Appendix 1

Medway and Swale Health and Care Partnership Delivery Plan Update with an Overview of Development of Integrated Neighbourhood Teams

Population Health Management

Population Health Management (PHM) has been a priority for the Medway and Swale Health and Care Partnership (HaCP) since its inception in 2021. The programme holds key lines of delivery, detailed further in the report. However, one of the key functions of PHM is shaping locally determined priorities through the PHM Analytics function, which operates as a group that analyses data to identify areas of health inequalities. This is then triangulated with local intelligence and engagement to understand the needs at place and impact the wider determinants of health have on health outcomes. The HaCP are committed to using data and intelligence to inform priorities to ensure that programmes of work align with local need.

Key to the PHM programme is the Voluntary, Community, Social Enterprise and Faith (VCSEF) Framework that was signed in 2022. The Framework provided principles that offered a basis for organisations to work in partnership across our system as equal partners. By doing so, relationships have evolved, with the organisations being essential to understanding the local populations needs, as well as delivering programmes of work that are key to addressing inequalities in Medway and Swale.

The HaCP have dedicated Programme Management support for all the workstreams that provide meaningful engagement, to allow a mechanism to feed engagement activities into the system, as well as supporting the Integrated Care Board (ICB) held contracts for engagement.

Engagement with the communities within Medway and Swale is integral to the HaCP. The HaCP are taking a community led approach to reduce inequalities and improve outcomes across Medway and Swale. It is pivotal to the HaCP that solutions and improvements are made within the communities.

There are various groups under the Engagement programme, including the People & Communities Group, the Patient Participation Groups, and a Gathering Insights Network that has been formed with VCSEF representatives and a work plan has been developed.

In relation to INT engagement, ICB colleagues commissioned the National Association of Primary Care (NAPC) to consult with stakeholders including VCSEF partners, primary, community, and secondary care, to support the co-production of a system approach to Integrated Neighbourhood Teams (INT) across Kent and Medway through a NAPC INT System Development Framework (Appendix 1).

Within our ambition of agreeing our place-based 5-Year INT Strategy, the key question “What Matters to You?” will be part of our stakeholder engagement to ensure our communities voice is at the heart of design with co-development of future INT models of care to be delivered at place.

As we move toward our long-term vision for INTs, this community-driven approach ensures that care is proactive and preventative, improves outcomes and reduces health inequalities. Through continuous engagement, collaboration, and data analysis, PHM and INTs will work together to deliver the right care, at the right time, and in the right place for the people of Medway and Swale.

Programmes such as the Health Catalyst and Making Every Adult Matter (MEAM), described later in this document, revolve around engagement, and feedback from such assignments gets fed

into the groups as above. In October 2023, the feedback from the listening events through the Health Catalyst programme was compiled and themed to report to the HaCP Quality and Safety Board for action. The insights included some issues that sit within Health and Social Care but drew particular attention to the impact of the Wider Determinants of Health, including a sense of belonging and safety in the community.

Additional programmes around engagement include the Involving Medway and Swale programme and Healthwatch insights which are regularly fed into the HaCP.

Delivery Plan Priorities 24/25

To achieve the abovementioned five-year priorities, the clinical pathway areas and the overall Kent and Medway Integrated Care System (ICS) Strategy, the HaCP have seven priority areas for delivery in 24/25 which are based on the five-year priorities.

The below graphic demonstrates how these areas align with the ICS strategy.

	Kent and Medway ICS Strategy Priorities:					
	Give children and young people the best start in life	Tackle the wider determinants to prevent ill health	Support happy and healthy living for all	Empower patients and Carers	Improve health and care services	Support and grow our workforce
24/25 Delivery Plan areas						
Social Regeneration	•	•	•	•	•	•
Transforming flow and discharge			•	•	•	
Community frailty		•	•	•	•	
Integrated Neighbourhood teams	•	•	•	•	•	•
Population Health Management	•	•	•	•	•	•
Financial controls	•	•	•	•	•	•
Workforce	•	•	•	•	•	•

The ICS Strategy and Medway and Swale HaCP Delivery Plan for 2024–2025 align perfectly with the mission that INTs will play a pivotal role in delivering on five critical clinical priorities identified for pathway reviews, ensuring that care is community-centred and meets the unique needs of our populations. Here’s how INTs will contribute:

- **Diabetes:**

  INTs will support patients through holistic care plans, fostering consistent management and prevention strategies to improve diabetes outcomes locally.

- **Ambulatory Care Sensitive Conditions (ACSC):**

  ACSC are those conditions for which effective management and treatment in the community should limit emergency hospital admission. INTs will work across the care spectrum, supporting individuals with conditions like Chronic Obstructive Pulmonary

Disease (COPD), Cardiovascular Disease (CVD), and Heart Failure, helping to reduce preventable hospital admissions and improve quality of life.

- **Self-harm in 10–24-year-olds:**

  Through local partnerships, INTs will provide tailored, community-based mental health support, helping to address self-harm risk factors early and offer targeted interventions.

- **Frailty:**

  INTs will deliver proactive, personalised care for frail patients, helping them to stay safe, active, and well-supported within their communities.

- **Cancer – Early Diagnosis:**

  INTs will collaborate with cancer services to promote early diagnosis and support patients through the journey, from screening and diagnosis to ongoing community support.

Through these efforts, INTs are key enablers, translating ICS Strategy goals into practical, impactful care at the community level. This approach ensures our communities benefit from integrated, responsive healthcare tailored to their needs.

The application of Population Health Management in Medway and Swale

Core20PLUS5 derives from the national focus on Health Inequalities. Core20PLUS5 is broken down into:

- **Core20 – The top 20% most deprived areas**
- **PLUS – locally determined inclusion health groups**
- **5- key clinical areas of health inequality**

Whilst predominantly the local intelligence reflects the same clinical priorities, there are other local inequalities (as identified above). The PHM programme supports the implementation of programmes across partner organisations, such as physical health checks for Learning Disabilities and Serious Mental Illness. However, there are also local initiatives that are being delivered.

Early Diagnosis of Cancer as one of the key priorities for the HaCP for 24/25 is managed under the PHM programme, where data is being assessed to understand where there are inequalities in access, experience and outcomes to screening programmes, and where there are tumour groups that disproportionately affect the population in Medway and Swale.

A project on bowel screening has been working with those in the most deprived areas, where there are health inequalities evident in relation to bowel screening, which is reflected in cancer mortality data. This project is being delivered by the VCSEF who are key to engaging with communities. This has supported engagement with over 1,000 individuals and has been centred around active listening and breaking down barriers to people undertaking screening. Individuals involved in the project have committed to using their qFIT test – a non-invasive screening tool designed to detect hidden blood in the stool, as a result. A full report of this project is expected in quarter four.

An additional project is being mobilised in Medway and Swale, seeking to empower the community to self-organise, develop and design solutions to barriers that prevent early diagnosis and/or treatment. It is expected this will begin delivery in quarter four.

Throughout these initiatives, INTs will be instrumental, serving as the connection to ensuring the seamless integration of PHM insights and interventions across all HaCP workstreams. By aligning PHM-driven projects with INTs, the HaCP not only reinforces its commitment to health equality but also strengthens the capacity to respond to specific community needs—ultimately driving improved outcomes across Medway and Swale.

As INTs evolve, they will build on these community-driven changes, leveraging local insights to deliver proactive, preventative care that is tailored to the needs of the community. This transformation will not only enhance patient experiences and outcomes but will also drive organisational development by upskilling the workforce and breaking down silos, enabling a more integrated and efficient approach to care within existing resources.

The Health Inequalities Allocation has served as both a catalyst and a bridge toward the full realisation of INTs. By funding these place-based projects, the HaCP enables early interventions that address critical disparities and INT-aligned strategies. These projects offer valuable insights into how INTs can deliver tailored, community-oriented care and highlight the need for an integrated system where health inequalities are addressed as part of holistic neighbourhood health management.

Health Inequalities Allocation

The Medway and Swale HaCP have held a budget for Health Inequalities, enabling place-based programmes of work to begin to address local inequalities. This budget has been held by the HaCP from 23/24, and all programmes are demonstrating ability to reduce inequalities. This is summarised below.

Through strategic investment and targeted projects, the HaCP is fostering the natural development of INTs as the ultimate expression of place-based care. As each initiative addresses distinct health inequalities, INTs will eventually unify these efforts into a seamless, inclusive system of care. With the Health Inequalities Allocation as the starting point, INTs will become the foundation for sustainable, equitable healthcare across Medway and Swale, ensuring every community receives the support and resources needed for long-term health and wellbeing

Clinical Variation

The Clinical Variation programme is an enabling function across the HaCP priorities. The aim of the programme is to work with primary care to improve clinical coding, improve disease prevalence identification, improve patients' outcomes and ensure conditions are managed appropriately, as well as identifying patients at risk of developing certain long-term conditions and inviting them on to the preventive programmes. Improved outcomes are recorded via the GP Surgeries Quality and Outcomes Framework (QOF).

A risk stratification method, developed in collaboration with local experts, has year to date identified 16,612 high-risk patients in the most deprived areas, including those with frequent emergency department (ED) visits. Already, 9,531 patients have been reviewed across four long-term conditions. This targeted work serves as a model for INTs, illustrating the power of data-driven, focused interventions within neighbourhoods

Using 2023 data from the Primary Care Network (PCN) in Kent and Medway, the HaCP identified that avoidable admissions for ACSCs are above the national average of 859, across all Medway PCNs, with Gillingham PCN, for example, reporting 1,345 admissions. This trend points to the need for comprehensive, locally focused solutions—precisely what INTs aim to deliver. INTs will

build on the Clinical Variation programme's success by uniting multidisciplinary teams around at-risk patients in their communities, ensuring continuity

The Clinical Variation programme is paving the way for INTs by creating a foundation of consistent, preventive care that can be scaled at the neighbourhood level. As INTs emerge, they will bring together multi-professional teams—GPs, pharmacists, social workers, and other specialists—to conduct holistic reviews and tailor care to everyone. By embedding these teams within communities, INTs will enhance the impact of the Clinical Variation programme, delivering high-quality care that addresses each patient's needs in a personalised, community-oriented way.

Through this approach, the HaCP is driving long-term transformation. By investing in programmes that improve clinical practices, address health inequalities, and target high-need areas, the partnership ensures that Medway and Swale communities benefit from a robust, integrated system of care. The Clinical Variation programme and INTs together represent a powerful step toward equitable and accessible healthcare across all neighbourhoods

Making Every Adult Matter (MEAM)

The MEAM programme takes a trauma-informed, strengths-based approach to support individuals experiencing multiple disadvantages. By working with a broad partnership across housing, public health, the NHS, social care, police, probation, and voluntary services, MEAM aims to address the systemic barriers that hinder access to services and contribute to poor outcomes.

In 2023/24, Medway became one of 10 new localities selected by the national MEAM organisation to receive support, and the programme has been managed locally by the HaCP team. Focused on individuals at high risk of premature death, such as those experiencing rough sleeping, the programme addresses some of the most severe health inequalities—especially around premature mortality and poor access to care.

MEAM Programme Highlights

A core element of the MEAM programme was the recruitment of two MEAM Coordinators funded through Health Inequalities funding. These coordinators were hired in November 2023 and have since worked with individuals facing multiple challenges. Through the Medway Multiple Disadvantage Network (MMDN), the coordinators have been able to connect these individuals to tailored support services. In 24/25, the programme continues to engage individuals and provide trauma-informed care to those who are often excluded from mainstream services.

Improving Frontline Collaboration

The programme recognised the potential overlap between MEAM and other initiatives, such as the Rough Sleeper Initiative (RSI) and the Blue Light Project. Rather than creating more complexity, the focus has been on integrating efforts to streamline services. The MMDN has made a noticeable impact on frontline collaboration, as seen in the feedback from partners working on the ground. Quotes from outreach workers, healthcare professionals, and complex care staff highlight the positive results of this integrated approach, noting that the MEAM service provides crucial support for individuals who might otherwise be overlooked by mainstream services.

"I see firsthand the benefits of the work your team do with this cohort and hear the positive comments made in relation to the ongoing support clients receive from MEAM, it's clear to see that there are some clients that feel everyone had given up on them until they were supported by MEAM and have been given a new hope that they can make positive changes to their lives. My personal view is that we haven't yet seen the full benefits of what MEAM

support can achieve for our clients until we have a more cohesive approach across all services and providers but that's certainly something to look forward to."

Quote from Complex Care Outreach Nurse.

"I honestly can't speak highly enough of the service. I know [the MEAM coordinators] aren't qualified social workers, but they hold the social work values, and they always put the client first. My experience of the MEAM service has been fantastic and it is a very valuable service. What makes the service fantastic is the fact the workers apply a non-judgemental, anti-discriminatory and anti-oppressive approach to working with the client group, which in turn enables them to build a positive working relationship with the clients. I feel that the client is always at the centre of the process, and I do feel person-centred care is key. My view is that nothing is too much for the MEAM service and they will do their best to accommodate this, for example supporting clients to attend appointments, referrals for accommodation are just a few examples."

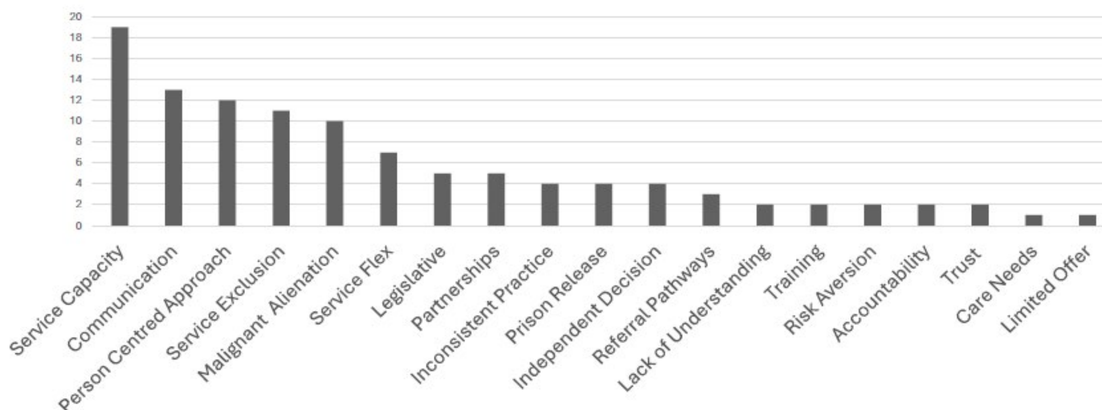
Quote from Rough Sleepers Clinical Mental Health Specialist.

Achievements and Impact of MEAM

Since its launch, the programme has seen significant success in improving access to healthcare and other services for people with complex needs. For instance, 158 sessions have been held in the first half of 2024/25, including multi-disciplinary team (MDT) meetings and supported appointments. This support led to 65 healthcare appointments, including mental health, sexual health, and primary care visits, helping to reduce reliance on emergency care. A cohort audit revealed that many of these individuals had previously only accessed healthcare through emergency routes, but through MEAM they were successfully linked to ongoing care, including GP registration and specialised treatment, such as residential detox and rehab.

A comprehensive review of 18 MEAM/MMDN cases identified 108 barriers individuals faced in accessing services, including issues related to complex trauma, domestic abuse, neurodivergence and cognitive impairments like alcohol-related brain damage. These barriers were presented to the Strategic Group, with recommendations for improving support services, particularly for individuals with complex needs that are not adequately addressed by existing services. Our biggest challenge to ensure continuity of this vital service is non-recurrent funding of the project.

Breakdown of Barriers



MEAM within future INTs

As the MEAM programme progresses, INTs will play a critical role in sustaining and expanding this work. The MMDN's success in bringing together multi-agency support for people with complex needs provides a clear model for how INTs can function in Medway and Swale. INTs will be able to build on the partnerships already established through MEAM, ensuring that a cohesive, collaborative approach to care continues for individuals facing multiple disadvantages. By bringing together health, social care, and community services, INTs can help to address the gaps identified by MEAM, ensuring more people are supported holistically within their communities, rather than falling through the cracks of fragmented services.

In the long term, INTs will further streamline the care process by offering more personalised, integrated care to those with the most complex needs—helping individuals to navigate and overcome the systemic barriers that have long prevented them from accessing the support they need. This evolution will be vital to ensuring that the gains made through the MEAM programme are sustainable and that all individuals, regardless of their circumstances, are given the opportunity to thrive.

Social Prescribing

Social Prescribing has been identified as a key component of personalised care, connecting people to help and support in their community, based on what matters to them and their individual strengths and needs. The Social Prescribing programmes seeks to support the VCSEF through capacity building, by funding the social prescription together with a seed funding element.

By enhancing the capacity of local organisations and integrating them into care pathways, Social Prescribing acts as an enabler for INTs to deliver more comprehensive and tailored support.

In terms of potential outcomes from social prescribing, data from a cohort of 98 people accessing a befriending service that is open for referrals shows 51% reported a reduction in use of GP appointments, 20% reported reduction in A&E, 8% reported a reduction in 999 calls and 20% a reduction in accessing mental health services. 62% to 79% reported improvement in the 4 ONS questions – Life Satisfaction, Worthwhile, Happier and Anxious

Health Catalyst

The Community Health Catalyst Programme plays a vital role in addressing health inequalities in Medway and Swale by actively engaging with individuals from the most deprived areas and Inclusion Health Groups. By listening to those who have historically been seldom heard, this programme helps uncover the unique health challenges faced by these communities. Through listening events, signposting, social prescribing, and community grants, the programme has provided support to 3,354 individuals, with 758 people actively engaged in the process. Action plans have been created for 1,883 individuals, and funding has benefited 33 organisations and over 6,000 individuals.

This programme is not just about gathering data; it's a critical enabler in the co-design of solutions to the inequalities experienced by marginalised communities. The insights from the listening events provide a wealth of information that informs the development of INTs, ensuring that the needs of the most vulnerable populations are front and centre in the design and delivery of care.

By integrating the Community Health Catalyst programme's findings into the planning and development of INTs, we can ensure that care is tailored to the specific needs of the community. The engagement insights help identify the barriers to access, gaps in service provision, and specific local needs, which can then be addressed through more targeted, responsive care within the INTs. This ensures that INTs are not just reactive, but proactive in addressing the health and social care needs of those who are most at risk of poor health outcomes.

As INTs are developed, the insights from the Community Health Catalyst programme will be essential in shaping the model of care. By incorporating the experiences and needs of the most deprived groups, the INTs will be better equipped to provide equitable, inclusive care that reduces health inequalities and improves outcomes for all populations, especially those that are typically harder to reach.

Building Community and Well-Being through Yoga: Meet Simran

Simran, a 45-year-old woman, lives in a tight-knit Sikh community, facing both physical and mental health challenges. A recent leg injury had limited her mobility, and the loneliness of staying at home took a toll on her emotional and physical well-being. Simran's struggles with chronic pain and isolation weren't uncommon—many women in her community faced similar issues but had few accessible resources to help them.

Simran's case reflects a broader issue within her community. Many Sikh women, particularly older adults, suffer from physical limitations, feelings of isolation, and mental health concerns. Without proper intervention, many of these issues could lead to further health complications requiring NHS services, such as emergency care or ongoing medical treatment.

Through the Programme, a 10-week yoga programme designed to promote physical health and mental relaxation was developed. Each session gave participants a safe space to explore gentle movement, improve mobility, and practice breathwork— focusing not just on physical recovery, but on preventing further health deterioration that might result in A&E visits.

The sessions provided an accessible alternative to medical intervention, helping participants manage their conditions before they escalated. Simran was encouraged to join after hearing about the sessions through her local Gurudwara. Initially hesitant due to her injury, she soon began to experience a significant improvement in both her physical mobility and emotional well-being.

By the end of the 10 weeks, Simran not only regained her mobility but also reported increased emotional resilience. What's more, she had avoided repeated visits to her GP and potential hospital admissions by proactively addressing her health concerns through yoga. Simran wasn't the only one to benefit—many other participants also experienced health improvements, from better breathing to reduced pain from chronic conditions. "I had broken my leg, and the pain used to be unbearable. Through yoga, I've gained so much mobility and now feel confident in my body again," said Simran. "If it wasn't for these sessions, I might have needed more medical intervention."

Social Regeneration

The Health and Care Partnership's Social Regeneration Programme builds on the Population Health Management Programme and two years of extensive engagement with the most vulnerable communities when questions were posed as to what measures would support better health and care outcomes, not one individual stated a clinical intervention, instead referencing elements that sat in the wider determinants of health such as housing, employment, education and overwhelmingly the need for a sense of belonging to the community.

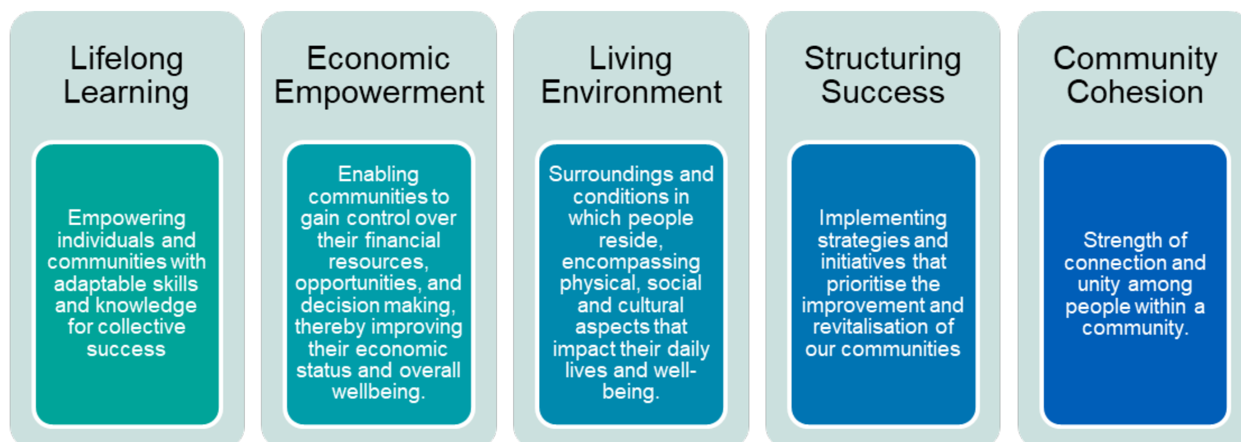
Recognising the growing significant influence that social determinants have on health and wellbeing, Social Regeneration offers a transformative approach to address the root causes of health disparities and enhance the overall quality of life within our communities.

The Social Regeneration Launch Conference was held 19th March 2024. The conference served as a catalyst for change with the outcome being to come away with leaders in the community changing their practice to 'own and participate' in the health and wellbeing of the community. The audience were asked to think boldly and decisively in pursuit of positive change, with the purpose of the event being a call for action, how can we put down our organisational boundaries and work differently for communities across Medway and Swale.

The launch event brought together a wide range of system partners who signed the pledge for Social Regeneration and to explore 'The Art of the Possible', delegates including those from Social Housing, Education, VCSEF, Local Authority Public Health and Housing, Kent Police and Local Businesses all signed up and agreed to be a part of the Social Regeneration agenda.

Social Regeneration was given HaCP executive approval in April 2024 as a 5-year priority programme and serves as a commitment to work collaboratively with system partners at place to offer innovative solutions to complex issues that impact the health and wellbeing of the population we serve.

The five themes that underpin the social regeneration programme are:



The HaCP social regeneration strategy is 10-year ambition to reimagine our systems, structures, policies, and processes to better serve the needs of individuals and communities within Medway and Swale. It requires health and care services to come together with education, employment, housing, local business, and our voluntary sector to work differently and find solutions for collective challenges. It's about the 'Art of the Possible'.

By working collaboratively with our partners, employing innovative and varied approaches, to explore the Art of the Possible, we can make best use of collective assets and resource to enhance provision and create innovate solutions that build capacity within our system to reduce health inequality and actively impact on our communities for the better.

In the long term this programme of work will ensure that the places where people live, now and in the future, offer new opportunities, promote and improve health and wellbeing and reduce inequalities so that people have better lives, in stronger communities, and achieve their potential.

In the context of INTs, this programme will be integral in shaping how local teams engage with and address the needs of their communities. INTs will not just provide medical care but will also play a crucial role in linking individuals to broader social services and resources, such as housing, employment support, and educational opportunities. By embedding Social Regeneration's principles within INTs, these teams will become a cornerstone for delivering holistic care that addresses the full spectrum of factors impacting health, ultimately leading to more sustainable and equitable health outcomes.

As the programme progresses, the collaboration between the HaCP and community partners will ensure that INTs are equipped with the tools, support, and resources they need to provide more comprehensive care. The aim is to create a community-centred approach, where INTs work seamlessly with local systems to reduce health disparities, improve quality of life, and build a stronger, healthier Medway and Swale.

Ultimately, the end game is to have INTs at the heart of a truly integrated system, working together with local stakeholders to address both the health and social needs of individuals. This collaborative approach will help create communities where people are empowered to live healthier lives, stay well, and achieve their full potential.

Transforming Flow and Discharge (TFD)

The TFD Programme is a 5-year system priority and supported by the HaCP Programme Team on behalf of partners. The programme aims to improve patient experience and outcomes by ensuring efficient discharge and effective pathways. There are four areas of focus for this programme

Focus Areas:

1. **Transfer of Care Hub (ToCH) Development**
   A hub responsible for the coordination of discharge planning for people with new or increased needs requiring post discharge health and/or social care support.

2. **Discharge to Assess (D2A) Commissioning including market management**
   Commissioning of a model to assess patients in their own home or place of residence to establish ongoing support requirements.

3. **Data**
   Ensuring overview of data in relation to discharge is via agreed source and developed to show impact of interventions put in place.

4. **Organisational Development and Governance**
   Establishing roles and responsibilities of key stakeholders and a mechanism for oversight and assurance of programme areas within and supporting programmes relating to Transforming Flow and Discharge.

Success will be seen through change to process and system improvement metrics, with overall system improvement being measured through decreases in acute length of stay of 7+ days, 14+ days, 21+ days.

To ensure patients receive timely, appropriate, and coordinated support upon discharge, our HaCP commits to a principle of Early Discharge Planning. This approach emphasises planning from the point of admission to facilitate safe, person-centred transitions back into the community or next stage of care. Our goal is to minimise delays, reduce readmissions, and improve patient outcomes by actively involving multidisciplinary teams, patients, families, and community resources from the outset

Our HaCP is committed to implementing and supporting a Discharge to Assess (D2A) model, a model all about funding and supporting people to leave the hospital when it is safe and appropriate to do so. This approach enables patients to be discharged from acute care settings as soon as they are medically stable, with further assessments and care planning conducted in their familiar home environment. By supporting this model, we aim to enhance patient recovery, improve flow within acute services, and foster collaborative community-based care

The INTs are a natural extension of these efforts. They provide ongoing care for frail patients after they are discharged, helping them to stay well at home. INTs will offer holistic patient reviews, ensuring care plans are up-to-date and aligned with patients' needs. They'll also help complete Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Forms, which document a patient's preferences for emergency care and treatment, ensuring that their wishes are respected during critical situations.

INTs will work closely with the Single Point of Access (SPoA) and D2A model to make sure that frail individuals have the right support in place once they leave the hospital. They will play a vital role in helping to manage long-term conditions, reducing the likelihood of unnecessary hospital admissions, and making sure patients have access to the right services in the community. By providing this ongoing support and follow-up care, INTs will help prevent avoidable readmissions and ensure patients stay healthy and well at home. This approach provides a seamless transition from acute care to community care, aligning perfectly with the goals of the TFD programme.

Community Frailty

The Community Frailty Programme is a 5-year system priority focusing on early intervention, coordinated care, and community-based resources, to improve the care and support of frail individuals in the community. The programme is supported by the HaCP's Programme Team on behalf of partners, to work collaboratively to identify improvements, measure the effectiveness of interventions, and adapt services as needed to meet evolving needs of frail individuals in the community.

The areas of focus for this programme are:

- **Single Point of Access (SPoA) for alternative care pathways to avoid conveyance**
- **Proactive Frailty Assessment and Intervention**
- **Establishing a community frailty model**
- **Improving Flow and Supported Discharge**

Nationally SPoA have been designed to simplify access to a range of services for patients. The Medway and North Kent SPoA is now operational and will serve as a central hub, for local multi-disciplinary teams consisting of acute, community and SECAmb staff. Calls to the SPoA are triaged and clinically assessed to see if a community pathway might be more suitable alternative to an emergency department visit.

When a frail individual experiences a sudden deterioration in their health or a crisis at home, staff in the SPoA can support ambulance crews on the ground to access urgent community response teams, as an alternative to conveying to hospital. Urgent Community Response teams must respond to urgent referrals within two hours, and therefore, play a vital role in providing rapid support in the community, to avoid unnecessary hospital visits.

Urgent Community Response Teams bring together nursing, therapy, and social care staff who can provide wrap around care for patients who have experienced a fall, had an exacerbation of a chronic condition, or had an urgent social care crisis. These teams offer care within the patient's home or local community, helping them avoid hospitalisation and maintain their health in a familiar environment.

To ensure continued support to SPoA, community teams will need to be strengthened to ensure they are robust and have sufficient capacity to help frail patients avoid an unnecessary admission to hospital. The development of additional services such as virtual ward pathways for frail patients will help bolster community provision, along with step up beds. Virtual wards (also known as hospital at home) enable patients to get hospital level care at home safely and in familiar surroundings, helping speed up their recovery while also freeing up hospital beds.

For complex frail patients with multiple health and social care issues, needing ongoing support, the vision for the future is for community teams such as Urgent Community Response and Virtual Ward to refer into INTs to ensure longer-term help and support is provided to prevent avoidable readmissions and ensure patients stay healthy and well at home.

As well as having reactive services that can respond to urgent situations, the need to address frailty proactively is crucial, as it significantly impacts the health and well-being of older people in Medway and Swale. Frailty is a complex condition that can lead to sudden health declines and hospital admissions if not identified and managed early. Identifying high-risk individuals before their condition worsens, allowing early interventions to be put in place to provide additional support is crucial.

Routine frailty assessments will be introduced in primary care and community settings to identify individuals at risk. This will allow healthcare teams to implement preventive measures

Integrated Neighbourhood Teams

The main ambition of the INTs is to provide holistic, person-centred care in the community, helping individuals stay well at home and avoid hospital visits. By focusing on areas such as frailty, complex care, and long-term conditions, INTs bring together health professionals, social care providers, and community organisations to ensure that people get the right care in the right place at the right time.

The INTs will also play a key role in reducing pressures on our hospitals, especially during busy times like winter. They will help reduce the length of time people stay in hospital by supporting early discharge and providing ongoing care in the community. By doing this, we can improve patient experiences, reduce hospital readmissions, and support people in managing their conditions better.

INTs will be developed in seven localities across Medway and Swale, focusing on areas where there is the highest need. These teams will be structured around local primary care networks, with the aim of providing care closer to home and reducing the need for patients to travel across the region. The seven localities are:

- Strood and Peninsula
- Gillingham
- Rainham
- Lordswood, Wayfield and Weeds Wood
- Rochester and Chatham Central
- Sheppey
- Sittingbourne

INTs will help tackle some of the key health inequalities that exist in Medway and Swale. By working to reduce the barriers created by multiple deprivation, the INTs will address priority health issues such as frailty, complex care, and multimorbidity (the presence of two or more chronic conditions).

A key part of the INT approach is collaboration. The teams will work closely with a wide range of partners, including voluntary and community organisations, to ensure that people receive care that is not just clinical but also addresses the wider factors affecting their health. The experiences of the pandemic have shown us the power of community knowledge and the importance of working together, which is why we will ensure that the voluntary sector's role is reflected in the way we design and deliver INT services.

The key principles of INTs are to deliver care that is person-centred, holistic, and integrated. Here's what that means in practice:

Person-centred care:

We place the individual at the heart of care, ensuring their preferences and values guide all decisions.

Holistic approach:

We look at all aspects of health, including physical, mental, and social well-being.

Integrated care delivery:

We ensure smooth communication and coordination between all care providers, including health services, social care, and community organisations.

Preventive care:

We focus on prevention, early intervention, and health promotion to help people stay well.

Community empowerment:

We engage local communities, helping them take an active role in their care and decision-making.

Technology and innovation:

We use digital tools to improve care delivery, share information, and streamline services.

By embracing these principles, INTs will help create a more connected, effective, and sustainable healthcare system that meets the needs of individuals in Medway and Swale.

INTs are transforming community healthcare by empowering local teams to care for patients in a more collaborative, holistic way. Rather than using a "command and control" approach, senior leaders work to create an environment that encourages autonomy, accountability, and growth for INTs. These leaders also help build strong local partnerships, breaking down barriers and offering mentorship to guide INTs through both successes and challenges.

In Medway, Implementation Sites are being launched to support complex care patients with high emergency department usage. Partnering with Medway Maritime Foundation Trust (MFT) and using the High Intensity Users list, these teams will conduct comprehensive health and social care assessments to better support patients. Weekly Integrated Locality Reviews help ensure that the needs of these patients are addressed quickly and effectively, which is especially crucial as we prepare for winter.

As INTs continue to grow, they will develop specialised approaches to support areas like Avoidable Admissions, Diabetes, Frailty, and Discharge Transformation. Community INT teams will be central to these efforts, creating individualised care plans and coordinating across the system to deliver better outcomes. Through ongoing data review, INTs will ensure their work continues to drive meaningful improvements across all healthcare streams.

Financial Controls and Workforce

The HaCP's 5-year priorities focus on two key areas: financial control and workforce alignment. These priorities are not just about numbers or administrative tasks—they are crucial to ensuring that our healthcare system works efficiently for everyone in Medway and Swale, especially those needing the most support.

When it comes to financial control, the aim is simple: we want to make sure that the resources we have are used effectively. This means ensuring that money flows directly to local services that are essential for people in their communities, such as GP practices, local clinics, and social care

teams. The focus is on improving the whole healthcare journey for residents—making sure that from the moment someone enters the system to the time they receive care, there are no unnecessary gaps or delays. Financial control here helps make sure services have the funding they need to work smoothly and effectively.

In workforce alignment, the focus is on building a strong and flexible workforce that can deliver the right care, at the right time, and in the right place. This means creating a system where staff across health and social care—from doctors to social workers to nurses—are working together more seamlessly. Workforce alignment is about ensuring that these professionals have the support they need and the opportunity to develop in their roles. For the people of Medway and Swale, this means that when you need care, you'll be seen by a team that is well-trained, well-supported, and ready to work together to meet your needs.

Both priorities tie directly into the INTs, as they are local teams of healthcare professionals who work together to support people in their own communities, offering a more joined-up approach to care. By focusing on financial control, we can ensure that funding is directed to these local teams, helping them deliver care closer to home. Meanwhile, workforce alignment will ensure that these teams are made up of skilled and supported professionals, working flexibly across different areas of care to meet the needs of the community.

For the public, this means a healthcare system that is more responsive, easier to navigate, and delivers care in the community where people live, rather than in hospitals. It's about building trust in local services and ensuring that the professionals working in the system feel valued, motivated, and able to offer the best possible care. Ultimately, these efforts aim to make Medway and Swale not just a better place for people to receive care, but a better place for healthcare workers to thrive, too.