Kent and Medway Joint Health and Wellbeing Board

A meeting of the committee will be held on:

Date: Thursday, 28 June 2018

Time: 4.00pm

Venue: St George's Centre, Pembroke Road, Chatham Maritime, Chatham ME4 4UH

Membership: *non-voting Members		
	Councillor Sarah Aldridge*	Swale Borough Council, Cabinet Member for Health and Wellbeing
	Ian Ayres	Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs
	Councillor David Brake	Medway Council, Portfolio Holder for Adults' Services
	Mr Paul Carter, CBE	Kent County Council, Leader and Cabinet Member for Traded Services and Health Reform
	Councillor Howard Doe	Medway Council, Deputy Leader and Portfolio Holder for Housing and Community Services
	Glenn Douglas	Accountable Officer for the eight CCGs in Kent and Medway
	Matt Dunkley, CBE	Kent County Council, Corporate Director Children, Young People and Education
	Catherine Foad	Chair, Healthwatch Medway
	Mr Graham Gibbens	Kent County Council, Cabinet Member for Adult Social Care
	Mr Roger Gough	Kent County Council, Cabinet Member for Children, Young People and Education

Steve Inett	Chief Executive, Healthwatch Kent
Councillor Alan Jarrett	Medway Council, Leader and Portfolio Holder for Finance
Chris McKenzie	Medway Council, Assistant Director Adult Social Care
Mr Peter Oakford	Kent County Council, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health
Councillor Martin Potter	Medway Council, Portfolio Holder for Educational Attainment and Improvement
Matthew Scott*	Kent Police and Crime Commissioner
Andrew Scott-Clark	Kent County Council, Director of Public Health
Councillor Tony Searles*	Sevenoaks District Council
Caroline Selkirk	Managing Director of Ashford, Canterbury and Coastal, South Kent Coast, and Thanet CCGs
Penny Southern	Kent County Council, Corporate Director Adult Social Care and Health
Ian Sutherland	Medway Council, Director of Children and Adults
James Williams	Medway Council, Director of Public Health
TBC*	Kent and Medway Local Medical Committee

Agenda

1 Election of Chairman

To elect a Chairman of the Kent and Medway Joint Health and Wellbeing Board for the forthcoming year.

2 Election of Vice-Chairman

To elect a Vice-Chairman of the Kent and Medway Joint Health and Wellbeing Board for the forthcoming year.

3 Apologies for absence

4 Declaration of Disclosable Pecuniary Interests and Other Interests

Members are invited to declare the existence and nature of any interests in relation to any agenda item in accordance with the relevant Council's Code of Conduct.

5 Urgent matters by reason of special circumstances

The Chairman will announce any late items which do not appear on the main agenda but which he/she has agreed should be considered by reason of special circumstances to be specified in the report.

6 Membership of the Kent and Medway Joint Health and Wellbeing Board **(Pages 5 - 14)**

This report sets out the current position on the membership of the Kent and Medway Joint Health and Wellbeing Board (Joint Board) and advises the Joint Board of a request from Kent County Council that Dr Robert Stewart be appointed as a non-voting member of the Kent and Medway Joint Health and Wellbeing Board.

7 Prevention Action Plan **(Pages 15 - 30)**

This report provides the Joint Board with further information concerning the Kent and Medway Sustainability and Transformation Partnership (STP) Prevent Action Plan. This Plan has been developed to align and coordinate preventative actions within the NHS and other public-sector organisations with existing Local Authority Public Health programmes and pathways.

8 Sustainability and Transformation (STP) Local Care Update **(Pages 31 - 88)**

This report provides the Joint Board with a summary of progress implementing local care across Kent and Medway. The report has a focus on the aims, objectives and key deliverables of local care, in addition to the governance arrangements and integration with the Better Care Fund, integrated planning and financial investment, the communications strategy, enablers and risks and issues.

9 Strategic Commissioner Update **(Pages 89 - 98)**

This report updates the Joint Board on the development of a single Strategic Commissioner across all eight Clinical Commissioning Groups (CCGs), including progress to date, the proposed role of the Strategic Commissioner, opportunities around integrated health and social care commissioning, governance arrangements and next steps.

10	**Work Programme** The report advises the Joint Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Joint Board an opportunity to shape and direct the Joint Board’s activities.	**(Pages 99 - 102)**

For further information please contact Jade Milnes, Democratic Services Officer on Telephone: 01634 332008 or Email: jade.milnes@medway.gov.uk

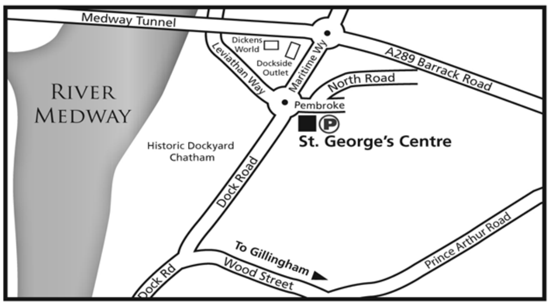
Date: 20 June 2018

Reporting on the meeting: Members of the press and public are entitled to report on this meeting except where the public are excluded, as permitted by law. Reporting includes filming and recording of the proceedings and use of the internet and social media such as tweeting and blogging to report the proceedings. Guidance for people wishing to exercise this right is available on the Council’s website and in the public seating area at the meeting.

It is helpful if people wishing to film the proceedings could contact the Council’s media team in advance on 01634 332736 or by email to pressoffice@medway.gov.uk. Please sit in the front row or other designated area if you wish to report on the meeting. If you are attending and do not wish to be filmed or recorded please sit at the back of the public seating area.

http://www.medway.gov.uk/thecouncilanddemocracy/reportingonmeetingsguidance.aspx

Please note that Wi-Fi can be accessed at the St George’s Centre as follows:
Name = CAN-St Georges Centre, Password = StGeorge01



This agenda and reports are available on our website
www.medway.gov.uk

A summary of this information can be made available in other formats from **01634 333333**

If you have any questions about this meeting and you want to speak to someone in your own language please ring **01634 335577**

বাংলা	331780	ગુજરાતી	331782	ਪੰਜਾਬੀ	331784	كوردي	331841	اردو	331785	Русский	332374
中文	331781	हिंदी	331783	Polski	332373	এঃহৎশফব	331786	فارسی	331840	Lietuviškai	332372

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
28 JUNE 2018
MEMBERSHIP OF THE KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

Report from: Julie Keith, Head of Democratic Services

Author: Jade Milnes, Democratic Services Officer

Summary

This report sets out the current position on the membership of the Kent and Medway Joint Health and Wellbeing Board (Joint Board) and advises the Joint Board of a request from Kent County Council that Dr Robert Stewart be appointed as a non-voting member of the Kent and Medway Joint Health and Wellbeing Board.

1. Budget and Policy Framework

1.1 Membership and the appointment of Dr Robert Stewart as a non-voting member to the Kent and Medway Joint Health and Wellbeing Board is a matter for the Joint Board.

2. Background

2.1 On 20 February 2018 and 21 March 2018 respectively, the Health and Wellbeing Boards of Medway Council and Kent County Council agreed to the establishment of the Joint Board together with the terms of reference and membership of the Joint Board as set out in Appendix 1 of the report.

2.2 If at any time after the establishment of the Joint Board either Authorities' Health and Wellbeing Boards wish to appoint additional non-voting members of the Joint Board, this may only be done after consultation with the Joint Board (Paragraph 5 (e), Appendix 1 of the report). It is a matter for the Joint Board to determine, as it considers appropriate, the appointment of additional non-voting Members.

3. Advice and analysis

3.1 The current membership of the Joint Board is as follows:

3.2 Voting Members of the Kent and Medway Joint Health and Wellbeing Board

3.2.1 The Leader of each Council and up to three other members of each Council nominated by the respective Leaders (or their substitutes):

Kent County Council (KCC) Councillors (4)	**Medway Councillors (4)**
Mr Carter, CBE	**Councillor Brake**
Mr Gibbens	**Councillor Doe**
Mr Gough	**Councillor Jarrett**
Mr Oakford	**Councillor Potter**

3.2.2 The Corporate Director of Adult Social Care and Health for Kent and the Assistant Director Adult Social Care for Medway:

Penny Southern (KCC) **Chris McKenzie** (Medway)

3.2.3 The Corporate Director Children, Young People and Education for Kent and the Director of Children and Adults Services for Medway:

Matt Dunkley, CBE (KCC) **Ian Sutherland** (Medway)

3.2.4 The Director of Public Health for each Local Authority:

Andrew Scott-Clark (KCC) **James Williams** (Medway)

3.2.5 Healthwatch representatives for Kent and Medway who must not be a Member of a Health Overview and Scrutiny Committee for either Authority and may each have a named substitute:

Steve Inett (Kent)	**Cath Foad** (Medway)
(Substitute – to be advised)	**(Substitute – Margaret Cane**)

3.2.6 A representative of each Clinical Commissioning Group (CCG) (noting that section 197 (7) of the Health and Social Care Act 2012 provides for one person to represent more than one CCG on a Health and Wellbeing Board subject to the agreement of the Board). Each CCG representative may have a named substitute:

Glenn Douglas:	Accountable Officer for the eight Clinical Commissioning Groups (CCGs) in Kent and Medway
Ian Ayres:	Managing Director for Dartford, Gravesham and Swanley; Medway; Swale; and West Kent CCGs
Caroline Selkirk:	Managing Director of Ashford, Canterbury and Coastal, South Kent Coast, and Thanet CCGs

(Substitutes – to be advised)

3.3 Non-voting Members of the Kent and Medway Joint Health and Wellbeing Board

3.3.1 The Police and Crime Commissioner – **Matthew Scott**

3.3.2 A representative of the Kent and Medway Local Medical Committee (who may also have a named substitute) – **To be advised**

3.3.3 Observer representatives from two District Councils in Kent (aligned with the footprint of the Integrated Care Systems)

Councillor Sarah Aldridge (Swale Borough Council)
Councillor Tony Searles (Sevenoaks District Council)

(Note: Current job titles have been used in the report. These may vary from the job titles in the Terms of Reference).

3.4 Appointment of an additional non-voting member

3.4.1 On 14 May 2018, at the agenda setting meeting for this meeting of the Joint Board, representatives from Kent County Council reported that there had been some discussion at the Kent County Council Health and Wellbeing Board in relation to the appointment of Dr Robert Stewart to the Joint Board as a non-voting member, in his capacity as Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation.

3.4.2 It was advised that the Design and Learning Centre (DLC) for Clinical and Social Innovation has been recognised as a Service Improvement and Innovation Facility for the Kent and Medway Sustainability and Transformation Partnership (STP) in collaboration with the Medway and Swale Centre for Organisational Excellence (MaSCOE) and the Kent Surrey and Sussex Academic Health Science Network (KSS AHSN). The DLC is also a workforce, learning and research hub.

3.4.3 Kent County Council believe that Dr Robert Stewart as the Clinical Design Director of the Design and Learning Centre would provide the Joint Board with a link with the STP, given its previous role supporting the Kent and Medway health and social care integration pioneer partnerships.

3.4.4 The Joint Board is asked to consider the appointment of Dr Robert Stewart as a non-voting member of the Kent and Medway Joint Health and Wellbeing Board.

4. Financial, legal and risk management implications

4.1 In exercise of their powers under Section 198(c) of the Health and Social Care Act 2012, Kent County Council and Medway Council have agreed to establish the Kent and Medway Joint Health and Wellbeing Board as an advisory joint sub-committee of both Health and Wellbeing Boards to advise them on any matter related to the exercise of their functions for a time limited period of two years to start from 1 April 2018.

4.2 At the end of this time limited period the Board may agree to continue the arrangements with approval through the relevant governance arrangements for each authority.

4.3 There are no financial or risk management implications arising from this report.

5. Recommendations

5.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

i) note the current position on membership of the Joint Board as set out in paragraphs 3.2 and 3.3 of the report; and

ii) consider and decide whether Dr Robert Stewart should be appointed as a non-voting member of the Kent and Medway Joint Health and Wellbeing Board in his capacity as the Clinical Design Director of the Design and Learning Centre.

Lead officer contact
Julie Keith, Head of Democratic Services, Telephone: 01634 332760
Email: julie.keith@medway.gov.uk

Appendices
Appendix 1 – Kent and Medway Joint Health and Wellbeing Board Terms of Reference

Background papers
None

Governance Arrangements for the Kent and Medway Joint Health and Wellbeing Board

1. The Medway Health and Wellbeing Board and the Kent Health and Wellbeing Board are each separately responsible for discharging the following statutory powers and duties for their own areas:

(a) Preparation and publication of a Joint Strategic Needs Assessment (JSNA) – Section 196 of the Health and Social Care Act 2012.

(b) Preparation and publication of a Joint Health and Wellbeing Strategy to meet the needs identified in the JSNA – Section 196 of the Health and Social Care Act 2012

(c) Assessment of need, preparation and publication of a Pharmaceutical Needs Assessment – Section 128A of the National Health Service Act 2006

(d) For the purpose of advancing the health and wellbeing of the people in either Kent or Medway, to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner – Section 195 of the Health and Social Care Act 2012

(e) Encouragement to persons who arrange for the provision of any health related services in Kent and Medway to work closely with the Board – Section 195 of the Health and Social Care Act 2012

(f) Encouragement to persons who arrange for the provision of any health or social care services in Kent and Medway and to persons who arrange for the provision of any health-related services in the area to work closely together – Section 195 of the Health and Social Care Act 2012

(g) Provision of such advice, assistance or other support as thought appropriate by the respective HWBs for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services – Section 195 of the Health and Social Care Act 2012

(h) Involvement in preparation or revision of CCG Commissioning Plans – Section 26 of the Health and Social Care Act 2012

(i) Review of draft CCG Commissioning Plans before the beginning of each financial year (and any in - year revisions to plans) and provision of an opinion to the CCG as to whether or not the draft, or any revisions ,take proper account of the Joint HWB Strategy (with an option to provide an opinion to NHS England) -Section 26 of the Health and Social Care Act 2012

(j) Provision of advice to the local authority that established the HWB of its views on whether the local authority is discharging its duty to have regard to the JSNA and Joint Health and Wellbeing Strategy – Section 196 of the Health and Social Care Act 2012

(k) Provision of a view to NHS England when the annual performance assessment of CCGs is conducted, on the contribution of the CCG to the delivery of the Joint HWB Strategy – Section 26 of the Health and Social Care Act 2012

2. Establishment of an advisory joint sub-committee to be known as the Kent and Medway Joint Health and Wellbeing Board

(a) In exercise of their powers under Section 198 of the Health and Social Care Act 2012 which permits two or more Health and Wellbeing Boards to make arrangements for any of their functions to be exercised jointly, Kent County Council and Medway Council have agreed to establish an advisory joint sub-committee to be called the Kent and Medway Joint Health and Wellbeing Board KAMJHWB) for a time limited period of two years to start from 1st April 2018.

3. Operating principles

(a) The KAMJHWB is an advisory sub-committee which 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 (STP) Plans for Kent and Medway.

(b) It will seek to:

i. Ensure collective leadership to improve health and well-being outcomes across both local authority areas, to enable shared discussion and consensus about the STP across the Kent and Medway footprint in an open and transparent way;

ii. Help to ensure the STP has democratic legitimacy and accountability, to seek assurance that health care services paid for by public monies are provided in a cost-effective manner.

iii. Consider the work of the STP and encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner

iv. Take account of and advise on the wider statutory duties of Health and Social Care Partners

4. Key Functions

(a) To consider and influence the work of the STP focussing on prevention, Local Care and wellbeing across Kent and Medway.

(b) To consider and shape the development of Local Care within the STP which will impact on adult social care delivery in both authorities, advising the Kent and Medway Health and Wellbeing Boards accordingly.

(c) To give advice to the STP in developing clear plans and business cases to assist commissioners in making best use of their combined resources to improve local health and well-being outcomes, particularly relating to the Local Care and Prevention work streams, making recommendations to the Kent and Medway Health and Wellbeing Boards on support that could be provided.

(d) To keep NHS commissioning plans under review, insofar as they relate to STP Plans to ensure they are taking into account the Kent and Medway JSNAs and local HWB Strategies, referring back to the STP Programme Board and respective Kent and Medway Health and Wellbeing Boards where they do not.

(e) To champion integration in local care delivery, including working with the STP to establish a Kent and Medway Local Care Board

(f) To support the development of the Clinical Strategy

(g) To ensure alignment of the Kent and Medway JSNAs with population health needs to inform the STP Case for Change and the associated Clinical Strategy

(h) To consider and advise on the development of the STP Preventative work-stream given it is heavily focussed on Public Health functions within both upper-tier authorities

(i) To consider and advise on the development of options for the local authorities' role in a Strategic Commissioner arrangement with Health – the engagement in which remains a matter for each of the local authorities.

(j) To consider options for the Local Authority role in the development of Integrated Care Systems (previously known as Accountable Care Partnerships), the engagement in which remains a matter for each of the local authorities.

.

5. Membership

(a) The Chairman of the KAMJHWB will be appointed at the first meeting of the Board and thereafter at the first meeting of the Board after the annual meetings of Kent County Council and Medway Council. It is expected that the position of Chairman will be rotated between the chairmen of the constituent authorities' Health and Wellbeing Boards on an annual basis.

(b) The Vice-Chairman of the Joint Board will also be appointed at the first meeting of the Board and thereafter at the first meeting of the Joint Board after each Kent and Medway Annual Council meetings. It is expected that the position of vice-chairman will also be rotated on an annual basis and will be the chairman of the authority's Health and Wellbeing Board who is not the chairman of the KAMJHWB.

(c) Voting members of the KAMJHWB are as follows:

- The Leader of each Council and up to three other members of each council nominated by the respective leaders (or their substitutes)
- The Director of Adult Social Services for Kent and the Assistant Director Adult Care Services for Medway
- The Director of Children's Services for Kent and the Director of Children and Adults for Medway
- The Director of Public Health for each local authority
- Representatives of the Local Healthwatch organisations for Kent and Medway who must not be a Member of a Health Overview and Scrutiny Committee for either authority and who may each have a named substitute
- A representative of each Clinical Commissioning Group (noting that section 197 (7) of the Health and Social Care Act 2012 provides for one person to represent more than one CCG on a HWB subject to the agreement of the Board). Each CCG representative may have a named substitute.

(d) Non Voting Members of the KAMJHWB are as follows:

- The Police and Crime Commissioner
- A representative of the Kent and Medway Local Medical Committee (who may also have a named substitute)

(e) The KAMJHWB may appoint other persons to be non-voting members as it considers appropriate. If at any time after the establishment of the Joint Board either of the authorities' Health and Wellbeing Boards wish to appoint additional non-voting members of the Board this may only be done after consultation with the KAMJHWB. In addition there should be observer representatives from two District Councils in Kent (aligned with the footprint of the Integrated Care Systems)

(f) With the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may also be included.

6. Procedure Rules

(a) **Conduct**. Members of the KAMJHWB must comply with the relevant Council's Code of Conduct.

(b) **Registration and Declaration of Interests**. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the KAMJHWB. A register of interests is held by Kent County Council and Medway Council. Members of the KAMJHWB must register interests as required by the relevant Council's code of conduct. A Member of the Board or any substitute may not participate in a discussion of or vote on any matter in which he or she has a DPI or other significant interest (both those already registered and those disclosed at the meeting) and must withdraw from the room during such discussion.

(c) **Frequency of Meetings**. The KAMJHWB will usually meet quarterly. The date, time and venue of meetings are fixed in advance by the JKAMHWB. At the end of the time limited period the Board may agree to continue its arrangements with approval through the relevant Council governance for each authority.

(d) **Meeting Administration**. Administration for the KAMJHWB will be rotated annually between Kent County Council and Medway Council.

- The Joint Board will give at least five clear working days' notice in writing to each member of every ordinary meeting of the KAMJHWB, to include any agenda of the business to be transacted at the meeting.
- Papers for each KAMJHWB meeting are published at least five clear working days in advance.
- Late papers may be added to the agenda at less than five days' notice only where the Chairman is satisfied that the business is urgent by way of special circumstances which must be specified in the minutes.
- Meetings will take place in public with provision for exclusion of the press and public where confidential or exempt information is likely to be disclosed as defined in the Local Government Act 1972.

(e) **Special Meetings**. The Chairman or Vice-Chairman may convene special meetings of the KAMJHWB in addition to scheduled meetings as considered necessary

(f) **Minutes.** Minutes of all of KAMJHWB meetings are prepared recording:

- the names of members of the KAMJHWB (and any substitutes) who are present at a meeting and any apologies for absence
- details of all proceedings and resolutions of the meeting
- Minutes are normally published and circulated before the next meeting of the KAMJHWB, when they are submitted for approval by the KAMJHWB and are signed by the Chairman.

(g) **Agenda.** The agenda for each meeting normally includes:

- Apologies for absence
- Declarations of interest
- Minutes of the previous meeting for approval and signing
- Reports to the KAMJHWB
- Any item which a member of KAMJHWB wishes included on the agenda provided it is relevant to the Terms of Reference of the Board must be notified to the Chairman and relevant Democratic Services Officer at least one calendar month before the meeting however any decision to include an item on any agenda rests with the Chairman and Vice-Chairman following advice from the relevant officers.

(h) **Absence of Members and of the Chairman**. If a member is unable to attend a meeting, they may provide an appropriate substitute to attend in his/her place (noting that CCG, LMC and Healthwatch representatives must have named substitutes). The Democratic Services Officer for the meeting should

be notified of any absence and/or substitution prior to the meeting. Any substitute member must register his/her interests, in accordance with either the Medway or Kent Councillor Code of Conduct and these must be published before participation as a formal member of the Joint Board is permitted.

(i) The Chairman presides at KAMJHWB meetings if he/she is present. In their absence the Vice-Chairman presides. If both are absent, the KAMJHWB appoints from amongst its members an Acting Chairman for the meeting in question.

(j) All matters coming before the KAMJHWB shall be decided by a majority of the members of the Board present and voting thereon at the meeting. In the case of an equality of votes the person presiding at the meeting shall have a second or casting vote.

(k) **Quorum.** A third of the total number of voting members of the Board, and at least one representative from each of the two councils, form a quorum for the KAMJHWB meetings. No business shall be transacted at any meeting of the KAMJHWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman must either suspend business until a quorum is re-established or declares the meeting at an end.

(l) **Adjournments**. By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the KAMJHWB may be adjourned at any time to be reconvened at any other day, hour and place, as the KAMJHWB decides.

(m) **Order at Meetings**. At all meetings of the KAMJHWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. The Chairman decides all questions of order that may arise.

(n) **Overview and scrutiny**. Overview and scrutiny (within the meaning of the Local Government Act 2000 and The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) will be the responsibility of each constituent Authority and the appropriate scrutiny arrangements of each Authority will apply. No member of a Health Overview and Scrutiny Committee from either Kent County Council or Medway Council may also be a member (or substitute member) of the KAMJHWB.

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
28 JUNE 2018
PREVENTION ACTION PLAN

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

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

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

Allison Duggal, Deputy Director of Public Health for Kent County Council

Summary

Kent and Medway's Public Health team have been working in partnership and engaging with a wide range of stakeholders to develop the Kent and Medway Sustainability and Transformation Partnership (STP) Prevention Action Plan, set out at Appendix 1 to the report.

The STP Prevention Plan identifies priority health and wellbeing outcomes for the population of Kent and Medway that fall predominately under the responsibility of the NHS, but working in partnership with local authorities and other stakeholders.

The Joint Board is asked to note the progress of the Kent and Medway STP Prevention workstream and support the priorities and actions identified within the STP Prevention Action Plan.

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. The Plan will aid the delivery and is therefore consistent with the NHS Five Year Forward View.

1.2 There are a number of workstreams within the Sustainability and Transformation Plan including a prevention workstream. In this respect care for patients is transforming to a model which prevents ill health, intervenes earlier and delivers integrated care closer to home. This aligns with Medway Council's Policy Framework, particularly the Council Plan priority "Supporting

Medway's people realise their potential"; and with Kent County Council's strategic outcomes:

- Children and young people in Kent get the best start in life
- Kent communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life
- Older and vulnerable residents are safe and supported with choices to live independently.

2. Background

2.1 Local Authorities (LA) receive funding from the NHS, via Public Health England (PHE) who are accountable, to commission or provide health improvement services. 2018/19 budgets are:

- Kent County Council (KCC) £67,58m
- Medway £17,22m.

2.2 LA Public Health (PH) budgets have been reduced by an average of 2.48% per annum since 2015/16 and another 2.6% reduction is planned for 2019/20.

2.3 LAs are required to deliver a number of services which include:

- Healthy Child Programme 0-5 Five mandated assessments
- Comprehensive sexual health and community contraceptive services
- Weighing and measuring of children at reception year and year six
- NHS Health Checks
- PH advice to the NHS System
- Commissioning of drug and alcohol services.

3. Local Authority Public Health Delivery in Kent and Medway

3.1 Kent and Medway Local Authorities have a good track record of ensuring high quality public health services are commissioned or directly provided, to improve the health and wellbeing of their populations. Both Authorities deliver bespoke population wide health improvement programmes:

- Medway- A Better Medway
- Kent- One You Kent.

3.2 Each Authority also performs well in relation to national benchmarking against the mandated services listed in paragraph 2.3.

3.3 Both Authorities have a good digital offer and are very experienced at running major Public Health campaigns, moving towards delivering integrated services aimed at individuals and families with multiple life-style issues, providing the largest "size of the prize" (improving outcomes).

3.4 Both Authorities have worked hard to join up delivery across the broader system. In Kent, partners, particularly Districts are very supportive and are delivering joined up offers supporting both One You Kent and STP prevention plans, e.g. East Kent districts have comprehensive plans to deliver their elements of the Kent Tobacco Control Plan.

3.5 KCC moved to a partnership model with their key health improvement provider Kent Community Healthcare NHS Trust. This involves working collectively to develop programmes such as:

- One You Kent
- Healthy Child Programme 0-5.

3.6 Medway Council has a different model, with the majority of health improvement services provided “in-house”, via the ‘A Better Medway’ service.

4. Update on the Development of the Kent and Medway STP Prevention Action Plan

4.1 The Kent and Medway STP Prevention Action Plan, set out at Appendix 1 to the report, has been developed to align and coordinate preventative actions within the NHS and other public-sector organisations, with existing Local Authority Public Health programmes and pathways.

4.2 The prevention workstream has taken a broad definition of prevention to include:

- Primary (stop condition from happening)
- Secondary (stop condition from happening again)
- Tertiary (good treatment to prevent further progression/events).

4.3 The Kent and Medway Prevention STP workstream is co-chaired by the Directors of Public Health for Kent and Medway. This workstream has oversight from and reports to the Kent and Medway STP Programme Board and is advised by the Clinical and Professional Board.

4.4 Core membership of the prevention workstream include Local Authority public health consultants and specialists, NHS communications leads, Public Health England, NHS England, Clinical Commissioning Group (CCG) commissioners, and public representation. Other parties are invited on an issue by issue basis. The prevention workstream has established a GP co-production task and finish group. This GP forum has been tasked with supporting the development and delivery of the STP Prevention Action Plan, within primary care and across other NHS settings.

4.5 To ensure system wide collaboration, the prevention workstream includes representation from a range of clinical networks. These include:

- Kent & Medway Cancer Alliance
- Kent and Medway Local Maternity System
- National Diabetes Prevention Programme
- Mental health (including Suicide Prevention).

4.6 The prevention workstream is aligned to other STP networks; including Digital, Clinical, Local Care, Acute Care, Mental Health and Workforce. These arrangements are regularly reviewed and amended inline with overall governance processes for the Kent and Medway STP.

4.7 The focus of the prevention workstream to date has been the development of the overall STP Prevention Action Plan and ensuring all local work is aligned to deliver the expressed outcomes.

5. Prevention priorities for Kent and Medway

5.1 The prevention priorities for Kent and Medway are:

- Reducing tobacco usage prevalence
- Reducing obesity prevalence
- Reducing alcohol consumption
- Physical activity.

5.2 These priorities have been identified as tackling them is key to reducing the risk factors that give rise to premature death and disability in Kent and Medway, namely:

- Cancer
- Cardiovascular disease and stroke
- Respiratory disease
- Mental ill-health.

5.3 People living in the most disadvantaged areas of Kent and Medway are more likely to be at risk from premature mortality associated with the identified priorities. Taking decisive action to address these issues will therefore help to reduce health inequalities across Kent and Medway.

5.4 High level plans have been agreed for these priorities. The prevention workstream is developing detailed delivery plans for specific areas, in consultation with stakeholders and within the resource envelope of the STP.

5.5 Most recently, progress has been made in the following areas:

- Identification of residents with atrial fibrillation using new electronic devices
- Approval of a Making Every Contact Count project, which funding has been identified for roll out in 18/19
- Funding secured for a suicide prevention project
- Join up of the smoking in pregnancy projects across Kent and Medway
- Audit being undertaken of CCG specific expenditure on prevention activity across Kent and Medway.

6. Interdependencies

6.1 The prevention workstream is continuing to develop a comprehensive delivery system across Kent and Medway with the two PH departments working collectively and joined up with Clinical Networks.

6.2 Local care delivery is critical to the success of prevention. There is more work to do with the GP co-production task and finish group to firm up pathways across the system. This work includes ensuring local services and access routes are mapped, self-care, self-management opportunities are built on and promoted and more use is made of existing community capacity and capability to signpost people to services and activity locally available.

6.3 Given size of the prize, all clinical pathways need to start with prevention. This is the aspiration of the STP Programme Board, Clinical Board and reaffirmed by direct feedback from public consultation events.

7. Risk management

7.1 There is a risk of a cultural expectation that prevention is a specialist public health endeavor. The only way to deliver prevention at scale is for the whole system to play its part.

7.2 A limited PH resource means the programme is in desperate need of a programme manager. This has been addressed and the STP has funded a programme manager for the prevention workstream who will shortly be appointed.

7.3 Local Leadership is really important, especially within the NHS. Chief Executives, senior management teams and local clinicians must all be advocates for prevention.

8. Financial implications

8.1 There are no financial implications for Kent County Council or Medway Council arising directly from this report. NHS funding for STP prevention workstream activity is currently being addressed by the STP finance workstream.

9. Legal implications

9.1 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

9.2 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 focussing on prevention, local care and wellbeing across Kent and Medway.

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

10. Conclusion

10.1 The Prevention Workstream now has in place all the key individuals and organisation to take forward the ambitious action plan that has been developed for Kent and Medway. There is clear governance and oversight of delivery in place. All stakeholders are committed to delivering the objectives set out the prevention action plan and both Kent County Council and Medway Council have built solid foundations, which will be used to take forward the agreed actions.

10.2 The Kent and Medway Programme Board have acknowledged the need to accelerate the progress of identifying funding to support the NHS commissioning of specific services. Local NHS organisations have engaged

in this process and are undertaking an audit, led by CCG Directors of Finance to try and identify the resource gaps.

10.3 There needs to be engagement of local care to embed prevention across the system and an agreement for prevention to be the first element addressed in all future NHS pathway developments.

11. Recommendations

11.1 The Kent and Medway Joint Health and Wellbeing Board is asked to note the progress of the prevention workstream and support the priorities and actions identified within the Prevention Plan.

Lead officer contact

Scott Elliott, Head of Health and Wellbeing Services, Medway Council, Dock Road, Chatham, ME4 4TR, Email – scott.elliott@medway.gov.uk

Allison Duggal, Kent County Council, Email – Allison.duggal@kent.gov.uk

Appendices

Appendix 1 - Kent and Medway STP Prevention Action Plan (updated June 2018)

Background papers

None

To shift the balance of care from reactive to proactive

APPENDIX 1

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
People are aware of how to look after themselves and are encouraged and assisted to take responsibility for their own health.	• Fewer people smoke • Fewer people are overweight or obese • More people undertake the recommended amount and mix of physical activity • Fewer people drink to excess • More people have positive mental wellbeing	• Advertising, media and social media campaigns (One You Kent, A Better Medway) boost awareness of what people can do to look after their health and why it is important – linking in with national media coverage and opportunities (e.g. Taking Care of Dad) • Advertising, media and social media campaigns (One You Kent, A Better Medway) boost awareness of range of services to help people become healthier, including apps, websites (such as Explore Kent), and local fitness / community opportunities • Health and wellbeing champions/Health Champions (such as hairdressers) and peer supporters (such as for breastfeeding) are trained to talk to people about their health/ ways to improve their health • Primary and community care staff, including pharmacists, have materials and training to make use of “teachable moments” with people at point when they are ready to change and give out clear messages to patients about benefits of healthy lifestyle • Make use of public spaces e.g. libraries, children’s centres, to publicise events such as Splashathon, Medway Mile, Park Run, local fitness events (such as half marathons) and resources such as One You Kent, Explore Kent • Evidence-based work with parents and children to set healthy habits, in particular around healthy eating and nutrition	Sept/Oct 2018 Sept/Oct 2018 April 2019 April 2019 April 2020 April 2020	-A Better Medway website has been refreshed and relaunched. A ‘Book Now’ feature will be added in July then a more formal promotion of the site will commence -Review of Medway Champions programme complete. New MECC focussed prog to be rolled out from April 18. 7 Key events for engagement have been identified across Medway for 2018/19. With the first Medway20 event taking place in Rainham on 19 May Medway Little food explorers

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
				and little chefs cookery and nutrition sessions being delivered across range of child and family hubs
People are involved in decision making and care planning • People enabled to make decisions about where, when and how they access health & social care in primary, secondary, and independent sector, within the Local Care Model. • Promote use of Health Help Now, commissioned across most of Kent and Medway, which has information about local services and advice on which to use for different symptoms	• Staff competent to support people in prioritising their needs, helping them get information to make informed choices. • People are able to access different types of support dependant on their needs- (range of different providers/options) • Integrated rehabilitation between community health services and social care enablement. Supporting a person-centred assessment and care plan. • People have the maximum opportunity to remain at home, while receiving effective clinical and social care. • Promote the use of social prescribing.	• Reduction in those accessing ambulatory A&E (target TBC) • increase in proportion of older people supported to live at home (Social Care Metric) • Proportion of people who use services who have control over their daily life (2015/16 baseline) • Develop a tool to record patient involvement in decision making.	April 2020 April 2020 April 2020 April 2020 April 2020	-Development of a Social Prescribing model in Medway that is being used with care navigation and VCS contracts and external funding bids

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
Improve early detection and treatment of risk factors related to non-communicable diseases • Consistent assessments of need • People are able to access appropriate care and support in the primary and secondary care settings • [Effective referral system for all relevant services] • Continue to develop high-quality, consistent care that is evidence based, protocol driven, safe and of a high standard that improves patient outcomes • Local public mental health campaign	• care pathways, guidelines and information given to the patients and carers are evidence based and consistent • Effective referral system, with common points of access and integrated triage. • Continue to develop high-quality, evidence based care that improves patient outcomes • Increase availability of digital self-care packages • Individuals are identified as at risk of a LTC, or having a LTC	• Whole system approach to the identification and management of people at risk of an adverse event related to cardiovascular, respiratory disease or diabetes. For example: - Increase the number of patients diagnosed with hypertension, increasing the completeness of Hypertension registers - Support self management and adherence to treatment and lifestyle guidance, increasing self-monitoring of BP for patients on QOF Hypertension register - Increase the number of people with respiratory conditions (COPD, asthma) who are vaccinated and protected against seasonal influenza - Engage and support patients diagnosed with COPD who smoke to quit - Review the whole system approach to managing people with COPD within Kent and Medway - Establish programme to scope and improve the detection of atrial fibrillation (AF) within Kent and Medway, to align this with comparator organisations - Reduce the risk of cardiovascular events in the those already diagnosed with atrial fibrillation, through improving self-management and use of appropriate anticoagulants for those who would benefit - Prevent the onset of type 2 diabetes in people at risk of the condition, through a full rollout of the DPP and an increased marketing of the service - Improve the identification of diabetes in at risk	Ongoing April 2019 February 2019 Ongoing December 2018 April 2019 Ongoing April 2019 April 2019	-currently working with PHE to deliver the Kent and Medway AF project Local care workstreams have range of quality improvement projects in place and in

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
	• Increased public mental health campaigns based on local needs and behavioural insight principles	populations. Outcome metrics benchmarked at comparator STP level - Improve the management of type 2 diabetes, increasing self management to ensure patients maintain optimal values in relation to HB1C - Establish IAPT programmes for patients with LTC - Implement care navigation programmes across STP footprint. - Perform local public health needs assessments for mental health and suicide prevention - Implement guidance on local authority actions to prevent suicide - Use behavioural insight/economics to develop messaging around public mental health campaigns, including 6 ways campaign	April 2020 Ongoing June 2018 June 2018 Ongoing	planning. These include scaling structured diabetes education programmes across Kent and Medway and a single commissioned DPP programme for all Kent and Medway CCGs Additional Care Navigators being recruited and developed through the local care workstream. Specific Actions set out in Mental Health Strategy. Connect5 train the trainer programme being rolled out across Kent and Medway 19 trainers (multi-agency) trained in Medway.
Optimise workforce Capacity and Capability • There is a competent and knowledgeable workforce with the appropriate skills to be responsive to the populations needs. • The workforce is trained to deliver health promotion advice	• Integrated care pathways used to plan workforce development across health, social care and other settings. • Role descriptions and individual responsibilities are amended to enable sufficient flexibility to allow realignment of services as required to	• Targets and measures to be agreed and set by LWAB to include: • x amount of staff trained • all new job descriptions reflect prevention agenda • record uplift in volumes of referrals (to see if the contacts do count and conversations are leading to higher rates of referrals to services)	April 2019	LWAB have approved MECC proposal and funding has been identified for roll out in 18/19. Includes train the trainer model to ensure sustainability. PH represented on LWAB, targets being established.

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
• Front line staff are supported and encouraged to contribute to continuous improvement as well as to provide high quality, responsive person-centred care.	meet the changing needs of patients. • Education and training programmes are developed to ensure the workforce has appropriate clinical and interpersonal competencies that include behaviour change and self-management. • Ensure appropriate staff are aware and trained in Making Every Contact Count and social prescribing. • Develop programme of multi-skilled workforce and hybrid workers. • Promote the use of social prescribing.	Specific Solution focussed therapy training programme commissioned for healthcare professionals, to enable them to engage and signpost individuals to appropriate support (at teachable moments)	September 2019	Funding agreement with HEE to be signed off in June 2018. Process to commission training provider to be initiated in July 2018.
Effective Commissioning • Use new and existing STP resources to support primary secondary and tertiary prevention • A collaborative approach to strategic commissioning of	• Reduce duplication of care through clear and effective governance of service provision, for both individuals and services as a whole. • Effective and efficient use of all resources; including staff, equipment and estates	• Clear service specifications for evidence based prevention interventions in place and integrated prevention pathways in place across Kent and Medway. • Performance management system to evaluate impact of prevention interventions in place Outcome focussed prevention CQUINs developed, implemented and performance managed with identified providers across primary and secondary care in Kent and Medway	April 2020 April 2020	-Medway 0-19 contract fully embedded prevention. CCG/MC community rehab, Care navigation. CVS specs in process of embedding -smoking CQUINs in place and being worked on by Medway community healthcare CiC

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
prevention focussed activity is put in place • Evidence of Return on Investment (ROI) and capacity planning for prevention.	• Revising the business cases for the prevention work as more evidence becomes available, using systems modelling approach	• All commissioned contract opportunities are assessed for opportunities to embed prevention agenda within service specification and KPIs	April 2020	-Medway Council Procurement strategy requires new providers/contracts to embed workplace health
Smoking Cessation and Tobacco Control	• Reduce the prevalence of smoking in Kent and Medway • Provide direct smoking cessation support after discharge • Assure that there is tailored support for people with mental health conditions • Move to smoke free status across Kent and Medway • Greater signposting of smokers to smoking cessation • Work with appropriate agencies to reduce the availability of illicit tobacco in communities • Target populations with highest smoking prevalence (i.e. routine	• Ensure smoking advisors located in each of the acute trust sites across Kent and Medway • All Acute and Community Trusts and the mental health trust to be smoke free across Kent and Medway • GPs and other health professionals are encouraged to develop routing CO monitoring and encourage smoking cessation services for patients. • Introduce Very Brief Advice for smokers to be delivered by health care professionals and incorporating asking and recoding smoking status, advice on the best way of quitting and offering referral to specialist support and the prescription of medication if appropriate. • Use MECC or similar programme(s) to ensure all pregnant women are CO monitored and referred to smoking cessation services when needed. • Use MECC or a similar programme to raise awareness of the harms of smoking in pregnancy and develop routine CO monitoring in clinical settings followed by referral to smoking cessation services where required. • Implement smokefree school gates and measure the number of schools with smokefree policies.	April 2019 September 2018 September 2018 September 2018 September 2018	Acute advisors within MFT and discussions with the Medway planned care board are about to commence, regarding stop before the op policy mobilisation The Medway Maternal Smoking Strategy has been approved by Medway HWB with the action plan being progressed by the strategy partnership

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
	and manual workers) to attend a cessation support service • Reducing smoking at time of delivery • Smoke Free School Gates • Provide a range of digital quit support services and smoking cessation campaigns	• Roll-out of Kent and Medway smoking cessation campaigns based on behavioural insight work, collaborating with partners	September 2018	

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
Obesity and Physical Activity	• Care pathway changes to all long-term conditions • Whole Systems Approach • Environmental changes • Planning restrictions • Physical activity • Weight Management • Support adults and children to achieve a healthy weight • Increase breastfeeding rates • Create healthy settings for children and employees	• Public Health professionals to work with appropriate clinicians within specialist teams to implement routine process of obesity related subjects being discussed, recorded and reported within routine treatment • Adopt a Whole Systems Approach to tackling obesity, obesogenic environments and lack of physical activity across adults and children • All NHS and Care sites to become healthy setting with changes to food offer, placement and pricing. • Explore ways of working with planning colleagues to reduce obesity and overweight • All NHS and Care sites to support physical activity for staff, patients and visitors • Collaboration with Public Health England on the Whole System Approach – including information and training sessions and implementation of Let's Get Moving • Scale up existing Tier 2 weight management for adults across Kent and Medway • Explore provision of a universal Tier 2 weight management service for children and families across Kent and Medway, ensuring equity of access for residents • Scale up existing Tier 3 weight management for adults across Kent and Medway • Implement Tier 3 weight management for children across Kent and Medway with a multi-disciplinary team • Develop referral pathways with both primary and secondary care services to ensure that people are referred to appropriate services • Develop a care pathway within the school public health	All - September 2020	Medway Local Plan is currently in development with strong policies being developed to bolster the hot food takeaway guidance note

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
		and health visiting services in line with their contractual obligations • Promoting healthy eating, physical activity and healthy weight campaigns to the public and professionals, reinforcing messages of how to achieve a healthy weight • Support all appropriate and community sites to achieve the highest standard of UNICEF Baby Friendly accreditation and implement a range of evidence based infant feeding initiatives • Work with schools, pre-schools and employers to ensure settings promote physical activity when they can and develop a whole food approach • Support children and adults to achieve basic physical literacy skills and develop home cooking skills and confidence • Identify and/or develop a range of digital support solutions (such as apps) that can support people to lead healthier lives and promote these services to residents		Sugar Smart Medway campaign is planned for launch in July 2018, encouraging residents and organisations to reduce their sugar intake BFI stage 3 assessment at MFT being prepared and neonatal stage 1 assessment Medway schools and pre-schools healthy settings award being launched in 2018

To shift the balance of care from reactive to proactive

Priority Outcomes	Priority outcomes for the integrated change programme	Actions	Timescales	Progress
Improved prevention of cardiovascular disease, cancer and maternal health	Collaboration with Public Health England on the primary and secondary prevention of cardiovascular disease	Detection and treatment of atrial fibrillation Detection and treatment of hypertension Detection and treatment of hypercholesterolaemia	April 2019 April 2019 April 2019	
	Collaborate with the local Cancer Network, PHE and partners around cancer screening and cancer prevention	Use the local Health Protection Committees to assure the cancer screening services and local immunisations. Work with partners in the cancer network on developing opportunities to discuss healthy living and survivorship with cancer patients Work with partners on primary and secondary cancer prevention e.g. smoking cessation		
	Collaborate with the Local Maternity System around healthy lifestyles and improved maternal health	Work with partners to develop messages around maternal health e.g. smoking cessation, healthy weight maintenance, alcohol and immunisations.	April 2019	

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
28 JUNE 2018
SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) LOCAL CARE UPDATE

Report from: Caroline Selkirk, STP Local Care Senior Responsible Officer

Author: Cathy Bellman, STP Local Care Lead

Summary

This report summarises the progress of the implementation of Local Care across Kent and Medway and in particular focusing on the:

1. Local Care aim, objectives and key deliverables for 2018/19
2. Governance arrangements and integration with the Better Care Fund
3. Integrated planning and financial investment
4. Communications strategy including co-production
5. Enablers
6. Risks and issues.

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 states that the first priority is 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. Background

2.1 Local Care aim, objectives and key deliverables for 2018/19

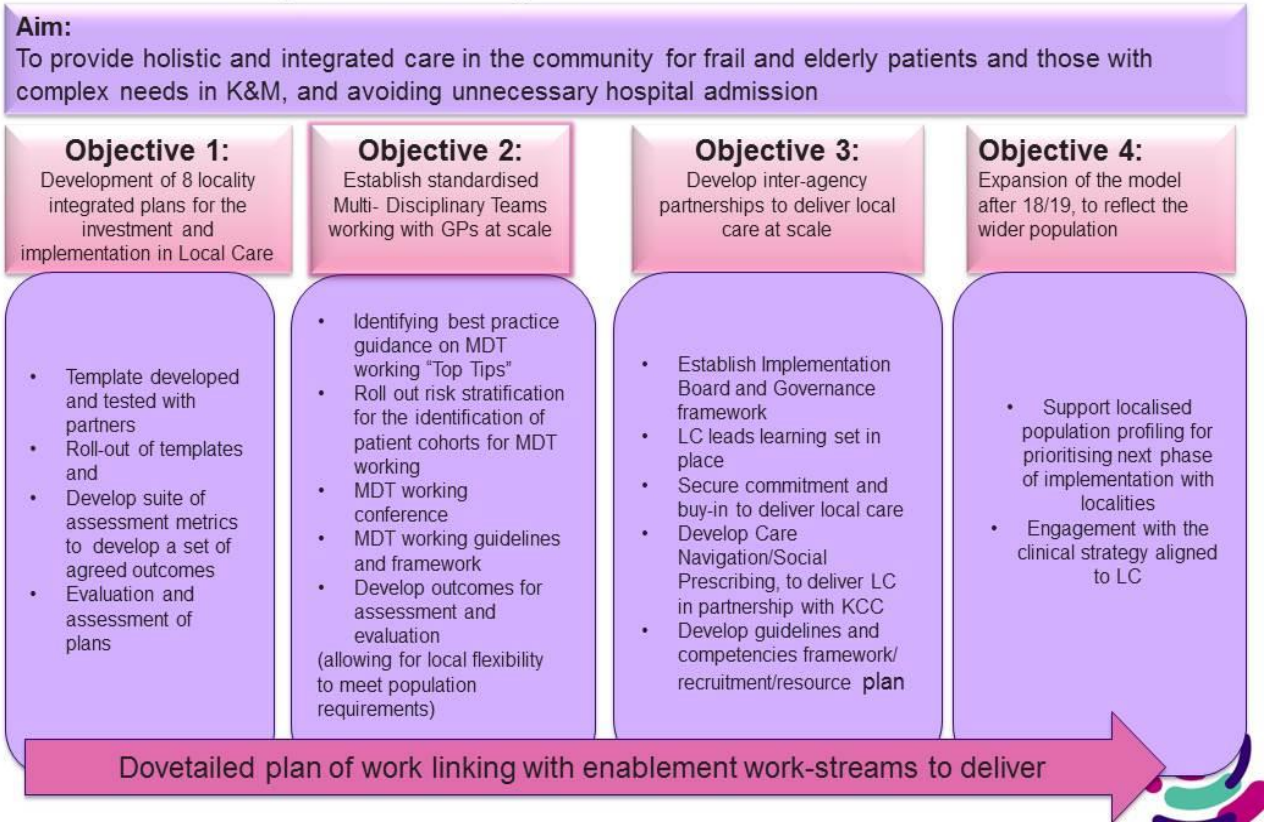
2.1.1 Local care is a new model of delivery of **integrated health and care** services **close to where people live**. It is a **collective commitment** of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well. In 2018/19 the focus is to

develop integrated teams, around GP practices working at scale for populations of 30-50,000, with 4 key objectives:

- Development of 8 integrated locality plans, for the investment and implementation of Local Care;
- Establish standardised multi-disciplinary teams (MDTs) around GP practices working at scale;
- Develop interagency partnerships to deliver Local Care at scale; and
- Start work on expansion of the model after 2018/19.

2.1.2 Running through and crucial to achievement of these 4 objectives is the need to ensure Local Care is aligned to and informing enablers such as workforce, estates and IT (Please refer to figure 1 below).

Figure 1. Local Care Objectives 2018/19



3. Governance Arrangements and Integration with the Better Care Fund

3.1 Across Kent, different forums exist to deliver Local Care and bring coordination to implementation. Discussions with Local Care Area Leads and Better Care Fund (BCF) Strategic Leads (for Kent), identified the need to streamline the existing governance.

3.2 Proposals for changing the structures within STP Local Care and Kent Pioneer were discussed and agreed at 15 January 2018 Kent Pioneer meeting.

3.3 The structure below has been agreed at the newly formed Local Care Implementation Board and Local Care Leads meeting.

3.4

The new arrangements will:

- Deliver Local Care across Kent and Medway by aligning existing working groups and structures.
- Provide suitable forums for shared learning and shared delivery of plans.
- Ensure the Better Care Fund implementation sits within Local Care structures and achieves Local Care aims and objectives.

(Similar discussions are underway with Medway for their BCF reporting and governance aligned to Local Care).

3.5 Figure 2 sets out the Local Care Governance structure and Appendix A to the report sets out the membership list for the Local Care Implementation Group and Local Care Leads Meeting.

Figure 2. Local Care Governance Arrangements

4. Integrated planning and financial investment

4.1 Significant levels of work have been undertaken across Kent and Medway (K&M) to achieve 8 Clinical commissioning Group (CCG), locality integrated plans for the delivery and investment in Local Care.

4.2 The initial focus was to meet the national timelines for CCG and NHS provider plan submissions to NHS England on 30 April 2018 which has been achieved.

4.3 Further work is now required to develop these plans into system level plans, in particular with social care and voluntary sector, as well as aligning plans with wider partners. The focus for 2018/19 being to focus on:

- **Multi-disciplinary team (MDT) and patient enrolment,**
- **Care model development; and**
- **Enablers (linking with workforce, estates, IT)**.

4.4 As expected different parts of Kent and Medway (K&M) are at different levels of maturity and this mirrors the work on the maturity matrices, undertaken in October 2017. There is a focus across all geographies on supporting primary care in line with the GP Forward View. It is fair to say that all areas are at a slightly different starting point with care model developments:

- Canterbury and Coastal is further ahead on MDT roll out and patient enrolment, which is to be expected following vanguard funding, and is now at a place to increase activity.
- East Kent CCGs are working collectively on a care home support model, review of community hospital beds and work around the tiers of care (tiers 1 and 2 being activity which could be provided within a community setting, with tier 3 in acute setting).
- West Kent's plans are now at the level of maturity to identify a trajectory of 471 new patients targeted in each quarter, as well as detailed plans for falls prevention and home visiting.
- North Kent and Medway are at an earlier stage of roll out of MDTs but with positive work underway.
- All areas have a focus on falls prevention and rapid home visiting.

(Appendix B to the report sets out the summary milestones for each locality).

4.5 An update report on the planning process was presented to the K&M Sustainability and Transformation Partnership (STP) Board on the 14 May 2018, **with the Board being asked and agreeing specifically to ensure:**

- **Alignment of Social Care resources** with Local Care, etc.
- **Continued and collective commitment for Local Care** and align cross organisational priorities to meet the system pressures (stemming A&E growth).
- **Championing the change in culture** required to deliver Local Care, develop **clinical champions** for the change and win the **hearts and minds of leaders and staff** as to Local Care being the right thing to do for patients, staff and the system.
- Consider how to **accelerate the 'discharge planning and re-ablement' part** of the clinical model?

5. Communications Strategy and Co-production

5.1 The Local Care Implementation Board has agreed that there needs to be a structured and coordinated communications strategy; involving members of the public, as well as the statutory, voluntary and charitable sector in co-design of Local Care. A draft discussion document for developing a communications and engagement strategy was considered at the meeting on 8 June 2018 (set out at appendix C to the report).

5.2 **The aims of the strategy will be to:**

- Clearly explain the need for Local Care/ Care in the Community.
- Clearly explain the objectives and benefits of establishing multi-disciplinary teams around GP practices working at scale (30-50,000).
- Ensure people are given genuine opportunities to be involved in the Local Care communications strategy.
- Ensure channels for co-design of communication materials.

5.3 The agreement of the strategy is not however stopping the development and initiatives to engage and involve partners and public in the co-design services, with co-production workshops underway to:

- Develop the requirements for Care Navigation and Social Prescribing, with a view to being able to standardise and industrialise.
- Develop the “wider family” for Dorothy – working on the Clinical Strategy to develop pathways for the entire population in an integrated joined up fashion.
- Simplify and standardise the language we use across K&M, providing clarity internally, across the STP, and externally with the general public.

5.4 **Local Care Conference 18 April 2018**

The conference was the culmination of many months of work to make sure health and social care professionals, as well as other partners including the voluntary sector, district councils and Kent Fire and Rescue Service understood and are developing multi-disciplinary teams to embrace the emerging model of local care. The conference was a particular success in terms of delivery, output and feedback. A wide variety of health, social care and voluntary organisations were present.

A video on MDT working was produced and is being shared widely as part of ongoing communications and to support public understanding.

What is an MDT?
https://vimeo.com/266106311/4e6484f8d2

There is also a piece of work underway to standardise and simplify the language used to describe the delivery of Local Care in an attempt to get consistency across Kent and Medway.

(Please refer to appendix D to the report for full conference report)

6 Enablers

6.1 As well as the obvious collaboration and joint working with other STP Workstreams (as with the clinical strategy work described above), there has been a concerted effort in the development of Local Care, to understand the key enablers for success and alignment with other key Workstreams, namely:

- Workforce
- Estates
- IT

6.2 Across the board there is a level of concern as to the status of enablers to support Local Care delivery. To begin to mitigate this there was a meeting on the 24 May 2018, with CCG, Social Care and provider Local Care Leads, where the STP workstream leads for these areas began to scope out key requirements and potentially look to set up task and finish groups (drawing on wider CCG staff as necessary) to work on plans and solutions.

7. Risk management

7.1 As part of the CCG planning process there were risks colleagues documented and raised, which they are working through with partner organisations to locally mitigate; further work will be required to identify risks as the system level plans are developed. This will all form part of the overarching Local Care risk register and reviewed regularly at the Local Care Implementation Board. Below are the risks taken to the STP Programme Board on the 14 May 2018, for agreement and support, across workstreams, to mitigate strategic risks.

7.2

Culture:

- Not achieving the cultural change required across all organisations to make the implementation of Local Care a reality.

Communication:

- Lack of a single narrative for Local Care, and consistent use of language- individual providers engage and communicate in different ways.

Workforce:

- Challenges around availability and type of workforce development to develop Local Care.

Financial:

- Failure to identify the investment for Local Care to implement the model across Kent and Medway.
- Lack of availability of central funding resources for IT infrastructure and development to support Local Care and integrated working.
- Inconsistent business case processes across organisations, hindering collective decisions for Local Care.
- Availability of capital for estates development for Local Care.

8. Financial implications

8.1 The initial planning process is looking to identify investment from each CCG, as well as alignment of the Better Care Fund in delivery of Local Care, with agreement of all Local Care and Finance Directors across CCG and provider organisations. The planning and investment process has been agreed and ratified by both Local Care Implementation Board and STP Programme Board. It is also the intention to work collectively, across Kent and Medway, in business case development, in order to be ready for any potential funding opportunities which may arise.

9. Legal implications

9.1 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 of the Health and Social Care Act 2012.

9.2 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 focussing on prevention, local care and wellbeing across Kent and Medway.

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

10. Summary

10.1 The STP Programme Board has assurance that:

- Local Care is on track to deliver agreed objectives for 2018/19
- Has detailed plans with identified investment for the delivery of integrated MDTs across K&M
- Has a defined governance framework and reporting process
- Is developing a communications and engagement strategy which involves all partners in co-production of services
- Is engaging with other workstreams to ensure dovetail with enablers and
- Has an understanding of risk to the programme and is working on mitigation.

11. Recommendations

11.1 The Kent and Medway joint HWB is asked to note the progress of the Local Care workstream and to agree that at future meetings the Joint Board will monitor the progress of the workstream.

Lead officer contact
Caroline Selkirk, Local Care Senior Responsible Officer, Email: **c.selkirk@nhs.net**

P.A. Belinda Hunnisett, Email: **belindahunnisett@nhs.net,** Tel: 03000 424711, 07712 427805

Cathy Bellman, Local Care Lead, Email: **Cathy.bellman@nhs.net**, Tel: 07721643583

Appendices
Appendix A – Membership of the Local Care Implementation Group and Local Care Leads Meeting
Appendix B - Local Care Milestones
Appendix C - Draft Communications and Engagement Strategy
Appendix D - Local Care MDT Conference Report

Background Papers
None

APPENDIX A

Meeting	Local Care Implementation Group Members

ATTENDANCE LIST

Job Title	Organisation
Leader of the Council	Kent County Council (KCC)
Leader of the Council	Medway Unitary Authority
Managing Director East Kent and Local Care SRO	East Kent NHS
Medway ,North and West Kent	Medway, North and West Kent NHS
Director Director Older People and Physical Disability	KCC
Director of Public Health, Prevention SRO	KCC
CCG Clinical Chair, Clinical Board Co-Chair	NHS Swale CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS C&C CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS Thanet CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS SKC CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS Swale CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS Ashford CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS West Kent CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS Medway CCG
CCG Clinical Chair, Clinical Board Co-Chair	NHS Dartford Gravesham and Swanley CCG
Clinical Lead and Special Advisor	Encompass MCP
Chief Executive Officer (CEO)	Medway Community Healthcare

Job Title	Organisation
CEO	Kent Community Health NHS Foundation Trust
CEO	East Kent Hospitals University Foundation Trust
CEO	Dartford and Gravesham NHS Trust
CEO	Medway Foundation Trust
CEO	Kent and Medway Partnership trust
CEO	Maidstone and Tunbridge Wells NHS Trust
Managing Director	Virgin Care Services Ltd
Chief Finance Officer	NHS West Kent CCG
Customer account Manager	South East Coast Ambulance Service
Medical Secretary	Kent Local Medical Committee (LMC)
Chairman	LMC
Member	Patient and Public Advisory Group
CEO	Involve Kent
CEO	Red Zebra
Manager	Healthwatch Medway
Minute taker	STP PMO
Local Care Lead	Kent & Medway Sustainability and Transformation Partnership
PMO Lead	STP
Workforce Lead	STP
Associate Director	Integrated Care 24

Meeting	Local Care Leads Meeting

ATTENDANCE LIST

Job Title	Organisation
Local Care Director	Thanet CCG
Local Care Director	South Kent Coast CCG
Local Care Director	Ashford CCG
Local Care Director	Canterbury and Coastal CCG
Local Care Director	West Kent GGC
Local Care Director	Medway CCG
Local Care Director	Dartford Gravesham and Swanley CCG
Local Care Director	Swale CCG
Local Care Director	Kent Community Health NHS Foundation Trust
Local Care Director	Virgin Health Care Ltd
Local Care Director	Medway Community Trust
Local Care Director	East Kent Hospitals NHS Foundation Trust
Local Care Director	Maidstone and Tonbridge NHS Trust
Local Care Director	Medway Foundation Trust
Local Care Director	Dartford and Gravesham NHS Trust
Local Care Director	Kent and Medway Partnership Trust
Local Care Director	Kent County Council
Local Care Director	Medway Unitary Authority
Local Care Director	South East Coast Ambulance Trust
STP Workstream lead	Workforce

Job Title	Organisation
STP Workstream lead	IT
STP Workstream lead	Estates
STP Workstream lead	Primary Care
STP Local Care	Project Manager
STP Local Care	Minute taker

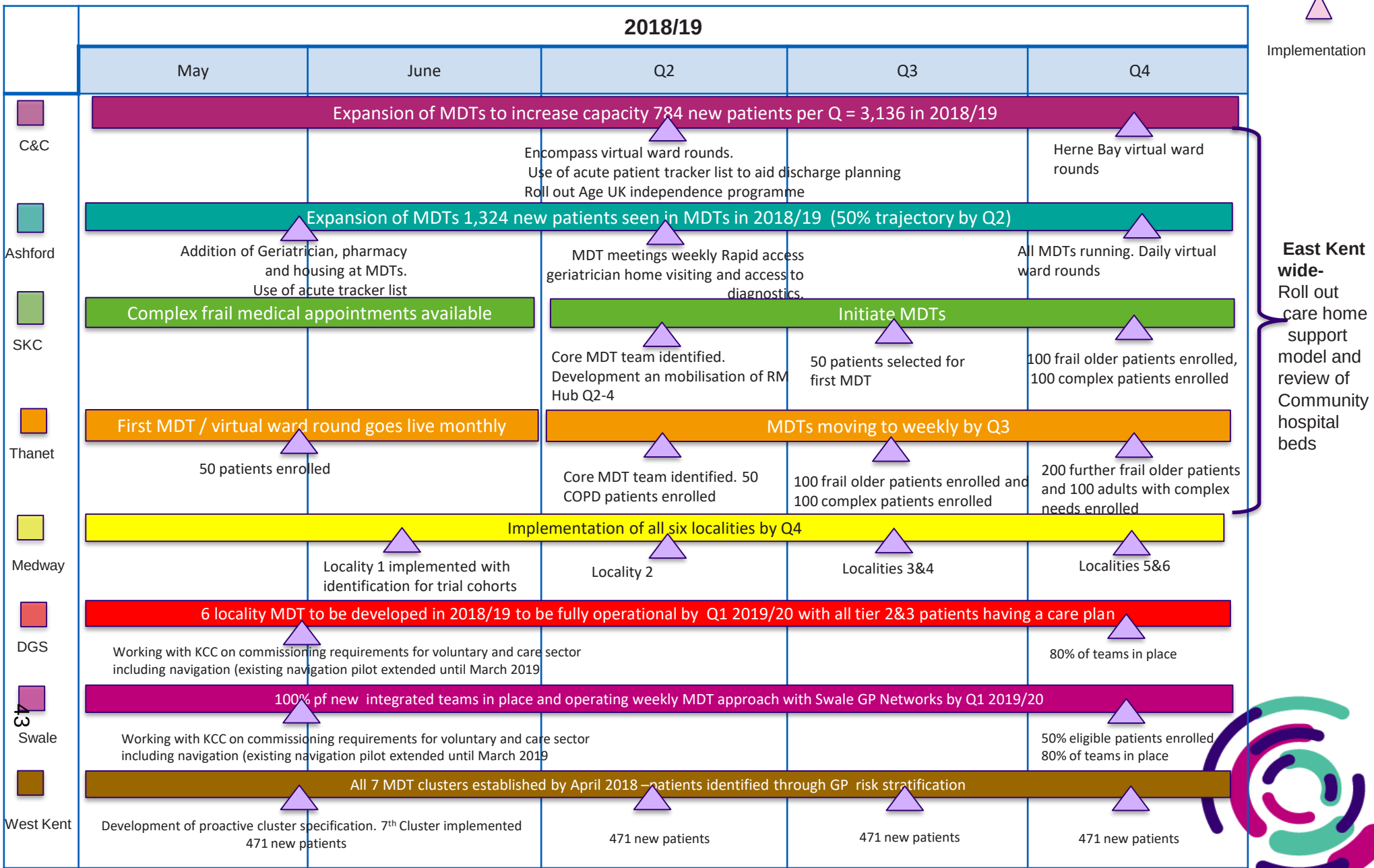
Locality Plans

MDT and Patient Enrolment

APPENDIX B

Key:

Implementation



Locality Plans

Care Model Development

Key: Implementation

2018/19

	May	June	Q2	Q3	Q4
C&C	Roll out of GPFV and 10 high impact changes, maintain improved access and optimisation of primary care staff				
	Go live UTI/ Cautionary Pathway. Go live cardiology and rheumatology tiers of care Go live UTC at Estuary View		Go live DVT/ Cellulitis pathway	Go live MSK , dermatology and element of ophthalmology tiers of care (TOC). Go live clinical pathway urology	Commence heart failure, gastroenteritis, asthma, children's pathway design. Go live diabetes TOC and primary care mental health support worker
Ashford	Roll out of GPFV and 10 high impact changes, maintain improved access and optimisation of primary care staff				
	MECS ophthalmology, Go live UTI/Cautionary Wet AMD TOC. Roll out wound clinics to remaining hubs		GP improved access target. pathway, cardiology TOC Go live DVT/ cellulitis pathway Roll out catheter clinics to remaining hubs	Go live dermatology TOC	Go live **diabetes TOC** and mental health group psycho-education and primary care mental health support worker
SKC	Focus on the development of Primary Care Hubs – offering 35-50,000 appointments by Q4				
	Primary care access hubs and rapid home visiting service, and additional primary care mental health workers live	Mobilise, rheumatology TOC	Mobilise UTI pathway , rheumatology and Wet AMD TOC	Mobilise DVT and COPD pathways. Respiratory, MECS ophthalmology, MSK TOC	Go live for wound and catheter clinics, cardiology, dermatology TOC, falls prevention model
Thanet	Focus on complex frailty model to support primary care and build on ART as an east Kent offer by Q4. UTC at QEQM ,Q2 and 3				
	Go live urology local care provision, wet AMD roll out		GP improved access target. Wound clinics go live, Cardiology, rheumatology TOC go live	Social prescribing framework, DVT , UTI, catheter goes live. Step up/down beds at Westbrook. Respiratory and MSK TOC go live	Falls prevention initiative with KFRS goes live, additional primary care mental health, evaluation of diabetes pilot
Medway	Initial focus on in –hours provision for MDTs building in Q4 to OOHs provision				
			In hours team in place, discharge support	Scope services to be delivered locally	OOHs team in place, links to social prescribing. Directory of services.
DGS	Building a rapid access service to support primary care				
				Rapid response service live Q3&4	
Swale	Building a rapid access service to support primary care				
					Rapid response service live Q4
West Kent	In Quarter 1 – commissioning model for falls service approved, complete reviews of Rapid Response/ Home Treatment Service, development of proactive cluster specification, Home First Pathway 2/3 capacity agreed for 18/19 and phased roll out of integrated MSK service to be agreed.				
	Commissioning models agreed		Signposting care navigation project go live		

Locality Plans

Enablers

Key:
Implementation

2018/19

	May	June	Q2	Q3	Q4
C&C	System wide identification and recruitment of staffing to deliver frailty model and support tiers of care. Ongoing OD workshops				
	Develop Encompass and Herne Bay GP Partnerships. Implement teleconferencing to support MDTs			Digital interoperability development allowing SECAmb to access the MIG	
Ashford	System wide identification and recruitment of staffing to deliver frailty model and support tiers of care. Ongoing OD workshops				
	Development of Alliance between Ashford Community Providers and KCHFT. Implement teleconferencing to support MDTs			Digital interoperability development allowing SECAmb to access the MIG	
SKC	System wide identification and recruitment of staffing to deliver frailty model and support tiers of care. OD development Qs 3-4				
	Local design by dialogue events with rolling comms and engagement Q2-4. Implementation of interoperable IT systems within primary care access hubs		Capital bid for Romney Marsh and Folkestone Hubs Q2 -4	Digital interoperability development allowing SECAmb to access the MIG	
Thanet	System wide identification and recruitment of staffing to deliver frailty model and support tiers of care.				
	Development of a Primary Care Home OD programme Q1-2. Mobilisation of ETTF IT investment programme. Skype go live for MDT working. Local design by dialogue events		Full Business case drafted for Quex integrated hub/spoke and Westwood Cross integrated hub. Care model offer published	Leadership development programme. Full Business cases for complete for Margate Integrated Hub	Full Business case complete for UTC at QEQM
Medway	System wide staffing and OD development by Q4; examples; geriatrician, pharmacy care navigation, specialist mental health and palliative care support.				
		Employment of coordinator	Business case for 2x Healthy Living Centres		IT system interoperability with full EMIS migration and access to e- consult/ skype
DGS	A programme of estates capital bids to increase local capacity for integrated working along with system wide OD programme Q2-4, OD audit and annual MDT workshop				
	Business case started for 5 hub developments –completion date Dec 2020			IT system interoperability Q3&4 with skype consultations in Q4	
Swale	A programme of estates capital bids to increase local capacity for integrated working along with IT solutions to interoperate and APPs for patient self - activation.				
	Work on proposed Sittingbourne Hub – competition date of Dec 2020	system wide OD programme Q2-4		Proposed commencement of building work at Chestnut GP premises	Proposed completion of Sheppey Health and Wellbeing Hub Skype consultations
West Kent	System wide culture and organisational development plan - jointly developed and delivered along with comms strategy. Hub development project Feb –Aug 2018				
	Recruit workshop manager and begin scoping workforce requirements	IT-Continued roll out of CPMS for sharing patient care plans Review outputs from population dynamic modelling tool			

East Kent wide-working with EKHUFT to agree activity reduction and resolve stranded costs

This page is intentionally left blank

A Communications and Engagement Plan for the Implementation of Local Care

Situation:

This paper provides an overview of the communications and engagement work to support Local Care in Kent and Medway.

Local Care is a key work-stream within the Kent and Medway Sustainability and Transformation Partnership and is a new model of delivery of integrated health and care services close to where people live. It is a collective commitment of the health and care system in Kent and Medway to fundamentally transform how and where we will support people to keep well and live well.

Background:

The Kent and Medway Local Care work-stream was set up in November 2016 and has so far developed and refined a new clinical model for Adults and Older People with complex needs, typified by the "Dorothy" model. The model is a Kent and Medway wide framework against which detailed local planning can continue. It has been developed through over 12 workshops and is supported by an investment case.

The work-stream has defined the key objectives for Local Care for 2018/19 and is supporting localities to develop detailed roll out plans and required investment.
It is important that there is a clear and transparent communications and engagement plan to support the work-stream moving forward.

The Local Care Implementation Board has agreed that there needs to be a structured and coordinated communications strategy; involving members of the public, as well as the statutory, voluntary and charitable sector in co-design of Local care.

Initial engagement has happened with senior staff in CCGs to act as the 'conveners' or 'facilitators' of Local Care planning in their geographies – the intention for them to facilitate discussions with partners and ensuring that plans are either co-developed or at the very least shared and the views of partners incorporated.

Assessment:

There is a requirement for a communications and engagement strategy following the principles that the communications strategy is;

- **Considered and accurate** – Good communication starts and ends with getting the basics right. We must make sure all communications consider the needs of the intended audience and deliver accurate and consistent messages to all group.

- **Targeted and tailored** – Consistent doesn't need to mean the same. There are a broad range of stakeholders with different areas and levels of interest. We must make sure we target the right messages using the right channels for different audiences.

- **Inclusive and meaningful** – Staff and stakeholders are spread across a large geography, and come from multiple organisations with diverse backgrounds. There is a need to ensure effective systems and channels in place to reach everyone..

- **Timely and proactive** - Communications and engagement that is either premature or late loses impact; failing to deliver its objective and wasting resources. All communications and engagement activity must be delivered at a time that's appropriate for the message and the audience.

- **Honest** – Linked to meaningful communications and engagement there is a need to be open and honest.

Recommendation:

Communications and engagement strategy needs to meet the objectives for Local care. For 2018/19 these are to;

1. Establish standardised Multi- Disciplinary Teams, working with GPs at scale
2. Develop integrated case management and individualised anticipatory care plans
3. Develop inter-agency partnerships to deliver local care at scale and harness community resources.

The strategy will;

- Clearly explain the need for Local Care/ Care in the Community
- Clearly explain the objectives and benefits of establishing multi-disciplinary teams around GP practices working at scale (30-50,000)
- Ensure people are given genuine opportunities to be involved in the Local Care communications strategy
- Ensure channels for co-design of communication materials

Key messages:

The narrative for Local Care in 2018/19 needs to focus on the benefits across Kent and Medway to;

- work differently to keep people well and in their own homes for as long as they possibly can be
- Share resources and work in a more coordinated and joined up way.

And by doing so will;

- Deliver services closer to home
- Avoid unnecessary hospital admissions
- Provide value for money and the sustainability of services to meet the requirements as set out in the NHS Five Year Forward View.

A core narrative will be developed based on those identified by the Local care work-stream and will deliver the wider objectives of the STP, and should focus on delivery of service improvements for people over cost/efficiency benefits.

Proposed Action Plan for Developing a Communications Roll Out Plan For Local Care:

Action	Desired Outcome	Owner	Timeframe
Present the Strategy to the June Local Care Implementation Board	• **For comments/ amendments.** • **Agreement/ ratification to action**	**Cathy Bellman**	**8 June 2018**
Socialise the strategy internally across the STP work-streams	• **Identify synergies and opportunities to align, to avoid duplication**	**Cathy Bellman**	**After 8 June 2018**
Identify a communication and engagement lead to lead work on deliverables and timelines	• **To work on deliverables and timelines**	**STP Programme Lead**	**June 2018**
Take the detailed action plan to the Local care Implementation Board	• **Agreement ratification**	**Cathy Bellman**	**July 2018 – or sooner if happy to do this virtually**
Commence communications and engagement activities for Local care	• **To meet the key objectives of the Local Care Communications and Engagement Strategy**	**Cathy Bellman and Communications and Engagement Lead**	**June / July 2018**

This page is intentionally left blank

APPENDIX D

Post conference report

Multi-Disciplinary Working Conference – The heart of local care

Wednesday, 18 April 2018, 9.30am to 4.30pm
Mercure Maidstone Great Danes Hotel, Ashford Road, Maidstone, Kent ME17 1RE

Prepared for: Cathy Bellman, Local Care Lead, K&M STP
Prepared by: Communications and Marketing, Kent Community Health NHS Foundation Trust
Date: Wednesday, 25 April 2018

Contents

Appendices

Background

The conference was the culmination of many months of work to make sure health and social care professionals, as well as other partners including the voluntary sector, local council and Kent Fire and Rescue Service understood and are developing multi-disciplinary teams to embrace the emerging model of local care.

The local care model is being developed as a key element of the Kent and Medway Sustainable and Transformation Plan (STP).

The conference was aimed at frontline staff from all STP partners and beyond, as well as managers, with representation from the STP.

The conference

Getting local care right for patients means health and social care professionals truly working as multi-disciplinary teams (MDTs) and cutting out the amount of jargon the NHS uses.

That was the key message. Highlight of the conference was the film where we saw "poetry in motion". Please click on the link to be able to view .

What is an MDT?
https://vimeo.com/266106311/4e6484f8d2

What is an MDT? starred local colleagues and helped to articulate the vision and challenges of working this way.

From the conference there is also a piece work underway to look at standardising and simplifying language used to describe services across Kent and Medway- at the moment this is causing some confusion with the public.

Frontline colleagues from across the health and social care sector, as well as partner organisations, including Kent Fire and Rescue Service and the Heart of Kent Hospice were there.

Speakers like trainee advanced clinical practitioner in frailty Carrie Mandeville told of the advantages of integrating teams. Senior figures from Kent and Medway STP, including Chief Executive Glenn Douglas and Caroline Selkirk, Managing Director for East Kent Clinical Commissioning Groups and Senior Responsible Officer for Local Care, answered questions from delegates.

Dr John Ribchester spoke about how the Encompass Vanguard works; Local Care Lead for Kent and Medway STP Cathy Bellman and Nicola Cloughley, Health and Social Care Co-ordinator, shared some of the top tips for MDT working, and geriatricians Shelagh O'Riordan and Gwenno Batty explained that being part of a big MDT means fewer repeat assessments, so they can work on what the frailest patients need.

Notes from the plenary sessions have been combined for this report as **appendix five.**

Summary

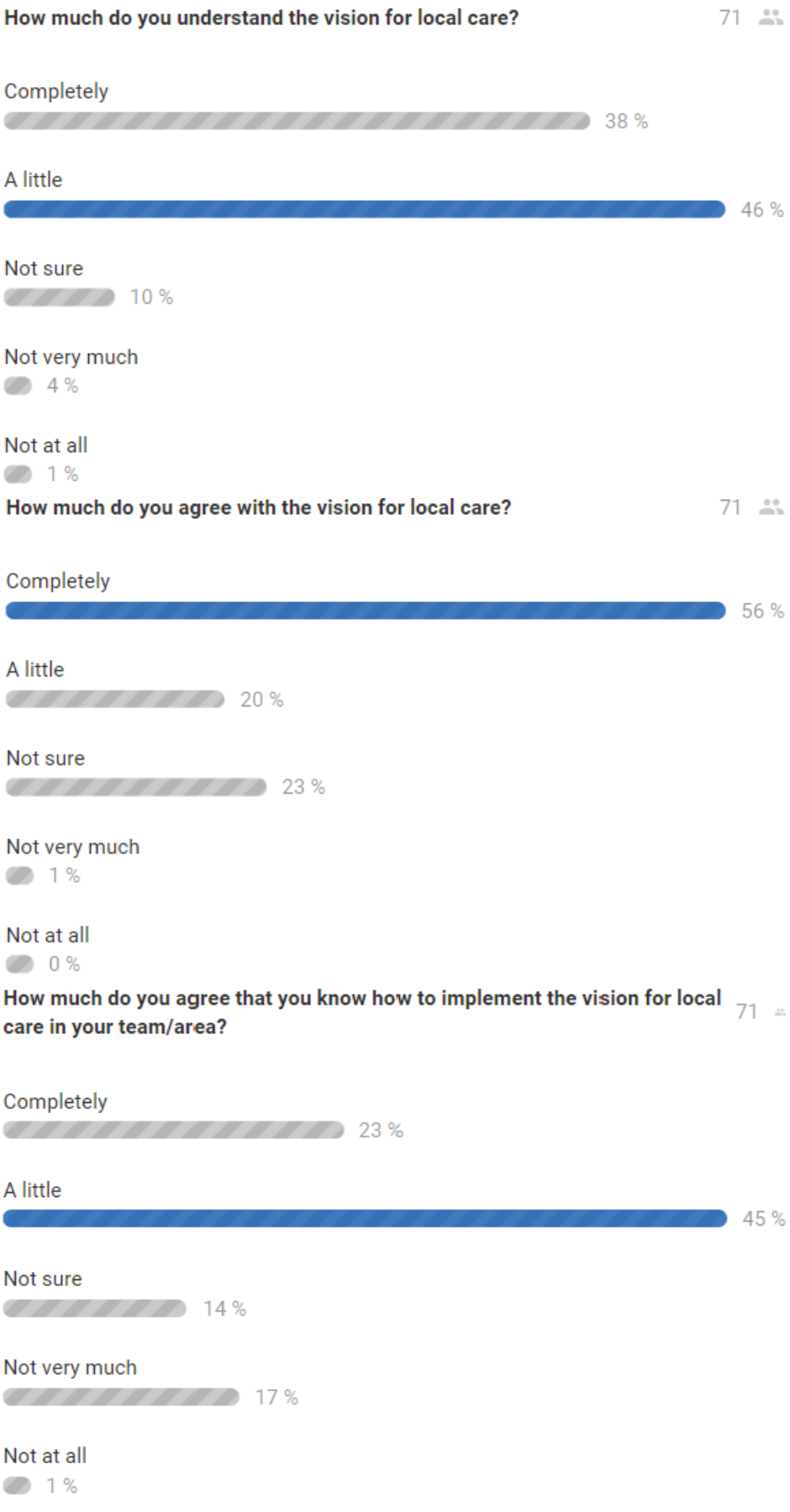
The aim of the day was to share the great examples of multi-disciplinary working and make sure we have the energy and ideas to put it into practice across Kent and Medway.

Frontline staff took part in eight workshops and we have pulled all the notes and comments from the workshops together in this report as **appendix four.**

As you will see in **appendix one**, we have gathered all questions asked on Sli.do and in the room on the day, together with the answers. We have also incorporated delegate feedback as **appendix two** and you can see the role social media played in the day in **appendix three.**

Appendix one: Sli.do analytics

Participants sent 333 votes in 6 polls
Morning vote: 71 participants **Afternoon vote:** 40 participants



How much do you understand the vision for local care? 40

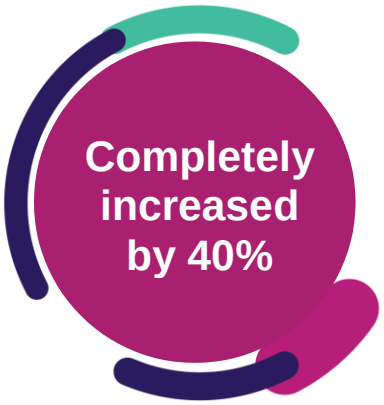
Completely
78 %

A little
23 %

Not sure
0 %

Not very much
0 %

Not at all
0 %



How much do you agree with the vision for local care? 40

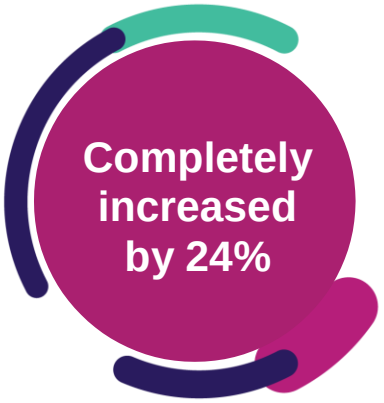
Completely
80 %

A little
18 %

Not sure
3 %

Not very much
0 %

Not at all
0 %



How much do you agree that you know how to implement the vision for local care in your team/area? 40

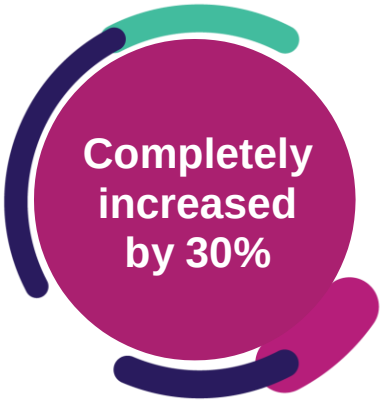
Completely
53 %

A little
43 %

Not sure
5 %

Not very much
0 %

Not at all
0 %



Attendees asked 49 questions with a total number of 73 likes

90% of questions were asked anonymously

1. What do you mean by local care and what are you trying to achieve?
2. What is the STP and what is it trying to achieve?
3. How are adult social care and health working together?
4. Not sure the public need to understand all of the language we use, but they do need to know how to access services. Are there plans to change entry points?
5. Could you pease define local care and how does STP is going to support its development?
6. Can we all stop using acronyms and just use plain english
7. How important are relationships between the organisations to enable the STP to be successful and how do you manage conflicts
8. What help (money?) will we get with implementing the technology required to underpin MDT meetings.
9. How can the STP make itself more aligned to local care visions and aspirations? It feels very centralised and removed from Local Care.
10. How do we keep parity in access and services whilst maintaining and championing the local flavours?
11. What is STP
12. With lots of different local models across Kent & MEDWAY, how do we keep this simple and user-friendly for all agencies and agencies involved?
13. How can we encourage GPS to engage with the CHOCs when they are already pressed for time to engage with the CHOCs?
14. We must not forget the contributions that can be made by the family and community
15. How does STP support ares in different stages of development?
16. Are we going to have more staff in the community to be able process the quick response needed for the patients discussed at CHOC
17. What will the multi disciplinary team do to make reasonable adjustments so that those with very complex needs will benefit from the range is services available
18. We have worked in and with MDTs for many years so what is different in the K&M local care model?
19. Pleased that we will call the localities networks rather than Chocs, hubs, primary care homes etc. Very confusing!
20. Will NHS and Social Services have access to the same software for a joined up services?
21. How are the needs of Carers being addressed across the STP and local care modelling?
22. Where or how best do functions such as air quality, planning, Flood prevention, good quality jobs engage with Local Care approach?
23. Remember therapists. It's not only GPSIs and ANPs who can keep people out of hospital
24. How do people access the vanguard choc services out of hours?
25. Maybe we need to ensure patients take their medication into hospital when time allows to save NHS money and the elderly over medicating when they get home
26. The Encompass model is successful- which of all the elements can you put most of its success own to?
27. Primary Care Network - do we honestly believe the general public will understand what this means?
28. How do the ambulance trust and other out of hours services access /interact with mdts to ensure patients care plan is followed?
29. Hi Cathy, are we only supposed to ask question on slido?
30. Question to clinical staff involved in the Encompass MDTs: What message would you pass on about the impact that attending MDTs has had on your workload?
31. Are the slides going to be circulated
32. Can delegates get all the slides please?
33. How are the local care systems taking learning from other teams in the NHS, social care and other areas of the country?
34. Can MDT teams refer patients directly to secondary or acute services? e.g. frailty ward at Pembury?
35. What is red zebra?

36. Do the social prescribers and care navigators visit patients at home or is it all GP based
37. Shouldn't patients or the person who is being discussed be part of the MDT? And if not physically possible what about a virtual MDT through Skype ?
38. I'm from local authority housing department- how can I get involved and Help?
39. How are Kent Fire And Rescue utilised within tbe MDT?
40. How can we ensure the patient/ person is totally involved in the decision making of the MDT when they are not in the MDT meeting?
41. Can 111 service refer people to MDT, including out of hours. In my experience they default to telling people to go to A&E!!
42. As a non clinician I'm suprised we have to push MDTs - Is the STP seeking a mandate to develop MDTs across the patch with a view to supporting investment
43. Please can you tell us when /how end of life / hospice care fits into the Dorothy model it is not mentioned?
44. Can we turn the air con off? ☃️
45. How quickly do patients get the feedback/ decisions following the MDT meeting
46. Has there ever been a patient who has attended an MDT discussion about their care plan?
47. What happens when a patient has a crisis and there is no MDT scheduled
48. New models presentation didn't mention funding. Vanguards were funded, won't local providers want to know what funding will support their model development?
49. Wewould love to have more involvement from hospice staff but despite invitation, they haven't had staff available to attend. Can this change?

What were the most popular questions?

Anonymous 6 0

How can we encourage GPS to engage with the CHOCs when they are already pressed for time to engage with the CHOCs?

Anonymous 5 0

How are adult social care and health working together?

Anonymous 4 0

What do you mean by local care and what are you trying to achieve?

Anonymous 4 0

Shouldn't patients or the person who is being discussed be part of the MDT? And if not physically possible what about a virtual MDT through Skype ?

Anonymous 3 0

Can we turn the air con off? ☃️

What were the main topics?

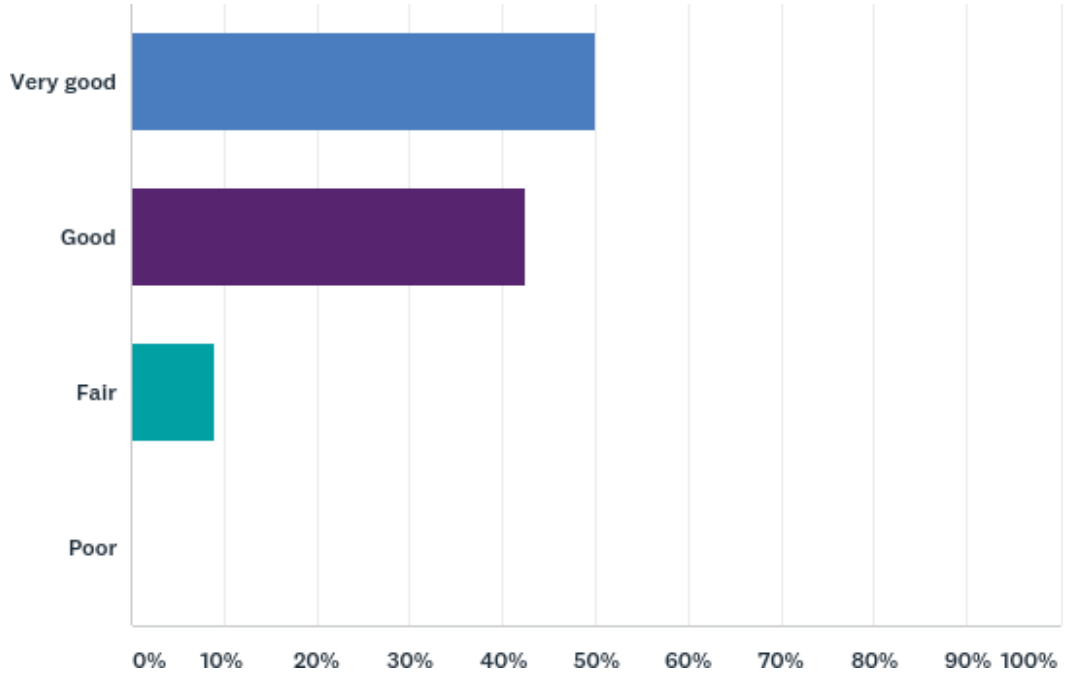
Who were the most influential participants?

F	Frances Hopes	3	3
J	John Battersby	1	0
	Anonymous users	44	67

Appendix two: Delegate feedback

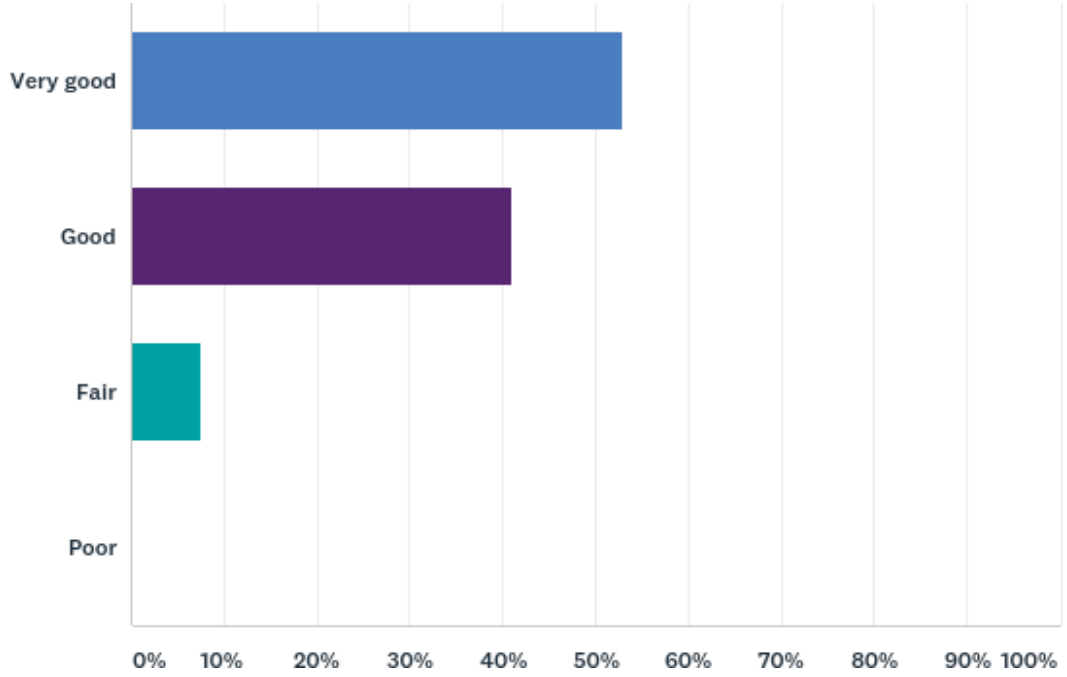
Total number of delegates: 193
Total number of respondents: 66
34 per cent of delegates completed a feedback survey.

Q1. Overall, how would you rate today's event?



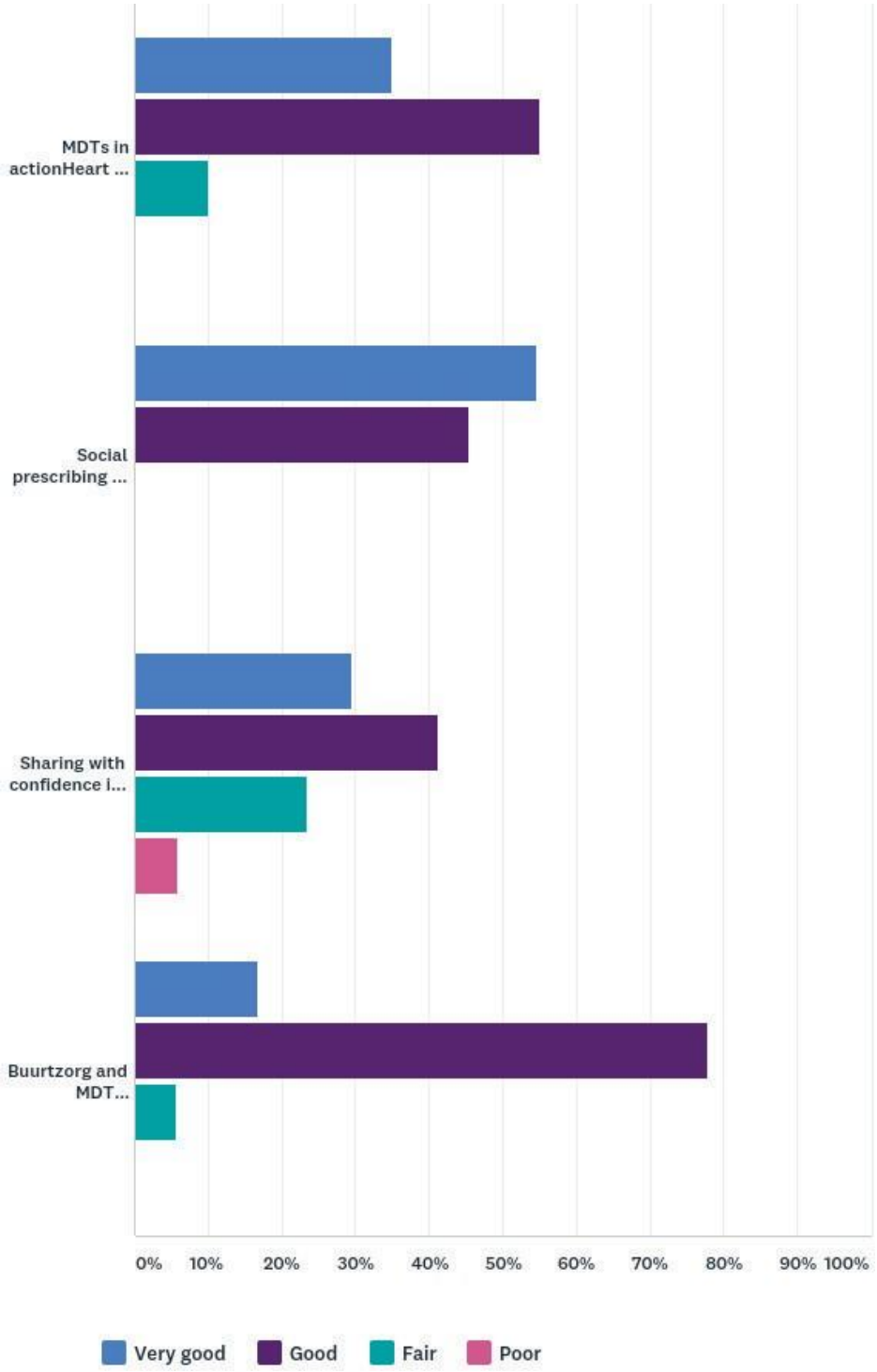
ANSWER CHOICES	RESPONSES	
Very good	50.00%	33
Good	42.42%	28
Fair	9.09%	6
Poor	0.00%	0
Total Respondents: 66		

Q2. How would you rate the venue?



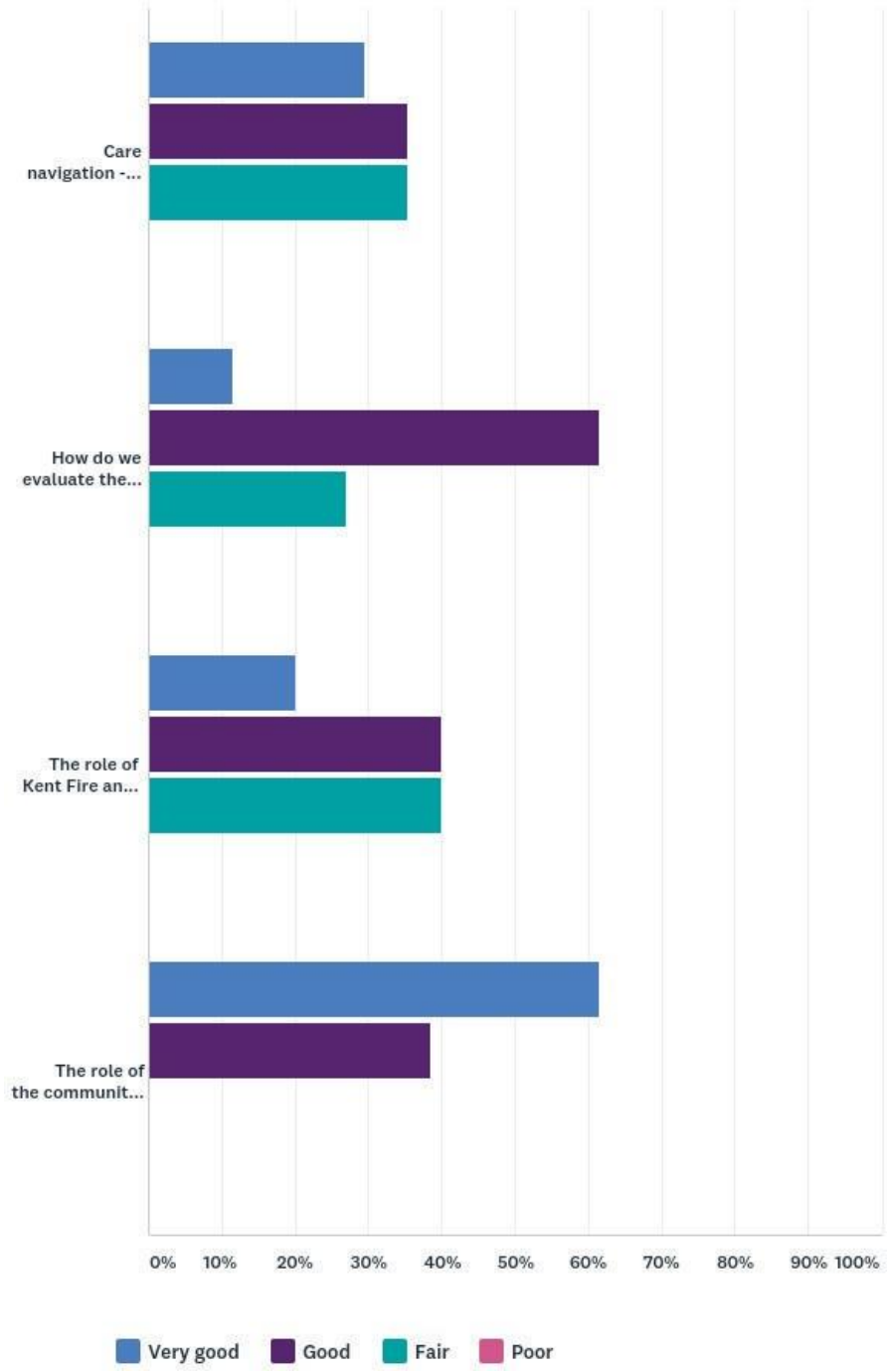
ANSWER CHOICES	RESPONSES	
Very good	53.03%	35
Good	40.91%	27
Fair	7.58%	5
Poor	0.00%	0
Total Respondents: 66		

Q3. How would you rate the workshops? (session one)



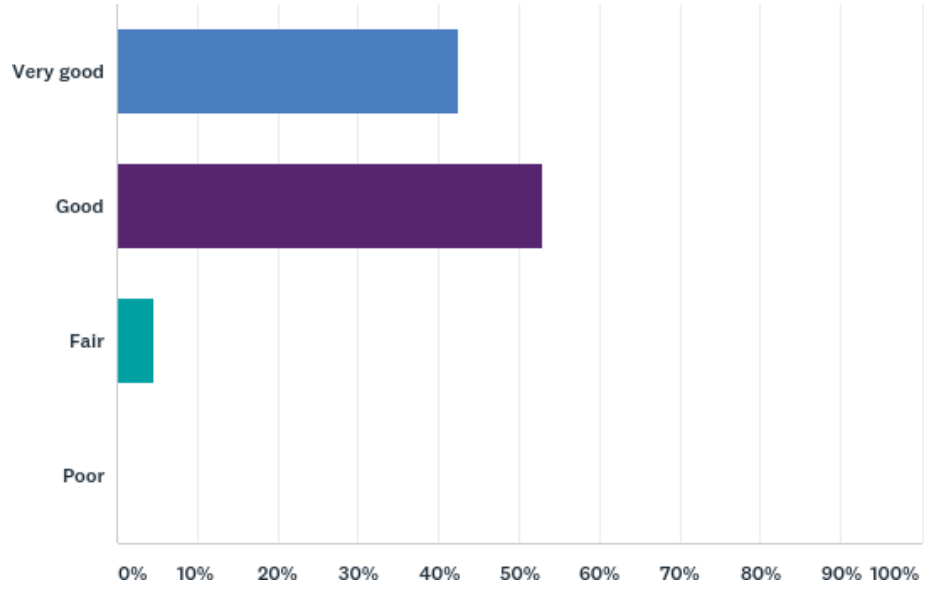
	VERY GOOD	GOOD	FAIR	POOR	TOTAL
MDTs in actionHeart of Kent (front)	35.00% 7	55.00% 11	10.00% 2	0.00% 0	20
Social prescribing – what is it?Heart of Kent (middle)	54.55% 6	45.45% 5	0.00% 0	0.00% 0	11
Sharing with confidence in MDTsHeart of Kent (back)	29.41% 5	41.18% 7	23.53% 4	5.88% 1	17
Buurtzorg and MDT workingHollingbourne	16.67% 3	77.78% 14	5.56% 1	0.00% 0	18

Q4. How would you rate the workshops? (session two)



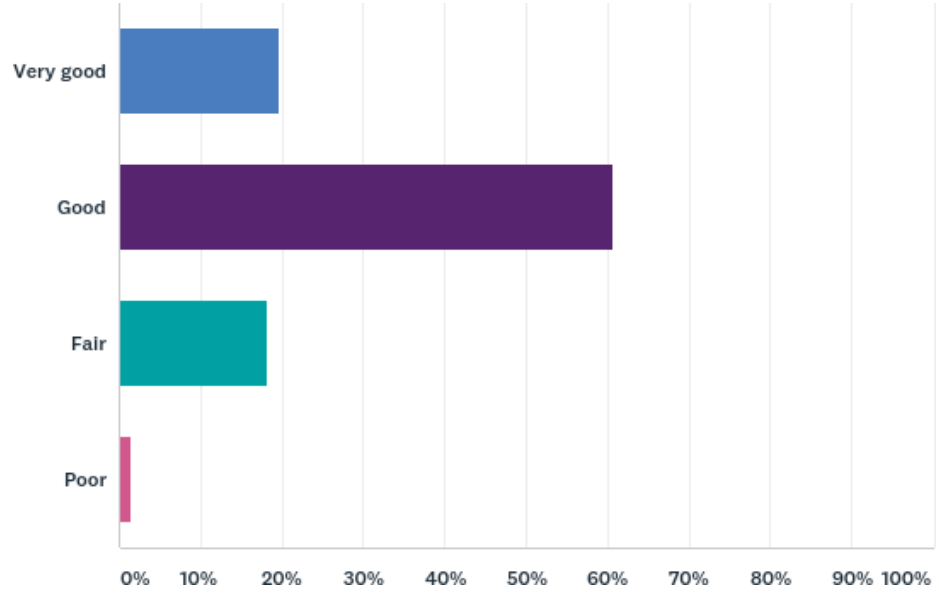
	VERY GOOD	GOOD	FAIR	POOR	TOTAL
Care navigation - what is it and who does it? Heart of Kent (front)	29.41% 5	35.29% 6	35.29% 6	0.00% 0	17
How do we evaluate the impact of MDT working?Heart of Kent (middle)	11.54% 3	61.54% 16	26.92% 7	0.00% 0	26
The role of Kent Fire and Rescue in MDT workingHeart of Kent (back)	20.00% 2	40.00% 4	40.00% 4	0.00% 0	10
The role of the community guardian volunteer within SECAmbHollingbourne	61.54% 8	38.46% 5	0.00% 0	0.00% 0	13

Q5. How would you rate the main presentations?



ANSWER CHOICES	RESPONSES	
Very good	42.42%	28
Good	53.03%	35
Fair	4.55%	3
Poor	0.00%	0
Total Respondents: 66		

Q6. How would you rate the question and answer session/s?



ANSWER CHOICES	RESPONSES	
Very good	19.70%	13
Good	60.61%	40
Fair	18.18%	12
Poor	1.52%	1
Total Respondents: 66		

Q7. What was the most useful part of the event for you?

Answered: 58
Skipped: 8

- Deeper understanding of reality of how MDTs operate.
- As an officer of a LA housing team, looking at how we can offer help to other agencies. Cathy Bellman was brilliant!"
- I loved the 'how do we evaluate the impact of MDT working' and also the new care models presentation.
- Hearing about what other services offer.
- Clarification of more terminology and the presence of social care!
- Understanding STP vision/partners and networking know that STP vision is aligned to our organisations.
- Networking with other people.
- How can hospices support local care - very engaging. Informative :)
- Networking opportunities from across the Kent health economy.
- Networking. Great to see such a strong KCHFT presence and influence.
- Listening to practitioners re realities of working in the LC groups. Understanding current established links with a range of community organisations.
- Information of new services and more integrated working.
- Main presentations.
- Gaining a vision of how this can be repeated.
- Meeting different disciplines and networking.
- Listening to our colleagues - learning about different ideas and some of which will be feeding back to my surgery. Networking.
- Opportunity to share what fire and rescue service can support.
- Networking. Learning about progress so far.
- The hospice talk.
- I found the whole day very useful.
- Our vanguard in action - very good overview. How hospices can support local care.
- Buurtzorg model talk - help to plan future service provision.
- The bringing together of so many services/agencies/professionals.
- Workshops
- Being able to share experiences and knowledge.
- Hearing about dementia support available.
- General networking and looking at different models of care.
- Understanding, social prescribing and care navigation.
- Understanding what other areas are doing for MDT
- All very good.
- Networking. Overview of STP/local care. Vanguard experience of MDT working.
- MDTs in action was helpful
- Partnership working.
- Networking with others and finding out how other areas are working together.
- IG issues with setting up MDT.
- Hospice talk - enlightening and interesting.
- The workshops. However I would have liked the opportunity to attend some of the other workshops, although I understand that would be difficult due to time constraints.

- Opportunity to network. Learning about information sharing specifically for MDTs.
- Social prescribing: Weshould look more at competency and how SP is for all ages - not just frail/elderly.
- Social prescribing breakout. Inspirational, great presentations, thought provoking.
- Red Zebra presentation was excellent - all about people.
- Interactivity and being able to be part of conversation through Q&A.
- Workshop two.
- The presentation by the long-term condition nurse.
- Confirmation that our MDT is going in re-direction needed for local care (STP).
- Networking - discussion as to how integration could be a value to SU and their families.
- All very relevant - questions answered - solutions, tips and lessons learned. Presentations were very informative, interesting and current.
- Networking with other health professionals who are doing MDT in other locality.
- The workshops especially the Buurtzorg. Understanding of what services delivered by the hospice.
- Sharing experiences with various colleagues across Kent and Medway. Talk by Sarah Pugh.
- The practical examples of how the MDT works.
- Good to see that everyone is committed to change and everyone is moving forward in basically the same way.
- Networking. Interesting to hear what teams have been up to but it is now the time to act and take action to make a change.
- Seeing and hearing how other areas are facilitating MDTs/HUBS.
- Networking opportunities - already proving very helpful! Will be going to visit MDT working in Encompass!
- Sharing details of how MDTs organised in some areas.
- An understanding of the various models of MDT.
- Networking and workshops.

Q8. If we were to hold a similar event in the future, what would you like us to cover?

Answered: 40
Skipped: 26

- Barriers to success - talking to those on the ground about what the real provisions are without an eye to the budget - successful outcomes and limited budget aren't always compatible.
- Greater participation of social care demonstrating its contribution and share partnership with the integration process.
- Share operational tools:
  - assessments
  - outcome tools
  - terms of reference
  - standard operating procedures
  - MDT formats
- Networking with more 'local' agencies.
- Think about your audience and pitch accordingly. Jargon buster. Speakers from social care/voluntary sector - felt most of presentations targeted clinicians/health service.
- Vision for mental health services within LC groups.
- Definitely
- How to utilise voluntary sector into every day practice.
- More discussion on social services input. They are a very valuable and have knowledge which is essential to the MDT.
- MDT shared learning in other areas. More from workforce input in MDTs.
- Views from other CCGs. More accessibility for front line staff.
- Strategies to support engagement.
- The influence of paramedic prescribing on health and social care ask Andy Collin of SECAmb.
- How are these plans represented on 'ground floor' level? Opportunity to attend more breakout sessions (it was hard to choose from such valuable talks)
- More information stands. Ester model. More people sharing their stories and impact of MDTs on their lives and care.
- The same - would like to see similar event inviting more 'junior/shop floor' staff who would benefit greatly.
- Main focus on communication.
- Same again!
- More voluntary sector collaboration.
- How we can promote integration in health and ss.
- Joint working between second care and primary care, including CCGs.
- All areas.
- More systematic and focussed workshops.
- Cover all acronyms.
- Updates really on the same.
- Other areas that are implementing MDT and their experiences.
- The possibility of a more joined up care with the acute care setting - more discussions around that.
- Case studies and examples of good practices - especially as a direct result of MDT working.
- Case studies.
- Follow up on progress from today. More info on defined plans. Updates on key models mentioned.
- To know what's happening in our CCG area.

- Consent/information sharing/GDPR/IG/sharing information
- Budgets and pulled resources affect pulled budgets.
- More about funding will be used. How services holding budgets will use them budgets to make MDT part of everyday support for SU.
- Personally with my field of work - Neurodevelopmental Conditions - specialist MDTs and new models of care in the system for high cost, lower number with cohorts.
- More GP participation.
- Needs to celebrate everything happening across Kent, including Medway and west Kent.
- The patients contribution to the MDT as it appears they are no involved in the crucial part of the meeting. Decision are made without them being present.
- Get more GPs to stand up front.
- More input from primary care; the roles, purpose, value and patient outcomes/experience. Any additional information on clinical outcomes impact on primary care.

Q9. Do you have any other comments or suggestions?

Answered: 31
Skipped: 35

- Engage more with local care beyond social care - we influence and place shape many of the care assess that patients/people value more than anything else (in Caroline's words).
- IG session was just an IG training session. Thought it would be more about the Kent Care Record and how that's going to work. Teach us to suck eggs!
- There was an assumption that all those attending would know what STP/local care/vanguard etc. were - coming from voluntary sector. The workshops I attended didn't really cover what they said they would: IG - I was hoping to come away with practical info/guidance but felt it was pitched at much higher level. care navigation - sessions focussed heavily on one you, would have been more useful if it covered care navigators have generally focussed on framework.
- Too many cakes for a health conference!
- Very good event. Better understanding of HSCC role.
- Still not quite sure how much wider voluntary sectors organisations will be involved in MDT. Would be good to have a clearer view on this. Whether organisations and which ones, would be included - on an on-going basis or on a case by case basis and if there would be any financial incentive to do so as resources are so tight. Full cost recover in my organisation per hour ranges from £22-£28 per hour. Attending MDT meetings could prove very costly financially.
- Have a panel to answer Q&A.
- A better understanding of the HSCC roles as I feel this was explained at the end incorrectly. We do have experience and training in the health and social care sector and from feeling very positive throughout the day felt slightly deflated at the end.
- As care co-ordinator at New Dover Road I would like more training re CHOC IT. I am getting CIS this week which will be useful.
- Would be useful to have a list of delegates. May have been useful to have a panel for Q&A and spend more time on slido questions which a lot weren't answered.
- Invitation process was not all encompassing for provider organisations. Needed better accessibility for the right staff.
- Would have like longer breakout sessions as they felt a bit rushed.
- Thank you to Cathy Bellman for pulling this all together.
- I would have like to be made aware sooner so I could arrange for my Bb case managers to also attend (only made aware at another managers meeting 7 days ago)
- Confusion over the different models - how do they come together/complement each other to enhance/support MDTs? Slightly longer lunch to allow networking.
- I'd like to have been able to attend more than one workshops session as all looked interesting. Thank you so much!
- A well organised day. Well hosted by Cathy. Great presentation by Sarah Pugh - hospices. Shame it was a bit cold in main hall! Thank you.
- Interactive sessions/presentations. Public contribution.
- Thanet was not discussed in the whole event. We have excellent MDT work that has proven to decrease hospital admission and support early discharge. We work very closely with our local GPs and first response for ambulance.
- Unable to see presentations from back of the room. Presentations shorter and options to attend like workshops. Enable different audiences to choose topics of interest.
- Very good day. I wasn't sure what to expect but it has been very helpful.
- The room was quite spacious to accommodate everyone, however, it was quite difficult to see the screen properly from the back of the room. Air con - too cold!

- Venue was a bit hostile to the delegates charging their phones and laptops.
- Good mixture of people present and presenting.
- Care delivery for all SU needs to be sustainable and realistic. Care models developed need to have an end result. Pilots need to lead to action and not end as a blue sky wish aim.
- Again jargon jargon jargon!!! I'm a coal-face worker and very corporate based and having film about jargon and the patients but managers have not learn lessons.
- It would be useful to involve GPs, IDT/acute representatives.
- If you are going to use slido then please respond to the questions and comments being posted.
- There was quite a bit of repetition in the morning sessions. I feel the that things need to start happening - there is lots of talking and not enough doing. Plus there needs to be realism about resourcing and what can realistically be delivered within current financial constraints.
- It's a shame the wifi at the venue didn't work very well.
- The elephant in the room is finance/investment. It does a dis-service to colleagues to revisit old ground time-over but not empowering/giving the tools to take forward. the CCGs have created levels of working that to some degree have disabled moving forward - I'm really hopefully that what we are contributing now can achieve fruition. The will is there! Jane McVea - did touch on this - very welcome.

Appendix three: Twitter engagement

#KMlocalcare

Beckie Burn @BeckieBurn
Also well done to the fabulous @CathyBellman for leading the charge & organising a really practical & inspirational day @KMhealthandcare #KMlocalcare twitter.com/kmhealthandcarâ€¦

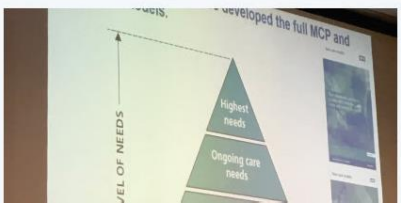
Red Zebra Social Prescribing @BeWellKent
Shelagh @jupiterhouse1 &Gwenno delivering great talk . Good to work with them in MDT's.Excited to see #pimpmyzimmer #kmlocalcare @CathyBellman @AgelessThanet @NHSCCCCG #socialprescribing @kmptnhs @ARTofWellbeingW #CommunityEngagement

Carrie Mandeville @mumwifenurse
Great talk from @SarahJanePugh discussing MDT support from the hospice and the services that they deliver #KMlocalcare https://t.co/PS6jTaBr9B

CityImpactKent @CityImpactKent
Sarah Pugh CEO HeartofKent Hospice blowing myths about the work of hospices . Inspiring talk #kmlocalcare @community @kmptnhs @BeWellKent @CathyBellman @NHSCCCCG

Jo Frazer @Jo_Frazer
What were the greatest achievements of the vanguard programme? #KMlocalcare https://t.co/VNKYW3kkWh

Sarah Pugh @SarahJanePugh
New care models being discussed by Jane McVea at @KMhealthandcare #KMlocalcare conference https://t.co/amraxJRxCf



MaSCOE @_MaSCOE
Medway is implementing a fantastic programme of local care for its residents. If you want to be part of those vital improvements for patients then come to Medway and take part with us #KMlocalcare #BestOfPeople #BestOfCare twitter.com/SharHoss/statuâ€¦

Kent & Medway STP @KMhealthandcare
Thanks to all who shared updates from today's #kmlocalcare conference. Well done to colleagues at @NHSKentCHFT for putting on such an important event. Embedding excellent #MDT led out-of-hospital care in K&M will make a huge difference to so many living with ongoing care needs

CHSS @CHSS_Kent
Great turn-out at the @KMhealthandcare MDT conference today - here's CHSS Researchers Rasa and Sabrena in action! #KMlocalcare https://t.co/3SipGCAo6Y

Claire Casarotto @ClaireCasarotto
Moving and passionate presentation from Sarah Pugh about the role of Hospices in local care delivery. Fake news and myth-busting completed very eloquently to @KMhealthandcare #KMLocalcare https://t.co/E7Cud8VBOP

Jo Frazer @Jo_Frazer
What is next - a change of acronym! #KMlocalcare https://t.co/FUJBrqjcXj

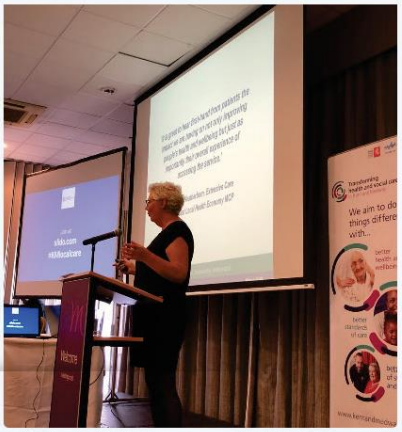
Carrie Mandeville @mumwifenurse
Watching the awesome Gwenno Batty and @jupiterhouse1 present the workings of the frailty team within the context of local MDTs #KMlocalcare https://t.co/qskVzGFIDJ

Sarah Pugh @SarahJanePugh
Gwenno Batty from @NHSKentCHFT at #kmlocalcare talking about impact of 'pimp my zimmers' campaign in care home reduced falls by 60%. @KMhealthandcare

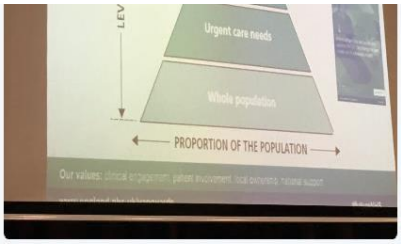
CityImpactKent @CityImpactKent
Sarah Pugh saying hospices can support local care with expertise in endoflife , enablement & preventing crisis #kmlocalcare @CathyBellman @BeWellKent @NHSCCCCG @T4CG #community

Sharif Hossain @SharHoss
Amazed to hear that only 23% of @heartofkenthosp funding is from government #KMlocalcare

KentCommunityHealth @NHSKentCHFT
#KMlocalcare Jane McVea from NHS England talks about new models of care and the way they are working. https://t.co/kWuOmNzgTf

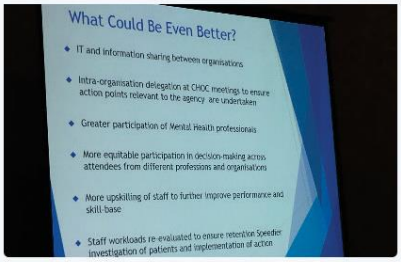


Shelagh O'Riordan @jupiterhouse1
The 2 queens of @NHSKentCHFT frailty team have found their correct chairs! #KMlocalcare https://t.co/3uryGxepSE



Sharif Hossain @SharHoss
Missed the #KMlocalcare tag Sarah!
twitter.com/SarahLeng1/staâ€¦

Beckie Burn @BeckieBurn
Using @encompassmcp evaluation from @UniKent to learn lessons as we roll out local care across the county - really interesting reflection on how we have truly joint decision-making & not just delegation to the highest grade in the room @KMhealthandcare #KMlocalcare https://t.co/wSnQ3RLyXc



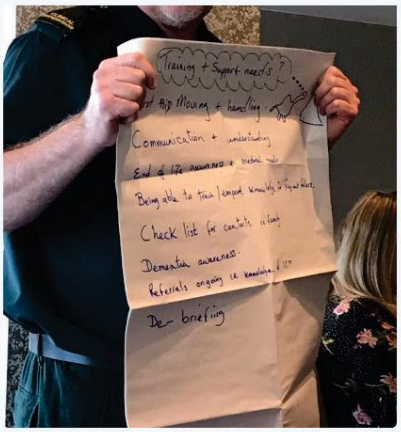
Carrie Mandeville @mumwifenurse
Great workshop from John @SECAmbulance talking about the role of the community guardian volunteer to provide non injury fall support to patients
👍🏻#KMlocalcare @KMhealthandcare
https://t.co/Oqf6L4AYAE

Red Zebra Social Prescribing @BeWellKent
#KMlocalcare @CathyBellman explaining MDT's

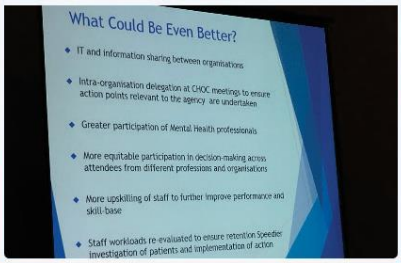
Jo Frazer @Jo_Frazer
Quote from @josdeblok "let nurses, nurse" - good luck to the #Buurtzorg pilot #KMlocalcare @KentDLC @KMhealthandcare https://t.co/ql61cJh73X

Jo Frazer @Jo_Frazer
Great to hear Jane McVea talk about the need to focus on the whole poplulation not just those with the highest need! #KMlocalcare https://t.co/hJJDTHstvX

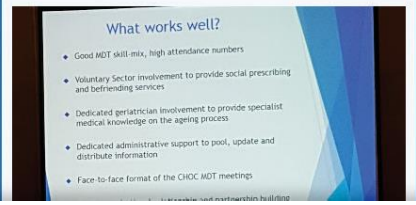
Carrie Mandeville @mumwifenurse
Clinical Lead for the Canterbury DN team Sam Twyman talking through our ideas for the training and education needs of a community volunteer with John Battersby @SECAmbulance #KMlocalcare #itsacamelnotadinosaur https://t.co/LgyruWHJ8e



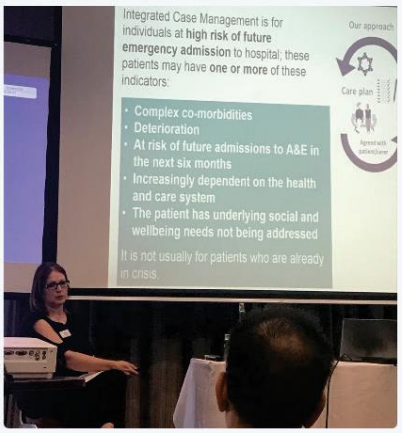
Beckie Burn @BeckieBurn
Using @encompassmcp evaluation from @UniKent @CHSS_Kent to learn lessons as we roll out local care across the county - valuable reflection on how we need to have truly joint decision-making & not just delegation to the highest grade in the room @KMhealthandcare #KMlocalcare https://t.co/QOV2quJucy



Sharif Hossain @SharHoss
What works well in an MDT? #KMlocalcare https://t.co/ctEKLcVyIJ



Carrie Mandeville @mumwifenurse
Pre lunch workshop with Gayle @encompassmcp and Dr Becky Prince discussing MDT meetings AND Integrated Case Management. Hearing from local teams and those slightly further afield. Lots of different ideas #KMlocalcare https://t.co/X2cxCvJEK3



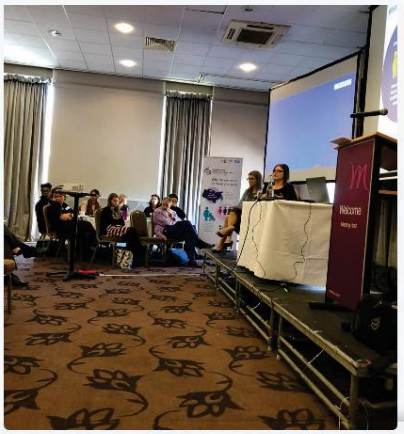
Jo Frazer @Jo_Frazer
Findings on what works well from @UniKent research and what could be even better! #KMlocalcare https://t.co/f9spixCSUh

Jo Frazer @Jo_Frazer
Interesting that the @UniKent Vanguard research showed that BEING in the room mattered, missing the meeting meant missing actions, or delaying actions #KMlocalcare @KMhealthandcare @KentDLC

KentCommunityHealth @NHSKentCHFT
#KMlocalcare Rebecca Bradd on navigating care: Effectively communication g and enabling people to be able to access services is key. https://t.co/vMfEI9bgfn

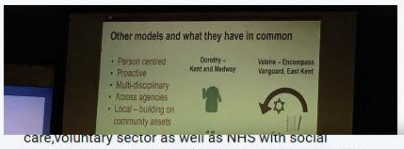
Jo Frazer @Jo_Frazer
Views that Mental Health and GP engagement is crucial to the success of #Buurtzorg #KMlocalcare @KentDLC @KMhealthandcare

KentCommunityHealth @NHSKentCHFT
#KMlocalcare Gayle Savage explaining how patients at heart of multi-disciplinary team working - examples bring to life. https://t.co/S6CXoY8V09



KentCommunityHealth @NHSKentCHFT
#KMlocalcare networking is vital to joined up working in @KMhealthandcare #stp #nhs https://t.co/wtmpGktkw5

Beckie Burn @BeckieBurn
There may be a bunch of different models with different names, but they all share the same design principles says @CathyBellman #KMlocalcare @KentDLC @KMhealthandcare - most important thing is being focused on making a difference to the patient https://t.co/ufZ3BRHQHO



care,voluntary sector as well as NHS with social prescribing to deliver Local Care and what matters to the person @KentDLC #KMlocalcare twitter.com/jupiterhouse1/â€¦

KentCommunityHealth @NHSKentCHFT
Delegates enjoying our poetic #mdt presentation #kmlocalcare https://t.co/pZADdFZAJ5

KentCommunityHealth @NHSKentCHFT
#KMlocalcare Anne Ford talks #Oneyou, lifestyle advisers and dealing with needs before starting the lifestyle journey. https://t.co/76VPkEkRQt

Jo Frazer @Jo_Frazer
Research from the Vanguard by @UniKent shows that MDT working made team members have a better experience #KMlocalcare

Jo Frazer @Jo_Frazer
Fragmentation in Local Care over the different models, how do we align, what are the commonalities and how do we ensure consistency #whatmatterstome #Best4ESTHER #Buurtzorg #KMlocalcare @KMhealthandcare @KentDLC

Beckie Burn @BeckieBurn
Really practical discussion about how MDTs work in both sides of the county & how to balance standardising approach with flexing for local circumstances - again all about the patient #KMlocalcare @KMhealthandcare https://t.co/U0danDokxy

Design & Learning Centre Kent @KentDLC
Sharing #Buurtzorg and #2SeasTICC #project at #KMlocalcare conference @2seasticc @MedwayHealth @NHSKentCHFT @Kent_cc https://t.co/otSNM6gTLE

Robert Stewart @robert4stewart
Kathy Bellman says that the main focus core MDT member - aligns ESTHER philosophy of care with Dorothy, Valerie and Buurtzorg @KentDLC #KMlocalcare

Steven Laitner @SteveLaitner
@alf_collins @danwellings @simonenright .We're talking about MDTs today. I still think this poses a real challenge for Shared Decision Making as the person is not in the "consulting" room @jupiterhouse1 @CathyBellman @NHSKentCHFT @JeremyTaylorNV @MightyDredd #KMlocalcare

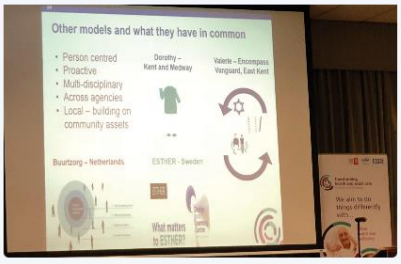
Jo Frazer @Jo_Frazer
Ah that moment in workshop where someone in the room is having their own conversation and not showing respect to the people talking ☹ #KMlocalcare https://t.co/13CUyRfDfo

KentCommunityHealth @NHSKentCHFT
#KMlocalcare Dr Becky Prince explains why it is important to take ownership and have knowledge of patients to make multi-disciplinary team approach work really well. https://t.co/pDpFjYetwK

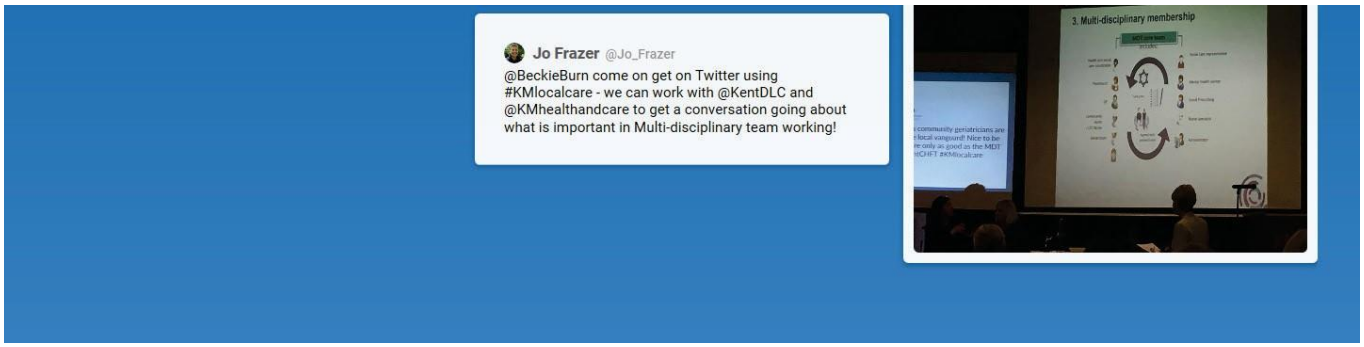
Jo Frazer @Jo_Frazer
Brilliant - "first coffee....then care" #Buurtzorg #KMlocalcare https://t.co/MuYNeCkVsT

Jo Frazer @Jo_Frazer
About to hear more about Buurtzorg and how it fits into #KMlocalcare

Jo Frazer @Jo_Frazer
It's important to understand that all the different models are actually the same! #KMlocalcare #Best4Esther https://t.co/b7Zc84s2B9



Beckie Burn @BeckieBurn
Hearing from colleagues running MDTs in @KMhealthandcare about their experience of what works, backed up by evidence in two new national reports from @AnnaStarling (journals.sagepub.com/doi/full/10.11â€¦) & @NHSProviders (nhsproviders.org/learning-from-â€¦) #KMlocalcare @CathyBellman https://t.co/FNjKaX02Nq


Jo Frazer @Jo_Frazer
@BeckieBurn come on get on Twitter using #KMlocalcare - we can work with @KentDLC and @KMhealthandcare to get a conversation going about what is important in Multi-disciplinary team working!
3. Multi-disciplinary membership

Appendix four: Workshop round-up

Workshop reports will be provided as separate documents also, so they can be shared as appropriate.

Workshop: MDTs in action

Facilitators:
Gayle Savage, CHOC Development Manager east Kent
Dr Becky Prince, West Kent CCG

Note taker: Fay Sinclair, Kent Community Health NHS Foundation Trust

Slide notes

Slide 1: Gayle Savage

- Bringing everyone together in one place.
- MDTs work very well in some areas but everyone not at same level.
- We started by looking at very frail.

Slide 2

- As per presentation.

Slide 3

- The MDT should be about the patient, not about who is paying.
- You build relationships with colleagues and families.
- You share your skills and knowledge.
- You realise how many tools you have between you to help the patient.

Slide 4

- Data is great and tools are great, but remember to use your professional judgement too. Trying to plan ahead is crucial for this cohort of patients and working with the voluntary sector can also help to pick up these patients.

Slide 5

- You don't have 30 people sitting round a table all day.

Slide 6

- Health and social care coordinators are integral to this.
- Patient tracker list is something the acute trusts use.
- We have access to see this now so discharge is not delayed, piloting it in Canterbury.

Slide 7

- We had issues with data sharing at first, but now we have good data sharing.
- Communications and engagement are so important, the more you do, the better you are.
- There are some GP surgeries/providers that just don't get it but hold your nerve.

Slide 8: Becky Prince

- Our MDTs last one hour.
- We have one GP present to give perspective and we use the SBAR tool.

Slide 9

- We are split into cluster in the west Kent area and for the past year, we have been doing this, building it gradually across the clusters.
- We have an MDT coordinator, similar to an admin role – essential.

Slides 10 and 11

- As per the presentation.

Slide 12

- We ran a number of cases in a pilot MDT and have now this week just rolled out the final phase of the project across wet Kent.
- Be clear on your primary objective.
- People need to take ownership and have knowledge re the patient.

Slide 13

- As per the presentation.

Slides 14 to 17

- As per the presentation.

Slide 18

- Time out for GPs – we have a 10-minute slot where we can dial in by phone or use Skype. We try to order in district nursing teams.
- Patients given feedback – will have things explained to them about who is leading, who has been decided to be the most appropriate person to be case manager.

Slides 19 and 20

- As per the presentation.

Slides 21 and 22

- As per the presentation.

Workshop notes

- Do health and social care coordinators manage the mailboxes? If so, how do they keep up as we have lots coming through?
- Can patients join in the MDT meeting via Skype?
- It is an evolving process at the moment.
- Is there a minimum number of professions/people that have to be there for it to be an MDT?
- How do we build in capacity?
- MDTS are really important because on the back of them, you can build up some really great relationships.

Workshop: Social prescribing – what is it?

Facilitators:
Fiona Keyte, Social Prescribing Manager
Jenny Walsh, Head of Operations, Red Zebra Community Solutions

Note taker: Beverley Bryant, Kent Community Health NHS Foundation Trust

Slide notes

Presentation started 20 minutes late, so some slides were skipped.

Slide 1
Who are Red Zebra and what do we do?

- We do not provide services so we can be completely independent.
- We do provide the Connect Well database and run a volunteer centre.

Slide 2
What is social prescribing and how would you define it?

- It's anything prescribed not by a GP
- It's a non-medical treatment for illness
- It's about signposting to relevant services using a central point of resources / a directory
- It's all about an individual and where they live. A person living in Dover will be socially prescribed differently to someone living in Canterbury
- It's about a person's wellbeing, including housing, social isolation, gardening, social events etc.
- There is a clear link between unmanageable debt and poor mental health. Social prescribing can offer navigation to housing and legal help
- It's about connecting with the wider community
- It promotes wellbeing
- Sometimes GPs have done all they can medically but still a person presents as being unwell. This is where social prescribing can help
- We need to get away from a 'medical model of care'. To concentrate on illness rather than wellbeing is not the answer. People want a life, not a service.

Slide 3

- As social prescribers, the aim is to get people up the Maslow's hierarchy of needs

Slide 4

- There are lots of different ways organisations can deliver social prescribing
- Today's session will describe how Red Zebra do it which is face to face with an electronic directory of 650 different activities for the person to choose from to suit them

Slide 5
YouTube film

Slides 6 to 12
Skipped

Slide 13
Film

Slide 14
In conclusion:

- Red Zebra will offer you an opportunity to support people
- We are looking into opportunities to provide special moments for end of life patients
- There is no right or wrong way of delivering social prescribing

Workshop notes

Groups were asked what they thought social prescribing was.
Answers have been captured above.

Workshop: Sharing with confidence in MDTs

Facilitators:
Alan Day, STP Information Governance Lead
Gail Spinks, Head of Information Governance, Maidstone and Tunbridge Wells NHS Trust

Note taker: Chloe Crouch, Kent Community Health NHS Foundation Trust

Slide notes

Slides delivered as per presentation.

Workshop notes

Is the term care defined?
This to some extent is left to the professional's judgement. We would recommend that whatever decision is taken about someone's care, it is always documents. Implied consent does not apply to non-regulated professionals.

Is 'direct care' hands on?

- It is whatever affects the care of that individual. Decisions have to be situation specific.
- Any information that is in the health social care arena is considered high risk.
- Governance of meeting and team is critical as you can only share and discuss patient information if you are involved in the patient's circle of care.

How does this affect Voluntary Community Sector?
Essentially VCS will see little difference, but it always comes back to who the patient has been informed about that will be involved in their care.

Workshop: Buurtzorg and MDT working

Facilitators:
Helen Martin, Director Planned and Urgent Care, Medway Community Health
Vicky Ellis, Assistant Director Clinical Governance, Kent Community Health NHS Foundation Trust

Note taker: Charlotte Morgan, Kent Community Health NHS Foundation Trust

Slide notes

Slide 1

- Welcome and introductions

Slide 2

- What is Buurtzorg/Transforming Integrated Care in the Community (TICC)
- Hear thoughts from group about embedding TICC into the local care model

Slide 3

- Established in 2006
- Nurse led
- Pioneering
- Now over 14,000 staff with a back office of 50 staff
- Client satisfaction is high
- Best employer in the last four out of five years

Slide 4

Explained the Buurtzorg onion model:

- Dorothy/ESTHER in the middle
- Community led model
- Informal network = MDT
- Based on the same local care principals

Slide 5

- Work with Dorothy to provide person-centred care
- 63 per cent of time is patient facing
- Self-management – informal and formal networks
- Continues for as long as people need

Slide 6

Informal networks explained:

- People we often take for granted
- Buurtzorg nurses work with patient's support network – family, neighbours etc.
- Nurses are local – can knock on their door – meaning response and support is quick.

Slide 7

- Nurses sit down with their patients and have a coffee and a chat – what support is needed?

Slide 8

- Staff are often part-time
- Teams self-direct and are coached, not managed
- Coaches support 40 to 50 teams
- No one manager or set roles – roles and tasks rotate e.g. doing the roster
- IT is fit for purpose for the team
- Sickness rates have reduced, as well as costs/overheads
- Reduction in incidents and complaints
- Over the last five years there have been three formal complaints to head office

Slide 9

Formal networks explained:

- No need to share a lot of electronic records
- Integral part of MDT
- 40 per cent of time spent networking
- Care is joined up, for example team continue to support if patient is admitted to hospital. If required nurses learn new skills in order to continue to support. This may be via a neighbouring team

Slide 10

- How the model fits in with local care

Slide 11

- EU, match funded project
- KCHFT, MCH and KCC are partners
- Four year project
- Blueprint to implement across 2Cs area

Slide 12

Groups discussed:

- What are the challenges and barriers to implementing Buurtzorg?
- What do you think are the key roles to develop and training needs?

Workshop notes

Group work was collected by Helen Martin and Vicky Ellis. There was a brief comments and Q&A session at the end of the workshop, detailed below.

Question: How do we ensure mental health is embedded in the model?
One Care pilot identified many patients has mental health needs. We are talking with KMPT to ensure mental health is integrated via a virtual team or network. Training needs are also being considered. Buurtzorg does have a mental health arm which could link with KMPT and the STP in the long-term.

Barrier: Will getting GPs engaged be a problem? They don't currently engage with the MDT.
The first pilot in Medway will be in Hoo and the team have been meeting with and involving GPs. This will be a step by step process to roll out, making sure GPs are on board as the model is built around practices/surgeries.

Challenge: There are lots of different models for local care – it's very fragmented.
That is the main reason we are here today. We want to align the common themes from those models – patient-centred care in the community. Buurtzorg hasn't been implemented successfully anywhere else because the systems don't change. We need to get management, commissioners and regulators on board in order to accept the changes.

Question: What about governance and standardised care if teams are self-managing?
We need to trust staff. They are bound by their code of conduct. Polices are there to fall back on if required and back office and HR functions are a last resort, not a first.

Question: Where will this team or extra teams come from?
Part of the project is to identify barriers and evaluate resources needed.

Workshop: Care navigation - what is it and who does it?

Facilitators:
Rebecca Bradd, Workforce Lead, Kent and Medway STP
Anne Ford, Assistant Director Health Improvement Services, KCHFT

Note taker: Fay Sinclair, Kent Community Health NHS Foundation Trust

Slide notes

Slide 1

- Stand up if you know what care navigation is?
- Shout out some words that demonstrate what a care navigator is to you?

Slide 2

- Very complex to work in health and social care.
- From coordination perspective, we are trying to make it easier for people to access services.

Slide 3

- What are the key elements of care navigation?

Slides 4 to 9

- Delivered as per presentation.

Slide 10

- Have you heard of the One You brand? (Half the room wasn't).

Slide 11

- Used to be health trainers – deal with needs first before going on a lifestyle journey.

Slides 12 to 14

- Delivered as per presentation.

Slide 15

- MDTS look after top 5 per cent of the population, with health prevention; we want to help people in the low to moderate categories.

Slide 16

- Making every contact count.

Slide 17

- Plethora of apps available on PHE website.

Slide 18

- We will discuss this more in table discussion.

Slide 19

- This website has a self-referral form on it, use it.

Workshop notes

Anne and Rebecca's comments:

- Noticed that there is a lot of really proactive work happening within primary care. For example, there was one lady that spoke about a be-friending scheme for the over 70s. She has a group of people ranging from 70-93 that are supported with social isolation. This lady is particularly proactive and GP's also refer to her anyone they think needs support with their social side of life or are socially isolated.
- This cohort of patients is not your top five per cent unwell population. They are in the lower tiers of the diagram.

- This generated a conversation about risk stratification and whether there needs to be another way of doing this across the GP population and not just top 5%

The other points raised were:

- There is a lot of confusion about care navigators roles. They differ depending on organisation that you work in. Some work with the top five per cent whereas others are called different name and work for different organisations like AGE UK.
- Health Improvement work predominantly in Local Super Output Areas (most deprived) to support clients to make positive behaviour changes to help with choosing healthy lifestyle options however, often clients present with complex social issues such as debt, housing, unemployment, domestic problems and they need support from external agencies to help them with their current situation. Changing behaviours will come second to the social issues for most clients seen. This requires navigation to other agencies and therefore, they have a signposting or referral role to other community assets that can help with their situation while still trying to support them with their journey of healthy lifestyles.
- There is a secondary complication with the ONE YOU Brand and Lifestyle role in that they differ depending on where you live in the County. South West Kent area and part of North Kent offer a different lifestyle offer.
- MECC – Anne to have a conversation with PH commissioners to ask what the current situation is with upscaling MECC training. (Wendyslator@nhs.net) raised this point.
- ONE YOU Resources required so KCHFT to send to Pippa Lee. Care Navigator AGE UK. 01795 477520 (Sarah H – please can you make contact as per our conversation)
- Swale@ageuksittingbourne.org.uk

Therefore:

- Clarity about roles and who does which part of the navigation.
- Match the level of competency to the part of the navigation role on offer.
- Strategically look at how these roles look in the future, including risk stratification across the population and be clear on roles.

General comments made during table discussions:

- What's in a name? Care navigator implies access to/going into care.
- Success = working together.
- Care navigation = sign-posting, enabling, empowering, advice, supporting, coordinating, referring, wellbeing, listening, pathways, holistic, patience, knowledge.
- Different titles for care navigator: PIC, care navigator, patient care co-ordinator, CN TL, care navigation commissioner, friend, paramedic practitioner.
- Age UK still got health trainer resources – should they have new ones?

Positives:

- Different roles take on the care navigation function.
- Access to wide directory of services.
- Empowering others.

Challenges:

- No single role.
- Ensuring information is available and up-to-date.
- Overlaps – care navigator and case manager.
- Confusing for patients.
- Being clear but flexible locally.
- Decision-making – boundaries/risks.

Workshop: How do we evaluate the impact of MDT working

Facilitators:
Sabrena Jaswal and Rasa Mikelyte, University of Kent

Note taker: Anna Hinde, Kent Community Health NHS Foundation Trust

Slide notes

The presentation was about the Community Hub Operating Centre (CHOC) and the goals of a CHOC, which aims to deliver joined up care, reduce A&E admissions and reduce acute care.

Workshop notes

Q. How do people get on the CHOC caseload?
The question we've been asked is how do we convince GPs this works? Clinicians have raised this issue and we all know that getting GPs on board may be difficult. Once they see the prominence of CHOCs and the value of them, we hope they will be positive about them. There are more people attending now, from different sectors – care homes for example – and as CHOCs begin to grow and establish we are certain that GPs will be interested.

Q. How do you refer?
Clinicians will need to contact a GP who is on a CHOC and then the suitability of the patient would be discussed.

Q. CHOC teams – how have these improved as a result of evaluation / the pilot?
More professionals are now showing up at CHOC meetings but there needs to be an understanding that clinicians or those representing the service need to attend on a regular basis in order for CHOCs to work better. There is no continuity if there are gaps in the attendees at each meeting and this results in actions not getting moved on. Feedback includes comments such as 'I now understand what other organisations do'.

Q. When's best to evaluate?
Before they have even started. MDT is not a new idea and we need to look at other evaluation to understand where we are starting from. The University of Kent can look at data from what's happened previously and offer advice when it comes to setting up CHOCs. The bottom line is that the service user is the priority and we mustn't forget that.

Q. How do you choose whose on a caseload?
Safeguarding factors and mental capacity influence who is on a caseload and teams often work together to give consent for patients with these issues. Choice and consent are big ethical questions but once these have been discussed at CHOCs, the best options are then laid out for the patient. MDT process helps to make decisions and different inputs – medical vs social care – can help build up a bigger picture of that patient's needs.

Admin support is key to the success of CHOCs. We have seen the model on paper but how does that work in each area? At each CHOC meeting it would be worth colleagues spending five minutes at the end discussing what went well and what needs to change. If this is done at every meeting then we can refine the model along the way.

Workshop: The role of Kent Fire and Rescue in MDT working

Facilitators:
Richard Stanford- Beale, Project Manager, Kent Fire and Rescue

Note taker: Chloe Crouch, Kent Community Health NHS Foundation Trust

Workshop notes

- How does the health service learn from the fire prevention agenda? In health, the more you do, the more you are paid for that service. It should be the other way round. Payment for prevention, such as with Fire and Rescue.
- Health and social care professionals need to recognise risks and refer on to fire and rescue service.
- Any case discussed at an MDT should be referred on to the Fire and Rescue Service for a 'safe visit'.
  Duplication within the system? Need to be careful that KFRS (Kent Fire and Rescue Service) is not duplicating the work of a falls prevention service. KFRS can catch people earlier before they become really frail and are a high falls risk.

Workshop: The role of the community guardian volunteer within SECAmb

Facilitators:
Karen Ramnauth Voluntary Services Manager, Q Volunteering
John Battersby Community Guardian Lead, Q Volunteering

Note taker: Beverley Bryant and Charlotte Morgan, Kent Community Health NHS Foundation Trust

Slide notes

Slide 1

- Volunteer Community Guardians (VCGs) will look after 999 patients who have fallen
- Sadly, fallers can be left on the floor for some time, even after once they are found
- Patients who fall need help to get up as quickly as possible
- VCGs will improve the welfare of fallers

Slide 2

- The core roles of SECAMB
- PAD = public access defibrillators sites

Slide 3

- A snap shot of SECAmb calls on Easter bank holiday Monday
- 2,662 calls taken, 1240 patients transported to hospital, 1422 patients left on scene or dealt with by telephone triage or cancelled calls

Slides 4 to 6

- Examples of the types of pressures on SECAmb

Slides 7 to 12

- Examples and data to support the need for VCGs

Slide 13

- Complications of non injury falls

Slide 14

- Current way non injury falls are treated by SECAmb
- VCGs will be activated to take over the pastoral care of a faller once the ambulance crew have assessed for injuries which will free the crew up to respond to more 999 calls

Slide 15

- Examples of how other organisations could assist with the pastoral care of fallers

Slide 16

- Examples of lifting devices VCGs could use to assist fallers up

Slide 17

- The overall objective of the VCGs will be to release resources and increase clinician availability to treat the most urgent patients in the community whilst maintaining an appropriate service to older patients

Slide 18

- Second objective will be to promote social action, sign post to other services, reach out to under-represented groups and increase volunteer numbers

Slides 19 and 20

- Skipped

Slide 21

- Group work to decide the spec of the VCGs, what training they need and how they should be recruited.

Slide 22 to 24

- Skipped

Workshop notes

Each table discussed the spec of the VCGs, what training they need and how they should be recruited. Brief feedback was given and SECAmb took the notes.

Appendix five: Plenary sessions

Note taker: Fay Sinclair, Kent Community Health NHS Foundation Trust

Our Vanguard in action

Dr John Ribchester, GP and Clinical Lead for the Encompass Vanguard:
Slides delivered as per presentation.

Life as part of an MDT

Carrie Mandeville, Trainee Advanced Clinical Practitioner in Frailty
Slides delivered as per presentation.

Why focus on MDTs and top tips for MDT working

Cathy Bellman, Local Care Lead, Kent and Medway STP and Nicola Cloughley, Health and Social Care Co-ordinator, Kent Community Health NHS Foundation Trust
Slides delivered as per presentation.

New care models

Jane McVea, Deputy Head System Support and Development New Care Models/System Transformation Group, NHS England

- The vanguards are starting to show slower admissions to acute trusts.
- They just want to know there is someone at the end of the phone.
- Think about what forces you apart when you are working towards the same goal.

How can hospices support local care?

Sarah Pugh, Chief Executive Officer Heart of Kent Hospice

- There are 20 hospices fully funded by the NHS, a further 220 are independent charitable organisations, which get a bit of NHS funding.
- For every £1 given by the NHA, we generate £3.
- We are rated outstanding by CQC and look after 220,000 patients in Tonbridge and Malling, Maidstone and Aylesford.
- Hospices can make a very big difference in local care and we want to work with you.
- We are very much focussed on holistic approach. Most of our patients are in the community and not in the hospice itself.
- Believe hospice expertise can contribute and make difference.
- Lots of training programmes within the hospice, we would love to support you, but must remember re capacity too.

Role of the geriatrician

Shelagh O'Riordan and Gwenno Batty, Consultant Geriatricians Kent Community Health NHS Foundation Trust

- Need to be working with the frailest patients – too many assessments means people may miss out on what they need – therapy/time.
- Part of very big MDT – do lot of MDT working in care homes.
- Home First has come in and helped.
- Need to be getting patients home.

Comments, questions and answers

Asked at the welcome, introduction, plenary and closing sessions:

- GPwsi = GP with special interest.
- Very much working on the frailty model inter-relationship.
- Also looking at how we work with people who have a range of disabilities.
- On a journey – significant progress made in past year.
- Want to bring care workers and care homes into the MDTs.

Also see appendix one: Sli.do analytics

- Can we have consent to use both films used here today for people to view in the wider domain – they sum everything up really well and it would be great to share?
- Probably haven't given enough thought to administration needed.
- Probably not given quite enough thought to the contributions our colleagues in hospices are making and what more they can offer. Same is true for how we can involve colleagues in housing and benefits.
- Whole country has been split into STP areas. It is about how we work together across the health and social care sectors and given the audience here today, our wider partners to move forward with making local care work.
- We have got to get this bit right. My role is to point us in the right direction and give people space and time to make this happen.
- What happens in health and social care together, enables people to be as independent as possible and that is what we want.
- We have looked at the evidence that works. What matters are the relationships you have with those you are working with for the benefit of the patient?
- How can the STP make it more aligned to local care?
- The STP has looked at evidence to provide the right interventions.

This page is intentionally left blank

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
28 JUNE 2018
STRATEGIC COMMISSIONER UPDATE

Report from	Glenn Douglas, Kent and Medway CCGs Accountable Officer / Kent and Medway Sustainability and Transformation Partnership Chief Executive
Author:	Michael Ridgwell, Programme Director, Kent and Medway Sustainability and Transformation Partnership

Summary

This report updates the Kent and Medway Joint Health and Wellbeing Board on the development of a single Strategic Commissioner across all eight Clinical Commissioning Groups (CCGs). It is for information only.

1. Budget and Policy Framework

1.1 Developing a Strategic Commissioner role aligns with the outcomes of the Kent and Medway Sustainability and Transformation Plan.

2. Background

2.1 The Clinical Commissioning Groups (CCGs) across Kent and Medway are developing a strategic commissioner function to work across all eight CCGs. The aim is to strengthen how the CCGs work together as where doing so can drive service improvements that patients need and expect.

2.2 Making strategic commissioning decisions across multiple CCGs is good because it provides consistency and reduces duplication. It will improve services for patients by reducing variation in quality and access to care and will drive up standards across all providers.

2.3 Progress to date towards development of this function includes:

- all eight CCGs have committed to establishing the strategic commissioner for Kent and Medway and sharing a senior management team with one accountable officer (chief executive). Glenn Douglas has now been confirmed as the new accountable officer. Glenn also retains his existing role as chief executive of the Kent and Medway Sustainability and Transformation Partnership;
- three co-design workshops have taken place including CCG Governing Body members, staff and public and patient representatives;

- initial thoughts have been developed on governance arrangements; and;
- a next steps discussion paper is being considered by CCGs ahead of wider discussions with partners and stakeholders.

2.4 The current intention is for the Strategic Commissioner to operate from April 2019 in shadow form. During 2018/19 we will be establishing the design and governance arrangements and giving further consideration to options for a permanent model.

2.5 The report attached at appendix 1 sets out further detail on progress to date as well as the proposed role of the Strategic Commissioner, opportunities around integrated health and social care commissioning, governance arrangements and next steps.

3. Risk management

3.1 The Strategic Commissioner development is part of the system transformation workstream within the Kent and Medway STP. Risks are proactively managed through the overall risk register for the STP and reported through the STP Programme Board on a regular basis. Current risks relate to ensuring effective engagement in the design of the strategic commissioner across internal and external audiences.

4. Consultation

4.1 The development of the Strategic Commissioner involved engagement with the body members across the eight CCGs including lay-members, staff and GP member practices. NHS England was also engaged and approved the appointment of the single accountable officer.

4.2 The creation of a Strategic Commissioner does not change the statutory responsibilities of each member CCG and formal consultation was not required.

5. Financial implications

5.1 There are no direct financial implications for Medway Council and Kent County Council arising from this report. Overall the development of strategic commissioning within the NHS aims to make better use of NHS budgets by driving consistency across all eight CCGs and supporting wider transformational change of NHS services. Shared management team arrangements within the CCGs will also be more efficient and help the CCGs to retain and attract high calibre commissioning staff.

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 also consider and advise on the development of options for the Local Authorities' role in a Strategic Commissioner arrangement with Health.

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

7. Recommendation

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to note the update provided on the Kent and Medway Strategic Commissioner function set out at Appendix 1 to the report.

Lead officer contact

Michael Ridgwell, Programme Director Kent and Medway Sustainability and Transformation Partnership,
Email:mridgwell@nhs.net

Appendices

Appendix 1 – Strategic Commissioner Update for Kent and Medway Joint Health and Wellbeing Board

Background papers

None

This page is intentionally left blank

Kent and Medway Joint Health and Wellbeing Board

Strategic Commissioner Update

28 June 2018

Introduction

- The eight Clinical Commissioning Groups (CCGs) across Kent and Medway are developing a strategic commissioner function to work across all eight CCGs. The aim is to strengthen how the CCGs work together, where doing so can drive service improvements that patients need and expect, specifically to support improvements in:
    - life expectancy;
    - disease free life years;
    - reducing inequalities in health and wellbeing; and
    - improving the experience of care.

Background

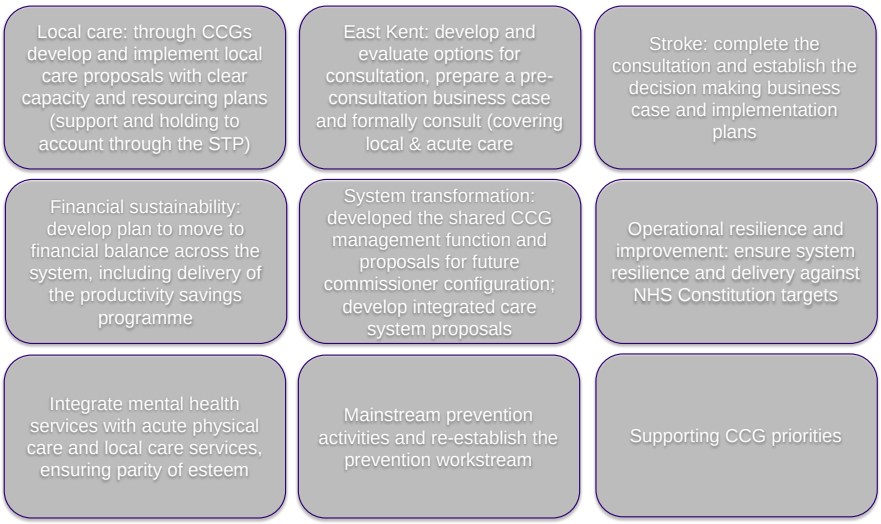
- Making strategic commissioning decisions across multiple CCGs is beneficial because it provides consistency and reduces duplication. It will help improve services for patients by reducing variation in quality and access to care and will drive up standards across all providers. It is essential because:
    - some services do not lend themselves to being commissioned effectively by single CCGs
    - commissioning the Sustainability and Transformation Partnership's (STP's) plans needs to be given a statutory basis; and
    - NHS commissioning needs to adopt a more strategic role across the whole of Kent and Medway, particularly in relationship with other commissioning partners such as local authorities.
- Strategic commissioning arrangements are becoming common across the NHS, however, there is no single preferred model for either their scope or governance options. To help develop the most effective model for Kent and Medway experience and learning will be gleamed from those areas where these arrangements have already been established.
- The following outlines progress to date:
    - All eight CCGs have agreed in principle to establish the strategic commissioner for Kent and Medway
    - Three co-design workshops have been undertaken with CCG Governing Body members, staff and public and patient representatives
    - Initial thoughts developed on governance arrangements (see detail below), which will be further tested through the STP governance review, including a Strategic Commissioner Steering Group (terms of reference attached as appendix A) and Strategic Commissioning Governance Oversight Group
    - Next steps discussion paper being considered by CCGs ahead of wider discussions with partners and stakeholders including the Joint Health and Wellbeing Board

Role of the strategic commissioner

- The specific responsibilities which the strategic commissioner will take on are being developed in the next phase of detailed design work. Initial discussions have taken place and further detailed work is being planned to agree what commissioning responsibilities should be enacted at different geographical levels:
    - Kent and Medway wide
    - Sub-systems (operating on a smaller geography than Kent and Medway but across a number of CCGs)
    - Individual CCGs
    - Sub-CCG (e.g. delegated commissioning within new / emerging integrated care arrangements)
- In agreeing in principle to establish a strategic commissioner, the eight CCGs agreed that its aim should be to build capacity and capability across the CCGs and STP, and to work together where doing so can drive improvements in services for patients and efficiencies for the health and social care system. It is important to be clear that there is no intention for all commissioning to be 'lifted up' to or undertaken at a Kent and Medway level. It is important to preserve and develop frontline clinical leadership of commissioning and the ability to tailor health services to the needs of local populations where appropriate to tackle specific needs or health inequalities.
- Discussions to date have identified general principles on areas which CCGs do best at a local level and those where a strategic commissioner could add value. These initial ideas will now be developed through a detailed design phase to identify the exact responsibilities the strategic commissioner will take on.

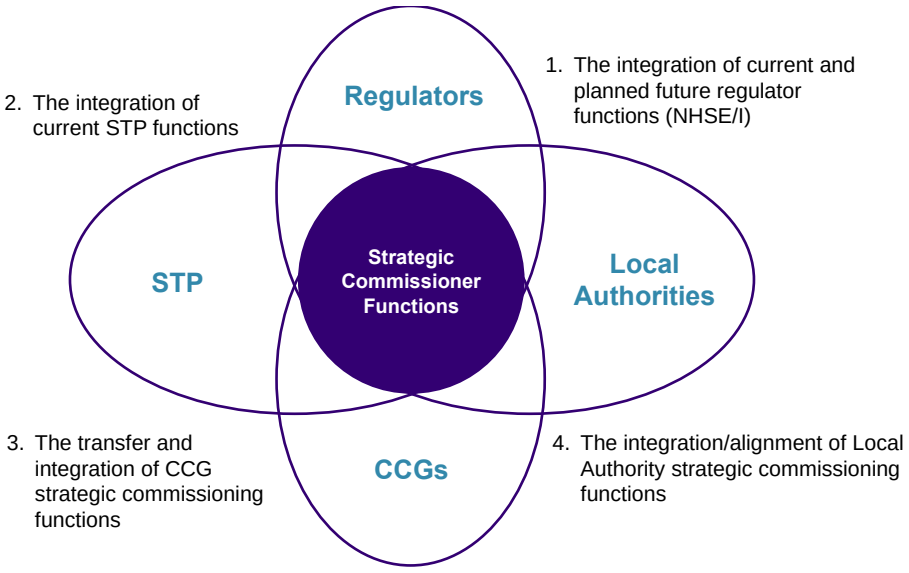
- Ensuring the provision of a full range of health services (covering physical and mental health and including prevention) and tackling health inequalities will continue to be the focus for the strategic commissioner. Establishing priorities within this, the local authority Joint Strategic Needs Assessments and Public Health system leadership will guide specific prioritisation as it does now.

- Through the STP a number of over-arching priorities have been identified, which the strategic commissioner will support:



Integrated health and social care commissioning

- To date the work has focused on NHS commissioning and specifically the remit of CCGs. Moving forward, the detailed design work will focus on engaging further with Kent County Council and Medway Council on options for integrated commissioning across health and social care; and with NHS England (South) on which of their commissioning and assurance responsibilities could be managed at the Kent and Medway level. The development of the strategic commissioning potentially sees a range of functions from different organisations being aligned or consolidated:



- As can be seen from the above diagram the development of the strategic commissioner presents an opportunity to not only consolidate a range of CCG commissioning functions, where there is a rationale to do so, but also integrate or align a range of commissioning functions across other bodies.

- The recently revised case for change was broadened to include a section on children and mental health and the subsequent Clinical Strategy for Kent and Medway includes these components as key priority areas for the area. Work is currently underway to develop an implementation plan for the Clinical Strategy, which needs to inform the development of commissioning arrangements for children's health, learning disability services and mental health services. The work on developing the strategic commissioning arrangements not only needs to determine what commissioning responsibilities should be enacted at different geographical levels but also needs to consider whether greater integration is warranted between NHS commissioners and upper tier local authorities (e.g. including lead commissioning arrangements).

Governance arrangements – strategic commissioner

- There are two distinct elements of governance for the strategic commissioner. The first to create the right model and the second for how its work will be governed once established:
    - **Establishing the strategic commissioner** - To steer and oversee the creation of the strategic commissioner a **Strategic Commissioner Steering Group** has been established (the terms of reference are set out at Appendix A) an **Strategic Commissioner Governance Oversight Group** will be established (consisting of lay and independent from CCG governing bodies – the terms of reference are in development)
    - **Operationalising the strategic commissioner** - The options are currently being explored and discussed within the CCGs. Assuming no legislative change, the approach for the initial shadow year is likely to involve establishing one or more joint committees of CCGs; to which the CCGs would delegate decision making authority for certain responsibilities. The design process must also include effective ways to involve clinicians, patients and the public from each CCG area in the work of the strategic commissioner.
- It is important to remember that the clinical commissioning groups remain the statutory organisations with decision making authority. Final agreement on both the above elements will need to be approved by each of the eight CCGs through their governing bodies, as well as by NHS England as part of their assurance role (including approval by NHS England of any change to the structure and constitutions of CCGs should these be proposed).
- The aim is to avoid an overcomplicated or bureaucratic process, in fact the creation of a strategic commissioner is an opportunity to streamline and improve commissioning governance in Kent and Medway.
- The work of the strategic commissioner will not alter the oversight and scrutiny arrangements that local authorities have over NHS commissioning.
- There will be local authority representatives from Kent and Medway on the oversight group and there will be regular updates to the Kent and Medway Joint Health and Wellbeing Board, local authority Health and Wellbeing Boards where appropriate, in addition to Oversight and Scrutiny Committees.

Governance arrangements – Sustainability and Transformation Partnership

- An STP Governance review is underway as it has become apparent that a tension remains between the STP "programme" governance arrangements and the governance arrangements of the statutory organisations. It important to draw a distinction between these two. The review will take into account the following considerations:
    - how to streamline meetings;

- new and emerging workstreams and their alignment to current STP priorities (these include the Primary Care and System Resilience and Performance);
- the development of the strategic commissioner steering group and Strategic Commissioner Governance Oversight Group;
- leadership arrangements for key workstreams;
- role of provider chairs and non-executive directors; and
- whether an independent STP chair should be appointed.

- The review will report back to the STP Programme Board in July with recommendations.

Next steps and time line

- The current intention is for the strategic commissioner to operate from April 2019 in shadow form. During 2018/19 the detailed design of the responsibilities and governance arrangements for the strategic commissioner will be completed as well as giving further consideration to options for a permanent model.
  - CCG governing bodies discuss options internally (through June/July 2018)
  - STP programme board update on governance (July 2018)
  - Complete detailed design of responsibilities and form (end August 2018)
  - Final proposal for sign-off by CCGs (Oct 2018) and NHS England (Nov 2018)
  - Internal change programme for any affected teams (Dec 2018 – March 2019)
  - Go-live in shadow form 1 April 2019

Appendix A: Proposed terms of reference for Strategic Commissioner Steering Group

1

Strategic Commissioner Steering Group

In 18/19, the remit of the Steering Group will be to provide steer to the following areas:

Remit	• Detailed design of the Strategic Commissioner and its interactions with key Boards and organisations such as JSNA, HWB, STP Programme Board, individual providers and integrated care partnerships, and CCGs. • Detailed design to cover both the specific responsibilities and objectives of the strategic commissioner as well as its governance form. In relation to governance, the Strategic Commissioner Steering Group (SCSG) will receive proposals recommended by Strategic Commissioner Governance Oversight Group (SCGOG) • Wider provider transformation is out of scope of the SCSG although updates from MNWK and EK MDs should be provided to this Group on any significant developments in order to ensure alignment with commissioning changes • The SCSG must refer all formal decisions to the statutory governance vehicles of CCGs and other relevant organisations. The purpose of this group is to steer the programme of work such that effective proposals can be put forward for formal decision making
Role	• Provide strategic leadership to the development of the Strategic Commissioner • Ensure that the programme delivers its milestones and outcomes on time and to budget (based on agreed plan TBD) • Ensure that risks to implementation are identified and effectively managed • Ensure that the programme engages effectively with all necessary stakeholder groups in the development of proposals
Membership	• K&M Accountable Officer • CCG Clinical Chairs (8) or nominated deputies • Managing Director EK & MNWK (2) • Local authority representation (2) • Lay/independent member representation for EK and MNWK (2)
In attendance	• STP Programme Director and other STP staff as relevant to agenda items
Meeting frequency	• Monthly + dependent on work programme
Chair	• Chair: Robert Bowes. Deputy: TBC

2

Strategic Commissioner Steering Group

Principles for Terms of Reference

Principles for Terms of Reference	• Provide strategic leadership for the development of the strategic commissioner and assurance for the delivery of the programme plan as per agreed timeline and to budget. • Shapes the design and development of the transitional arrangements and future arrangements for the strategic commissioner • Has responsibility to establish and lead task and finish groups to deliver finite pieces of work relating to the strategic commissioner and transitional arrangements • Steering group members will have responsibility to develop proposals for K&M. However, will not have authority to make decisions. The SCSG must refer all formal decisions to the statutory governance vehicles of CCGs and other relevant organisations. • The SCSG will report directly into CCG Governing Bodies (or future collaborations such as joint committee) with a dotted line to the STP Programme Board in order to ensure system engagement and oversight. • All members are responsible for cascading information back to respective organisations and decision making Boards

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
28 JUNE 2018
WORK PROGRAMME

Report from: Julie Keith, Head of Democratic Services

Author: Jade Milnes, Democratic Services Officer

Summary

The report advises the Joint Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Joint Board an opportunity to shape and direct the Joint Board's activities.

1. Budget and Policy Framework

1.1 On 20 February 2018 and 21 March 2018 respectively the Health and Wellbeing Boards of Medway Council and Kent County Council agreed to establish the Joint Board as an advisory sub-committee of the Kent and Medway Health and Wellbeing Boards as provided for in the Health and Social Care Act 2012.

1.2 The Joint Board has been established for a time limited period of two years commencing from 1 April 2018.

1.3 This Board facilitates a collaborative approach on the issues emerging from the Sustainability and Transformation Partnerships (STP) for both Local Authorities. Given the responsibilities of both Local Authorities in social care and public health, there is a joint focus on the STP local care and prevention work streams.

2. Background

2.2 Agenda setting meetings will be held on a regular basis. These give officers guidance on information that Members wish them to provide on an issue. The first agenda setting meeting took place on 14 May 2018.

2.3 At this agenda setting meeting it was discussed and recommended that the following matters should be standing agenda items:

a) Progress on Prevention Strategy for Kent and Medway;
b) Progress on Local Care including Local Care Implementation Board;
c) Workforce; and
d) Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities

2.4 With respect to updates on the progress of the Prevention Strategy for Kent and Medway, it was suggested that the Joint Board should explore the following priorities in more depth across future meetings:

- Reducing tobacco usage prevalence
- Reducing obesity prevalence
- Reducing alcohol Consumption
- Physical activity

2.5 These topic areas align with the prevention activity areas within the Kent and Medway STP Prevention Programme. It is recommended that an in depth review of reducing tobacco usage prevalence be undertaken at the next meeting of the Joint Board.

2.6 At the agenda setting meeting, it was also suggested that the following reports be programmed for consideration at a future meeting of the Joint Board:

- Update from Dr Robert Stewart to highlight the work of the Design and Learning Centre for Clinical and Social Isolation
- Encompass Vanguard – reflections as the national vanguard programme comes to an end.

2.7 Following the agenda setting meeting, officers requested that the report on workforce be deferred to the next available meeting owing to essential officers not being available for the June meeting and to enable a full discussion when they were present.

3. Dates for future meetings

3.1 Table 1 sets out the future meeting dates and associated agenda despatch dates.

Meeting Date	Agenda Despatch
19 October 2018 4pm	11 October 2018
14 December 2018 9.30am	6 December 2018
19 March 2019 4pm	11 March 2019

Table 1

4. Risk implications

4.1 There are no specific risk implications arising from this report.

5. Financial and legal implications

5.1 There are no specific financial or legal implications arising from this report.

6. Recommendations

6.1 The Kent and Medway Joint Health and Wellbeing Board is asked to:

- agree to the standing agenda items set out at paragraph 2.3 to the report being added to the Work Programme;

- agree that an in depth review of reducing tobacco usage prevalence be scheduled on the Work Programme under the standing report item “Progress on Prevention Strategy for Kent and Medway” for the next meeting of the Joint Board;

- consider and decide whether the following reports be added to the work programme for a future meeting of the Joint Board:
    - Design and Learning Centre for Clinical and Social Isolation
    - Encompass Vanguard

Lead officer contact
Jade Milnes, Democratic Services Officer
Telephone: 01634 332008, Email: jade.milnes@medway.gov.uk

Appendices
None

Background papers
None

This page is intentionally left blank