Kent and Medway Neighbourhood Health Plan

(Draft version 2)

18.08.26

Improving health and wellbeing through integrated neighbourhood working across Kent and Medway.

Balancing local and system-wide needs

- A core concept of neighbourhood health is that it responds to local needs and involves local stakeholders. However, neighbourhood health also needs to be coordinated across the Kent and Medway system to avoid fragmentation and confusion for patients, residents and those delivering services
- There is, therefore, a Kent and Medway Neighbourhood Health Plan and separate plans (or sections, depending on how things evolve) for Kent and for Medway. The Kent and Medway plan contains all of the shared content, while the separate plans for Kent and for Medway contain locally-specific content.

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Introduction

- The Neighbourhood Health Framework (NHF) requires systems develop a Neighbourhood Health Plan (NHP) overseen by the Health and Wellbeing Board.
- Health Strategy in Kent and Medway in recent years has been underlined by the Integrated Care Strategy (ICS). This is driven by the Robert Wood Johnson model of impacts on health and has led to better consideration of socio-economic, lifestyle and environmental as well as health and care service impacts
- Following this, and in line with the Ten-Year Plan, the system, including the NHS, has looked to better address prevention, health inequalities and the wider determinants of health (WDH). The NHP is an opportunity to accelerate work in these areas.
- The NHP is an opportunity to ensure all partners can contribute to, and have their ambitions furthered by, Neighbourhood health to improve local health and wellbeing through action to tackle local inequalities and the WDH and achieve key partner and system priorities.
- Development and delivery in Kent and Medway will require actions that are led at both a system wide and at a very local level. The development of the NHP reflects this, with a balance of top down centrally defined and locally agreed priorities and actions.

Purpose and rationale

The Kent & Medway Neighbourhood Health Plan will translate national neighbourhood health expectations and local population priorities into a shared framework for action.

WHAT IS THE PLAN?

- Brings together NHS objectives, local health and wellbeing priorities and population health evidence.
- Agrees a small number of shared outcomes, priorities and measures for neighbourhood health.
- Clarifies responsibilities, governance and operational partnerships across the NHS, councils, providers and wider partners.
- Connects system-wide ambition with neighbourhood and hyper-local action.

WHY IS IT NEEDED?

- The national Neighbourhood Health Framework requires systems to develop a locally owned plan overseen by Health and Wellbeing Boards.
- Kent and Medway needs a shared route for accelerating prevention, reducing inequalities and addressing wider determinants of health.
- The Plan creates a balance between centrally defined NHS expectations and priorities agreed locally with partners.
- It provides the partnership framework for action to reduce avoidable hospital and residential care admissions and support independence.

TIMING AND ALIGNMENT

2026/27

Co-develop the Plan, agree priorities, governance, measures and delivery arrangements.

By April 2027

Complete the development tasks and prepare for implementation.

From 2027/28

Implement the locally owned Neighbourhood Health Plan.

Developing and delivering the Plan

The Plan will combine system-wide direction with locally led action, informed by evidence, engagement and learning.

THE PLAN WILL INCLUDE:

- How NHS objectives will be delivered
- How Delivery of local goals around inequalities and health outcomes are supported
- Linked to JSNA
- Confirm geographies, organisational responsibilities, governance and operational partnerships

MAKING THE PLAN WORK:

- Drive key actions at a system and local level that will reduce acute and residential admissions.
- Define how the wider system will support local partnership priorities in their local action plans.
- Agree a small number of key system partner priority measures alongside the national NHS measures

SYSTEM OPPORTUNITY:

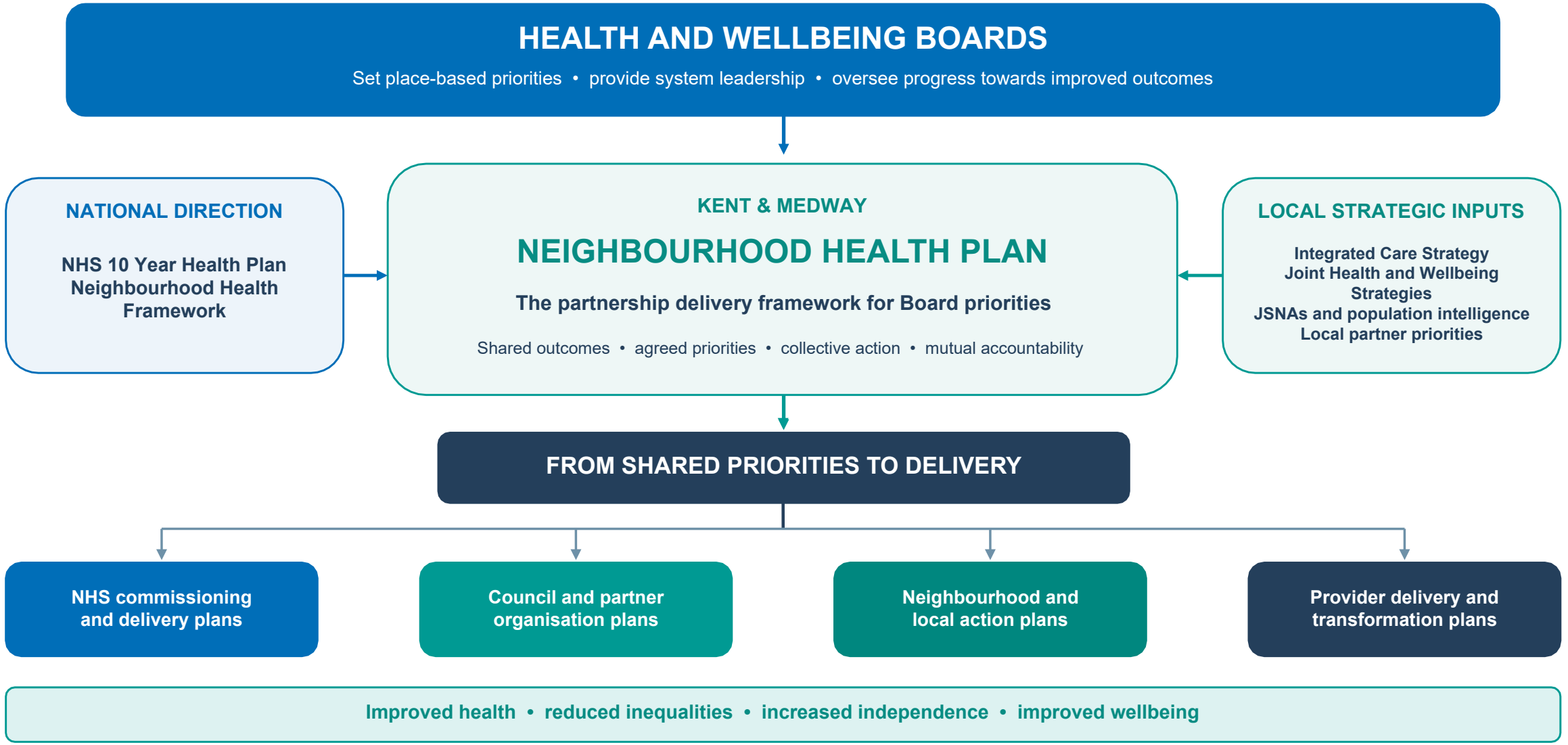
- Develop systems and structures at a local and higher level to deliver key evidence-based interventions Local clinical leadership is key.
- Deliver the key priorities of ALL partners, including the NHS, County, Unitary and District with win-wins.
- The plan must deliver on both sustainability challenges around reducing emergency hospital and care home admissions and address inequalities and wider determinants.
- The plan needs to support local partnerships at district and community level through system level approaches.
- Include opportunities Mental Health and Children and Families

DEVELOPING THE PLAN:

- The Integrated Care Strategy (ICS) remains the appropriate System Strategy
- System Clinical Leaders will define key evidence-based interventions that prevent hospital and residential care admissions
- Districts are engaged in discussions on how local partner priorities and actions can be supported
- Engagement has taken place with partners including Kent Housing Group to agree roles in NH.
- Leads for Mental Health and on Children and Young People are engaged
- The System will learn from the local NH pilots
- The NHP is informed by Healthwatch/EK360 insights into population needs

Health and Wellbeing Board priorities to delivery

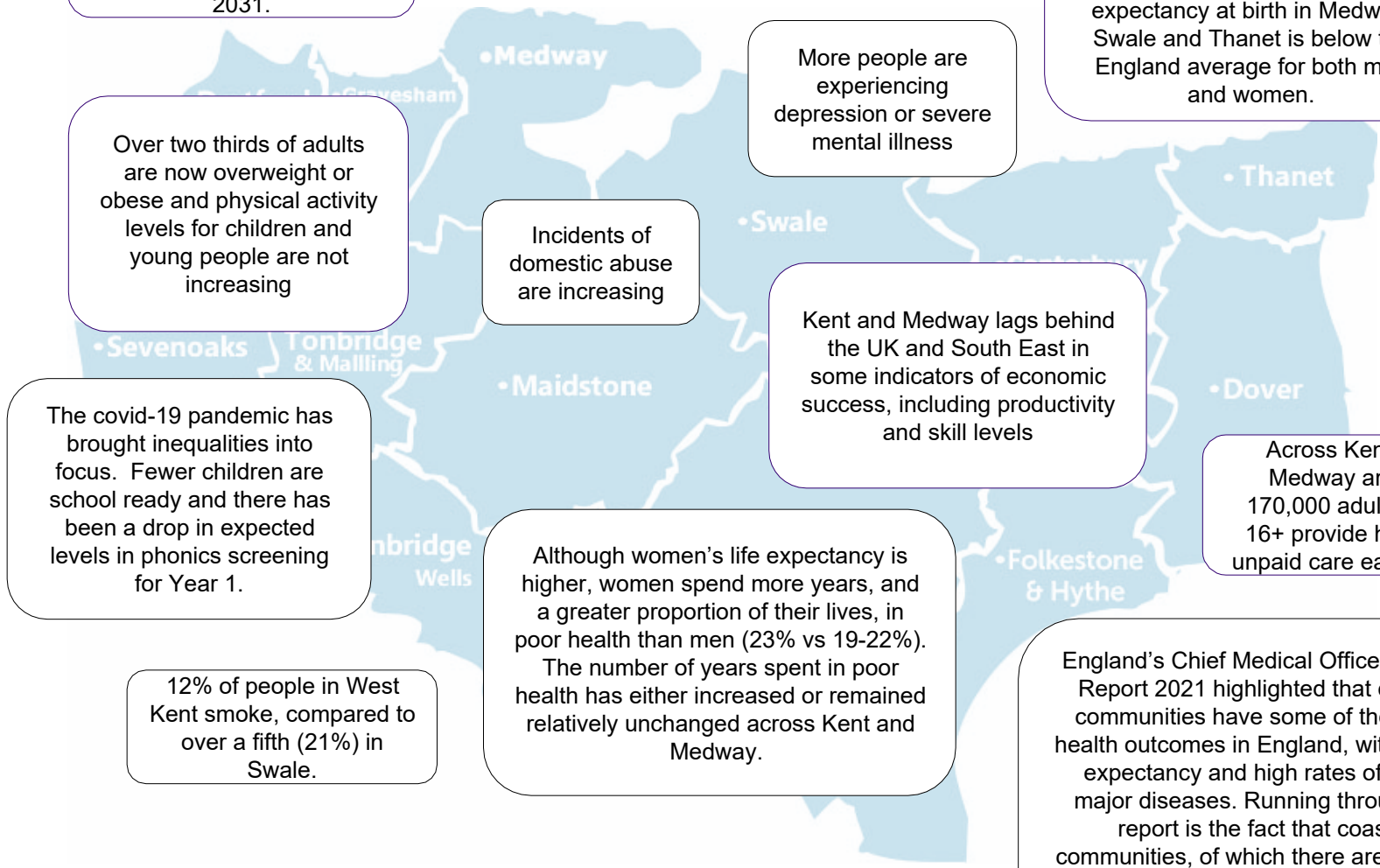
The Kent and Medway Neighbourhood Health Plan provides a shared framework for turning Board priorities into coordinated action. It brings together national expectations, local priorities and population insight to agree shared outcomes and focus collective delivery.



Strategic Context: The Integrated Care Strategy

Kent and Medway is an attractive place for so many who choose to make their lives here. With close proximity to London and mainland Europe, and a plethora of green spaces known as the 'garden of England', it is home to some of the most affluent areas of England. Nevertheless, it is also home to some of the most (bottom 10%) socially deprived areas in England. This correlates with the health outcomes achieved. With the current cost of living crisis, these disparities will persist or worsen without our concerted, collective effort.

Kent and Medway Integrated Care Partnership was formed in 2022 and led the development of the Integrated Care Strategy (ICS) following consultation with local people, organisations and partnerships. It is underpinned by our Joint Strategic Needs Assessments, individual subject-specific strategies and the Medway Joint Local Health and Wellbeing Strategy. It was adopted as the Kent Joint Local Health and Wellbeing Strategy.



Our population is growing faster than the national average - over 20% growth is predicted between 2011-2031.

In Medway and Swale, local survival rates for cancer, in particular lung cancer, are among the lowest in the country.

Life expectancy is no longer increasing in Kent and Medway. In all areas, apart from Thanet, the gap in life expectancy is wider for men than women. Life expectancy at birth in Medway, Swale and Thanet is below the England average for both men and women.

More people are experiencing depression or severe mental illness

Over two thirds of adults are now overweight or obese and physical activity levels for children and young people are not increasing

Incidents of domestic abuse are increasing

Kent and Medway lags behind the UK and South East in some indicators of economic success, including productivity and skill levels

The covid-19 pandemic has brought inequalities into focus. Fewer children are school ready and there has been a drop in expected levels in phonics screening for Year 1.

Across Kent and Medway around 170,000 adults aged 16+ provide hours of unpaid care each week

Although women's life expectancy is higher, women spend more years, and a greater proportion of their lives, in poor health than men (23% vs 19-22%). The number of years spent in poor health has either increased or remained relatively unchanged across Kent and Medway.

12% of people in West Kent smoke, compared to over a fifth (21%) in Swale.

England's Chief Medical Officer Annual Report 2021 highlighted that coastal communities have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. Running through the report is the fact that coastal communities, of which there are many in Kent and Medway, have multiple, overlapping but addressable health problems.

Acronyms

Delivering together

Kent and Medway is a large and diverse area, and the Integrated Care Strategy recognises that delivery of the shared outcomes will need to be tailored to local places and specific needs. This plan sets out only the main system-level strategies and activities that will drive work to deliver the outcomes.

Our Integrated Care System is made up of many other partners who also lead strategies and activities that will play an important role in improving the health and wellbeing of the Kent and Medway population. It would be impossible to capture all of these, and it is important that local areas and partners have the flexibility they need to meet the needs of the people they support. However, this activity is a vital part of the success of our system and the ICP will continue to develop its connections with partners across places and sectors.

The voluntary, community and social enterprise sector is an integral part of our system at every level and helps shape strategy and activity as well as providing vital support in our communities.

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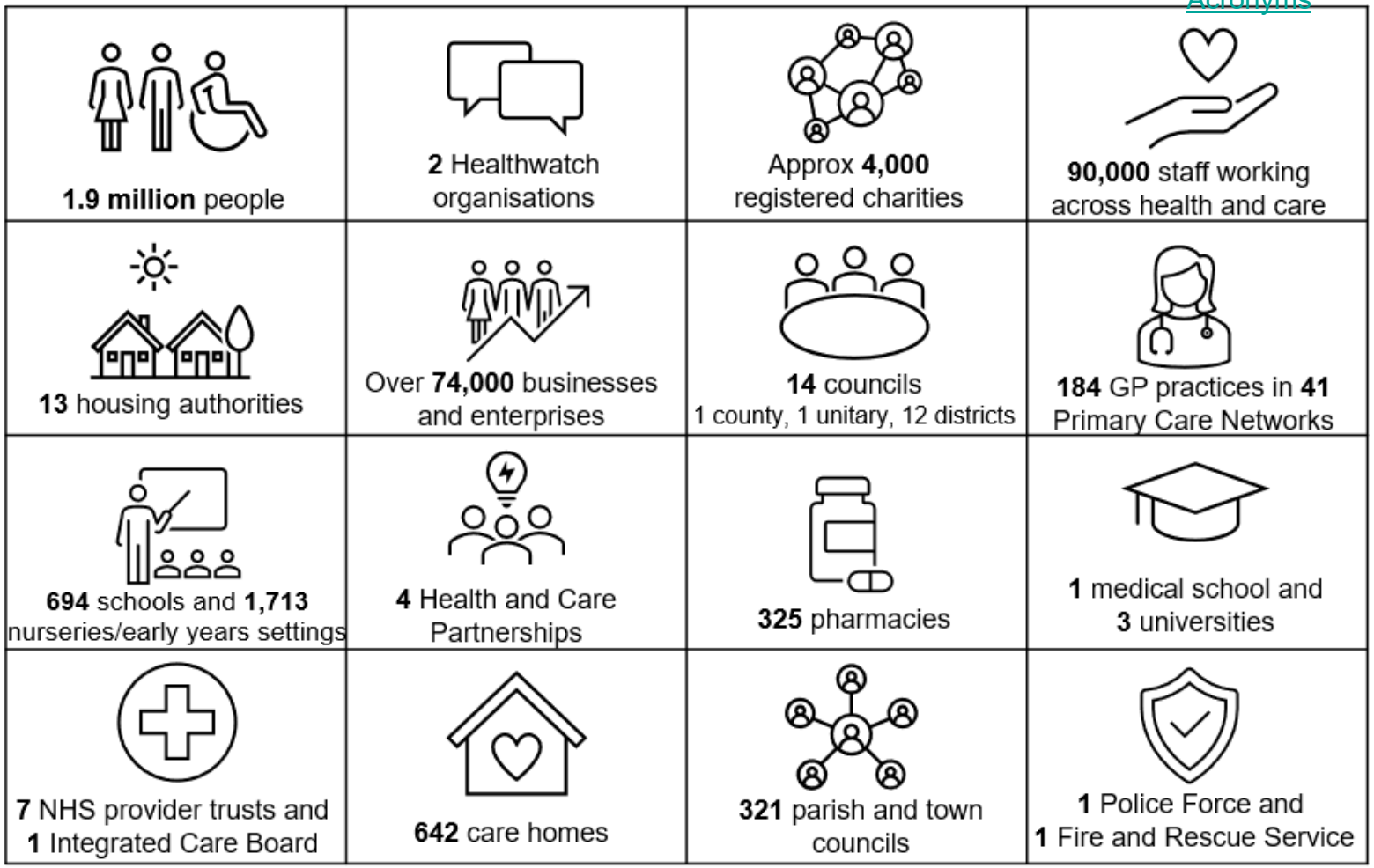


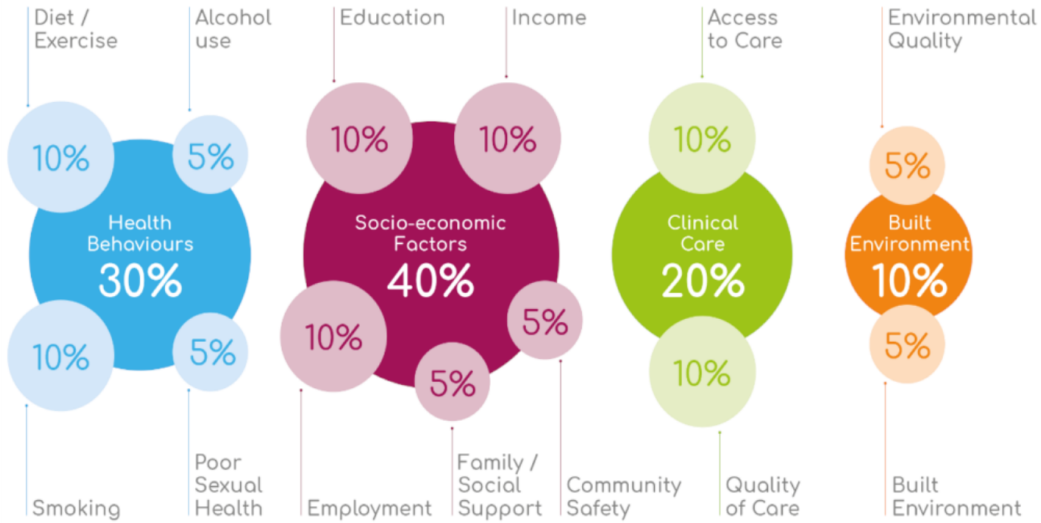
Role of Health and Care Partnerships and District & Borough Councils

Health and Care Partnerships and District & Borough Councils have a key role in improving health and wellbeing through local action involving key local partners including the local VCSE to deliver the priorities for their place supported by appropriate programmes of work and action plans. Together, these place-based plans will have significant impact on the overall delivery of our shared strategy. Place-based priorities and plans have been reflected in this shared delivery plan.

The Integrated Care Strategy remains relevant now:

- ✓ Key measures of health and wellbeing are getting worse, or not improving as fast as the national average. We must take a **different approach and all tackle the wider determinants of health** (see figure of Robert Wood Johnson model).
- ✓ We must seize the **enormous opportunity** that working as an integrated system presents to bring real improvements to the health and wellbeing of our population and put our services on a sustainable footing, within the context of the resource and demand pressures and constraints we all face.

- ✓ This strategy uses a consensus to agree and focus on the **priorities we must deliver together as a system**, so all partners can target our limited resources and assets where we can make the biggest improvements and deliver value for money together.
- ✓ This strategy should not provide the 'how'. We recognise that **local partners** are best placed to **understand local needs** and the actions required to tackle them. The strategy will be supported by delivery plans which are organisation or subject matter specific.
- ✓ The strategy will enable a balance between universal preventative services and bespoke additional support for those with greatest needs, also known as **proportionate universalism.**
- ✓ There is recognition that we additionally need to ensure the **NHS plan** is delivered with its focus on **prevention, community-based care and digital** solutions, and the actions detailed in the **Neighbourhood Health Framework** are delivered



Overview of the Integrated Care Strategy

Our vision:
We will work together to make health and wellbeing better than any partner can do alone

Together we will…

Give children and young people the best start in life	Tackle the wider determinants to prevent ill health	Support happy and healthy living for all	Empower patients and carers	Improve health and care services	Support and grow our workforce

What we need to achieve

• Support families and communities so children thrive • Strive for children and young people to be physically and emotionally healthy • Help preschool and school-age children and young people achieve their potential	• Address the social, economic and environmental determinants that enable people to choose to live mentally and physically healthy lives • Address inequalities	• Support people to adopt positive mental and physical health • Deliver personalised care and support centred on individuals providing them with choice and control • Support people to live and age well, be resilient and independent	• Empower those with multiple or long-term conditions through multidisciplinary teams • Provide high quality primary care • Support carers	• Improve equity of access to services • Communicate better between our partners when changing care settings • Tackle mental health issues with the same priority as physical illness • Provide high-quality care to all	• Grow our skills and workforce • Build ‘one’ workforce • Look after our people • Champion inclusive teams

Enablers:
We will drive research, innovation and improvement across the system
We will provide system leadership and make the most of our collective resources including our estate
We will engage our communities on our strategy and in co-designing services

MEDWAY'S JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2024-2028

GOAL: Improve the physical and mental health and wellbeing of Medway residents and reduce inequalities.

PURPOSE: To ensure everyone in Medway lives a long, healthy, and happy life, with people valuing self-care and helping others. Opportunities are available to all throughout life to help people grow and create a brighter future. Medway is a place where help is easily available, places are connected, and when people move between services, their journey is seamless.

People are proud to live in Medway and feel part of their community.

PRIORITY THEME 1

HEALTHIER & LONGER LIVES FOR EVERYONE

- Babies and children are healthy, happy, and safe. They develop well and are ready to start school.
- People in Medway are supported to live healthy, long and happy lives, and value self-care.
- Vulnerable adults lead fulfilling lives in a caring environment that ensures their wellbeing and safety.
- Older people live with dignity and stay independent for as long as possible.
- Good mental health is enjoyed by everyone. People can cope with life's challenges, sleep well, have positive relationships, and experience a sense of purpose and fulfilment.

PRIORITY THEME 2

REDUCE POVERTY AND INEQUALITY

- All children achieve a good level of education leading to secure employment in adulthood.
- Outcomes are improved for those in vulnerable and disadvantaged groups, such as children in care and care leavers.
- People and families can access healthy food, have steady jobs, and live in affordable, good quality homes.
- People in Medway are supported in managing the cost of living.

PRIORITY THEME 3

SAFE, CONNECTED AND SUSTAINABLE PLACES

- Services are close to where people live and accessible by active transport such as walking or cycling, or using public transport.
- People and organisations work together to create a sustainable, clean and green environment.
- Green spaces can be accessed and used by all.
- People feel safe in their neighbourhood.

PRIORITY THEME 4

CONNECTED COMMUNITIES AND COHESIVE SERVICES

- People feel connected with their community, have a sense of belonging and strong support networks.
- Everyone can find and access services and information easily, with support to ensure digital inclusion.
- Organisations work together so when people move between services, their journey is seamless.
- There is trust and respect between services, organisations and users, regardless of their differences; diversity is recognised and embraced.

Government guidance for Neighbourhoods

NAPC

Neighbourhood health will only work as a **joint endeavour** between the NHS and local authorities, alongside wider partners.

Three principles of public sector reform:
- Integrated services around people's lives
- Improve outcomes, by focusing on prevention rather than crisis management
- Devolve power to local areas, which understand local needs, with services with and for people.

Measuring success of neighbourhood health

National minimum goals and objectives, plus locally developed aims and outcomes defined through neighbourhood health plans under the leadership of Health and Wellbeing Boards.

National NHS goals, objectives and metrics

1 Improve health outcomes

Targets include:
- reducing non-elective admissions
- improving outcomes for long-term conditions
- improving quality and access to care for children
- better end of life care

2 Improve access to general practice

Objectives include:
- 90% of clinically urgent patients seen the same day by March 2027
- faster access to routine GP care
- improved patient satisfaction

3 Improve experience of planned care

This will include:
- reducing variation in outpatient referrals
- improving coordination of outpatient care & reducing secondary care follow-up appointments

4 Improve urgent and emergency care
- Improving co-ordination of care for high priority cohorts (frailty, care homes, end of life)
- reducing emergency department attendances
- improving ambulance response times
- improving hospital discharge processes

5 Improve patient and staff satisfaction
- introducing patient-reported experience and outcome measures
- ensuring 95% of people with complex needs have an agreed care plan
- introducing neighbourhood staff experience measures

6 Local goals
- Health and Wellbeing boards recommended to consider the local outcomes framework for health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration
- Enabling those who receive long term support to live in their home
- Adults whose needs are met by admission to residential and care homes
- Consider how neighbourhood plans align with wider public service reform

Aims

- Improve people's health and care outcomes
- Organise services around the person
- Reduce pressure on acute services
- Cut waste and duplication
- Help the NHS deliver against core targets

Delivering neighbourhood health

To deliver neighbourhood health, the NHS and local authorities must transform how they work together alongside wider partners including **voluntary, community and social enterprise organisations (VCSEs).** ICBs will ensure neighbourhood health becomes the default model of care

Reform agendas

1 Improve routine healthcare

The NHS will support GP access recovery by:
- through new GP access targets
- improving online access
- ensuring practices open during core hours, and reform out of hours
- providing faster access to care

GPs will be empowered to deliver better care through:
- proactive population health management
- reduced bureaucracy
- improved access to specialist advice

2 Improve proactive care
- Develop Integrated Neighbourhood teams to deliver better management of Long term conditions, frailty, children and young people and cancer
- Grow community services
- Reform outpatients, with closer working between GPs and specialists

3 Better alternatives to hospital care
- Expand urgent community response services
- Increase the capacity of virtual wards
- Increase intermediate care capacity
- Piloting 24/7 neighbourhood mental health centres

Read how NAPC helps partners implement neighbourhood health.

Contracting models

ICB → IHO → MNPs → SNPs

Single Neighbourhood Providers (SNPs): Deliver neighbourhood services through integrated teams within a defined area; allow primary care to offer services beyond core GP contracts.
Multi-Neighbourhood Providers (MNPs): Coordinate services across multiple neighbourhoods, supporting consistency, service design and shared risk for the registered population list.
Integrated Health Organisations (IHOs): Hold a whole-population budget, allocate resources across pathways, redesign services and invest in prevention. Initially likely led by high-performing NHS trusts, in partnership with primary and community providers.
All primary care contracts remain nationally contracted. PCNs might evolve into SNPs. More guidance to follow.

Changes for 2026/27

- Neighbourhood footprints considered in terms of local authority boundaries
- Reduce non-elective admissions
- GP access
- Establish integrated neighbourhood teams
- Improve outpatient pathways
- Confirm use of Better Care Funding (BCF)
- Improve primary secondary care interface
- Confirm organisational ownership of deliverables
- Improve data-sharing arrangements
- Plan for April 2027 to April 2029

Other headlines

- **Neighbourhood Health Centres (NHCs)**: 250 neighbourhood health centres by 2035, 120 by 2030
- **Workforce:** staff working differently rather than entirely new staff groups providing proactive, preventative personalised care, organisational boundaries
- **Finance:** ICBs prioritise funding for neighbourhood health services locally. National support will include: financial incentives encouraging the shifting care from hospital care to community, reforms to payment mechanisms, & support for outcome-based contracting

NAPC welcomes the continued focus on population health and prevention at a local level.
The national voice for primary and community care, NAPC is a not-for-profit membership organisation leading change, driving innovation and supporting partners across the health and care ecosystem.

Contact us: napc@napc.co.uk • www.napc.co.uk

Healthcare we need to plan for

Spending £250 million a year more than we have; we are £100 million 'overfunded'

Highest prevalence of frailty in over 50s in the south-east region

14.9% of children and young people in Kent and Medway have depression, the highest rate in the south east

Demand is greater than capacity and long waiting times impact outcomes. By 2030, we will need 1.7 million more GP appointments and acute demand will increase by 19 per cent for those aged over 65

£500 million (and growing) estate maintenance backlog. Large parts of estate and infrastructure not fit for 21st century effective healthcare

Circulatory diseases and cancer are the leading causes of poor quality of life and death in Kent and Medway

Digital innovation is challenging to embed and scale

Variability in staff experience and performance.

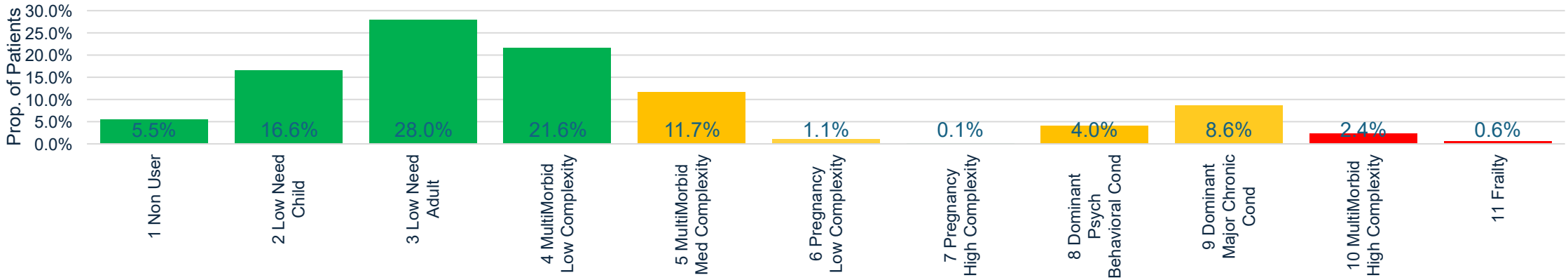
In five years, 70 older people will be presenting to emergency departments every day and 30 will be admitted to acute beds each day. The 85+ year age group is growing at the fastest rate

Patient experience is inconsistent and not always something we can be proud of

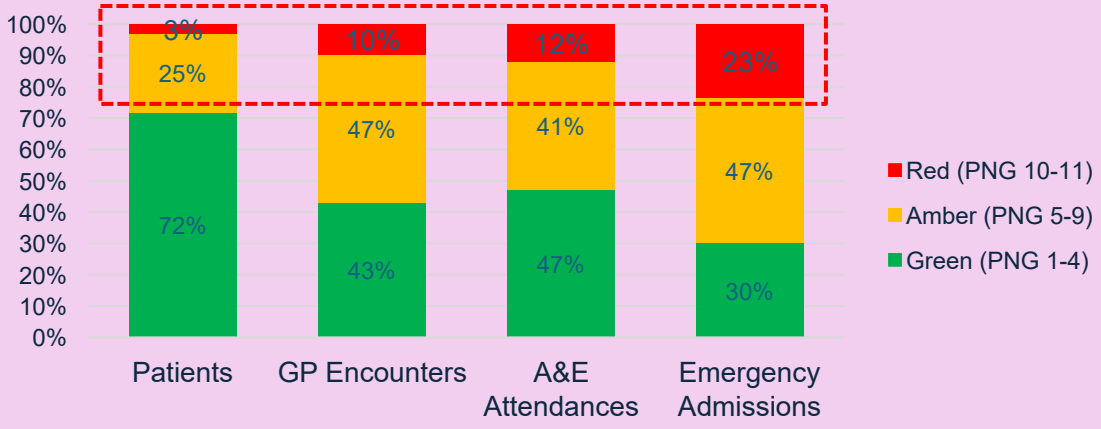
Significant health inequalities, particularly in coastal areas – 12-year lifespan gap

Population segmentation

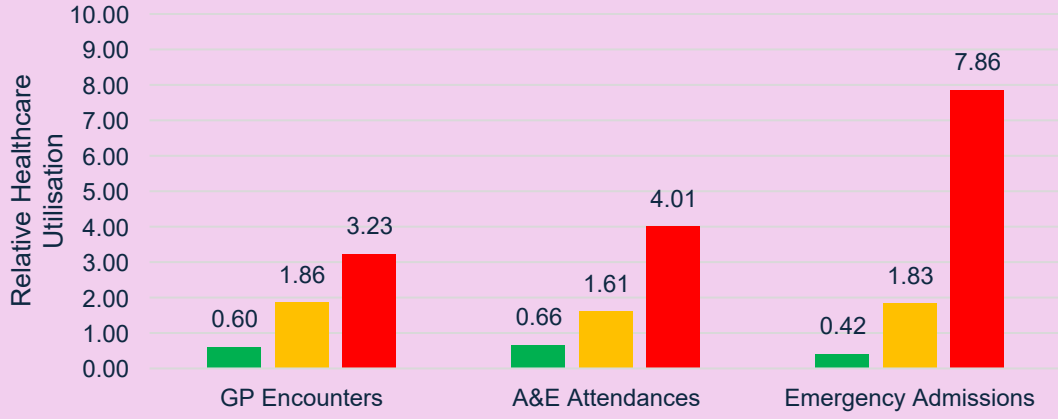
Patient Need Group (PNG) segmentation takes a multimorbidity approach to categorising patients across Kent and Medway.



PNG 10-11 (Red) account for 3% of the pop. but 10% of GP encounter and almost 25% of emergency admissions



PNG 10-11 have >3x more GP encounters, 4x more A&E attendances and 8x as many emergency admission compared to the average patient



Resident insight and shared priorities

How public engagement has informed the priorities, outcomes and measures for the Plan

Community Engagement Activity Undertaken

Engagement Activity Undertaken

Healthwatch and EK360 undertook community engagement activity across a few Kent and Medway , including:

Kent:

- Ashford
- Dover
- Folkestone & Hythe
- Tonbridge & Malling
- Swale

Medway:

Rochester
Gillingham

Further localities continue to be explored through ongoing engagement activity

Key Themes Raised by Residents:

The following themes consistently emerged through community conversations:

- Mental Health and Wellbeing
- Community support, social connectedness and belonging
- Community safety and anti-social behaviour
- Financial Hardship and cost of living pressures
- Access to services, transport and local amenities
- Health ageing and independence
- Children and young people
- Wider Determinants of Health
- Prevention and early intervention

What This Tells Us

Community engagement highlights the issues that matter most to residents and provides an important complement to strategic evidence and population health data. These insights have informed the development of Neighbourhood Health Plan priorities and delivery approaches.

What residents told us

EK360 and Healthwatch place-based engagement identified recurring themes across six local areas.

ENGAGEMENT COVERAGE

Six place-based views

- Ashford
- Rochester
- Gillingham
- Folkestone & Hythe
- Swale
- Tonbridge

Themes varied in prominence by place, but a consistent picture emerged.

COMMON THEMES ACROSS PLACES

Mental wellbeing

A recurring concern across all six areas.

Community connection

Belonging, social cohesion and local networks matter.

Prevention and early support

Residents want support before needs escalate.

Healthy ageing and independence

Remaining independent and supported close to home is important.

Community safety

Safety and the local environment affect wellbeing.

Inequalities and wider determinants

Cost of living, transport and access shape outcomes.

Residents describe health and wellbeing through everyday life, communities and access to local support, not through services alone.

Detailed place-by-place matrix included in the appendix.

From resident insight to shared priorities

Resident insight has informed and reinforced the emerging priorities, alongside strategic, population health and partner evidence.

WHAT RESIDENTS TOLD US

- People are concerned about mental wellbeing and access to support
- Strong communities and social connections matter to health and wellbeing
- Support should be available earlier, before problems become crises
- People want to remain independent and live well for longer
- Cost of living, transport and access to local services affect health
- Local community organisations provide important support

Resident voice

WHAT THIS TELLS US

- Health is shaped by more than health and care services
- Earlier support can prevent deterioration and escalation
- Community assets and VCSE organisations are central to delivery
- A neighbourhood approach is needed to connect support around people

Interpretation

HOW THIS SHAPES THE PLAN

- Prevention and early intervention
- Mental health and wellbeing
- Independence and ageing well
- Inequalities and wider determinants
- Children and families
- Neighbourhood delivery and community capacity

Plan response

Resident insight has informed and reinforced the priorities alongside strategic, population health and partner evidence.

Shared priorities, outcomes and measures

The Plan will connect locally agreed priorities to a small set of shared outcomes and measures, creating a clear line from ambition to delivery.

KENT & MEDWAY PRIORITIES

Prevention and early intervention • inequalities and wider determinants • children and families
Mental health • independence and ageing well • neighbourhood delivery

SHARED OUTCOMES

Improved healthy life expectancy • reduced inequalities • greater independence and wellbeing
Fewer avoidable hospital and residential care admissions • improved access and experience

HOW WE WILL MEASURE PROGRESS

POPULATION HEALTH

- Healthy life expectancy
- Health inequalities
- Mental wellbeing

SYSTEM IMPACT

- Non-elective admissions
- ED attendances
- Residential care admissions

ACCESS & EXPERIENCE

- General practice access
- Planned care
- Patient experience

NEIGHBOURHOOD DELIVERY

- MDT coverage and coordination
- VCSE engagement
- Social prescribing and plans

Measures will combine national framework requirements with locally agreed indicators and delivery milestones.

Kent County Council Adult Social Care priorities:

1. **Delivering** major recommissioning programmes and strengthening market stability, quality and value for money
2. **Developing** our workforce, digital infrastructure and enablers that support safe, efficient and modern practice
3. **Strengthening** practice, safeguarding, decision-making and quality assurance, including delivery of the CQC Improvement Plan
4. **Managing** demand and affordability through better pathways, decision-making and commissioning rather than reliance on in-year savings alone
5. **Shifting** investment upstream through prevention, enablement, community support and technology enhanced lives
6. **Improving** discharge, intermediate care and joint working with health partners to reduce delays and system pressure

A range of key themes, detailed below, present an opportunity to embed Neighbourhood Health into existing activities within the Delivery & Transformation Plan.

Opportunities: Key Outputs from ASC Workshop

- **Prevention and Early Intervention** Focus will shift more to upstream action, with a greater focus on identifying people earlier, supporting rising-risk cohorts and preventing escalation into statutory services recognising a need to "invest to save" and protect prevention activity.
- Neighbourhood health provides an opportunity to strengthen ASC's preventative approach by supporting earlier intervention, targeted support and improved connection to community resources before people reach crisis point.
- **Demand Management, Pathways and Decision Making** There are challenges associated with increasing demand, limited capacity and the need to use resources more effectively. There are benefits in pathway mapping, reducing duplication, simplifying access routes and improving the consistency of decision-making. We should focus professional time on preventative activity by reducing unnecessary processes and improving how people move through health and social care systems.
- Neighbourhood health can support clearer pathways, improved decision-making and more effective management of demand by ensuring people receive the right support at the right time and in the least restrictive way possible.

- **Independence, Enablement and Discharge.** Action must help people remain independent reducing reliance on long-term care with a greater focus on enablement, rehabilitation and strengths-based practice, alongside recognition that hospital admission and discharge pathways represent a key opportunity to intervene earlier and improve outcomes. This includes admission avoidance, prevention at the point of admission, stronger hospital discharge arrangements and investment in community-based support as alternatives to long-term dependency.
- Neighbourhood health can support a seamless pathway that promotes independence before, during and after periods of ill health, ensuring enablement, discharge and community support operate as a single system focused on helping people recover and remain at home
- **Integrated Working and Workforce Culture** We need to break down organisational barriers and work more effectively across health, social care and community partners. Including improving relationships, communication and shared decision-making, with more joint visits, integrated roles and locality-based working. Co-location may enable stronger partnership working. There needs to be some cultural change, with professional trust and greater confidence in strengths-based practice.
- Neighbourhood health can promote integrated ways of working that bring services together around the individual, supported by shared ownership of outcomes, multidisciplinary working and a culture of collaboration.

- **Data, Digital and Population Health Intelligence** Data sharing and digital integration are key enablers of neighbourhood health. Partners need a better understanding of rising risk, unmet need and pathways into services. Partners need to explore integrated data, shared systems, waiting list visibility, AI-enabled solutions and the need for "one version of the truth" to support earlier intervention and coordinated care.
- Neighbourhood health can utilise data, digital technology and population health intelligence to identify people earlier, improve service coordination and support more proactive interventions.
- **Community Capacity, VCSE and Commissioning** Neighbourhood health cannot be delivered without community assets, voluntary organisations and local networks supporting wellbeing, preventing escalation and reducing demand on public services. Opportunities include strengthening VCSE infrastructure, expanding Community Wellbeing Services and using commissioning to create more preventative, community-based support.
- Neighbourhood health can strengthen community capacity by building stronger partnerships with VCSE organisations and commissioning services that support prevention, resilience and independence within local communities.

DRAFT children and young people priorities

1. **Delivering** major recommissioning programmes and strengthening market stability, quality and value for money
2. **Developing** the workforce across the system, digital infrastructure and enablers that support safe, efficient and modern practice
3. **Strengthening** practice, safeguarding, decision-making and quality assurance, including delivery of CYP and SEND reforms
4. **Managing** demand and affordability through better pathways, decision-making and commissioning rather than reliance on in-year savings alone
5. **Shifting** investment upstream through prevention, enablement, community support and technology enhanced lives
6. **Improving** discharge, intermediate care and joint working with health partners to reduce delays and system pressure

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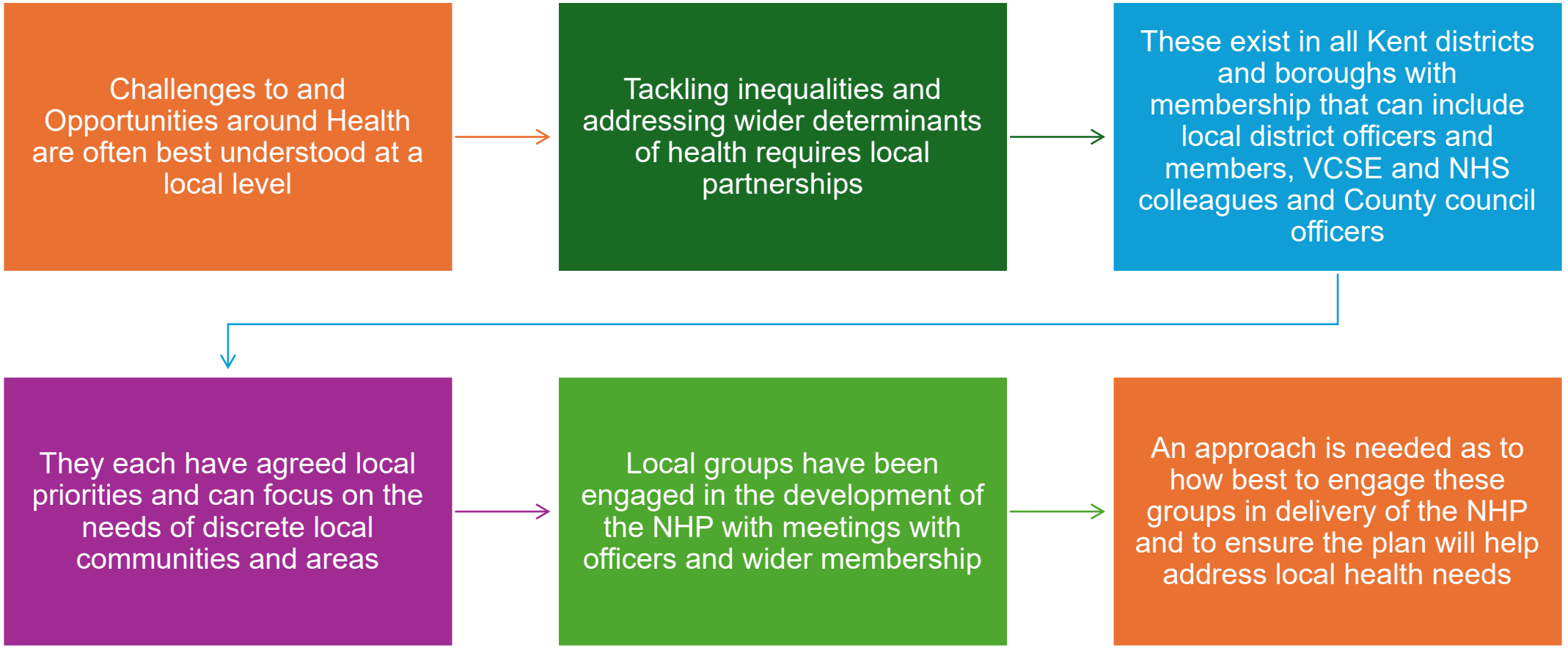
Opportunities

- **Prevention and Early Intervention** Focus will shift more to upstream action, with a greater focus on identifying people earlier, supporting rising-risk cohorts and preventing escalation into statutory services recognising a need to "invest to save" and protect prevention activity.
- Neighbourhood health provides an opportunity to strengthen preventative approach by supporting earlier intervention, targeted support and improved connection to community resources
- Support self management so that families and carers feel able to manage clinical conditions safely and appropriately at home
- **System Integration**
- Coordinate closely across education, social care, and voluntary (VCSE) partners using shared decision-making and streamlined "tell-us-once" navigation for families
- **Demand Management, Pathways and Decision Making**.
- For example, identifying support for children with behaviours that challenge before they go into crisis and end up in hospital and/or placements break down.

- **Timely Community Access:** GPs use integrated neighbourhood teams (INTs) to provide direct, local access to paediatric expertise alongside mental health and community services.
- For example taking an MDT approach to children's care within primary care setting bringing together paediatricians, GPs, social prescribers, social care, mental health services and VCSEF to reduce the number of appointments families are given and ensure a clear consistent care plan is in place and understood by all. **Integrated Working and Workforce Culture**.
- Align neighbourhood teams with community assets like Best Start Family Hubs to support babies and children aged 0 to 5.
- Align neighbourhood health teams with the children's and SEND reforms

- **Data, Digital and Population Health Intelligence** Data sharing and digital integration are key enablers of neighbourhood health. Partners need a better understanding of rising risk, unmet need and pathways into services. Partners need to explore integrated data, shared systems, waiting list visibility, AI-enabled solutions and the need for "one version of the truth" to support earlier intervention and coordinated care.
- Families are able to better navigate the system to access the right support and only need to tell their story once.
- Children with disabilities are clearly flagged within the system and reasonable adjustments are made to meet their need.
- **Community Capacity, VCSE and Commissioning** Neighbourhood health cannot be delivered without community assets, voluntary organisations and local networks supporting wellbeing, preventing escalation and reducing demand on public services. Opportunities include strengthening VCSE infrastructure, expanding Community Wellbeing Services and using commissioning to create more preventative, community-based support.
- Neighbourhood health can strengthen community capacity by building stronger partnerships with VCSE organisations and commissioning services that support prevention, resilience and independence within local communities.

Local Health Partnerships and Alliances



District Alliance Priorities

District	Title
Ashford	Ageing well, Housing, Young People
Canterbury	Health and wellbeing and self-care , Poverty, Homelessness and housing, teenage mental health
Dartford	Building Community Capacity, Dementia friendly community, Healthy Behaviours, Children and families, Older people and Ageing Well, WDH, Food Security, HiAP,
Dover	Healthy Minds, Healthy Weight and Lifestyle, Long Term Conditions
Folkestone and Hythe	Ageing Well, Building Community Capacity, Prevention
Gravesham	Embed a Health in All Policies (HiAP) , Young people, MECC, Longe Term Conditions
Maidstone	Empower communities , improve housing and environment, better partnership work
Sevenoaks	wider determinants of health, lever power of communities, promote healthy behaviour
Swale	Community, Economy, Environment, Health and Housing
Thanet	Employment, Mental Wellbeing, Frailty
Tonbridge and Malling	Improving children's health and healthy weight, Mental health, Age well
Tunbridge Wells	Addictions, Loneliness and isolation, Mental health, Obesity and Physical inactivity, Older people and people with disabilities

Key outputs from discussions with Alliances

- Local partners need consistent defined operational links at PCN level
- VCSE need to be engaged at Strategic level as well as locally
- Folkestone and Hythe holistic pilot approach and learning endorsed
- There is a need to balance clinical and WDH actions
- Mental health, children, housing, education, deprivation and transport issues cited
- Opportunities for coordinated social prescribing to help link PCNs to alliances
- Mapping of local services
- Sustainable funding for local initiatives

- Summary output by Districts engaged is available on link.....

NHS priorities for neighbourhood delivery

NHS services will shift from reactive, hospital-focused care towards proactive, integrated support closer to home.

1 Proactive neighbourhood care

Identify people at greatest risk earlier and coordinate support around frailty, complex needs, care-home residents, long-term conditions, mental health and children and young people.

2 Stronger primary care and urgent access

Improve general practice access, use community pharmacy more effectively and help people reach the right service first time.

3 Community care at greater scale

Bring together urgent response, virtual wards, hospital-at-home, rehabilitation, reablement and discharge support across nine footprints.

4 Planned care closer to home

Use Advice and Guidance, single points of access, straight-to-test pathways and community specialist services to reduce unnecessary hospital appointments.

5 Sustainable delivery

Use data, digital technology, workforce, contracts and funding differently to improve outcomes, productivity and financial sustainability.

SELECTED NATIONAL REFERENCE POINTS

- **10%** fewer admissions and bed days for specified high-priority cohorts by March 2029
- **90%** urgent GP patients seen the same day by March 2027
- **25%** outpatient diversion in ten high-volume specialties by March 2027
- **95%** people with complex needs to have an agreed care plan by 2027

National reference points are for context. Kent and Medway baselines and trajectories will be confirmed through the outcomes framework and annual planning process.

These priorities describe how NHS services will support delivery of the shared Plan, working with councils, providers, primary care, VCSE partners and communities.

From priorities to delivery over three years

Over the next three years, NHS services will move from establishing the model, to expanding it, to making neighbourhood working the normal way care is organised.

2026/27 ESTABLISH AND CONNECT

- Make Single Neighbourhood Health operational for complex and highest-risk populations
- Confirm responsibilities, pathways and escalation arrangements
- Begin urgent access and outpatient reform
- Put data-led commissioning and accountability foundations in place

2027/28 EXPAND AND SHIFT

- Extend proactive care to rising-risk populations, mental health and children and young people
- Implement consistent community and intermediate care
- Move selected planned care and diagnostics closer to home
- Align contracts, workforce and funding with neighbourhood delivery

2028/29 EMBED AND SUSTAIN

- Make neighbourhood care the normal operating model
- Reduce avoidable reliance on hospital-based care
- Provide simpler pathways with fewer hand-offs
- Sustain access, outcomes, productivity and financial balance

HOW SHARED PRIORITIES BECOME NHS DELIVERY

Neighbourhood Health Plan
Agreed priorities, outcomes and model

Three-year NHS plan
Phased pathway, workforce, activity and financial change

Annual commissioning intentions
Specific service and provider expectations

Contracts, investment and assurance
Funding, specifications, measures and oversight

The Kent and Medway Neighbourhood Model

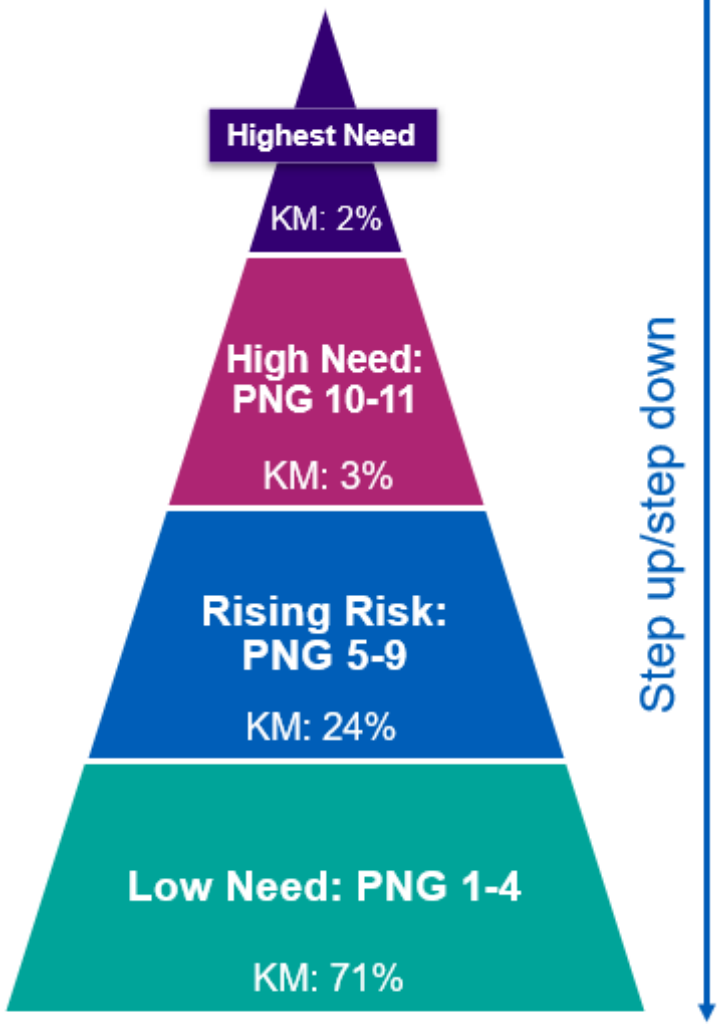
Health and care model, neighbourhood footprints and delivery arrangements

Neighbourhood Health and Care Model

Population Need Group	
	End of Life
	Highest complexity Care Home
11	Frailty
10	Multi Morbidity High Complexity
9	Dominant major chronic condition
8	Dominant psychiatric behavioural condition
7	Pregnancy – High complexity
6	Pregnancy – Low complexity
5	Multi-morbidity medium complexity
4	Multi-morbidity Low complexity
3	Low need adult
2	Low need child
1	Non-user

Patient needs

What are the levels of need in Kent and Medway?



Step up/step down

Care will be:

- Proactive identification and prevention
- Accessible and reliable ongoing care
- Rapid reactive care when needs arise
- The Integrated Neighbourhood Team working with one team ethos.
- Care matched to complexity, delivering the right intervention at the right time
- Improved outcomes, experience and continuity for all patient groups.

Where and by which teams:

- Predominantly out of hospital-general practice, neighbourhood, and people's homes/ care homes.
- GP teams, community health, mental health, social care, pharmacy, Hospice, Acute and voluntary sector partners working together
- Multi-neighbourhood teams provide higher-acuity, hospital-level care at home
- An integrated neighbourhood workforce wraps around patients across, predominantly, out of hospital setting.

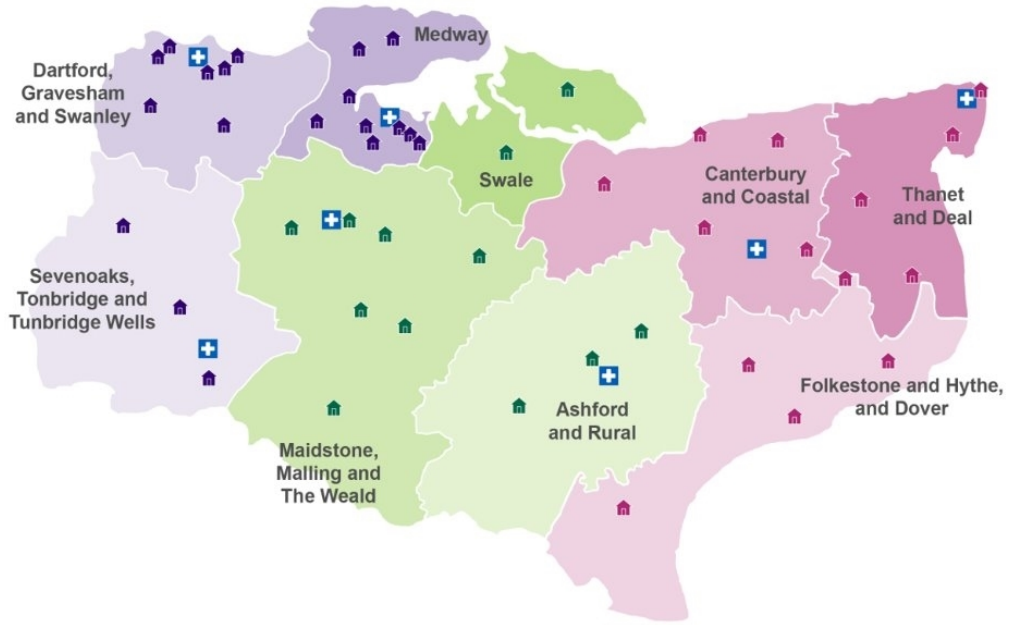
Key enablers

- Modern General Practice Access Model
- Population segmentation and risk stratification
- Digital transformation and interoperability
- Shared records
- Provider collaboratives

- Clinical governance/risk management
- Contracting mechanism / risk sharing
- Workforce
- Finance
- Clinically led
- Estates
- Communication and Engagement

Our neighbourhood footprints

A consistent framework for organising local delivery while reflecting communities, population need and existing partnerships.



	Multi-neighbourhood footprint	Registered patients
1	Dartford, Gravesham & Swanley	297,955
2	Medway	338,780
3	Swale	109,030
4	Canterbury and Coastal	221,200
5	Thanet and Deal	205,020
6	Dover, Folkestone & Hythe	180,890
7	Ashford and Rural	216,000
8	Maidstone, Malling and The Weald	297,990
9	Sevenoaks, Tonbridge & Tunbridge Wells	241,660

SINGLE NEIGHBOURHOODS

45 geographic footprints, each covering around 30,000–50,000 residents and broadly aligned to PCN footprints. They provide the local basis for relationship-based care and partnership working.

MULTI-NEIGHBOURHOODS

Nine wider footprints bring together several single neighbourhoods to coordinate services, workforce and capability that need greater scale.

How single and multi-neighbourhoods work together

The two neighbourhood levels connect proactive health and care services with community assets, prevention and wider support.

PRIMARY CARE › SINGLE NEIGHBOURHOOD › MULTI-NEIGHBOURHOOD › ACUTE HOSPITAL

Support increases as needs change, while maintaining a consistent emphasis on prevention, independence and care close to home.

SINGLE NEIGHBOURHOOD

Proactive and coordinated care for defined populations

- Identifies people who would benefit from earlier, proactive support
- Coordinates support around individuals, families and communities
- Connects primary care, community health, mental health, social care and VCSE partners
- Links clinical care with prevention, wellbeing, community assets and wider support

CONNECTED MODEL ⟷

MULTI-NEIGHBOURHOOD

Scaled services serving several single neighbourhoods

- Provides urgent, specialist and recovery services requiring greater scale
- Coordinates pathways, workforce and resources across neighbourhoods
- Supports diagnostics, rapid response, rehabilitation and hospital-at-home
- Connects local prevention and support with specialist and acute services when needed

Together, the two levels connect local prevention, wellbeing and community support with increasingly coordinated and specialist health and care services as people's needs change.

System Action to support Local Health Partners

Agree mechanism to allow local NHS engagement with local partnership through PCNs/SNTs

Define key lessons from local NHHIP pilots to deliver key system objectives including reduced hospital and residential care admissions, reduces GP attendances and improved, local joined up partnership working.

Develop a coordinated joined up approach to social prescribing

Develop systems with VCSE Alliances and leadership to enable local VCSE partners to play an optimally effective role in improving health

Produce local health profiles at community/PCN level to inform local action

Mental Health

Mental Health Challenges and Opportunities

- Mental health need is rising, increasingly complex and unevenly distributed, with high-risk cohorts, significant hidden need and stark geographic variation driving avoidable pressure across urgent and emergency care and can lead to early deaths.
- MH Conditions are concentrated in areas of deprivation exacerbated by multimorbidity and variation in access/ barriers to access.
- These inequalities make a clear case for shifting to proactive, equitable preventative neighbourhood models that intervene earlier, strengthen community and VCSE support, and reduce reliance on crisis pathways.
- This requires a coordinated whole-system response - spanning acute care, mental health services, primary care, local authorities, VCSE organisations, criminal justice partners, substance misuse, carers and people with lived experience and local residents- working together to build resilient, integrated community-based mental health support.
- There is a significant opportunity to use community assets, hyperlocal alliances, economic development and creative partnerships to strengthen the opportunities and lived experiences of people with mental health problems.

High Level Objectives

Focus is on high-impact objectives where local and national evidence shows the greatest opportunity to move activity away from crisis pathways:

- **Reducing avoidable Emergency Department presentations and inpatient bed occupancy** through enhanced neighbourhood and primary care mental health support, including Assist & Embrace and short-term step-down alternatives to prolonged KMMH admission.
- **Establishing a sustainable, well supervised Additional Roles and Reimbursement Scheme (ARRS) mental health practitioner workforce** in primary care, protecting and growing these roles and using new GP contract flexibilities to support future expansion.
- **Using best evidence and research to tackle suicide and self harm and deaths from despair**– strategically and locally – increasing opportunities to ensure people get help earlier, better mental health networks, peer support, training and community assets and enhancing the LIVE WELL model.
- Additionally, Linked to Long Term Conditions, **Reshaping the dementia pathway** by closing the post diagnostic support gap and rebalancing delivery between KMMH and VCSE partners, enabling specialist teams to focus on evidence based clinical interventions while community organisations provide personalised support closer to home.

Priority 1: ED presentations and step-down beds

- Develop short term step-down bed offer that enables clinically ready-for-discharge patients to move from acute wards into a transitional setting for assessment, stabilisation and discharge planning.
- Trust-wide extension of Assist & Embrace model alongside a new Start-Afresh CBT/ACT clinic to provide early stabilisation, psychological support and co-produced safety planning for people at risk of crisis escalation, reducing inappropriate ED presentations and supporting safer, more timely transitions back into community care.

Impact across the pathway:

- Improving flow and discharge- through short-term step-down capacity that release acute beds, reduce CRFD related pressure and prevent high-cost private placements.
- Crisis-prevention models –reducing inappropriate ED presentations and preventing avoidable discharge.
- Targeted upstream flow-improvement interventions – reducing OOA placements and LOS and improving system flow.

Priority 2: Dementia Pathway

Kent and Medway already have several initiatives underway that provide a strong foundation for a neighbourhood-based dementia model:

- 43 VCSE Dementia Care Coordinators (DCCs) across all 42 PCNs providing proactive case management, navigation, carer support and continuity from pre-diagnosis to end-of-life. Focus is on wider, non-clinical need, enabling specialist teams to focus on diagnosis, medication and complex presentations. There are also Hospital Dementia Coordinators including at Darent Valley Hospital
- Community Wellbeing Service: A county-wide VCSE wellbeing service offering early help, social connection, lifestyle support, benefits advice, housing guidance and carer support providing a ready-made infrastructure for neighbourhood dementia support, strengthening prevention and reducing isolation. The service is being redesigned for launch late 2027.

- NNHIP Dementia Transformation Programme testing how specialist mental health expertise can be embedded within neighbourhood teams:
  - Level 1: Dementia support in care homes
  - Level 2: Community diagnostic pilot delivering “diagnosis closer to home through neighbourhood teams” and MDT decision-making supported by secondary care
  - Level 3: Specialist oversight, advanced practitioners and consultant input integrated into neighbourhood MDTs

The NNHIP programme has shown that effective dementia pathways require “primary care, mental health, community, social care and VCSE partners to work as a single system.” This learning directly supports the shift towards neighbourhood-based post-diagnostic support.

Proposed Model for Dementia Pathway:

- Improve ascertainment of people with dementia increasing levels of diagnosis to the level of peers.
- The mental health trust to deliver assessment, diagnosis, medication and CST (cognitive stimulation therapy). Living Well with Dementia to be delivered by partners.
- The model protects evidence-based clinical interventions, makes efficient use of specialist capacity, and strengthens neighbourhood-based support. Delivery will require upfront investment and/or system-wide savings if elements of the model are delivered by partner organisations, ensuring the neighbourhood-based capacity needed to achieve the intended benefits is fully funded and sustainable.
- Ensure strong carer support learning from the recent Carers' Health Needs Assessment.

Priority 3: ARRS Mental Health Practitioners

- Standardisation of the ARRs roles (with room for local tailoring), specific links into MHT including formal supervision, and a single identified link person in each neighbourhood
- Mental Health Practitioners will receive formal, structured clinical supervision from KMMH, embedded as a core requirement agreed with GP partners to ensure consistency, safety and sustainability across neighbourhoods. This will provide clear clinical governance, strengthen links between primary and secondary care, and address the isolation and variability highlighted in previous reviews.
- Retire the “MH ARRS” label, which carries stigma and does not reflect the breadth or purpose of the role. A refreshed role identity will support clearer communication with patients and staff, improve professional recognition, and reinforce the practitioner’s function within integrated neighbourhood mental health teams.

Live Well (a wraparound easy to access Early Help approach to well being)

- Live Well Kent & Medway: A county-wide VCSE wellbeing service offering early help, social connection, lifestyle support, benefits advice, housing guidance and carer support. LWK provides a ready-made infrastructure for neighbourhood well being support, strengthening prevention and reducing isolation.
- Easy step up and step down access to mental health support, advocacy and recovery – linking community support to talking therapies
- No Wrong Door approach – trauma informed and peer led approaches to well being and resilience

Further Priority actions

- Enhanced costing and activity modelling for ED step-down beds, ARRS roles and dementia post-diagnostic support, including assumptions on flow, length of stay, avoided admissions and reduced out-of-area placements.
- Development of a clear outcomes and impact framework with defined KPIs to track changes in ED presentations, repeat attendances, crisis escalation and continuity of care.
- Further analysis of high-risk cohorts driving ED activity — including self-harm, trauma-related distress, complex emotional needs and long-term conditions linked to health anxiety - distinguishing between those known and unknown to KMMH and identifying gaps in earlier contact.
- Alignment of the proposed model with the ICB's mental health commissioning review to ensure future commissioning intentions support neighbourhood-based prevention and early intervention.
- System-wide collaboration to develop the detailed investment ask, recognising that recurrent funding requirements will ne

Potential Community Action in Neighbourhoods

Many local Alliances/Partnerships have mental health as a priority, proposed actions to be considered could include:

- Rapid local asset mapping—of trusted routes, gaps, local connectors and opportunities.
- Agree one public mental health “proof of practice” with a defined cohort, local delivery partners, intervention, equity objective, outcome measure and learning plan.
- Strengthen trauma-informed practice, stigma reduction, social connection and community resilience through existing local infrastructure rather than stand-alone NHS schemes.
- Connect this explicitly to existing prevention programmes: suicide prevention, substance misuse, gambling harm, domestic abuse, family support, employment, cultural and physical activity partnerships.

Neighbourhood clinical-community integration

- A route into early help that does not depend solely on specialist thresholds.
- Understanding and implementing links to NHS Talking Therapies and social prescribing and recovery planning
- A defined process for bringing people with complex, repeated or escalating need into an MDT.
- A named coordinator/keyworker and shared recovery plan for the agreed high-need cohort.
- A physical-health and medicines offer for people with serious mental illness.
- Clear links between primary care, community mental health, social prescribing/Live Well, substance misuse, housing and VCSE.
- A robust step-down and post-crisis follow-up arrangement.

Areas for further work

- Primary , specialist and urgent care need to be fully integrated
- Prevention of Suicide, self harm and deaths with despair need to be a key focus
- Every person needs a recovery plan with 72 hour follow up for people who self harm
- A clear plan is needed for people with Addictions
- Ensure optimal adherence to NICE depression pathway in primary care

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LOCAL PILOTS NNHIP and CHATHAM ACCELERATOR

National neighbourhood health implementation programme

Scope:

Build a trusted INT in all 3 District PCNs built on good relationships focussed on the needs of our population providing proactive, reactive and an improved outpatient service model.

Aim is to develop a real world *minimum viable product* of a proactive and reactive cohesive INT and test new outpatient approaches in the Folkestone District during the NNHIP programme. Initial focus will be those with complex needs and frailty, bringing community health, care and VCSE assets together.

QI approach to all 3 workstreams, proactive, reactive and outpatients.

Practical work on key enablers including digital infrastructure (IT), and better use of estate.

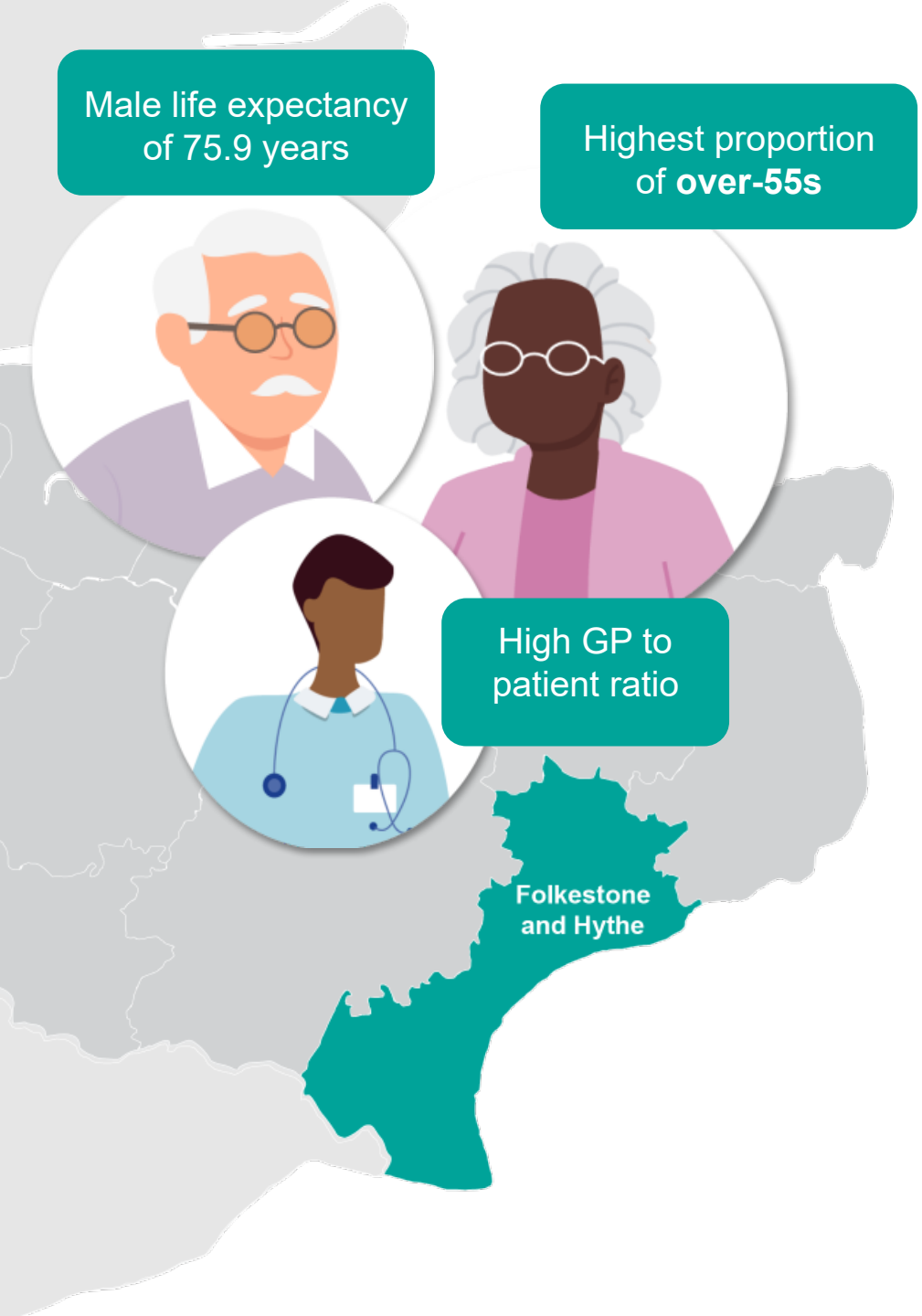
The work is delivered through a QI approach and is **data driven for all 3 workstreams, proactive, reactive and outpatients.**

Impact is monitored monthly through a **dashboard** which includes key metrics - people's and staff experience, impact upon unplanned emergency attendance, length of stay and admission to hospital initially for the most complex population cohort.

PDSA testing of change ideas
PDSA 1 – Coordinator role alignment
PDSA 2 – Shared assessment
PDSA 3 - Directory of services
PDSA 4 – Social MDT
PDSA 5 – Patient voice
PDSA 6- Children's and young people

PDSA testing of change ideas
PDSA 1 – Co-location
PDSA 2 – Cohort identification
PDSA 3 –Additional services
PDSA 4 – Directory of services
PDSA 5 – Management of CMR

PDSA testing of change ideas
PDSA 1 – Community out-patient appointments
PDSA 2 – Alternative out-patient provision
PDSA 3 – Patient activation
PDSA 4 – Digital literacy
PDSA 5 – Making every contact count



Folkestone and Hythe District

26 miles of coastline, 4.7million visitors every year and growing in popularity. Distinct communities – urban, rural and coastal geography

Health inequalities

Third highest levels of deprivation across Kent and Medway with some of the lowest life expectancy rates.

Residents experience higher rates of cancer, hypertension, stroke and COPD.

Workforce and demand:

Substantial workforce challenges

3 Primary Care Network area coterminous with District Council Boundary.

GP to patient ratio is **1 to 2637** for the Marsh, 2,695 for Folkestone, Hythe and Rural and 2901 for Total Health Excellence West.

The local acute hospital is William Harvey Hospital. Experiencing some of the most extreme pressure in 12 hour waits in the country

Ageing population

Highest proportion of **over-55s** in county, with **42 care homes** across the district

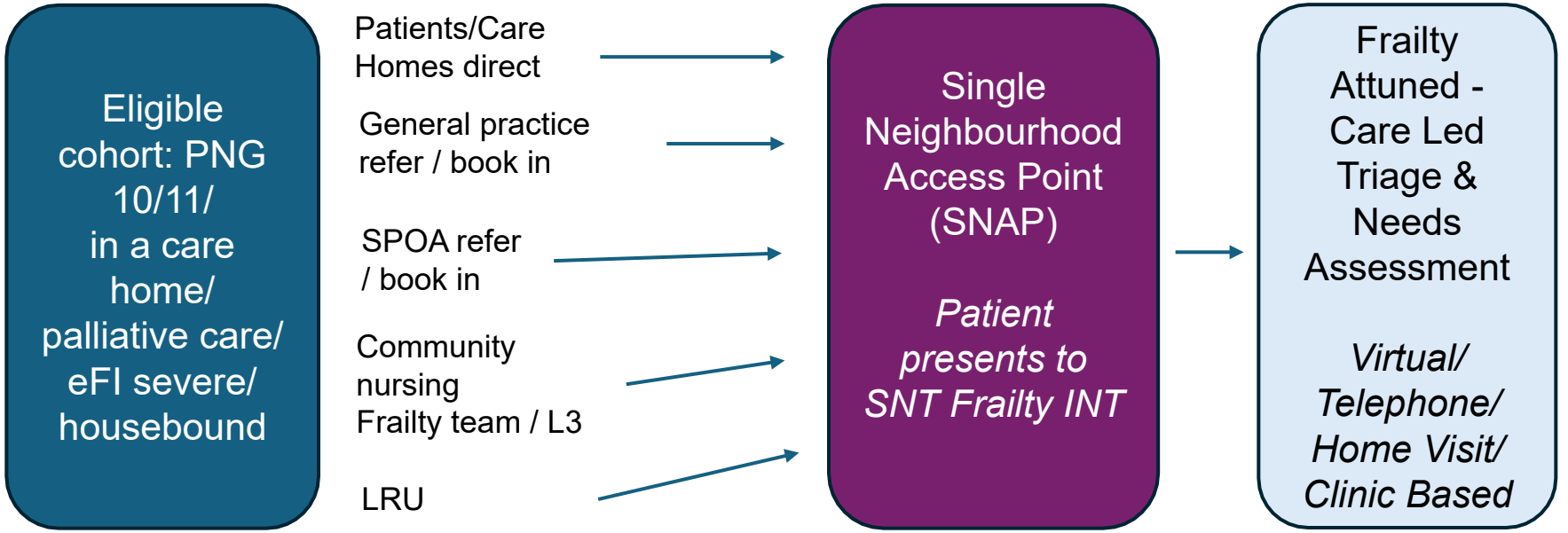
25% is **over 65** and projected to grow the fastest in Kent in the next decade.

48% rise in social care costs **by 2035** projected.

Over 50 care homes – KCC alone place over 400 people across the district

Folkestone, Hythe & Rural PCN NNHIP Model

Reactive Model: central co-located INT team



Level 3
Advice and guidance
H@H / Virtual Ward
Admission to Acute
Nr Pt Testing

MDT intervention

- Urgent nursing input
- Urgent therapies
- GP Ax and treatment including prescribing for EOL, Respect, JIC
- Home First or Social Care need*
- Mental Health Provision*
- Urgent Voluntary Response*
- Community bed admission*
- Step up

* Phase 1 priority access by **core team members**

Proactive Model: Case Finding

Level 1 Proactive and routine care

Review of "Top 100" from eligible cohort based on mortality risk score to ensure core interventions (e.g. CGA, ReSPECT, Structured Medication Review) in place or offered alongside other appropriate action, e.g. MDT referral

The Proactive Workstream - Total Health Excellence West (THEW) PCN

Discover:
Building on developed proactive neighbourhood MDT, workshops held to identify next steps for improvement and expansion of the model. Areas of success and strength identified in existing model for both adults and children's MDTs.

Design: Key areas of focus identified. These were:

- Integrating workforce further improving collaborative neighbourhood working
- New approach to patient voice
- Digital integration & shared information systems – CGA usage, TEAMs channel
- Widen remit to include reactive element for Complex Care patients
- Children's care MDT considering next improvement aims e.g. reduction in school non-attendance

Deliver: A series of improvement initiatives have started building on existing work and starting new ideas:

- Review of Care Coordinators, Social Prescribers and Age UK Care Navigators to support a one team approach. Engagement with KCC, KCHFT, Age UK and Involve Kent. Single job description.
- Directory of Service – using the JOY platform if compatible with EMIS Clinical Services to build local DOS accessible to all partners
- THEW testing a Social MDT held a staff workshop to support initial design and team development.
- Test single initial assessment across all teams for proactive work
- Patient Participation Group support with identifying opportunities for wider patient and public engagement, including harder to reach communities
- Continuing the MDT's and sharing of the learning with all PCN's across Folkestone and Hythe
- Data driven, early signals in data of reduction in cohort admissions

The Outpatient Workstream – The Marsh PCN

Discover:

Residents reported that accessing care can be difficult due to travel requirements for outpatient appointments, poor coordination between services, communication challenges, appointment booking difficulties, and digital exclusion, all which impact experience and accessibility of care.

Design:

Key areas of focus identified.
These were:

- Pre-operative assessment appointments closer to home
- Supported discharge/admission avoidance
- Improved support for patients diagnosed with pre-diabetes/diabetes
- Mental health appointments closer to home
- Accessible Oncology care

Deliver:

A series of improvement initiatives have been identified and designed to bring care closer to home, improve coordination between services and test more integrated ways of working:

- Pre-operative assessment – hybrid pathway between the PCN and EKHUFT enabling clinically suitable elective patients to complete elements of their pre-op assessment at a local GP practice.
- Safe to be at home model - designed to enable supported discharge and admission avoidance. The service will provide non-regulated interventions to help people with complex needs to return home sooner.
- Community diabetes improvement - a quality-improvement workstream responding to the Marsh's higher-than-average prevalence of diabetes and pre-diabetes. Delivery includes mapping the current pathway and agreeing priorities for targeted improvement.
- Mental health care closer to home - a six-month test offering eligible patients the choice of attending face-to-face or group Mental Health Together appointments at the Lighthouse on the Marsh rather than travelling to Folkestone or Canterbury.
- Locally accessible oncology support - new-patient conversations and pre-chemotherapy clinics in New Romney, alongside work to improve transport information and support for people travelling to hospital for treatment or outpatient appointments

NNHIP Model - Challenges and Lessons Learned (Note: Pilot still live)

Successful neighbourhood integration requires more than aligning services. It is dependent on shared clinical models, clear roles, compatible infrastructure, accessible estates and a unified cultural shift toward collaboration.

- Estates locally – access to space and associated funding/governance arrangements owing to fragmented estates portfolios across the geography.
- Variance in understanding of urgent care provision through primary care lens vs community staff.
- Clinical responsibility/risk management when adopting news ways of working different to contractual terms. Roles and responsibilities need clarification, so all know the scope of the team/individuals.
- Operational barriers are not typically easy to resolve, especially in a timely manner, e.g. blood tests, primary care IT for community staff, data sharing and information governance processes across systems.
- Challenge to integrate teams at pace to adapt to new ways of working and obtaining estate and resource to enable co-location of staff.
- Data/evidence challenge – quantitative evaluation data is difficult to obtain from EMIS, which is an operational system for primary care which by nature is not episodic, unlike many other healthcare systems which operate with defined pathways.

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Holding slide for Chatham Accelerator pilot

Together, we can

Hi level phasing

The following organizes the effort around five domains of focus together with six enabling workstreams that will need to be addressed. It sets out a phased approach to implementation that builds upon a critical path of development as well as an engagement approach that generates both "bottom up" engagement and learning as well as "top down" strategic direction.

Phased implementation approach:

- **Shorter term (0 – 12 months)**: Focus on establishing the governance and **leadership** of Neighbourhoods, identifying the geographical neighbourhood boundaries and building momentum **and engagement among frontline teams**
- **Medium term (6 months – 2 years)**: Focus on defining the core neighbourhood **delivery model** through a PDSA test and learn approach, **engagement of residents and communities** in co-production of interventions, and expansion of model to effectively **align with system partners**
- **Longer term (1 – 3+ years)**: Focus on **embedding a prevention** focus, use of digital and other tools, **re-alignment and devolution of neighbourhood budgets** and the measurement of impact and evaluation

Engagement layers:

- **Frontline team engagement**: Protected time and headspace to attend PDSA-focused workshops, reflective learning events and facilitated support to test and learn from different neighbourhood models. Collation of best practice models and systemic barriers to progress
- **Operational management engagement**: In addition to attendance at PDSA-focused improvement events, specific coaching and mentoring to build capacity and capabilities across both managerial and clinical/professional leads
- **Senior leader engagement**: Support for scale and spread of best practice models and resolution of systemic barriers, prioritisation of resources to support “left shift”, development of strategic direction of travel in line with learning from the frontline, coaching and mentoring for senior leaders

Illustrative Place/Neighbourhood delivery roadmap – BASE PLAN

Focus of workstream
Maturity Domain
Maturity Enabler

High-level Place and Neighbourhood development roadmap

Shorter term (0 – 12months)

Leadership, structure and neighbourhood definition

- 1: Develop population health understanding by team
- 2: Agree core team membership
- A: Establish neighbourhood governance and leadership
- B: Map current digital systems, PHM tools – establish data foundations
- E: Mobilise Neighbourhood workforce

Intelligence, infrastructure and workforce model

- 1: Establish population health management capability
- 2: Develop neighbourhood interventions and model
- 3: Community-led co-production
- C: Identify and engage physical and community assets
- D: Align commissioning intentions
- F: Develop shared outcomes framework

Critical Outputs

- Neighbourhood geographies confirmed
- Leadership, governance and agreed vision in place
- Initial population understanding

Critical Outputs

- PHM priority cohorts defined
- Neighbourhood model development
- Data foundations in place
- Agreed outcomes framework

Medium term (6 months – 2 years)

Identify integrated neighbourhood core offer

- 2: Identification of neighbourhood blueprint/core offer
- 4: Identify resident & patient engagement approaches
- 5: Improve alignment of teams with acute, VCSE, social care partners
- B: Systematise use of digital and data tools e.g. neighbourhood dashboards
- E: Focus on collaborative leadership and team behaviours

Mainstream & expand neighbourhood working

- 2: Accelerate and expand implementation of model
- 3: Continue iterative community-led co-production cycles
- 4: Continue resident & patient activation activities
- C: Co-location and hub development aligned with redesigned pathways
- D: Consider opportunities to delegate neighbourhood budgets
- F: Begin programme evaluation

Critical Outputs

- Neighbourhood core offer identification
- Collaborative leadership & culture development
- Resident and patient engagement

Critical Outputs

- Neighbourhood model expanded and embedded
- Strong community role in care delivery
- Opportunities and mechanisms to delegate budgets identified

Longer term (1 – 3+ years)

Integration and resource alignment

- 1: Refine PHM and cohort prioritisation with prevention focus
- 5: Further develop neighbourhoods in support of care pathways
- D: Ensure commissioning and investment is aligned
- E: Shared workforce planning across system to support neighbourhoods

Evaluation, learning and scaling of model

- 3: Scale community capacity and prevention programmes
- 4: Expand self-management and digital support
- A: Ensure leadership and governance continues to be fit for purpose
- F: Evaluation of outcomes, experience and activation measures

Critical Outputs

- System and pathway alignment with neighbourhoods
- Identification of resource and investment opportunities

Critical Outputs

- Measurable outcomes & activation improvement
- Leadership & governance arrangements aligned
- Expanded community capacity & prevention focus

Leadership & senior teams: Set strategic direction, foster permissive culture, establish cross-sector governance and accountability frameworks, unblock systemic barriers leveraging support of local, regional and national partners

Operational management: Specific investment in leadership development, collaborative working, enabling innovation and a learning culture

Frontline teams: Frontline trust and relationship development, PDSA test and learn, protected headspace to consider neighbourhood delivery model and new ways of working, bottom-up generated insight and interventions

Programme Management and Oversight

Delivery Journey

The Plan describes a phased three-year transformation journey which will evolve as neighbourhood delivery matures across Kent and Medway.

Year	Focus
Year 1	Foundations and highest-risk cohorts
Year 2	Expansion of neighbourhood delivery, including CYP
Year 3	Mature neighbourhood model

The neighbourhood model should describe a long-term transformation journey, recognising that neighbourhoods are starting from different levels of maturity and that implementation will be phased over several years. Existing local partnership arrangements should be supported and built upon rather than replaced.

Enablers

- Integrated Data and Data Sharing
- Future of KMCR and John Hopkins tool
- IAG solutions
- VCSE Infrastructure

Governance and accountability

Proposed arrangements for strategic ownership, partnership stewardship and delivery assurance

How the Plan will be governed

The Health and Wellbeing Boards provide strategic ownership; councils, the ICB and wider partners jointly steward the Plan; and the Programme Board coordinates implementation and assurance.

HEALTH AND WELLBEING BOARDS

Strategic ownership and oversight

JOINT STEWARDSHIP OF THE PLAN

Kent and Medway councils • Integrated Care Board • wider partners

NEIGHBOURHOOD HEALTH PROGRAMME BOARD

Coordinates development, delivery, risks and assurance

DELIVERY THROUGH EXISTING ARRANGEMENTS

NHS providers and Provider Alliances • councils • Health Alliances and local partnerships • neighbourhood teams • VCSE and communities

Shared outcomes, measures, risks and learning provide assurance back to the Boards

Proposed roles and responsibilities

The table sets out the proposed contribution of each partner. Formal decision rights, delegated authority, membership and escalation routes will be confirmed through supporting terms of reference.

PARTNER / GROUP	PROPOSED CORE RESPONSIBILITY
Health and Wellbeing Boards	Strategic ownership of the locally owned Plan; align it with JSNAs and joint local health and wellbeing strategies; oversee progress against agreed population outcomes.
Kent and Medway councils	Bring statutory responsibilities, population intelligence and local priorities; lead prevention, inequalities and wider determinants; align relevant council plans and services.
Integrated Care Board	Align NHS strategic commissioning, planning and investment with the Plan; commission and assure NHS delivery; support data, finance and system-wide enablers.
Neighbourhood Health Collaborative Board	Coordinate development and implementation; maintain the programme plan, dependencies and risks; consolidate assurance and escalate issues to the appropriate statutory body.
NHS providers and Provider Alliances	Co-design and deliver provider contributions; coordinate pathways, workforce and service transformation; provide assurance through existing provider governance.
Health Alliances and local partnerships	Shape local priorities and action; connect district, primary care, VCSE and community partners; support local coordination, engagement and feedback.
Single and Multi-Neighbourhood Teams	Translate the Plan into operational delivery for defined populations; coordinate multidisciplinary activity; test and improve local models; report outcomes, risks and learning.
VCSE, communities and people	Co-produce priorities and delivery approaches; contribute community assets, insight and services; provide feedback on access, experience and what matters locally.

Appendix/ Link

Outputs from meetings with local Alliances

Key Messages from local Health Alliances and partnerships

- **Ashford** Partnership would benefit from more consistant support from NHS leads and PCN reps. Currently have 1 year action plan. Will use current Alliance structure for now but aware will need to change as LGR develops. PH input and support to the Alliance is recognised and applauded.
- **Maidstone.** Who will set priorities and how will they be funded, how will Alliance link with NHS locally, Need to ensure VCSE have key role in strategic commissioning
- **Dover.** Need to align with Pride in Place initiative, need to shift resources with balance focus Kent and Medway wide and local, challenge around access dentist for children, Positivity around F and H pilot and desire that learning from this influences system including strong engagement PCNs with wider local partners and workforce aligned to local needs. Children's navigators mentioned. Recognition cost of VCSE activity, importance of involving local stakeholders in agreeing approach.
- **Gravesham.** Links needed at SNP level to ensure local focus, improve PCN engagement and NHS links with local partnership, bottom-up community led approach is important, need balance of actions between WDH and clinical. Further iterations of local priorities underway, value in qualitative metrices

Key Messages from local Health Alliances and partnerships

- **Folkestone and Hythe**, pilot well considered. Have SPOA with joined up statutory and VCSE working. VCSE integral and need resources, link at ICB level welcomed. Heterogeneity area noted with challenged Romney Marsh around transport and access. Many partnership groups/initiatives within local system may need better join up. Need strong PCN buy in to Alliance and wider working, MH and children issues need focus

- **Thanet,** Strong leadership, Alliance is seen as strategic, PCNs recognise importance WDH but little time to deliver on this, working with the willing in first instance, social prescribers important in delivering wider health and as link to primary care teams with local coordinated approach planned. Strong desire to have full PCN engagement starting with willing. Opportunity for GP surgeries to share local health information with the public.

- **Swale,** ensure mapping of local services already operating in communities that align with system priorities, improve collaboration, use existing local data to understand residents experiences and priorities. The value of the local partnership in collaboration, partnership working, information sharing and collective awareness was raised. Key local barriers to health included funding, transport and education. Recommendations around actions NHS and local partnership can take together included improved communication, service coordination, planning, resident engagement, outreach and use of local intelligence

Key Messages from local Health Alliances and partnerships

- **Canterbury**. Good PCN links with Alliance, Focus needed on wider determinants of health, particularly housing, employment and deprivation. PCNs face increasing pressure to prioritise complex care and frailty with new local contract. Sustainable funding needed for community-based interventions. Stronger neighbourhood working essential. VCSE critical role but faces funding and connectivity challenges, Social Prescribers are a key in linking healthcare with community. Improved coordination around funding opportunities
- **Tunbridge Wells.** Would benefit from improved links with the NHS. Have mental health navigators linked to the health action team partnership but not PCNs or SPOA to NHS leadership. Concern re low GP numbers and how VCSE can best link with primary care operationally with examples from maternity and mental health charities. Rural access to services, access for people who have deafness and women's health cited as issues. Opportunities around creative health mentioned

Summary of Public View of Health Determinants

What Residents Told Us: Emerging Themes from Place-Based Engagement

Theme	Ashford	Rochester	Gillingham	Folkestone & Hythe	Swale	Tonbridge
Mental Wellbeing	●	●	●●	●	●	●●
Community Connection & Social Cohesion	●●	●		●	●●	●●
Community Safety	●	●●	●●		●●	
Crime & Anti-Social Behaviour	●	●●	●●		●●	
Healthy Ageing & Independence	●●	●		●		●
Children & Young People	●				●●	
Prevention & Early Intervention	●		●	●	●●	●
Wider Determinants of Health	●●	●●	●●	●●	●●	●
Health Inequalities	●		●●	●●		●
Cost of Living / Poverty				●●		
Food Security				●●		
Transport & Access	●●			●		
Community Assets / VCSE Support	●			●●	●	●●

● = Theme identified

●● = Strong or dominant theme

Source: EK360/Healthwatch