HEALTH AND WELLBEING BOARD

Wednesday, 20th November, 2013

6.30 pm

Darent Room, Sessions House, County Hall, Maidstone

AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 20 November 2013 at 6.30 pm	Ask for:	**Ann Hunter**
Darent Room, Sessions House, County Hall, Maidstone	Telephone:	**01622 694703**

Tea/Coffee will be available 30 minutes before the meeting

Webcasting Notice

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UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item No

1 Chairman's Welcome

2 Apologies and Substitutes

3 Declarations of Interest by Members in Items on the Agenda for this Meeting

4 Minutes of the Meeting held on 18 September 2013 (Pages 7 - 12)

5 Joint Health and Social Care Learning Disability Self-Assessment Framework (Pages 13 - 22)

6 Health and Wellbeing Strategy Outcome 4 - People with Mental Health are Supported to Live Well (Pages 23 - 52)

7 The Integration Transformation Fund (Pages 53 - 80)

8 Assurance Framework (Pages 81 - 96)

9 Pharmaceutical Needs Assessment (Pages 97 - 102)

10 Revisions to terms of reference for CCG level health and wellbeing boards (Pages 103 - 116)

11 Co-option of members to the Health and Wellbeing Board (Pages 117 - 120)

12 Meetings for 2014

To note that meetings of the Health and Wellbeing Board in 2014 will be held on:
Wednesday 29 January;
Wednesday 26 March;
Wednesday 28 May;
Wednesday 16 July;
Wednesday 17 September;
Wednesday 19 November.

All meetings to be held in Sessions House, County Hall and start at 6.30pm

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

Tuesday, 12 November 2013

Please note that any background documents referred to in the accompanying papers may be inspected by arrangement with the officer responsible for preparing the relevant report.

HWB Membership

CCG Reps	**Clinical Lead**	**Officer**
Ashford CCG	*Dr Navin Kumta*	*Simon Perks*
Canterbury & Coastal CCG	*Dr Mark Jones*	*Simon Perks*
Dartford/Gravesham/ Swanley	*Dr Bhaskar Bora*	*Patricia Davies*
South Kent Coast	*Dr Darren Cocker*	*Hazel Carpenter*
Swale	*Dr Fiona Armstrong*	*Patricia Davies*
Thanet	*Dr Tony Martin*	*Hazel Carpenter*
West Kent	*Dr Bob Bowes*	*Ian Ayres*

District Councillor Representatives

Cllr Andrew Bowles	Swale BC
Cllr John Cunningham	Tunbridge Wells BC
Cllr Paul Watkins	Dover DC

Healthwatch
Veronika Segall- Jones

NHS England
Michael Ridgwell or *Felicity Cox*

KCC
Paul Carter
Andrew Ireland
Meradin Peachey
Graham Gibbens
Roger Gough
Jenny Whittle

Italics = statutory reps
CCG reps – each CCG has one vote

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KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 18 September 2013.

PRESENT: Dr F Armstrong, Mr P B Carter, Ms F Cox, Cllr J Cunningham, Mr G K Gibbens, Mr R W Gough (Chairman), Mr A Ireland, Dr M Jones, Ms V Segall Jones, Dr T Martin, Ms M Peachey, Mr S Perks, Mrs J Whittle, Dr D Cocker, Ms P Davies, Ms H Carpenter and Mr I Ayres

ALSO PRESENT: Ms M Blyth

IN ATTENDANCE: Mr M Lemon (Strategic Business Adviser), Mrs A Tidmarsh (Director of Older People and Physical Disability) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

33. Chairman's Welcome

(Item 1)

(1) The chairman said that following agreement of the HWB in May 2013 he had met with Deborah Tomlin from the South East Coast Clinical Networks who had expressed an interest in developing a relationship with the Health and Wellbeing Board. He said the networks were bringing forward work programmes that would be of interest to the Health and Wellbeing Board and proposed that these be presented to the Board in the future.

(2) The chairman said that since the last meeting of the Board there the NHS Call to Action had been made and there was a strong suggestion that health and wellbeing boards, local area teams, clinical commissioning groups and others had a role to play in public debate and engagement. He suggested that this should be considered by the Health and Wellbeing Board in due course

(3) The chairman said he would canvass opinion to determine whether the Kent Health and Wellbeing Board had a role to play in the Primary Care Call to Action.

34. Substitutes

(Item 2)

Apologies were received from Dr Bob Bowes and Dr Navin Kumta. There were no substitutes.

35. Declarations of Interest by Members in Items on the Agenda for this Meeting

(Item 3)

There were no declarations of interest.

36. Minutes of the Meeting held on 17 July 2013
(Item 4)

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 17 July 2013 are correctly recorded and that they be signed by the chairman.

37. Kent Safeguarding Children Board - 2012/13 Annual Report
(Item 5)

(1) Maggie Blyth, Independent Chair of Kent Safeguarding Children Board (KSCB), introduced her annual report which described the progress made in improving the safeguarding services provided to Kent's children and young people in 2012/13, and outlined the challenges for the next year. She also outlined the role and composition of the Kent Safeguarding Children Board and the recommendation set out in Working Together to Safeguard Children (2013) that annual reports of safeguarding children boards be submitted to health and wellbeing boards.

(2) Maggie Blyth said progress had been made across Kent in improving child protection arrangements and this had been acknowledged by the three most recent statutory inspections. She said the KSCB would continue to monitor the numbers of re-referrals to specialist children's services; the numbers of children with child protection plans being referred for a second or subsequent time; and that the spotlight would be retained on young people at risk of: going missing; child sexual exploitation; and trafficking; as well as understanding why certain groups of children, including some unaccompanied asylum seeking children, go missing and on children who required early intervention.

(3) Maggie Blyth said she would welcome the views of the KHWB on the following issues in particular:

- The placement of high numbers of children in Kent by other local authorities;
- Scoping the commissioning of services for children at risk of sexual exploitation and trafficking;
- Waiting times for assessment and treatment of some specific groups of children especially teenagers needing mental health and emotional wellbeing services.

(4) During discussion the need to communicate the findings of the KSCB and other organisations to practitioners engaging with children was raised as was the importance of sharing early warning signs picked up by GPs, education and other services.

(5) Felicity Cox reported that the directors of nursing in Kent, Surrey and Sussex were undertaking specific work to identify the issues and patterns in the provision of children and adolescent mental health services and would be able to report to this board and the KSCB in due course.

(6) Hazel Carpenter said:

- a children's summit would take place in Thanet next week to review a range of children's issues and agreed the ambition and direction of services for children;
- the report of an external review of safeguarding arrangements within Kent and Medway would be available at the end of the month;
- a year ago, the chief executive of Thanet District Council had written to local authorities placing children in Thanet and that she (Hazel Carpenter) had followed this up by writing to the 16 clinical commissioning groups in those areas and had received some positive responses

(7) RESOLVED:
  (a) That the progress and improvements made during 2012/13, as detailed in the Annual Report from the Independent Chair of Kent Safeguarding Children Board be noted.
  (b) That a formal response to the KSCB be prepared by the Health and Wellbeing Board in due course.
  (c) That mental health and emotional wellbeing services including early non-specialist intervention, the transition to adult services and tier-four provision be considered by the Health and Wellbeing Board.

38. 2013/14 Health Monies- Verbal Update
(Item 6)

(1) Anne Tidmarsh (Director of Older People and Physical Disability) gave an update on the Pioneer bid that had been considered at the meeting of the Health and Wellbeing Board on 17 July 2013. She said that 29 of the 110 bidders had been called for interview, it was anticipated that between 10-15 bids would be selected and the successful bids would be announced at the end of October.

(2) She also said work on health and social care monies was nearing completion and suggested that this together with outcome of the Pioneer bid and the review of governance arrangements requested at the last meeting be presented to the Health and Wellbeing Board on 20 November 2013.

39. The Integration Transformation Fund
(Item 7)

(1) Dr Robert Stewart (Clinical Design Director) joined the board for discussion of this item.

(2) Mark Lemon, Strategic Business Advisor, introduced the report which said that the £3.8bn Integration Transformation Fund (ITF) announced by the Government dramatically accelerated the timescales for achieving the integration of health and social services. He said Government expectations were that a fully integrated system would be in place by 2018 based on actions identified to start in 2014-15 and with significant delivery in 2015-16. The funding consisted of a number of existing components as well as new allocations from clinical commissioning groups' budgets.

(3) Mark Lemon said plans to spend the funding must be agreed by health and wellbeing boards who must assume responsibility for monitoring the achievement of targets, agreeing contingency plans for re-allocating funding if targets were missed and be satisfied that providers, especially acute hospital trusts, had been effectively engaged in the planning process.

(3) In response to a question it was confirmed that no new money being was being made available.

(4) During discussion the need to involve the acute sector and health education providers was acknowledged. It was also agreed that this was an opportunity to consider the funding and services in their totality including the third sector, the process would need to be clinically led with the support of the council and other organisations and, given the scale of change, the impact on patients would need to be monitored and controlled. It was further acknowledged that timescales were short, the development of the plan would need to dovetail with the development of operational commissioning plans and the key milestones and a timetable could be built into a piece of work being undertaken by NHS England.

(5) RESOLVED:

(a) That the timescales involved in the preparation of the Kent plan for the Integration Transformation Fund be acknowledged.

(b) That the Pioneer Group takes the work forward with support from elsewhere as required.

(c) That provider engagement already taking place at local and whole systems level be further strengthened.

(d) That progress in the preparation of the Kent Plan for the Integration Transformation Fund be reviewed at the next meetings of the Health and Wellbeing Board.

40. Long Term Conditions
(Item 8)

(1) Ian Ayres (West Kent CCG) gave a presentation called Mapping the Future – Towards a Blueprint for a Sustainable Health Care System in West Kent. He said that growth in demand for care had to be met without growth in resources, a change in health services was required to avoid a widening gap between income and spend and the Mapping the Future programme aimed to describe an agreed vision for the future. Workshops had been held during the summer involving patient representatives, professionals and managers covering four clinical topics as exemplars for how the system could be re-organised. Key themes emerging from the workshops had been distilled and work was underway to identify how the draft blueprint could be applied to activity and resource patterns.

(2) Patricia Davies (Dartford, Gravesham and Swanley CCG) gave a presentation called “Developing an Integrated Admissions Avoidance and Discharge Management Model”. The model brought together a multi-professional team

based approach to facilitating the timely discharge for people to ensure best outcomes for patients, timely access to community-based health and social services and the optimum use of acute, community and social services. She also outlined the enablers and key elements of the model as well as possible key performance indicators.

(3) The chairman thanked Ian Ayres and Patricia Davies for their presentations.

41. Update on the Assurance Framework for the Kent Health and Wellbeing Board

(Item 9)

(1) Mark Lemon (Strategic Business Advisor) introduced the report which proposed that indicators relevant to the Kent Health and Wellbeing strategy were taken as the basis to develop an overview of the health and social care system across Kent. These indicators would form a relatively simple Assurance Dashboard for the KHWB to assess current service effectiveness. In addition indicators had been derived from the NHS England South Escalation Framework that could alert the Board to potentially unsustainable pressures in the component sectors. The Dashboard would also provide assurance to the Health and Wellbeing Board on a regular basis if overall status of the indicators was progressing in the right direction.

(2) During the discussion it was suggested that additional indicators be included in the dashboard relating to "no place of safety", out of area acute bed placements and to monitoring progress on the implementation of the transformation plan.

(3) RESOLVED:

(a) That the contents of the paper be noted and the proposal for the development of a Kent wide assurance framework be approved.

(b) That the development and ownership of the dashboard for regular monitoring of the agreed indicators be approved.

(c) That a populated dashboard be presented to the next meeting of the Health and Wellbeing Board on 20 November 2013 with further reports at six-monthly intervals.

42. Improving Health Outcomes for Children and Young People - Better Health Outcomes Pledge

(Item 10)

(1) Meradin Peachey (Director of Public Health) introduced the report which asked the Kent Health and Wellbeing Board to consider and endorse the Better Health Outcomes for Children and Young People pledge.

(2) The Department of Health, the Local Government Association, the Royal College of Paediatrics and Child Health, and Public Health England had sent a joint letter to all lead members for children and young people and the chairs of health and wellbeing boards in July 2013 highlighting consistently poor health

outcomes for children in England especially amongst those in vulnerable groups such as looked after children. The letter also noted considerable variations in child health across England with international comparisons showing clear areas for improvements in child health outcomes. The signatories to the letter called for all health and wellbeing boards to sign up to the "Better Health Outcomes for Children and Young People pledge" to demonstrate a commitment to giving children and young people a better start in life.

(3) Meradin Peachey said the pledge listed five ambitions for the Health and Wellbeing Board and these were in direct alignment with Outcome 1 of the Kent and Health and Wellbeing Strategy which aimed to give every child the best start in life, with a particular focus on the integration of services for 0-11 year olds and improving the mental health of children and young people.

(4) RESOLVED:

(a) That the Better Health Outcomes for children and young people pledge be endorsed.

(b) That to ensure the success of Ambition 2 of the pledge the need to plan for the following be noted:

(i) seamless pathways for children and young people aged 0-25;

(ii) integrated holistic multi-agency services that recognise the correlation between children's wellbeing and family and community systems;

(iii) inclusive services that are accessible for all with clear transitional arrangements in place for young carers, parent carers, adult carers and disabled people of all ages.

(c) That children's issues be considered in the light of the pledge at a meeting of the Health and Wellbeing Board.

43. CCG- Level HWBs' Children's Sub Group
(Item 11)

(1) Jenny Whittle (Cabinet Member for Specialist Children's Services) introduced the report which set out the terms of reference for the Clinical Commissioning Group Level Health and Wellbeing Boards' Children's Sub Group (Children's Operational Group).

(2) During discussion concerns were raised about the capacity of clinicians to support all the groups being established and about the governance arrangements for reporting to two different groups.

(3) RESOLVED to defer consideration of this matter to a future meeting of the Health and Wellbeing Board.

44. Date of Next Meeting - 20 November 2013

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
To: Health & Wellbeing Board
Date: 20th November 2013

Subject: **Joint Health & Social Care Learning Disability Self-Assessment Framework (JHSCSAF)**
Classification: Unrestricted

1. Summary

1. Kent Clinical Commissioning Groups and Local Authority have worked together on the Kent Joint Health & Social Care Learning Disability Self-Assessment Framework. The presentation for the Health & Wellbeing Board will give a position statement of the Kent JHSCSAF and asks the Health & Wellbeing Board firstly to hold Clinical Commissioning Groups, Local Authorities and the Kent Learning Disability Partnership Board accountable for completing and publishing the JHSCSAF, then to ensure the results are incorporated into Kent's Joint Strategic Needs Assessment and the Health & Wellbeing Strategy for Kent.

2. Introduction

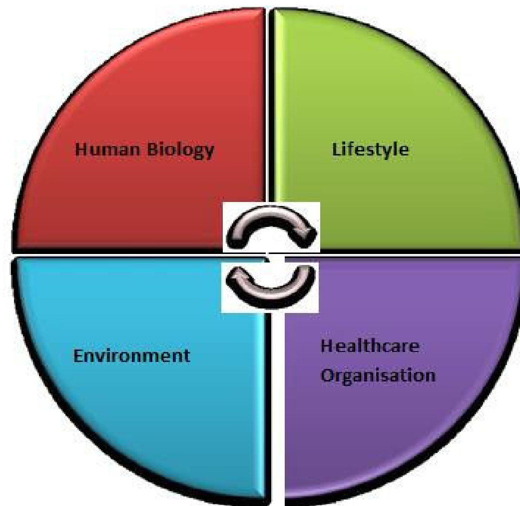
1. The Joint Health and Social Care Learning Disability Self - Assessment Framework is a single delivery and monitoring tool that supports Clinical Commissioning Groups (CCGs), and Local Authorities (LAs), to assure NHS England, Department of Health and the Association of Directors of Adult Social Services on the following:

- *Key priorities in the:*
  - Winterbourne View Final Report Annex B (WBV)
  - Adult Social Care Outcomes Framework 2013-14 (ASCOF)
  - Public Health Outcomes Framework 2013-2016 (PHOF)
  - National Health Service Outcomes Framework 2013-14 (NHSOF)
  - Health Equalities Framework

- *Key levers for the improvement of health & social care services for people with learning disabilities;*
  - Equality Delivery System
  - Safeguarding Adults at Risk requirements
  - Health & Wellbeing Boards
  - Consultation and co-production with people with learning disability and family carers
  - Progress Report on Six Lives and the provision of public services for people with learning disabilities

A. Rationale

1. The Joint Health and Social Care Learning Disability Self - Assessment Framework (JHSCSAF) and subsequent improvement plans will ensure a targeted approach to improving health inequalities and achieving equal and fulfilling citizenship, helping commissioners and local people assess how well people with a learning disability are supported to STAY HEALTHY, BE SAFE and LIVE WELL.



2. A simple public health model (Lalonde's health field 1994) highlights that people with learning disabilities are disadvantaged in all four domains and experiencing poorer health than the non-disabled population, because of:

- Greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnectedness.
- Increased risk of health problems associated with specific genetic, biological and environmental causes of learning disabilities.
- Communication difficulties and reduced health literacy.
- Personal health risks and behaviours such as poor diet and lack of exercise.
- Deficiencies relating to access to healthcare provision.

3. **People with learning disabilities are 58 times more likely to die before the age of 50 than the general population (Hollins et al 1999)**

   There are numerous reports on the Improving Health and Lives (IHaL) website about the health and wellbeing of people with learning disabilities. IHAL: http://www.improvinghealthandlives.org.uk/publications/year/2011.

   Kent's Needs Assessment 2013 – life expectancy is increasing for People with a learning disability however mortality rates remain the same and are three times higher than the general population for people with severe learning disabilities.

   Life Expectancy (2002 figures):
   74 years people with a mild learning disability
   67 years people with a moderate learning disability
   58 years people with a severe learning disability

   The median life expectancy for people across all learning disabilities in Kent is slightly below England's average.

B. National Enablers

1. There are a number of national enablers in place to improve the health & social care of people with learning disabilities and whenever possible the self-assessment framework is aligned with these:

- Safeguarding and Equality Delivery System
  - Monitor Compliance Framework: Foundation Trust Pipeline
  - Data from the Public Health Observatory
  - Direct Enhances Service for Annual Health Checks
  - Quality Outcomes Framework (QOF) register for Learning Disabilities
  - QOF register for Down Syndrome
  - Care Quality Commission (CQC) inspection of assessment and treatment units
  - CQC Essential Standards for Care
  - Winterbourne View Final Report Annex B (WBV)
  - Adult Social Care Outcomes Framework 2013-14 (ASCOF)
  - Public Health Outcomes Framework 2013-2016 (PHOF)
  - National Health Service Outcomes Framework 2013-14 (NHSOF)

- Statutory Adult Safeguarding Boards- Law Commission outlined legislative framework
- ‘No Secrets’ remains policy driver: Making Safeguarding everybody’s business
- Quality Governance Framework including QIPP and CQUIN
- Six Lives – Progress report on Healthcare for People with learning disabilities
- Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD)

2. The benchmark also assesses the underlying Legislative Framework and tests how this works for people with learning disabilities:

   - Mental Capacity Act including Deprivation of Liberty 2007
   - Vulnerable People’s Act 2006
   - Equality Act 2010
   - Human Rights Act 1998
   - Autism Act 2009
   - Health and Social Care Act 2012
   - Carers Services and Recognitions Act 1995

C. The process in more detail

1. *Nominated Leads*

A lead should be identified in both the Clinical Commissioning Group(s) and the Local Authority(s). Your leads will have a good knowledge of the mainstream health & social care agendas, and have sufficient seniority to influence their provider and commissioner partners. The nominated leads are not expected to have all the answers but they have a crucial role in coordinating the responses.

Kent nominated leads are:
Penny Southern, Director of Learning Disability and Mental Health, KCC
Sue Gratton, Associate Partner, KMCS (on behalf of the Kent CCGs)

Getting
Ready
Meetings

2. *Getting Ready Meetings*

These are crucial so everybody has a clear understanding of their role and provide information and evidence for Big Health & Wellbeing Check Up Day. Ideally, you should use existing meetings and networks and link into these. They will enable people with learning disabilities and family carers to have time together to think through some of the targets and objectives. They should be coordinated by the nominated leads. It would be useful to get a good written record of what people have said. People should bring that with them to the Big Health & Well-Being Check Up Day, and it should also be handed in so that it can be used in the feedback report. The JHSCSAF this year wants to hear positive and negative real life stories of experience that explain why a locality thinks particular areas are strong or need improvement. The ultimate quality assurance is the experience people with learning disability and family carers have. The different targets often involve very different people, so it may be useful to hold 'target specific' meetings.

Kent's meetings & dates:
Kent Learning Disability Partnership Board – **2013**: 25th January, 24th April, 30th July, and 15th October – **2014**: 21st January
Good Health Group – **2013**: 15th January, 29th April, 21st May, 16th July, 17th September, and 19th November

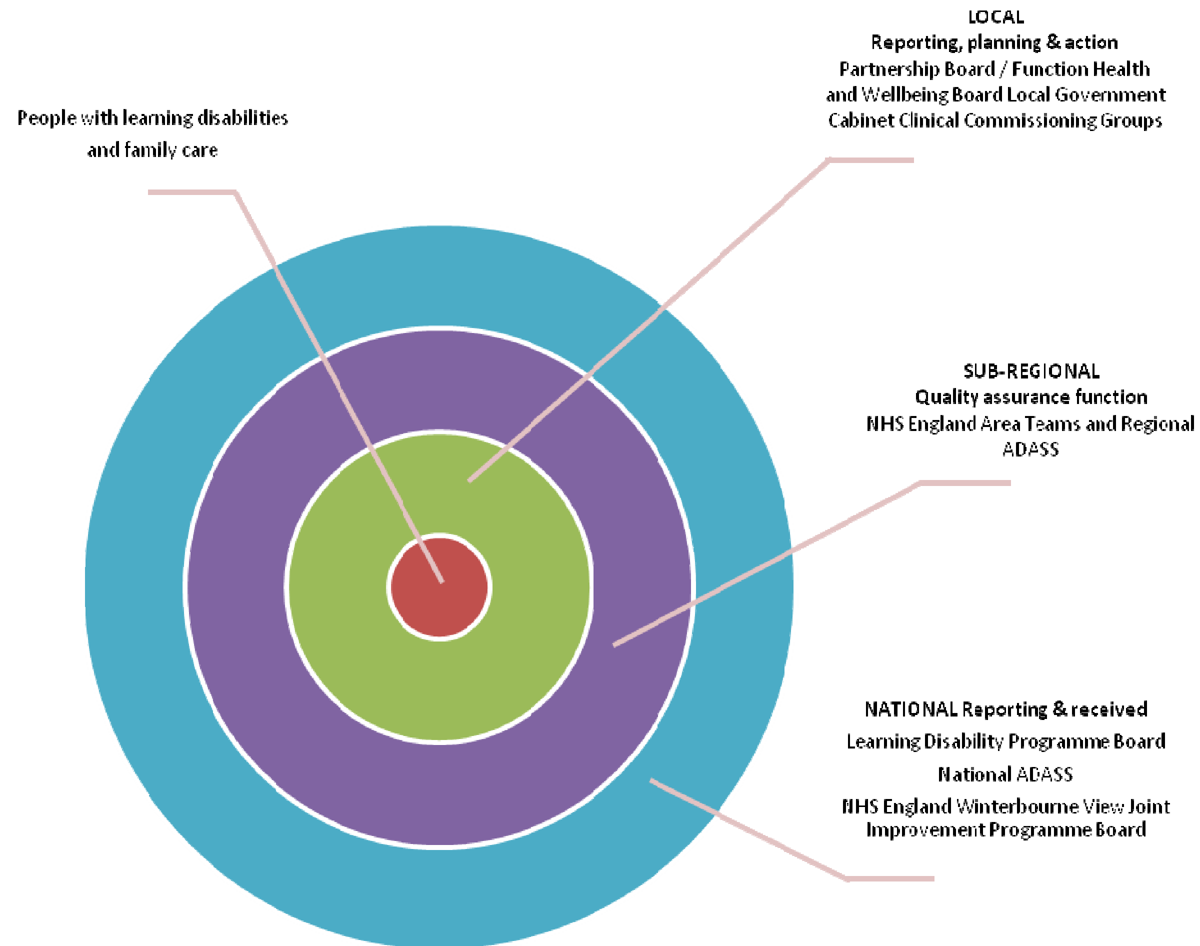
3. *Big Health & Wellbeing Check Up Days*

The aim of this day is to discuss and vote on the targets in the JHSCSAF and identify actions to progress. This step is key in fulfilling the vision laid out in the White Paper '*Local Democratic Legitimacy in Health'*

Kent:
Kent Big Health Check Day – 19th November 2013

4. Governance

1. This year there is a huge change in the health and local authority structures nationally. Here is how quality assurance will be undertaken.



5. Collecting evidence and submission

1. The process followed should now enable the health & social care leads to complete the JHSCSAF with qualitative and quantitative information. The leads will benchmark their local progress against the national framework. This is then submitted online and received by the Area Team lead and the regional ADASS lead for learning disabilities.

6. Submission

1. **Quality Assurance** - Clinical Commissioning Group(s) and the local authority(s) will work together on the JHSCSAF. The results of their work will be published by IHaL.

   NHS England Area Teams and regional ADASS leads will receive the completed JHSCSAF from each local area for whom they have responsibility. As part of the assurance process they will want to consider the approach to be taken locally to:

- Seek views from people with learning disability, family carers and the 3rd sector
- I dentifying areas of best practice and areas of concern where a deep dive or sector led improvement may need to be undertaken
- Provide joint feedback to local areas including people with learning disability and family carers

D. Timeframe

Date	Action
Early August 2013	National launch + SAF information on IHaL website and data entry tool available
August – 30 November 2013	Evidence gathering and submission of IHaL website until closure date
December 2013	Planning for agenda of the Health & Wellbeing Board before March 2014 Begin quality assurance process at the level of NHS England Area teams and Local Authorities
January – March 2014	Quality assurance process begins Area Teams and regional ADASS will receive local JHSC SAF reports Action plans to be submitted for publication on website by end of March Submission of processed information for use in commissioning intentions 2014 / 2015 Local reporting to Health & Wellbeing Boards (June 2014) Centralised analysis by IHaL of local JHSC SAF returns
March / April 2014	Presentation to Ministerial Learning Disability Programme Board

E. Conclusion

Over the past 3 months the CCGs, KMCS, Public Health, Kent District Partnership Board, Integrated Teams, District Partnership Group & User Carer Forums and KCC Performance Teams have been collecting data for Kent's Joint Health and Social Care Learning Disability Self-Assessment Framework.

The presentation sets out the key highlights for Kent and asks the Health & Wellbeing Board to support and agree submission to the IHaL website which will allow the Public Health Observatory (Improving Health and Lives) to analyse Kent against the nationally agreed benchmark and will enable Kent to assess their progress.

F. Recommendations

- For the Health & Wellbeing Board to note the content of the report
- To support and agree Kent's Joint Health and Social Care Learning Disability Self- Assessment Framework for submission and publication
- To agree that the outcomes will be part of the Joint Strategic Needs Assessment and Health & Wellbeing Strategy for Kent
- To return to the Health & Wellbeing Board in 2014 to share the results and monitor progress against the Kent Implementation Plan

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By: Roger Gough, Cabinet Member for Education and Health Reform – Chair of the Health & Wellbeing Board

To: Health & Wellbeing Board

Date: 20th November 2013

Subject: **Health and Wellbeing Strategy Outcome 4 - People with Mental Health Issues are supported to 'Live Well'**

Classification: Unrestricted

Introduction

The need to improve Mental Health provision is a key challenge for Health and Social Care commissioners and stakeholders. Mental health issues affect one in four individuals at some point in their lives and this continues to rise. Early intervention and a range of high quality services will improve efficiency and outcomes for the local population of Kent.

The Kent JSNA 2010 states that at any time in Kent there are approximately 160,000 people suffering from common Mental Health issues, 60,000 people with severe Mental Health issues and 12,000 with severe mental illness such as schizophrenia and bi polar conditions.

The overarching strategic context for the delivery of Mental Health services in Kent is set by:

- The NHS Outcomes Framework
- No Health Without Mental Health
- The Kent Health & Wellbeing Strategy 2012/2013

In order to ensure that there are a range of services to meet individual needs, Statutory Services including Clinical Commissioning Groups (CCG), Families and Social Care (FSC) and Public Health (PH) need to work in partnership with the voluntary and independent sector to improve Mental Health and Wellbeing.

The following suite of papers provide information regarding the range of services currently commissioned by Clinical Commissioning Groups, Families and Social Care as well as Public Health and give an overview of the current investment and performance against Outcome 4 of the Kent Joint Health & Wellbeing Strategy – People with Mental Health Issues are supported to 'Live Well'.

The papers:

1. Health & Wellbeing Strategy Outcome 4 – People with Mental Health issues are supported to 'Live Well' – Appendix A
2. CCG delivery against the 2012 Kent Health & Wellbeing Strategy – Appendix B

3. Report for Kent Health & Wellbeing Board on Mental Wellbeing in Kent - Appendix C
4. Health & Wellbeing Board Presentation

   This summarises the reports and forms an opportunity for a decision around Mental Health provision in Primary Care

Appendix A

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
	Andrew Ireland, Corporate Director - Families and Social Care
To:	Health & Wellbeing Board
Date:	20 November 2013

Subject:	Health and Wellbeing Strategy Outcome 4 - People with Mental Ill Health Issues are supported to 'Live Well' - UPDATE
Classification:	Unrestricted

Summary:	To provide an update on progress for the Health and Wellbeing Board on the Kent Joint Health and Wellbeing Strategy - Outcome 4 – People with Mental Ill Health Issues are supported to 'Live Well'; to update progress against the 2010 – 2015 five year Live it Well commitments: to report on the successful launch of a revised website to support the strategy and other initiatives to promote Mental Health and Wellbeing in Social Care and Public Health
Recommendations	The Health & Wellbeing Board is asked to NOTE the continuing progress towards the Health and Wellbeing strategy and the development of local resources to support it.

1. Introduction

1) The Mental Health "Live it Well" strategy complements the Health and Wellbeing Strategy and was presented to Members at the Adult Social Services Policy Overview and Scrutiny Committee in March 2010. It sets out the strategy for delivering Kent's Mental Health Services for the next 5 years. The aim of the strategy is to promote good Mental Health and Wellbeing in the community, reduce the number of people who have common Mental Health problems, and lessen the stigma and discrimination associated with mental ill health Issues.

2) "Live it Well" targets prevention to those at higher risk; but also wants to make sure the right services are there when people need them. Services will be personalised, will involve service users and their families in equal partnership, will aid recovery and will help people reintegrate into their communities. They will promote the best care and promote accessible, supportive and empowering relationships. Wherever possible, services will be community-based and close to where people live.

3) These attributes were decided following consultation with service users and carers. They said they wanted services that were local, personalised, timely and non-stigmatising. The "Live it Well" strategy fits well with the National policy "No Health without Mental Health" and with KCC's "Bold Steps": in particular helping people take responsibility for their Mental Health care through extending choice and control, and reducing disadvantage and dependency.

2. Policy Background Live it Well Strategy

1) The strategy is based on 10 commitments, to be delivered during the lifetime of the 5 year strategy. These are:

    1. Public services, the voluntary sector, and the independent sector will work together to improve Mental Health and Wellbeing.

    2. We will lessen the stigma, discrimination and unhelpful labelling attached to Mental Ill Health Issues and those using Mental Health services.

    3. We will reduce the occurrence and severity of common Mental Health problems by improving wellbeing for more people at higher risk.

    4. We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of Mental Health needs in the treatment of all those with physical conditions and disabilities.

    5. We will reduce the number of suicides.

    6. We will ensure that all people with a significant Mental Health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.

    7. We will ensure that all people using services are offered a service personal to them, giving them more choice and control.

    8. We will deliver better recovery outcomes for more people using services with care at home as the norm.

    9. We will ensure that more people with both Mental Health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service.

    10. We will deliver more effective Mental Health services for offenders and those anywhere in the criminal justice system.

3. KCC's Investment

1) Kent County Council spends £24.1 million on Mental Health services across Kent. £9.4 million relate to a Section 75 Partnership Agreement which is in place between Kent County Council and Kent and Medway NHS and Social Care Partnership Trust. This covers over 270 seconded staff that are in secondary Mental Health services and the Council's statutory functions. Staff provide a range of services including an Approved Mental Health Professional service, Care Management Services, Short Term Recovery Services as well as a Carer Assessment service for people known to the service. A board is in place to oversee and monitor the effectiveness of joint working mechanisms between Kent County Council and Kent and Medway NHS and Social Care Partnership Trust, ensuring that safe and effective joint working is maintained between both organisations. KCC spends £4.9 million within the voluntary sector to provide a range of universal services. £9.8

million is spent on community services including supporting 262 service users in residential care.

2) Kent Public Health (alongside FSC) has a 10 point evidence based programme for improving mental wellbeing across Kent. There is approximately £750k investment into wellbeing campaigns, improvements and developments to the Live it Well Website, investment into domestic violence workers, asset mapping and development, workplace wellbeing, men's Mental Health (including ex-military), working with libraries to create wellbeing hubs and considerable investment into Mental Health first aid training. In addition – the needs assessments for Mental Health and psychological therapies are underway and due for completion in December 2013. The Annual Public Health Report will give focus to Wellbeing.

3) There is a commitment from Social Care and Public Health and our CCG colleagues to build upon the work of Rethink Mental Illness and Kent and Medway NHS and Social Care Partnership Trust's report into Young People's Mental Health in Kent and Medway. The report was launched at the 'Gaining Momentum' event held in August. The key themes from the day included promoting better mental health for young people and building resilience, early intervention by increasing resources in communities and ensuring that services are in place to support recovery. Families and Social Care are leading a workshop with partners in January 2014 to develop an action plan for young people with mental health needs in transition.

4. Progress towards delivering Outcome 4 – People with Mental Ill Health Issues are Supported to 'Live Well'

1) There has already been substantial progress with a number of these commitments. KCC has made a contribution, either in a leading role or in supporting Health colleagues, in many initiatives designed to deliver on these commitments. These include The Live it Well website. This website is a collaboration between KCC, the CCGs and Sevenoaks Area MIND. It provides easy access to good quality, extensive information about local Mental Health and Wellbeing services.

2) A revised "Live it Well" search facility by CCG areas was launched in August 2013. This new database enables people to look for local information in a new way. People can search under common Mental Health issues i.e. anxiety or depression, addiction, money and debt as well as by CCG locality or if they are a carer or older adult. All of the resources, news and other information on the site are now exportable into a PDF document to print / email or save. This website is receiving over 4,000 'hits' a month.

3) "The Live it Library" is where service users and carers can tell their recovery story through the Live it Well website and is a collaborative project between Live It Well (KCC), Kent and Medway NHS and Social Care Partnership Trust (KMPT) and Rethink Mental Illness. These online resources of people who have experienced or are experiencing Mental Health issues tell their stories. The aim of the library is to share stories, challenge stigma, promote understanding, offer hope and enable people to speak honestly about their experiences. The Live It Library pages continue to be added to – they now contain over 30 personal stories. Working in partnership with Public Health, a full time post has been created to provide a

platform to deliver Public Health Campaigns over the coming year. The website is found at www.liveitwell.org.uk.

4) Live it Well is promoting personalisation, giving more choice and control to service users. There are now 16 brokers accredited by Signpost UK, an independent organisation working across Kent. There have been over 99 people accessing the Life Plan tool to identify the areas of support required. These brokers have assisted KCC in helping over 800 people to receive self-directed support.

5) KCC has contributed to the development of a new protocol for services for those people with both Mental Health needs and substance misuse, to ensure services work together and people receive effective services. These have been backed up with promotion and training activities across all involved organisations in the statutory and independent sectors. The protocol can be found at www.liveitwell.org.uk/bigger-picture/dual-diagnosis

6) Primary Care has a key role to play in Mental Health services, over 90% of people are treated exclusively in Primary Care. A key priority has been to increase the resources available in this sector. This has been achieved through a partnership approach with Public Health, CCGs and FSC, with £500k new investment being made available to develop the Primary Care Community Link Worker service. Building on the existing pilot in Thanet, a new 2 year contract with Porchlight, a voluntary sector provider, has commenced on the 1st October 2013. This will see an additional 16.6 posts across Kent. Their role will be to work with General Practices to signpost to other organisations, as well as providing short term interventions to improve individuals' Mental Wellbeing.

7) In order to facilitate service users' discharge from secondary Mental Health services back to Primary Care, Kent and Medway Commissioning Support Service are piloting with the majority of CCGs a Primary Care Mental Health Specialist role. Under this pilot, the practitioner's role is to identify service users; support the GP in managing someone's Mental Health and ensures that they are linked into community resources. Through the innovative piece of work there have been 37 service users more appropriately supported this year.

8) The Commissioning intention for 2013/14 will be to review KCC's Mental Health Social Care response to Primary Care, to ensure that social care assessments are undertaken. This will see a proportion of resources move out of secondary services to provide a more targeted response to service users who are discharged from secondary care as well as new primary care referrals.

9) Adults with severe Mental Health problems are one of the most socially excluded groups in society. Although many want to work, less than a quarter actually are in employment. People with severe Mental Health problems have the lowest employment rate for any of the main groups of disabled people. Employment services are an important resource for people with Mental Health issues. Everyone who experiences Mental Health problems has the right to individually tailored support to obtain or maintain employment that matches their preferences, their strengths and their needs.

10) CCGs and KCC spend £1.47m on employment services across the sector with a range of providers, both statutory and non-statutory. These services provide employment interventions including, vocational profiling, occupational action plans, skills development and work placements, as well as providing training activities which enhance confidence and the ability to build workplace relationships. They also support service users in employment. Across Kent in 2012/13 our employment services provided a service to 3,997 service users from both primary and secondary care and supported 1,139 into sustained employment of 13 weeks or more.

11) Kent and Medway NHS and Social Care Partnership Trust report on a monthly basis the number of people in employment. The NI 150 target across Kent is 12% of all service users known to secondary Mental Health services are in employment. The Trust continues to exceed this target with the June 2013 figure being 13%.

12) Everyone needs a stable roof over their head, in order to keep or find a job, build a social network, or participate in a range of other opportunities. Loss of accommodation is most likely to happen to the more vulnerable or disadvantaged members of our society. Often, assistance at the right time can prevent a full-scale, long term crisis. We believe that Supported Accommodation services are an important resource and we recognise the need for service users to have the opportunity to live a fulfilled, active and independent life, by providing suitable housing. A range of supported accommodation has been developed over the last five years, to meet individual need; in conjunction with our District and Borough Housing Partners. Through working together we have seen an additional 215 units of new supported accommodation across Kent. Strategic Commissioning are currently producing an accommodation strategy which will identify further gaps in service provision for people with mental health needs.

13) Clear leadership roles for the safeguarding agenda are being established in each community Mental Health team. In addition KCC has employed 4 Safeguarding Coordinators who are supporting teams with safeguarding practice, record keeping and data quality. The coordinators also provide training, induction and carry out regular audits to assist with performance management and learning from experience. The KCC safeguarding competency framework is currently under review. Once this is complete, consideration will be given to how this can be introduced in Mental Health within the context of professional capability and competency frameworks.

14) KCC and KMPT have established joint mechanisms and governance structures for performance monitoring. There is joint ownership of an improvement plan which builds on good practice and addresses areas for development identified through both internal and external audit processes, local and national developments and guidance. A regular forum for safeguarding leads is also provided through partnership arrangements.

Recommendations

The Health & Wellbeing Board are asked to NOTE the continuing progress towards the Health and Wellbeing strategy and the development of local resources to support it.

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Background document:

Live it Well: the strategy for improving the Mental Health and Wellbeing of people in Kent and Medway 2010 – 2015.

NHS
West Kent
Clinical Commissioning Group

Health and Wellbeing Strategy Outcome 4 - People with Mental Ill Health Issues are supported to 'Live Well' - UPDATE

Ian Ayres - 20 November 2013

Patient focused
Providing quality,
improving outcomes

By: Ian Ayres, Coordinating Commissioner to the Mental Health Contracts across Kent, Accountable Officer for West Kent CCG

To: Health & Wellbeing Board

Date: 20 November 2013

Subject: Health and Wellbeing Strategy Outcome 4 - People with Mental Ill Health Issues are supported to 'Live Well' - UPDATE

Classification: Unrestricted

Summary: To provide an update on progress for the Health and Wellbeing Board on the Kent Joint Health and Well Being Strategy - Outcome 4 – People with Mental Ill Health Issues are supported to 'Live Well'

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1. BACKGROUND

1. Mental health is affected by issues in the environments we live in, including crime and the perception of crime; proximity to green spaces; housing; unemployment; debt & income levels; the quality of employment for those who do have work; the ability to live independently & autonomously and the freedom from pain and ill health

2. The Kent Joint Health and Well Being Strategy establishes the vision of how Mental Health Services should be designed and commissioned, responding to local need and accessible to all.

3. This has focused Health Commissioners to work with key partners within the Local Authority and stakeholders to transform how Mental Health Services are being delivered; moving away from the traditional hospital based setting and work towards a responsive service that will support people with mental health to live well in their own community.

4. Health Commissioners have capitalised on this opportunity through innovation to ensure care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment and that human rights are protected.

5. CCGs now know more than ever before about the caseload mix of people with serious mental illness in Kent.

6. In March 2012/13 there were approximately 4815 adults in contact with secondary care services in East Kent of whom 2005 were more complex cases.

7. In West Kent, there were 3814 adults aged 18-64 in contact with secondary care services in March 2012/13 of which 1603 were more complex.

8. There were 3962 people over 65 on secondary care caseloads in East Kent and 2385 in West Kent in March 2012/13.

9. Therefore any commissioned Mental Health Services must continue to work towards

   - Improving rates of recognition and diagnosis in Kent and getting people into the right services when they need them;
   - Ensuring more people with mental ill health are recovering;
   - Ensuring more people with mental ill health have good physical health; as identified in the strategy.

2. PROGRESS TOWARDS OUTCOME 4 OF THE STRATEGY

(A)Strategic Measure – Improving rates of recognition and diagnosis in Kent and getting people into the right services

www.liveitwell.org.uk

Developed in partnership with Kent County Council to provide the public, GPs and other clinicians in Kent with help to maintain their wellbeing and quickly find support and information when needed.
Functionality includes a personal support handbook which visitors can create online. Live it Well promotes the 5 evidence based ways to wellbeing and provides practical help.
The information is designed to help early recognition of mental ill health and enable patients and their families to access support to improve their quality of life. Peer support, information on health and social care services including financial support and employment services and other resources to keep well and how to access them are provided as well as information for Carers. Visitors can also access a live online support service.

ACTIVITY TO DATE

During April-June of this year 5444 people visited the Live it Well website compared to 1445 in the same period 2010.

Improving Access to Psychological Talking Therapy in Primary Care

Primary care psychological therapies are available through self -referral or GP referral to offer treatment for people with common mental health disorders such as anxiety or depression

Investment in primary care psychological therapy in Kent has **risen from £1.8 million** in 2009/10 **to £6 million** in 20012/13. In 2010 there were **5663** referrals to primary care talking therapy in Kent compared **to 25560** in 12/13. A 78% increase within 3 years.

As of 2012/13 Patients have an improved choice of ten providers and therapies through the Any Qualified Provider Framework.

During 2013/14 **31,855** referrals to primary care talking therapy are expected across Kent of which 25,484 should enter treatment.

ACTIVITY TO DATE

Recovery rates in Kent are better than the England average with all CCG areas achieving or near the 50% target apart from Thanet where cases are more complex.

Mental Health Matters Helpline

Mental Health Matters helpline is now available 24 hours a day, 365 days a year.
People feeling distressed, anxious, or down, are able to call the Mental Health Matters helpline on 0800 107 0160, round the clock.

Support workers at the helpline use counselling skills to provide confidential emotional support and guidance, free of charge. They also have details of local and national support services.

ACTIVITY TO DATE

There were 3963 calls made to the helpline between April and June 2013 compared to 2078 in the same period of 2011. This is a 47% increase over 2 years.

Primary care mental health workers – pilot project

To provide specialist care to people with stable long term mental health conditions who would otherwise be in need of secondary care services.

This project is delivered within the GP community setting, which provides opportunity to work with patients in improving their physical health and well being.

This might include smoking cessation, weight management, tackling malnutrition, drug and alcohol misuse. In East Kent there are 7 and DGS and Swale there are 4 and more planned for next year.

ACTIVITY TO DATE

Evaluation of the pilot is scheduled to be completed by quarter 4 of this financial year.

Community Link Workers

A new community support scheme for patients with Mental Health conditions that are living independently is in the implementation phase across CCGs.

Community Link Workers, work closely with GPs to help identify practical solutions to issues such as housing, access to benefit and employment.

ACTIVITY TO DATE

Evaluation of the pilot is scheduled to be completed by quarter 4 of this financial year.

Liaison Psychiatry Services based in Acute General Hospitals

The role of these services is to prevent unnecessary admissions and reduce length of stays for patients with a mental illness in Acute Hospital.

ACTIVITY TO DATE

There was a 20% reduction in the number of people known to secondary care mental health services who attend Emergency Departments at Acute General Hospitals with no physical medical need during 2012/13

By Q1 of this financial year, 668 people in Kent were seen by Liaison services in Acute General Hospitals.

Early Intervention in Psychosis

This scheme provides systemic support to young people and their families s to maintain employment, education and socially inclusive activities to prevent admission to more formal mental health services.

ACTIVITY TO DATE

168 new cases will receive intensive interventions during 2013/14 in Kent.

Crisis Home Treatment Services

Provide interventions and support to treat people in their own homes and prevent admission to mental health acute inpatient hospitals unless required.

ACTIVITY TO DATE

2390 referrals were received by Crisis Home Treatment services in Q1 2013/14 in Kent.

(B)Strategic Measure – Ensuring more people with mental health are recovering

Recovery-oriented services

Commissioners are working with providers to support people to build lives for themselves outside of mental health services with an emphasis on hope, control and opportunity.
The Implementing Recovery programme provides tools for people to assess how well they are doing and take steps to become more recovery-oriented.
A transformation programme is underway to embed recovery-orientated practice in Kent. Progress has been made, however there is more to do to ensure that the workforce is available to provide the care needed.

Part of this area of improvement is to embed the use of clinical outcome measures such as the Recovery Star and Health of the nation outcome scores. This will provide information on the progress of people towards the aims they have agreed themselves in their personal care plans.

ACTIVITY TO DATE

From the 1st October 2013 every new service user in secondary care will have a personal care plan including a crisis plan and will have had greater involvement in the agreement of their care plan.

(C)Strategic Measure – Ensuring more people with mental health have good physical health

People with a severe mental illness die up to 20 years younger than their peers in the UK (Chang et al., 2011; Brown et al., 2010). The mortality rate among people with a severe mental illness aged 18-74 is three times higher than that of the general population (HSCIC, 2012).

Whilst there has been some improvement in the monitoring of physical health in secondary care services more work is required to improve the communication between secondary and primary care. The integration of physical health into decisions about prescribing and monitoring of medication has improved as evidenced in the results of the 2012/13 CQC community survey.

ACTIVITY TO DATE

100% of inpatients receive a physical health check as inpatients in mental health acute wards.

In Community mental health services only 33% of people were recorded as having had a physical health check in Q1. This is expected to be at 90% by the end of 2013/14.

Whilst the figures would appear to be low, this is an improvement from previous years when data on physical health checks was not collected in secondary care community services.

An innovation scheme to improve the measure of nutrition, swallowing assessments and appropriate interventions for people with severe dementia has been introduced in 2013/14 for people receiving secondary care.

3. AREAS OF FOCUS FOR MENTAL HEALTH COMMISSIONING IN 14/15

Health Commissioners will continue to:

- Promote independence and ensure the right care and support is available to prevent crisis.
- Build skills and teams to enhance psychiatric and psychological care
- One point of access 24 hours 7 days a week for urgent advice or assessment.
- Improve interagency working, particularly police, acute trust, GP and social care.
- Ensure that all people with a significant mental health concern or their carers can access a local crisis response service at any time
- Whole system working to serve the needs of people with long term physical conditions and medically unexplained symptoms
- Improve communication between primary and secondary care leading to better physical health care, intervention and monitoring.

- Embed recovery orientated practice engaging with the patient to ensure they are consulted and agree their own care plan
- Enhance recovery care and communication with general practice during recovery and discharge period.
- Increase the employment rate among people under the care of secondary mental health services.

4. RECOMMENDATIONS

For the Board to note the report.

Report for Kent Health & Wellbeing Board on Mental Wellbeing in Kent

There are two *key* public health indicators in the National Public Health Outcomes Framework. These are 'Suicide' and a 'potential placeholder' for 'social isolation'. The 'placeholder' indicator means that it is not clear yet how this indicator will be measured or monitored. Therefore for the purposes of this report only progress on Suicide will be discussed.

However, Appendix 3 shows that on the new national measure of subjective well-being, the Kent population appears to be happier but more anxious then the England population.

1. Introduction: Suicide – Why this is an important issue for Kent

Suicide is a major public health issue and is a devastating event for families and communities. Suicide rates in Kent are slightly lower compared to England. In Kent 121 people (aged over 15) committed suicide or died by undetermined causes[i] in 2012. Suicide is responsible for almost 1% of all deaths in Kent and is the highest cause of death in people aged 25-44 years old and one of the three leading causes of death in young people under 25. The Clinical Commissioning Group (CCG) with the highest suicide rates in Kent is South Coast Kent CCG.

A new national suicide strategy was published in 2012 with a stronger emphasis on public mental health and supporting families than previous strategies. This supports the National strategy for Mental Health "No Health without Mental Health" which outlines a holistic approach to improving population mental wellbeing. Suicide is often used as a 'proxy indicator' for public mental wellbeing and can indicate poor access to mental health services.

In Kent – there is a 'Kent and Medway Suicide Prevention Strategy' and this strategy runs up to 2015 but due to key policy changes is now due for refresh.

This report will outline key facts and figures about suicide in Kent and provide an update on what the current strategy has achieved and where to go next.

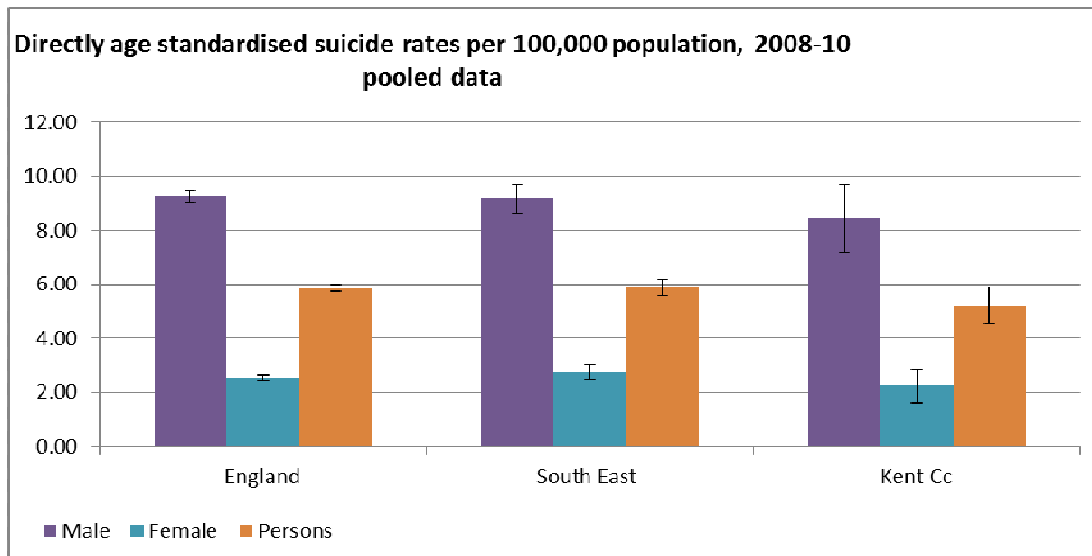
1.1 Suicide Rates in Kent

In Kent the Suicide rate for men is 8.43 per 100,000 people, for women, 2.24 per 100,000 people and for combined population 5.24 per 100,000 people for 2008-10 (Figure 1).

It is commonly acknowledged in the field of suicide research that official statistics underestimate the 'true' number and rate of suicide. The main reason for this is the misclassification of deaths i.e. the cause of death is coded as something other than suicide. An example of this may be where a coroner cannot establish whether there was intent by the individual to kill him/herself and the cause of death may be recorded as one of 'undetermined intent' or 'accidental'. This may occur in situations where the death involved a road traffic accident or where there is long term illness. It could also be

difficult to determine whether there was intent to die in situations of self-harm leading to suicide. This is why the actual number of suicides is usually higher than the reported numbers.

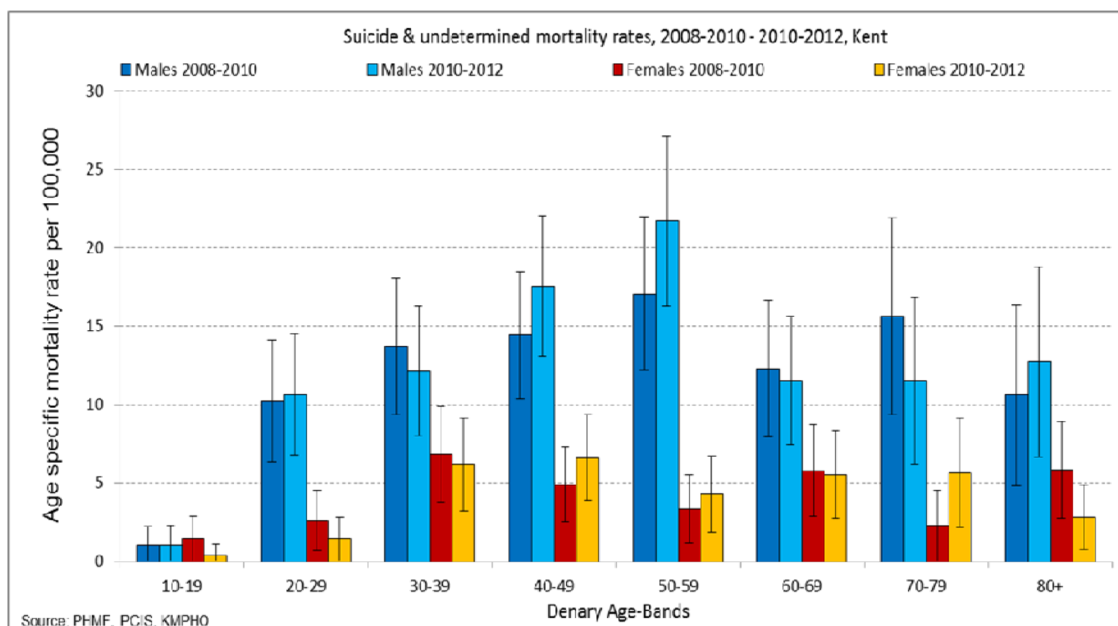
Figure 1



2. Who is at Risk of Suicide in Kent?

Most suicides in Kent are committed by white men aged between 30 and 60 (figure 2). This is similar to the national pattern. Based on national data approximately 30 per cent of people committing suicide have been in contact with mental health services. It is likely that the majority - between 65 and 75 per cent - have *not* been in contact with mental health services. This is why preventing suicide needs to involve people from a wide range of agencies and not just mental health services.

Figure 2



There are five main groups of people who are most at risk from committing suicide.

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups (doctors, nurses, veterinary workers, farmers and agricultural workers - probably because they have ready access to the means of suicide and know how to use them).

The Kent and Medway Suicide Prevention Action Plan for 2010-13 target these high risk groups.

There are also nine key groups identified in the National Suicide Prevention Strategy as needing tailored and targeted approaches to public mental wellbeing in order to reduce their suicide risk.

The Nine Key Groups are:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Kent Strategy and Action Plan will be reviewing these interventions in the next 12 months.

2.1 Self Harm or 'Para Suicide'

The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population. (Self-poisoning and self-injury in adults, Clinical Medicine, 2002)

People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past. (National Collaborating Centre For Mental Health). People who self-harm repeatedly are at a higher and persistent risk of suicide and even death. (Owens et al, 2002: Hawton et al, 2003).

In contrast to the trends in completed suicides, the incidence of self-harm has risen in the UK over the past 20 yrs and is a worrying feature of our society. Recent audits have highlighted that self-harm is high among young women.

In 2011 Public Health in West Kent conducted an audit of self-harm cases in A&E departments. Applying National Prevalence rates suggested that in 2007 an estimated 30,414 people in West Kent had a history of self-harm. The audit took place from 1st November 2011 to 31st January 2012 and found 126 cases of deliberate self-harm in that period. Of the cases audited, 62% were women and

38% men while 37% of all cases were aged between 16 and 25yrs and 72% of the cases aged 16- 25 yr. were young women.

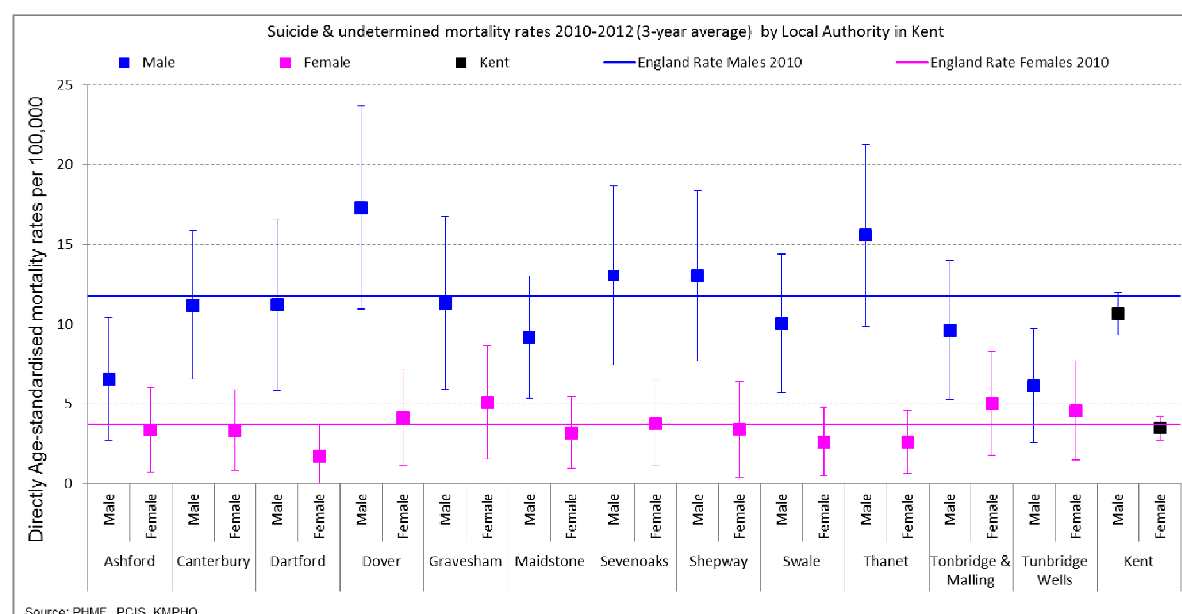
3. How do people commit suicide in Kent?

The majority of deaths due to suicide are a result of hanging. Men usually use this method. The next most used method is falling from a high point or throwing self onto rail tracks or traffic. Amongst women the most used method is poisoning (pills or other substances), however more recent reports from national data shows that women are using more aggressive methods of suicide.

4. Where are the 'hot spots' in Kent for Suicides?

Due to relatively small numbers of people committing suicides in each Kent district (see Appendix 1) the hot spot areas can fluctuate year on year. The highest number of people committing suicide in 2012 was from Dover District, where there were 17 deaths. When converted into rates (so that population size is accounted for) it is Dover and Thanet that are the hot spots for men and Gravesham, Tonbridge & Malling and Tunbridge Wells for women (Figure 3) as their rates are above that of the England average.

Figure 3



4. What are we doing about this? Review of Kent and Medway Suicide Prevention Plan 2010-2015.

There are five core actions outlined in the Kent & Medway Suicide Prevention Plan. These are:

- Reducing risk in high risk groups
- Promoting the wellbeing in the wider population
- Reducing the availability and lethality of methods of suicide
- Improving reporting of suicides in the media
- Monitoring of suicides and statistics

Appendix 2 provides a brief report on progress and achievements to the Plan.

The plan has been largely successfully implemented. It must be noted that there were no NHS PCT funds allocated for public mental health in the last 5 years and therefore actions taken to implement the plan were largely bending mainstream funding to become more responsive to the public's mental health.

The Mental Well Being Programme in Kent from 2010 to present consisted of:

- The Live it well website
- A Local signposting pilot at primary care in Thanet
- Implementation and audit of psychological therapies
- Improving data and needs assessment
- Improving veteran and military wellbeing via a Kent wide counselling programme and network
- Investment and delivery of a young healthy minds programme to enable wider reach for CAMHS (Child mental health services)
- Time to Change campaign (anti Stigma)
- Investing in Health Trainers for offenders in probation services
- Working with Library services to provide books for well being
- Mental Well Being Impact Assessment in West Kent

4.1 New Investment into Public Mental Well Being by Public Health KCC

An evidenced based 10 point Plan for Well Being is in progress in order to tackle Adult Mental Well Being in Kent from 2013 to 2015 and has been progressed in the Public Health 100 day plan. This Mental Well Being Plan will be delivered in partnership with directorates across KCC and will benefit Health and Well Being Partners.

The 10 Point Plan is as follows:

i. Large Scale **Campaigns** using social marketing and working with other councils in the south east. **Signposting:** The Live it Well website will be improved and marketed to the whole population and publicised widely. (with FSC)
ii. **Workplace Health :**Across all directorates including Training
iii. **Primary Care:** GP practices will have workers who will link patients with common mental illness to community programmes and wellbeing services. (with FSC)
iv. **Community Development and Engagement**: Men will be targeted by using an innovative social marketed community engagement programme called SHEDs. This will also target ex-military. It is a peer support and outdoor activity programme that benefits the whole community. Also working with KCC Dementia friendly towns – community innovation funds will be strengthened. (With Customer and Communities & FSC)
v. **Asset Mapping:** There are many wellbeing programmes that are not funded by KCC or NHS that can be publicised and used to improve wellbeing. This programme will find them and map their economic and social impact to enhance and provide value for the public and commissioners. (With BSS Policy): Pilot areas Dover and Swale.
vi. **Mental Health Inequalities:** Conduct large scale mental wellbeing impact assessments (which is an internationally recognised community participation and action planning

methodology) to improve outcomes for people in targeted populations. (with Districts and CCGs and Voluntary Sector)

vii. **Training:** roll out Mental Health First Aid Training (suicide awareness) systematically across Kent

viii. **Improve Health of People with Mental Health Problems:** Health Trainers for people in community mental health services

ix. **Community Resilience Building** via **Healthy Living Centres:** Working with Libraries and Pharmacies to turn the community into a wellbeing friendly environment (with Customer and Communities & CCGs)

x. **Audit and Evaluation:** Continue to provide high quality data and evaluation on performance e.g. suicide and self-harm audit and psychological therapy access audit.

Report Author

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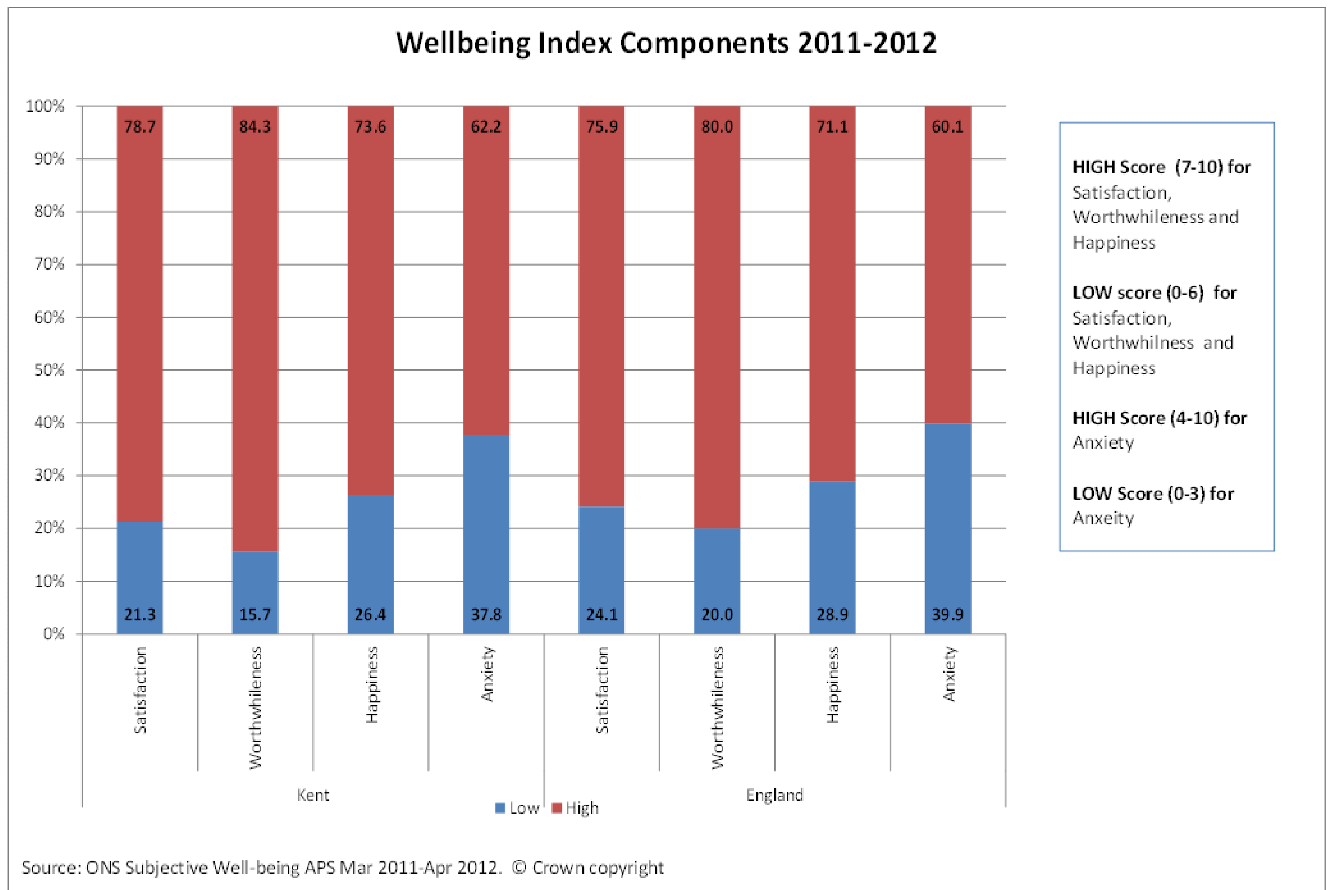
The Kent and Medway Public Health Observatory

Appendix 1

Kent Well Being Index: Compared to England Average.

Kent scores on the new subjective wellbeing scale (measured by the Office of National Statistics) show that people in Kent are more satisfied, feel more worthwhile and more happy then the average England population, however- Kent scores indicated the population are more anxious then the England population.



Appendix C

Appendix 2

1.1Number of deaths from suicide and undetermined causes by district

Local Authority	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Ashford	13	9	*	11	7	9	*	6	7	7	*
Canterbury	12	12	14	14	13	10	9	14	10	10	10
Dartford	10	*	9	8	7	7	*	9	*	9	6
Dover	6	11	17	15	6	14	10	12	9	12	17
Gravesham	8	15	12	7	7	12	6	7	8	9	8
Maidstone	14	13	12	14	13	8	11	15	7	9	15
Sevenoaks	9	8	12	*	10	9	*	9	7	9	15
Shepway	11	17	*	13	8	8	*	9	10	12	8
Swale	*	9	17	9	14	10	9	15	11	6	10
Thanet	9	15	14	8	12	17	11	13	8	17	14
Tonbridge & Malling	6	8	6	8	7	11	7	14	11	9	9
Tunbridge Wells	14	14	7	14	10	11	14	9	7	7	7

1.2 Number of deaths from suicide and undetermined causes by CCG

Clinical Commissioning Group	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Grand Total
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	81
NHS Canterbury CCG	12	16	16	16	16	17	10	20	13	13	15	164
NHS DGS CCG	22	28	27	16	18	22	8	21	15	23	22	222
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	201
NHS SKC CCG	17	26	20	27	13	20	12	19	18	24	22	218
NHS Swale CCG	4	7	16	8	12	5	8	11	9	3	8	91
NHS Thanet CCG	9	15	15	8	12	17	11	13	8	17	14	139
NHS West Kent CCG	39	35	31	39	36	36	35	42	30	29	38	390
Grand Total	**139**	**148**	**148**	**146**	**137**	**148**	**102**	**151**	**114**	**129**	**144**	**1506**

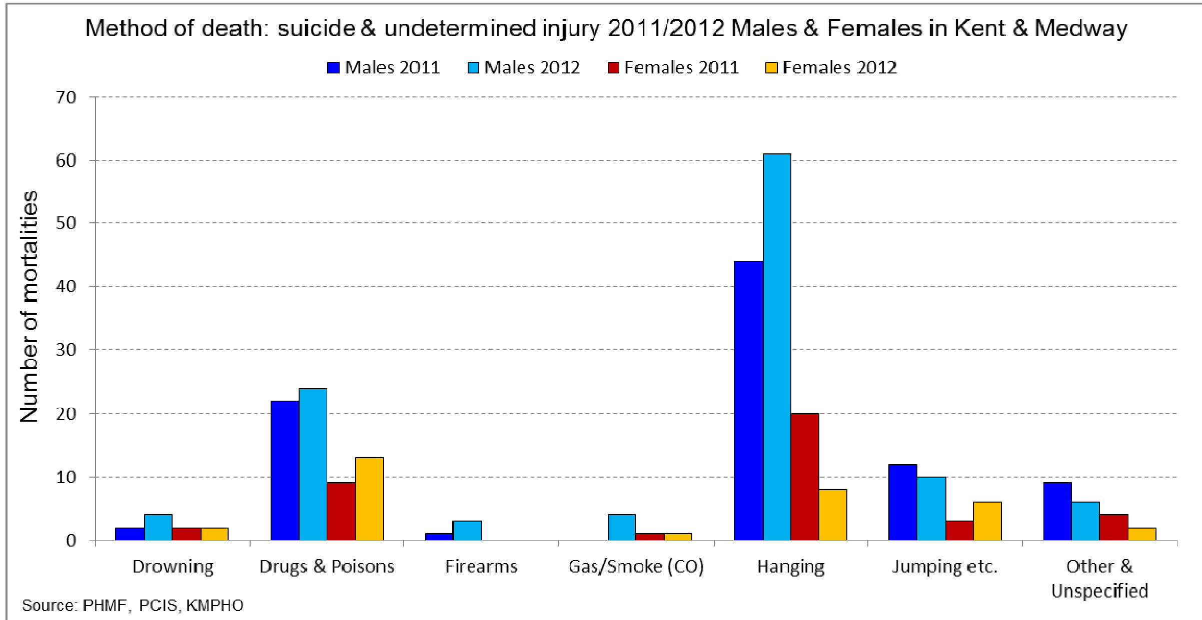
Year	Drowning	Drugs & Poisons	Firearms	Gas/Smoke (CO)	Hanging	Jumping etc.	Other & Unspecified	Grand Total
2002	5	14		1	8	5	2	**35**
2003	2	9			15	1	3	**30**
2004	3	15			6	3	4	**31**
2005	3	20		1	14	3	7	**48**
2006	2	13		1	10	1	6	**33**
2007	2	16		1	8	4	3	**34**
2008	4	10		1	11	1	2	**29**
2009	6	12			12	3	6	**39**
2010	1	10		1	13	3	3	**31**
2011	2	9		1	20	3	4	**39**
2012	2	13		1	8	6	2	**32**
Grand Total	**32**	**141**		**8**	**125**	**33**	**42**	**381**

1.3 Main method of suicide 2002-2012 in Kent and Medway females

1.4 Main method of suicide 2002-2012 in Kent and Medway males

Year	Drowning	Drugs & Poisons	Firearms	Gas/Smoke (CO)	Hanging	Jumping etc.	Other & Unspecified	Grand Total
2002	6	30	4	2	40	9	13	**104**
2003	4	22	3	1	66	11	11	**118**
2004	4	27	4	1	57	11	13	**117**
2005	4	25	2		53	7	7	**98**
2006	3	23	6	5	47	15	5	**104**
2007	9	32	1		49	9	14	**114**
2008	3	14	2		44	3	7	**73**
2009	6	25	3	2	54	12	10	**112**
2010	3	15	1		48	8	8	**83**
2011	2	22	1		44	12	9	**90**
2012	4	24	3	4	61	10	6	**112**
Grand Total	**48**	**259**	**30**	**15**	**563**	**107**	**103**	**1125**

1.5



Appendix C

Appendix 3

Summary of the Suicide Prevention Implementation Plan 2010-15

Priority	Actions taken/population affected	Status /activities
1. Reducing risk in high risk groups	High risk groups include: • those with mental illness • those who self-harm • offenders • older people • unemployed • those abusing substances	• Appropriate suicide prevention plan in place in KMPT. • Mandatory training of staff in suicide prevention and risk assessment continues • KCA and KDAAT are now part of the Steering Group • Ligature audits completed & recommendations implemented in KMPT. • Self-harm audit in A & Es carried out in East & West Kent & findings widely disseminated including in all councils. • Recommendations made to extend Liaison Psychiatric service in West Kent to 12 midnight every day like in East Kent • Some/most GPs need development to quickly identify patients at risk of suicide & training is being sourced • Mental Health services for prisoners now appropriately funded. • Training was carried out by programme manager for carers in West Kent in Feb 2013. Carers, especially carers looking after older people are targeted in next wave of mental health 1st AID training this month.
2. Promoting wellbeing in the wider population	• Those in financial difficulties • Those bereaved through suicides • Those misusing substances.	• Publication of articles in local papers • Radio interviews • Community sign posting now available through several avenues like One Stop shop, voluntary organisations, Liveitwell.org.uk etc. • KMPT supporting better access to information for those bereaved by suicide • KDAAT actively participating in the steering group should lead to better joint working between services

		• Having an equitable use of IAPT services
3. Reducing availability & lethality of methods	• Those deliberately dying by bridges & train stations • Those taking an overdose of prescribed drugs	• Hot spots have been identified including Ashford Bridge & Whitstable train station using data shared by Police • Samaritans have put posters & signage in place on the Whitstable line. http://www.thisiskent.co.uk/Woman-hit-train-suicide-spot/story-13688307-detail/story.html#axzz2XzSEb6mp • On-going discussions with KCC Major Capital Project unit re Ashford Bridge signage
4. Improving reporting of suicides in media	The media (including internet sites) could influence the decision of some population groups, such as young people to take their own lives through copycat action	Reporting monitored on an on-going basis through cuttings of press reporting and TV programmes
5. Monitoring of suicide statistics	Police, KMPT & other agencies sharing information collected with group.	• There is regular local monitoring of suicide trends in Kent and Medway • Baseline information has also been obtained on the trend of self-harming behaviour • Coroners have agreed to give regular updates to the KMPHO

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[i] Undetermined causes are a category of coroner verdict that is counted along with Suicide by the ONS and is regarded as ‘probable suicide’.

By: Roger Gough, KCC Cabinet Member for Education and Health Reform & Chairman of the Kent Health and Wellbeing Board

To: Health and Wellbeing Board - 20th November 2013

Subject: The Integration Transformation Fund

Classification: Unrestricted

Summary

Since the announcement of the Integration Transformation Fund (ITF) in August further details have been issued by government and a planning template has been circulated for completion by CCGs. Timescales have been further defined and progress has been made in Kent. This report updates the Health and Wellbeing Board on these developments. It should be read in conjunction with the other reports before the Board relating to the Kent Integrated Care and Support Pioneer programme; integrated system intelligence; and the proposed system leadership programme.

Recommendations:

The Kent Health and Wellbeing Board is asked to:

1. Approve the delivery mechanisms for the ITF plan and mandate the Integration Pioneer Steering Group to begin delivery of the plan.
2. Consider establishing a programme support group for the Integration Transformation Fund planning process from across the Board's member organisations.
3. Receive the final draft of the ITF plan for Kent at the meeting scheduled for 29 January 2014

1. Introduction

1.1 At the last meeting of the Kent Health and Wellbeing Board a report was presented giving details of the recently announced Integration Transformation Fund. It was agreed that progress towards the planning and implementation of the ITF would be reported to each subsequent Board meeting. Since the last meeting further information has been issued by the government regarding the fund and work has started in Kent towards production of the plan.

2. Government information

2.1 The LGA and NHS England issued further details of the ITF in October. Emphasis is again placed on the need to create a shared plan for the totality

of health and social care activity and expenditure and this should extend "way beyond" the effective use of the mandated pooled fund. The ITF plan is intended to form the first part of a five year strategy for health and social care. The associated NHS planning framework will invite CCGs to agree five year strategies with a two year operational plan covering the ITF.

2.2 Further recognition is given to the requirement that ITF funding will need to be diverted from already committed core activity as it will "significantly exceed" any existing pooled budget arrangements.

2.3 Ministers have yet to decide on the performance metrics that will decide the allocation of the "pay for performance" element of the fund (also known as the "at risk" money) but local discussions are not to be confined by what can be measured and should focus on using the fund as a catalyst for agreeing a joint vision of how integrated care will improve outcomes for local people.

3. Distribution of the fund

3.1 Detailed funding allocations to councils will be announced in the normal way through the Autumn Statement and will be for two years – 2014/15 and 2015/16. For 14/15 the existing s256 transfer for social care to benefit health (£900 mil) plus the extra £200 m will be distributed under the existing allocation formula. The distribution of the full £3.8 bn for 15/16 is still subject to ministerial decision. Allocations will be notified to health and wellbeing boards based on the aggregate of these two mechanisms. Full details, including the pay for performance elements, will be included in the notification letter to boards being sent out in due course.

4. Potential indicators

4.1 Latest guidance recognises that the number of measures that can be utilised are limited because it must be possible to baseline them in 2014/15 and for simplicity should be relatively few. Ministers have yet to confirm the preferred indicator set but currently under consideration are:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of re-ablement
- Admissions to residential and nursing care
- Patient and service user experience

4.2 Work is continuing to develop indicators that better reflect outcomes for individuals to be introduced in 16/17.

5. Legislative change

5.1 The Department of Health are considering whether any changes to legislation will be necessary to implement the ITF and further details will be made available as and when necessary.

6. Health and Wellbeing Board responsibilities

6.1 The Health and Wellbeing Board will sign off the plan but for the DH the Board is advised that it "will be valuable to be able to":

- Aggregate the ambitions set for the fund across all Health and Wellbeing Boards
- Assure that the national conditions have been achieved; and
- Understand the performance goals and payment regimes have been agreed in each area

6.2 A draft template has been circulated that it is expected will be used in developing, agreeing and publishing the integration plan (attached as Appendix A).

6.3 In addition local areas are required to compile an agreed shared risk register which as a minimum will cover risk sharing and mitigation if activity volumes do not change as anticipated.

6.4 Jointly agreed plans will need to be signed off by the Health and Wellbeing Board, constituent councils and the CCGs.

6.5 It follows that the Kent Health and Wellbeing Board will assume responsibility for ensuring that the commissioning decisions of its member organisations are properly informed by the ITF plan and that activity is aligned with the priorities identified through the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. The Joint Health and Wellbeing Strategy itself is currently under revision and will reflect the ITF plan.

7. Government support and assurance

7.1 The assurance process will be aligned to existing NHS planning rounds.

7.2 Each region will have a designated lead local authority Chief Executive to work with the NHS Area and Regional Teams, local authorities and other interested parties to identify how Boards can support one another and work collaboratively. (In Kent this may be helpful in considering the Medway dimension).

7.3 The national Health Transformation Task Group will co-ordinate advice, guidance and support.

8. Timetable

8.1 Health and Wellbeing Boards are required to return the completed planning templates by 15th February 2014 to enable aggregation at a national level and identify any challenges that have arisen. It is proposed that the Kent Health and Wellbeing Board meeting on the 29th January receives the final draft ITF plan for approval prior to submission.

9. Developments in Kent

9.1 Department of Health Integrated Care and Support and Pioneer Programme

9.1.1 Kent has been successful in achieving Department of Health Integrated Care and Support and Pioneer Programme status following the submission of our bid earlier this year. The Integration Pioneer Steering Group has been established and has met for the first time. As agreed at the last Kent Health and Wellbeing Board meeting it is considering how it will develop the plan for the ITF in Kent.

9.1.2 Further details on the Pioneer programme are given in the specific report before the Board today. The appendix to the report includes the Terms of Reference for the Kent Integration Pioneer Steering Group and a diagram showing its governance and relationship to associated work streams and groups. The inclusion of Children and Transition issues in the Group's Terms of Reference should be noted and the Board may wish to ensure this that integration of children's commissioning and services is appropriately reflected in the ITF plan.

9.1.3 The Pioneer Programme and the Integration Transformation Fund are separate but intrinsically linked and it is logical for the Kent Integration Pioneer Steering Group to provide the focus for delivery of the ITF on behalf of the Kent Health and Wellbeing Board. The Health and Wellbeing Board may wish to consider whether the work on the Integration Transformation Fund should be supported through a designated Programme Team drawn from a range of Board members including CCGs.

9.2 Systems Leadership programme

9.2.1 The Board will also have before it today a report on the Systems Leadership programme that is engaged in Kent. Full details are incorporated in that report but it is intended that the programme focuses on some of the leadership and organisational issues that may influence the delivery of the ITF in Kent.

9.3 Integration position statement template

9.3.1 As agreed at the last Board meeting all members of the Health and Wellbeing Board have been requested to complete a template giving details of the initiatives in their area that promote integration and service redesign intended to reduce hospital activity. This information will help provide a baseline from which to assess progress towards full integration by 2018 and the ITF over the next two years.

9.3.2 The Board may also benefit from understanding the total amount of the aggregation of financial deficits across the health and social care system in Kent that the ITF and other integration activity will need to address to ensure a sustainable health and social care system from 2018 onwards.

10. Conclusions

10.1 Activity including the Integration Pioneer Steering Group and the System Leadership support programme is being aligned with the ITF in order to ensure maximum support is available to deliver the objectives of the fund in Kent but the timescales for completion of the ITF plan in Kent are now even more challenging given the acceleration of the date for submission to 15th February. By then the Board must be satisfied that the plans drafted are robust and realistic and that the aggregation of intentions of each of the seven CCG areas in Kent reflect the needs and aspirations of the people of Kent. It should also be noted that part of the plan template includes reference to the consultation activity undertaken with local people in the compilation of the plan.

11. Recommendations:

11.1 The Kent Health and Wellbeing Board is asked to:

- Approve the delivery mechanisms for the ITF plan and mandate the Integration Pioneer Steering Group to begin delivery of the plan.

- Consider establishing a programme support group for the Integration Transformation Fund from across the Board's member organisations.
- Agree to receive the final draft of the ITF plan for Kent at the meeting scheduled for 29 January 2014

12. Background Documents:

- The Integration Transformation Fund – report to the Kent Health and Wellbeing Board 18th September 2013
- Department of Health Integrated Care and Support and Pioneer Programme - report to the Kent Health and Wellbeing Board 20th November 2013
- System Leadership - report to the Kent Health and Wellbeing Board 20th November 2013
- Integrated Systems Intelligence- report to the Kent Health and Wellbeing Board 20th November 2013

13. Contact:

Mark Lemon

Strategic Business Advisor

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By:	Anne Tidmarsh, Director of Older People and Physical Disabilities, KCC
To:	Kent Health and Wellbeing Board, 20 November 2013
Subject:	**Department of Health Integrated Care and Support and Pioneer Programme**
Classification:	Unrestricted

Summary: Kent has been successful in becoming an Integrated Care and Support Pioneer. This paper provides an update on the governance arrangements for delivery within the programme and the links to the Integration Transformation Fund.

For Information

1. Introduction

1.1 The Health and Wellbeing Board supported the submission to become Department of Integration Pioneers in July and the creation of a group to coordinate the work programme involved.

1.2 Kent has now been successful in its bid and has been named as one of 14 areas in the Department of Health Integrated Care and Support Pioneers Programme (see appendix). Kent will be supported by a team from NHS Improving Quality and delivery within programme will include an independent evaluation of outcomes achieved. A launch conference for the Pioneer programme will take place on 3 December with representatives from across Kent's bid attending.

2. The Integration Pioneer Steering Group

2.1 To support the delivery of the Pioneer Programme a sub-group of the Kent Health and Wellbeing Board has been convened The group is an informal working group of the Health and Wellbeing Board, linked to local HWBs to support partners in delivery. Existing governance arrangements retain accountability.

2.2 The group will help set aims, objectives and priorities within the Integration Programme and inform the development of outcome measures and the new Health and Wellbeing Strategy. Membership of the group includes leads from across the Pioneer partners and additional members can be co-opted as required.

2.3 The Steering Group met on 4 November and agreed the terms of reference (see appendix). Further work is to take place on mapping existing local delivery of integration against the outcomes identified within the Pioneer bid, to create a measurable programme plan. The group agreed that Programme Management on behalf of all partners would be provided via the existing Health and Social Care Integration Programme Team.

3. The Integration Transformation Fund

3.1 As a DH Pioneer there is no additional funding provided, however delivery of the Integration Pioneer Programme is underpinned by the ITF. The latest LGA letter on ITF states *"Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches."*

3.2 The Integration Pioneer Steering Group will help coordinate the development of the ITF plans prior to final sign-off by the HWB in March.

4. Conclusion

4.1 Kent becoming an Integration Pioneer provides clear opportunities to deliver integrated care and support at pace and scale. The DH are keen to "barrier bust" and will offer significant support to Pioneers and access to national organisations to help unblock any existing barriers to integration.

4.2 In developing the bid Kent has already made significant steps in developing a shared vision of what can be achieved. However it will require co-ordinated approach to delivery via the Integration Pioneer Steering Group and successful implementation of the Integration Transformation Fund to achieve the level of transformation required to make sustainable change.

5. Recommendation

The Kent Health and Wellbeing Board is asked to: 5.1 Note the creation of the Integration Pioneer Steering Group and that the Steering Group will coordinate the creation of the ITF plans.

6. Contact details

Report author:
Jo Frazer, Programme Manager Health and Social Care Integration, Families and Social Care, Kent County Council
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Kent Integration Pioneer Steering Group – Terms of Reference

Aims and Objectives
Provide a strategic direction and oversee successful delivery of Health and Social Care Integration in Kent. With a particular focus on:

- Whole system integration
- Workforce
- Information systems / Information Platform development
- Year of Care
- Innovation
- Monitoring against the national Narrative (I Statements).

The group is currently working within the context of the Integration Pioneer Proposal and therefore currently focusing on adults with long term conditions and older people. Children and Transition is to be considered at a future point.

Governance
The group is an informal working group of the Health and Wellbeing Board, linked to local HWBs to support partners in delivery. Existing governance arrangements retain accountability.

The group will feedback/report to the joint CCG/FSC DMT, the Health and Wellbeing Board and other relevant groups as required.

A governance map is attached.

Membership
Dr Robert Stewart (Chair)
Roger Gough, Chair Kent Health and Wellbeing Board
Ian Ayres, Accountable Officer West Kent CCG
Patricia Davies, Accountable Officer DGS/Swale CCg
Simon Perks, Accountable Officer Ashford/Canterbury and Coastal CCG
Hazel Carpenter, Accountable Officer South Kent Coast/Thanet CCG
Andrew Ireland, FSC
Anne Tidmarsh, OPPD
Mark Lobban, Strategic Commissioning
Meradin Peachey, Public Health
Michael Ridgewell, NHS England Area Team
Alison Davies, Head of Innovation Research and Development, KMCS
Marion Dinwoodie, CEO, Kent Community Health NHS Trust
Justine Leonard, Kent and Medway Social Care Partership Trust
Julie Pearce, Chief Nurse, Director of Quality & Operations, EKHUFT (acting as Acute Sector lead)
Amber Christou, Head of Housing Swale Borough Council (acting as District Lead)
Jo Frazer, Pioneer/HASCIP Programme manager
Jade Caccavone, Executive support team

Other associated members will be part of a virtual group and will attend meetings when required. The virtual group will have access to the agendas and papers for all meetings via an information sharing portal.

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Tasks
The Steering Group will help coordinate the delivery of the objectives identified in the Kent Pioneer bid. These were:

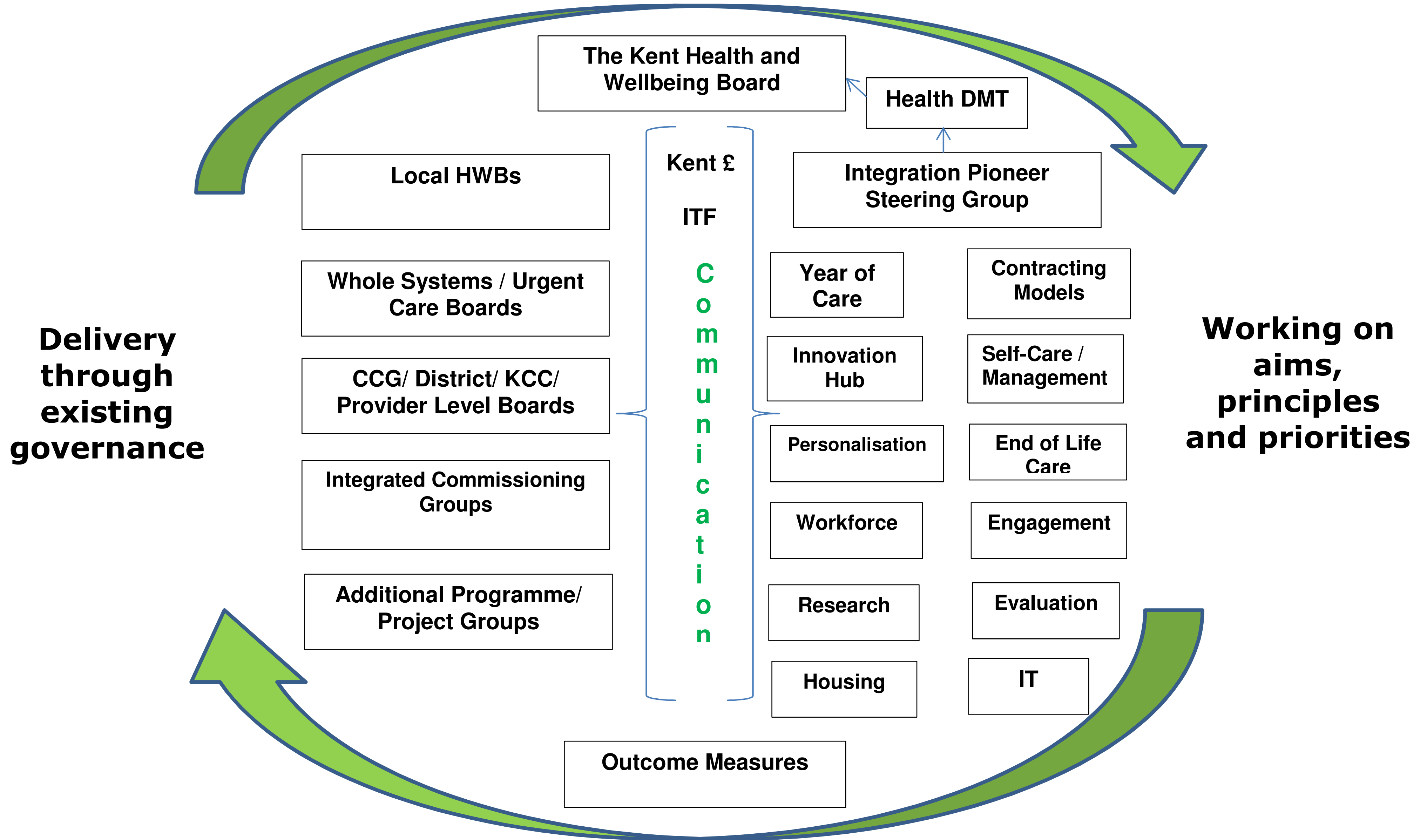
Integrated Commissioning:
- Design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of hospital and care home admissions.
- The Health and Wellbeing Board will be an established systems leader.
- Clinical Design partnerships between the local authority and CCGs with strong links to innovation, evaluation and research networks.
- Year of Care tariff financial model and risk stratification will be tested and adopted at scale.
- Integrated budget arrangements as the norm alongside Integrated Personal Budgets.
- Outcomes based contracts supported by new procurement models will be in place that incentivise providers to work together.

Integrated Provision:
- Good person centred integrated care will be evidenced through use of the Narrative.
- Proactive models of 24/7 community based care, with fully integrated multi-disciplinary teams. The community / primary / secondary care/ voluntary sector care interfaces will become integrated.
- A new workforce with skills to deliver integrated care.
- Leadership of the integrated workforce with a commitment to ‘place’.
- Integrated IT systems to improve patient / service user care, underpinned by personal health records that can be accessed by the individual –“Nothing about me, without me”.
- We will systematise self-care so that people with long term conditions can do more to manage their own health and social care needs to prevent deterioration and over-reliance on services.
- New kinds of services that bridge current silos of working where health and social care staff can “follow” the citizen, providing the right care in the right place.

Additional:
- Position innovation at the centre of integration, including the development of the Kent Innovation Hub.
- Develop integrated citizen involvement, including co-production and use of The Narrative (I Statements).
- Implement an effective evaluation framework.
- Identify research initiatives that can support both evaluation and implementation of integration.

Frequency of Meetings / Administration
The Steering group will meet every two months in advance of the HWB and will be chaired by Dr Robert Stewart or delegated to Anne Tidmarsh. The meetings will be organised and minutes taken by OPPD Executive Support.

Kent Integration Pioneer Steering Group Governance



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From:	Roger Gough, Cabinet Member for Education and Health Reform Meradin Peachey Director of Public Health
To:	Kent Health and Wellbeing Board
Subject:	Integrated Intelligence: how it will support Integrated commissioning?
Classification:	Unrestricted

Summary:

Integrated or whole systems intelligence is increasingly seen as the game changer for integrated commissioning and transformation change to meet the future challenges faced in our health and social care economy. In Kent, much work has already been done to move towards an agreed system to develop a framework to understand how use of health and social care services varies across the whole population, how and what services need to be transformed and improved, and more importantly building local evidence for whole system change, moving towards an integrated model of care.

This paper makes a case for whole systems intelligence and a need to have a cultural shift from analysing data at an organisational level to analysing information across the complete patient pathway. This should include health and social care as well as information on socio, economic and environmental factors that contribute to health and wellbeing. In this regard it is about the effective sharing and management of information at a citizen level, scaled up to a population level to effectively understand the holistic nature of integrated care and the many confounding factors that affect health and social care outcomes and a person's resilience to improved wellbeing.

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Note the importance of this area of work and its links with the wider integration agenda.

(ii) Endorse the establishment of a task and finish group to support the Integration Pioneer Steering Group to establish the necessary processes and mechanisms to construct the plan and deliver the aims and objectives across Kent.

1. Introduction

- A report by the UK Administrative Data task force in 2012 states that **administrative data** collected and held by government departments or agencies has the potential to provide an evidence base that would contribute a rich new resource for research, policy making and evaluation. Improving access to and linkage between **administrative datasets** for research and statistical purposes would have demonstrable effects on economic growth and help us respond more effectively to challenges related to the health and wellbeing of people. Making better use of these under-utilised resources will provide efficiency gains through the re-use of existing data, reduced reliance on more expensive methods of data collection and will speed the production of policy-relevant research. This sits neatly with the current government agenda on integration.
- In Kent, like the rest of the UK, public sector organisations generate extraordinary quantities of **administrative data** in the course of running services – from housing benefits in the district authorities to hospital admissions in the NHS. The term *big data* has come to refer to these very large datasets, and *big data analytics* to refer to the process of seeking insights by combining and examining them.
- An abundance of data and computing power gives us new ways to organise, learn and innovate. The purpose of this brief is to raise awareness to the Kent HWB around the opportunity for data and analytics to transform public service delivery, the challenges this agenda poses for the public sector, and to make recommendations for how commissioners might begin to realise the former whilst addressing the latter.

2. Why is integrated / whole systems intelligence important and what are the benefits?

2.1 Population changes

Demographic changes in our population over the last 30 years have changed considerably how our public sector services, particularly hospitals, are being utilized and who utilizes them. For example, an ever increasing aging population means an increased number of complex frail elderly with multiple chronic and social problems need to access a number of services across health and social care at the same time.

2.2 Commissioning with limited resources

A national funding gap in the NHS of £30 billion by 2020 means that the current approach to commissioning service by service needs to change radically and be more integrated; using intelligence system across the whole system more innovatively. Commissioners need the relevant resources and technical expertise to develop a **longitudinal system using metrics that are person centered / population based, rather than the activity or performance of individual organisations or services.**

Improving the health and wellbeing of the population requires commissioners to have a **cross sectional** understanding how prevention and preventative services impact differently at different population risk groups, eg. impact of healthy lifestyle interventions on wider population (**primary prevention**) versus the impact of

health checks on people at risk of a long term condition (**secondary prevention**) versus the impact of re-ablement and rehabilitation services (**tertiary prevention**) for patients with complex needs.

2.3 Researching and evaluating factors / wider determinants of health and wellbeing

In the health and social care arena, enhanced use of administrative data and analytics for example, could help ensure patients in care homes receive the right medicines at the right times, or help hospitals further personalise patient care and advice to minimise readmissions after surgery. In the welfare arena, better segmentation and personalisation could help identify the support that unemployed people need and get them into long term work.

Research and evaluation can help to inform the redesign of services, and take a more holistic approach including an understanding of the impact of social, environment and economic indicators on a person's likelihood of poorer out comes, additional support etc which will help considerably towards JSNA and JHWS development process as illustrated in Box 1.

Box 1– Research value of administrative data

The 2012 report on *The UK Administrative Data Research Network: Improving Access for Research and Policy* highlights the value that could be derived from such a resource relates to the policy relevant research it enables, examples of which include:

- **Addressing social mobility – by linking data on education, training, employment, unemployment, incomes and benefits**
- **Researching causal pathways over the life course – linking data on education, health, employment, incomes and wealth**
- **Comparative analysis of access to, and the provision of, social care support for the elderly.**
- **Informing policies designed to tackle poverty – linking data on housing conditions, health incomes and benefits**
- **Constructing indicators of parental employment, social background, childcare and relating these to the provision of social care for children**
- **Linking data on (re)offending behaviour, incomes, benefits and health – exploring the role of poor mental health**

In addition to linking administrative data together across government departments, value can also be gained from linking administrative data to other studies, including ongoing longitudinal and other surveys. Linkages of this type have considerable potential for reducing the burden on respondents to such surveys and for improving the quality and extent of the information they provide.

2.4 Understand population need and measuring impact on the whole system

The Kent JSNA is formulated from various needs assessments around different programme areas, diseases and at risk groups, and is supported by local health and social care maps that have some of the core data elements plus other local indicators. It also uses information derived from the national core minimum dataset

which is a suggested list of indicators that should be used as a minimum to describe population need across organisational sectors and themes.

While information is reported in these respective areas to reflect population need, there is still a limited understanding of how all these areas can be contextualised in the whole system, particularly in terms of impact on services. Limitations in the way data is currently accessed and stored within organisations also limits the analysis of data, focusing around specific pathways of care which is the traditional commissioning model. For example chapters on each long term conditions (eg. COPD and Diabetes) explain hospital readmission activity and QOF prevalence in detail, but they fail to distinguish how many of them have multiple long term conditions and their differential impact on other services such as social care and community health.

2.5 Supporting Implementation of Integrated Care

The current national agenda promotes the move to a pro-active preventative integrated care model through various incentives and policy drivers (explained in detail later). This means that intelligence systems need to be more inclusive, holistic and extensive for two reasons:

- To understand the baseline as to how our population are utilizing all services across the systems with a view to work out how each service can be redesigned / re-orientated towards an integrated more cost effective model of care, thus channelling the right amount of investment and disinvestment more systematically between hospitals and the community without destabilising the local economy.
- To design a more robust framework in monitoring and examining the benefits and impact of integrated care not just on organisations but on the whole system over time.

Local data will provide in-depth information for establishing priorities for local action through the Health and Wellbeing strategy and for developing integrated models of care.

3. How is data being used in Kent for intelligence / commissioning purposes?

- A multitude of public sector organisations currently collect and utilise data and data systems. An audit carried out by the Kent & Medway PCT Cluster listed up to a hundred different clinical and management information systems utilised by the different commissioners and provider organisations.
- However, specific mapping is still required to describe the current and future picture of information systems that are being used for intelligence and commissioning purposes. One of the more locally developed systems utilised by GPs in the last few years is the Management Information System in DGS CCG which reports primary care and secondary care utilization information onto one dashboard, developed by the Kent & Medway Health Informatics Service. This tool enables GPs to understand the individual patient needs, and is useful at a CCG commissioning level to understand gaps and outliers within the system. Other dashboards are being used by the remaining CCGs.

- The Kent & Medway Public Health Observatory (KMPHO) routinely link data from different sources to examine and describe relationships between different risk factors and common outcomes eg. death rates 30 days after hospital discharge where both death registry data and hospital admission data are linked together for analysis. More recently it completed an extensive exercise describing service utilization across a risk stratified population where up to 10 different datasets were linked at a patient level which has helped to explain how risk stratification approach could be used for integrated commissioning and integrated care.

4. **What are the challenges?**

4.1 Intelligence based on programme areas versus whole system intelligence

- Business intelligence teams in public sector organisations perform a number of functions particularly activity / contract monitoring and performance management, usually derived from nationally set frameworks and targets, but they are usually orientated around their respective organisational boundaries.
- This means that while we may have good understanding of how many patients / clients are utilizing a specific service because the organisation is collecting data for that purpose, very little understanding is available as to how the same patients / clients are utilizing other services within a defined time period ie. the whole patient / client journey. Several case studies below illustrate the problems within key programme areas.

Case Study 1 – Child Health

Child health data is collated in numerous places and feeds into several repositories, for example, the Child Health Record (red book), National Child Measurement Programme, services such as CAMHS, sexual health clinics, KDAAT etc. As such it can be hard to get an oversight of the population perspective for child health in Kent especially when trying to identify those cohorts with the greatest needs, for example looked after children, unaccompanied asylum seekers, children with disabilities etc. Linking health data with that held by other agencies such as schools and social care is also a current difficulty as highlighted by the problem public health have encountered in identifying health needs of those educated at home, health assessments conducted for looked after children and rates of teenage pregnancy in children in need / at risk. KIASS have been undertaking parallel streams of work such as triangulation of data sources from various agencies to create heat maps and are exploring the development of a single platform to inform case management. However, this is different from data linkage (at citizen level) for the whole population because the latter would give far greater understanding of the needs of specific cohorts and how commissioning could therefore be integrated to reduce duplication of services and ensure needs are being met holistically.

Case Study 2 – Mental Health

Mental health data is stored in numerous places and at many differing levels and as such it makes it hard to get an overall picture of the mental health need in the population. The epidemiology of mental health is problematic as it is often applying national survey data to local populations. The use of the MINI 2K is also used to predict mental health need (this is an index of current severe mental health demand and is not based on need in the population). Data is collected in primary care on both common mental illness (QoF depression), and on Severe (QoF CPA) and there is also another QoF measure for long term conditions with severe mental illness. However, much of this data is not linked up together or with Mental Health Trust in patient data. On top of this there is wealth of data and information in the IAPT psychological counselling service, which again is fragmented and rarely triangulated with QoF or patient records. Linking this data at a citizen level, particularly with other long term conditions and with other issues such as sickness records and social care data may well enable us to improve patient outcomes, streamline services and provide an integrated and wraparound care in a more timely fashion.

4.2 Information Governance

- Until recently, national and international legislation on data protection, patient confidentiality and information governance have not clearly distinguished between the use of shared information and data for effective public sector service commissioning for the benefit of community or population, and the use of sharing information for the benefit of the patient / citizen. **The key to integrated intelligence is the safe transfer of data at a pseudononymised level to understand the various factors, barriers and gaps to improved integrated services, providing holistic support to a patient / client but aggregated at a whole population level. This differs from the sharing of individual patient records for care coordination which is about individual patient / client care. Commissioners need to be clear at what level we will be using and accessing the data so that information governance arrangements can enable, not block access.**

- The Caldicott2 Review and HSCIC report issued in the last two months have given suggestions and guidance as to how local areas can carry out their own data linkage, analysis and reporting of data complementing a similar role to be carried out nationally by the HSCIC.

4.3 Linking datasets and improving data quality at a local level

- Most administrative datasets used by public sector organisations are not designed for research purposes and thus not subject to statistical standards or quality controls. As the systems that generate them change, so might the data. They may be difficult to access, and linkage may be prohibited or may not be feasible.

- There is still a local need to explore issues around data quality and completeness, particularly primary care data from GP practices. As data is used and fed back this drives up data quality – especially as those responsible for the data collection begin to see the value to their own areas of business. In this regard discussion is required how this may be taken forward.
- Apart from information governance and data quality there is still the question as to how data sets from different organisations can be linked **at a patient / citizen level,** using a common identifier. While all NHS provider organisations utilise the NHS number for the routine recording of data, non-NHS organisations like district authorities and third / voluntary sector organisations do not and thus resource is required to assign and upload NHS numbers onto existing datasets and databases.
- District authorities hold important data such as housing service provision and council tax (the Nuffield Trust have acknowledged in past reports the importance towards effective integrated commissioning) but may not fall under the remit of HSCIC for data linkage at a national level, which would therefore require local action.

5. How will data integration support local strategic policy drivers?

- Kent's application to be an **Integration Pioneer** acknowledges the importance of whole system intelligence as a key driver for whole system change, moving towards an integrated model of care and building the local evidence base for innovation around service integration.
- The £3.8bn **Integration Transformation Fund (ITF)** announced by the Government expects our area to move toward a fully integrated health and care system by 2018. Outline plans must be agreed by the Kent Health and Wellbeing Board by April 2014 as how this will be achieved, roles and responsibilities of partner organisations, especially acute trusts, and contingency plans if targets are missed. A whole system intelligence solution will not only help inform plans for transformation change but also underpin a robust evaluation and monitoring framework for the progress of that change.
- Kent's recent entry **as an early implementer site into the national Year of Care programme** also uses a whole system intelligence approach to design a new tariff system that will incentivise provider organisations across health and social care to integrate care services around the patients with multiple long term conditions. A key part of the national team requirements is using a **longitudinal person / population centred metric system over time** to test the validity of the new currencies and tariffs.
- A whole systems intelligence approach can also have a positive impact on KCC's own transformational work '**Facing the Challenge'** and the move towards integration.

Appendix 1 highlights the changes between current and proposed system.

6. What needs to happen next?

A cross organisation task and finish group comprising representation from various intelligence teams and information governance, which should report to the Kent Pioneer stakeholder group. The purpose of the group would be:

- Articulate the strategic vision of integrated intelligence in Kent and how it fits with national and Kent Pioneer vision for integration.

- Explore what local and national programmes / projects are currently undertaking similar work.
- Design and support the proposed mapping of integrated intelligence systems identifying where data linkage is required and the resources to do it.
- Identify where data quality is an issue of concern from the various data sets of different organisations, wherever feasible and ensure commissioners are aware of these concerns.
- Discussion around the ability to link datasets to be shared across organisations and utilized by CCGs using appropriate front end / dashboard solutions. The DGS MIS system is a good example. While not all data from all organisations is included it gives an example of what can be done. In this regard Kent Public Health is currently exploring an in house equivalent solution for the purpose of research and evaluation, as explained earlier. Discussion is also underway to explore the possibility of the KMPHO to become and interim safe haven, moving towards an accredited safe haven status which will enable much of the vision outline above to be a reality in the near future.

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Note the importance of this area of work and its links with the wider integration agenda.

(ii) Endorse the establishment of a task and finish group to support the Integration Pioneer Steering Group to establish the necessary processes and mechanisms to construct the plan and deliver aims and objectives across Kent

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Appendix 1

	Current System	Proposed System
Location	Intelligence systems are disparate, organisational based, NHS or non NHS, commissioner or provider	A trusted third party (ie. Public Health) will be able to access link de-identified datasets from different intelligence systems of different organisations **No new data needs to be collected**
Purpose	Mainly for **activity and performance monitoring** of organisations, services and programmes aligned with national outcomes frameworks and performance measures. Limited use for commissioning integrated care	Mainly for **researching** causal pathways of wider determinants of health and wellbeing, **evaluation** of services to improve quality and access, target at risk groups. Ideal for commissioning integrated care
Improving Data Quality and completeness	Process maybe patchy depending on each individual organisation and their obligation to do so. Minimum standards / requirements are limited as they are activity focused rather than patient / citizen focused	Process can be systematised because approach to intelligence will be person / population centric and contribute towards rolling improvement in payment / tariff contract arrangements. Organisations will be obliged to meet enhanced standards as per contract obligations
Information Governance	Most systems are organisational based so IG arrangements for data sharing using a common person identifier across organisations are limited	Data sharing across various organisations NHS, non NHS will be the norm not exception. Current IG requirements are that a trusted third party with an accredited safe haven status can be allowed to access and link de-identified datasets using a common pseudonymised identifier
Longitudinal functionality	Organisations are able to track their activity and performance over time but cannot fully explain causation	Trusted third party will be able to 'track and trace' population sub groups over time and how and why they are utilizing services more robustly
Data linkage	Limited or no data linkage across organisations. Most datasets limited to activity while will have costing data as well	Data linkage will enable in depth analysis across a range of information from demographics, case mix, service utilization activity and costs
Outputs	Most intelligence systems will have bespoke 'front end' solutions or dashboards which report on key indicators derived from national guidelines. However their usefulness in understanding population need will be limited	Datasets linked at a patient / citizen level will enable much more localised precise understanding of how population need impacts on service utilization and spend which can contribute more substantively to products such as the JSNA, JHWS, CCG and district health profiles

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System Leadership – Local Vision – Kent

Summary of the project

This project will focus on supporting **system leadership** across Kent to develop further its approach to integrated commissioning.

The impetus and catalyst behind the development of system leadership is the planning and implementation process required for the **Integration Transformation Fund (ITF)**. This project is about 'how' to make system leadership happen. The analogy is made with diving into deep water. System participants are standing by the side of the pool, with a hesitancy to dive into system working. This project aims to put in place the leadership understanding, behaviours and actions that will enable system leaders across Kent to overcome the barriers to taking the risk of diving in. Specifically, the project will address:

- implications resulting from what organisations need to do to meet the challenge of implementing the ITF and working effectively as a system
- how organisations can use the Health and Wellbeing Boards, as well as other structures, to achieve this
- understanding the roles and responsibilities at different levels, specifically between the KCC health and wellbeing board and the CCG health and wellbeing boards
- understanding, therefore, of what organisations can expect and need from others around the table
- what exactly organisations can bring to this, including risk analysis and mitigation

Key **participants** will include:

- Kent Health and Wellbeing Board members
- CCG Health and Wellbeing Board members
- District authority stakeholders
- Integrated Commissioning Group members

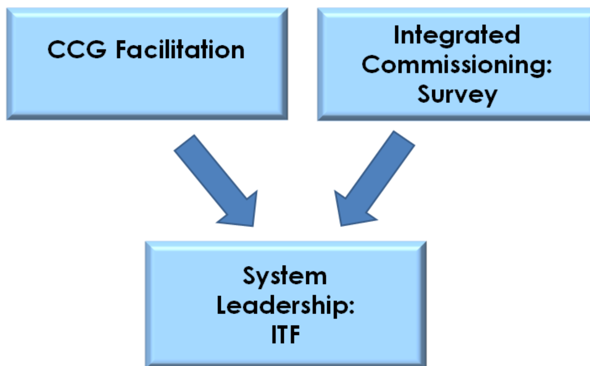
Providers will be brought into the system leadership work through the development of system leadership at CCG level, where service delivery is focused.

Outcomes and outputs from this project relate to the changes or development in system leadership knowledge and behaviours necessary to make integrated commissioning and the use of the ITF work. A draft 'road map' will also be produced that describes how the parts of the system are lined up, and work together, in a way that leads towards effective integrated commissioning.

This systems leadership project will be delivered using a 2-stage process:

- a system-wide challenge and clarifying **workshop**
- **bespoke support** to identified system leaders and groups as a result of the outcomes from the workshop

This phase of the system integration work builds on **earlier projects**, illustrated below:



There is therefore a body of knowledge to build on in making step change in system leadership to deliver the ITF. Project milestones and progress reports will be aligned to the ITF implementation plan, with the interface between the ITF plan, the Pioneer work and the System Leadership project providing the criteria for monitoring and evaluation.

Key Contacts

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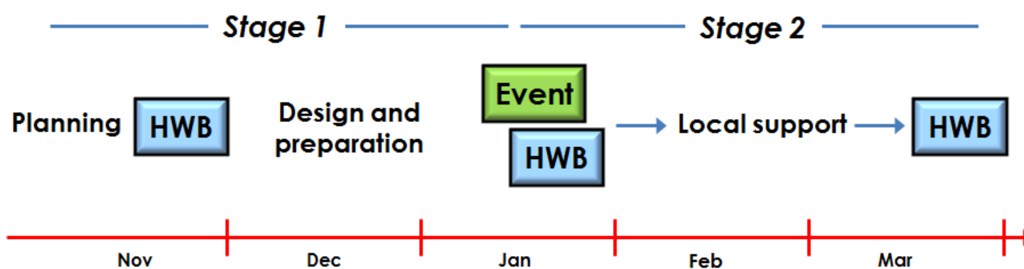
Intended / hoped outputs and outcomes – How are leadership behaviours and actions going to change and what effect will this have?

The inter-related outcomes overlap and support each other, and together work towards strengthening system leadership in order to deliver the ITF:

- system leaders and their organisations will be clear on their **roles and responsibilities** involved in successful use of the ITF
- system leaders and their organisations will take up the **accountability** necessary to perform their roles and responsibilities
- system leaders and their organisations will clarify new and/or changes in **mindset and behaviour** necessary to operationalise the ITF effectively
- a '**road map**' will be produced that describes how the parts of the system are lined up and working together in a way that leads towards effective integrated commissioning
- system leaders and their organisations will develop an understanding of how to assess **risks**, and to take responsibility for mitigation

Planned process

System leadership development will be progressed in 2 stages, illustrated in the figure below:



Stage 1 – County level

The first stage is built around a **whole system workshop** for Kent Health and Wellbeing Board, whose members will have the opportunity to explore the significant opportunities to improve outcomes for service users through integrated commissioning and alignment of different elements of health and social care, and other related public services. A priority area from the Pioneer bid, which has meaning to all participants across the County, will be extrapolated and used to provide a real-time action focus for learning and application through this workshop format.

In the first part of the workshop mixed groups of participants will be asked to determine how specific challenges in the identified area might be addressed through applying their combined commissioning responsibilities and levers, as well as pooled budgets. We propose to use **hypothetical** but realistic integrated commissioning challenges as a means to address these issues. This will not only generate ideas on how integrated commissioning will work for real, but will also enable participants to develop:

- Insight to how the relationship between County and CCG level organisations will function effectively
- a deeper appreciation of each other's approaches to commissioning
- insight to their respective strengths
- understanding of specific barriers to be overcome

- insight to differences in ways of working and changes in behaviours necessary

Drawing on the experiences of the first part, participants in the second part will focus on addressing the question, '**so what** does this tell us?' They will draw on their experiences of tackling the commissioning challenge to establish agreements/options about the roles, responsibilities and necessary behaviours of the key stakeholder leaders and groups, and identify what enabling work and support different parts of the system will need in order to make integrated commissioning work well.

This is envisaged to be a **full-day workshop**, illustrated in the figure opposite. It is recognised, however, that some board members may not have this full time available, so the preference is full attendance in the morning, with the afternoon building on the positioning work of the morning discussion.

Preparatory work and design of the hypothetical will be carried out in conjunction with the KCC team.

A draft 'road map' will be produced as a result of the workshop that describes how the parts of the system can line up and work together in a way that leads towards effective integrated commissioning/ITF implementation. At this stage the 'road map' will present options for the way ahead, which will be developed and clarified in Stage 2.

Stage 2 – CCG level

This second stage of the system leadership initiative will build on the outcomes of the workshop held at Stage 1, and will provide 'enabler' support to selected leaders/groups where particular system leadership development needs have been identified.

The workshop will have surfaced a number of issues that are perceived as barriers to 'diving' into the deep water of system working. The exact nature of Stage 2 will therefore depend on the output of Stage 1, but we anticipate taking forward some of the following **activities**:

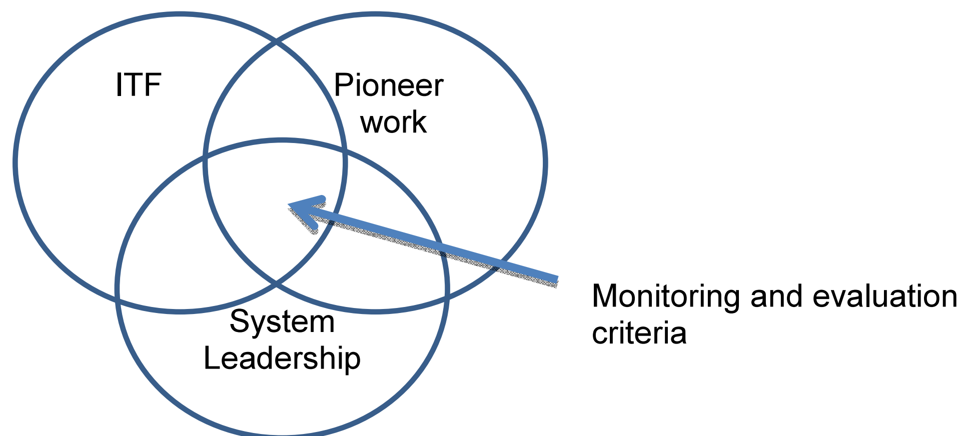
- Using the hypotheticals locally to tease out practical system leadership issues, and to explore the implications of different courses of action
- Facilitation of specific conversations among system leaders that might be helpful in overcoming blockages to system working
- Aligning the development of system leadership with the development of the ITF plan
- Providing clarification of options for the way forward, and appraisal of the best route/s to take
- Development of an agreed 'road map' among all stakeholders that aligns the work behind ITF, Pioneer and system leadership implementation

Providers can be engaged at CCG level as part of this system leadership development work. The activities in Stage 2 will have the project outputs and outcomes firmly in mind, so there will be flexibility in using the resources of this second stage to ensure that these are met.

Key milestones / Review points
Project milestones and review points will be aligned with the ITF planning and reporting process. They will include: Nov 20th – Agreement with H&WB on the aims, activities and outcomes of this system leadership initiative Dec-Jan – Preparatory work for system leadership workshop Jan tbc – Hold the Stage 1 system leadership workshop Jan 29th – Present outcomes to H&WB and obtain agreement for Stage 2 Feb-Mar – Carry out Stage 2 Mar 26th – Present project findings to H&WB

Planned monitoring and evaluation process – Have leadership behaviours changed, if so what and how? Did you get the expected outcomes, what else has changed as a result?

The project monitoring and evaluation process aligns with the ITF, the Pioneer work and the System Leadership programme, as illustrated in the Venn diagram below:



The overall outcomes are both substantive and behavioural, recognising that the firm outcomes of the ITF and Pioneer work cannon be achieved without the alignment of appropriate behaviours, ways of working and responsibilities across the system.

The start-up stage of the system leadership project will therefore involve alignment of the outcomes of the three initiatives. By focusing on the 'how' of implementation, the system leadership work will seek to align leadership behaviours and mindsets that enable implementation of both ITF and the Pioneer work. Success of this system leadership project will therefore show up in more effective implementation of the other two projects.

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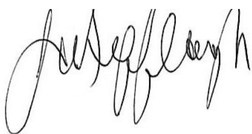
Planned enabler input and days	
30 enabler days are available for this system leadership facilitation, shared across key activities as shown in the table below:	
Activities	**Days**
Workshop design and planning	10
Workshop delivery enablers/facilitators	2
Production of a draft 'road map'	1
Support to individual commissioning system leaders/groups	14
Project learning and report	1
Feedback to KCC HWB	2
Our team of enablers will carry out these days, maximising availability and sharing knowledge.	

Name:[please complete]
Position: [please complete]
Date: [please complete]

Signed for and on behalf of the local lead body
[please complete]
…………………………………………………………..

Name: John Deffenbaugh
Position: Director, Frontline
Date: 28 October 2013

Signed for and on behalf of the enabler(s)



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By:	Meradin Peachey Director of Public Health
To:	Kent Health and Wellbeing Board
Date:	20 November 2013
Subject:	Assurance Framework
Classification:	Unrestricted

For Decision:

The Health and Wellbeing Board is asked to:

- Note the data outlined in the Assurance Framework, as agreed at the meeting in September 2013.

Introduction

This report aims to provide the Kent Health and Wellbeing Board with performance figures on a suite of indicators based on Kent's Health and Wellbeing Strategy; it is focused and arranged on the 5 Outcomes with additional system stress indicators.

The indicators were drawn from a number of existing frameworks and responsible agencies across Kent and England, as agreed at the Health and Wellbeing Board meeting in September 2013

- Kent Public Health and the Public Health Outcomes Framework,
- NHS England and the NHS Outcome Framework,
- Families and Social care and the Adult Social Care Outcome Framework.
- NHS England South Escalation Framework.

The Assurance Framework is in development and indicators are still evolving, this will need to be taken into consideration when interpreting the Assurance Framework. The report has the most recently available data, both from local and national data sets, which are referenced. As the framework develops further work will look into the available geographical subsets of the indicators both at CCG level and district level, where possible.

Due to the number of indictors within the Assurance Framework it is proposed that the Outcomes are rotated with the more detailed framework section showing just one Outcome per report, with the system stress indicators in detail for every Board. This report focusses on Outcome 1 and at the next Board meeting on 29th January 2014 a detailed report will be presented on- Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.

Key to KPI Ratings used

GREEN	Target has been achieved or exceeded
AMBER	Performance at acceptable level, below Target but within 10%
RED	Performance is below 10% of the target
⇧	Performance has increased relative to previous levels (not related to target)
⇩	Performance has decreased relative to previous levels (not related to target)
⬄	Performance has remained the same relative to previous levels (not related to target)

Data quality note: All data is categorised as management information. All results may be subject to later change.

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Executive Summary

The following tables provide a visual summary of the indicators within each outcome domain.

The recent status refers to the rating for the last reporting period; time frames are detailed in the body of the report or available on request. The Direction of Travel similarly refers to the movement from the last reporting period.

Outcome 1: Every child has the best start in life

Indicator Description - Targeted	Previous Status	Recent Status	Direction of Travel
1.1 Increasing Breastfeeding Initiation Rates	Data collation and reporting temporarily suspended. For explanation please see Indicator 1.1		
1.2 Increasing Breastfeeding continuance 6-8 weeks	Data collation and reporting temporarily suspended. For explanation please see Indicator 1.2		
1.3 Improve MMR vaccination uptake – Two doses (5 years old)	87.2%	90.5%	⇧
1.4 Reduction in the number of pregnant women who smoke at time of delivery	16.8%	15.2%	⇩

Indicator Description - Associated	Previous Status	Recent Status	Direction of Travel
1.5 Unplanned hospitalisation for Asthma (primary diagnosis) people aged under 19 years old	Kent & Medway Public Health Observatory will be providing for next report		
1.6 Unplanned hospitalisation for Diabetes (primary diagnosis) people aged under 19 years old	Kent & Medway Public Health Observatory will be providing for next report		
1.7 Unplanned hospitalisation for Epilepsy (primary diagnosis) people aged under 19 years old	Kent & Medway Public Health Observatory will be providing for next report		
1.8 Decrease CAMHS average waiting times for routine assessment form referral (incl. Medway)	9 weeks	7 weeks	⇩
1.9 Increase proportion of SEN assessments within 26 weeks	87.2%	90.6%	⇧
1.10 SEN Kent children placed in Independent or Out of County Schools (number)	554	537	⇩
1.11 Reduction in Conception rates for young women aged under 18 years old (rate per 1,000)	35.3	31.0	⇩

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

Indicator Description - Targeted	Previous Status	Recent Status	Direction of Travel
2.1 Reduction in the under-75 mortality rate from Cancer (rate per 100,000)	105.9	102.54	⇩
2.2 Reduction in the under-75 mortality rate from Respiratory Disease (rate per 100,000)	22.5	22.4	⇩
2.3 Increase in the proportion of people receiving NHS Health Checks of the Target number to be invited (proxy for under-75 mortality)	28.3%	38.7%	⇧
2.4 Increase in the number of people quitting smoking via smoking cessation services (number. proxy for under-75 mortality)	2,541	1,401	⇩
2.5 Reduction in the number of hip fractures for people aged 65 and over (rate per 100,000)	477.0	469.0	⇩
2.6 Reduction in the rates of deaths attributable to smoking in all persons (rate per 100,000)	-	7170.86	-

Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

Indicator Description - Targeted	Previous Status	Recent Status	Direction of Travel
3.1 The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services	84%	86%	⇧
3.2 Clients with community based services who receive a personal budget and/or direct budget	76%	76%	⇔
3.3 Increase the number of people using telecare and telehealth technology (number)	1,596	1,937	⇧

Outcome 4: People with mental health issues are supported to "live well"

Indicator Description - Targeted	Previous Status	Recent Status	Direction of Travel
4.1 Reduction in the number of suicides (DASR per 100,000)	7.54	7.36	⇩
4.2 Increased employment rate among people with mental illness/those in contact with secondary mental health services	Indicator in development; awaiting further data (ASCOF)		

Indicator Description - Associated	Previous Status	Recent Status	Direction of Travel

Indicator Description - Associated	Previous Status	Recent Status	Direction of Travel
4.3 Increased crisis response of A&E Liaison within 2 hours – Urgent	85%	77%	⇩
4.4 Increased crisis response of A&E Liaison all urgent referrals to be seen within 24 hours	100%	100%	⬄
4.5 Number of adults receiving treatment for drug misuse (primary substance. Number)	3415	tbc	-
4.6 Number of adults receiving treatment for alcohol misuse (primary substance. Number)	1651	1794	⇧

Outcome 5: People with dementia are assessed and treated earlier

Indicator Description - Targeted	Previous Status	Recent Status	Direction of Travel
5.1 Improvements in the rates of diagnosis in Kent	Awaiting Information from KMCS		
5.2 Increase in effectiveness of post diagnosis care in sustaining independence and improving quality of life for an increased number of people	Awaiting Information from KMCS		
5.3 Reduction in care home placements	Awaiting Information from KMCS		
5.4 Reduction in hospital admissions	Awaiting Information from KMCS		

Indicator Description - Associated	Previous Status	Recent Status	Direction of Travel
5.5 People waiting longer than 12 weeks to access memory services	Awaiting Information from KMCS		

System stress indicators: derived from the NHS England South Escalation Framework

Indicator Description – Acute Trusts	Previous Status	Recent Status	Direction of Travel
6.1 Bed occupancy Rates, Day only			
Dartford and Gravesham NHS Trust	90.7%	97.7%	Refer to section 6.1
East Kent Hospitals University NHS Foundation Trust	94.6%	95.0%	
Maidstone and Tunbridge Wells NHS Trust	97.6%	97.2%	
6.2 A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge			
Dartford and Gravesham NHS Trust (all)	96.2%	94.2%	Refer to section 6.2

Indicator Description – Acute Trusts	Previous Status	Recent Status	Direction of Travel
East Kent Hospitals University NHS Foundation Trust (all)	92.9%	89.2%	
Maidstone and Tunbridge Wells NHS Trust (all)	96.6%	95.1%	
6.3 Number of Emergency Admissions	To be further discussed and developed with NHS England		

Indicator Description – Social care / Community Care	Previous Status	Recent Status	Direction of Travel
6.4 Number of Delayed days, Acute and Non-Acute for Kent	1,965 days	1,969 days	Refer to section 6.4
6.5 Infection control rates	Awaiting Information from NHS England		

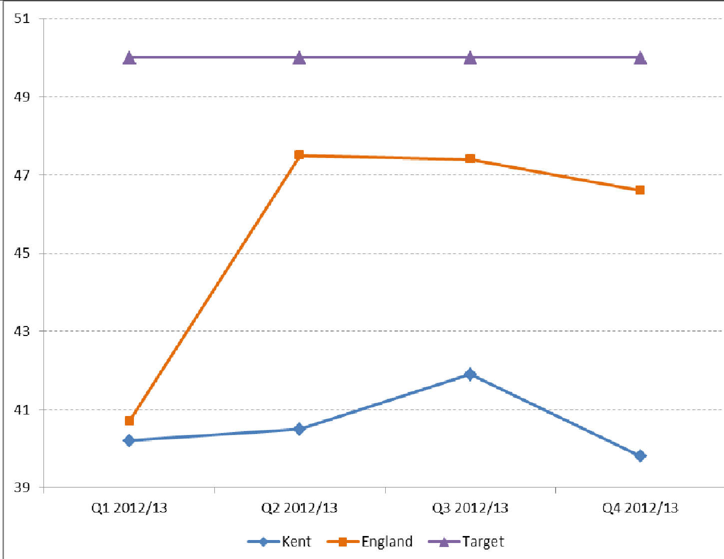
Indicator Description – Primary Care	Previous Status	Recent Status	Direction of Travel
6.6 GP Attendances	Awaiting Information from NHS England and Indictor Development		
6.7 Out of Hours activity / 111 call volumes	Awaiting Information from NHS England and Indicator Development		

Assurance Framework

Outcome 1: Every child has the best start in life

1.1 Increasing Breastfeeding Initiation Rates
Data collation and reporting temporarily suspended by NHS England, Public Health England, Department of Health and the Health and Social Care Information Centre while assessing options. Collection will recommence in Q3 however reporting will not be till the end of Q4.

1.2 Increasing Breastfeeding Continuance 6 - 8 weeks



Public Health Kent are currently consulting on current and future service provision on breastfeeding support services in Kent, with the aim of putting services out to tender within the next year. This will ensure coverage and quality of service going forward.

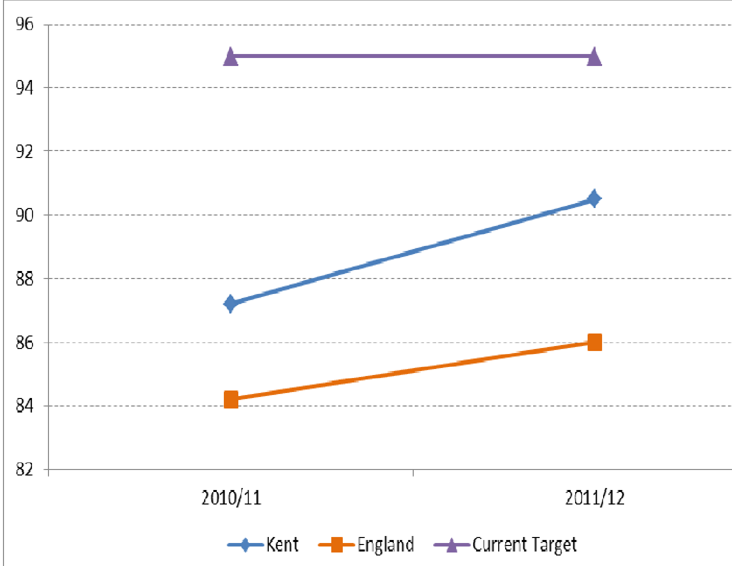
Data collation and reporting temporarily suspended by NHS England, Public Health England, Department of Health and the Health and Social Care Information Centre while assessing options. Collection will recommence in Q3 however reporting will not be till the end of Q4.

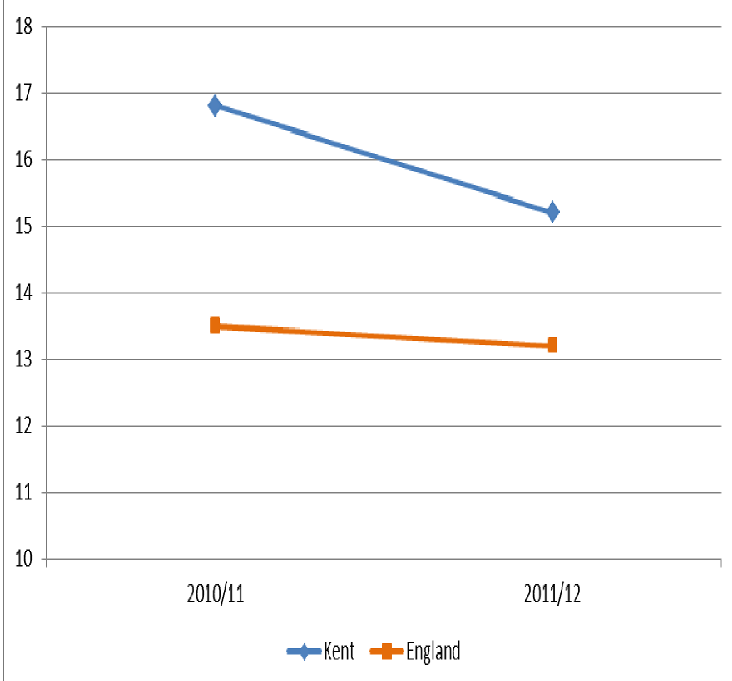
To ensure accurate data reporting for the current year Kent Public Health will be working with GP practices and the Child Health Information Department on data collection. This will aim to ensure coverage levels of 95% once data submissions recommence.

Successful infant feeding is important to the future health of the child. Breastfeeding specifically confers a number of health benefits to both the baby and to the mother; a report commissioned by UNICEF in 2011 described the economic benefits of breastfeeding. There is very strong evidence that breastfeeding prevents:

- four acute conditions in infants: gastrointestinal disease, respiratory disease, otitis media, and necrotising enterocolitis (NEC)
- breast cancer and other cancers in mothers.

In addition the UNICEF reports that there is good evidence that if the number of babies receiving any breastmilk at all rose by 1% this could lead to a small increase in IQ. A very modest increase in exclusive breastfeeding rates could lead to at least three fewer cases of Sudden Infant Death Syndrome annually. A modest increase in breastfeeding rates could result in a reduction in childhood obesity by about 5% which would mean a decrease of 16,300 obese children in the UK.

1.3 Improve MMR vaccination uptake – 2 doses 5 years old	
 **Target:** Current target is 95% Figures provided in the Public Health Outcomes Framework are currently presented here while further local provision is being sourced. **Responsible authority:** NHS England **Source:** PHOF November 2013	Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise (Public Health Outcomes Framework: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000004/are/E06000015)

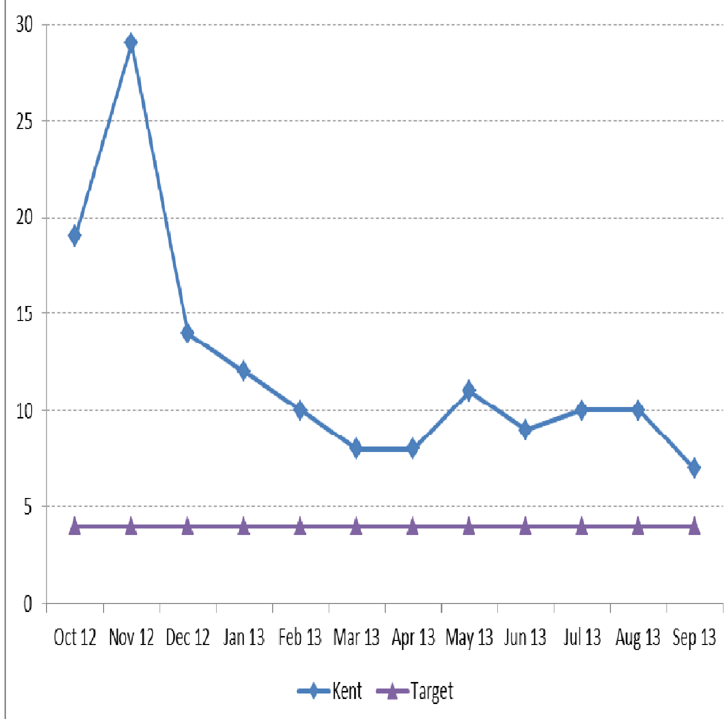
1.4 Reduction in the number of pregnant women who smoke at time of delivery	
 Measure is percentage Data collation and reporting temporarily suspended by NHS England, Public Health England, Department of Health and the Health and Social	Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant (Public Health Outcomes Framework: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/1

Care Information Centre while assessing options. Collection will recommence in Q3 however reporting will not be till the end of Q4. Figures provided in the Public Health Outcomes Framework are currently presented here **Responsible KCC Directorate:** Public Health **Source:** PHOF November 2013	02/page/6/par/E12000004/are/E06000015

1.5 Unplanned hospitalisation for Asthma (primary diagnosis) people aged under 19 years old
Awaiting provision from Kent & Medway Public Health Observatory

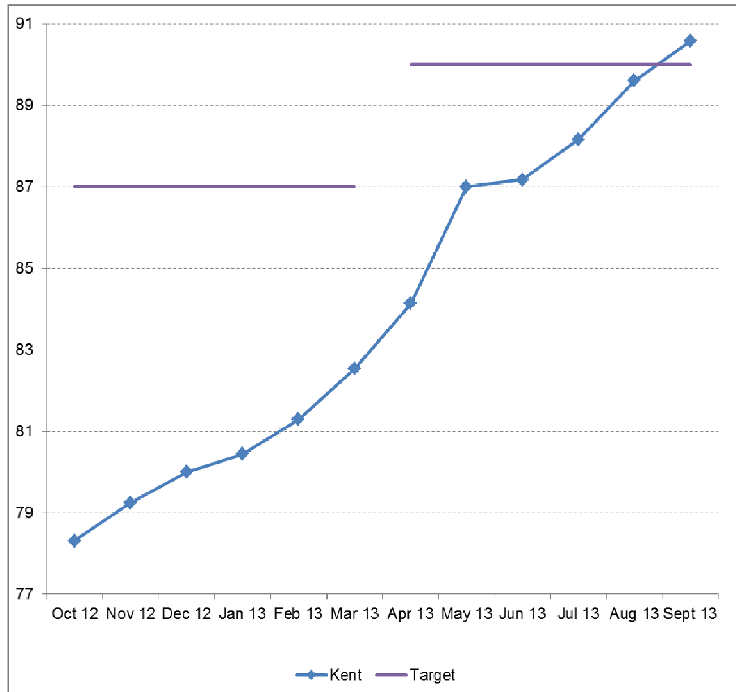
1.6 Unplanned hospitalisation for Diabetes (primary diagnosis) people aged under 19 years old
Awaiting provision from Kent & Medway Public Health Observatory

1.7 Unplanned hospitalisation for Epilepsy (primary diagnosis) people aged under 19 years old
Awaiting provision from Kent & Medway Public Health Observatory

1.8 CAMHS average waiting times for routine assessment form referral (includes Medway)	
 Measure is in weeks **Target:** Current target is 4 week average waiting time	Recommendations made by Ofsted, the National Support Team from the Department of Health in 2010 and Christchurch University included the need to move towards Early Intervention and clearer referral pathways, as there were a large number of young people referred to Tier 3 CAMHS who could have been seen earlier and more effectively in Early Intervention Services. Monitoring the waiting times is crucial to ensure young people are supported earlier and are seen quicker to ensure the appropriate help is identified even if the need is to signpost them on elsewhere.

There has been a period of transition with the implementation of a new single provider; It systems and processes are in development. Figures currently include Medway. This information can be provided by CCG **Responsible authority:** NHS England **Source:** Kent and Medway Commissioning Support	

1.9 SEN assessments, Percentage within 26 weeks



Measure is Percentage

Target: 90% within 26 weeks (excluding exceptions)

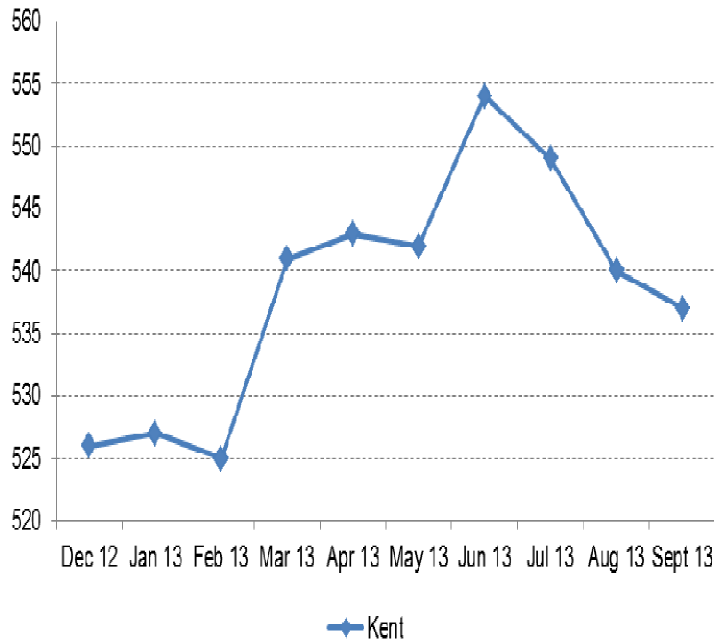
Figures are rolling 12 months
This indicator can be further provided by District.

Responsible KCC directorate: Education, Learning & Skills
Source: Management Information Kent County Council

There is considerable evidence of the benefits of early and timely intervention to address children's SEN. Parents are concerned that SEN statements should be completed within the statutory time limit so that appropriate intervention to meet their children's SEN can begin.
(DOE: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/219452/main_20text_20osr192011.pdf)

There are plans through the SEND strategy to increase the capacity of mainstream and special schools to reduce delays arising from placement pressure. Delays can also be due to late receipt of medical advice and this has been discussed with the Health and Well Being Board to obtain their support in ensuring this work is appropriately resourced (Quarterly Performance Report Quarter 1, Kent County Council Cabinet. Richard Fitzgerald)

1.10 SEN Kent children placed in Independent or Out of County Schools



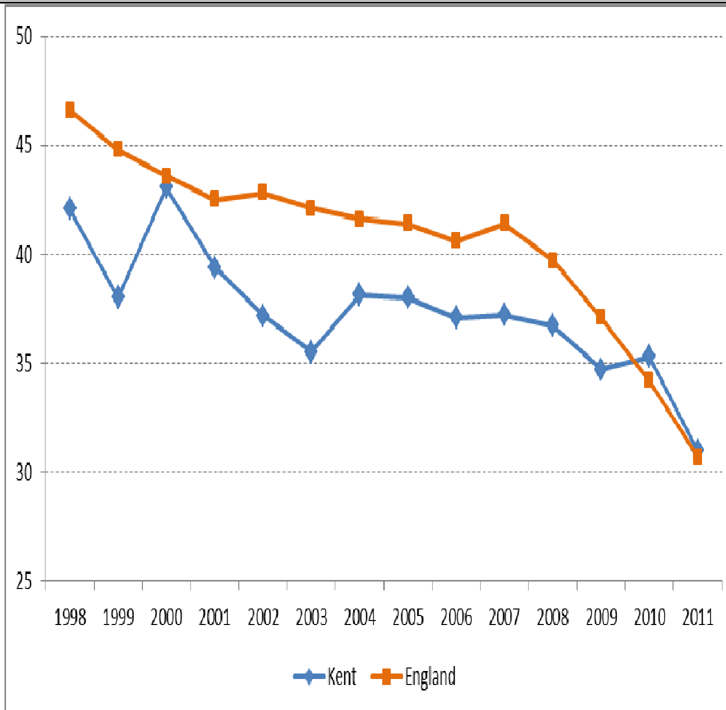
Measure is number
Figures are rolling 12 months

This indicator can be further provided by District.

Responsible KCC directorate: Education, Learning & Skills
Source: Management Information Kent County Council

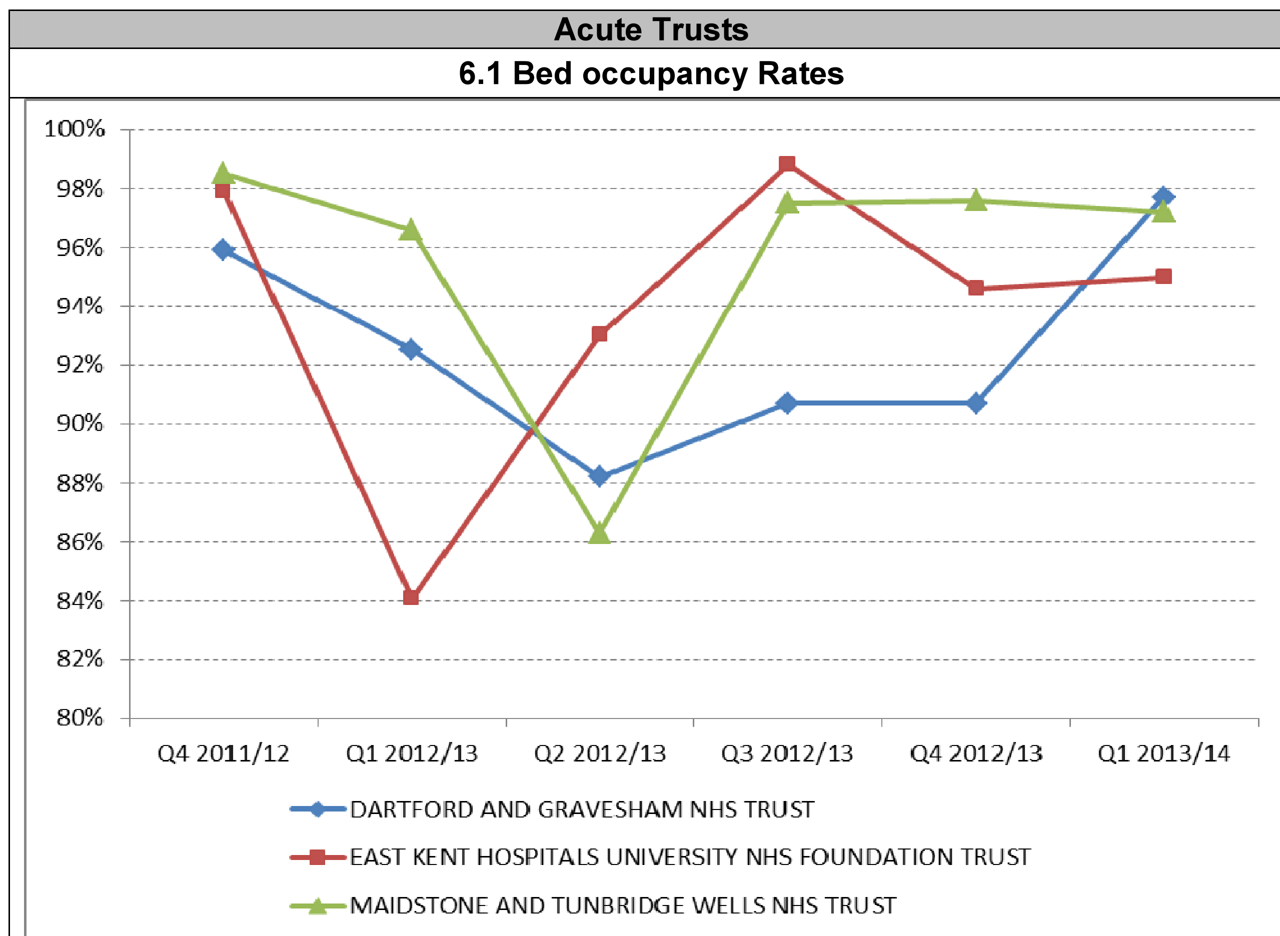
Kent County Council has put into place a 3-year plan, the aims of which are:

- To Increase internal capacity at Kent Schools
- Create 200 places in state-maintained Kent special schools
- To Increase capacity in main stream schools to have adequate provision for those with low level need

1.11 Conception rates for young women aged under 18 years old	
 Rate per 1,000 females aged 15 – 17 years old. This is an annual figure which can be produced at District level. **Responsible KCC directorate:** Public Health **Source:** ONS. Kent & Medway Public Health Observatory. Kent County Council	Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems. (Public Health Outcomes Framework:http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000004/are/E06000015)

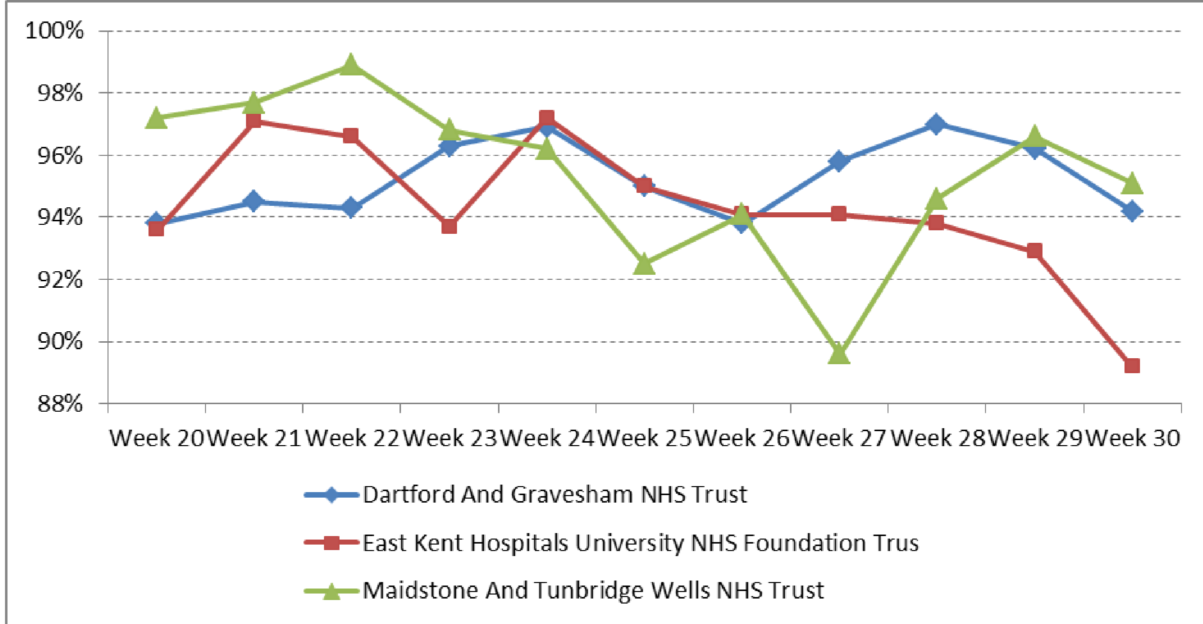
System stress indicators: derived from the NHS England South Escalation Framework

Acute Trusts
6.1 Bed occupancy Rates



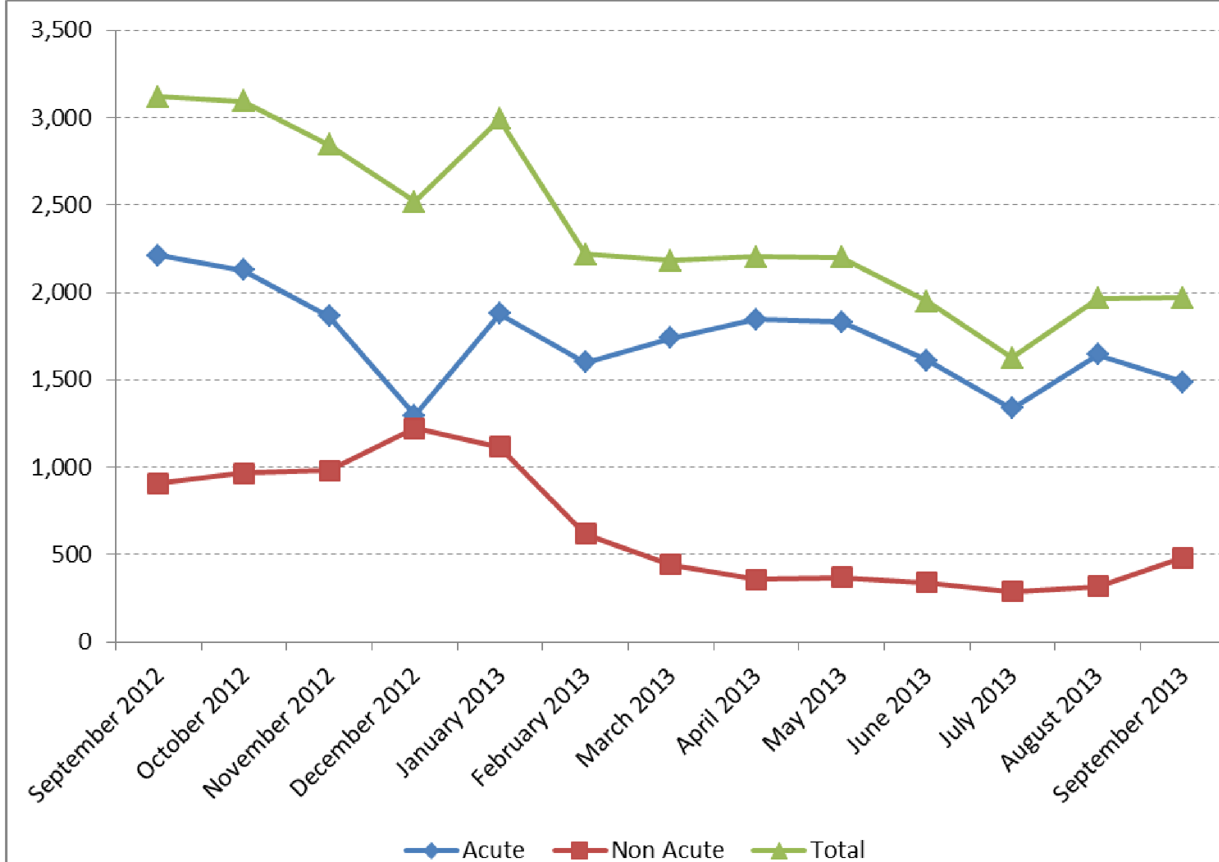
% of occupied beds open day only. Quarterly figures.
Comparative groups will be included for the next report.

Responsible Authority: NHS England
Source: NHS England. November 2013.
http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-day-only/

6.2 A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge

% within 4 hours. Weekly figures for 2013/14 (Week 30 is week ending 27/10/2013) Comparative groups will be included for the next report. **Responsible Authority:** NHS England **Source:** NHS England. AE SitRep November 2013. http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/

6.3 Number of Emergency admissions
To be further discussed and developed with NHS England

Social Care / Community Care
6.4 Number of Delayed days, Acute and Non-Acute for Kent



Number of delayed days during the reporting period, Acute and Non Acute at Local Authority level – Kent.
Comparative groups will be included for the next report.

Responsible Authority: NHS England
Source: NHS England. November 2013.
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

6.5 Infection control rates
Awaiting Information from NHS England

Primary Care
6.6 GP Attendances
Awaiting Information from NHS England and Indicator Development
6.7 Out of Hours activity / 111 call volumes
Awaiting Information from NHS England and Indicator Development

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From: Roger Gough Cabinet Member for Education and Health Reform

Meradin Peachey Kent Director of Public Health

To: Kent Health and Wellbeing Board.

Subject: Pharmaceutical Needs Assessment

Classification: Unrestricted

Summary

This document sets out the statutory requirement for the Kent Health and Wellbeing Board to have developed and consulted upon a Pharmaceutical Needs Assessment (PNA) by April 2015. The accompanying paper details the background, what the implications are and recommends an organisational structure to oversee development and publication of the PNA.

The Kent and Medway Public Health departments have agreed we should do the work once for Kent and Medway in order to avoid duplication and effectively use ours and partners resources.

Recommendations

Kent Health and Wellbeing Board are asked to:

1. Note the requirements for producing and publishing a Pharmaceutical Needs Assessment.
2. Agree the recommendation to set up a Joint Kent and Medway Steering Group to oversee the production, consultation and publication of the Kent PNA and Medway PNA.

1. Introduction

The Health and Social Care Act 2012 transferred responsibility for developing and updating Pharmaceutical Needs Assessments (PNAs) to health and wellbeing boards (HWBs) with a requirement to publish the first HWB Board Pharmaceutical Needs Assessment by 1st April 2015. This is a statutory obligation.

2. Purpose

The purpose of this document is two-fold;

1. To draw this to the attention of both the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board, to ensure both Boards are aware of the legislative requirements.
2. To seek agreement of how we jointly manage the process of undertaking the PNA and publishing the results in a Kent PNA and a Medway PNA.

Discussions between Kent County Council Public Health and Medway Council Public Health and NHS England have led to the agreement that we undertake this work once for Kent and Medway therefore avoiding duplication and effectively using our scarce resources.

The PNA will enable NHS England to make decisions on future applications for NHS pharmaceutical services after 1st April 2015, and thus the PNA will need to be fit for purpose and continue to be maintained and up-to-date for the next three years when the next PNA is expected to be published (i.e. 2018).

3. Background

Primary Care Trusts were required to carry out Pharmaceutical Needs Assessments (PNAs) that related to assessing need for pharmaceutical services. These needed to have been consulted upon and published by 1st February 2011 and indeed were for the three former Kent Primary Care Trusts, Eastern and Coastal Kent, Medway and West Kent.

The Health and Social Care Act 2012 transfers responsibility for developing and updating of PNAs to health and wellbeing boards (HWBs).

If a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by NHS England Area Teams. This process is known as market entry.

Market entry for NHS pharmaceutical services contracts has been evolving over the past number of years from a regulatory control system to a needs based system.

Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services Regulations ("the 2013 Regulations")), applications must now prove they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance selling (internet or mail order only) basis.

Pharmaceutical Services in relation to PNAs are defined as:

- "essential services" which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service; i.e. the dispensing of medicines, promotion of healthy lifestyles and support for self-care;
- "advanced services" which community pharmacy contractors can provide subject to accreditation as necessary – these are Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use reviews and the Stoma Customisation Service for dispensing appliance contractors;
- Locally commissioned services (known as enhanced services) commissioned by NHS England.

However, from experience, we do know that gaining a pharmaceutical contract is the essential foundation of community pharmacy and gives some financial stability; the previous system has been extremely litigious through the NHS Appeals Authority and through judicial review. As the PNA is the document against the need for a pharmaceutical services contract being granted (the test for market entry) it is important that the needs assessment is undertaken in an appropriate way and maintained between times.

4. Scope

The essence of the PNA is to undertake a service review of pharmaceutical service provision, making judgements about the adequacy of pharmaceutical services to meet local needs and consulting upon those judgements to ensure a fair and reasonable assessment.

The review will therefore include pharmaceutical provision through community pharmacy, dispensing doctors and appliance contractors, make reference to mail order or internet pharmacies and include enhanced services.

The total scope of the PNA will need further work, as, at the time of writing, there appears to be some contradiction in the guidance about whether all services commissioned through community pharmacy (by CCGs and Local Authorities) will be subject to the PNA (as they were in PCTs) or just those commissioned via NHS England.

5. Consultation

The NHS (Pharmaceutical Services and Local Pharmaceutical Services Regulations ("the 2013 Regulations")) sets out with whom and the minimum period for which the PNA should be consulted upon. The regulations also set out the minimum stakeholders that the draft PNA should be consulted with.

These include:

- Local Pharmaceutical Committee
- Local Medical Committee
- Any persons on the pharmaceutical list including dispensing doctors
- LPS Chemists
- Health watch
- NHS Trust or Foundation Trusts
- NHS England
- Neighbouring H&WB Boards

Kent County Council and Medway Council will also need to comply with other legislation and will therefore need to consult with the public more broadly as the users of pharmaceutical services.

6. Time line

The Kent Health and Wellbeing Board and Medway Health and Wellbeing Board are required to publish the first PNA by 1st April 2015 and thereafter every three years. There is also a requirement to publish a revised assessment as soon as is reasonably practical after identifying a significant changes to the availability of pharmaceutical services since the publication of the last PNA. There is also a requirement to publish supplementary statements of change where it is considered a full new PNA is not necessary (e.g. the granting of a new pharmaceutical services contract).

7. Resources

This is a large piece of work which will extend over a considerable period of time. As well as information gathering from the organisations commissioning services from pharmacies as to current and future needs, there needs to be extensive work done by public health teams mapping the health and social needs of the local population compared to provision of pharmaceutical services. Work also needs to be done

looking at future changes that could impact upon pharmaceutical need such as new housing estates, closure of local industry, and future commissioning plans for health and social care.

The resourcing of this work has been discussed and further discussions will be needed, however given the current financial situation it is likely that all parties will support the worked being carried out by existing teams with no extra resources, and thus built into Public Health and Kent and Medway Public Health Observatory work plans.

8. Project organisational structure

In order to effectively manage the process of scoping and developing the Kent PNA and the Medway PNA it is proposed that a joint Kent and Medway PNA steering group is convened to oversee all elements of scoping, production and consultation. This paper has been shared with Medway Public Health department who are in agreement that we do the preparatory work together in order to be consistent across the NHS England Local Area Team geography.

Membership to include:

- KCC Public Health and Medway Public Health (to co-lead)
- Kent and Medway Public Health Observatory (for mapping)
- NHS England Area Team representative
- KCC Engagement representative (for consultation)
- Medway Council Engagement representative
- Kent Local Medical Committee (officer and dispensing GP representative)
- Kent Pharmaceutical Committee (officer and community pharmacist)
- Kent Local Pharmacy Network representative
- HealthWatch Kent
- HealthWatch Medway
- CCG representative(s)

Terms of Reference to be agreed by the group, broadly however the group's responsibility will be to agree the following:

- The final scope of the PNA
- Detailed timelines in order for the individual Health and Wellbeing Boards to sign off the local PNA for publication by March 2015.
- Geographical area at which PNA will make most sense to analyse (the Kent area is too broad, the last PNA were analysed at District levels but this may still be at too high a level).
- Data set requirements to assess pharmaceutical need.

- How best to publish to enable NHS England to make decisions on pharmaceutical list market entry applications.
- How subsequent amendments are to be handled (a statutory requirement).

9. Recommendations

Kent Health and Wellbeing Board and Medway Health and Wellbeing Board are asked to:

1. Note the requirements for producing and publishing a Pharmaceutical Needs Assessment
2. Agree the recommendation to set up a Joint Kent and Medway Steering Group to oversee the production, consultation and publication of the Kent PNA and Medway PNA.

10. Contact Details

For Kent County Council:
Andrew Scott-Clark, Director of Public Health Improvement
(andrew.scott-clark@kent.gov.uk).

For Medway Council:
Alison Barnett, Director of Public Health
(alison.barnett@medway.gov.uk).

By: Roger Gough, Cabinet Member for Education and Health Reform

Geoff Wild, Director of Governance and Law

To: Kent Health and Wellbeing Board

Date: 20 November 2013

Subject: Revisions to terms of reference for CCG level health and wellbeing boards

Classification: Unrestricted

For Decision: The Kent Health and Wellbeing Board is asked to:

1. Agree the amendments to the terms of reference and procedure rules set out in Appendix 1 of this report;
2. Review the arrangements after one year of operation.

Background

1. On 29 May 2013, the Kent Health and Wellbeing Board (HWB) resolved to establish a series of CCG level Health and Wellbeing Boards (local HWBs) to focus on the following key areas:

   - CCG level Integrated Commissioning Strategy and Plan
   - Ensure effective local engagement
   - Local monitoring of outcomes
   - Delivery of local projects

2. As sub-committees of a Kent County Council committee, the governance arrangements (e.g. terms of reference and declaration of pecuniary interests) are the same as those applied to any other County Council committee or sub-committee.

3. The terms of reference for the local HWBs were drafted to be as flexible and permissive as possible within the KCC governance arrangements.

4. The seven local HWBs based around CCG boundaries have all been set up and are meeting regularly. Some are still new and have held preliminary meetings whilst others have been meeting for longer and are quite well established.

5. A number of issues have arisen relating to terms of reference and although none has been sufficiently serious to affect the business of the local HWBs it is important they are resolved.

6. The issues requiring clarification within the terms of reference are:

a) The status of district council officers as potential members of local health and wellbeing boards and whether they would be bound by the Kent Code of Conduct requiring them to disclose pecuniary and other significant interests;

b) Arrangements for the completion and registration of disclosable pecuniary interests and resolving any potential conflicts of interest;

c) The flow of business between local HWBs and the HWB;

d) Representation of local HWBs at the HWB;

e) Public participation arrangements in meetings of local HWBs;

f) Scrutiny and Call-In arrangements for local HWBs;

g) Decision-making arrangements

2. District Council Officers

2.1 The status of district council officers and dealing with potential conflicts of interest was discussed at the Kent Secretaries meeting held on 10 September 2013.

2.2 It is highly unusual to have officers and external partners voting on a council committee or sub-committee. The Health and Social Care Act 2012 established health and wellbeing boards as forums for collaborative local leadership and were to be different from ordinary local authority committees in a number of important areas. The Act requires that the Director of Adult Social Care, the Director of Children's Services and the Director of Public Health be members of the HWB. There are however no such officers at district/borough or city level. The predominant feeling of district, borough and city council officers is that they should not be formal members of local HWBs and should attend meetings in an advisory capacity.

2.3 It is therefore proposed that the terms of reference and procedure rules for local HWBs be amended to make it clear that all council officers are advisory members and as such are not subject to the Kent Code of Conduct for Members.

3. Arrangements for the completion and registration of disclosable pecuniary interests and resolving any potential conflicts of interest

3.1 The Register of Disclosable Pecuniary Interests is held by the KCC Monitoring Officer.

3.2 Kent County Council has written to all members of the local HWBs asking for Declarations of Pecuniary Interests forms to be completed. As soon as forms are completed and received by Democratic Services they are published on the KCC website.

3.3 Work is underway to create links between the HWB web pages and district, borough and city councils' websites.

3.4 A guidance note on the Kent Code of Conduct for Members has been circulated to all members of local HWBs.

3.5 The nature of health and wellbeing boards may lead to conflicts of interest among members particularly in relation to the representatives from CCGs who are both providers and commissioners of services. As the local HWBs are sub-committees of the HWB, any conflicts of interest will be resolved in accordance with the Kent Code of Conduct for Members and with the advice of the Monitoring Officer.

4. The flow of business between local and county boards

4.1 The relationship between the local HWBs and the HWB continues to develop and common expectations about how business will flow need to be established. All local HWBs are keen to set out a work programme based on common themes and priorities linked to the needs of local population and most are looking to synchronise their business with that of the HWB.

4.2 A meeting of the chairs of all the local HWBs and the chairman of the HWB is planned for 19 December 2013.

4.3 A memorandum of understanding may be required but at this time no amendments are proposed to the terms of reference or procedure rules for the local HWBs.

5. Representation of local boards at the Kent Health and Wellbeing Board

5.1 Local HWBs are represented on the Kent HWB by one of their members who is also a member of the Kent HWB.

6. Public participation arrangements in meetings of local HWBs

6.1 The arrangements for district, borough and city council meetings vary with regard to the ability and rights of members of the public to participate in meetings. KCC's constitution allows very limited public participation at meetings. Among local HWBs there are different approaches to the involvement of the public in meetings, with some boards opting to invite contributions from the public in various ways, while others "meet in public" rather than have "public meetings".

6.2 As the local HWBs are sub-committees of the HWB, KCC's Constitution regarding formal arrangements for public participation at meetings prevails. There may, however, be times when it is appropriate to hear from members of the public or other local organisations about matters being discussed and this is a matter for local discretion. Therefore no changes are proposed to the terms of reference or to the local HWBs' procedure rules.

7. **Scrutiny and Call-In arrangements for local HWBs**

7.1 Formal health scrutiny powers under the Health and Social Care Act 2012 are exercised by the Health Overview and Scrutiny Committee at Kent County Council. However, under the regulations, these powers do not automatically include scrutiny of the HWB or local HWBs. Any issues that arise will be dealt with in accordance with the Protocol for Overview and Scrutiny Inter-Authority Co-operation and the Protocol for the Health Overview and Scrutiny Committee in KCC's Constitution. The guiding principle for health scrutiny activity at county, district and borough level is that it seeks to be complementary and not unnecessarily duplicate work.

8. Decision making arrangements for local HWBs

8.1 It is expected that wherever possible the local Health and Wellbeing Boards will conduct their business on the basis of reaching an agreed consensus. Currently it is also the case that the Boards have no delegated decision making powers and therefore are not able to take independent decisions that are binding upon their constituent organisations and it is unlikely that voting will be necessary under present arrangements.

8.2 During the evolution of the local Boards across the County it has become evident that there are substantial differences between the Kent HWB and the local boards. For example the officer representation on the Kent Board is designated by the Health and Social Care Act 2012 and applies to specific officer posts. These posts do not exist at district level and there are no direct equivalents. The Kent HWB is based on local authority geography whereas the local boards follow CCG boundaries. This means there are local boards that include one district authority within their area whilst others contain up to four. At the Kent HWB the principle of no one set of organisations being able to outvote any of the others can be relatively simply applied but this is not the case for all of the local boards given their various configurations.,

8.3 There is no single solution that can easily reconcile the variation in membership of boards across the county. The simplest solution is the one proposed in the attached draft governance arrangements which requires the local boards to operate through achieving consensus and obviates the need for voting and recognises that no decision making responsibilities have been delegated to the boards.

9. Conclusion

9.1 The local HWBs' terms of reference and procedure rules are attached at **Appendix 1** and for ease of reference include the amendments proposed in the paragraphs above.

Recommendations

The Kent Health and Wellbeing Board is asked to:

1. Agree the amendments to the terms of reference and procedure rules set out in Appendix 1 of this report;
2. Review the arrangements after one year of operation

Background Documents - none

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Appendix 1

Local Health and Wellbeing Boards

Governance Arrangements

The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

- secure better health and wellbeing outcomes in Kent
- reduce health inequalities and
- ensure better quality of care for all patients and care users.

The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner. It is supported in this work by a series of sub-committees referred to as local Health and Wellbeing Boards (local HWBs).

As sub-committees of a Kent County Council committee, the governance arrangements (e.g. terms of reference and declarations of disclosable pecuniary interests) are the same as those applied to any other County Council committee or sub-committee.

At this time no decision has been taken to delegate any decision making responsibilities to the local HWBs. Instead they will be asked to make recommendations to both the HWB and their partner bodies. This position may change in the future.

Role of the local Health and Wellbeing Boards

The local HWBs will lead and advise on:

- the development of a CCG level Integrated Commissioning Strategy and Plan;
- ensure effective local engagement;
- monitor local outcomes.

They will focus on improving the health and wellbeing of the people living in their CCG area through joined up commissioning across the NHS, social care, district councils, public health and other services (that the HWB agrees are directly related to health and wellbeing), in order to secure better health and wellbeing outcomes in their area and better quality of care for all patients and care users.

Terms of Reference:

The local HWBs will:

1. Be appointed as sub-committees of the Kent Health and Wellbeing Board (a committee of Kent County Council);

2. Develop a CCG level Integrated Commissioning Strategy and Plan, based on the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and partners Commissioning Plans. This will be approved by the Kent Health and Wellbeing Board;

3. Consider the totality of the resources in the CCG area for health and wellbeing and consider how and where investment in health improvement and prevention services could (overall) improve the health and wellbeing of local residents;

4. Work with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities;

5. Endorse and promote joint arrangements where agreed and appropriate; including the use of pooled budgets for joint commissioning (s.75), the development of appropriate partnership agreements for service integration, and the associated financial protocols and monitoring arrangements, making full use of the powers identified in all relevant NHS and local government legislation;

6. Undertake monitoring of local outcomes;

7. Ensure effective local engagement on health and care issues, using existing engagement mechanisms where necessary and linking in to any county level engagement work where established;

8. Develop a local Communication and Engagement Strategy to ensure clear lines of communication/consultation with residents, County Council, Neighbourhood Forums and Patient/Public Networks;

9. Provide advice (as and when requested) to the Kent Health and Wellbeing Board on local service reconfigurations that may be subject to referral to the Kent County Council Health Overview and Scrutiny Committee (HOSC) or the Secretary of State on resolution by KCC HOSC;

10. Be the focal point for joint working in the CCG area to ensure facilities and accessibility, in order to enhance service integration;

11. Report to the Kent Health and Wellbeing Board on an annual basis on its activity and progress against the milestones set out in the Integrated Commissioning Strategy and any established work plan;

12. Responsible for overseeing local project resource to facilitate local pathway redesign, as appropriate;

13. Provide recommendations on how and where investment, resources and improvements can be made within the CCG area;

14. Identify how to make the best use of the flexibilities at the Board's disposal.

Membership:
The local HWBs have similar membership to that of the Kent Health and Wellbeing Board. Typically membership is as follows:

- District/Borough/City Council Leader/Senior Member
- Kent County Council Cabinet Member or Deputy Cabinet Member
- CCG Senior Officer
- CCG GPs
- Healthwatch representative
- Other representatives as identified and agreed by the local HWB, e.g. voluntary sector

Advisory Members
- District/Borough/City Council senior officers
- Kent County Council Families and Social Care Corporate Director (or his nominee)
- Kent County Council Public Health Consultant
- Chair of the Children's Operational Group (when appointed)

Changes to membership of the local HWBs will not need to be notified to the Kent HWB.

In addition to the core membership, other people can be invited by the Chairman to attend the meeting to present as and when required.

All meetings will be held in public.

The Chairman will be elected by the local HWB.

Local Health and Wellbeing Boards

Procedure Rules

1. **Conduct.**
   Members of local HWBs are required to subscribe to and comply with the Kent County Council Code of Conduct for Members. Non-elected members of local HWBs (e.g. GPs) will be co-opted members and, as such, are also covered by the Kent Code of Conduct for Members for any business they conduct as a member of the local HWB. Council officer representatives will be advisory members and as such not subject to the Kent Code of Conduct for Members.

2. **Declaration of Disclosable Pecuniary Interests.**
   Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any sub-committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared, however they cannot have a vote on that matter.

3. **Frequency of Meetings.**
   Local HWBs meet at least quarterly. The date, time and venue of meetings is fixed in advance by the local HWB.

4. **Meeting Administration.**
   - Local HWB meetings are advertised and held in public and administered by the nominated District/Borough/City Council.
   - Local HWBs may consider matters submitted to them by local partners.
   - The administering Council publishes and gives at least five clear working days' notice in writing to each member of every ordinary meeting of the local HWB, to include any agenda of the business to be transacted at the meeting.
   - Papers for each local HWB meeting are sent out at least five clear working days in advance.
   - Late papers may be sent out or tabled only in exceptional circumstances and with the agreement of the chairman.
   - Local HWBs hold meetings in private session only in accordance with the Access to Information Procedure Rules and the Local Government Act 1972 (as amended)
   - Local HWB meetings will be webcast where the facilities are in place.
   - The Chairman's decision on all procedural matters is final.

5. **Meeting Administration of Sub Committees**.
   Local HWBs are administered by a District/Borough/City Council in each area. They will be subject to the provisions stated in these Procedure Rules.

6. **Special Meetings.**
   The Chairman may convene special meetings of a local HWB at short notice to consider matters of urgency. The notice convening such meetings shall

state the particular business to be transacted and no other business will be transacted at such meeting.

The Chairman is required to convene a special meeting of a local HWB if they are in receipt of a written requisition to do so signed by no less than three members of the local HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

7. **Minutes.**

Minutes of all local HWB meetings are prepared recording:

- the names of all members present at a meeting and of those in attendance;
- apologies;
- declarations of Disclosable Pecuniary Interests and Other Significant Interests
- details of all proceedings, decisions and resolutions of the meeting.

Minutes are circulated to each member before the next meeting, when they are submitted for approval by the local HWB and are signed by the Chairman.

8. **Agenda.**

The agenda for each meeting normally includes:

- Minutes of the previous meeting for approval and signing;
- Declarations of Disclosable Pecuniary Interests and Other Significant Interests
- Reports seeking a decision from the local HWB;
- Any item which a member of the local HWB wishes included on the agenda, provided it is relevant to the terms of reference of the local HWB and notice has been give to the Clerk at least nine working days before the meeting.

The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

9. **Chairman and Vice Chairman's Term of Office.**

The Chairman will be elected by the local HWB. The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the local HWB, at the first meeting of the local HWB succeeding that date.

10 Membership

Members will usually comprise:

- District/Borough/City Council Leader/Senior Member
- Kent County Council Cabinet Member or Deputy Cabinet Member
- CCG Senior Officer
- CCG GPs
- Healthwatch representative
- Other representatives as identified and agreed by the local HWB, e.g. voluntary sector
- District/Borough/City Council senior officers (non-voting)
- Kent County Council Families and Social Care Corporate Director (or his nominee)
- Kent County Council Public Health Consultant
- Chair of the Children's Operational Group (when appointed)

Council officers will be advisory members of the boards.

The process for nomination of members and named substitutes is a matter for each nominating organisation.

11. Absence of Members and of the Chairman.

If a member is unable to attend a meeting, a named substitute may attend in their absence, subject to them being of sufficient seniority to agree and discharge decisions of the Board within and for their own organisation.

The Clerk of the meeting should be notified of any absence and/or substitution at least five working days prior to the meeting.

The Chairman presides at local HWB meetings if they are present. In their absence the Vice-Chairman presides. If both are absent, the local HWB appoints from amongst its members an Acting Chairman for the meeting in question.

12. Decision making arrangements .

Local HWBs will conduct their business on the basis of reaching a consensus. Local HWBs have no delegated decision making powers and are therefore not able to make decisions that are binding on the constituent organisations. .

13. Quorum.

A third of voting members form a quorum for local HWB meetings. No business requiring a decision shall be transacted at any meeting of the local HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

14. Adjournments.

By the decision of the Chairman, or by the decision of a majority of those members present, meetings of local HWBs may be adjourned at any time

to be reconvened at any other day, hour and place, as the local HWB decides.

15. Order at Meetings.

At all meetings of local HWBs, it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

16. Suspension/disqualification of Members.

At the discretion of the Chairman any body with a representative on a local HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman.

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By:	**Roger Gough, Cabinet Member for Education and Health Reform**
To:	**Health and Wellbeing Board**
Date:	**20 November 2013**
Subject:	**Co-option of members to the Health and Wellbeing Board**
Classification:	**Unrestricted**
Past Pathway of paper	**Not applicable**
Future Pathway of paper	**Selection and Member Services Committee**

Summary: This report invites the Health and Wellbeing Board (HWB) to consider a change to its terms of reference to enable it to co-opt members. It also asks the HWB to consider the co-option of Dr Robert Stewart to its board should an amendment to the terms of reference be agreed.

Recommendations:

1. That the Selection and Member Services Committee be asked to agree an amendment to the terms of reference for the HWB to enable the co-option of non-voting members.

2. That authority be delegated to the Chairman of the HWB to invite Dr Robert Stewart, Clinical Design Director, White Gate Design to become a non-voting, co-opted member of the Health and Wellbeing Board subject an amendment to its terms of reference being agreed by the Selection and Member Services Committee.

1. Background

1.1 Views have been expressed that the HWB would like to co-opt a member to its board.

1.2 There is no provision in the HWB's current terms of reference for the co-option of members.

1.3 The Selection and Member Services Committee is responsible for making or arranging appointments and nominations of any non-council members on council committees (Appendix 2, Part 2 paragraph 6 (h)(vi) of the Constitution).

1.4 The HWB is therefore asked to consider making a recommendation to the Selection and Member Services Committee that an amendment be made to its terms of reference to enable it to co-opt non-voting members.

2. Financial Implications

2.1 There are no financial implications arising from the co-option of members. .

3. Bold Steps for Kent and Policy Framework

3.1 The HWB is a board of commissioners charged with encouraging integrated working with partners in Kent and works with existing partnerships to ensure the most appropriate mechanism is used to deliver service improvement in health, social care and in reducing health inequalities. It therefore contributes to the following priorities:

- Improve how we procure and commission services
- Empower social service users through increased use of personal budgets.

4. Legal Implications

4.1 Section 194 of the Health and Social Care Act 2012 specifies that each upper tier local authority must establish a health and wellbeing board for its area. The legislation and regulations have been drafted with the deliberate intention of allowing flexibility for local authorities and their partners to set up and run health and wellbeing boards that suit local circumstances.

4.2 The County Council formally established the Kent HWB with effect from 1 April 2013 at its meeting on 28 March 2013.

4.3 The membership of HWB was agreed as

- The Leader of Kent County Council or his nominee*
- Corporate Director for Families and Social Services*
- Director of Public Health*
- Cabinet Member for Adult Social Care & Public Health
- Cabinet Member for Business Strategy, Performance and Health Reform (now updated to Cabinet Member for Education and Health Reform)
- Cabinet Member for Specialist Children's Services
- Clinical Commissioning Group representation: up to a maximum of two representatives from each consortium (e.g. Chair of CCG Board and Accountable Officer)*
- A representative of the Local HealthWatch*

- A representative of the NHS Commissioning Board Local Area Team*
- Three elected Members representing the District/Borough/City Councils (nominated through the Kent Council Leaders.

* denotes statutory member of the HWB.

4.4 In addition to identifying the statutory membership of HWBs the Health and Social Care Act 2012 allows for the appointment of *"such other persons or representatives as the local authority thinks appropriate".*

4.5 This provision is not specifically included in the terms of reference of the HWB.

5. Equalities Implications

5.1 The are no direct equalities implications arising from the co-option of members to the HWB as every proposal for a co-option would be considered on its own merits.

6. Proposed Co-option

6.1 The HWB has invited Dr Robert Stewart, Clinical Design Director from White Gate Design to contribute to its meetings on a number of occasions as an expert witness, particularly in the development of integrated and sustainable health and social care provision. The HWB would like to be able to formally co-opt him to the board.

6.2 Dr Stewart is the Clinical Design Director at White Gate Design, a practising GP and has previously been the Medical Director for Clinical Commissioning and Strategic Change for NHS Kent and Medway. As such, he is well placed to understand the clinical and managerial challenges facing the NHS and KCC in integrating health and social care and assist with the development of a shared vision of how to meet them.

7. Conclusion

7.1 In order to co-opt Dr Stewart or any further non-voting members to the HWB, an amendment is required to its terms of reference.

8.	**Recommendations:**
8.1	That the Selection and Member Services Committee be asked to agree an amendment to the terms of reference for the HWB to enable the co-option of non-voting members to its board.
8.2	That authority be delegated to the Chairman of the HWB to invite Dr Robert Stewart, Clinical Design Director, White Gate Design to become a non-voting, co-opted member of the HWB subject an amendment to its terms of reference being agreed by the Selection and Member Services Committee.

9. Background Documents -

- Health and Social Care Act 2012
- Report to Selection and Member Services on 14 March 2013 “Establishing the Kent Health and Wellbeing Board
- Report to County Council on 28 March 2013 Developing Better Health Care for Kent

10. Report Author:

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