Kent and Medway Joint Health and Wellbeing Board

A meeting of the committee will be held on:

Date: Tuesday, 9 October 2018

Time: 3.00pm

Venue: Civic Suite - Level 2, Gun Wharf, Dock Road, Chatham ME4 4TR

Membership: *non-voting Members		
	Councillor Sarah Aldridge*	Swale Borough Council, Cabinet Member for Health and Wellbeing
	Dr John Allingham*	Kent Local Medical Committee
	Ian Ayres	Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs
	Councillor David Brake (Chairman)	Medway Council, Portfolio Holder for Adults' Services
	Mr Paul Carter, CBE	Kent County Council, Leader and Cabinet Member for 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 and Public Health

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
Chris McKenzie	Medway Council, Assistant Director Adult Social Care
Councillor Martin Potter	Medway Council, Portfolio Holder for Educational Attainment and Improvement
Mr Peter Oakford (Vice-Chairman)	Kent County Council, Deputy Leader and Cabinet Member for Finance and Traded Services
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
Dr Robert Stewart*	Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation
Ian Sutherland	Medway Council, Director of Children and Adults Services
James Williams	Medway Council, Director of Public Health

Agenda

1 Apologies for absence

2 Record of Meeting **(Pages 5 - 12)**

To approve the record of the meeting held on 28 June 2018.

3 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.

4 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.

5 Briefing Paper: Care Quality Commission Review and Emerging National Context for Health and Wellbeing Boards **(Pages 13 - 22)**

This report provides the Joint Board with an opportunity for discussion on the position of the Joint Board in response to emerging national views on system wide leadership and governance. It focuses on the Care Quality Commission's reviews across 20 Health and Social Care systems and explores recommendations made by CQC following their critical review of wider partnership working in other areas. The report also sets out changes expected in the immediate future that may impact on the work of the Joint Board.

6 Prevention Dashboard Progress **(Pages 23 - 34)**

This report presents the Joint Board with six indicators forming a subset of the Prevention Dashboard. The report also sets out context and progress for each indicator.

7 Reducing Tobacco Usage **(Pages 35 - 42)**

This report provides the Joint Board with an overview of the current position and key actions in Kent and Medway in respect of the Sustainability and Transformation Partnership (STP) Prevention Action Plan priority area 'reducing tobacco usage prevalence'.

8 Sustainability and Transformation Partnership (STP) Local Care Update **(Pages 43 - 114)**

This report provides the Joint Board with a summary of the progress implementing Local Care across Kent and Medway between June and September 2018.

9 Strategic Commissioner Update **(Pages 115 - 118)**

This report updates the Joint Board on the development of a single Strategic Commissioner across all eight Clinical Commissioning Groups (CCGs).

10 Work Programme **(Pages 119 - 122)**

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.

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

Date: 1 October 2018

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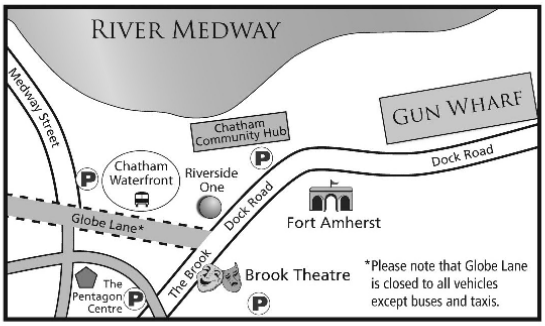

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Meeting of Kent and Medway Joint Health and Wellbeing Board

Thursday, 28 June 2018

4.00pm to 5.30pm

Record of the meeting

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

Present:

Sarah Aldridge, Swale Borough Council, Cabinet Member for Health and Wellbeing
Councillor David Brake, Portfolio Holder for Adults' Services, Medway Council (Chairman)
Mr Paul Carter, CBE, Leader and Cabinet Member for Traded Services and Health Reform, Kent County Council
Glenn Douglas, Accountable Officer for the eight CCGs in Kent and Medway and Chief Executive of the Kent and Medway STP
Matt Dunkley, CBE, Corporate Director of Children, Young People and Education, Kent County Council
Cath Foad, Chair, Healthwatch Medway
Mr Graham Gibbens, Cabinet Member for Adult Social Care, Kent County Council
Mr Roger Gough, Cabinet Member for Children, Young People and Education, Kent County Council
Steve Inett, Chief Executive, Healthwatch Kent
Councillor Alan Jarrett, Leader of Medway Council
Mr Peter Oakford, Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health, Kent County Council (Vice-Chairman)
Matthew Scott, Kent Police and Crime Commissioner
Andrew Scott-Clark, Director of Public Health, Kent County Council
Tony Searles, Sevenoaks District Council
Penny Southern, Corporate Director Adult Social Care and Health, Kent County Council
Dr Robert Stewart, Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation
Ian Sutherland, Director of Children and Adults Services, Medway Council
James Williams, Director of Public Health, Medway Council

Substitutes:

Councillor David Carr, Medway Council (Substitute for Councillor Martin Potter, Medway Council)
Lorraine Goodsell, Deputy Managing Director, East Kent CCGs (Ashford, Canterbury and Coastal, South Kent Coast and Thanet CCGs) (Substitute for Caroline Selkirk)
Simon Perks, Deputy Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs

(Substitute for Ian Ayres)
Councillor Rupert Turpin, Portfolio Holder for Business Management, Medway Council (Substitute for Councillor Howard Doe, Medway Council)

In Attendance: Karen Cook, Policy And Relationships Adviser (Health), Kent County Council
Dr Allison Duggal, Consultant in Public Health, Kent County Council
Julie Keith, Head of Democratic Services, Medway Council
Sameera Khan, Assistant Head of Legal Services, Medway Council
Jade Milnes, Democratic Services Officer, Medway Council

116 Election of Chairman

Councillor David Brake was elected as Chairman for the forthcoming year.

117 Election of Vice-Chairman

Mr Peter Oakford was elected as Vice-Chairman for the forthcoming year.

118 Apologies for absence

Apologies for absence were received from Councillors Doe and Potter, Dr John Allingham (Kent Local Medical Committee Representative), Ian Ayres (Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs), Chris McKenzie (Assistant Director, Adult Social Care Medway Council) and Caroline Selkirk (Managing Director of Ashford, Canterbury and Coastal, South Kent Coast, and Thanet CCGs).

119 Chairman's Announcements

The Chairman welcomed Members to the first meeting of the Kent and Medway Joint Health and Wellbeing Board and set out the purpose and focus of the Joint Board.

The Chairman emphasised that the Joint Board had been constituted as an advisory sub-committee of Kent County Council's and Medway Council's Health and Wellbeing Boards and explained that the respective Health and Wellbeing Boards would each continue to have responsibility for their own statutory functions.

It was noted that the Joint Board had been set up in response to the work of the Sustainability and Transformation Partnership (STP) to develop the way in which health and social care services in Kent and Medway are financed, commissioned and delivered. In this context and given the role of each Local Authority in commissioning and delivering public health and social care services, it was explained that the Kent and Medway Health and Wellbeing Boards had agreed that the key focus of the Joint Board would be prevention

and local care. In addition, it was agreed that the aim of the Joint Board would be to influence and shape the future design and delivery of these services and their alignment with the health and care services at STP level.

The Chairman stated that the work of this Joint Board would strengthen the collaboration between the two Local Authorities and with the STP to ensure the best outcomes for residents.

120 Declaration of Disclosable Pecuniary Interests and Other Interests

Disclosable pecuniary interests

There were none.

Other interests

There were none.

121 Urgent matters by reason of special circumstances

There were none.

122 Membership of the Kent and Medway Joint Health and Wellbeing Board

Discussion:

The Chairman presented an update on the current membership of the Joint Board and stated that he was pleased to note that the Police Crime Commissioner and representatives of the District Councils in Kent had accepted the invitation to join the Joint Board.

The Chairman explained that following the publication of the agenda he had been advised that the named substitute for Ian Ayres (CCG Representative) and Caroline Selkirk (CCG Representative) had been nominated, these in turn being:

- Simon Perks, Deputy Managing Director for Dartford, Gravesham and Swanley, Medway, Swale and West Kent CCGs; and
- Lorraine Goodsell, Deputy Managing Director of the East Kent CCGs (Ashford, Canterbury and Coastal, South Kent Coast and Thanet).

The Chairman advised the Joint Board that the Kent Local Medical Committee nominee and named substitute were Dr John Allingham and Dr Caroline Rickard respectively.

With reference to the request from Kent County Council's Health and Wellbeing Board to appoint Dr Robert Stewart as a non-voting member of the Joint Board, in his capacity as Clinical Design Director for the Design and learning Centre for Clinical and Social Innovation, a Member expressed support for this appointment and explained to the Joint Board that Dr Robert Stewart was an

integral part of Kent's Health and Wellbeing Board and that he had recently undertaken new work with the Local Authority and the STP.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the current position on membership of the Joint Board, as set out in paragraphs 3.2 and 3.3 of the report;
b) noted the appointment of Loraine Goodsell as the named substitute for Caroline Selkirk and Simon Perks as the named substitute for Ian Ayres;
c) noted the appointment of Dr John Allingham as the representative of the Kent and Medway Local Medical Committee and Dr Caroline Rickard as the named substitute; and
d) agreed the appointment of Dr Robert Stewart 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 for Clinical and Social Innovation.

123 Prevention Action Plan

Discussion:

Medway Council's Director of Public Health set out the importance of the prevention workstream within the Kent and Medway STP in delivering financial savings, improving health outcomes for service users and bringing wider community benefits. Emphasis was given to the need to embed prevention across all of the Kent and Medway STP workstreams, with particular consideration given to prevention when commissioning or re-designing health and social care services.

In introducing the latest iteration of the Prevention Action Plan, set out at Appendix 1 of the report, Medway's Director of Public Health highlighted that the Kent and Medway Public Health teams had collaborated with partners to develop the Plan. This included patients and members of the public, in addition to the agencies set out at paragraphs 4.4 and 4.5 of the report.

In response to a question concerning the challenges in measuring the impact of the prevention workstream, it was explained that the Prevention Action Plan was accompanied by a detailed work programme and that the outputs and outcomes could be quantified by the Local Authority Health Intelligence Teams. The Joint Board was advised that it would receive updates on progress towards delivery of the Prevention Action Plan.

A Member commended the report. He also expressed a view that wider issues, beyond public health matters where prevention was also important, could have been addressed within the report. He gave examples including falls, loneliness and suicide prevention. Medway's Director of Public Health recognised that these were important areas for consideration and that these topics could be considered in greater detail at future meetings of the Joint Board. He added

that with regards to suicide prevention, funding of circa £700,000 had been secured for suicide prevention work across the Kent and Medway STP area in 2018/19.

A Member suggested that the links between the prevention workstream, General Practitioners (GPs) and local care initiatives, such as social isolation/ social prescribing work, should be better. In response, the Joint Board was advised that the prevention workstream was advised by the Clinical and Professional Board and that a GP co-production task and finish group had been established by the prevention workstream. It was added that this GP forum had reviewed the Prevention Action Plan.

Members expressed support for the Joint Board to establish a set of key measurable outcomes which focus on prevention and local care and which were aligned with the STP workstreams. It was suggested that the Joint Board monitor achievement of these outcomes via a dashboard showing trends and including a Red, Amber, Green (RAG) rating.

A Member commented that updates on activity within the Prevention Action Plan focussed principally on Medway. It was requested that future iterations of the Plan provided updates for both Kent and Medway. The Joint Board was advised by Medway's Director of Public Health that the Prevention Action Plan was held on an online portal which was regularly updated by partners and would ensure future updates reflected activity and progress in Kent and Medway.

In response to a concern that the Prevention Action Plan did not address drug and substance misuse, the Joint Board was advised that Local Authorities were already obliged to address substance misuse and that the Action Plan had focussed on addiction, in particular nicotine addiction. It was explained that the focus was on nicotine addiction because this affected the largest adult cohort. It was added that under the Kent and Medway STP, there was an opportunity to enhance interventions in key areas to achieve a faster reduction in the number of people stopping smoking.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the progress of the prevention workstream and supported the priorities and actions identified within the Prevention Plan;
b) agreed that at the next meeting of the Joint Board consideration would be given to proposed prevention and local care outcomes which can be measured and monitored during the life of the Joint Board; and
c) recommended that the outcomes agreed by the Joint Board be presented to the Local Care Implementation Board.

124 Sustainability and Transformation (STP) Local Care Update

Discussion:

The Deputy Director of the East Kent Clinical Commissioning Groups (CCGs) updated the Joint Board on the progress towards implementing local care across Kent and Medway. She highlighted that local care was a new model of delivering integrated health and care services close to where people live. It was added that in 2018/19 the focus would be to develop multi-disciplinary teams clustered around GP practices to achieve the four objectives set out in Figure 1 of the report.

With reference to the One Conversation Model, the Joint Board was advised that feedback from professionals and others had been positive and in particular it was reported that communication had improved, there was less duplication of effort and fewer gaps in care.

The Deputy Director of the East Kent CCGs also drew the Joint Board's attention to the local care governance arrangements and integration with the Better Care Fund (BCF), integrated planning and financial investment, the communications strategy, enablers and risks and issues.

Members expressed support for the direction of travel of the local care programme and commented that there was a need for additional investment in local care, in particular preventative local care based around GP practices.

A Member also expressed concern about the fragility of the BCF grant funding and future funding provision. It was noted that at a national level there was a need to ensure that the BCF was continued into the future and was more sustainable.

In response to a question regarding stemming the increase in people attending hospital Accident and Emergency (A&E) departments, it was explained that as a result of the Vanguard Model there had been a demonstrable change in the attendance and admission to A&E. For example, the Canterbury and Coastal area reduced attendances by 4-5%. It was added that as the model was scaled up, the downward trend would continue. However, the Joint Board was advised that a whole system approach would be needed, working in collaboration with partner agencies.

Decision:

The Kent and Medway Joint Health and Wellbeing Board noted the progress of the local care workstream and agreed that at future meetings the Joint Board will monitor the progress of the workstream.

125 Strategic Commissioner Update

Discussion:

The Accountable Officer for the Kent and Medway CCGs and the Kent and Medway STP Chief Executive updated the Joint Board on the progress towards the development of a single Strategic Commissioner across all eight CCGs and outlined the benefits of making strategic commissioning decisions across the Kent and Medway footprint. The benefits set out for the Joint Board included, providing greater leadership when managing health system issues and greater influence over large service providers.

The Joint Board was advised that a Joint Committee of the eight CCGs was being established which would have delegated powers to deliver the Strategic Commissioner function. In response to a question concerning a reduction in bureaucracy, reference was made to a longer term aspiration to formally merge the CCGs into one body. However, this process could only be done with CCG agreement. The Joint Board was also advised that in parallel, proposals to devolve regulator responsibilities from NHS England and NHS Improvement were expected.

The Accountable Officer for the Kent and Medway CCGs and the Kent and Medway STP Chief Executive recognised that CCGs needed to be confident in and engage with the changing landscape. There was also a need to partner with other agencies and Local Authorities to commission services effectively. A Member expressed support for the direction of travel and championed intelligent joint commissioning to achieve value for money.

With regards to a question concerning whether the Strategic Commissioner would form part of the Kent and Medway STP, it was explained that the Strategic Commissioner would work under the umbrella of the Kent and Medway STP but would not form part of it. It was added that the Kent and Medway STP currently had no legal standing. This was because national legislative changes were required to change the Health and Social Care Act 2012.

In response to a concern regarding how well the eight CCGs would work together to meet local needs, the Joint Board was advised that the move to a Strategic Commissioner Model would require measures to ensure that need was being met across localities in order to deliver localism.

Decision:

The Kent and Medway Joint Health and Wellbeing Board noted the update provided on the Kent and Medway Strategic Commissioner function, set out at Appendix 1 to the report.

126 Work Programme

Discussion:

The Head of Democratic Services at Medway Council introduced the work programme report and advised the Joint Board that the reports on the work of the Design and Learning Centre for Clinical and Social Innovation and Encompass Vanguard could be programmed for October and December respectively.

A Member sought clarification on who would produce the reports and requested that all reports needed to include input from Medway Council and Kent County Council. He added that they must be fit for purpose, succinct and vibrant.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) agreed the standing agenda items set out at paragraph 2.3 to the report being added to the work programme;
b) agreed 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;
c) agreed that the following reports be added to the work programme of the Joint Board:
    1. Design and Learning Centre for Clinical and Social Innovation; and
    2. Encompass Vanguard.

Chairman

Date:

Jade Milnes, Democratic Services Officer

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KENT AND MEDWAY

JOINT HEALTH AND WELLBEING BOARD

9 OCTOBER 2018

BRIEFING PAPER: CARE QUALITY COMMISSION REVIEW AND EMERGING NATIONAL CONTEXT FOR HEALTH AND WELLBEING BOARDS

Report from: David Whittle, Director of Strategy, Policy, Relationships and Corporate Assurance, Kent County Council

Author: Karen Cook, Policy and Relationships Adviser (Health) Kent County Council

Summary:

This paper provides an opportunity for discussion on the position of the Joint Board in response to emerging national views on system wide leadership and governance. It focuses on the Care Quality Commission's reviews across 20 Health and Social Care systems and explores recommendations made by CQC following their critical review of wider partnership working in other areas. It also sets out changes expected in the immediate future that may impact on the work of the Joint Board.

1. Budget and Policy Framework

1.1 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.

1.2 The operating principles of the Joint Board set out that it will encourage persons who arrange for the provision of any health or social care services in Kent and Medway to work in an integrated manner and advise on the development of the Sustainability and Transformation Partnership (STP) Plans for Kent and Medway. In doing so the Joint Board will ensure collective leadership to improve health and well-being outcomes in the area and help to ensure the STP has democratic legitimacy and accountability.

1.3 This report is consistent with both Local Authorities' budget and Policy Framework.

2. Background

2.1 In July 2018 two national reports were published considering the progress of integration and the impact of those changes on people using health and social care services. These were (see overleaf):

- Care Quality Commission: *Beyond Barriers: How Older People Move Between Health and Care in England*. This summarised the findings from 20 system wide inspections from across England examining how well organisations were working together to deliver health and social care for older people.

- National Audit Office: *The Health and Social Care Interface*. This "think piece" presented and discussed 16 challenges to improved joint working drawing out the risks presented by inherent differences between the health and social care systems and how national and local bodies are managing these.

2.2 These documents were followed in August by *Key Questions for the Future of STPs and ICSs* published by NHS Providers which set out the position of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) and tried to answer a number of questions on collaboration and integration.

2.3 Both the reports from the Care Quality Commission (CQC) and National Audit Office (NAO) call for system wide leadership, either through a Health and Wellbeing Board (HWB) or the STP Programme Board, whatever is most appropriate or workable in an area. These reports do not conclude which approach is favourable stating only that both HWBs and STPs can be effective in bringing together local leaders to plan and deliver services. The CQC reported that in the local systems it has reviewed it was difficult to identify where system-level leadership accountability lay.

2.4 This lack of clarity about where system leadership should come from is raised in the briefing from NHS Providers which suggests that locally based responses to national transformation drivers and the development of STPs has created a patchwork of different offers across the Country, all at differing levels of maturity and with differing Governance models.

2.5 The conclusions and recommendations from these reports merit further analysis by the Joint Board. All papers agree that barriers remain to system working and there must be clarity about what can and cannot be delivered within existing legislative, regulatory and governance frameworks.

2.6 However, in Kent and Medway where we have a strong and inclusive STP Programme Board and a Joint HWB on the STP footprint we are in a strong position to demonstrate system level leadership is in place. However, despite CQC's recommendation that there must be a place for system wide joint decision making legal and organisational barriers exist that mean that key decisions cannot currently be made on behalf of the whole system.

3. **System Barriers**

3.1 The NAO report plainly sets out the barriers that exist and although they are fully understood at a local level it is useful to rehearse them again (see overleaf):

3.1.1 **Financial challenges**

- Both the NHS and local government are under financial pressure, which can make closer working between them difficult. This could deter organisations in partnerships from seeking system-wide benefits that may be detrimental to them as individual organisations.
- Short-term funding arrangements and uncertainty about future funding make it more difficult for health and social care organisations to plan effectively together.
- Additional funding for health and social care has at times been used to address the immediate need to reduce service and financial pressures in the acute sector.
- Current accountability arrangements, set by legislation, emphasise the need for individual organisations to balance their books.
- Different eligibility requirements for health and social care make it difficult to plan services around the needs of the individual.

3.1.2 **Culture and structure**

- Traditional boundaries between the NHS and local government, and between individual organisations within these sectors, lead to services being managed and regulated at an organisational level.
- The NHS and local government operate in very different ways and can have a poor understanding of how the other side's decisions are made.
- Complex governance arrangements are hindering decision-making within local health and social care systems.
- Problems with local leadership can destabilise or hold back efforts to improve working across health and local government.
- The geographical areas over which health and local government services are planned and delivered often do not align, which can make it difficult for the relevant organisations and their staff to come together to support person-centred care.
- Problems with sharing data across health and social care can prevent an individual's care from being coordinated smoothly.
- New job roles and new ways of working could help to support person-centred care, but it is difficult to develop these because of the divide between the health and social care workforces.

3.1.3 **Strategic issues**

- Differences in national influence and status, as well as public misunderstanding of how social care is provided and funded, have contributed to social care not being as well represented as the NHS.
- Organisations across a local system may have misaligned strategies, which can inhibit joint local planning.
- Central government in the past has had unrealistic expectations of the pace at which the required change in working practices can progress.
- Progress to date has demonstrated that joining up health and social care can support a greater focus on preventative services and the wider determinants of health

3.2 This extract is copied verbatim from the NAO report and not all of it is applicable to Kent and Medway. For example, complex governance

arrangements are raised as a potential barrier. The Joint Board was created to streamline governance across the STP footprint and the STP recently presented a new model for system wide governance that will simplify arrangements. Further we have good examples of information sharing and coordination of care planning supporting good delayed transfer of care rates which are better than the England average.

3.3 However, despite progress local systems can make through joint working the NHS Providers Briefing goes further in suggesting that the organisational barriers that prevent joint decision making will remain in place:

> *With parliamentary time tied up with Brexit, there remains no window for a substantial revamp of the Health and Social Care Act (2012), although we understand the government is minded to make minor amendments to legislation where it can. Our view is that although the existing legislative framework does not prevent collaboration between NHS and care bodies, we are so far away from the spirit and letter of the 2012 Act, particularly with regard to issues of governance, that a substantial review of legislation will be required.*

The report expresses concern that without national guidance then systems, organisations and individuals will be putting themselves at risk by trying to work around the current legislation.

4. The role of Health and Wellbeing Boards

4.1 All three reports concentrate on the need for broader leadership and how this can only develop out of trusted relationships where there has been stability of leaders and the willingness of organisations to work together beyond their own statutory remit for the benefit of the whole system. CQC's *Beyond Barriers* recognises that the 20 systems inspected were those known to be struggling and that there is good work happening in all systems to some extent. It acknowledges that success is mostly apparent and more advanced where there are established, long term relationships which have allowed for "work arounds" to have been agreed.

4.2 However, in the CQC report there is a lack of clarity about where system wide governance could come from. The report implies that leadership from either is acceptable - as long as there is leadership:

Both HWBs and STPs can be effective in bringing together local leaders to plan and deliver services. What is most important is that there is an established vison, local buy in, and a place where decisions can be made on behalf of the system. This is where local leaders can be held to account for system performance at leadership level.

4.3 Despite this, the role of Health and Wellbeing Boards is recognised as a key part of local governance arrangements. They are currently the main statutory mechanism for overseeing efforts to join up health and social care services and they have a role in exercising wider oversight of the system and for promoting transformational change. The STP has no statutory powers.

We saw the potential of the HWBs to provide effective collective leadership for the system. We found examples of this where the HWB had clarity of role and

purpose, representation from across the system, and a strong and committed leadership. HWBs could hold organisations in a system to account through setting out clear accountability between partners for the delivery of shared goals. We found examples of the HWB providing scrutiny and challenge, including over Better Care Fund (BCF) and STP progress.

4.4 However, there are very few places in the country where this is currently happening with the debate continuing, even in advanced systems about how joint decision making can happen outside the defined legal and constitutional obligations of each individual organisation and how sovereign organisations can be held to account by each other. The CQC report found that in the systems they assessed that Health and Wellbeing Boards were not fulfilling their potential, they varied in their effectiveness and were at different stages of development, underused where the STP footprints did not align and side-lined by emerging arrangements.

4.5 The development of the Joint Board has ensured that Kent and Medway are in a very different position. The Joint Board is fully engaged, working across the STP footprint to effectively fulfil its statutory legal and democratic function to support planning and commissioning in the local Health and Social Care system. This arrangement has attracted national attention with interest from the Local Government Association, The Department of Health and Social Care and the Ministry of Housing, Community and Local Government.

5. Recommendations for building a sustainable system

5.1 The CQC report recognised that much of the change needed to build sustainable system leadership is in the hands of Government and national bodies:

To build on these strong foundations, overcome the fragmentation of the system, and ensure that more people experience high-quality, personalised care, we need to see changes to:

- *the way the performance of health and social care is measured*
- *the funding arrangements for health and social care*
- *the way the future shape and skills of the workforce are planned, and*
- *regulation and oversight of health and social care.*

5.2 Despite this CQC ended its report with a series of recommendations listed below and it is helpful to explore how the work of the Joint Board can be assessed as supporting delivery of these:

5.2.1 Encouraging and enabling commissioners to bring about effective joined-up planning and commissioning

Local leaders should create an agreed joint plan for how older people are to be supported in their own homes, helped in an emergency, and then enabled to return home safely. This plan must maximise the potential contribution from voluntary, community and social enterprise organisations.

Local leaders must take a reformed approach to funding that allows and encourages local systems to deliver this plan by aligning and pooling their budgets.

A joint plan exists through the Case for Change supported by the work programme for the Local Care workstream. Encouraging and enabling joined up commissioning fits within the Board's terms of reference to review and influence commissioning plans as they develop from the emerging Strategic Commissioner function.

5.2.2 A new approach to performance management

There should be a single, joint, nationally agreed framework for measuring the performance of how organisations collectively deliver improved outcomes for older people. This would operate alongside oversight of individual provider organisations and use metrics that reflect outcomes for people – including from primary, community, social care and independent care providers – rather than relying primarily on information collected by acute hospitals.

A national framework would be a helpful tool for both the STP and the Joint Board and NHS Digital has recently published a range of data based on the STP footprint. However in lieu of a final nationally agreed set of indicators the STP is developing its own local performance dashboard that will be shared with the Joint Board to create the opportunity to challenge and discuss progress and impact on outcomes for local people. The Joint Board has also asked for the presentation of agreed performance measures as part of the standing items on Local Care and Prevention.

Local leaders should give more emphasis to investing in models of care that support prevention and avoid unwarranted admission to secondary care. To support this, local leaders must actively and effectively share information about people across organisational boundaries, with support from national leaders to make this possible and with the appropriate safeguards in place to maintain public confidence.

Local Care has its own workstream and action plan within the STP Programme and prevention is embedded across the STP. Progress reports on both Local Care and Prevention are part of the forward plan for the Joint Health and Wellbeing Board and form part of its terms of reference. It is within the remit of the Joint Board to request updates on the development of the Kent Care Record which will share information on an individual across health and social care as this will support the implementation of Local Care.

5.3 A move to joint workforce planning

Local leaders should agree joint workforce plans, with more flexible and collaborative approaches to staff skills and career paths. These plans should reflect and work in tandem with Health Education England and Department of Health and Social Care workforce strategies, anticipated later this year.

Workforce is a standing item on the Joint Board Agenda. The STP workforce workstream will inform this and is connected to the Local Workforce Action Board where there is representation across the system. The new Workforce Strategy is due to be presented to the Joint Board at the next meeting.

5.4 Better regulation and oversight of local systems

*To support the improved planning and reformed commissioning at a local level, government should consider new legislation to allow CQC to regulate local systems and hold them to account for how people and organisations work together to support people to stay well. This would also ensure that reg*ulation *does not just look at individual organisations but focuses on the quality of care experienced by people across the services they use.*

This is a national issue regarding the role of regulators. However, the Joint Board itself is evidence for regulators of how we are working together across Kent and Medway at a system level to look at commissioning plans and how people receive their care.

6. Horizon Scanning- Emerging context

At a national level, transformation is driving continued change.

6.1 **Regulation and the resurgence of regions:** NHS England and NHS Improvement have announced their intention to work more collaboratively including the development of seven new joint regional offices. NHS Providers see this as symbolising the blurring of the commissioner/provider split at a national level that is echoing locally through the formation of Integrated Care Systems and Integrated Care Partnership draft contracts. Whilst there has been no guidance yet as to how the new regional offices will relate to STPs, emerging ICSs and local systems - as well as Trusts and CCGs - the report suggests STP/ICS footprints will develop important relationships with the seven new regional NHSE/I offices.

6.1.1 Alongside that CQC, as seen above in their recommendations, has been using special powers to undertake the pilot work required to inspect system working but have highlighted the need for new powers to make this a routine part of its assessment. On 16 September CQC announced an extension of the system review programme stating that it had been asked to undertake 3 further system wide inspections and 3 follow up visits. It can be expected that CQC will continue to undertake these types of inspections, which include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources.

6.2 National Planning and Social Care Green Paper

6.2.1 The NHS's 10-year plan is due to be published later this year, alongside the long delayed Social Care Green Paper. The scope of the NHS plan is slowly being revealed with the following workstreams amongst 14 confirmed to date:

- Cancer
- Cardiovascular and respiratory
- Mental health
- Learning disability and autism
- Healthy childhood and maternal health
- Prevention, personal responsibility and health inequalities
- Workforce, training and leadership

6.2.2 The workstreams, which have been developed by NHS England and NHS Improvement, are a key part of the NHS's response to the Prime Minister's call for a long term NHS plan, the first five years of which have been backed by a new funding settlement. In June it was announced that there would be additional annual increases for the NHS of 3.4% per annum, amounting to an extra £20.5 billion a year by 2023/24.

6.2.3 Meanwhile the contents of the Green Paper remain less precise and with no additional financial support identified the debate on long term funding for Social Care continues. The Government has said that the proposals will "ensure that the care and support system is sustainable in the long term" and will set out a number of options for consultation.

6.2.4 Other topics that the Government have said will be included in the Green paper include integration with health with the NHS and social care systems operating as one, support for family and carers, workforce, specialist housing and technological developments.

6.2.5 These key documents will no doubt impact on the work and priorities of Health and Social Care partners and the Joint Board will wish to have a view on local responses to these national changes.

7. Conclusion

7.1 In conclusion, it is nationally recognised that successful progress towards integration and system wide leadership is dependent on a range of local and national factors, most crucially the length of times partners have been working together in this way, with some advanced systems working in similar partnerships of 10 years or more. The Kent and Medway STP, which was only created 2 years ago continues to mature and build those important working relationships. The creation of the Joint Health and Wellbeing Board has attracted national interest as a future model and provides further evidence that Members and Senior Managers across our footprint are ambitious to create the right foundations for governance that will underpin whole system working and overcome the barriers described in this paper. However new national legislation will be necessary if the Government's intention to have a fully integrated health and social care system is to be realised. The publication of the NHS 10-year plan and the Social Care Green paper later this year will be central to the work of the Joint Board going forward.

8. Risk management

8.1 The continued existence of a vibrant and challenging Joint Board mitigates the risk of criticism if the area is inspected under a whole system approach.

9. Financial implications

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

10. Legal implications

10.1 There are no legal implications arising directly from this report.

11. Recommendation

11.1 The Joint Health and Wellbeing Board is asked to comment on and note this report and the contribution that the Joint Board makes to system wide leadership across Kent and Medway Health and Social Care.

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Appendices

None

Background papers

Care Quality Commission: Beyond barriers: How Older People Move Between Health and Care in England: (available online) https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england 3 July 2018

National Audit Office: The health and social care interface: (available online) https://www.nao.org.uk/report/the-health-and-social-care-interface/ Published date: July 4, 2018

NHS Providers: Briefing, Key Questions for the Future of STPs and ICSs. (available on line) https://nhsproviders.org/key-questions-for-the-future-of-stps-and-icss Published Date: August 13 2018

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
9 OCTOBER 2018
PREVENTION DASHBOARD PROGRESS

Report from:	James Williams, Director of Public Health for Medway
	Andrew Scott-Clarke, Director of Public Health for Kent
Author:	Allison Duggal, Consultant in Public Health & STP Prevention Lead
	Scott Elliott, Head of Health and Wellbeing

Summary

This report presents requested Public Health indicators forming the Prevention Dashboard. The report also sets out, in the form of commentaries on each section, context and progress relating to the indicators.

1. Budget and Policy Framework

1.1 The STP Prevention Action 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.

1.2 The prevention priorities for Kent and Medway are:

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

1.3 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
- Diabetes
- Respiratory disease
- Mental ill-health.

2. Background

2.1 On 28 June 2018, the Joint Board agreed that at the next meeting of the Joint Board consideration would be given to proposed prevention and local care outcomes which can be measured and monitored during the life of the Joint Board. At the agenda setting meeting on 3 September 2018, it was agreed that a subset of outcomes be presented as a dashboard to the Joint Board. These outcomes would relate primarily to the prevention topic presented at the meeting (agenda item 7). It was also noted that the dashboard for local care was being compiled and would be presented to the Joint Board at its next meeting.

2.2 Appendix 1 shows a subset of the prevention dashboard outcomes.

3. Advice and analysis

3.1 Adult smoking prevalence

3.1.1 Kent County smoking prevalence is above the national prevalence. Of note are the rises in prevalence in Canterbury and Gravesham, Sevenoaks and Tunbridge Wells. Thanet is an outlier with a prevalence rate of 23.7 per 100,000 population.

3.1.2 Current priorities are the delivery of workplace 'Quit Clubs' targeting routine and manual workers, the development of quit support services in Acute Trusts and the development of Smokefree hospitals. Darent Valley Hospital is now fully Smokefree.

3.1.3 Professor Robert West recently provided advice to Ashford GPs and the CCG to support the implementation of basic medication support in line with the UCL Smoking Plus model. Discussions are in place with Ashford GPs and CCG to pilot this programme in Ashford to achieve a target of 250 quitters.

3.1.4 In addition, there is work to reduce illicit tobacco supply and demand in Kent and Medway, to reduce initiation of smoking in young people and to introduce Smoke Free School Gates in many areas across Kent and Medway. The Kent and Medway Public Health E-cigarette guidance paper will be published shortly in October 2018.

3.1.5 Smoking prevalence in Medway has been gradually declining and was as high as 23.6% in 2013 compared to 17.6% now in 2018. Medway has a well-established stop smoking service and delivers a range of services across the area, including a specialist stop smoking shop in Chatham high street. Nationally the numbers accessing stop smoking services is declining, however, in 2017/18 Medway achieved an increase in: the rates of people setting a quit date, achieving a quit at 4 weeks and an increase in the percentage of successful quitters.

3.1.6 The lack of capacity to tackle the expanding number of shops selling illicit tobacco decreases the opportunity to reduce the supply and demand of illegal and cheap tobacco. The recent NEMS report suggested that Medway has the highest prevalence of hand rolling tobacco in the South East at 58% and the

highest level of availability from all sources. Trading standards are accountable for over two hundred and seventy plus statutory duties and feel that they are disproportionately addressing the three statutory duties that cover their involvement in illegal tobacco.

3.2 Smoking at Time of Delivery

3.2.1 Smoking at Time of Delivery is a priority issue for KCC Public Health and the team have been working with partners to improve services, particularly in the areas of Folkestone and Hythe, Swale, Dover and Thanet where rates compare unfavourably with the English average and bring the entire county below the English average.

3.2.2 KCC Public Health has worked with local midwives to improve CO monitoring rates and there have been significant increases in referral rates to Stop Smoking Services. Specialist clinics are being delivered to pregnant women and their partners and Home Visit Advisers have been piloted in Thanet, South Kent Coast and Swale. These have resulted in 118 quits over the last 11 months (compared to 55 quits across the whole of Kent in the core Stop Smoking Service) and the intention is to extend the Home Visit model to the rest of Kent from April 2019. Another programme being rolled out across Kent is the 'What the Bump?' campaign which has been successful in Swale and Medway.

3.2.3 Work is ongoing to secure the funding for the Smoking in Pregnancy Midwives and to deliver a digital platform to provide self-help and motivational advice for quitters.

3.2.4 The Medway stop smoking service has developed a new holistic approach to addressing the multiple disadvantages that this group face. Based on a survey of the key issues, the sessions include advice around nutrition, relaxation, financial advice, infant feeding, baby first aid, respiratory health and exercise in pregnancy. The stop smoking team are working closely with the midwifery teams to ensure that all staff are adequately trained. Smoking in pregnancy is a key priority for the Local Maternity System (LMS) and performance is monitored via this group.

3.2.5 To achieve the national ambition of 6% by 2022, there needs to be a 2.35% year on year reduction in the numbers of women smoking. There are many factors that contribute to these disadvantages, and the social networks within high prevalence communities can undermine quitting and increase the potential for relapse. The challenges faced in everyday life can made changes harder to sustain.

3.3 Physical Activity

3.3.1 Generally, rates of physical activity in Kent are better than the national average. However, there is variability across the County and Gravesham is an outlier with rates below the English average. KCC Public Health is working with partners in the Districts and Boroughs and with Kent Community Health NHS Foundation Trust (KCHFT) to deliver health improvement services. There is also work with Ebbsfleet Healthy New Towns programme to improve

physical activity and community cohesion. This work will impact on Gravesham as one of the surrounding districts. Monies from the STP workforce workstream are being used to develop Motivational Interviewing skills in staff groups in Kent. This is currently at a small scale but will include a 'train the trainer' component which should aid sustainability.

3.3.2 Public Health have contributed to the Kent Sport and Physical Activity Conference, to be held in October 2018 and will be presenting the Key Note Speech on the day. There is also a bid in preparation for work to reduce obesity rates, increase physical activity and reduce worklessness in East Kent. This is a piece of collaborative work with the Health in Europe Centre, KCHFT and Betteshanger Country Parks.

3.3.3 Rates of physical activity in Medway are similar to those across the rest of England. The dashboard shows no significant change from the data in 2015/16.

3.3.4 Medway has launched two new promotional videos to increase the uptake of the Health Walks and cycling groups schemes. These volunteer lead projects are free to join and with over 3,000 residents participating, represent a popular local intervention.

3.4 <u>Adult Obesity</u>

3.4.1 Kent has higher rates of adult obesity than England and the districts and boroughs that are particular outliers include Dartford, Swale and Maidstone.

3.4.2 KCC Public Health is working with partners in the Districts and Boroughs and with KCHFT to deliver health improvement services, which include weight management. However, it is not clear whether the current services are appropriate and there is currently a Health Needs Assessment in preparation on obesity in Kent, which will include a review of evidence for interventions for adult obesity.

3.4.3 In addition, the development of Motivational Interviewing (MI) skills in the workforce, using monies from the STP workforce work stream should impact on the ability of the health and social care workforce in Kent to raise the issue of weight with their clients and signpost them to services.

3.4.4 The proportion of adults in Medway who are overweight or obese is similar in comparison to the level across England for the most recent year's data. This compares favorably to figures for 2015/16 show Medway's position as worse than that across England.

3.4.5 Medway launched the Man vs Fat local football league in September, with 72 participants attending. The format involves weekly football games, coupled with the players individual weight loss determining the scores for matches and team points won. The 16 week season will be evaluated at the end of the pilot, to see if a wider roll out is needed.

3.5 Childhood Obesity

3.5.1 Childhood obesity is a national problem and although Kent is better than the national average, the national rates are poor and the local aggregate data masks a considerable outlier in Gravesham. Rates of childhood obesity are rising in many areas such as Folkestone and Hythe and Thanet.

3.5.2 There is a Health Needs Assessment (HNA) in preparation on obesity, including childhood obesity and public health are sending representatives to the LGA/ADPH conference on childhood obesity.

3.5.3 Kent will be one of the authorities receiving draft new guidance on the use of a Whole Systems Approach to Obesity and will be piloting this approach over the coming year to improve results in both children's' and adult obesity programmes.

3.5.4 There is ongoing work with children's services and local partners to develop interventions for childhood obesity and KCC uses Change 4 Life and One You to promulgate the genuine principals of health promotion messages on children's weight.

3.5.5 Levels of childhood obesity in Medway are at a similar level to the rest of England.

3.5.6 A wide range of interventions are in place to support healthy weight in children, these are tailored to meet the needs of children of different age ranges and also to engage families in healthy eating.

3.5.7 Medway hosted its annual Healthy Weight Summit on 25 September 2018. This whole system partner event aims to increase the awareness and action of local partners, encouraging them to work collaboratively to tackle childhood obesity.

3.6 NHS Health Checks

3.6.1 The data on NHS Health Checks demonstrate that Kent is not hitting its targets for the delivery of health checks, although the authority is hitting the target for invites. This is the result of changes to the IT system used for the NHS Health Checks and now that issues with the new system have been resolved, the numbers are expected to improve in the next quarter.

3.6.2 There is ongoing work with our providers to improve uptake of the NHS Health Check and we link in with National campaigns to improve awareness of this programme.

3.6.3 The Medway Health Check Programme continues its outreach work. During the summer this has focused on the series of Council events, with good numbers of health checks being delivered to residents who typically don't engage with primary care services. The Health Check team have also broadened their scope piloting the atrial fibrillation testing kits and providing heavy support for the know your numbers campaign, giving free blood pressure checks to all residents.

4. Risk management

4.1 There are no risks identified as arising directly from this report.

5. Financial implications

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

6. Legal implications

6.1 There are no legal implications arising directly from this report.

7. Recommendation

7.1 The Kent and Medway Joint Health and Wellbeing Board is asked to consider and note the progress on the included outcomes and continue to support the prevention workstream to achieve the prevention plan priorities.

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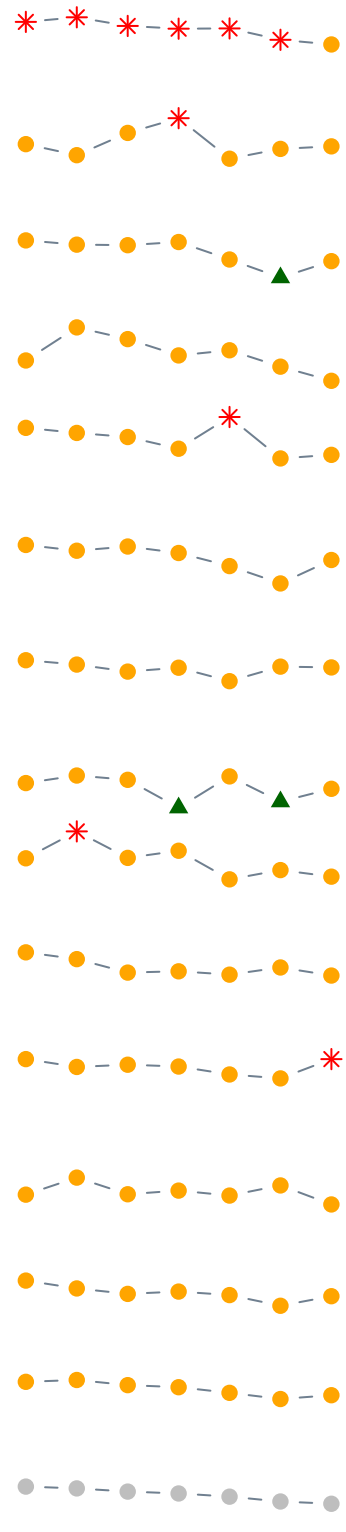
Appendices
Appendix 1 – Dashboard indicators

Background Papers
None

Smoking prevalence 18+ (%)

Prevalence of smoking among persons 18 years and over



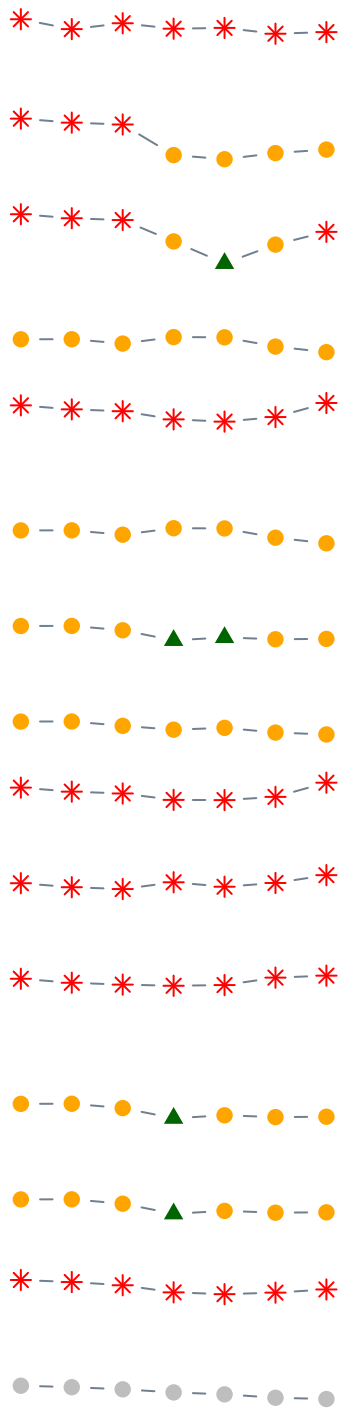
	Rate	Number	Target rate	Target number	Reduction
Medway	17.6	37,596	12.0	25,634	11,962
Ashford	18.1	17,538	12.0	11,627	5,911
Canterbury	14.8	19,782	12.0	16,039	3,743
Dartford	10.2	8,199	10.2	8,199	0
Dover	18.7	17,222	12.0	11,052	6,170
Gravesham	18.3	14,868	12.0	9,750	5,118
Maidstone	17.1	22,215	12.0	15,589	6,626
Sevenoaks	12.0	11,073	12.0	11,073	0
Folkestone & Hythe	16.5	14,809	12.0	10,770	4,039
Swale	17.9	20,106	12.0	13,479	6,627
Thanet	23.7	26,277	12.0	13,305	12,972
Tonbridge and Malling	11.6	11,353	11.6	11,353	0
Tunbridge Wells	15.0	13,591	12.0	10,873	2,718
Kent	16.3	197,002	12.0	145,032	51,970
England	14.9	6,456,947	12.0	5,200,226	1,256,721

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018−10−01)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Smoking at time of delivery (%)

The number of mothers known to be smokers at the time of delivery as a percentage of all maternities. A maternity is defined as a pregnant woman who gives birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in a NHS hospital



	Rate	Number	Target rate	Target number	Reduction
Medway	17.1	638	6.0	224	414
Ashford	12.3	180	6.0	88	92
Canterbury	15.2	207	6.0	82	125
Dartford	9.7	125	6.0	77	48
Dover	19.6	211	6.0	65	146
Gravesham	9.7	117	6.0	72	45
Maidstone	9.7	190	6.0	118	72
Sevenoaks	9.7	111	6.0	69	42
Folkestone & Hythe	20.1	193	6.0	58	135
Swale	20.8	346	6.0	100	246
Thanet	19.7	299	6.0	91	208
Tonbridge and Malling	9.7	133	6.0	82	51
Tunbridge Wells	9.7	111	6.0	69	42
Kent	13.8	2,223	6.0	967	1,256
England	10.7	65,023	6.0	36,461	28,562

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018−10−01)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Physically active adults (%)

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

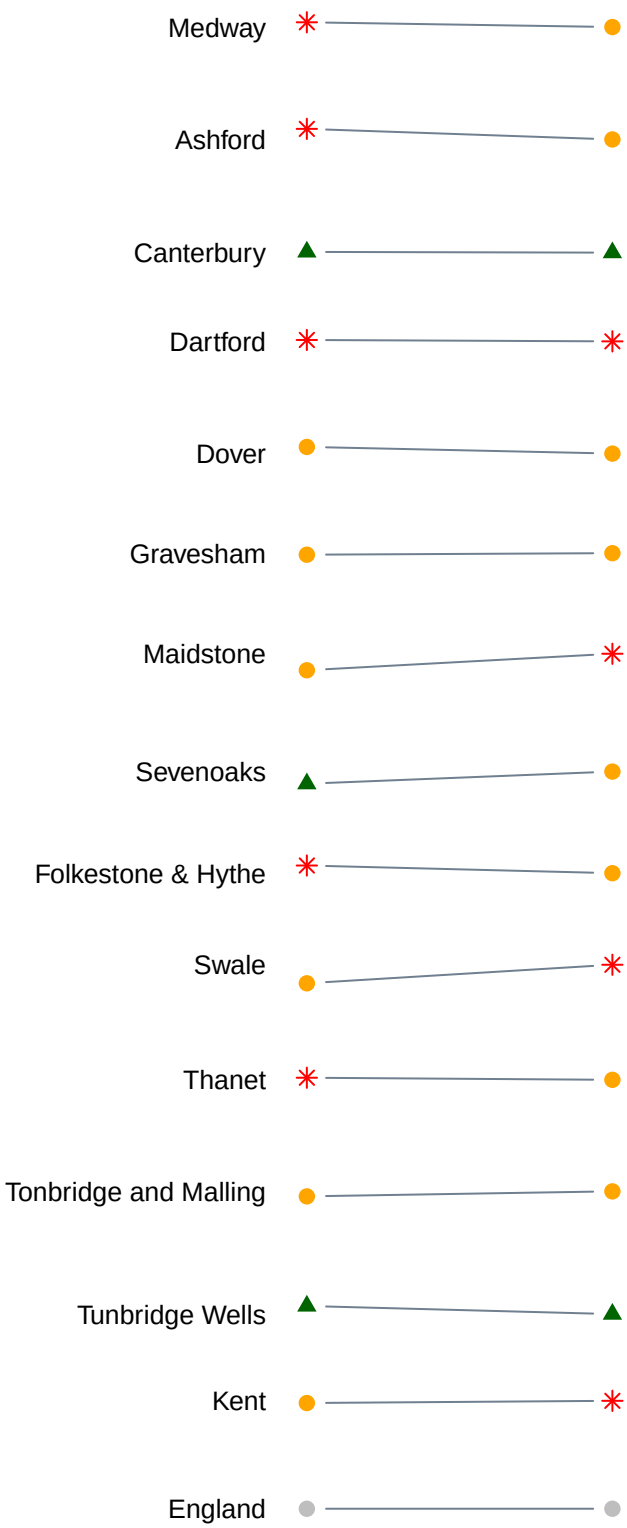
	Rate	Number	Target rate	Target number	Increase
Medway	65.8	138,287	70.0	147,114	8,827
Ashford	67.6	65,296	70.0	67,614	2,318
Canterbury	70.8	93,592	70.8	93,592	0
Dartford	63.9	51,608	70.0	56,535	4,927
Dover	65.9	60,398	70.0	64,156	3,758
Gravesham	61.4	49,085	70.0	55,960	6,875
Maidstone	68.1	87,808	70.0	90,258	2,450
Sevenoaks	70.9	64,773	70.9	64,773	0
Folkestone & Hythe	65.6	58,368	70.0	62,283	3,915
Swale	63.3	70,916	70.0	78,422	7,506
Thanet	72.0	79,127	72.0	79,127	0
Tonbridge and Malling	72.3	70,533	72.3	70,533	0
Tunbridge Wells	69.8	62,681	70.0	62,861	180
Kent	67.8	813,906	70.0	840,316	26,410
England	66.0	28,453,028	70.0	30,177,454	1,724,426

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018−10−01)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Adults overweight or obese (%)

Percentage of adults aged 18 and over classified as overweight or obese



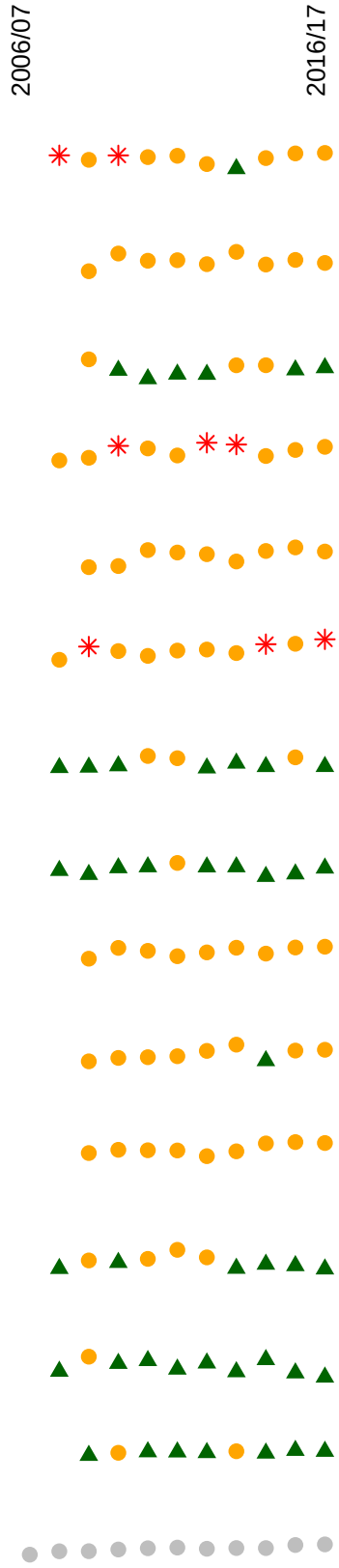
	Rate	Number	Target rate	Target number	Reduction
Medway	64.6	137,975	50.0	106,792	31,183
Ashford	59.8	58,672	50.0	49,057	9,615
Canterbury	54.5	73,275	50.0	67,225	6,050
Dartford	66.1	54,109	50.0	40,930	13,179
Dover	61.4	57,138	50.0	46,529	10,609
Gravesham	65.5	53,198	50.0	40,609	12,589
Maidstone	68.9	90,211	50.0	65,465	24,746
Sevenoaks	60.4	56,024	50.0	46,377	9,647
Folkestone & Hythe	63.1	56,857	50.0	45,053	11,804
Swale	72.7	82,713	50.0	56,887	25,826
Thanet	66.1	73,687	50.0	55,739	17,948
Tonbridge and Malling	61.9	61,452	50.0	49,638	11,814
Tunbridge Wells	50.0	45,612	50.0	45,612	0
Kent	63.0	767,107	50.0	608,815	158,292
England	61.3	26,815,277	50.0	21,872,167	4,943,110

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018−10−01)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

Obesity in children aged 10−11 (%)

Prevalence of obesity (including severe obesity, BMI greater than or equal to the 95th centile of the UK90 growth reference) among children in Year 6 (age 10−11 years)



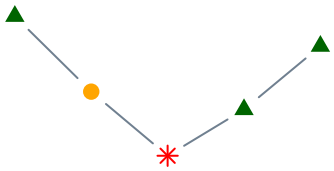
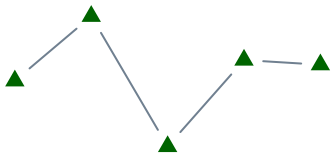
	Rate	Number	Target rate	Target number	Reduction
Medway	21.0	634	15.0	453	181
Ashford	18.4	249	15.0	203	46
Canterbury	17.0	233	15.0	206	27
Dartford	21.9	262	15.0	179	83
Dover	20.5	213	15.0	156	57
Gravesham	23.2	287	15.0	186	101
Maidstone	16.4	266	15.0	243	23
Sevenoaks	15.8	186	15.0	177	9
Folkestone & Hythe	20.8	219	15.0	158	61
Swale	19.8	305	15.0	231	74
Thanet	21.2	317	15.0	224	93
Tonbridge and Malling	14.7	194	14.7	194	0
Tunbridge Wells	12.5	133	12.5	133	0
Kent	18.5	2,864	15.0	2,322	542
England	20.0	111,169	15.0	83,377	27,792

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018−10−01)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

NHS Health Checks invitations offered

Percentage of the eligible population, aged 40 – 74 years, offered an NHS Health Check per financial year

	2013/14 – 2017/18	Rate	Number	Target rate	Target number	Increase
Medway		21.5	17,317	21.5	17,317	0
Kent		22.0	99,331	22.0	99,331	0
England		17.3	2,679,660	20.0	3,097,873	418,213

Comparison with England
● Similar ✳ Worse ▲ Better

Produced by Medway Public Health Intelligence Team (2018−10−01)
Source: Fingertips, Public Health England (https://fingertips.phe.org.uk)

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
9 OCTOBER 2018
REDUCING TOBACCO USAGE

Report from: James Williams, Director of Public Health for Medway
Andrew Scott-Clarke, Director of Public Health for Kent

Author: Julia Thomas, Senior Public Health Manager
Deborah Smith, Public Health Specialist
Jessica Brittle, Public Health Graduate

Summary

This paper seeks to provide members with some background information on the current situation, the services available and set out some key recommendations for the Joint Board to consider.

1. Budget and Policy Framework

1.1 The Sustainability and Transformation Partnership (STP) Prevention Action 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.

1.2 The prevention priorities for Kent and Medway are:

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

1.3 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
- Diabetes
- Respiratory disease
- Mental ill-health.

1.4 This report presents a ‘deep dive’ into reducing tobacco usage prevalence and aligns with Medway Council’s Policy Framework, particularly the Council

Plan priority “Supporting Medway’s people to 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 To improve the health of the population and reduce health inequalities across Kent and Medway there needs to be a shift from a reactive approach to a proactive approach. This needs to be carried out by embedding evidence-based prevention and early intervention across every part of the health and care system.

2.2 In terms of tobacco control, we have made great strides to reduce smoking prevalence and the harm that it causes. Despite this, smoking remains the leading cause of preventable illness and premature death in the UK and is attributable to over 200 deaths every day. This is equivalent to 1 in every 6 deaths in England. Furthermore, smoking remains one of the largest causes of health inequalities.

3. Prevalence of Smoking

3.1 **Adult Population** *(PHOF, 2018)*
Smoking prevalence for the adult population across Kent and Medway is as follows:

- Kent **16.3%**
- Medway **17.6%**
- England **14.9%**

3.2 **Smoking at time of Delivery** *(NHS Digital, 2018)*
The prevalence of smoking at time of delivery (SATOD) in pregnant women is reported by NHS Trust as midwives are responsible for recording and collating this data.

3.2.1 Data for Quarter 1, (April to June) by NHS Trust for 2018/2019 is as follows:

- NHS Medway **15.4%**
- NHS Swale **23.8%**
- NHS Ashford **15.2%**
- NHS Canterbury & Coastal **16.4%**
- NHS Thanet **20.5%**
- NHS West Kent **10.1%**
- NHS Dartford and Gravesham **9.3%**
- England average **10.4%**

3.3 **Young people** *(WAY survey, 2014-2015)*
The prevalence of smoking amongst 15-year olds is also higher in Kent and Medway as compared to England. Smoking prevalence at age 15 - current smokers

- Kent **10.5%**
- Medway **10.0%%**
- England **8.2%%**

3.4 **Routine & Manual Groups** *(PHOF, 2018)*
Routine and manual workers are identified in the UK as the group with the highest smoking rates. Locally this translates to the following:

- Kent **32.4%**
- Medway **23.9%**
- England **25.7%**

4. National Targets

4.1 The national vision, stated within the Tobacco Control Plan (2017-2022) is to create a Smokefree generation. To deliver this, the government sets out two aims, a shorter term aim for 2022 and a longer term more ambitious aim by 2027.

4.2 The short-term aim is to achieve the following targets by the end of 2022:

- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less.
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.
- Reduce the prevalence of 15-year olds who regularly smoke from 8% to 3% or less.
- Reduce smoking in pregnancy to 6%

4.3 The longer-term ambition is to achieve a tobacco free generation by 2027. This will be achieved when smoking prevalence is at 5% or below.

5. STP Prevention Action Plan

5.1 The Kent and Medway Sustainability and Transformation Plan Prevention Action Plan states that reducing prevalence in Kent and Medway is a key priority. Key actions to achieve this are as follows:

- All health and social care professionals to be suitably trained, resourced and confident to make every contact count raising the subject of smoking, making a referral and/or supporting smokers directly.
- Generate an increase in volumes of referrals received by the specialist smoking cessation services, who provide a range of tailored treatment services, including pharmacotherapy behavioural support and digital support. Targeted approach with key population groups where prevalence is disproportionately high such as pregnant women, those working in routine and manual occupations, and people living with a mental health condition.
- Creating smokefree environments at NHS and local authority sites, and at school gates.

- Highly visible advertising, media and social media campaigns to motivate people to quit smoking.

6. Existing actions to reduce smoking

- **Support services:** A number of specialist services are in place to reduce smoking prevalence with support based in GP Practices, community settings and establishments such as acute trusts and prisons. Locations for delivery are based on population need.

- **Maternal smoking services:** Trusts and stop smoking services work collaboratively to train midwives and other professionals involved in maternity services to effectively support women and their families to quit during pregnancy.

- **Tobacco control:** Each locality has a Tobacco Control Alliance comprising local partners who work collaboratively to implement approaches to reduce the harm associated with tobacco use. This includes addressing illicit tobacco, minimising the harm associated with exposure to tobacco related environmental pollutants and preventing uptake of smoking in young people.

7. Kent & Medway Local Authority Priority Actions for 2018/19

7.1 Kent

- Focus on Routine and Manual workers
- Support home visits for pregnant smokers and their families to deliver quit support aiming to reduce smoking in pregnancy rates and promote smoke free homes
- Support Acute and Mental Health Trusts with their smokefree site status. This will include maximising opportunities for all health professionals under Making Every Contact Count (MECC) to provide Very Brief Advice (VBA) to smokers and refer them to quit services
- Deliver quit services directly from acute sites to assist with referrals. Work with key mental health workers to provide quit support to people with mental health conditions to quit smoking
- Support the prevention of uptake among young people. Train youth workers, key school nurses and support workers to be Quit Coaches through MECC. Quit Coaches aim to prevent the uptake of smoking among young people and also provide tailored quit support to young people who already smoke
- Work with GPs to increase opportunities to advise smokers to quit through the implementation of the innovative Smoking + model and MECC. GPs are encouraged to prescribe NRT and/or Varenicline to smokers who do not wish to access stop smoking services
- Train health professionals in brief therapies (Motivational Interviewing, Cognitive Behaviour Therapy and Solution-Focused Brief Therapy) as part of the MECC programme, to improve the effectiveness of conversations that aim to encourage smoking cessation
- Promote smokefree environments by supporting local councils to ensure that parks for young children are smokefree. Additionally, support primary

schools to introduce a smokefree school gate policy. This has been developed in Ashford and Canterbury areas to date

7.2 **Medway**

- Targeted support for Routine and Manual workers
- Continue to deliver home visits for pregnant smokers and their families whilst actively promoting a 'Smokefree home status'
    - Medway Council to work collaboratively with Medway hospital to maintain their smoke free site status
    - Medway Council and Medway hospital to sign up to the tobacco control declaration
    - Medway Council to support Medway Mental Health Trusts with becoming smokefree sites, including maximising opportunities for all health professionals under Making Every Contact Count (MECC) to provide Very Brief Advice (VBA) to smokers and refer them to quit services.
- Promote smokefree spaces including parks and the smokefree school gates project
- Ensure that all midwives receive Very Brief Advice (VBA training)
- Support the prevention of uptake amongst young people by working with primary and secondary schools through the PSHE programme
- Train health professionals in brief therapies (Motivational Interviewing, Cognitive Behaviour Therapy and Solution-Focused Brief Therapy) as part of the MECC programme, to improve the effectiveness of conversations that aim to encourage smoking cessation
- Continue to monitor and support Health Visitors with their stop smoking targets
- Deliver VBA training to social care colleagues
- Continue to encourage GPs to participate in the online (VBA training), monitor and feedback on the numbers of referrals received
- Deliver key objectives on the Tobacco Control Action Plan
- Work with the community outreach nursing team at Medway hospital who provide support to families who have children presenting at accident and emergency with respiratory distress, in particular those that are exposed to tobacco smoke

7.3 Appendix 1 of the report set out an action list of recommended evidence based stop smoking interventions for Kent and Medway.

8. Risk management

8.1 Attaining the national targets and reducing smoking among vulnerable groups including; people with mental health conditions, young people who smoke, women who smoke in pregnancy and routine and manual workers, is fully dependent on the successful delivery of the action plan. MECC will go a long way to achieving national targets but further financial support is crucial in ensuring that the plan can be fully delivered and the vision of a Smokefree generation can be realised in Kent and Medway.

9. Financial implications

9.1 There are no financial implications as a result of this 'deep dive' report, however, scaling up existing or launching new interventions will require additional investment.

10. Legal implications

10.1 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

10.2 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.

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

11. Recommendations

11.1 The Kent and Medway Joint Health and Wellbeing Board is asked to support the specific actions set out in Appendix 1 of the report focussed on preventing and reducing the use of tobacco in Kent and Medway.

11.2 The Kent and Medway Joint Health and Wellbeing Board is asked to note the requirement for the NHS in Kent and Medway to identify resources for specific stop smoking interventions in the 'Health Care' settings that fall outside the remit of local authority stop smoking service provision.

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Appendices
Appendix 1 - Action list of recommended evidence based stop smoking interventions for Kent and Medway

Background papers
None

Appendix 1 Action list of recommended evidence based stop smoking interventions for Kent and Medway

STP/NHS

- Implement NICE PH48 guidance (https://www.nice.org.uk/guidance/ph48) in NHS services which includes implementing a fully smokefree NHS by 2020.
- Implement NICE PH26 Guidance (https://www.nice.org.uk/guidance/ph26) Smoking: stopping in pregnancy and after childbirth.
- Signing the NHS Smokefree Pledge http://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/ (an update to the previous NHS Statement of Support for Tobacco Control http://smokefreeaction.org.uk/smokefree-nhs/nhsstatement/).
- Ensure that all NHS Estates are Smokefree.
- Prescribing Stop Smoking medications.
- Making sure that everybody is asked if they smoke during contact with health professionals and if so, offered support to quit.
- Making Very Brief Advice training mandatory to all NHS staff and allowing them time to attend training sessions (either online or in house).
- NHS Trusts to encourage smokers who use, visit and work in the NHS to access support services and quit smoking.
- Promote links to "stop smoking" services across the health and care system and full implementation of all relevant NICE guidelines by 2022.
- All commissioners taking up the 2017-19 Commissioning for Quality and Innovation framework which includes tobacco as a national indicator for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.

Local authorities

- Provide access to training for all health professionals on how to help patients - especially patients in mental health services - to quit smoking.
- Identify the groups and areas with the highest smoking prevalence and take focused action aimed at making reductions in health inequalities in communities.
- Targeted mass media interventions, in the context of a comprehensive tobacco control programme.
- Work with key partners around illicit tobacco.
- Sign up to the Local Government Declaration.
- Roll out the Quit Coach programme across all Kent and Medway areas to reduce the take up and prevalence of young people smoking.
- Roll out the Home Visit Quit Advisers across all of Kent and Medway to reduce the prevalence of pregnant women who smoke.

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KENT AND MEDWAY

JOINT HEALTH AND WELLBEING BOARD

9 OCTOBER 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 (K&M) between **June and September 2018 f**ocusing on the:

1. Budget and Policy Framework
2. Review of progress to date and next steps
3. Planning timelines 2018/19 and 2019/20
4. Governance review in line with progress and alignment to Strategic Commissioning development
5. Communications update
6. Enablers
7. Risks and issues
8. Financial Implications
9. Legal Implications
10. Summary
11. Recommendation.

The Joint Board are asked to review progress, consider the approach for investment in Local Care and support the approach for Organisational Development.

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 identifies the priority to develop more and better local care services. There are a number of workstreams within the Sustainability and Transformation Partnership, one of which is a dedicated Local Care workstream to deliver the Plan.

2. Review of progress to date and next steps

2.1 The 28 June 2018 report to this Joint Board, articulated the 2018/19 4 key objectives:

- Development of 8 integrated locality plans, for the investment and implementation of Local Care;
- Establishment of standardised multi-disciplinary teams (MDTs) around GP practices working at scale (populations of 30-50,000);
- Development of interagency partnerships to deliver Local Care at scale; and
- Work on expansion of the model after 2018/19.

2.1.1 With some of this work now well underway, supported by the core STP team, it now feels like the right point to review progress to date and more importantly identify next steps in the delivery for Local Care.

2.2 In September 2017 the Local Care investment Case was agreed by all organisations across K&M; the model to be delivered through designated MDTs, bringing together staff from the health, social care, and the voluntary sector.

2.2.1 Significant progress has been made in some areas with the development of MDT working; the Encompass Vanguard provides compelling evidence of the impact that can be achieved when MDTs are properly resourced (see appendix A to the report, Encompass Legacy Report).

2.2.2 All eight Clinical Commissioning Group (CCG) areas, completed a maturity matrix, in October 2017, as a baseline assessment of the status of Local Care implementation, to guide the development of detailed plans and to identify support required. It showed, as expected, that parts of K&M are at different starting points and moving at different speeds.

2.2.3 Plans have moved on significantly since last autumn in their granularity with significant time and effort invested into this. A planning exercise, completed by all 8 localities (CCG localities), was initiated in April 2018 to help progress both their operational and financial plans in line with the Investment Case. This allowed the ability to review a bottom up approach and compare to the top down approach of the original Investment Case. To date the system has managed to identify investment in Local Care for 2018/19, with further work ongoing for 2019/20 and beyond.

2.3 The level of provider confidence in Local Care is still developing, in terms of both the progress of delivery and the scale of impact. The level of engagement between partners varies significantly between CCG localities, with all areas having more to do to work jointly with local authorities and voluntary sector in particular. There is further work to be done to increase the speed and scale of implementation in order to deliver maximum benefits for the K&M system.

2.4 The process has identified 7 critical areas which need addressed:

- **STP payment mechanism**
- **Information Flow**
- **Change in core processes**
- **Workforce**
- **Estates**
- **Communications and engagement**
- **Governance.**

2.4.1 Appendix B to the report gives the full details of the review, with actions to address these critical areas, showing progress to date and next steps. This will form the basis of work for the coming months.

3. Planning timelines 2018/19 and 2019/20

3.1 As above, the planning and investment for implementation of Local Care is maturing at pace. All 8 locality plans were refreshed in July 2018, giving greater detail of integration across organisations. The planning timeframes for 2018/19 and 2019/20 have also been agreed across the system.

3.2 The Local care Implementation Board (LCIB) has been asking for assurance around Local Care plans, including detail around the proposed investment and what has been delivered / spent in quarter 1. In order to provide this, the core team is undergoing some deep dives throughout August/ early September 2018 with each sub-system (east Kent, west Kent, Medway and north Kent respectively). The intention to go through the plans, both operational and financial, to understand the assumptions, bring to life the actual models / hubs / MDTs, ensure alignment with Local Authority plans, and agree on key risks / issues.

Next steps:

- **Early August 2018** - Test session on deep dive process with one locality to ensure robustness and desired output.
- **August / early September 2018** – deep dives completed with all localities.
- **Late September / early October 2018** – presentation of data to the Local Care Implementation Board.
- **Late September / early October 2018** – development of a reporting dashboard to track progress against objectives and outcomes for Local Care implementation. This will be presented to the next meeting of this Joint Board.

4. Governance

4.1 Local Care governance is being reviewed as part of a wider review of STP governance currently underway. This will ensure that there is no duplication with other forums and that there is clear accountability for Local Care.

5. Communications Update

5.1 The 28 June 2018 report gave an update on the agreed Communications Strategy for Local Care.

> **The aims of the strategy 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.

5.2 The newly appointed Director of Communications and Engagement for the STP has been working with the Local Care team to develop objectives and key milestones for 2018/19, as set out below:

Local Care Communications and Engagement 2018/19

Objectives
• To improve *understanding of the vision and ambitions* for local care among staff, patients, public and stakeholders, particularly around the benefits of establishing multi-disciplinary teams
• To ensure frontline staff are *confident and know how to run multi-disciplinary* teams with GPs at scale by sharing advice and best practice
• Identify opportunity for co-design to ensure target groups are given genuine opportunities to be involved and feedback
• Ensure consistent approach and messaging across health and social care to avoid confusion with multiple models
• To support partnership working and create a climate for cultural change
• *Gather data, insight and learning* to support design of models of care for the rest of Dorothy's family and other key groups as prioritised to ensure their feedback helps to *shape future models*
• Ensure alignment with communication and engagement activities with other workstreams, particularly workforce, digital, estates and primary care.

Milestones	Timing
• Refresh **stakeholder map** and **robust relationship plan**	July
• Prioritise engagement around **local care language**	July/Aug
• **Content plan** and commit to monthly updates on local care via STP bulletin with local care case studies	Aug – March 2019
• Launch **campaign** to tell whole story of local care	Sep/Oct
• Develop and review **core materials** – local care booklet, update STP website, hub map, film, FAQs for different audiences, reactive media statements etc	Sep-March 19
• Co-design model for **social prescribing**	July-Sep?
• Co-design model for **care navigation**	July-Sep?
• Co-design model for **carers app**	June - Mar 19
• Publicise **cluster organisational development toolkit** to support cultural change	TBC
• Co-design models of care for the **rest of Dorothy's family.**	In progress

Decisions / inputs required e.g. from other workstreams
• Decision on which terms to engage on for local care language
• Content for July STP bulletin

Immediate risks and issues
• Pace needed for local care language piece, as many terms already in use
• Full list of risks are detailed in full strategy

5.3 Local Care requires a change in culture in order to support the integration required to embed Local Care. An Organisational Development (OD) toolkit has been developed. There has been a robust process in the development phase which includes:

- All organisations across the STP area, and their OD Practitioners helping to co-develop the toolkit.
- A variety of professionals from across Health and Social Care feeding into the requirements, as well as supplying ideas and content.
- The Kent, Surrey and Sussex Leadership Academy in supporting the efforts of the Leadership & OD Network.
- This has been reviewed by the Local Care Leads, with a view to roll out from September 2018.

5.4 Communications and Engagement Events June to Sept 2018:

- Kent Count Council (KCC) for Care Navigation Social Prescribing tender – co-design sessions across all partners including Patient Public Advisory Group (PPAG).
- Presentation in September 2018 Social Prescribing event.
- Co-design of a Carers App, supporting anyone in a caring role across Kent and Medway - building on the “Stop Look Care” booklet, originally designed by Brighton and Hove CCG. Funding from the Encompass Vanguard in east Kent has allowed initial work for development. Presenting this at NHS Expo 5 September 2018 as an example of co-production (Appendix C to the report sets out the Carers APP presentation and Appendix D to the report sets out the Carers APP leaflet).

6. Enablers

As well as the obvious collaboration and joint working with other STP Workstreams (as with System Transformation and Primary Care above), there has been a concerted effort in the development of Local Care, to address the alignment with other key workstreams, namely:

- Workforce
- Estates
- IT

6.1 Workforce

6.1.1 Local Care is a key member of the Local Workforce Action Board (LWAB); the focus to develop the Kent and Medway Workforce Strategy based on best practice, current evidence and engagement/collaboration with key stakeholders. At the request of the Local Care Directors, a workforce workshop was held on the 16 August 2018 to review different aspects of workforce:

The aims of the strategy to:

- Numbers and type of staff required to roll out Local Care.
- Review the workforce plans to date across Kent and Medway.
- Learn from what is already happening – example from the work in west Kent re workforce modelling.
- Working together to develop a consistent approach for organisational development (OD); supporting to change the culture required when bringing staff from different organisations together to work as a teams, and making this sustainable.
- Training requirements for various roles moving forward.
- Ensure channels for co-design of communication materials.

6.2 **Estates and IT**

6.2.1 In their document 'Developing Robust Estates Strategies', published in June 2018, the Nuffield Trust stated;

"An effective system sees the efficient use of their combined estate and other infrastructure, such as IT, as a significant enabler to health and care staff working in partnership. And the whole point of organisations working in partnership in systems is to improve the experience of and outcomes for patients".
https://www.nuffieldtrust.org.uk/files/2018-06/nhs-restates-briefing-v6.pdf

6.2.2 Local Care is working together with Estates and IT workstreams respectively to develop and define the blueprint across Kent and Medway:

- Estates – following a presentation to the LCIB on the 11 July 2017, there was agreement to hold 'locality workshops' to look collectively at all the properties held within a location, explore opportunities to reduce revenue costs through co-location, to ensure that the estate is fully utilised, and work collectively on any funding bids for new estate to deliver good Local Care Services. This work is taking place during September / October 2018, through the estates workstream.

- IT – Local Care Directors are involved with The Kent Care Record (KMCR) delivery; a significant transformational change for the health and social care system in Kent and Medway, enabling health and social care professionals to access a shared data record of individuals requiring care or treatment.

7. Risk Management and Issues

7.1 As part of the CCG planning process there were risks colleagues documented and raised, which the actions described above will help to mitigate.

7.2 Further work will be required to identify risks as the system level plans are fully developed. This will all form part of the overarching Local Care risk register, reviewed regularly at the Local Care Implementation Board. Set out below are the key risks reviewed in July 2018 (see overleaf):

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 As set out in the body of the report, the investment has been identified for Local Care in 2018/19, with clear timelines for identifying the key deliverables in 2019/20 and beyond. There are no financial implications arising directly from this report i.e. notwithstanding the discussions happening elsewhere, this is an update report and there are no requests for resources.

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 focusing 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 Kent and Medway Joint Health and Wellbeing Board has assurance that:

- Local Care is on track to deliver agreed objectives for 2018/19;
- there are detailed plans with identified investment for the delivery of integrated MDTs across K&M;
- there is a defined governance framework and reporting process, which is flexible enough to meet the changes required as the STP strategy matures;
- the Local Care team are developing a communications and engagement strategy which involves all partners in co-production of services;
- the Care team are engaging with other workstreams to ensure they dovetail with enablers; and
- there is an understanding of risk to the programme and the Local Care team are working on mitigation.

(Please refer to Appendix E of the report, Local Care Updates; summary of progress in each locality, Sept 2018).

11. Recommendations

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

11.1.1 note the progress of the Local Care workstream;

11.1.2 support the approach for investment in Local Care as set out in paragraph 3.2 of the report, with a view to receiving an outcomes framework, progress of which will be presented to the December 2018 meeting of this Joint Board, and

11.1.3 support the Organisational Development (OD) approach, for the change in culture required to deliver Local Care.

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Appendices

Appendix A - Encompass Legacy report
Appendix B - Local Care Progress to date and next steps
Appendix C - Carers APP presentation
Appendix D - Carers APP leaflet
Appendix E - Local Care Updates; summary of progress in each locality, Sept 2018

Background Papers

The Nuffield Trust 'Developing Robust Estates Strategies'
https://www.nuffieldtrust.org.uk/files/2018-06/nhs-restates-briefing-v6.pdf

encompass
Working together for better health and care

Encompass Multi Specialty Community Provider (MCP) Vanguard

Testing New Models of Care

Interim Legacy Report

2015 to 2018

Document Reference No.	MCP006
Document Version	Interim Report Version 1
Report prepared by	James Shaw-Cotterill, Encompass Project Manager
Approved by	Encompass Executive
Document Date	January 2018
Approved	30 January 2018

Contents

"Improve the health and wellbeing of local people by working in partnership with local communities to create a sustainable health care system, integrating hospitals, GPs, social care and community services including the voluntary sector".

0. Executive summary

1 **New Ways of Working**

Between January and September 2015, 50 vanguards were selected by NHS England to take a lead on the development of 'New Models of Care' **(1)** to act as the blueprints for the NHS moving forward, and to be the inspiration for the rest of the health and care system; Encompass Multi-Speciality Community Provider (MCP) Vanguard, being one of those selected to try out new and improved ways of working.

2 **Integrated Care**

The ambition set out by Encompass was to deliver an integrated health and social care model, delivering high quality care which met people's needs, was coordinated to avoid duplication, easy to access and that enabled people to stay well and live independently for as long as possible in their home setting, to avoid them going into hospital.

3 **Encompass Journey**

This document describes the three year journey of Encompass; the results and difference it is making to patients and staff, describing how this model is using resources more effectively, improving the quality of care for the growing population and future needs, as well as influencing the future of health and social care in Kent and Medway.

1. Why work differently?

1.1 The case for change

The NHS is under pressure

	**P**eople are living longer, many of them with long term conditions (LTCs) which use up 70% of the NHS budget. We need to change what we currently do to better support older people in our area
	**A**cross Kent and Medway, health and social care have £3.6bn in funding but overspent by £141m last year. Without change we will be overspent by £486m by 2020/21
	**T**here is a shortage of healthcare professionals, affecting the ability to recruit to all staff groups, including GPs and nurses
	**T**he wider healthcare system is also feeling the effects of cuts in social care funding, with consequent increased demand on the health service adding to the pressure.

To tackle the challenges in health and social care we need to change the way we work to **improve care** and get **better value** for the money we have available.

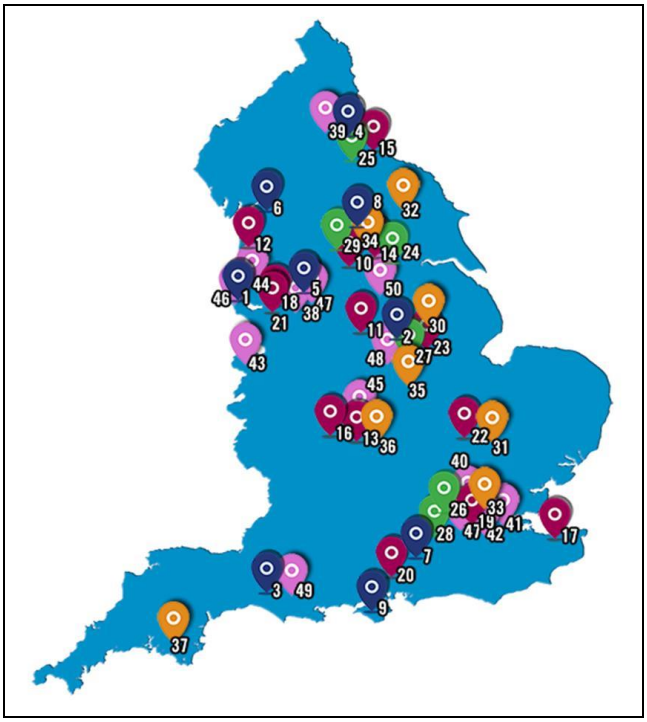
The NHS Five Year Forward View **(2)** advocates steps to break down barriers between organisations in order to release efficiencies, bringing **care closer to home** and **reduce the pressures on acute services**. This is also the vision for the 2016 Kent and Medway Sustainability and Transformation Plan (STP), **(3)** whose evidence base for its **'local care'** work stream suggest:

	**30%** of patients in acute hospital beds would be better looked after in an alternate location of care, either in a short term or step down bed or at home with community nursing or social care support
	**12%** of admissions through A&E are avoidable through more consistent decision-making at the front door, or better health and social care provision in the community
	**25%** of community hospital patients would be better cared for at home or in a community setting

Encompass has been testing new ways of working to integrate services, improve care and release efficiencies into the system.

2. Who are encompass

Encompass is part of the NHS 'vanguard programme' which means it made a bid to NHS England for transformation funding to improve the health of local people by testing New Models of Care.



Five Year Forward View

- New Models of Care are a key element of the Five Year Forward View
- Encompass (no.17 on the map) is one of 50 Vanguards in England selected to test new models of care
- There are 5 types of Vanguards:
  - Multispecialty Community Providers (MCP)
  - Primary and Acute Care Systems
  - Enhanced Health in care homes
  - Urgent and Emergency
  - Acute Care Collaboration

Encompass was established in 2015. It is a group of 14 GP surgeries across Ash, Canterbury, Faversham, Sandwich and Whitstable who are working together to test new ways of delivering services in communities and closer to people's homes.

Encompass has tested several changes including:

- Having joint health and social care multi-disciplinary teams looking at patients at risk
- Improving the way IT systems are accessed by everyone involved in care
- Looking at services outside of traditional health and social care (voluntary services, community groups etc.) which can provide relevant support (this is called social prescribing)
- Looking at net way of providing clinics locally (for example catheter and wound care) which previously would have required an outpatient appointment at a hospital
- Developing an app (Waitless) which gives local people up to date information on the best place to go for medical attention based on wait times and transport options.

The work done by Encompass up to September 2017 has led to:

1,189 Hospital admissions being avoided

8.2% Reduction in Hospital admissions

3. Who do we work with?

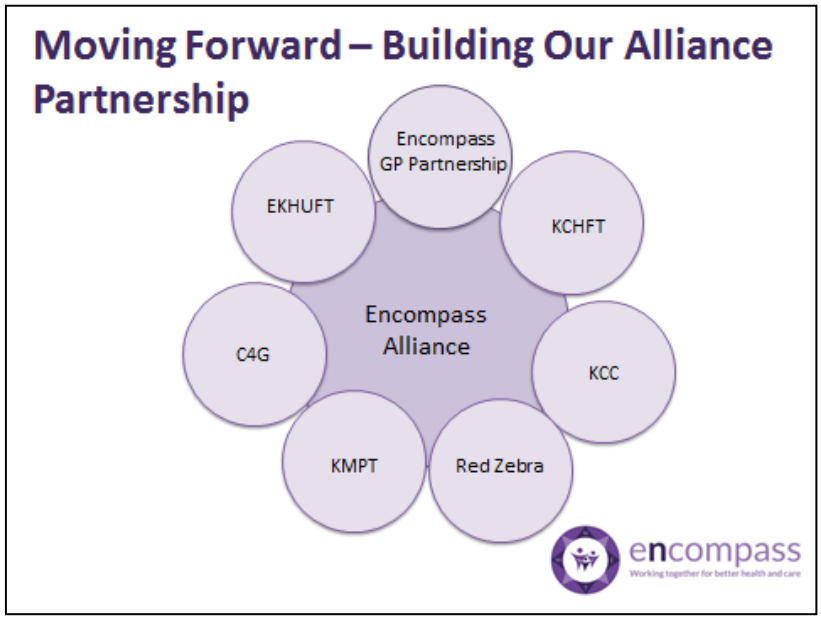
3.1 Practices

The practices listed below agreed to join Encompass with a view to forming a long term working relationship. The terms of the agreement were set out in a Memorandum of Understanding (MOU). An Encompass GP Partnership Ltd company was formed in October 2017 and will be one of the key partners in the overall Strategic Alliance.

- Ash Surgery
- Canterbury Medical Practice
- New Dover Road
- Northgate Medical Practice
- Sturry Surgery
- The Market Place Surgery
- University Medical Centre
- Canterbury Health Centre
- Faversham Medical Practice
- Newton Place surgery
- Saddleton Road Surgery
- The Butchery
- The Old School Surgery *
- Whitstable Medical Practice

*The Old School Surgery joined Encompass in October 2017

A Stakeholder Group and an Operational Group were formed to work with the partner organisations listed below. As the vanguard developed an Encompass Strategic Alliance and an Operational Alliance were formed in April 2017.

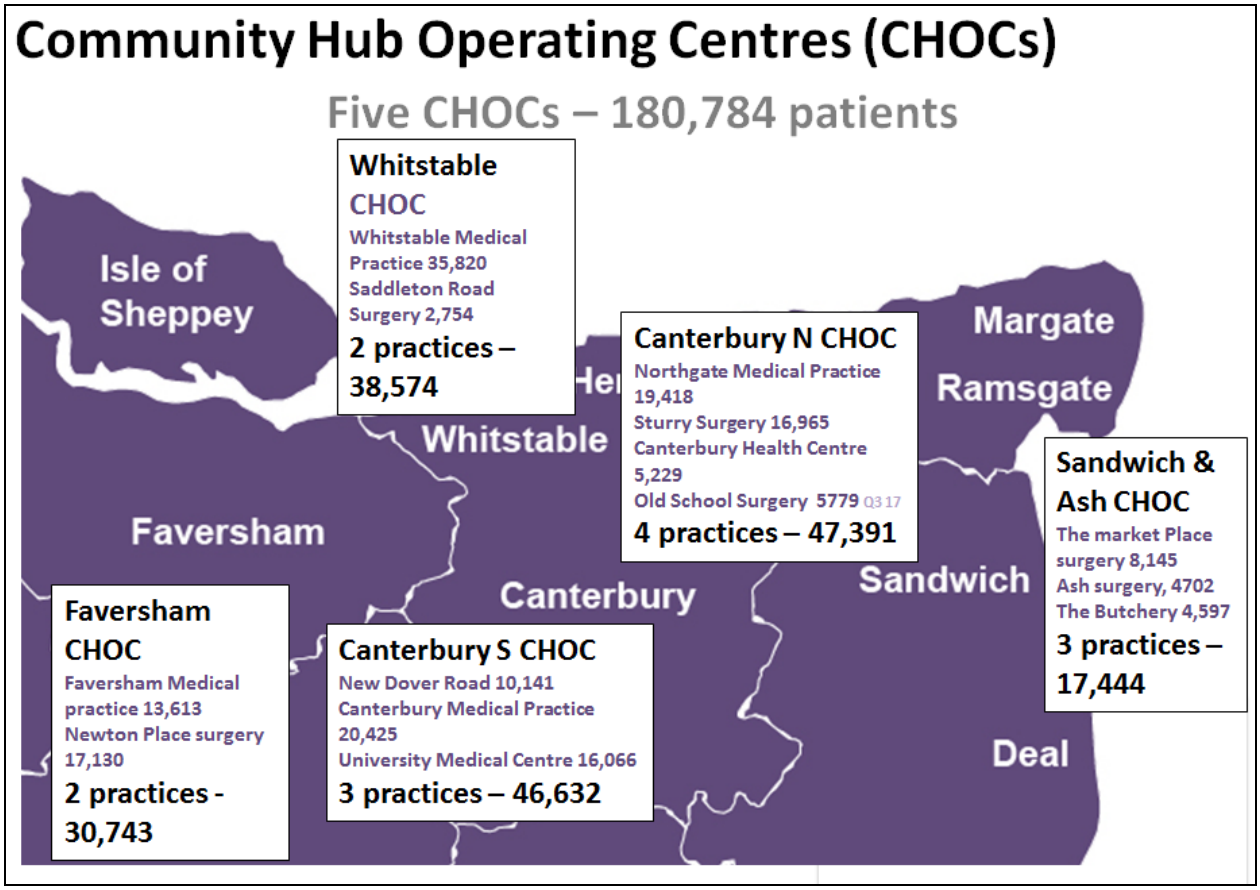


3.2 Partner organisations:

EKHUFT - East Kent Hospitals University NHS Foundation Trust
KMPT - Kent and Medway NHS and Social Care Partnership Trust
KCHFT - Kent Community Health NHS Foundation Trust
KCC - Kent County Council Public Health
KCC - Kent County Council Social Services
C4G - NHS Canterbury and Coastal Clinical Commissioning Group
SECAmb - South East Coast Ambulance Service NHS Foundation Trust
Red Zebra - Voluntary and community services

4. Our Geography

The Encompass practices are working at scale across the Canterbury and Coastal Clinical Commissioning Group (C4G) footprint in five 'community hubs' shown in the map below.



Based on Q3 2016 population data

5. Our Journey

Encompass is in the final year of a 3 year journey.

5.1 Practice momentum

The three founding practices were awarded MCP Vanguard status in April 2015. A core team was appointed and the value proposition for first year transformation funding was submitted to NHS England New Care Models Team (NCMT). The NCMT recommended that the MCP should look to scale up its population of approximately 53,000 patients. This lead to a number of engagement events. A further 13 practices signed up to the MCP Memorandum of Understanding (MOU) during July and August 2015. This increased the total number of practices to 16 with a patient population of almost 170,000. Over time some practices merged, consolidating the number to 13. More recently (October 2017) an additional practice signed the MOU taking the total number of practices to 14 and increasing the MCP patient population.

5.2 Transformation funding

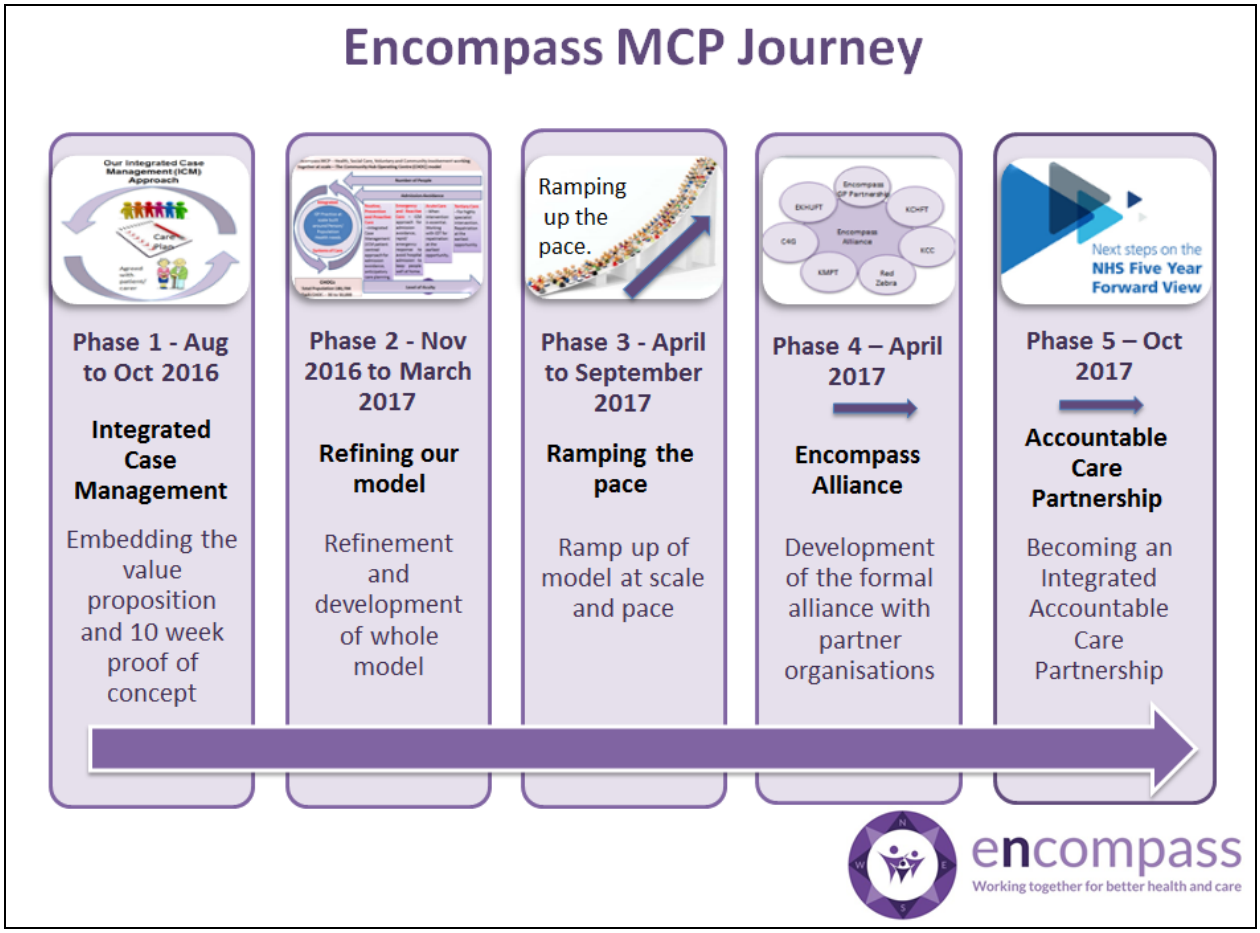
In November 2015 the NCMT approved the transformation investments needed to move Encompass new models of care forward. The funding was subject to a list of conditions aligned to progress against delivery milestones, sharing of learning and quarterly review meetings with the NCMT.

Encompass was required to submit two further value propositions for its 2016/2017 and 2017/2018 work programmes and was held to account by the NMCT for its delivery and outputs.

5.3 Mobilisation

Encompass has been working on a number of projects with partner organisations to mobilise new models of care across the MCP footprint. These are discussed further in section 6 of this report.

In August 2016 a significant proportion of the original Encompass core team moved on and a new team was put in place to focus on mobilising the 2016/2017 and 2017/2018 value proposition. The picture below shows the key phases of that journey.



6. Our Model

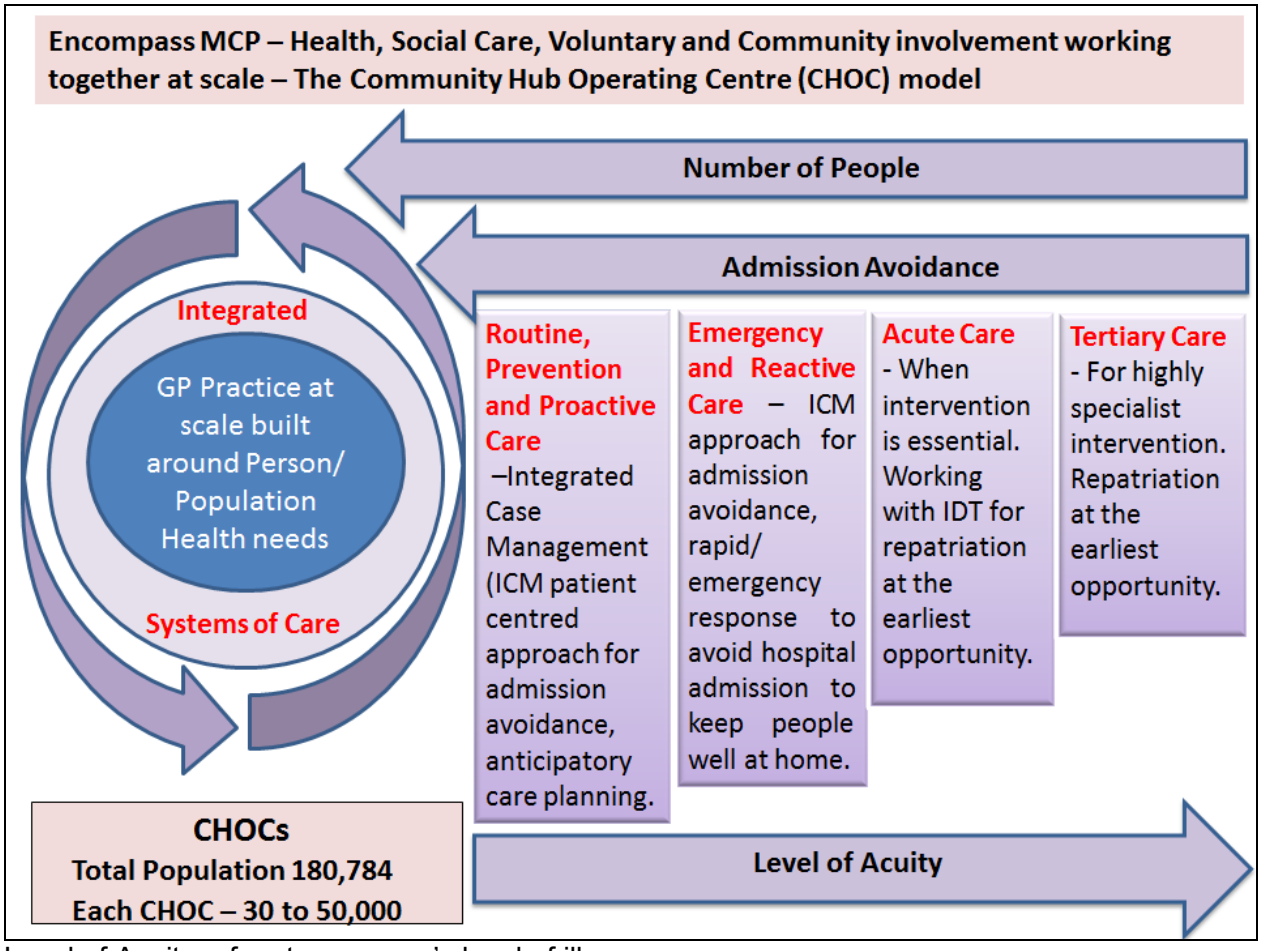
At its heart the Encompass model of care is about **integrated** working, **at scale** that is focused on delivering:

"High quality, outcome focused, person centred, coordinated care that is easy to access and that promotes wellness and enables people to live independently for as long as possible in their home setting".

The model operates across 5 community hubs of between 30,000 to 50,000 patient population groups. The Community Hub Operating Centres (CHOCS) were launched in geographical stages beginning in 2016 and bring together:

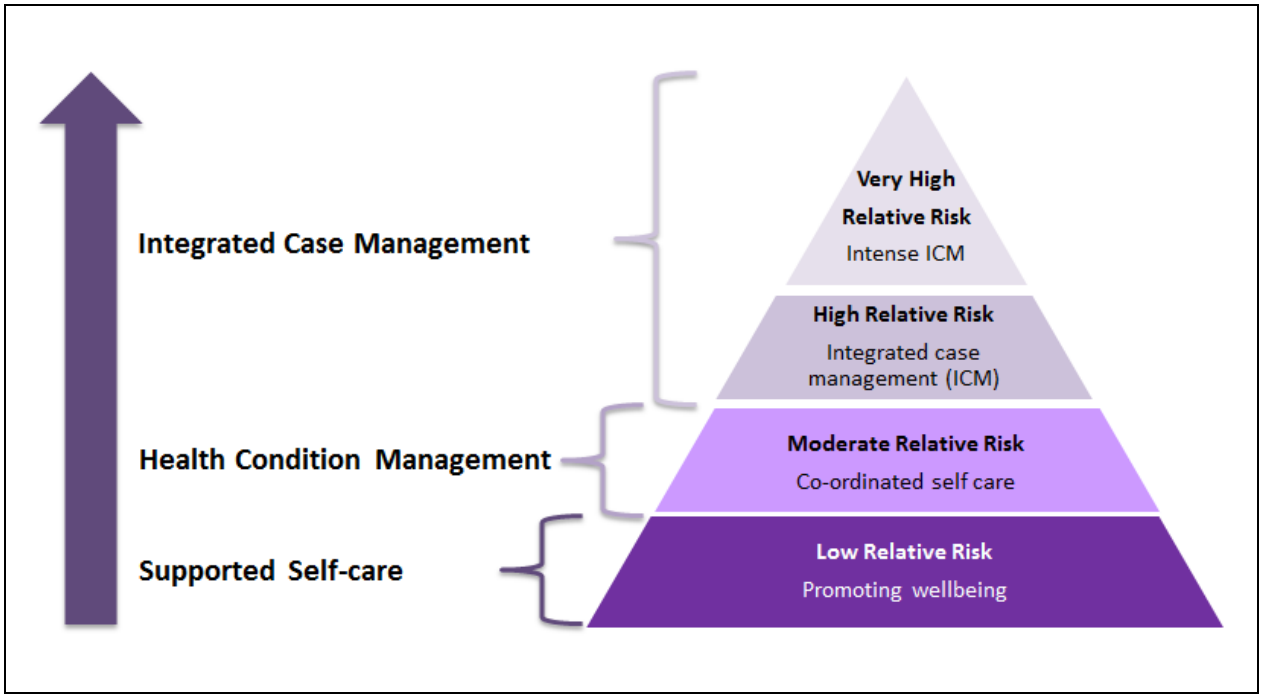
- Health
- Social care
- The voluntary sector
- Community involvement

These groups work together at scale as an integrated system of care around the patients' health needs, offering hub level services. As the picture below shows the level of need (in red) will determine the type of care provided.



Level of Acuity refers to a person's level of illness

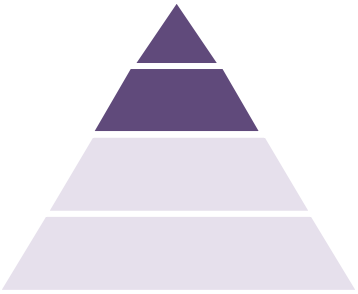
By working together at scale, CHOCs can identify cohorts of patients and manage them better in the community, closer to home, avoiding acute admissions. Patients can be referred into a CHOC by any health or care professional though the Local Referral Unit (LRU) provided the patient has consented. To ensure patients gain the most from this model of care the process begins by identifying patient's level of risk and health needs, shown in the triangle below.



The model seeks to deliver proactive care and support, focused on promoting health and wellness, rather than care and support that is solely reactive to ill health.

As the diagram shows there are three groups of interventions: Integrated Case Management, Health Condition Management and Supported Self-care.

6.1 Integrated Case Management



Integrated Case Management (ICM) aims to build relationships between health and social care professionals to improve health and wellbeing outcomes for patients at high risk of future emergency admission to hospital. Its success lies in the brining together of a Multi-Disciplinary Team (MDT) to support the management of patients who have:

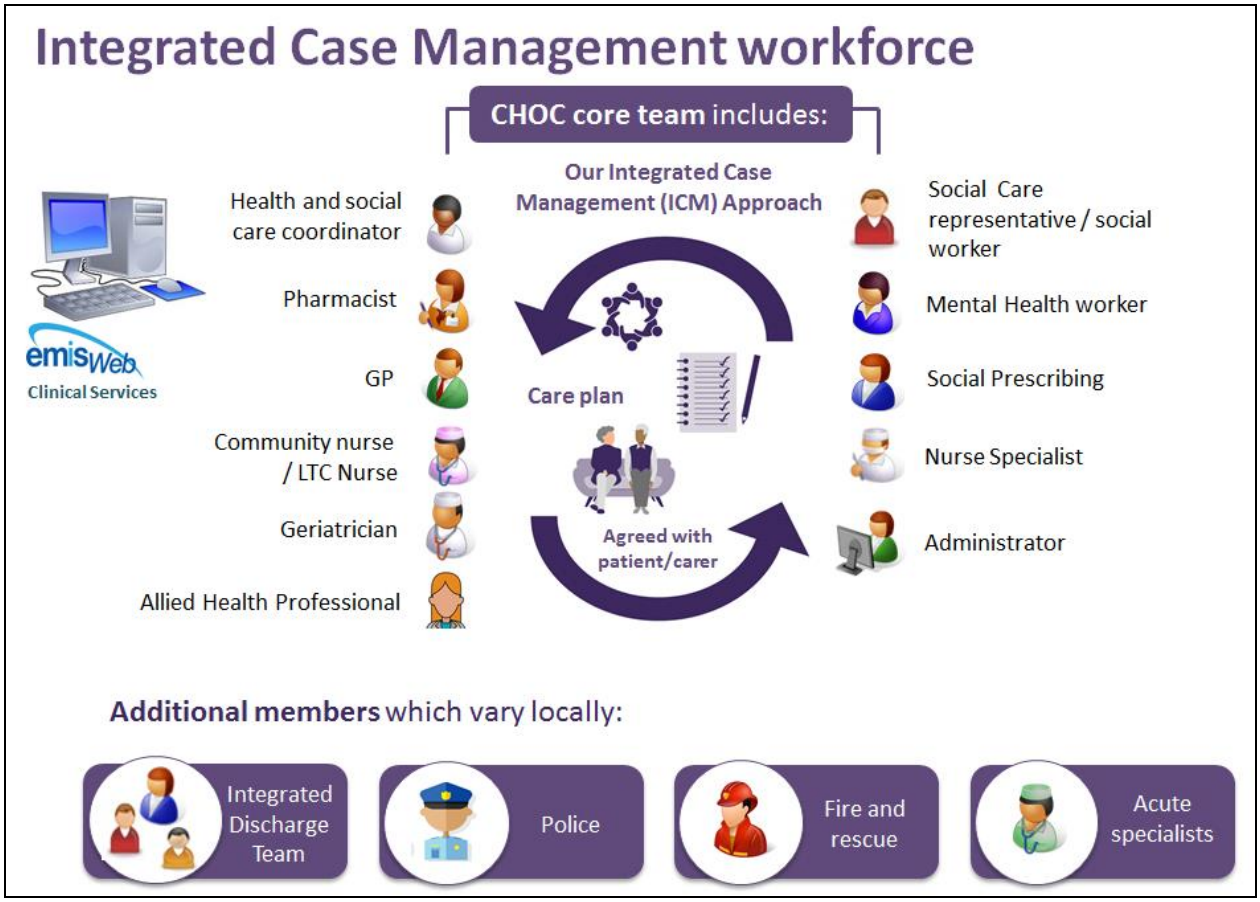
- the highest health complexity,
- with multiple co-morbidities,
- frequent hospital admissions,
- psychosocial issues,
- frailty, mental health conditions and
- poly-pharmacy.

ICM is initially aimed at the top 3% of the CHOC population with the highest risk stratification scoring or severe frailty. The service aims to reduce unnecessary hospital admissions, reduce avoidable A&E attendance, and facilitates early discharge from in-patient beds.

The Multi-Disciplinary Team

The concept is to prevent duplication from multiple services, prevent the patient having to repeat themselves, to co-ordinate the patients care, to put the patient at the very centre of their care, to identify any unmet need gaps and work as a team to address the patient in a cohesive way.
The patient is at the **centre of the plan of care** and is involved in the decision making process and the planning of their anticipatory **care management plan**.

The workforce consists of a core team in each CHOC locality and additional members with local variation as shown below.



The resources to run the meetings were sourced from the existing providers by working in a smarter more integrated way. Funding was available from the Vanguard to support some double running until Business as Usual commenced.

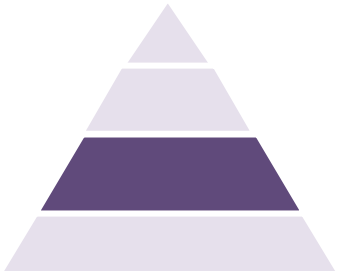
EMIS Clinical Services was funded and installed to support the CHOC process and data entry into the Clinical Care Plan. Data sharing agreements were put in place between the Provider Organisations and each Practice in order to support the viewing of the GP record during the meeting and from the practice.

6.1.1 ICM outcomes

- **1,900** patients have benefited from the ICM approach up to the end of October 2017
- The current case load for the service at any one time is around **150** patients each month
- Outcomes for the **29** patients that completed the initial 'proof of concept' programme have been tracked using their NHS numbers (with consent) and **76%** of these had not had any hospital admissions in the **12 months** since the completion of their intervention. (Data sources: local data collection and SUS data).
- There has been a marked reduction in emergency admissions (**8.2%)** and a reduction in short stay admissions of **33.1%**). (Data source: Secondary Uses Service data).

- **1,900** patients benefited
- **150** patient case load
- **76%** no admissions
- **33.1 %** reduction in short stays
- **8.2%** reduction in emergency admissions

6.2 Health Condition Management



Health condition management aims to support and empower people who have long term physical and mental health conditions, keeping them well and avoiding hospital admission.

Some of this involves moving some services, historically provided in a hospital, into the community and extending the roles of GPs and other healthcare professionals.

6.2.1 GPs offering additional services

Specialist GP services will mean that more people will be able to receive care from a GP surgery without the need to travel to hospital. This means that the skills and resources needed to deliver these services need to follow. Encompass has supported this training with matched funding for backfill and course costs for **12** practitioners across **seven** specialities including:

- Dementia
- Dermatology
- ENT
- Urology
- Ophthalmology
- Respiratory
- Cardiology

This will mean that outpatient appointments can come out of hospital settings and be delivered in practices close to home, only referring to hospital for more complicated conditions. The majority of the training commenced in September 2017 and will take on average 12 months to complete. Each practitioner signed a Learning Agreement committing to the training, guidance and providing a service once trained.

6.2.2 Catheter clinics

The catheter clinics were deployed following a phased approach across the CHOC localities beginning with Faversham in April 2016. The approach taken was to upskill practice nurses to the same level of competency as the community nurses.

It was designed this way to:

- Prevent unnecessary A&E attendance
- Prevent visiting the non- housebound by providing a catheter clinic within a GP surgery
- Provide access for any patient in the locality to attend a CHOC Catheter site even if they were not registered in that locality.

The practice nurses were trained by Kent Community Health Foundation Trust (KCHFT) community nurses in catheter care, funded by Encompass. Patients fitted with a catheter in EKHUFT, now leave with a catheter 'passport' and advice to go to their local CHOC for regular booked changes and also one of four sites with any catheter related issues if not near their local CHOC or if they have an emergency situation. An excellent working relationship has been established with the acute trust working closely with the Head Nurse of urology to arrange direct access to clinics if patients turn up unnecessarily. If a patient is discharged from Urology they contact the patients registered GP and pass on details of the catheter, size, make and frequency of change so a prescription can be raised to ensure stock is available in advance.

6.2.3 Wound care clinics

A task and finish group was set up to bring together community and practice staff to share learning and develop and set up a hub based model. A protocol and template were written to standardise competencies and frameworks across primary and community care so that patients have access to the same quality of care whether treated at the surgery or in their home.

Two licences for each practice were purchased for WoundMatrix software along with tablets for use within the clinics. WoundMatrix enables the secure capture, measurement and instant upload of wound images and data elements at the patient

point of care. The web-based mobile platform enables instant, accurate and reliable wound documentation and outcome tracking. Practices have been trained to use the software and work is being undertaken to explore the options of linking the software with the primary care clinical system.

6.2.4 Dementia support

Encompass has been working with Age UK to provide drop in dementia clinics. The Dementia Services Link Worker started working across the CHOCs in April 2017 providing holistic support for families and carers and signposting to additional support services. The majority of referrals are for Carers requesting ongoing one to one advice, information and support.

6.2.5 Group psycho-education

Encompass has been working with Invicta Health to support self-management / admission avoidance for individuals with a diagnosis of Bipolar Affective Disorder or Psychosis. The groups have helped individuals to be less isolated by meeting others with a similar diagnosis and have helped them to understand their condition and learn about relapse prevention to enable them to stay well and out of hospital. The groups have been running since January 2017. There is an example of a patient story with outcomes in **section 7.**

6.2.6 Community Paramedic Practitioner home visiting service

Helping patients stay out of hospital

Building on an earlier successful pilot a Paramedic Practitioner Scheme was developed by Encompass and the South East Ambulance Service (SECAmb). It was deployed across the CHOC localities in November 2015. The service involved a team of community paramedics undertaking urgent home visits on behalf of GP practices. This allowed GPs to focus on seeing patients in their surgery and patients to be seen more quickly in their own homes. Due to workforce and external pressure the provider needed to focus on core business and gave notice on the contract in March 2017.

Therefore practices started to employ their own paramedics to do house calls. A new Encompass GP Partnership Service Specification was written for a Paramedic Practitioner / Advanced Nurse Practitioner Service to reduce the pressure on member GP practices and 999 / 111 calls from patients unable to attend a surgery appointment or get a home visit; subsequently reducing hospital attendances and maximising GP time in surgery. The revised Rapid Home Visiting Service began in November 2017.

6.2.7 Community Pharmacist Service

KCHFT Pharmacy Team have been working with Encompass since August 2017 and are part of the core MDT workforce.

The team attend **CHOC** meetings to:

- build relationships with the other health and social care professionals
- actively participate in the MDT process, adding a pharmacy perspective to the discussions
- ask medicines-related questions
- highlight general medication issues
- act promptly to resolve questions that arise about a patient's ability to manage their medicines

The Pharmacy Team provide a domiciliary service, frequently **visiting patients** directly after the MDT meetings. The purpose of the visits is to assess the patients and to assist them in adhering to their medication regime potentially **reducing admission** or re-admission to hospital in the longer term. The team have achieved this in a number of ways:

- by optimising their regimens in conjunction with one of the prescribers present at the meeting. This also reduces prescribing costs;
- physically sorting their medicines out at home to reduce harm from medication; ensuring only those currently prescribed are available;
- promoting their independence by providing them with verbal and written information about their medicines and where necessary by supporting them to appropriately fill a multi-compartment aid (MCA), and;
- in cases where they are deemed unable to do this, to initiate a pharmacy-filled MCA or Medicine Administration Record (MAR) for carers to safety prompt/administer medicines.

Lead Pharmacist

"Allowing organisations to meet together on a regular basis has **broken down barriers** and **improved outcomes** for patients by enabling better **more informed care**."

6.2.8 Health and Social Care Co-ordinators

Health and Social Care Co-ordinators (HSCC) from KCHFT have been working with Encompass to support the CHOC localities since July 2016. They act as a key point of direct access for the CHOC receiving referrals / enquiries from the MDT meeting or via email for health and/or social care interventions.

The HSCC provide administration support to the CHOC MDT meetings such as minutes and actions logs. They are a key link liaising between social care, GPs, Community Nurses, Community Matrons, Case Managers, Occupational Therapists, Physiotherapists, Mental Health Teams and other key resources from the voluntary and private sector. This enables the HSCC to facilitate timely, effective and efficient use of collective staff resources within a community hub.

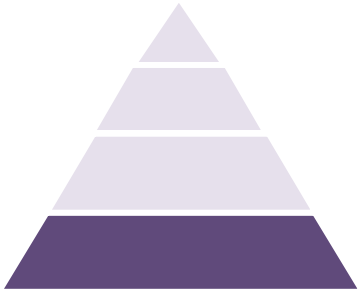
Health and Social Care Co-ordinators:

- Invite attendees to the CHOC meeting and ensure the smooth running of the meeting.
- Ensure the GP (EMIS) and Community (CIS) IT systems are working and available.
- Attend home / In Reach visits when required and referrals / actions.
- On occasions when required Chair the meetings
- Send referrals as discussed at the meeting
- Ensure EMIS has been updated
- Ensure CIS has been updated

6.2.9 Community Geriatricians

Community Geriatricians from KCHFT T have been working with Encompass to support the CHOC localities. They support medical decision making to keep people well in their own homes, liaise with relatives and carers, and communicate with: Community Continuing Health Care, Care Home Providers, the Acute Trust and identify and address Delayed Transfer of Care. The Community Geriatricians have been part of the core MDT workforce since quarter one of 2017.

6.3 Supported Self Care



Supported self-care is about supporting people to make healthier lifestyle choices to avoid preventable diseases. The aim:

- building strong social networks
- exercising more
- eating more healthy
- feeling more supported and in control of lives
- reduction in healthcare interventions for patients identified with social prescribing need

6.3.1 Social Prescribing

Encompass has been working with Red Zebra to provide a Social Prescribing service. Social Prescribing supports prevention and self-care, promoting independence and enabling people to connect with voluntary and community groups and other non-clinical services. It can help people to build social networks, keep healthy, reduce the need for medical care and address loneliness and social isolation.

350 activities delivered by 150 organisations are accessible via the social prescribing team and through an online directory, commissioned by Encompass, called 'Connect Well'. Connect Well is a public facing searchable website linking health and community in East Kent, this went live in March 2016. Healthcare professionals have been trained in using Connect Well to refer patients directly to services. Alternatively Red Zebra have coordinators who can arrange to meet individuals to help navigate the directory or patients can refer themselves online. The highest number of referrals has been from the CHOC MDT. Red Zebra started attending the CHOC MDT in July 2016. The Social Prescribing Coordinator is part of the core MDT workforce. To watch the Red Zebra social prescribing case study, go to: https://www.youtube.com/watch?v=Br4gAxRaAp8

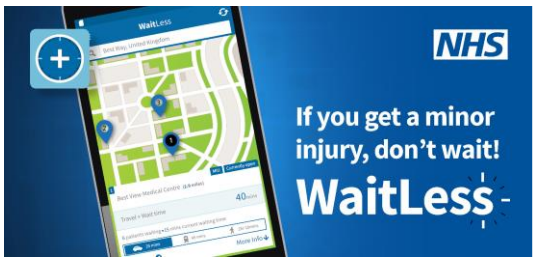
6.3.2 Health Trainers

The Health Trainer project began as a pilot in February 2016. The Health Trainer, from KCHFT, supported patients who wanted extra help to make lifestyle changes. Following the pilot the Health Trainer service was implemented across 3 CHOC sites from October 2017. The Health Trainers help motivate and encourage clients by setting goals and developing a personal health plan that suits the individual. Lifestyle changes include examples such as: weight reduction, stopping smoking, cutting down on alcohol or getting more active.

6.3.3 The Daily Mile

An initiative in schools to keep children active, bringing together Education, Public Health, NHS and Local Government to embed good health behaviours. The focus is to increase activity in school age children and supporting families. The CHOC MDT model is being used as a basis for moving this project forward to encourage integrated working across agencies.

6.3.4 WaitLess



WaitLess is a smartphone app designed to cut waiting times at Accident and Emergency (A&E) departments and Minor Injury Units (MIU) in east Kent. The WaitLess app combines up to the minute travel information with live waiting times so that patients can decide which urgent centre to head to for faster treatment for minor injuries.

The Clinical Lead for Encompass came up with the idea after seeing a similar app in use in Valencia, Spain. The app was co-designed by Encompass and patient groups in East Kent and developed by Transforming systems who enabled the real time feeds.

The app was launched in December 2016. This kind of innovation was the first of its kind in the UK and the potential impact was unknown. There have been over 15,000 downloads and 131,000 usages up to the end of October 2017. It was anticipated that perhaps 5% of patients attending A&E would be routed to MIU facilities. An overall shift of just over 6% of minor attendances from A&E to MIU facilities has been recorded up to end of September 2017.

The WaitLess app is free to download:

Download on the App Store https://itunes.apple.com/us/app/waitless./id1160745938?mt=8

ANDROID APP ON Google play https://play.google.com/store/apps/details?id=com.ts.waitless&hl=en

To watch the promotional video go to:
https://www.youtube.com/watch?v=jLWfILLC2fw

WaitLess promotional video

WaitLess also links to HEALTH *help* NOW. This app provides health advice and alternative treatment options.

7. Patient Stories

Valerie

Valerie is a 92 year old lady who cares full time for her husband who has dementia. She had stopped carrying out normal day to day tasks and needed trips to hospital after falling at home, all of which was impacting on her mental wellbeing.

She didn't understand all the different agencies visiting her and felt understandably confused by the system and complexity of visits from GPs, social workers and other professionals.

By brining those professionals **together** around the table to develop a **single care plan to meet Valerie's goals, it has transformed her life.** Her care plan focused on physical, mental and social needs, with a number of simple interventions that helped her feel more confident and able to cope at home. This includes a daily visit from a carer who speaks regularly to all the professionals involved in Valerie's care, and being given a falls wrist band and walking frame with a tray to help her to do normal day to day tasks.

To watch the Encompass video featuring Valerie go to:
https://www.youtube.com/watch?v=1xNnnFv8FCY&feature=youtu.be

"WaitLess"

"This app is so good. I broke my leg and needed it checked immediately and it told me what hospital had quicker service and how long it will be to wait – excellent"

Social Prescribing

Help with caring and tasks

"Amazed at how quickly things happened and we are extremely happy with the outcome / support."

Befriending and gardening

- A patient was calling his GP **3** to **4 times per week**, was **feeling lonely** and **isolated**.
- The patient was referred for befriending and gardening help.
- The GP described her patient as being much **brighter** since the support started and that he was talking about going on holiday. He **now calls once per week**, the **calls are shorter** and **more focused**.

"I look forward to the gardeners visit. The befriender is working well. My **confidence** is **increasing** and I go out for lunch once a week"

Mental Health Support

Group psychoeducation

A patient with a diagnosis of Bipolar disorder had two past admissions under section two of the Mental Health Act. She was a frequent attender at A&E (4 times in 2 months prior to intervention) and failed to attend routine health checks at her GP surgery.

The patient was invited to attend the Bipolar Psychoeducation Group and completed the group programme.

Outcome:

- **Reduced** medication by 25%
- **Maintained stability** in mental health by also incorporating healthy lifestyle activities discussed within the group programme
- Gradually **lost weight**
- Felt able to **return** to part time **work**

"I have an overall feeling of **improved quality of life.**"

8. What do others say

"Community Hub Operating Centre is the **highlight** of my week."

Consultant Geriatrician

"Hats off to you, **really good meeting** and **really good progress**, so **thank you**."

Aug 2017 Assurance meeting
New Care Models Programme Director NHS England

"

Working within the CHOC MDT has **improved delivery of person centred care**. CHOC facilitates **improved working relationships** between health, social care and the voluntary sector and **identifies gaps** in a patient's pathway that can lead to potential crisis. This is a meeting where **all voices are heard**, with no hierarchy.

CHOC meetings are not only about **meeting patient need** and **responding proactively**, they are also a useful forum for **sharing best practice**, discussing potential outcomes and evaluating pathways of care.

They are indeed **a weekly highlight** and I look forward to being part of its on-going evolution.

Long Term Conditions Lead Nurse

"

Smarter technology

Health and Social Care Co-ordinator

A lot of people assume that everyone involved in care can see their records already. But not only is that not true, it's also one of the most difficult parts about bringing the different organisations in health and social care together. The training on the new system has been fantastic. All the data for the patients who we are seeing through the Community Hub model is on there and we can add new patients as they get referred to us.

Data sharing means that if we're talking to a patient as a joined up team we all have access to the same information and can see if anything new has happened that we need to be aware of. It also means that when we decide on an action at the meetings we can notify their own GP immediately and ask them to put certain things in place.

Not all GPs could attend every meeting so this really helps spread awareness and get things actioned a lot quicker. As more and more people join the MDTs (hospice nurses have recently joined) we can see huge benefits for our patients in working this way.

"As a GP **I've never felt so connected to the community and voluntary sectors**. As I have passed over direct involvement with the MDT to a colleague, I'm pleased to see this connection continues thanks to updates being added directly to the medical record. **Let's hope this is the beginning of a new era of truly integrated working."**

Primary Care GP

"You are doing amazing cutting edge projects."

Sir Sam Everington
Chair Tower Hamlets CCG

Pharmacy

"The ability of the team to react in a timely way has been recognised by both colleagues and patients/family alike. Allowing various organisations to meet on a regular basis not only promotes pro-active thinking and doing, but also breaks down barriers and improves outcomes for patients by enabling better, more informed care.**"**

Lead Pharmacist

"It has been **great** to work as part of a functional multi-disciplinary team with great participation from so many providers.

I have seen first-hand how barriers are being broken down, networks created and as a result **patient care improved**, not only in its reactiveness, but also in anticipatory care-planning. The ability to get additional, up-to-date, information on patient's medical history or social situation from so many different agencies has helped colleagues understand their needs in a more **timely** way, in turn helping them to **deliver better care**. The flat hierarchy and revolving chair of the meeting ensure that **everyone's voice** is **heard** and **valued**. I really hope that this project is introduced as a permanent feature once this pilot finished."

Community Pharmacist

"5 star service"

"My mother received a 5 star service.**"**

Patient's daughter describes service

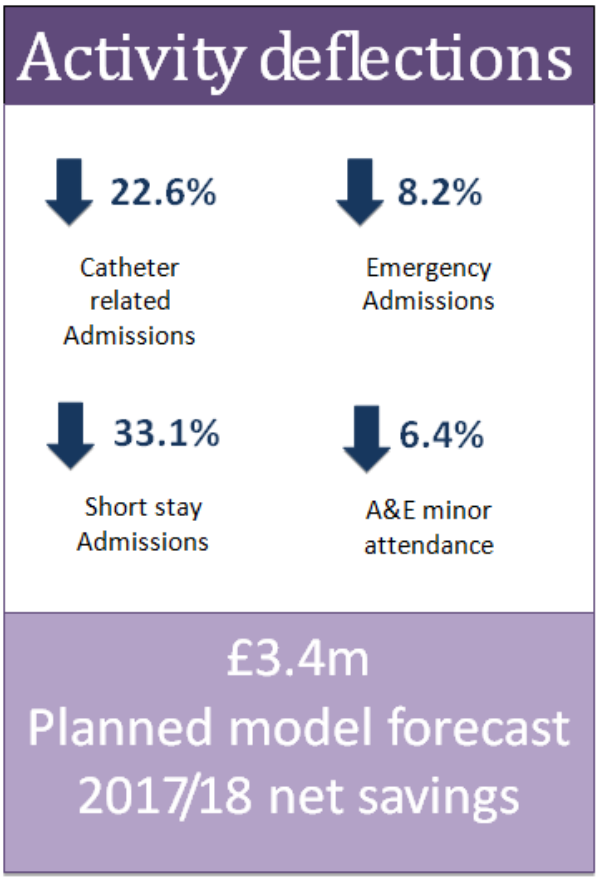
9. Our outcomes

Our progress has been monitored using a set of national outcomes, as defined by NHS England, with some additional outcomes that were agreed locally to reflect the local nature of our services.

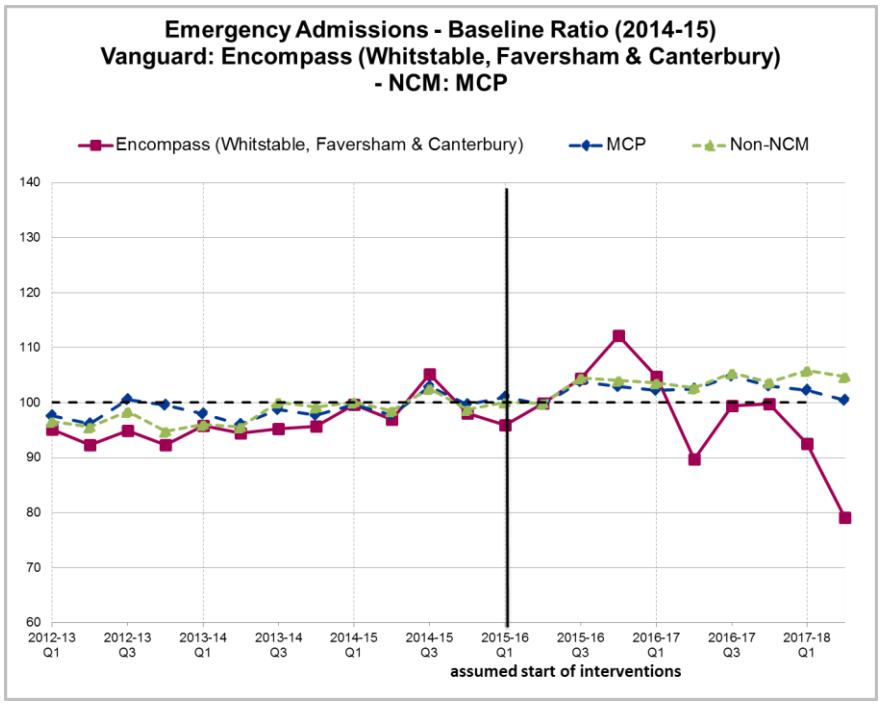
There has been a reduction against the emergency admissions national outcome of **8.2%** compared to the baseline period, with a greater reduction in short stay admissions (up to 1 day) in particular, primarily attributed to the ICM model.

Other developments have led to specific improvements in outcomes, for example a **22.6%** reduction in catheter related admissions compared to the baseline period, attributable to the catheter clinic service and a **6.4%** shift of minor attendances from A&E to MIU facilities, attributable to the WaitLess app.

We are on track to deliver the planned saving of £3.4m in 2017/18.



Our performance against the national emergency admissions outcome is shown in the chart below. Our **8.2% reduction** compares very favourably against the national **growth of 2.6%** for other MCP vanguard sites and **4.9% for non-vanguard sites**.



10. Enablers

10.1 Information Technology

Information Technology has been one of a number of key enablers in the development of New Models of Care.

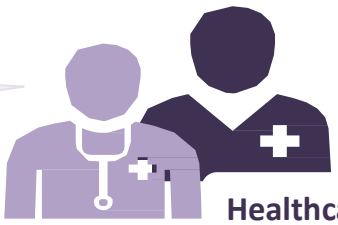
10.1.1 EMIS Clinical Services

emisWeb Clinical Services

The installation of EMIS Clinical Services (discussed in section 5.1) has meant that:

- A virtual register of ICM patients can be created, maintained and managed to ensure the patient receives timely and effective care across the practices in the locality hub
- Key clinical information can be viewed **during** the CHOC MDT meeting
- The CHOC team have access to the same information and can see if anything **new** has happened that they need to be aware of
- When an action is agreed at the CHOC MDT meeting the patients GP can be notified **immediately**
- Updates can be added **directly** to the medical record
- Duplication is avoided by pulling in key information from the patients record into the overarching care plan
- The care plan can be viewed and updated by the CHOC team and **shared** with the patient and CHOC professionals involved in the patients care
- 'Improved Access' at a CHOC level is available to patients through a hub level booking system

"We can see huge benefits for our patients in working this way."

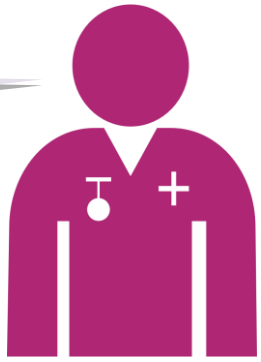


Healthcare Professionals

10.1.2 Medical Interoperability Gateway (MIG)

The MIG makes it possible for other clinicians treating patients to view parts of the GP clinical record, including the patients **care plan**. Clinicians from providers such as the Hospitals Trust, Pilgrims Hospice, Mental Health Trust, KCHFT, NHS111 and Out of Hours can see the patient's records, provided the patient has given permission.

The **MIG** GP record has helped us in pre-assessment **tremendously** for the following reasons …



Matron

Previously we may have sent pre-assessment patients with high blood pressure to GP's to get three baseline readings. If ok then proceed for surgery. However **now** we just need to check baselines **from GP records** if available and can proceed if within normal range. **Saving time, communication and appointments at GP Surgeries.** Also **reducing stress and time for our patients.**

Incomplete medical history can **now** be **checked on GP records. Improving safety** by reducing doubt, **time and communication**.
Can view any correspondence or summaries from outside east Kent such as from Kings etc. again saving time and communication.

I believe that overall this has **greatly helped both nursing and medical staff** within pre-assessment.

Pre-Surgical Preparation Matron

"Thank you for access to the records, long may this continue!**"**

"It is a **fantastic resource** that has greatly **improved patient care** and **safety**.
I have taught multiple doctors how to access the information, often accompanied by a **great sigh of relief** or **expression of delight** at the ease of the system.**"**

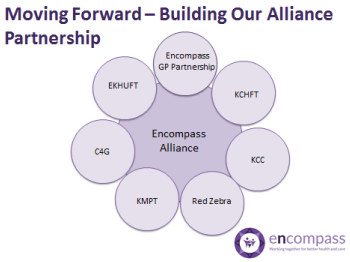
Consultant, EKHUFT

10.2 Data Sharing Agreement

To help improve quality and safety of care through more integrated working across organisations a Data Sharing Agreement was created. This was signed by each GP practice and local health and care organisation to allow the viewing of relevant, real time clinical information within a CHOC locality MDT meeting (as long as the patient gave consent). It also enables all the professionals involved in the multi-disciplinary teams to communicate and input data outside of the CHOC MDT meetings, where the patients are discussed. This has greatly improved efficiency and the ability to see more patients.

The agreement also enables those involved in the person's care to add to the record immediately during the multi-disciplinary meetings so that, for example, if the patient's specific GP is not at the meeting, the team can see exactly what happened and what the recommendations are.

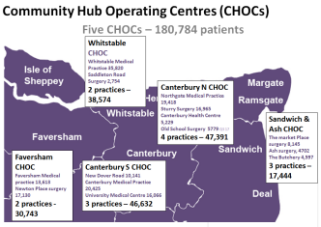
10.3 Alliance working



Encompass has developed a governance structure with partner organisations across statutory and non-statutory organisations to deliver the model of care. This Alliance approach is moving towards holding a formal contract to deliver services in collaboration. This approach has been shared and is being replicated across other localities

10.4 GP incentive scheme

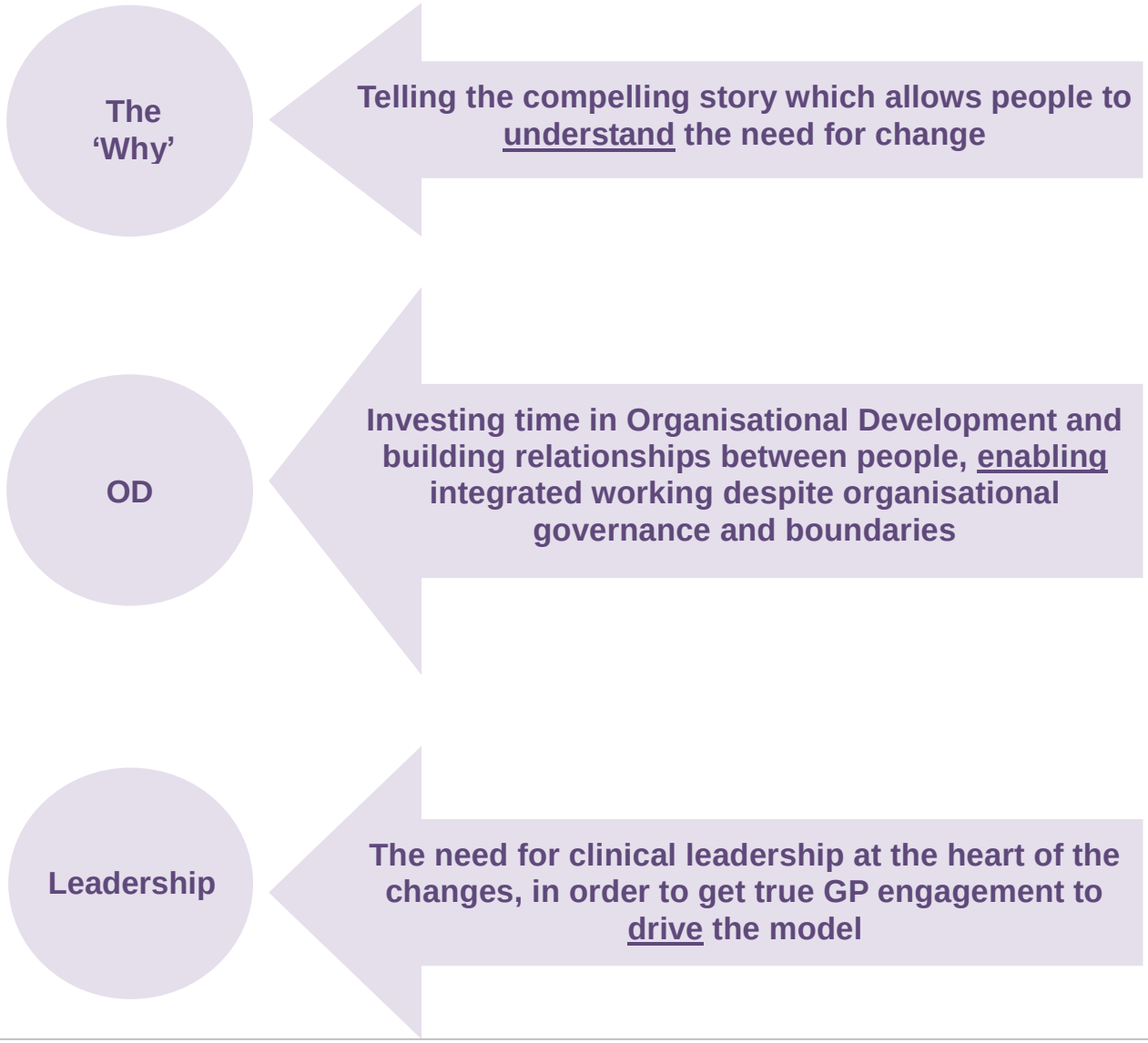
Encompass is implementing a three phase incentive scheme to enable and support Encompass practices to engage in, and deliver the local care model in line with the GP Forward View and STP vision. Incentives will be shared across the footprint and encourage joint working and sharing of resources.



10.5 Leadership and communication

During the Encompass journey we have observed **three** key factors for success in 'engagement in the model' to make it sustainable:

- The 'Why'
- Organisational Development
- Clinical leadership



All of the above takes time and sets a challenge in a system with pressure to change at speed and scale.

However, in order to tackle the system pressures outlined at the start of this report there is a need to work differently across a wider footprint and increase the scale and pace of transformation. A critical element in achieving this will be organisations proactively supporting their staff to align to the new ways of working. In Encompass the move to formation of a Strategic Alliance Board, including all key partners from across the health and care system, provided a catalyst for cultural change in shared accountability.

To ensure engagement of the model, relationship building cannot be underestimated. Nor can the **'ability to hold your nerve'** while putting the foundations in place to establish and grow New Models of Care. This can be especially true when the pressure is on to demonstrate results before the New Models have had sufficient time to develop, deliver and embed. Benefits of this time investment may not be apparent or measurable in the short term, however a lack of them will show in the medium to long term. The quote below was paraphrased by an Encompass clinician at the November (Q2) quarterly assurance meeting in 2017 with NHS England

"Not everything worthwhile can be measured, and not everything that can be measured is worthwhile"

11. Replicability and spread

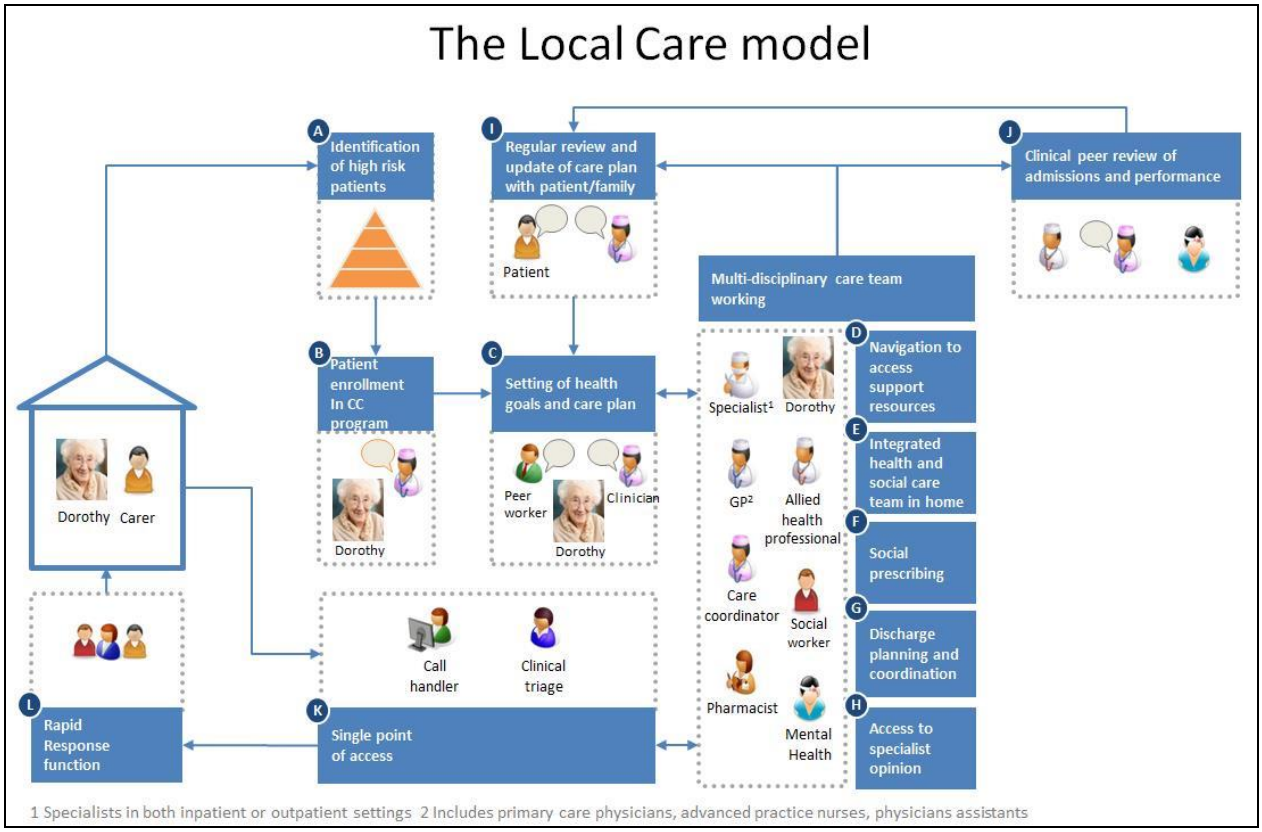
As a vanguard Encompass is expected to share learning. A selection of examples is given below of both local and national sharing of our work.

11.1 Locally

Locally this has been with:

- Partners in the Kent and Medway Sustainability and Transformation Partnership (STP) and influencing the STP work streams
- Statutory organisations such as Public Health, KCC and East Kent CCGs
- Members of the public at events such as Patient Participation Groups, Community Networks and Practice Open Day. Patient Leaflets into surgeries and the production of a patient focused film describing the New Models of Care
- The voluntary sector such as League of Friends, Women's Institute and Red Zebra (Umbrella org)
- The care sector such as the East Kent Carers Forum and Kent Health Watch
- Primary Care Practice engagement sessions locally and sharing the learning and resources developed across other localities and CCGs

The CHOC model is being used as the template for care of our most vulnerable (shown below), especially the frail elderly. This is at the heart of the frailty pathway, a multiagency pathway with focus to care for people in a community setting to avoid hospital admissions.



A number of promotional videos have been produced to share the learning, some of which have been mentioned earlier, such as the Encompass video in **section 7** and WaitLess video in **section 6**. The STP has made a 'Case for Change' video and the Encompass model is included in the video as a case study. A link to this video is in the box **below.**

To watch the STP 'Case for Change' video go to:
https://vimeo.com/226010439

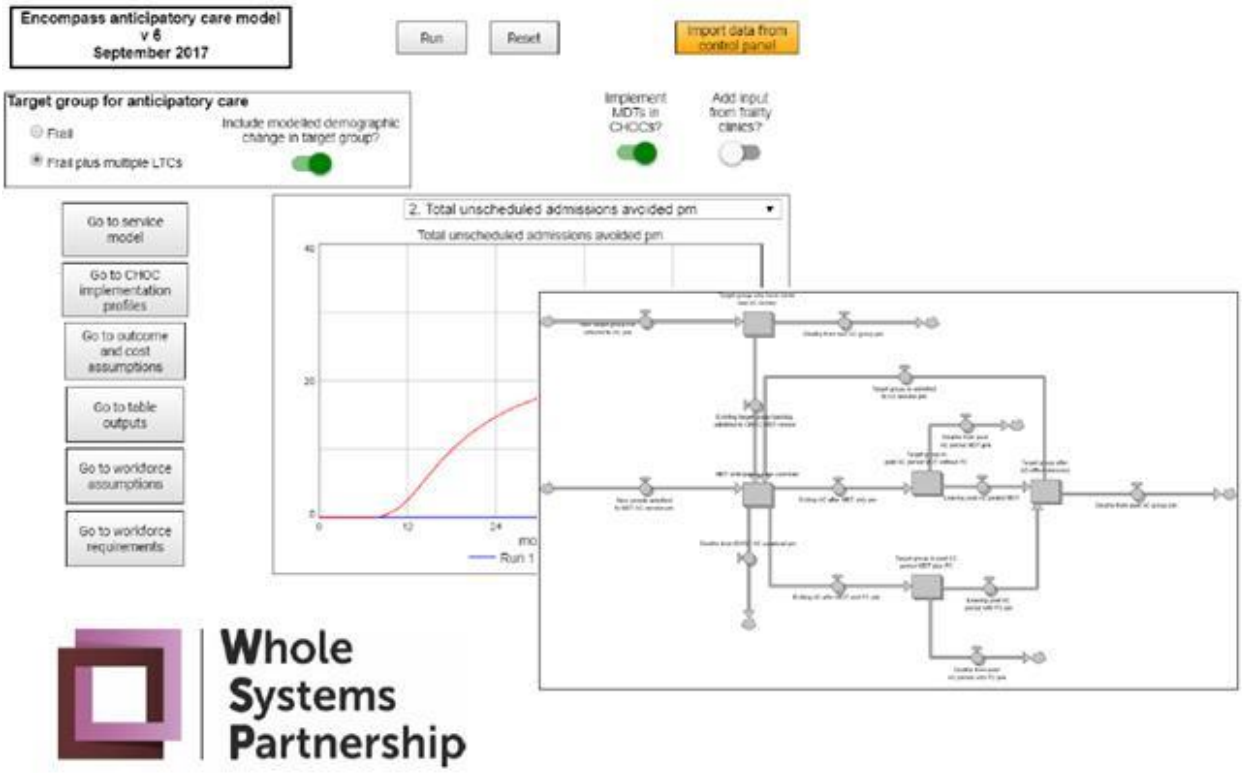
Encompass has been working with the STP and sharing learning from the New Models of care. We have produced a legacy slide set to explain the Models of Care and our journey and learning. This was presented at the STP conference in October 2017.

11.1.1 Understanding what services need to look like in the future

We have explored what the **demand**, **capacity** and **workforce** requirements would be for us to be able to continue to offer an ICM service to all patients that would benefit from it in the medium to long term. Working with 'The Whole Systems Partnership', we used a system dynamics modelling approach which draws on the rich data that is available from the Kent Integrated Dataset (KID) and from projections of underlying population health needs. The diagram **over leaf** shows the model developed by Whole Systems Partnership.

The model can also be configured to work in other geographical locations, helping with planning and implementation on a wider footprint to Encompass. It has been presented

to the East Kent STP Workforce Work Stream to consider whether the Tool might be utilised by the East Kent STP Workforce Work Stream in respect of workforce modelling for local care.



11.2 Nationally

Nationally we have spoken at forums and conferences. A number of articles have been published in specialist national media such as the Practice Nurse Journal, Primary Care Today and Pulse.

Secretary of State for Health - Visit

On 23 June 2016 Jeremey Hunt visited Encompass to learn more about the development of new ways of working to improve health and wellbeing services.

The event was attended by GPs from Encompass practices, leaders of partner organisations, representatives from the voluntary and community sector and members of the Encompass team.

Our website contains information about our services and case studies. We tweet our latest news on twitter and share good practice on the National e-newsletter **(shown over leaf)**. We have represented Encompass at Expo on a yearly basis and have produced a number of case studies for NHS England. We have been supporting CQC

with developing a regulation model for primary care at scale and have hosted a number of visits from other organisations to share the learning from our model.

National e-newsletter - example

Vanguards sharing good practice

New app gives people A&E waiting times

The WaitLess app designed by Encompass (Whitstable, Faversham, Canterbury, Ash and Sandwich) vanguard provides people with waiting times at all A&E departments and minor injuries units in East Kent. This is the first app to offer real-time updates combined with travel time information. It also uses a person's location to sign-post them to minor injury units if applicable, taking pressure off A&E services.

Issue 50 - Friday 27 January

The latest from the vanguards

- **Encompass (Whitstable, Faversham, Canterbury)** vanguard has produced a video about their work.

A number of documents and learning have been shared with NHS England and through presentations and discussions at our quarterly assurance meetings with NHS England. Clinicians on the front line delivering and shaping the New Models of Care have spoken at the assurance meetings about the benefits of the new ways of working.

At the Q1 and Q2 2017 assurance meetings it was noted that staff motivation and retention is a key contributor to sustainability of the model.

Q2 (Nov 17) assurance meeting quotes

"You should be really proud of what you have done. You have held your nerve and made **great progress across the model**."

Jane McVea, NHS England

"This work has reached a pivotal point; hold on to this, **this is the solution**. Hold onto local care as the solution."

Simon Perks, C4G AO

National recognition for work on local care – CCG Message 3 Oct 17

"

The way that **multidisciplinary** working at the Butchery Surgery in Sandwich is contributing to **high-quality care** has been highlighted in a new report published by the **CQC**.

The State of Care in General Practice 2014 to 2017 highlights evidence of practices, rated as **outstanding**, where **multidisciplinary team meetings** are having a **positive impact on care**.

As part of the work being led by **Encompass MCP**, the practice was involved in setting up a community hub operating centre (CHOC) within the town. This involved bringing together a team from different disciplines such as mental health, social care, community nursing, voluntary organisations and GPs to help make sure that the identified patients had a **joined-up care plan**, which met their needs, and focused on keeping them well at home.

Well done to everyone involved.

Accountable Officer, NHS Ashford and NHS Canterbury and Coastal CCGs

"

12. References

1. NEW CARE MODELS: Vanguards - developing a blueprint for the future of NHS and Care Services. 2016
   https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

2. NHS England (2014) Five Year Forward View [online] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

3. NHS England South (2016), Sustainability and Transformation Plans [online] https://www.england.nhs.uk/south/info-professional/stps/

Transforming health and social care in Kent and Medway

Local Care, Journey to Date and Next Steps:

This document seeks to do two things;

1. Give a brief recap of progress to date (July 2018) and
2. Suggest areas of action moving forward with the delivery of Local Care.

Situation:

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.

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.

* Data source Carnall Farrar

Background:

- In September 2017 the * Local Care investment case was agreed by the STP Programme Board. The intention to deliver better care and achieve £260m in cumulative net savings by 2020/21, and £143m per year thereafter across Kent and Medway
- The model was to be delivered through having designated Multi-Disciplinary Teams (MDTs) across Kent and Medway, bringing together staff from the health, social care, and the voluntary sector
- The focus has been on embedding MDT working and significant progress has been made in some areas
- The Encompass Vanguard provides compelling evidence of the impact that can be achieved when MDTs are properly resourced
- The Local Care Maturity Matrix demonstrated that overall progress across the STP has not been as rapid or universal as planned, and significant variation exists between areas.

* Data source Carnall Farrar

Assessment:

- Plans have moved on significantly since last autumn in their granularity
- Significant time and effort has gone into the planning
- Level of provider confidence in Local Care is still developing, in terms of both the progress of delivery and the scale of impact
- Level of engagement with partners varies significantly between CCGs and all areas have more to do to work jointly with local authorities and voluntary sector in particular

- To date the system has managed to identify **investment of £32M for Local Care**
- The planning exercise was initiated April 2018 to help localities progress both their operational and financial plans, in line with the **Local Care Investment Case, (which both the STP Programme and Implementation Boards have had sight of).**
- A planning exercise, completed by all 8 localities (CCG localities), allowed the ability to review this bottom up approach and compare to the top down approach of the original investment case.

The conclusions, in relation to the aspiration set out in the Investment Case show that the locality plans;

- aim to achieve 95% of the A&E savings, 79% of the Non- Elective (NEL) admission savings, but
- only 24% of the Occupied Bed Days (OBD) savings in 18/19
- Furthermore, CCGs plan to invest more in workforce and associated costs than was estimated in the Investment Case by 34%.

Recommendation:
There is a need for 7 critical areas to be addressed:

1. The STP payment mechanism
The need to ensure the money flows from commissioners to providers (the “mechanism”) within the contract to support investment in Local Care with consideration for;

- A performance incentive,
- Allocation based on A&E attendances, NEL admissions and OBDs
- The payment system should be based on robust analytics
- The need to clarify how you want to share risk (e.g. pooling of risk between providers)

2. Information flow
The need for information is critical .

- Population segmentation
- Agreed data-sharing or Joint Control agreements to be in place
- Performance dashboard with shadow capitation for each locality
- Minimum information requirements to deliver in 2018/19 and 2019/20

*There is a risk in delivery of the investment case if no progress is made in this area.

3. Change in core processes
To implement MDTs will require changes in the core process across organisations and team working and a need for a level of consistency. Alongside this there is a need for an organisational development programme to help facilitate the changes required.

4. Workforce
There is a need to define workforce requirements at a local level, establish gaps and plans to address these.

5. Estates
The Estates workstream is crucial for the role out of Local Care, in the development and implementation of both short-term and long-term estate strategies.

6. Communications and engagement
There is a need for continued communications and engagement for Local Care; supporting all communications across Kent and Medway, organisational development/ relationship building and co-design of services.

7. Governance

• Ensure maximum leverage by having a designated team (comprising of the CCGs and provider organisational leads) to drive Local Care
• Do not approve CCG contracts that do not embed the payment mechanism
• Likewise, do not approve capital plans without ensuring they include the Local Care aspiration
• Clarify the role of:

- STP governance
- CCG governance
- The Local Care, Workforce, Digital and Estates workstreams
- Provider and CCG Local Care Operational Leads

Areas to address	Key Actions	Progress to date
1. The STP payment mechanism	• Development and agreement of a performance incentive framework/scheme, • Allocation of monies based on agreed performance metrics; i.e. the per 1000 rates of A&E attendances, NEL admissions and OBDs • A payment system based on robust analytics.	• Local Care supported by Finance group • Extra-ordinary Finance / Local Care Directors meetings held (25/4/18 and 22/6/18). Deep dive into the proposed investment of £32M at meeting 27/7/18. • Local Discussions happening to review contractual and payment mechanisms
2. Information Flow	• Population segmentation to support decision making; to identify patients for enrolment for integrated case management • Agreed data-sharing or Joint Control agreements in place • Establishment of a performance dashboard (agreed shadow capitation for each area and ensure transparently) • Define the minimum information requirements to deliver in 2018/19 and 2019/20 • Data-sharing or Joint Control agreements are in place	• Analyst in post; Working with the “Community of Practice “ and Whole Systems Partnership • Analytical support offered to local Care Leads • “Top Tips” for MDT working includes detailed advice for data sharing from updated GDPR 2018. • July 2018 – work has started with Local Care Leads to develop dashboard and metrics • Time line agreed for reporting

Areas to address	Key Actions	Progress to date
3. Change in core processes	• Regular observations of MDT meetings within each locality and provide practical ongoing advice • Re-run the maturity matrix in October 2018 • Agree: a) Metrics and dashboard b) Level at which these metrics are measured and reported at c) Process for reviewing this information.	• MDT observations undertaken and development of MDT "Top Tips" • Local Care Leads have agreed timeframe of events for 2018/19 ; plan re-fresh, reporting and ongoing development (see appendix 1) • Reporting framework to be in place for Sept 2018 Local care Implementation Board
4. Workforce	• Identify common workforce issues across CCGs that require common solutions • Workforce workstream to develop overall Kent and Medway short-term and long-term workforce strategy for addressing the gaps in capacity • The strategy should address the roll out generic health and social care working training	• Local Care investment aligned to workforce planning • Local care risks align to workforce workstream • Local Care workstream Lead member of the LWAB to develop the K&M workforce strategy

Areas to address	• Key actions	• Progress To Date
5. Estates	• Agreed estates strategy for Local Care	• Local Care workstream Lead working closely with estates workstream • Local Care integral in the capital bid process • Item for the July 2018 Local Care Implementation Board- desired outcome to get agreement for an integrated approach to revue of estates in each locality
6. Communications and Engagement	The need for continued communications and engagement on Local Care; • Communications and engagement strategy and plan developed and agreed • CEOs of three acute trusts (DGS, MTW, MFT) and KMPT to nominate a Local • Care Operational Lead (a request was sent to providers in Feb, but nominations have only been received from EKHUFT, Virgin Care and KCHFT) • Local Care workstream to send out a communication of progress and next steps to both the staff and public • CCG Local Care leads to conduct grassroots work with local GP practices	• Objectives for Local Care 2018/19 (appendix 2 and overarching Communication Strategy agreed at the May 2018 Local Care Implementation Board • Local Care workstream lead working closely with new Director of Communications and Engagement to work on detailed plans for Local Care, specifically; ➢ Language, internally and externally ➢ Sharing progress/ learning of Local Care ➢ Good news (see Appendix 3, draft communications and engagement plan) Local Care Workstream to articulate the offer of support from the central team to support Localities (appendix 4)

Areas to address	Key Actions	Progress to Date
7.Governance	Governance: • Ensure maximum leverage from a single management team from the CCGs and from the Implementation Board • Do not approve CCG contracts that do not embed the payment mechanism • Likewise, do not approve capital plans without ensuring they include the Local Care aspiration Clarify the role of: ➢ STP governance ➢ CCG governance ➢ The Local Care, Workforce, Digital and Estates workstreams ➢ Provider and CCG Local Care Operational Leads	• Agreed Governance structure (appendix 5), • Review of STP governance - there is presently a review of the governance across the STP and now is time to have a discussion as to the potential support required for implementation of Local Care.

Appendix 2:Local Care aim, objectives and key deliverables for 2018/19

Aim:
To provide holistic and integrated care in the community for frail and elderly patients and those with complex needs in K&M, and avoiding unnecessary hospital admission

Objective 1:
Development of 8 locality integrated plans for the investment and implementation in Local Care

- Template developed and tested with partners
- Roll-out of templates and
- Develop suite of assessment metrics to develop a set of agreed outcomes
- Evaluation and assessment of plans

Objective 2:
Establish standardised Multi- Disciplinary Teams working with GPs at scale

- Identifying best practice guidance on MDT working “Top Tips”
- Roll out risk stratification for the identification of patient cohorts for MDT working
- MDT working conference
- MDT working guidelines and framework
- Develop outcomes for assessment and evaluation

(allowing for local flexibility to meet population requirements)

Objective 3:
Develop inter-agency partnerships to deliver local care at scale

- Establish Implementation Board and Governance framework
- LC leads learning set in place
- Secure commitment and buy-in to deliver local care
- Develop Care Navigation/Social Prescribing, to deliver LC in partnership with KCC
- Develop guidelines and competencies framework/ recruitment/resource plan

Objective 4:
Expansion of the model after 18/19, to reflect the wider population

- Support localised population profiling for prioritising next phase of implementation with localities
- Engagement with the clinical strategy aligned to LC

Dovetailed plan of work linking with enablement work-streams to deliver

Appendix 3:

Local Care Communications and Engagement 2018/19

Objectives

- To improve *understanding of the vision and ambitions* for local care among staff, patients, public and stakeholders, particularly around the benefits of establishing multi-disciplinary teams
- To ensure frontline staff are *confident and know how to run multi-disciplinary* teams with GPs at scale by sharing advice and best practice
- Identify opportunity for co-design to ensure target groups are given genuine opportunities to be involved and feedback
- Ensure consistent approach and messaging across health and social care to avoid confusion with multiple models
- To support partnership working and create a climate for cultural change
- *Gather data, insight and learning* to support design of models of care for the rest of Dorothy's family and other key groups as prioritised to ensure their feedback helps to *shape future models*
- Ensure alignment with communication and engagement activities with other workstreams, particularly workforce, digital, estates and primary care.

Milestones	Timing
• Refresh **stakeholder map**	July
• Prioritise engagement around **local care language**	July/Aug
• **Content plan** and commit to monthly updates on local care via STP bulletin with local care case studies	Aug
• Launch **campaign** to tell whole story of local care	Sep/Oct
• Update and review **core materials** – local care booklet, update STP website, hub map, film, FAQs for different audiences	Sep-March
• Co-design model for **social prescribing**	July-Sep?
• Co-design model for **care navigation**	July-Sep?
• Publicise **cluster organisational development toolkit** to support cultural change	TBC
• Co-design models of care for the **rest of Dorothy's family**	In progress
• Co-design model for **carers app**	Mar 2019

Decisions / inputs required e.g. from other workstreams

- Decision on which terms to engage on for local care language
- Content for July STP bulletin

Immediate risks and issues

- Pace needed for local care language piece, as many terms already in use
- Full list of risks are detailed in full strategy

Appendix 4: Local Care Offer Mapped Against The NHS Change Model, 2018

Skills packages for;
- Appreciative Enquiry
- Leadership
- Accountability
- Learning Styles
- Working styles
- Understanding your locus of control

Facilitation of System Workshops and OD for;
- Stakeholder mapping
- Co- design Workshops
- Engagement and messaging

Links to local and national drivers;
- CQC
- NHSI and NHSE
- Other STP workstreams
- Support for business planning

Analytical Support;
- Help with data analytics
- Support with cohort identification
- Data modelling and KPIs
- Working with partners on future data requirements
- Help to know what data to gather and what is already available

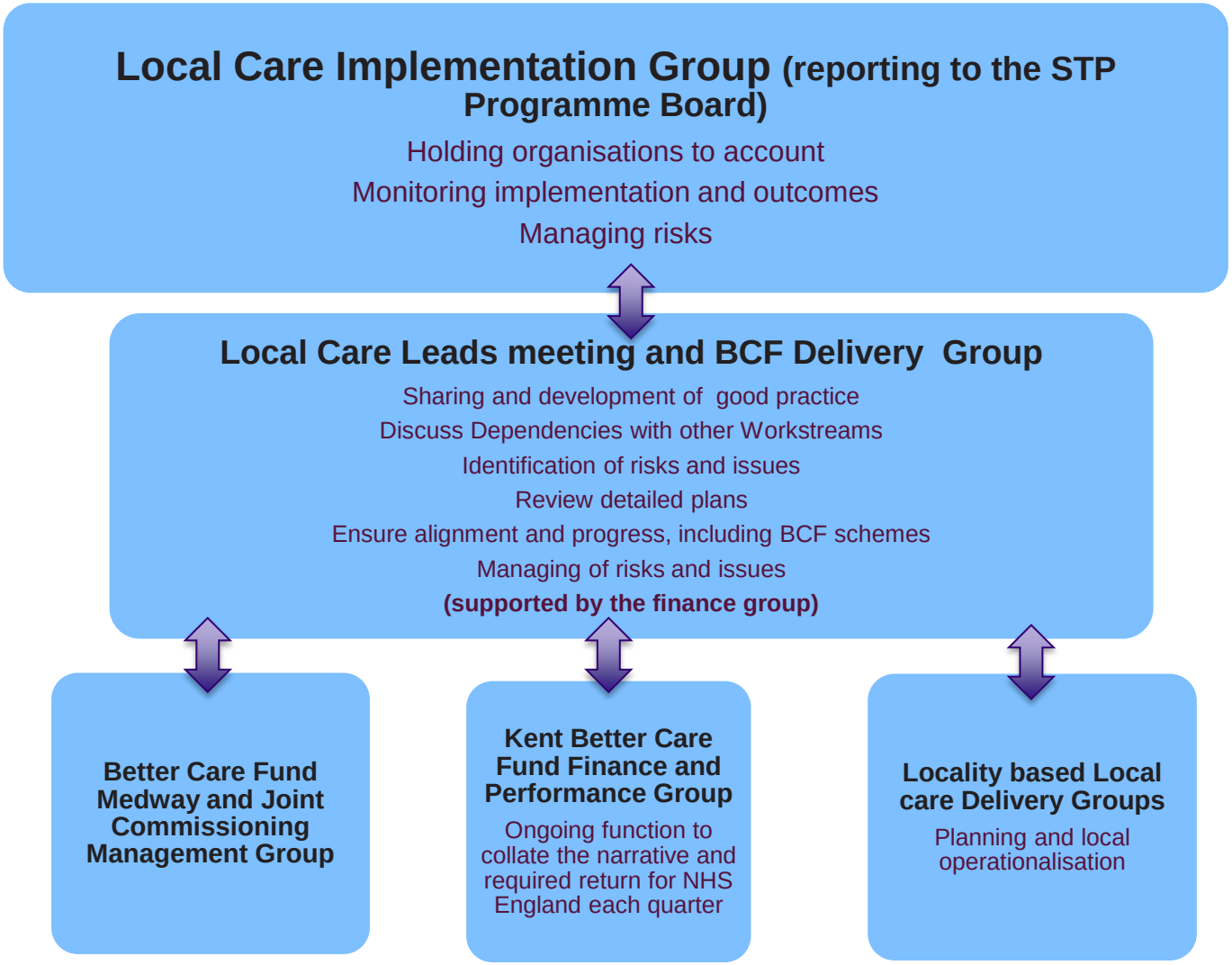
Skills packages for;
- Change management
- Resilience
- Sustainability
- SBAR effective communication

Quality Improvement tools;
- PDSA Cycles
- Logic Modelling
- Process Mapping
- Service re design
- Rapid improvement workshops
- Thinking Differently
- Working Productively
- Workplace organisation 5S

Project Management;
- Project plan templates
- How to run a project
- Introducing Lean efficiency

Developed by Cathy Bellman

Appendix 5: Governance

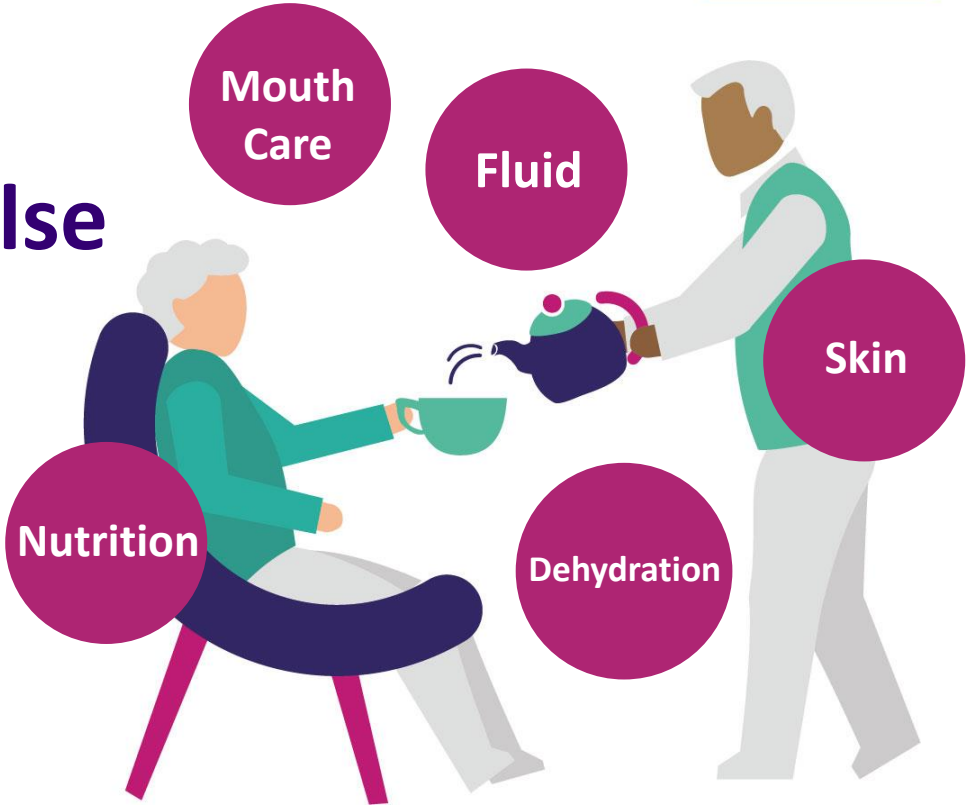


Carers' app

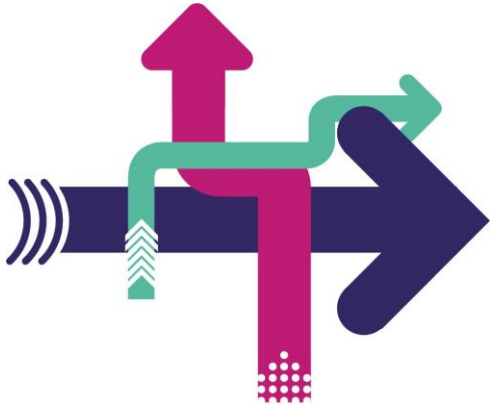
How co-production supports innovation

Supports everyone caring for someone else

Contains the fundamental care elements to keep people well, and out of hospital (nutrition, hydration, skin integrity etc.)



Building on success:



Innovation;

- Mobile digital solution
- Ease of access

Quality;

- Consistency of Practice across Kent and Medway
- Early detection of deterioration in health
- Access to standardised Education and Training
- Can be easily and centrally updated
- Information on services in each locality

Co-production Session

Carers' Voice

Expert clinical opinion

Clinicians

Patient Public Participation

Education

Administrators

Local government

Carer's Service users

Technical advisors

Helen Rignall

Primary Care Workforce Tutor

Brighton and Hove Clinical Commissioning Group

Transforming health and social care in Kent and Medway

Medway Council
Serving You

Kent County Council
kent.gov.uk

NHS

Kent and Medway Sustainability and Transformation Partnership:

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Carol Munt, patient partner and advocate
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70 YEARS OF THE NHS 1948 - 2018

Health and Care
Innovation Expo

Carers' app

How co-production supports innovation

Stop Look Care booklet

Originally designed by Brighton and Hove CCG, as a reference guide for people caring for others; promoting awareness of certain needs and identifying concerns and when to act.

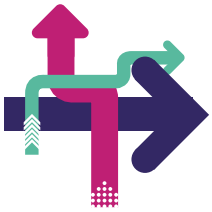
(shortlisted for a Nursing Times Award 2018).

Encompass Vanguard in east Kent, (one of the 44 NHS vanguards testing out new models of care), is taking this initiative another step with the development of a carers' app.

The app will

- have all relevant information included in the carers' booklet
- provide details of local services and sources of help and support
- have access to online videos
- have access to accredited online training resources.

The approach



Kent and Medway STP has agreed to support the vanguard work and develop the app across its footprint to ensure continuity in:

- the quality of care provision for all carers
- standardisation of training for employed carers
- the index of services in each locality to support carers, keep people well and in their own home environment, and to help avoid hospital admission.

There has been a real focus on collaboration with patient/carer leaders in development of the app; true co-production.

Transforming health and social care in Kent and Medway

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Transforming health and social care in Kent and Medway

Local Care Updates Sept 2018

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

East Kent

- Consistent care model signed up to across East Kent – current finessing the specific workforce configuration as part of the Pre-consultation Business Case (PCBC) work
- Focus on Integrated Case management for patients with complex needs
- Robust third sector and community development and primary care at scale (30-50,000 population)
- Investment for general practice transformation to support delivery of local care plan -expansion of MDTs, delivery of GP Forward View working at scale (30-50,000population) and development of 10 high impact changes.
- Alignment to East Kent Urgent/Emergency reconfiguration
- Developed and agreed a realistic trajectory for activity for integrated Case Management Model
- Hospital patient tracking list live in 2 areas, with plans to implement across East Kent (to support data sharing for Multi-disciplinary Team [MDT] discussions)
- Agreed consistent methods to measure activity and impact
- Contracts awarded to deliver Improved Access across East Kent from October 2018
- All areas have established extended primary care networks
- Development of collaborative/alliance arrangements; Place based models
- East Kent to pilot the STP Organisational Development toolkit at MDT and Federation level
- EK wide Governance structured agreed
- Communications support across strategic priorities

West Kent

- Governance structure for Local care delivery in west Kent
- All 7 MDT cluster up and running April 2018
- Provision of medical cover under Local enhanced services to care homes in place
- Training complete and signposting/ care navigation in general practice launched July 2018
- Implementation of new Falls prevention Service planned for Oct 2018
- Rapid response and Home Treatment service being expanded (planned from October 2018)
- Integrated communications and engagement plan in place for 2018/19
- Work is underway to develop a mental health local care model at pace and involving all stakeholders as equal and active partners.
- Implementation of an integrated Community Diabetes model – started Sept 2018
- Outpatient Transformation;
  - Stage 1- Integrated MSK Service Hip, knee, Spine integrated pathway implementation completed
    - Stage 2 - Integrated Pain Management Service completed.

Medway

- Governance arrangements to support Local Care
- Joint Better Care Fund framework for next 4-5 years
- A restructure of Adult Social Care Services into localities aligned to the Medway Model for Local Care took place in September 2017
- Underway with Community Service re-procurement (2/3 Local Care)
- Support for care homes – aligning GPs for weekly ward rounds and medicines review
- 18 new step up/step down beds -support for 72hrs post discharge– with Continuing Healthcare Assessment completed once discharged
- New Social Prescribing model
- Roll out of MDTs underway Co-ordinator role in Place (MCH)
- Almost all practices on EMIS WEB
- Identification of 6 localities – all with identified CCG support and clinical leadership
- Successful capital funding for 2 new Healthy Living Centres
- Undergoing a gap analysis on workforce requirements – using Whole Systems Partnership dynamic modelling tool
- Shifting from specialist to generic roles with providers working together
- Worked with patients and stakeholders to develop the “case manager” role – working with local university to support training (to meet 40% shortage)
- Medway CCG (with the Partnership Commissioning Team) are procuring a comprehensive Care Navigation service from a provider, to begin on October 2018 – part of a bigger social prescribing project lead by Medway Public Health
- Long term condition Pilot focussing on different levels of patient self-activation

DGS & Swale

- Implementing MDTs, working at scale of 30,000 – 50,000 population - first two MDT meetings in DGS. The aim is for 50% of MDTs to be in place and operating by the end of Q3.
- Provide effective Rapid Response services to support reductions in hospital admissions of the frail elderly population and reducing hospital Length of Stay
- Develop and align care navigation models currently operating to better manage patients who require support to manage their medical conditions, access the care they need and to live independently, ensuring avoid hospital admission.
- The focus for 18/19 is on older people with complex needs.
- For DGS 50% MDTs functioning by end Oct 18
- Swale has aligned practices to 3 hubs that meet the 30-50K population levels considered best practice for MDT working– on track, started Sept 2018
- Primary Care home visiting service to be established as per business case
- Business case for wider rapid response service being developed
- Alignment of CCG and provider staffing to MDTs with “team on a page “being developed
- Plan includes interim step of ensuring this alignment is reflected in practice based MDTs already in operation
- There are staffing risks in all providers, therefore working with partners to make best use of staff resources
- This is a key reason to move to locality MDT meetings and away from practice based
- Realignment of existing Care Navigators from Sept 2018 -procurement of new service from April 2019 aligned with Kent County Council

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
9 OCTOBER 2018
STRATEGIC COMMISSIONER UPDATE

Report from: Glenn Douglas, Kent and Medway CCGs Accountable Officer / Kent and Medway Sustainability and Transformation Partnership Chief Executive

Author: Simon Perks, Director of System Transformation, 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:

- the Director of System Transformation has been appointed. Simon Perks will commence his role at the beginning of October.
- an initial set of priorities have been agreed in principle, and will be discussed with CCG Governing Bodies;
- a draft Governance Framework has been developed to support the initial priorities;

- the development of the Operating Framework that will include the operational detail to the implementation of the strategic commissioner has been drafted; and
- a Steering group comprising of 8 CCG chairs, a Kent County Council representative, a Medway Council representative, CCG Lay members and the Accountable Officer for Kent and Medway CCGs has been established alongside the Governance Oversight Group tasked with the development of governance arrangements for Kent and Medway wide working.

2.4 The current intention is for the Strategic Commissioner to operate from April 2019 with an initial set of priorities. During 2018/19 we will be establishing the design and governance arrangements and giving further consideration to options for a long-term solution.

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 is not required unless there is formal merger of CCGs.

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.

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Appendices
None

Background papers
None

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
9 OCTOBER 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 Partnership (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 Appendix 1 to this report sets out the work programme. It should be noted that the work programme is likely to be subject to frequent changes and additions throughout the year and is for guidance only.

2.3 Members will be aware that agenda setting meetings are held on a regular basis. These give officers guidance on information that Members wish them to provide on an issue. An agenda setting meeting took place on 3 September 2018.

2.4 At this agenda setting meeting it was discussed and recommended that the report on Workforce be deferred to the Joint Board meeting on 14 December 2018, following completion of the Workforce Strategy.

2.5 In addition, owing to October's meeting date being brought forward, it was also recommended that the report on the work of the Design and Learning Centre for Clinical and Social Innovation be deferred until December so that Dr Robert Stewart could attend.

2.6 Members also reaffirmed that the report on Encompass Vanguard should be scheduled for the Joint Board meeting on 14 December 2018.

2.7 With respect to the standing agenda item concerning progress on the Prevention Strategy for Kent and Medway, it was recommended that the previously agreed priority areas be scheduled as follows:

- Reducing obesity prevalence (14 December 2018)
- Reducing alcohol Consumption (19 March 2019)
- Physical activity (date to be determined).

3. Dates for future meetings

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

Meeting Date	Agenda Despatch
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. Recommendation

6.1 The Kent and Medway Joint Health and Wellbeing Board is asked to agree the work programme attached at Appendix 1 to the report and to consider whether any changes need to be made.

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Appendices
Appendix 1 – Work Programme

Background papers
None

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD WORK PROGRAMME

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

a) Progress on Prevention Strategy for Kent and Medway

The Joint Board will explore the following priorities in more depth:

- Reducing Tobacco usage prevalence (19 October 2018)
- Reducing Obesity prevalence (14 December 2018)
- Reducing Alcohol Consumption (19 March 2019)
- Physical activity (date to be determined)

b) Progress on Local Care including Local Care Implementation Board

c) Workforce

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

Meeting Date (despatch date)	**Item**
14 December (6 December 2018)	Progress on Prevention Strategy for Kent and Medway – focus area reducing obesity prevalence
	Progress on Local Care including Local Care Implementation Board
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities
	Encompass Vanguard
	Work of the Design and Learning Centre for Clinical and Social Innovation
19 March 2019 (11 March 2019)	Progress on Prevention Strategy for Kent and Medway – focus area reducing alcohol consumption
	Progress on Local Care including Local Care Implementation Board
	Workforce
	Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities

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