APPENDIX D

Post conference report

Multi-Disciplinary Working Conference – The heart of local care

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

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

Contents

Appendices

Background

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

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

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

The conference

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

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

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

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

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

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

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

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

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

Summary

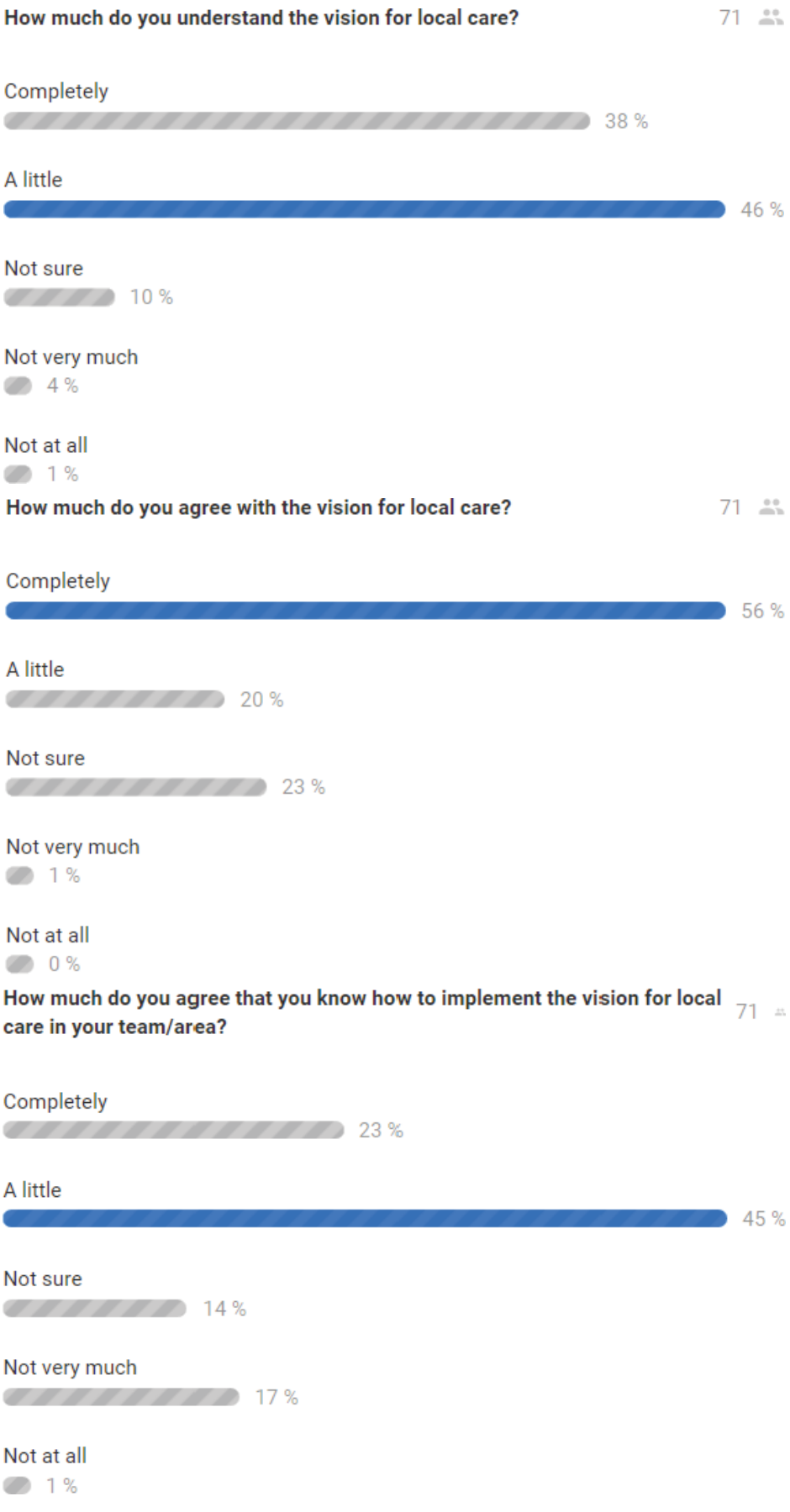
The aim of the day was to share the great examples of multi-disciplinary working and make sure we have the energy and ideas to put it into practice across Kent and Medway.

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

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

Appendix one: Sli.do analytics

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



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

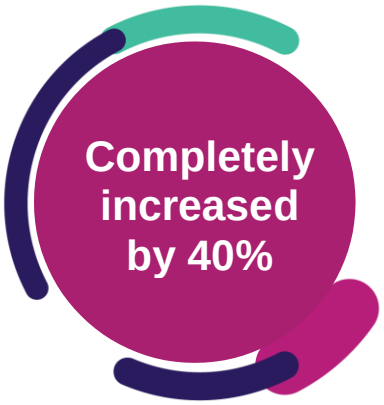
Completely 78 %

A little 23 %

Not sure 0 %

Not very much 0 %

Not at all 0 %



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

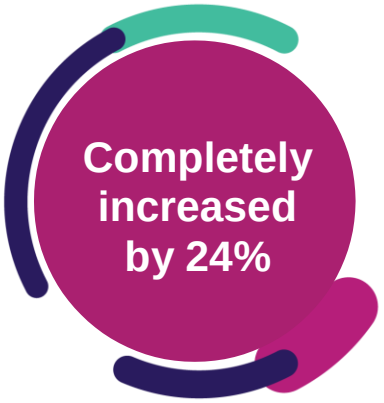
Completely 80 %

A little 18 %

Not sure 3 %

Not very much 0 %

Not at all 0 %



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

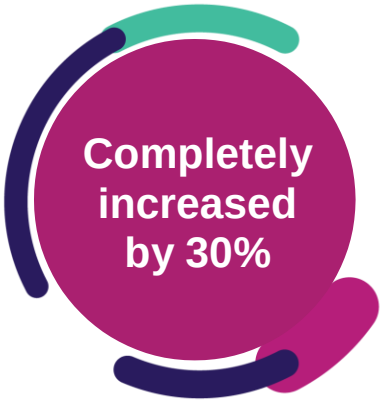
Completely 53 %

A little 43 %

Not sure 5 %

Not very much 0 %

Not at all 0 %



Attendees asked 49 questions with a total number of 73 likes

90% of questions were asked anonymously

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

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

What were the most popular questions?

Anonymous 6 0

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

Anonymous 5 0

How are adult social care and health working together?

Anonymous 4 0

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

Anonymous 4 0

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

Anonymous 3 0

Can we turn the air con off? ☃️

What were the main topics?

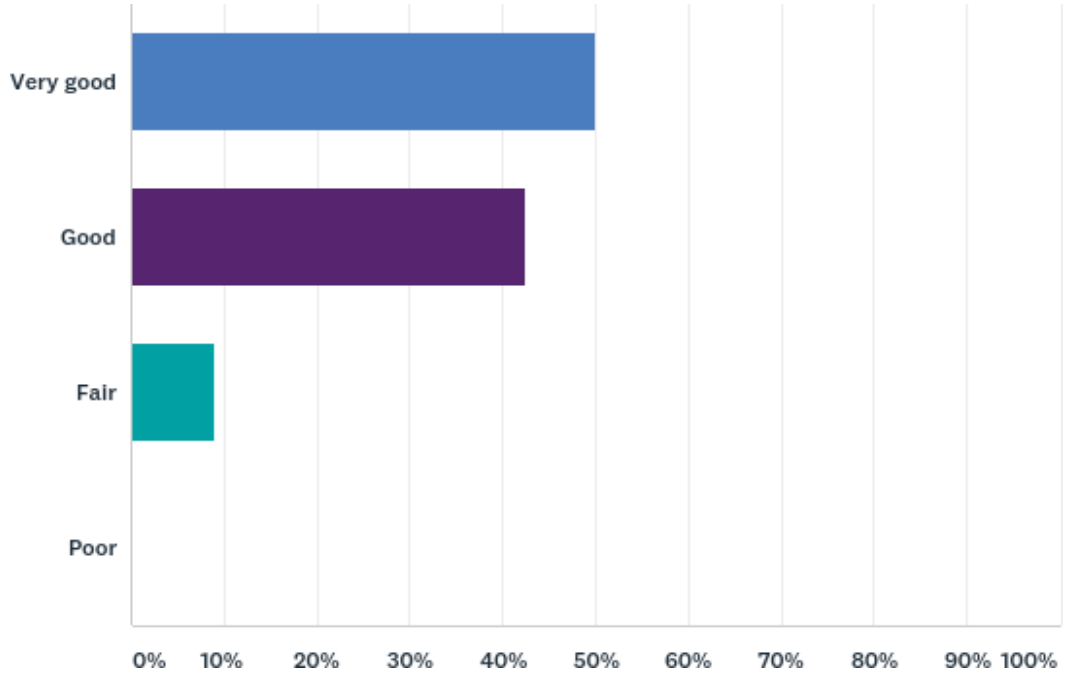
Who were the most influential participants?

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

Appendix two: Delegate feedback

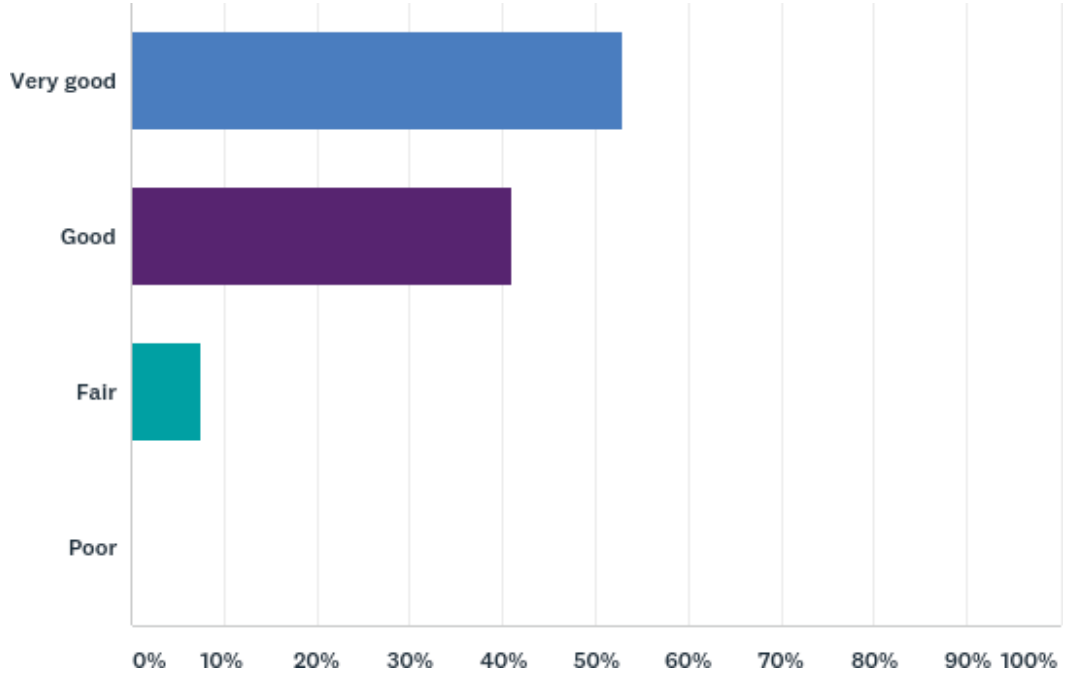
Total number of delegates: 193
Total number of respondents: 66
34 per cent of delegates completed a feedback survey.

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



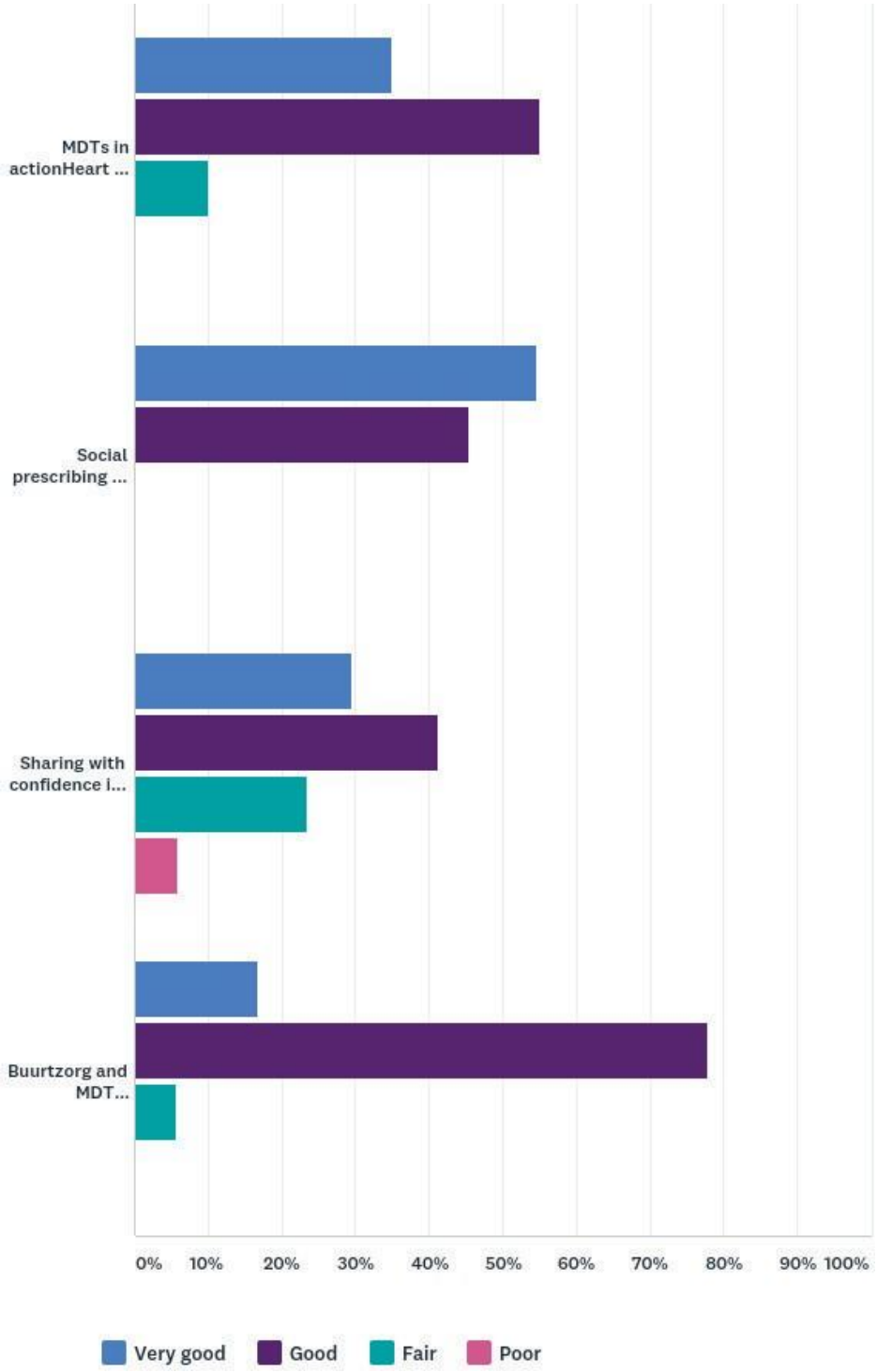
ANSWER CHOICES	RESPONSES	
Very good	50.00%	33
Good	42.42%	28
Fair	9.09%	6
Poor	0.00%	0
Total Respondents: 66		

Q2. How would you rate the venue?



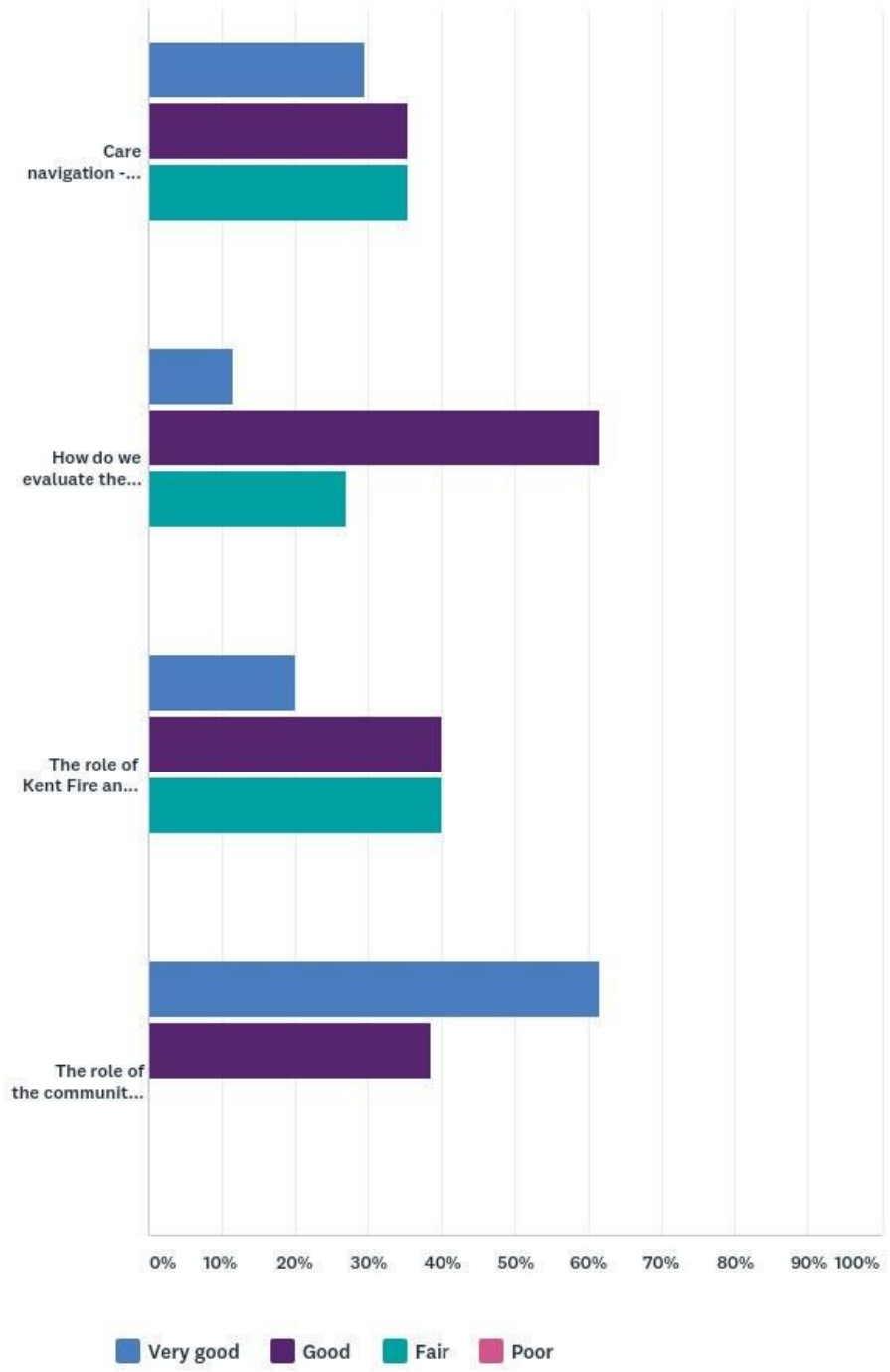
ANSWER CHOICES	RESPONSES	
Very good	53.03%	35
Good	40.91%	27
Fair	7.58%	5
Poor	0.00%	0
Total Respondents: 66		

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



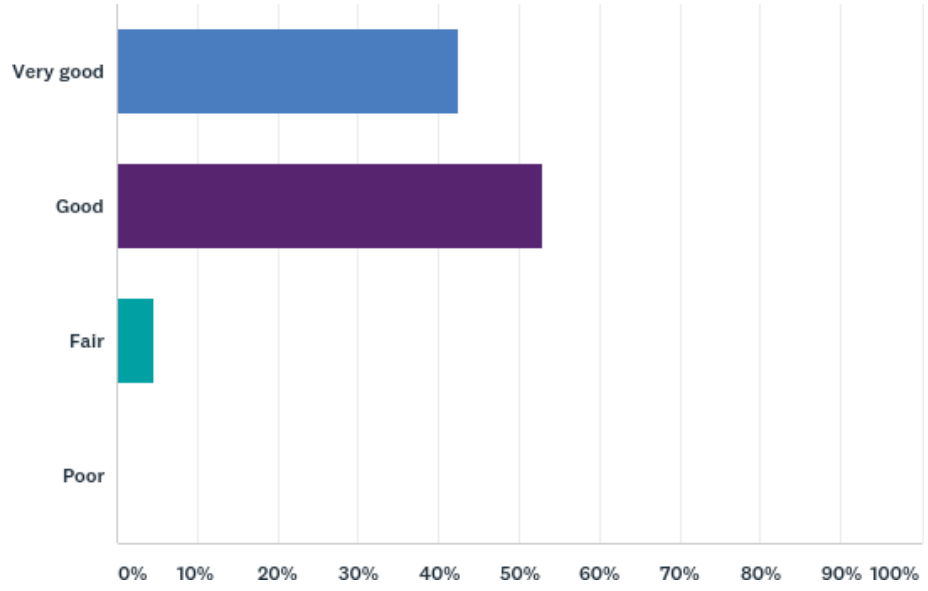
	VERY GOOD	GOOD	FAIR	POOR	TOTAL
MDTs in actionHeart of Kent (front)	35.00% 7	55.00% 11	10.00% 2	0.00% 0	20
Social prescribing – what is it?Heart of Kent (middle)	54.55% 6	45.45% 5	0.00% 0	0.00% 0	11
Sharing with confidence in MDTsHeart of Kent (back)	29.41% 5	41.18% 7	23.53% 4	5.88% 1	17
Buurtzorg and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

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



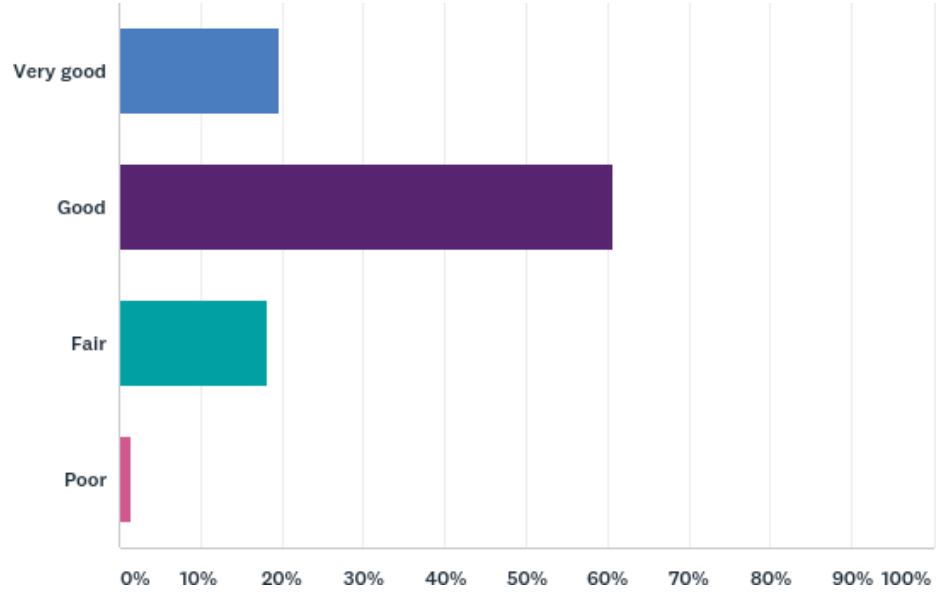
	VERY GOOD	GOOD	FAIR	POOR	TOTAL
Care navigation - what is it and who does it? Heart of Kent (front)	29.41% 5	35.29% 6	35.29% 6	0.00% 0	17
How do we evaluate the impact of MDT working?Heart of Kent (middle)	11.54% 3	61.54% 16	26.92% 7	0.00% 0	26
The role of Kent Fire and Rescue in MDT workingHeart of Kent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

Q5. How would you rate the main presentations?



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

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



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

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

Answered: 58

Skipped: 8

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

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

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

Answered: 40
Skipped: 26

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

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

Q9. Do you have any other comments or suggestions?

Answered: 31
Skipped: 35

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

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

Appendix three: Twitter engagement

#KMlocalcare

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

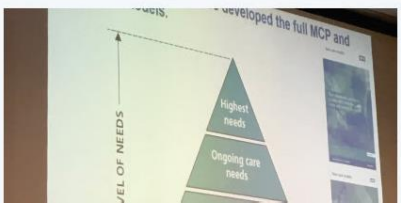
Red Zebra Social Prescribing @BeWellKent
Shelagh @jupiterhouse1 &Gwenno delivering great talk . Good to work with them in MDT's.Excited to see #pimpmyzimmer #kmlocalcare @CathyBellman @AgelessThanet @NHSCCCCG #socialprescribing @kmptnhs @ARTofWellbeingW #CommunityEngagement

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

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

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

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



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

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

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

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

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

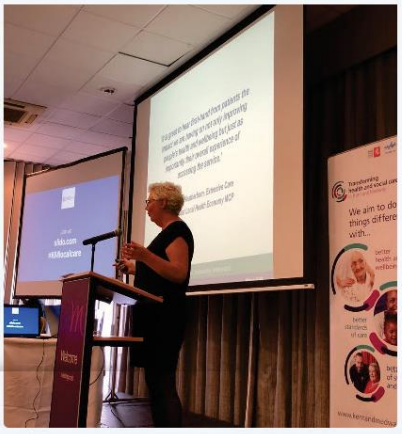
Carrie Mandeville @mumwifenurse
Watching the awesome Gwenno Batty and @jupiterhouse1 present the workings of the frailty team within the context of local MDTs #KMlocalcare https://t.co/qskVzGFIDJ

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

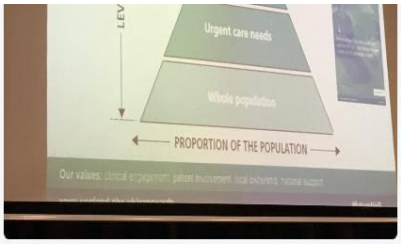
CityImpactKent @CityImpactKent
Sarah Pugh saying hospices can support local care with expertise in endoflife , enablement & preventing crisis #kmlocalcare @CathyBellman @BeWellKent @NHSCCCCG @T4CG #community

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

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

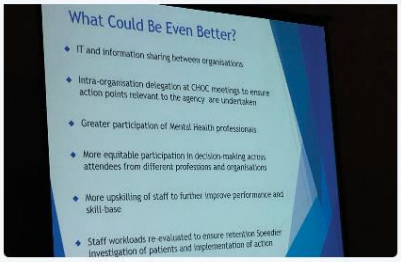


Shelagh O'Riordan @jupiterhouse1
The 2 queens of @NHSKentCHFT frailty team have found their correct chairs! #KMlocalcare https://t.co/3uryGxepSE



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

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



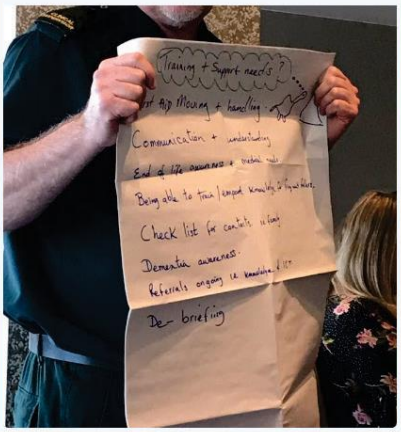
Carrie Mandeville @mumwifenurse
Great workshop from John @SECAmbulance talking about the role of the community guardian volunteer to provide non injury fall support to patients
👍🏻#KMlocalcare @KMhealthandcare
https://t.co/Oqf6L4AYAE

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

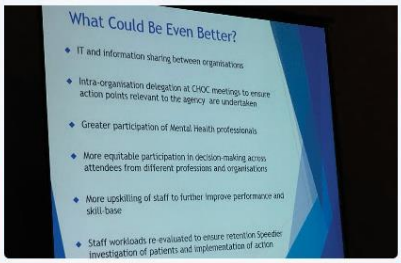
Jo Frazer @Jo_Frazer
Quote from @josdeblok "let nurses, nurse" - good luck to the #Buurtzorg pilot #KMlocalcare @KentDLC @KMhealthandcare https://t.co/ql61cJh73X

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

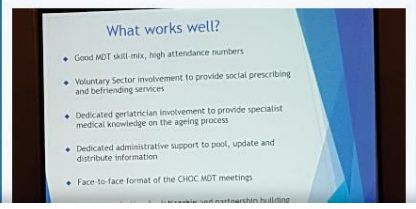
Carrie Mandeville @mumwifenurse
Clinical Lead for the Canterbury DN team Sam Twyman talking through our ideas for the training and education needs of a community volunteer with John Battersby @SECAmbulance #KMlocalcare #itsacamelnotadinosaur https://t.co/LgyruWHJ8e



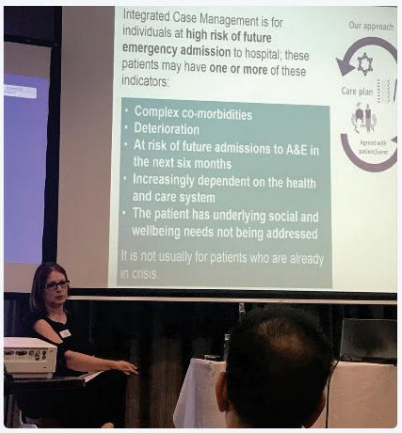
Beckie Burn @BeckieBurn
Using @encompassmcp evaluation from @UniKent @CHSS_Kent to learn lessons as we roll out local care across the county - valuable reflection on how we need to have truly joint decision-making & not just delegation to the highest grade in the room @KMhealthandcare #KMlocalcare https://t.co/QOV2quJucy



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



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



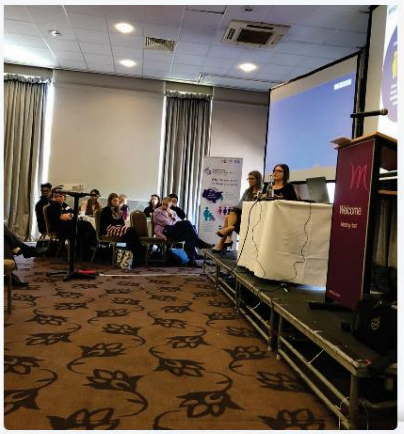
Jo Frazer @Jo_Frazer
Findings on what works well from @UniKent research and what could be even better! #KMlocalcare
https://t.co/f9spixCSUh

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

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

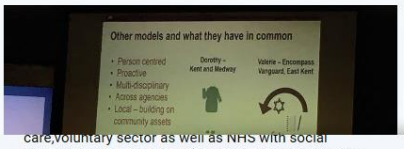
Jo Frazer @Jo_Frazer
Views that Mental Health and GP engagement is crucial to the success of #Buurtzorg #KMlocalcare @KentDLC @KMhealthandcare

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



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

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



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

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

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

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

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

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

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

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

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

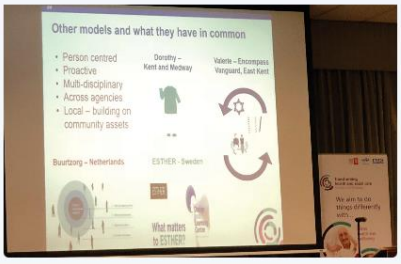
Jo Frazer @Jo_Frazer
Ah that moment in workshop where someone in the room is having their own conversation and not showing respect to the people talking ☺ #KMlocalcare https://t.co/13CUyRfDfo

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

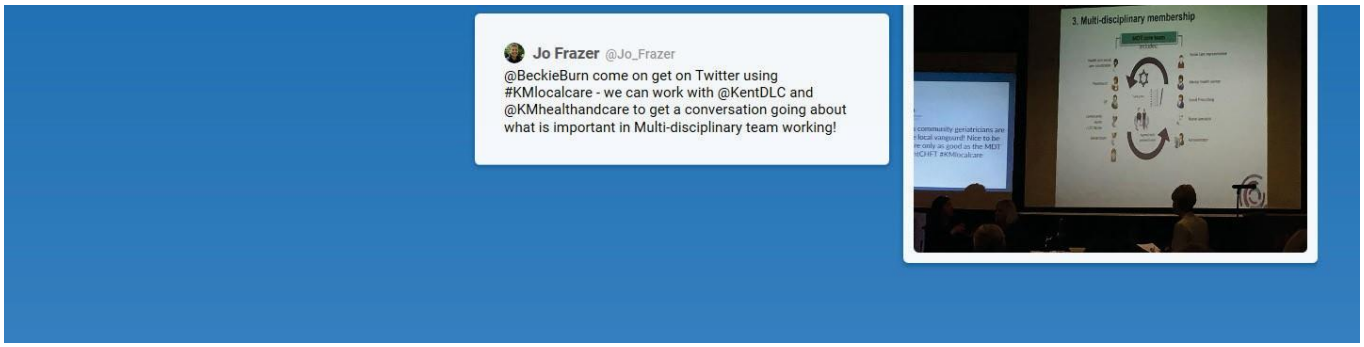
Jo Frazer @Jo_Frazer
Brilliant - "first coffee....then care" #Buurtzorg #KMlocalcare https://t.co/MuYNeCkVsT

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

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



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


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

Appendix four: Workshop round-up

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

Workshop: MDTs in action

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

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

Slide notes

Slide 1: Gayle Savage

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

Slide 2

- As per presentation.

Slide 3

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

Slide 4

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

Slide 5

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

Slide 6

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

Slide 7

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

Slide 8: Becky Prince

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

Slide 9

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

Slides 10 and 11

- As per the presentation.

Slide 12

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

Slide 13

- As per the presentation.

Slides 14 to 17

- As per the presentation.

Slide 18

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

Slides 19 and 20

- As per the presentation.

Slides 21 and 22

- As per the presentation.

Workshop notes

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

Workshop: Social prescribing – what is it?

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

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

Slide notes

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

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

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

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

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

Slide 3

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

Slide 4

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

Slide 5
YouTube film

Slides 6 to 12
Skipped

Slide 13
Film

Slide 14
In conclusion:

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

Workshop notes

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

Workshop: Sharing with confidence in MDTs

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

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

Slide notes

Slides delivered as per presentation.

Workshop notes

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

Is 'direct care' hands on?

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

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

Workshop: Buurtzorg and MDT working

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

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

Slide notes

Slide 1

- Welcome and introductions

Slide 2

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

Slide 3

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

Slide 4

Explained the Buurtzorg onion model:

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

Slide 5

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

Slide 6

Informal networks explained:

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

Slide 7

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

Slide 8

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

Slide 9

Formal networks explained:

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

Slide 10

- How the model fits in with local care

Slide 11

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

Slide 12

Groups discussed:

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

Workshop notes

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

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

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

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

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

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

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

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

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

Slide notes

Slide 1

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

Slide 2

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

Slide 3

- What are the key elements of care navigation?

Slides 4 to 9

- Delivered as per presentation.

Slide 10

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

Slide 11

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

Slides 12 to 14

- Delivered as per presentation.

Slide 15

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

Slide 16

- Making every contact count.

Slide 17

- Plethora of apps available on PHE website.

Slide 18

- We will discuss this more in table discussion.

Slide 19

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

Workshop notes

Anne and Rebecca's comments:

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

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

The other points raised were:

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

Therefore:

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

General comments made during table discussions:

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

Positives:

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

Challenges:

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

Workshop: How do we evaluate the impact of MDT working

Facilitators:
Sabrena Jaswal and Rasa Mikelyte, University of Kent

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

Slide notes

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

Workshop notes

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

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

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

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

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

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

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

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

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

Workshop notes

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

Workshop: The role of the community guardian volunteer within SECAmb

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

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

Slide notes

Slide 1

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

Slide 2

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

Slide 3

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

Slides 4 to 6

- Examples of the types of pressures on SECAmb

Slides 7 to 12

- Examples and data to support the need for VCGs

Slide 13

- Complications of non injury falls

Slide 14

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

Slide 15

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

Slide 16

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

Slide 17

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

Slide 18

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

Slides 19 and 20

- Skipped

Slide 21

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

Slide 22 to 24

- Skipped

Workshop notes

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

Appendix five: Plenary sessions

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

Our Vanguard in action

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

Life as part of an MDT

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

Why focus on MDTs and top tips for MDT working

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

New care models

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

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

How can hospices support local care?

Sarah Pugh, Chief Executive Officer Heart of Kent Hospice

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

Role of the geriatrician

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

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

Comments, questions and answers

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

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

Also see appendix one: Sli.do analytics

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