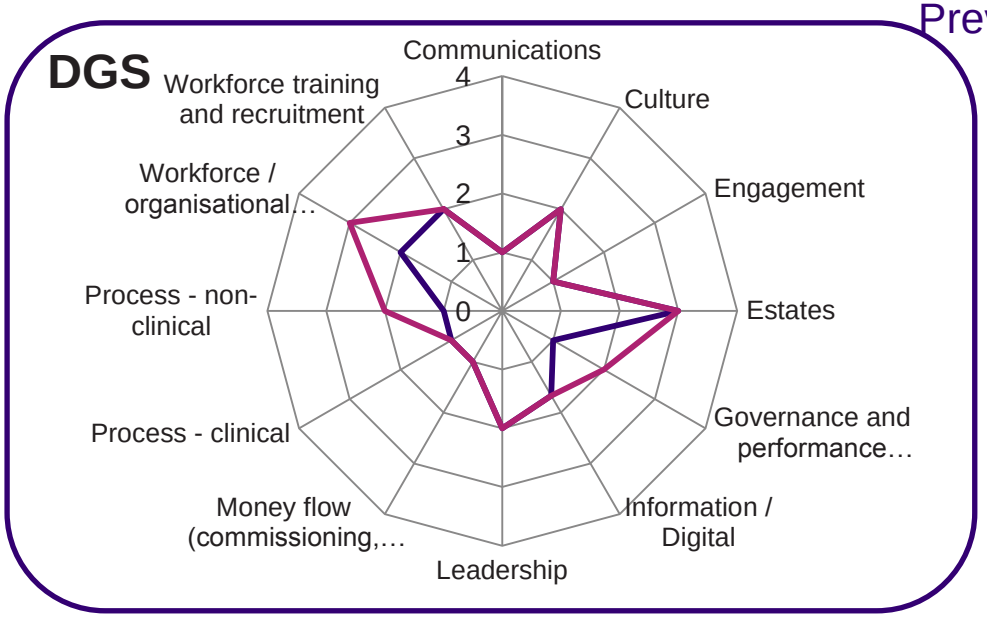
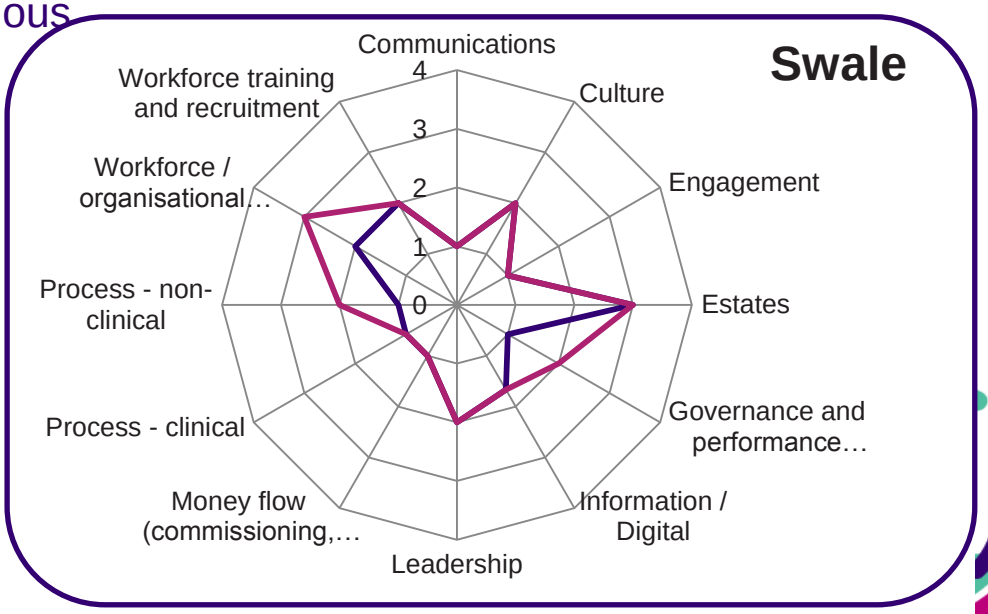
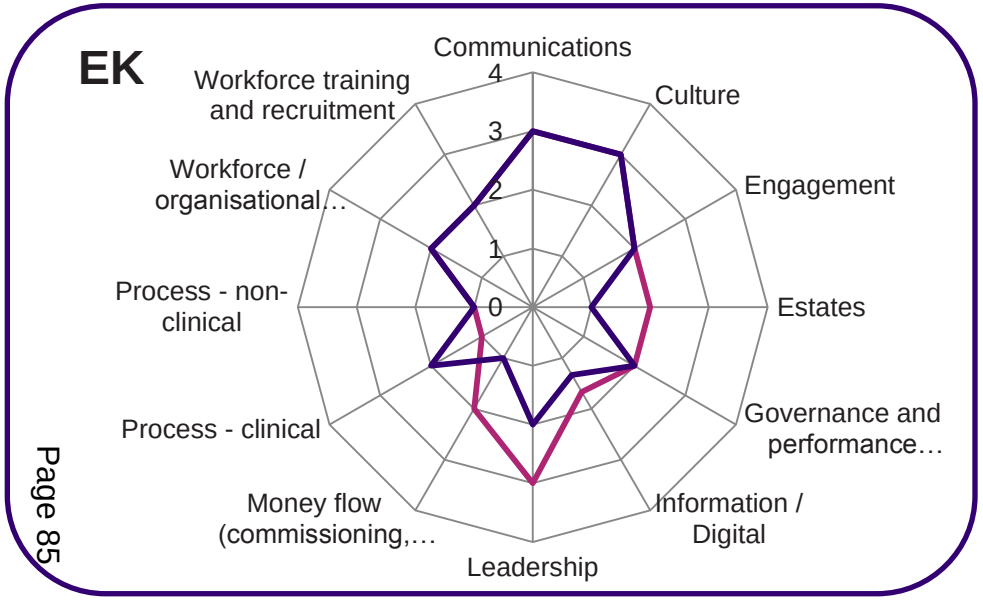




Enabling

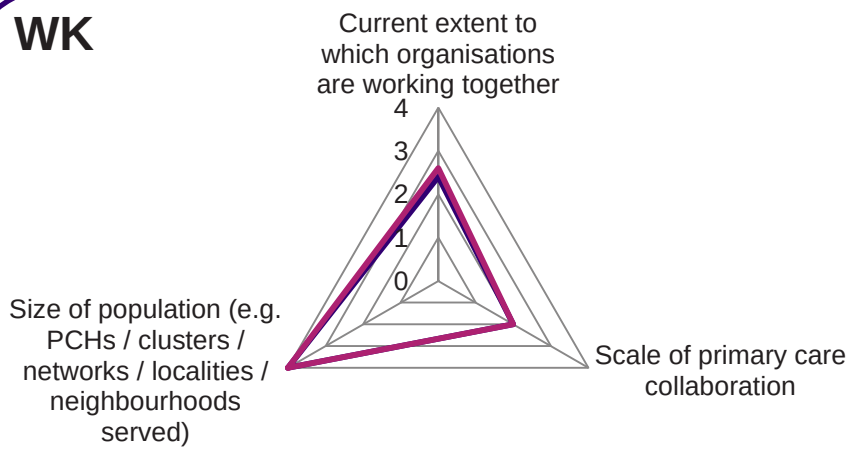


Commentary - EK

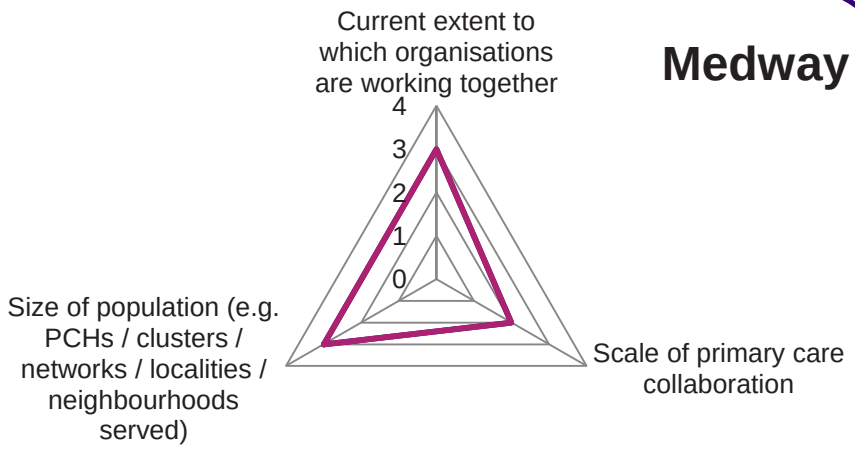
- As mentioned in slide 31 - taking the lowest score for EK CCGs has led to a reduction in some scores

Joint working (Scale)

WK



Medway



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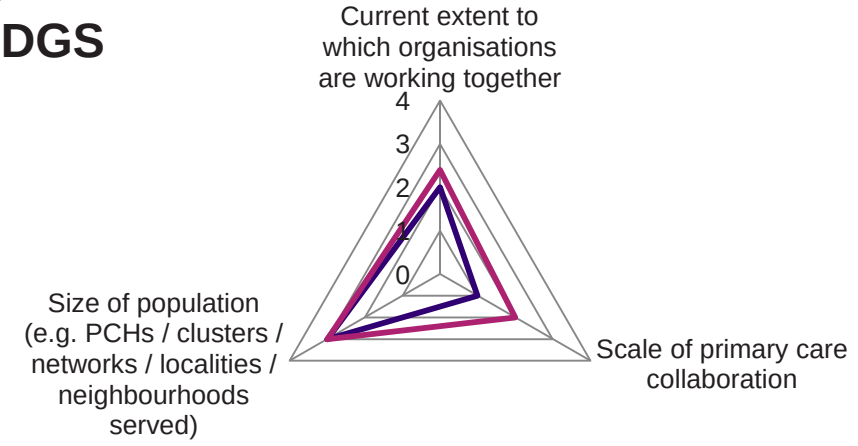
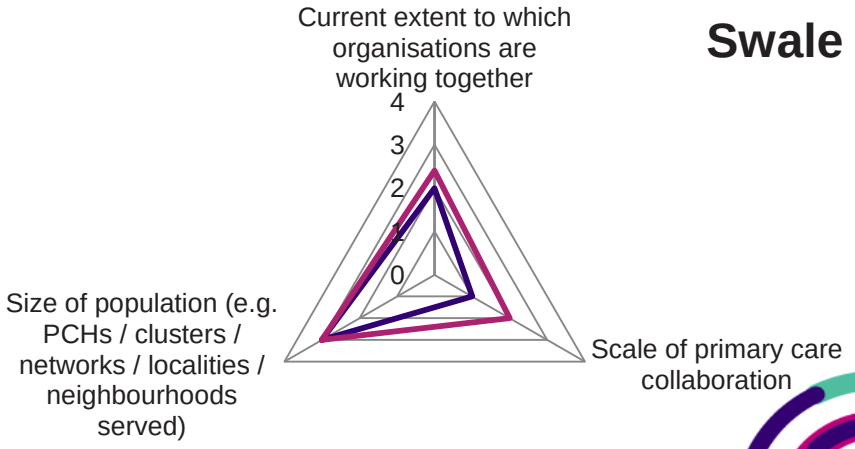
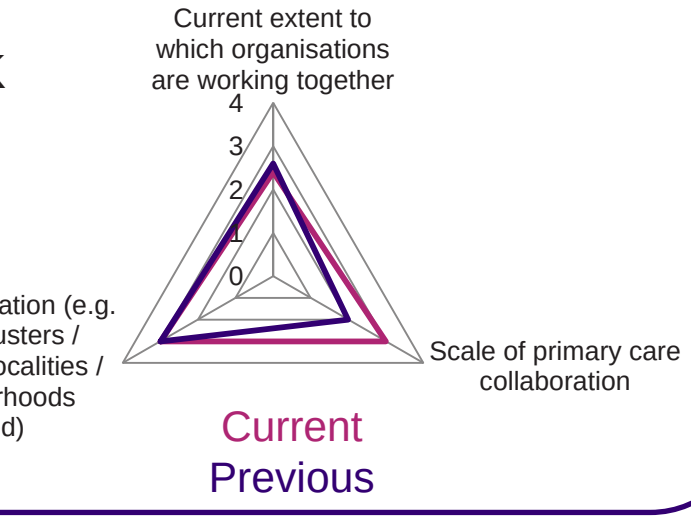


Swale



Joint working (Scale)

EK



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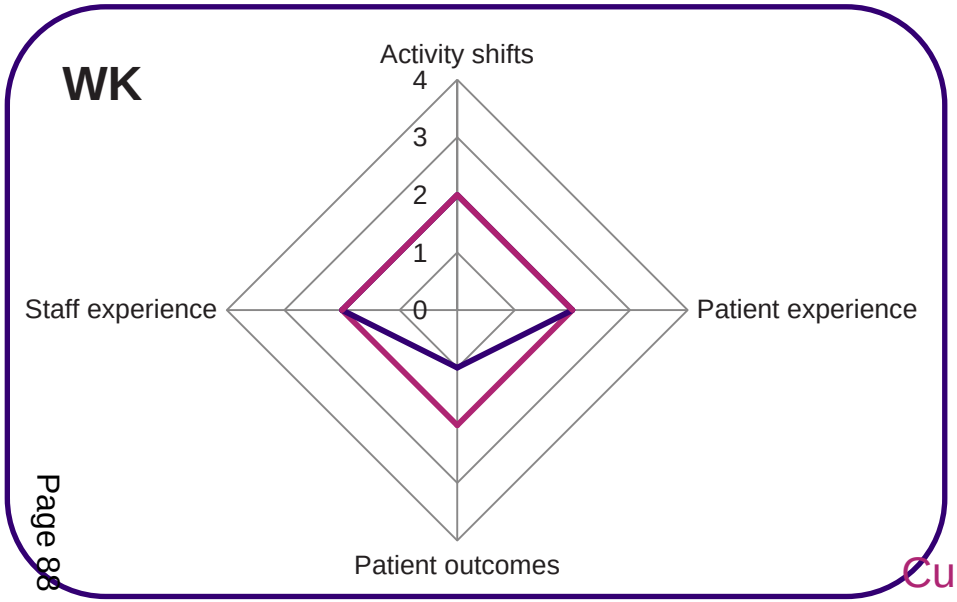

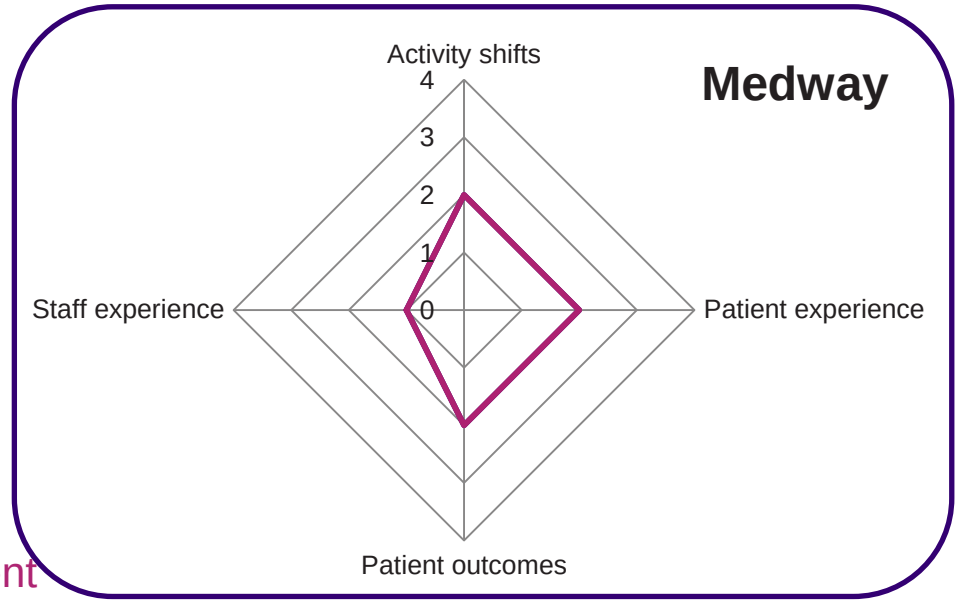

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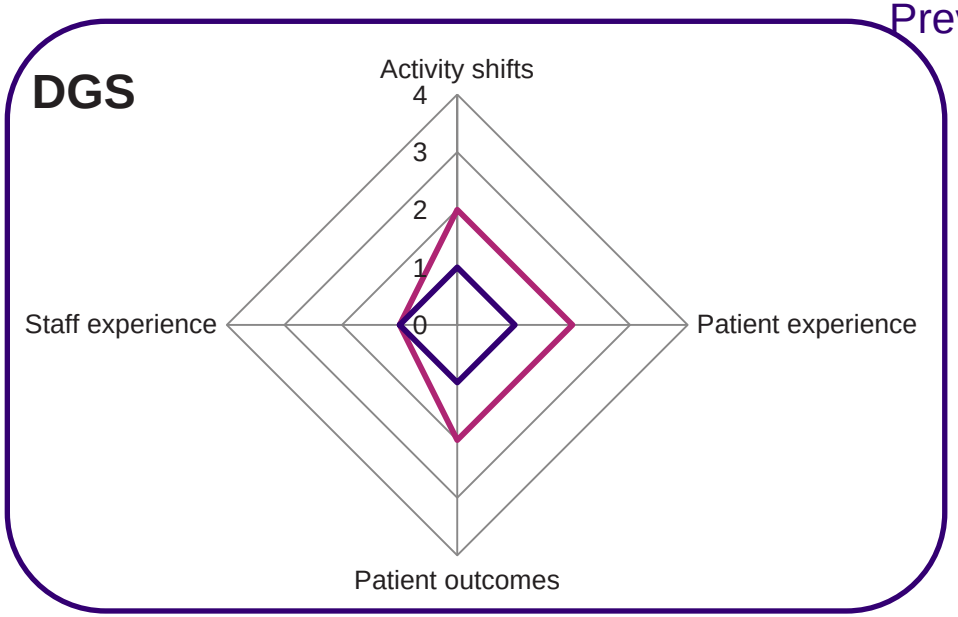

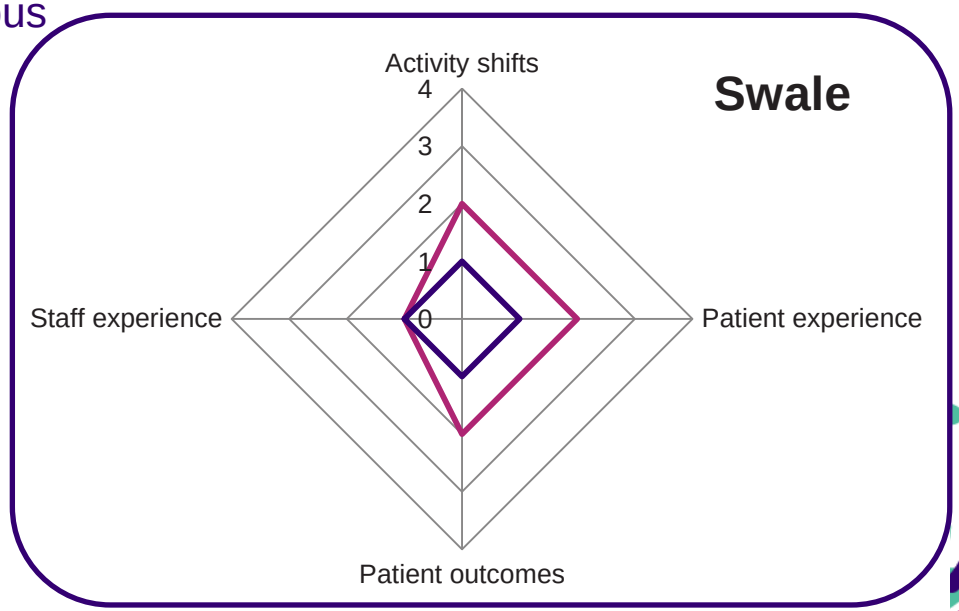

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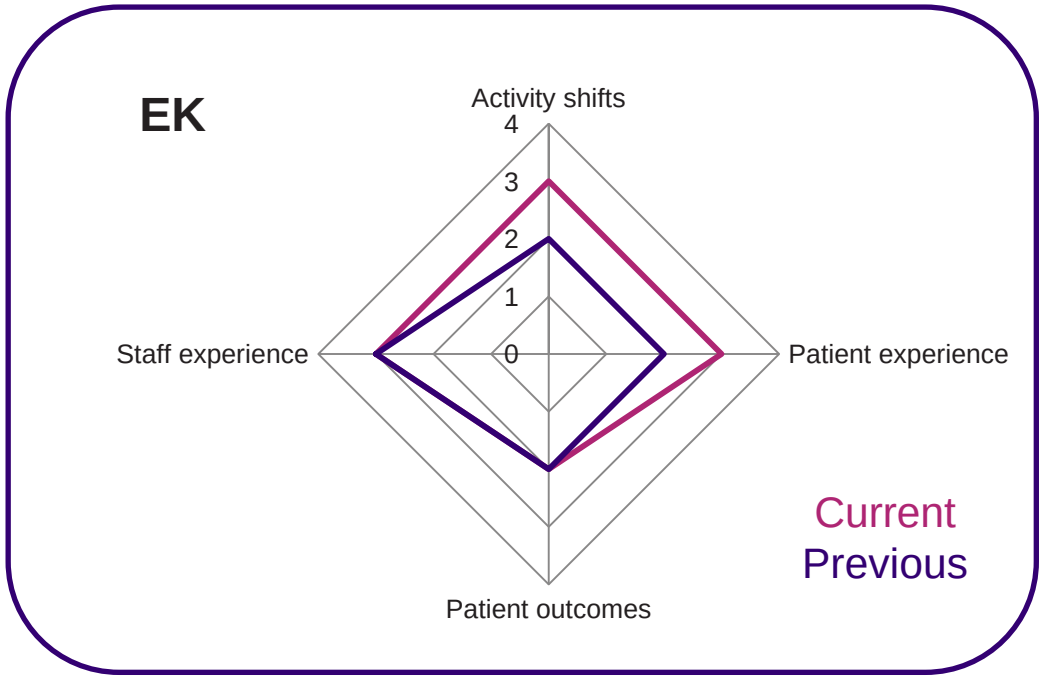
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Activity shifts
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Staff experience
Patient experience
Patient outcomes
Current
Previous

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Transforming health and social care in Kent and Medway

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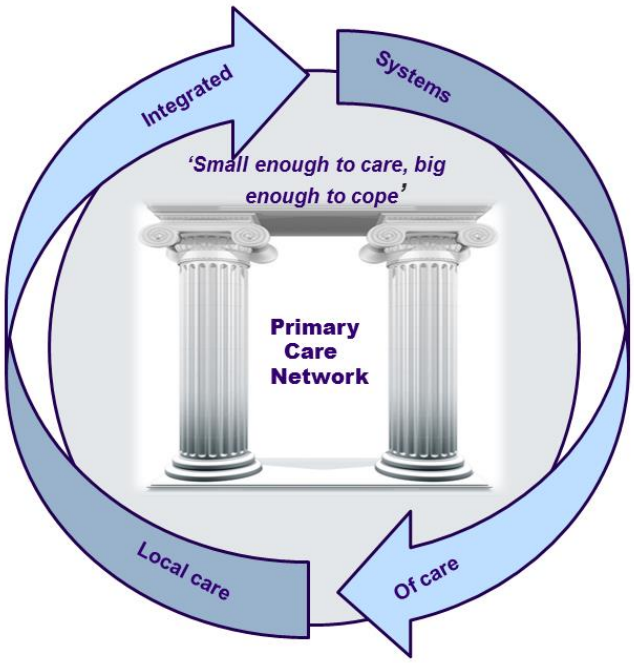
Appendix C

Local Care Multi-Disciplinary Team Framework

For Primary Care Networks

Kent and Medway STP

March 2019



Document Reference No.	LC003
Document Version	Draft V0.10
Target Audience/ applicable to	All staff members involved in patient care in the Integrated Case Management Pathway
Author	Kent and Medway STP, Local Care
Date Agreed	xxx
Date of Implementation/distribution	xxx
Review date	April 2020

Across Kent and Medway Groups of GP practices are coming together in partnership with community services, social care and other providers of health and care services, typically servicing populations of 30-50,000 as multi-disciplinary teams. These Primary Care Networks, (PCNs), provide a platform for providers of care to be sustainable in the future -

"Small enough to Care, and Big enough to cope"

The following document has been co-designed with partners across Kent and Medway and provides a framework for the PCNs which provide consistency of practice yet allows for variation locally.

Related Documents

Title	Reference
MDT Top Tips	LC002

Document Tracking Sheet

Version	Status	Date	Issued to/approved by	Comments / summary of changes
1.0	Finalised			

1. Background

1.1 Scoping workshop

The Kent and Medway Sustainability and Transformation Partnership (STP) were asked to support a scoping workshop with East Kent Clinical Commissioning Groups (CCGs) to explore content ideas for an MDT standards document. It was suggested an MDT framework would be helpful and would give structure to MDT meetings, a place to start and then adapt locally. The presentation for the workshop is embedded below. The main items discussed were collated into a first draft document and circulated to the group for comment.

Presentation developed by Cathy Bellman	Develop Draft Outline 4 MDT 11 01

2. Engagement

The draft MDT framework was circulated to colleagues across Kent and Medway for comment. The feedback has been really valuable in helping to develop and shape the framework.

2.1 Engagement tracking sheet

Version	Status	Date	Comments
V0	Workshop	11/01/19	Initial scoping workshop held with East Kent.
V0.1	Draft	06/02/19	Circulated to Local Care Lead for comment. Change made.
V0.2	Draft	11/02/19	Circulated to East Kent CCG Scoping workshop members for comment.
V0.3	Draft	19/02/19	East Kent Scoping workshop members feedback and comments included.
V0.4	Draft	28/02/19	Local Care Lead additional comments included following feedback from Medway LC Steering Group.
V0.5	Draft	14/03/19	Circulated to Local Care Leads, LMC and GP Federation Local Care Board Members for comment.
V0.5	Draft	22/03/19	Discussed at the Local Care Directors Meeting.
V0.5	Draft	26/03/19	Discussed with the Leader of Kent County Council. Check list added.
V0.6	Draft	26/03/19	Local Care Lead additional check list items following feedback from Medway LC Steering Group.
V0.7	Draft	08/04/19	Addition by Local care Lead, aligning to Primary Care Network (PCN) Development. Amendments to Federations and Organisational Development from STP Primary Care Lead to align to PCNs
V0.8	Draft	11/04/19	Feedback from Medway Clinical Lead for Mental Health. Amendments to: Leadership, defining the core membership including adding diagram, output and items to record in the care plan, referrals, criteria for patient identification, and ensuring the triage is by a clinical member of the MDT.
V0.9	Draft	12/04/19	Feedback from Medway CCG. Amendment to Practice MDT/Cluster MDT, consolidated throughput and quality, added effectiveness of meetings impacted by frequency, meeting themes are occasional, facilities of location added, clear about who has overall responsibility.
V0.10	Draft	17/04/19	Feedback from Virgin Care, DGS and Swale CCG. Amended Co-ordinator role to say some are trained as trusted assessor as not in all CCGs, Referrals made in consistent way-such as SBAR-as not all areas use SBAR, query about who will triage-addressed in v0.8, suggested that checklist is added into referral form, Federation amendments made in v0.7, meeting themes amendments made in 0.9.
		16/05/19	Social Care Older People & Physical Disability Senior Management Team Meeting. (Awaiting additions. Comments in red font to be elaborated and included in next version)
		28/05/19	Comments to be added from Health, Housing and Social Care Sub-Group meeting

3. MDT Framework Indicators

Twenty one indicators of effectiveness have been identified and refined by colleagues during the development process of this document to produce an MDT Framework for Kent and Medway. This will remain a live document and will continue to be refined as MDTs develop and processes evolve.

3.1 Involvement of patient / carers

Teams need to be aware of the 'Top Tips' for MDT working which supports this **MDT Framework** to ensure that patients / carers are at the heart of any decision making process.

MDT Top Tips:	Top tips for MDT working v5.4.docx

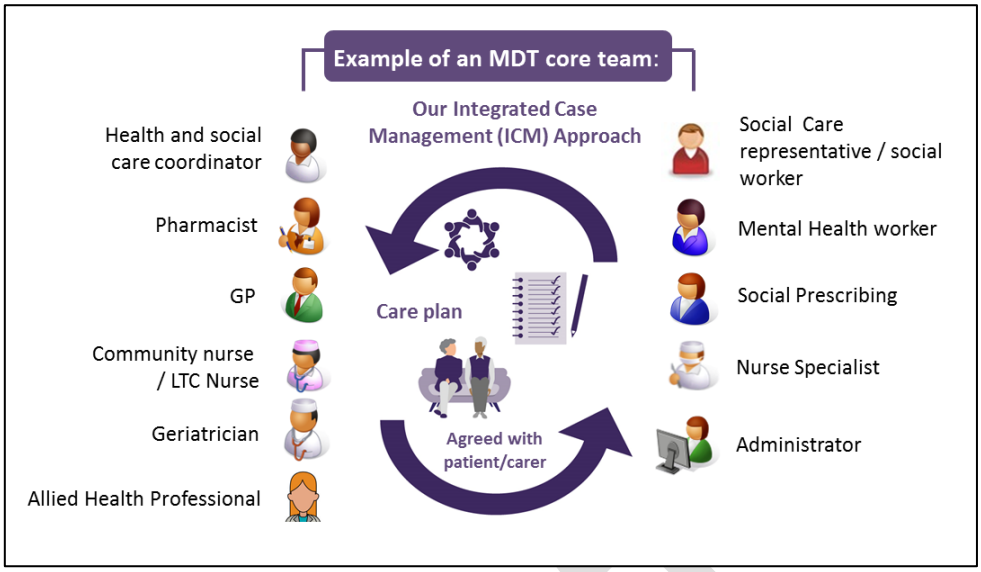
3.2 Leadership

The meeting needs to be led / chaired. This varies within each MDT. Examples of chairs/ those leading the group include: GP, Geriatrician, Practice Staff Member, Co-ordinator and Long Term Condition Nurse. Any decisions made need to be agreed by the team and clinically signed off.

3.3 Membership and attendance

The membership of the meeting may vary with a **core** membership team attending every meeting and additional members attending when needed (example shown in diagram 1). This will often be determined by the needs of the **individual being discussed** and availability of services in the local community. If a member is unable to attend ensure an update is sent or if another person is representing the person from the previous meeting ensure there has been sufficient handover to facilitate comprehensive feedback.

Diagram 1



Example of additional members which vary locally:

3.4 Information Technology:

This is a key enabler in the running and management of the MDT. Examples of the use of technology include; EMIS Clinical Services, The Medical Interoperability Gateway (MIG), video conferencing, data inputting templates, care plan templates, Patient Tracking List (PTL) and teleconferencing.

3.5 Data Sharing

There is an agreed process for data sharing. Joint Control Agreements are in place between the MDT and GP practice to allow the viewing of real time clinical data. An Integrated Case Management Joint Control Agreement is in place between the GP Practices, Providers Organisations and Local authorities.

3.6 Practice MDT/Cluster MDT

Practices will work together in clusters, developing economies of scale and making best use of resources at scale such as attendance of services at the MDT meeting. It is recognised that in the early stages of development some MDTs may be held at individual practice level, however as the MDTs develop these practices will move towards cluster working.

3.7 Output

There is an agreement within the MDT of what relevant and required information will be collected; this is collated on a care plan template. During the meeting the template is updated with key actions, agreed by all. The MDT will agree who leads and feeds back on the actions.

The MDT will agree when to safely discharge a patient after they have done all within their remit to support the patient.

3.7.1 The patients care plan needs to accurately document:

- The patients consent for referral to the MDT
- The patients goals/wishes and referral such as SBAR (which is a nationally recognised communications tool developed by NHS improvement)
- The referrers concerns
- Key actions discussed
- A nominated point of contact for questions/discussions/concerns
- Council info recorded

3.7.2 The MDT Case Load Check List has been completed:

- This is in appendix (1) on page (8). This can be added to the referral form to ensure consideration before the MDT.

3.8 Federations and Primary Care Networks

Practices are forming Primary Care Networks (PCN) in 2019/20.
Over time PCNs may form part of a larger working arrangement, such as a federation or other business model that achieves economies of scale. This may provide support services to the networks such as organisational infrastructure and governance, contract management, specialist staff and services, employment and career development, model design and population wellbeing and enable strategic partnerships. This may also be a way of ensuring a strong Primary Care voice within the Integrated Care Partnership (ICP) and Integrated Care System (ICS).

3.9 Co-ordinator

Each MDT will have a Co-ordinator. The Co-ordinator will ensure that the list of patients is circulated prior to the meeting (minimum 2 working days) and actions are followed up and completed. The Co-ordinator also ensures the referral form, such as SBAR (Situation, Background, Assessment, and Recommendation - a nationally recognised communications tool developed by NHS improvement) is populated and has recommendations for outcomes of the referral. In some areas the Co-ordinators are trained as trusted assessors (define) and can initiate first visits and refer on as appropriate. They are the pivotal link between all services. Ideally Co-ordinators will also support practices to proactively identify potential patients for MDT discussion. Add in a glossary of terms

3.10 Referrals

Referrals into the MDT are made in a consistent way such as the SBAR format: Situation, Background, Assessment, and Recommendation. The referral form is populated as much as possible from a clinical system to avoid duplication. The referral will state who the referral is from, what the referrer expects to gain from the referral e.g. social care assessment and clearly documents the patient's consent. The checklist in appendix (1) could be added to the referral form to ensure consideration before the MDT.

3.11 Quality

The quality of discussions needs to remain meaningful ~~high~~ with ~~good quality~~ smart actions being identified and proactive care remaining at the heart of the team:

- Enough time should be given for each individual discussed so that all members of the MDT are able to input into the care plan as appropriate
- To hurry the process may result in missing vital information/actions to the detriment of the care plan.

3.12 Criteria for patient identification

Team members are clear on who they are seeking to support.

3.12.1 MDT working supports the management of individuals who have:

- A high frailty score – define the scoring
- the highest health complexity,
- with multiple (3 or more) co-morbidities (long term conditions),
- frequent hospital admissions,
- Complex psychosocial issues,
- frailty, complex mental health conditions and
- poly-pharmacy (describe in more detail).
- Social care descriptors to be added

3.12.2 and are identified by:

- Frailty risk stratification tool such as the eFI (electronic frailty index)
- Other patient identification tools as they are developed such as the Patient Tracker List
- Frequent attendances to A&E or other services for health related needs
- Concern by any member of the MDT and acute hospital staff including Rapid Transfer Service
- Frequent Area Referral Management Service (ARMS) and Client Support Service contacts that may benefit from wider support

3.13 Action LOG

An action log will be populated ensuring momentum is maintained and progress updates are given.

3.14 Contact frequency

The frequency of face to face MDT meetings varies across the county from weekly (most common), fortnightly and monthly. Effectiveness of MDTs may be impacted by the frequency of meetings.

Contact between members of the team and other professions (such as hospital discharge teams) will be more regular. Once the team are formed and relationships built (*link to the Organisational Development toolkit*), other options to increase efficiency such as skype/video conferencing can be used. Contact will also happen regularly outside the meetings via e-mail, phone and through technology.

3.15 Meeting themes – Grouping clients/patients

It may be beneficial to schedule some themed meetings focusing on a specific theme such as Care Homes or Mental Health, so that key individuals are involved for the appropriate time period, to make best use of their valuable time.

3.16 Triage referrals

Referrals are triaged by a clinical member of the MDT to ensure the patients that would benefit most from the MDT are supported.

3.17 Location

Face to face team meetings generally take place at the same time and location at the agreed frequency intervals (most commonly, weekly). Locations are usually central to the team, easy to access and IT linked. Often the meetings take place in a GP practice. There are examples of other settings such as a Care Home. Link to 3.4 using technology

3.18 Terms of Reference

The MDT will have a Terms of Reference (TOR) clearly describing the vision and purpose of the team. An example TOR is shown in appendix (2) on page (10).

3.19 Shared responsibility

The MDT is one team with active participation of all team members at and between MDT meetings. This is a meeting where all voices are heard, with no hierarchy. Decisions made within the MDT are collectively agreed and documented. There is agreement as to who holds overall responsibility for the patient.

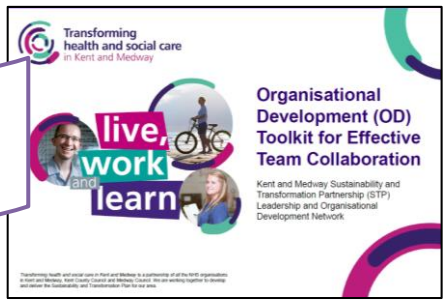
3.20 Organisational Development

Investing time in Organisational Development to build MDTs into the core working of Primary Care Networks is encouraged and supported to deliver joined up care for their populations.

3.20.1 Kent and Medway Organisational Development toolkit

The STP has developed an OD Toolkit to support the OD process. This is available on the kentandmedway.nhs.uk website (link below). If you would like support to use this toolkit or have any questions please e-mail Karen Ray: karen.ray@kent.gov.uk or Lisa Webb: l.webb5@nhs.net

To download the OD toolkit go to:
https://kentandmedway.nhs.uk/workstreams/work-force/



3.20.2 Learning Library

Federations or similar organisations may support the learning process through the Primary Care Networks by supporting them to come together and review cases to inform future practice. These could be collated into a 'learning library' so that every Primary Care Network and patient benefit from learning made and share best practice across their Primary care Network.

3.21 Safeguarding

Mental Capacity Assessment (MCA), Deprevation of Liberty Safeguards (Dolls), role of best interest (act in best interest of patient/client)/ Capacity. Each member of the MDT will have undertaken safeguarding training and will follow their organisations safeguarding procedure. Any safeguarding issues for the patient being discussed or carer or family member will be considered and recorded. Safeguarding will be considered as part of the check list in appendix (1) on page (8).

Referral form – can representative take information back to progress referrals. Don't want to avoid the referral form benefits. Use the SBAR to make referral in Ashford. Person meets the need of an assessment. Look at options over telephone assessment. Protocol for single process. One with SBAR one with MDM call into ARMS.

Name and tel for who needs feedback on the form.

Appendix 1

MDT Case Load Check List

The following checks are considered and recorded for patients that are on the MDT case load:

Description	Yes	No
1. **Flu or pneumococcal pneumonia:** If the patient is eligible for flu or pneumococcal pneumonia have they had the appropriate vaccination?		A
2. **Home safety assessment:** Does the patient require a home safety assessment from Kent Fire and Rescue?	A	
3. **Mental Health:** If the patient has a Mental Health condition is there a link to mental health either at the MDT or a way of referring?		A
4. **Carer:** If the patient is a carer are they are linked to care and support services?		A
5. **Cared for:** If the patient is cared for are they linked to care and support services?		A
6. **Safeguarding:** Is there a safeguarding issue for the patient being discussed or carer or family member?	A	

Is there a risk of fall or a need for a falls assessment?
Any other services going in we are not aware of
Social care – hording
Have we addressed what matters to ESTHER
Behaviour and communication

This check list can be added to the referral form to ensure consideration before the MDT.

encompass
Working together for better health and care

Appendix 2

Example of an MDT Terms of Reference

Terms of Reference
COMMUNITY HUB OPERATIONAL CENTRE, MULTI-DISCIPLINARY CARE PLANNING (MCP) MEETING

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	5 Sept 2016	Cathy Bellman	First Draft
1.0	Final	20 Oct 2016	Cathy Bellman	Agreed
1.2	Draft	12 April 2017	Cathy Bellman	Statement of purpose amended to include greater detail of purpose and make reference to the CHOC Integrated Case Management (ICM) pathway. Section 2 altered following Contract Negotiations to include greater clarity around organisational accountability and governance (sections 2.2 and 2.3)
1.3	Draft	18 April 2017	Cathy Bellman	Added Health and Social Care Coordinators to membership (3.1)
1.3	Final	Agreed virtually via email	Cathy Bellman	

1. STATEMENT OF PURPOSE

Community Hub Operating Centres (CHOCs) are a means whereby all professionals come together and share their knowledge and skills to co-ordinate how local people are supported to improve their own health and well-being and when they are ill or need help, they receive the best possible joined up care. The CHOC Integrated Case Management process (pathway version 1.3) develops a joint care plan for high risk patients in order to anticipate crisis and keep then in the community and support hospital admission avoidance. This process can be face to face or virtual.

2. OBJECTIVES

The MCP is a “step up” to intensive multi-disciplinary team (MDT), differing from the normal practice MDTs; a way of proactively working with a health and social care integrated team to

review existing assessments, identify gaps in care and address these in a joined up co-ordinated way to help avoid hospital admission, for those most at risk of accessing A&E.

The CHOC MCP will;

- Produce one integrated care plan agreed by the patient and shared across all services
- Increase efficiency by avoiding duplication of data and appointments
- Identify gaps in care and address these holistically
- Ensure that health and social care needs of the individual are identified and addressed
- Bring social prescribing into the process (the intensive may not only be medical but there may be a social care need such as carer breakdown for example).

(CHOC patients are escalated to the CHOC MCP at a time of increased risk for a period of time until their need stabilises and then they go back into the normal system of care).

3 RESPONSIBILITY AND GOVERNANCE

3.1 All members are responsible for identifying patients who require more intensive MDT intervention. These patients may be identified through;

- GP risk stratification process
- Local knowledge from the teams involved
- Attendance at A&E
- Patient concerns.

3.2 All members will abide by their own organisational governance (policies, procedures and existing line management arrangements).

3.3 All members are expected to work openly and transparently, raising any issues to with the CHOC MDT (clinical or operational), and attempt to resolve locally. If this route fails then individuals are expected to escalate through their organisational line management.

4 MEMBERSHIP AND ATTENDANCE

4.1 Membership

Representation from all parties in Health and Social Care;

- GP,
- Community Nursing,
- Paramedics,
- Intermediate Care Team,
- Long Term Conditions,
- Health and Social Care Coordinators,
- Specialist Nurses,
- Allied Health Professionals,
- Adult Social Care,
- Mental Health Services,
- Voluntary and Care Sector including Red Zebra for social prescribing.

4.2 Chairmanship

Clinical Lead for each CHOC locality or otherwise selected by the membership.

4.3 Quorum

The success of the CHOC MCP meetings will depend on attendance from all parties concerned; it is expected a deputy will attend in place of a substantive member.

4.4 Attendance by Others at Meetings

Others may be invited at the discretion of the MCP team.

5 FREQUENCY OF MEETINGS

CHOC MCP meetings are held weekly for an hour in each CHOC locality.

.

6 SUPPORT ARRANGEMENTS

Each CHOC MCP will be supported by an administrator who will annotate the care plan and distribute to all members.

7 REVIEW

TOR are to be reviewed yearly or sooner if any changes are agreed by the members.

8 CONFIDENTIALITY

All individuals discussed at the CHOC MCP will have consented to having their information shared.

All members of the CHOC MCP will be bound by their own organisational “code of Conduct” for confidentiality.

Creating a new commissioning landscape in Kent and Medway

Health and Wellbeing Board
June 2019

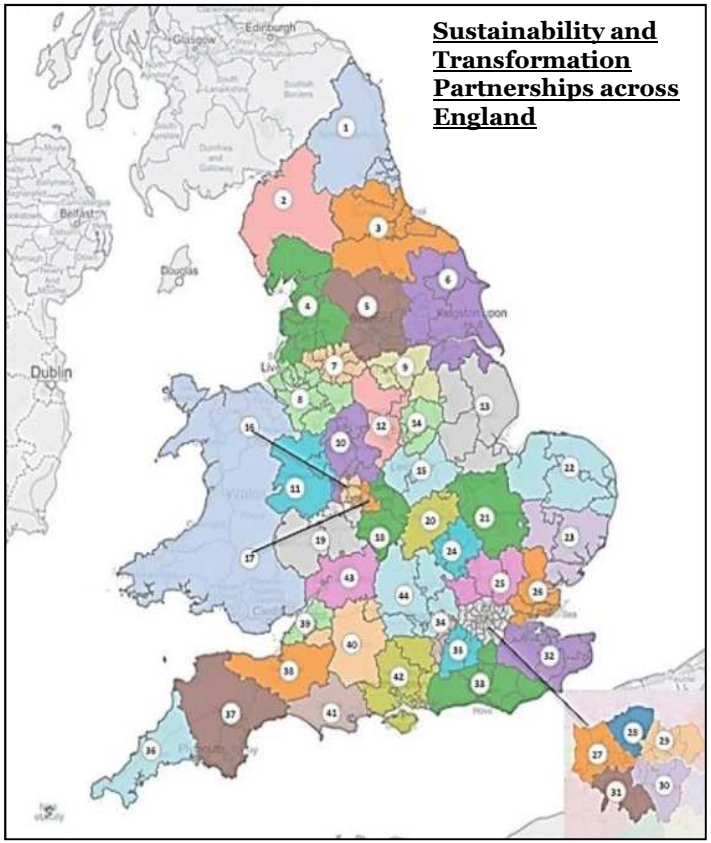
Background: The Five Year Forward View

The **Five Year Forward View** (2014) identified the following clinical priorities:

- **cancer**
- **maternity**
- **mental health**
- **learning difficulties**
- **dementia**
- **diabetes.**

Background: STPs

In autumn 2016, 44 Sustainability and Transformation Partnerships (STPs) were created across England.



Kent and Medway STP produced the Case for Change in March 2017, which identified the following priorities:

- **prevention**
- **cancer**
- mental illness
- long-term conditions
- localising care – moving away from acute hospitals and the service model changes this would require.

Background: The NHS Long Term Plan – January 2019

Key points

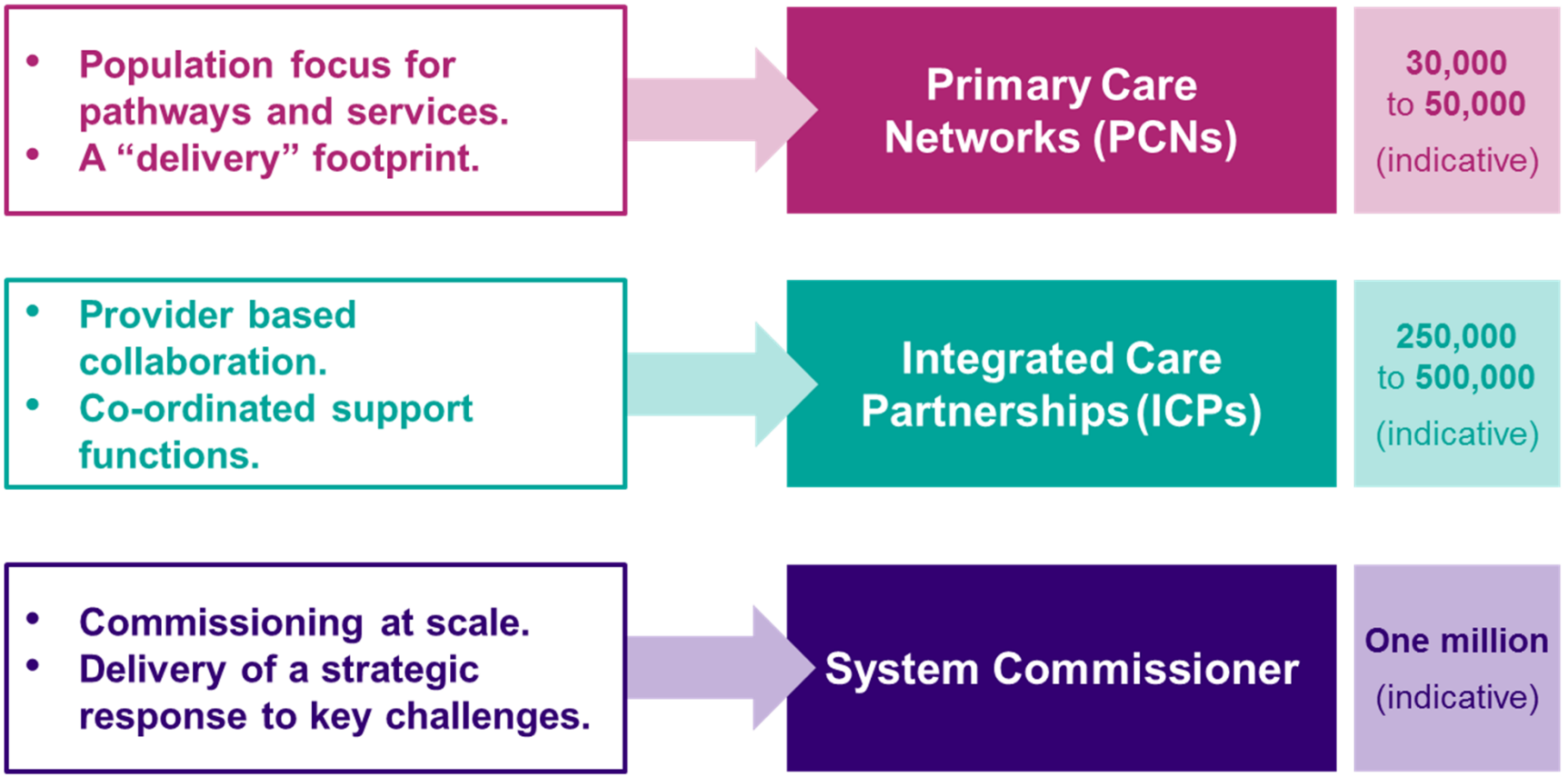
- Key areas of improvements for patients (with a renewed focus on primary care to help deliver this):
  - making sure everyone gets the **best start in life**
  - delivering **world-class care for major health problems**
  - supporting people to **age well.**
- Greater partnership working across health and social care via Integrated Care Systems (ICS) including Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs) to improve health and care for local people.
- Achieving the necessary workforce and improving value for money, including changes to the internal market and commissioning.

Ten key public health points in LTP

1. Prevention
2. Smoking
3. Obesity and type 2 diabetes
4. Diet and alcohol
5. Antimicrobial resistance and vaccines
6. Cancer
7. Mental health
8. Air pollution
9. Children and maternity care
10. Gambling

A number of these areas are already priority areas for K&M, others have been prioritised in local plans. **All require a multi-agency** whole population approach if they are to be **effectively and equitably addressed.**

Background: Evolving STPs into integrated care systems (ICSs)



Background

The internal market is now being dismantled – a move anticipated back in 2009/10:

> *…..we have had the disadvantages of an adversarial system without as yet seeing many benefits from the purchaser/provider split. If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the* ***purchaser/provider split may need to be abolished****.*

Report of Health Committee of House of Commons 2009

> *"……available research indicates that the NHS may have found itself in a* ***lose-lose situation—taking*** *on the* ***extra costs of competition without yet experiencing the benefits.***

Civitas Literature Review, NHS Market, Feb 2010

Collaboration is to the fore.

This means triple integration:

- NHS and social care
- Primary and secondary care
- Mental and physical wellbeing

Plus a fourth element:

- **Clinical and Managerial leadership**.

What does this mean for people?

- **Genuinely joined up local services** with patients at **the centre, one service, one team and one budget**.
- A joined-up focus for **population health** and the ability to **target resources** where most needed.
- Ability of system to **move at pace** to improve services across Kent and Medway for patients.

What does all this mean for GPs?

- CCGs member practices will remain statutorily '**triple accountable'** to their populations, to their members and to NHS England.
- To do this, they have **delegated the responsibility to the eight Governing Bodies in Kent and Medway.**
- Practices will want to work more closely with their neighbours in PCNs.

Primary Care Networks

Care for	a 'Neighbourhood' , population 30-50k
Members	Practices, and in time community staff, pharmacists, social prescribers and MDT members. Local Authorities? Voluntary sector?

BMA March 2019:
Bringing new benefits to patients: The development of PCNs will mean that patients and the public will be able to access:

- resilient high-quality care from local clinicians and health and care practitioners, with **more services provided out-of-hospital** and closer to home
- a more comprehensive and integrated set of services, that anticipate rising demand and support higher levels of self-care
- **appropriate referrals and more 'one-stop shop' services** where all of their needs can be met at the same time
- **different care models for different population groups** (such as frail older people, adults with complex needs, children) that are person-centred, rather than disease centred.

Primary Care Networks

- Anticipate around **41 PCNs** in Kent and Medway
- Some will choose to act with neighbours through **federated** arrangements
- Capable **PCNs integral to success** of integration of services
- **Single CCG** to ensure that PCNs are successful providers and strong, equal partners with their acute, community, mental health and social care partners within ICPs

Integrated Care Partnerships

Care for	a ‘Place’, population 250-750k
Members	Acute, community and mental health trusts, PCNs or federations, social care, local authorities, voluntary and community sector

- Majority of care delivered through ICPs – including all out of hospital or local care (tertiary, pan-Kent and Medway, very specialised services outside of ICPs)
- ICPs will hold contracts which are outcome and population focussed, rather than activity and individual based.
- ICPs will be established around natural patient flows (approximates to four acute trust catchment areas in K&M).
- ICPs at a very early stage of development and PCNs will be an integral part.
- ICP functions will include: pathway design and internal subcontracting to improve local population’s health from cradle to grave, reduce inequalities and deliver the best value for money;
- Partners will need to understand each other’s financial and clinical demands and capabilities to do this.

Moving to a single CCG – the case for change within the new system structure

All providers, including general practice, need to relate to one and other and combine to:

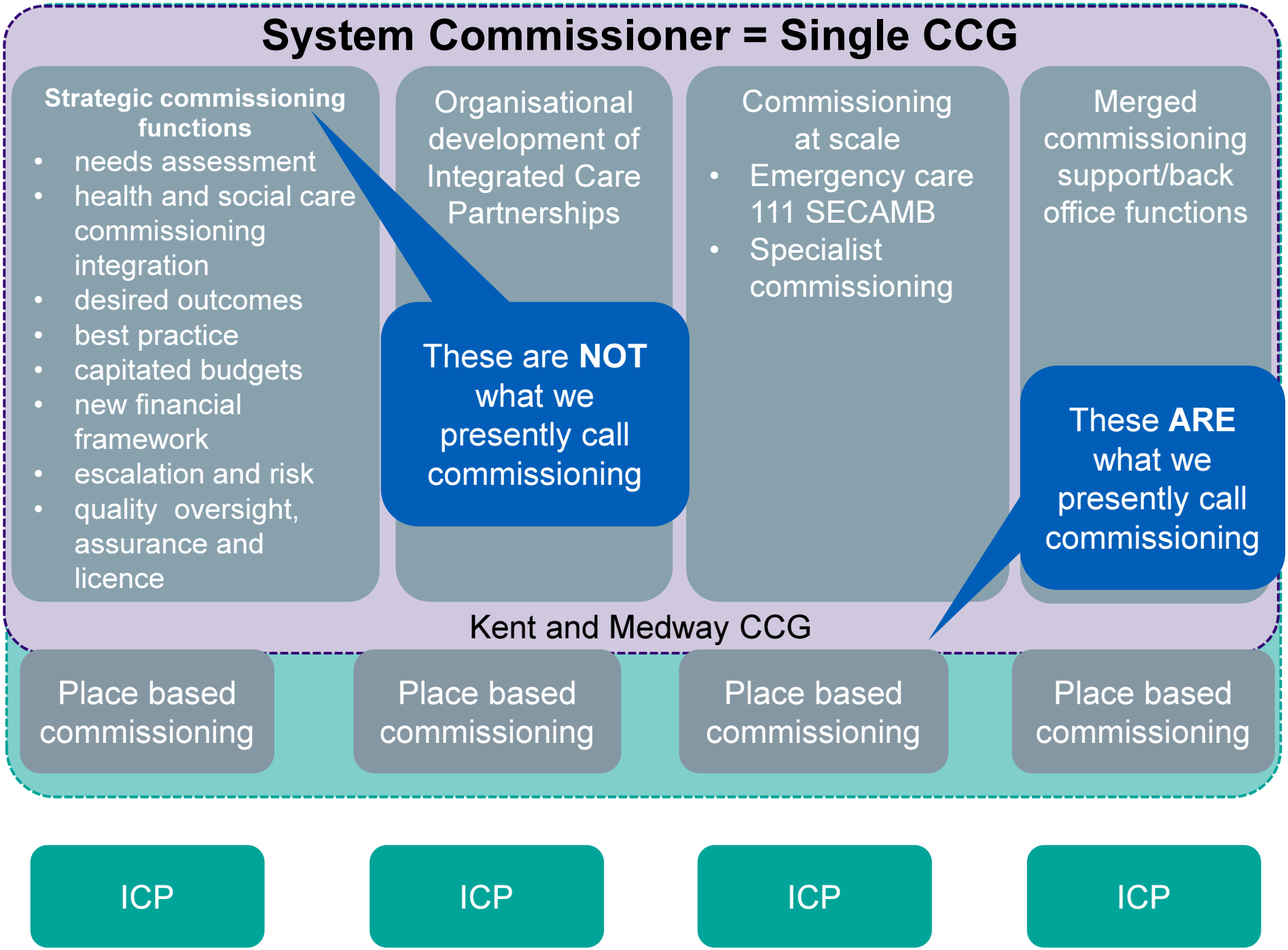
- transform our system to improve services for cancer, mental health, long-term conditions
- allow the opportunity to look after more people outside of hospital
- address the fragility of some sectors of the provider landscape.

This is a great challenge and one which no single CCG in Kent or Medway can tackle on its own.

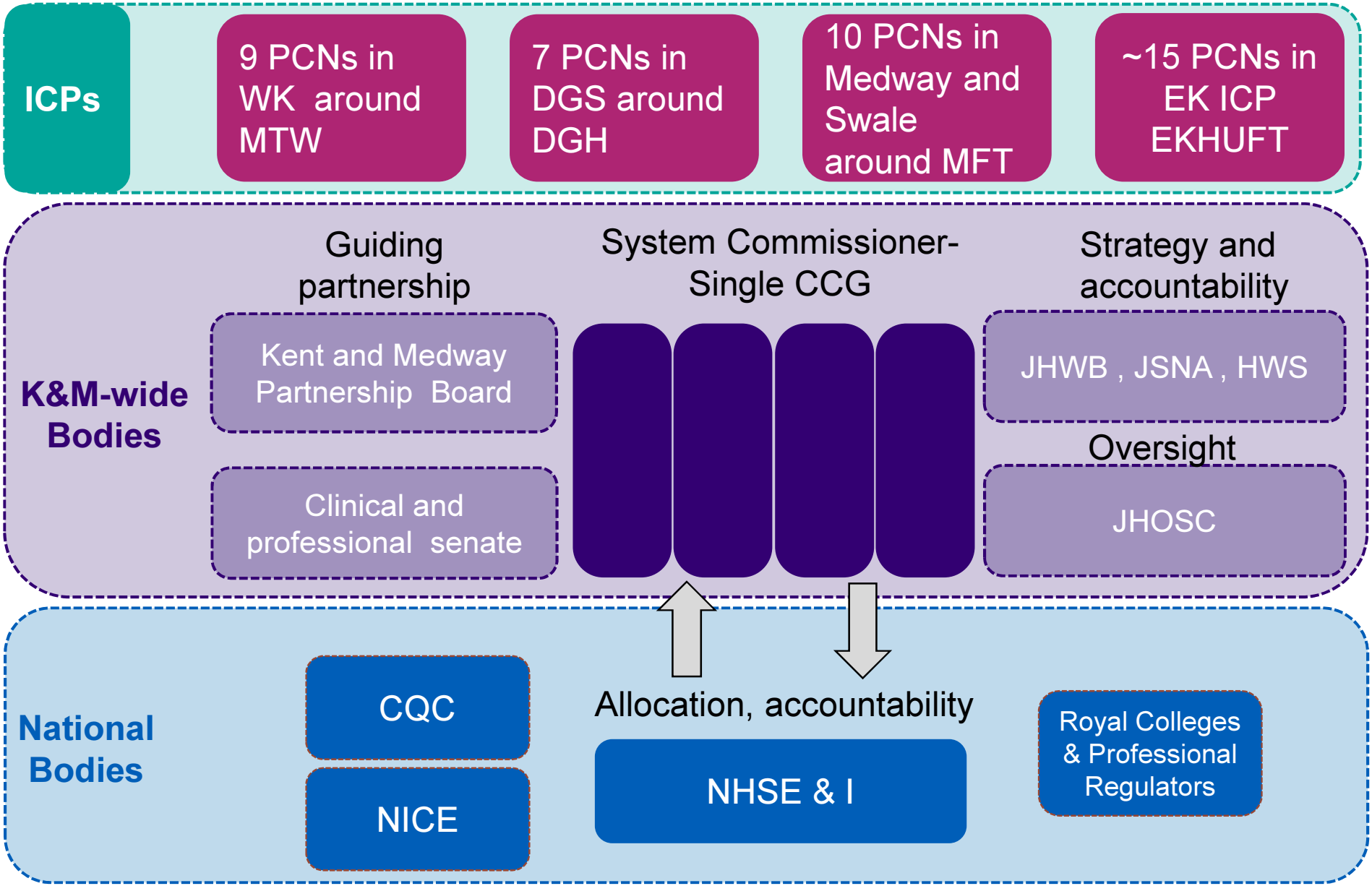
Moving to a single CCG – the case for change within the new system structure

- The benefits for the population include:
  - **consistency** of purpose and services across Kent and Medway;
  - a reduction, and eventually **elimination**, of financial, workforce and clinical risk **competition** between different providers and commissioners; and,
  - the potential for **more real clinical leadership** and innovation in local pathway design.
- NHSE clear that **each ICS will have a single CCG**
- Necessary move to **address major challenges across each ICS** area to deliver LTP ambitions and address current **fragility** in the system
- The health and care system needs **joining up**
- Present commissioning functions will take place within ICPs and GPs influence over pathways and services will be through PCNs and/or federations
- Commissioning will have to be delivered at **80% of present cost**
- The law prohibits two stage delegation of authority; thus a single CCG in Kent and Medway level precludes CCGs at local level

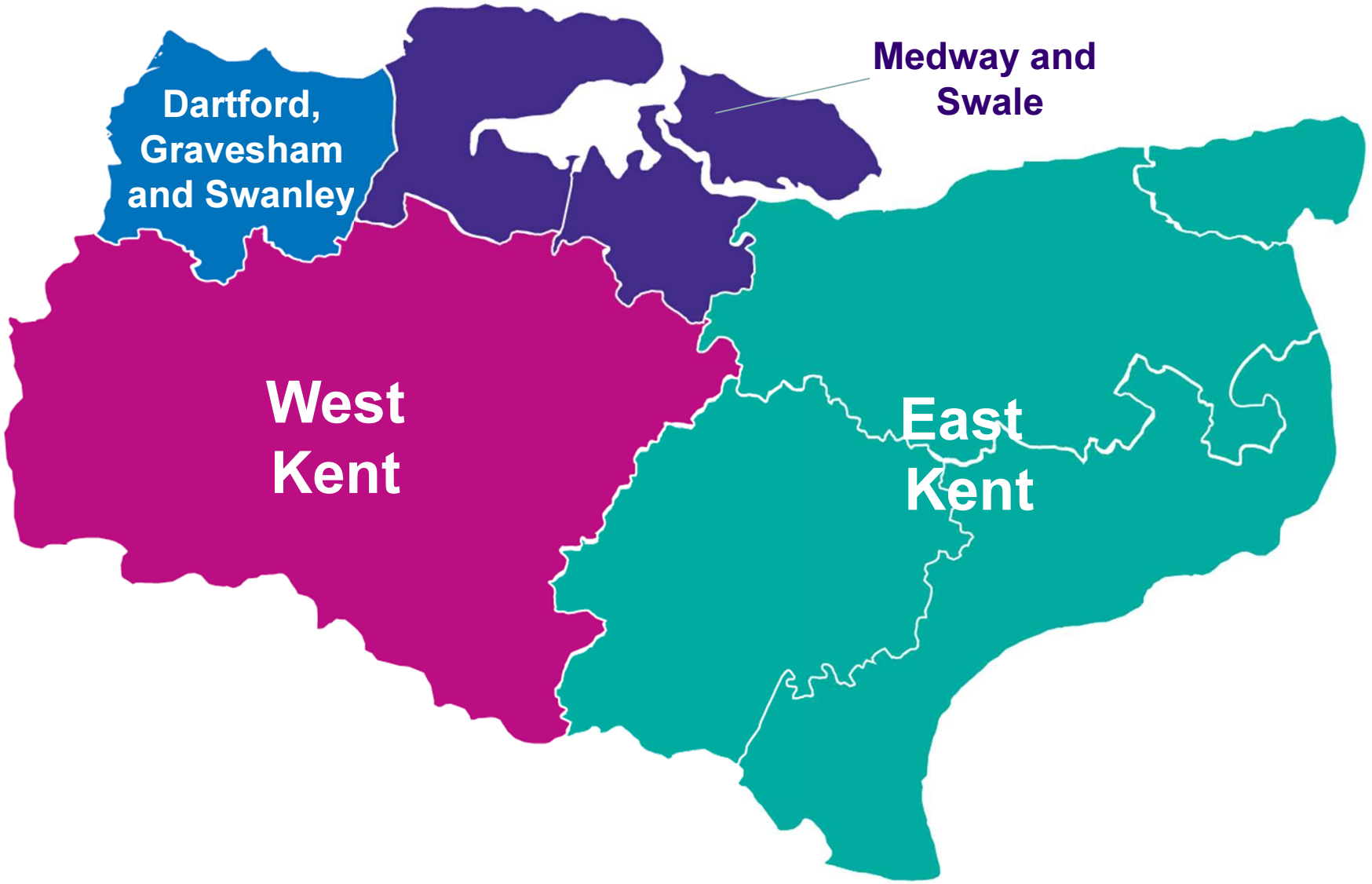
So what will the single commissioner do?


System Commissioner = Single CCG
Strategic commissioning functions
• needs assessment
• health and social care commissioning integration
• desired outcomes
• best practice
• capitated budgets
• new financial framework
• escalation and risk
• quality oversight, assurance and licence
Organisational development of Integrated Care Partnerships
Commissioning at scale
• Emergency care 111 SECAMB
• Specialist commissioning
Merged commissioning support/back office functions
These are NOT what we presently call commissioning
These ARE what we presently call commissioning
Kent and Medway CCG
Place based commissioning
Place based commissioning
Place based commissioning
Place based commissioning
ICP
ICP
ICP
ICP

Population health needs: inequalities, prevention and wider determinants of health to be addressed as well as priorities identified in the case for change and nationally mandated targets



Kent and Medway proposed Integrated Care Partnerships (ICPs)



Kent and Medway CCG – our values

- We are committed to improving the '**quality of life and quality of care**' for everyone in Kent and Medway, recognising that local areas may have **different needs and challenges** in terms of health and wellbeing.

- We will ensure **GPs are at the heart of the leadership** of the CCG in recognition of the integral role they play in understanding their local populations.

- We will **engage with clinical and professional colleagues** as well as with executive leadership of providers so expected outcomes are realistic.

- **GP leadership** of statutory commissioning functions will be maintained to deliver '**triple accountability**'.

Kent and Medway CCG – our values continued

- We will continue **to engage with patients and the public** so their insights and experiences influence and steer service design and improvement and offer them new and innovative ways to stay healthy and well for as long as possible.

- We will **building and foster closer relationships with key partners** such as the Kent and Medway Health and Wellbeing Boards to bring democratic legitimacy to NHS commissioning.

- We will **maintain the best of Kent and Medway CCGs' constitutions** and harness the **innovative drive of general practice in each PCN**.

Kent and Medway CCG – our vision

- Setting ambitious and achievable outcomes for the whole population of Kent and Medway, a **single CCG will drive improvements to health and wellbeing through improved prevention**, a reduction in health inequalities and the procurement of the highest quality and affordable services.
- Bringing the **very best of general practice to local people**, the CCG will enable, support and commission integrated care from local ICPs, including strong and vibrant PCNs.
- With a renewed emphasis on data to understand each local population's needs along PCN lines, the CCG will develop and foster **new financial and contracting models that support collaboration and integration** across all health and care sectors and partners.
- By making sure that we have the 'basics' right to help all partners, organisations, members of staff and clinicians to deliver their very best for local people through an integrated approach to **recruiting and retaining** our workforce, making sure our **buildings and facilities are fit for purpose** and that **our IT infrastructure supports the sharing of information** and the delivery of care.

Recommendations

- Note the current development of the Integrated Care system including the **system commissioner (single CCG), ICPs and PCNs**

- **Consider the priorities** set out in this paper drawn from the NHS Long Term Plan.

- Discuss what **future role the JHWBB** might take as the Kent and Medway ICS develops and what developmental work might be required in establishing such a role.

Transforming health and social care in Kent and Medway

Creating a new commissioning landscape in Kent and Medway

The future role of health and wellbeing board

1. Context

1.1 2019 to 2021 will be transitional years for health and social care in Kent and Medway as we move towards an Integrated Care System by April 2021. Both nationally and locally, this is a significant time of change and we must be clear to ensure that future ways of working effectively address the current gaps in meeting the health and social care needs of the people of Kent and Medway.

1.2 The NHS also needs to give greater priority to the prevention of ill health by working with local authorities and other agencies to tackle the wider determinants of health and wellbeing. This means tackling risk factors such as obesity and redoubling efforts to reduce health inequalities. It also means fully engaging the public in changing lifestyles and behaviours that contribute to ill health and acting on the recommendations of the Marmot report and other reviews to improve population health.

1.3 Health and Wellbeing Boards will therefore arguably have an even more important role in the Integrated Care System environment in their responsibilities for producing strategic needs assessments, developing health and wellbeing strategies and in the oversight of commissioning plans.

2. Ten key public health points in long term plan and other priorities

2.1 The NHS Long Term Plan aims to relieve pressure on services and ensure sustainability for future years and the development of Integrated Care Systems is seen as essential to realisation. There are a multitude of aims and initiatives within the 136 page document but the key public health priorities are:

- Prevention
- Smoking
- Obesity and type 2 diabetes
- Diet and alcohol
- Antimicrobial resistance and vaccines
- Cancer
- Mental health
- Air pollution
- Children and maternity care
- Gambling.

2.2 A number of these areas, for example cancer and children, are already priority areas for Kent and Medway while others have been prioritised in local plans for a number of years. All require a multi-agency whole population approach if they are to be effectively and equitably addressed, and we should perhaps reflect that a number have been on our ‘to do’ list for some time without achieving the improvements needed.

2.3 Furthermore, the evidence not only shows that in some areas we are not improving fast enough but that there has been a slow-down. It has been widely reported that improvements in life expectancy has slowed down for the first time since 2011. The principal contribution to that slow-down appears to be cardiovascular disease, respiratory (problems) and dementia.

2.4 In addition, as set out at a lecture titled 'The NHS and society' given by NHS England Chief Executive Simon Stevens to the Royal Society of Medicine in May, there are a number of priorities that the population should expect from the NHS and social care:

- Maintaining NHS efficiency
- Helping people to stay at or return to work
- Rethinking the reasons for service change
- Improving the regional loyalty of nursing and medical students
- Supporting social care
- Tracking health risks.

Again, a number of these will require the strategic steer of health and wellbeing boards and the design and delivery drive of multiple partners working in a more integrated way if they are to be effectively addressed.

3. Transforming the Kent and Medway Health and Social care System; progress to date

3.1 The starting point for change is that all providers, including general practice, need to relate to one another and collaborate to:

- Transform our system to improve services for cancer, mental health, long-term conditions
- Allow the opportunity to look after more people outside of hospital
- Address the fragility of some sectors of the provider landscape.

This is a great challenge and one which no single CCG in Kent or Medway can tackle on its own. To this end all eight CCG governing bodies have endorsed the proposal to move to a single CCG for Kent and Medway from April 2020; this proposal will be put to the membership of all eight CCGs later in the summer.

3.2 The four emerging Integrated Care Partnerships (ICPs) across Kent and Medway have started their development processes to varying degrees but have in place a defined leadership, have identified key partners and stakeholders and are working on their development plans. Primary Care Networks (PCNs) will form an integral part of ICPs through which the majority of care – including all out of hospital or local care – will be delivered.

3.3 The registration process for PCNs is nearly complete and it is anticipated there will be 41 networks covering the population of Kent and Medway. Some have chosen to act with neighbours through federated arrangements. The Kent and Medway support offer to PCN development is underway, this work is important as capable PCNs are integral to success of integration of services. The single Kent and Medway CCG will ensure that PCNs are successful providers and strong, equal partners with their acute, community, mental health, social care partners and others within ICPs.

3.4 Work has now started on the development of a Kent and Medway Integrated Care System (ICS). This will evolve from Kent and Medway STP and take the lead in planning and commissioning care for the populations and provide system leadership. It will bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care for Kent and Medway. A key component of the ICS will be the Health and Wellbeing Board as illustrated in the priorities set out above.

4. The future role of the Kent and Medway Joint Health and Wellbeing Board in an Integrated Care System

4.1 The health commissioning vision for Kent and Medway is: 'that by setting ambitious and achievable outcomes for the whole population of Kent and Medway, a single CCG will drive improvements to health and wellbeing through improved prevention, a reduction in health inequalities and the procurement of the highest quality and affordable services'.

4.2 This vision is underpinned by the following values:

- A commitment to improving the 'quality of life and quality of care' for everyone in Kent and Medway, recognising that local areas may have different needs and challenges in terms of health and wellbeing.
- Ensuring GPs are at the heart of the leadership of the CCG in recognition of the integral role they play in understanding their local populations.
- Engagement with clinical and professional colleagues as well as with executive leadership of providers so expected outcomes are realistic.
- GP leadership of statutory commissioning functions will be maintained to deliver 'triple accountability'.
- Engagement with patients and the public so their insights and experiences influence and steer service design and improvement and offer them new and innovative ways to stay healthy and well for as long as possible.
- Building and fostering of closer relationships with key partners such as the Kent and Medway Health and Wellbeing Boards to bring democratic legitimacy to NHS commissioning
- We will maintain the best of Kent and Medway CCGs' constitutions and harness the innovative drive of general practice in each PCN.

4.3 The Kent and Medway system is therefore at a point where the CCGs have started a process to establish a single, system commissioner for Kent and Medway with a clear ambition to improve health outcomes for the whole population, not least through maintaining and enhancing the role of clinical leadership. These commission changes are integral to the wide system change that is now gathering momentum which in turn is a response to the need to drive integration as a way of sustainably improving population health. National and local priorities are ambitious and will not be delivered through current organisational relationships and ways of working. Further, the recent history of health improvement and disease prevention is at best patchy and health and wellbeing boards have struggled to capitalise on their wide membership in effectively prioritising local need and accelerating improvement in areas identified.

4.4 The JHWBB is therefore asked to:

4.4.1 Note the current development of the Integrated Care system including the system commissioner (single CCG), ICPs and PCNs

4.4.2 Consider the priorities set out in this paper drawn from the NHS Long Term Plan.

4.4.3 Discuss what future role the JHWBB might take as the Kent and Medway ICS develops and what developmental work might be required in establishing such a role.

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KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD WORK PROGRAMME

Please note, the following items are standing items on each agenda*. By agreement of the Joint Board the focus of the item will be determined by the Joint Board and the Work Programme will be updated to reflect this.

a) Progress on Prevention Strategy for Kent and Medway

b) Progress on Local Care including Local Care Implementation Board

c) Workforce*

d) Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities

*the report on the Kent and Medway STP workstream, Workforce, will be presented to the Joint Board every six months.

Meeting Date (despatch date)	**Item**
17 September 2019 (9 September 2019)	Progress on Prevention Strategy for Kent and Medway
	Progress on Local Care including Local Care Implementation Board, focus areas: • Support for carers • Support for growing the voluntary sector
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
	Kent and Medway Child and Adolescent Mental Health Services (CAMHS)
	SEND Inspection Update
10 December 2019 (2 December 2019)	Progress on Prevention Strategy for Kent and Medway
	Progress on Local Care including Local Care Implementation Board
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
17 March 2020	Progress on Prevention Strategy for Kent and Medway

Updated 22/05/19 following email from W Dunmill re addition of SEND inspection update

(9 March 2020)	Progress on Local Care including Local Care Implementation Board
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
DATE TO BE DETERMINED	Programmes available to support weight management and effective ways to communicate them.
	Kent Medical School
	Update on the Kent and Medway response to the Long Term Plan
	Final Kent and Medway STP Five Year Plan