AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 28th January, 2015, at 6.30 pm Ask for: **Ann Hunter**

Darent Room, Sessions House, County Hall, Maidstone Telephone **03000 416287**

Refreshments will be available 15 minutes before the start of the meeting

Membership

Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr E Howard-Jones, Mr S Inett, Mr A Ireland, Dr M Jones, Dr E Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr R Stewart, Cllr P Watkins and Cllr L Weatherly

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By entering into the room you are consenting to being filmed. If you do not wish to have your image captured please let the clerk know immediately

UNRESTRICTED ITEMS

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

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

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

In accordance with the Members' Code of Conduct, members of the board are requested to declare any interests at the start of the meeting. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

4 Minutes of the Meeting held on 19 November 2014 (Pages 5 - 12)

To consider and approve the minutes as a correct record

5 Strategic Workforce Issues

To receive a presentation from Philippa Spicer, HE KSS Letb Director, on the strategic workforce issues relating to Kent

6 Early Years Restructure (Pages 13 - 18)

To receive a report setting out a series of recommendations to refresh a partnership approach to children and young peoples' services across the county

7 Integration Pioneer Update and Vision re the Five Year Forward View (Pages 19 - 24)

To note the update of the integration pioneer and vision re the Five Year Forward View and the added value Pioneer gives at a local level

8 A - Assurance Framework B - Update on Quality (Pages 25 - 58)

A. To receive a report containing performance figures on a suite of indicators based on the Kent Health and Wellbeing Strategy

B. To receive an update on progress in producing a quality report that fulfils the requirements set out in the Francis report and an overview of quality issues in Kent

9 Better Care Fund - S75 Agreement (Pages 59 - 152)

To note the progress made to date on developing the section 75 agreement to support delivery of the approved BCF plan

10 Minutes of the Children's Health and Wellbeing Board (Pages 153 - 156)

To note the minutes of the Children's Health and Wellbeing Board meeting held on 28 November 2014

11 Minutes of the Local Health and Wellbeing Boards (Pages 157 - 192)

To note the minutes of the local health and wellbeing boards

Ashford - none
Canterbury and Coastal – 25 November 2014
Dartford, Gravesham and Swanley – 29 October 2014
South Kent Coast – 16 September 2014 and 20 January 2015
Swale – 17 September 2014
Thanet – 13 November 2014
West Kent – 18 November 2014

12 Date of Next Meeting 18 March 2015

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, 20 January 2015

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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, 19 November 2014.

PRESENT: Mr R W Gough (Chairman), Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr E Howard-Jones, Mr S Inett, Mr A Ireland, Dr M Jones, Dr E Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr R Stewart and Cllr L Weatherly

IN ATTENDANCE: Ms J Frazer (Programme Manager Health and Social Care Integration), Mr T Godfrey (Policy Manager (Health)), Ms P Southern (Director, Learning Disability & Mental Health), Mr M Thomas-Sam (Strategic Policy Adviser), Mr T Wilson (Head of Strategic Commissioning (Children's)) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

107. Chairman's Welcome
(Item 1)

(1) The Chairman welcomed Cllr Mrs Lynne Weatherly who was taking over from Cllr J Cunningham as one of the district/borough council representatives on the Health and Wellbeing Board (HWB).

(2) Mr Gough drew the board's attention to the health and social care maps which were available on the Kent and Medway Public Health Observatory website.

(3) Mr Gough said that a provider networking event, hosted by the East Kent Hospitals University NHS Foundation Trust and sponsored by the HWB, on 22 September had been successful. Providers were keen to provide integrated services and asked that commissioners be equally integrated in their approach to commissioning. Providers were also interested in the vision for commissioning in the future.

(4) Mr Gough said he had drafted a response to a letter received from Jeremy Hunt urging HWBs to consider positions for providers on their boards. He had discussed this with some CCGs and there was broad agreement that it was not appropriate to include providers on the Kent HWB, however, links between the Board and the health economy level bodies in which providers played a strong role (such as the Executive Programme Board in North Kent) should be strengthened and formalised. He said he would circulate a draft response before submitting it.

(5) Mr Gough concluded by drawing the Board's attention to a report from Grant Thornton called "Pulling Together the Better Care Fund - Delivering improvements through integrated health and social care" and said some of the

key issues raised in this report would be considered in greater detail at the next meeting of the Kent HWB on 28 January 2015.

108. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr F Armstrong and Cllr P Watkins.

109. Declarations of Interest by Members in Items on the Agenda for this Meeting
(Item 3)

There were no declarations of interest.

110. Minutes of the Meeting held on 17 September 2014
(Item 4)

Resolved that the minutes of the Kent Health and Wellbeing Board held on 17 September 2014 are correctly recorded and that they be signed by the Chairman.

111. Update on the Joint Health and Social Care Self-Assessment Framework for 2013/14
(Item 5)

(1) Mr Gibbens, Cabinet Member for Adult Social Care and Public Health, introduced the paper. He also introduced Tina Walker, Co-Chair of the Kent Learning Disability Partnership Board and Daniel Hewitt, Co-Chair of the Good Health Group and commended the recommendations in the report to the board.

(2) The report asked the HWB to comment on the: 2013/14 National Comparison Action Plan including the progress made in the red indicators of the RAG rating; the way in which Kent was approaching the 2014/15 Joint Health and Social Care Self-Assessment Framework (JHSCAF) and the Kent Action Plan for the Winterbourne View. It also asked the HWB to agree the process for sign off of the JHSCAF to be submitted in January 2015.

(3) Tina Walker, Daniel Hewitt, David Holman, Penny Southern, Malti Varshney and Sue Gratton gave a presentation, copies of which were included in the agenda pack for the meeting.

(4) Following the presentation, Mr Gibbens said that the red ratings, and particularly the red rating for health screening for people with disabilities, were of concern and asked how this might be improved in the future. Examples were given of events and practices in Ashford, Canterbury & Coastal and South Kent Coast CCGs designed to raise awareness and improve outcomes. It was also suggested that simplifying the process for commissioning services might need further consideration.

(5) During the discussion, having a named clinical lead within each CCG was considered to be very important as was the ability to undertake clinical audits and to work collaboratively with GPs in order to understand the issues and develop realistic and achievable plans for improvement.

(6) It was suggested that it would be helpful for the HWB to understand the figures for admission and discharge of clients into the range of secure and non-secure hospitals. During discussion that followed the number of patients admitted through the CCGs and NHS England was confirmed as was the fact that more people had been discharged than had been admitted. The very complex needs of individuals was acknowledged and there was agreement that services had to be provided in the best interests of patients and service users and not be solely target driven. Mr Howard-Jones reported that work had been undertaken to understand how placements could best be made and ensure services were patient rather than target driven. The existence of targets had however been helpful in focussing on the needs of patients, including the safe discharge of those with complex needs.

(7) Ms Southern said that when the Winterbourne programme started the aim was to design sustainable pathways in the community and to invest money in community services not only to facilitate discharge but to prevent unnecessary admissions. She also said Kent had been subject to a "deep dive" and had made it clear to Andrew Cousins from the Winterbourne National Programme that Kent would continue to work within the principles of the programme with an approach focussed on the needs of users but this meant not all targets would be met. A letter on this matter was being drafted and she welcomed the HWB's support for the approach adopted.

(8) Resolved that the sign-off of the JHSCAF 2014 for submission in January 2015 be delegated to the Chairman

112. Kent Safeguarding Children Board - 2013/14 Annual Report
(Item 6)

(1) Gill Rigg, Independent Chair of the Kent Safeguarding Children Board introduced the annual report for 2013/14. She said the report described progress made up to eight months ago and there had been significant progress since then including the re-structure of the board and the development of a robust business plan. She also said the report had been submitted to the Head of Paid Service, the Leader of the Council and the Police and Crime Commissioner as required.

(2) In response to questions she said that: health colleagues were very engaged with safeguarding issues including undertaking the chairmanship of KSCB health sub-group and having a named GP on the Board. She considered the take-up of training within health services to be good and there was always a need to do more. She also said the financial restraints across the public sector had resulted in training being provided in ways other than attending traditional whole-day courses.

(3) During discussion it was confirmed that health agencies provided their own single agency training for safeguarding children and vulnerable adults, with the KSCB being responsible for multi-agency training. It was suggested that there was a need to progress multi-agency audits and that the HWB could facilitate

this by supporting the collection and provision of whole system data for review by the KSCB.

(4) Mrs Rigg said there was increased awareness of child sexual exploitation and the KSCB had commissioned an independent review which would contribute to the development of a plan for reducing child sexual exploitation.

(5) Resolved that:
(a) All partners represented on the HWB would commit to supporting multi-agency audits;
(b) The progress and improvements made during 2013/14, as detailed in the annual report from the Independent Chair of KSCB be noted.

113. Care Act 2014 - A New Legal Framework for Adult Social Care
(Item 7)

(1) Michael Thomas-Sam, Strategic Business Adviser to Social Care, introduced the report which sought to raise awareness and understanding of the main changes to the legal framework for adult social care and support services being established by the Care Act 2014 which would come into effect from April 2015. This would be followed by funding reforms (including a cap on care costs) with effect from April 2016.

(2) He said that the changes would have significant implications for Kent residents, Kent County Council and partners. He said local authorities would have to address new or extended responsibilities relating to the core duties of wellbeing and, in particular, in respect of prevention and integration. He also said there were significant changes to the national minimum eligibility criteria and the rights of carers to receive support. It was also anticipated that the number of people coming forward for needs and financial assessments would increase significantly because of changes to the cap on care costs.

(3) During discussion it was suggested that families and individuals would benefit as a result of the Care Act 2014 as it was significantly more generous than the recommendations set out in the Dilnot review and this should be communicated to the public. It was also said that the government had not yet confirmed the funding for the proposals and local authorities were awaiting the announcement of the funding in the Comprehensive Spending Review.

(4) It was suggested that the needs of carers be considered and that Healthwatch, in conjunction with KCC officers, would make a short presentation at a future meeting of the HWB.

(5) The requirement to assess the care and support needs of prisoners was welcomed and Mr Scott-Clark undertook to consider the impact as part of the Joint Strategic Needs Assessment (JSNA).

(6) Resolved that the key issues set out in the report and their implications as they may impact on the future development of the JSNA be noted

114. Kent Integration Pioneer Programme Update
(Item 8)

(1) Dr R Stewart introduced the report which provided an update on the work of the Pioneer. He said the Pioneer programme was one year old and that he would report to the HWB on the outcome of a workshop planned for December 2014. This workshop was to be supported by the Leadership Centre to further consider how the Integration Pioneer Steering Group could best ensure the aims and objectives of Kent as a pioneer could be achieved and how it could be used to share lessons learned, spread best practice and barrier bust across Kent. He also said that the Innovation Hub had been recognised by the EU as a site of excellence as part of the CASA European Innovation Programme.

(2) The importance of establishing the governance arrangements, including risk sharing arrangements, for the use of the Better Care Fund was emphasised and it was confirmed that a sub-group of finance officers established at the last meeting of the HWB on 17 September 2014 was due to report at the next meeting of the board on 28 January 2015.

(3) Resolved that:
- (a) The report and progress to date within Kent's Pioneer programme be noted;
- (b) The approach for developing workstreams in evaluation, Europe and the Innovation Lab be supported.

115. Systems Resilience
(Item 9)

(1) Tristan Godfrey, Policy Manager – Health, introduced the report which set out a number of challenges to the health and social care system that might require a whole-system response.

(2) During discussion assurances were given that there were tried and tested plans to respond effectively to major incidents such as terrorist threats, however a prolonged period of pressures and any enforcement of section 31 action presented greater challenges. Every effort was being made to model the potential impact and respond to changes in a planned way. The need for an informed debate with Public Health about health needs and the provision of services at the Kent and Medway level was identified and it was suggested that support from the HWB for these further discussions would be welcomed.

(3) Resolved that:
- (a) Work underway to plan responses to the immediate pressures be noted and the fact that consideration was being given to minimising the risk from longer term pressures be welcomed;
- (b) Consideration be given, outside the meeting, about how the HWB could continue to be assured that the risk of any one of the key challenges destabilising the whole health and care system is being minimised;
- (c) The report be noted.

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116. Minutes of Local Health and Wellbeing Boards
(Item 10)

(1) There was support for receiving minutes of local health and wellbeing boards as it facilitated the flow of communication. It was also suggested that consideration be given to how learning and best practice could be shared across the county and to be mindful of the potential of local health and wellbeing boards to drive forward change at the local level and to have a role in responding to issues relating to safeguarding children.

(2) Resolved that the minutes be noted.

117. a) Minutes of the Children's Health and Wellbeing Board b) Emotional Health and Wellbeing Strategy
(Item 11)

a) Minutes of the Children's Health and Wellbeing Board

(1) Resolved that the minutes of the Children's Health and Wellbeing Board held on 12 September 2014 be noted.

b) The Way Ahead: Draft Emotional Health and Wellbeing Strategy for Children, Young People and Young Adults (0-25) in Kent – Part 1

(2) Dave Holman, Head of Mental Health Programme Area - West Kent CCG, introduced the report. He said that: 50% of mental health issues were diagnosed before age 14; 75% before the age of 18; and accounted for about 6% of NHS spend. He described the process used by a multi-agency sub group to develop the draft emotional health and wellbeing strategy and how the views of children, young people and others had been gathered and used to inform the strategy. He also described the principles of the strategy, the engagement process currently underway and the next steps towards finalising the strategy and agreeing a delivery plan. He also said a rollover of existing contracts had been agreed to enable the new model and services to be procured and implemented.

(3) Thom Wilson, Head of Strategic Commissioning, said that an appreciative enquiry considered the engagement of young people and others to be an example of good practice. He also said the fact that a number of contractual arrangements would come to an end at the same time created a "golden opportunity" to implement the strategy and effect transformational change.

(4) The need for continued engagement with young people, particularly teenagers, was acknowledged as was the view that ideas about ways to engage would come from young people. It was suggested that Healthwatch was well-placed to monitor and review how changes in services were operating on the ground and to ensure young people continued to be at the heart of service development.

(5) It was also confirmed that performance data from the Sussex Partnership NHS Foundation Trust was available at both county and CCG level

(6) Resolved that:

(a) The Emotional Health and Wellbeing Strategy for Children, Young People and Young Adults (0-25) in Kent be recognised as sitting beneath the Joint Kent Health and Wellbeing Strategy as a key part of the response to two of its overarching outcomes;

(b) The invitation to attend an Emotional Wellbeing Summit, on 18 December, to support the development of the delivery plan be noted.

118. Promoting and Delivering the Kent Joint Health and Wellbeing Strategy - Progress reports from local Health and Wellbeing Boards
(Item 12)

Resolved that the progress report from local health and wellbeing boards be noted.

119. Date of Next Meeting - 28 January 2015
(Item 13)

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From: Andrew Ireland, Corporate Director Social Care, Health and Wellbeing, Kent County Council

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

Hazel Carpenter, Accountable Officer South Kent Coast and Thanet Clinical Commissioning Group

Patrick Leeson, Corporate Director Education and Young People's Services, Kent County Council

To: Health and Wellbeing Board

Date: 28th January 2015

Subject: **Integrating the approach of Children and Young Peoples Services**

Summary:

This report sets out a series of recommendations to refresh a partnership approach to children and young people's services across the County. The report reflects on some of the challenges that need to be overcome in partnership to improve our provision of children and young people's health and wellbeing services in Kent.

Recommendation(s): **Health and Wellbeing Board members** are asked to COMMENT on the report and the following recommendations.

Recommendation 1: All partners review the membership of the Children's Health & Wellbeing Board and identify appropriate representatives to ensure they are able to effectively represent them and help to steer the strategic direction for children's services in the county.

Recommendation 2: Review Outcome 1 of Kent's Health and Wellbeing Strategy – Give Every Child the Best start in Life. We propose that the Children's Health & Wellbeing Board review this Outcome to ensure that it meets the strategic priorities of the organisations involved, and can be used to drive the delivery of the most important priorities for the county.

Recommendation 3: Work in partnership across the Districts, CCGs and KSCB to review the arrangements for working together at a local level. We believe that the current system requires improvement to work effectively, and would want partners to work together to quickly establish a way to establish local governance which is meaningful and effective for all partners.

Recommendation 4: Public Health commissioners, in partnership with all colleagues across the Health and Wellbeing Board, refresh and re-develop the model for Health Visiting to deliver an integrated service for families with young children.

Recommendation 5: Working together Early Help & Preventative Services & Health Commissioners will agree the actions and programme of work to achieve the priorities of the Healthy Child Programme.

1. Context

1.1. Partners across the Health and Wellbeing Board are agreed that we need to work together to put the children and families of Kent first, and use our resources in the most effective way to improve outcomes.

1.2. Partnership working within children's services is a highly complex and challenging area. A key aspect in this is the broad range of partners involved in ensuring that children are safe and given the best possible opportunities. In addition to the county council and health commissioners are essential relationships with schools, districts, police and a range of other partners. Added to this is the complexity of status of different children in the county, alongside the varying responsibilities and accountabilities that partners have for working with children in need, looked after children, other local authority children and unaccompanied asylum seeking children.

1.3. Significant progress is being made in children's services developing greater partnership working between the council, health and wider partners. Over the past year there has been a focus on strengthening links which has included the establishment of the Children's Health and Wellbeing Board, and the commencement of the Collaborative Commissioning Project Board which is expected to lead to an integrated approach to commissioning in the future.

1.4. Alongside these are good examples of partnership working such as the example established through the new strategy for Emotional Wellbeing that has seen partners come together to put children and families at the heart of service design. A substantial amount of consultation continues to take place with children and families to implement this work.

1.5. However, there have also been some weaknesses. For example, decisions with an impact on the whole system have been made without due consideration of their effect. Channels of communication are not yet sufficiently established to ensure that all who need to know are fully informed of changes, and despite there being widespread commitment across the system our governance bodies for children's strategic development are not consistent, and this can complicate communication. A particular challenge has been to achieve consistent success in locally based working, such as through Children's Operational Groups.

1.6. A fundamental challenge we face is to ensure that we are able to work together with the same cohesive approach and outcome focus that we have in Emotional Wellbeing, across the whole of children's services. This paper is designed to spark a conversation about how to ensure we do so.

2. Public Health: The Healthy Child Programme

2.1. The national framework designed to drive a cohesive approach to children's health and wellbeing is the Healthy Child Programme (HCP). This is an evidence based Department of Health early intervention and programme for children, young people

and their families. First published in 2009 it provides a comprehensive framework for services in three volumes:

1. Pregnancy and the early years,
2. The 2 year review,
3. Children aged 5-19.

2.2. It provides a framework for the delivery of outcomes to keep children healthy and safe as well as ready to learn.

2.3. In order to achieve the recommended standard for the delivery of the programme local services for children and families must be fully integrated. This requires integration of the workforce including maternity, health visiting, school nursing and GPs working together with Early Help & Preventive Services and Safeguarding services in multi-disciplinary teams.

2.4. In Kent a number of strands of work are in progress to deliver this. A Healthy Child Programme and Early Help review group was established in September with commissioner and provider representation. This has delivered a review of Public health in maternity services which has reported recommendations to the Childrens Health and Wellbeing Board. Connected to this, the Childrens HWBB reviewed the arrangements for children's needs assessments and it has been agreed that a specific children's JSNA will be delivered across Kent during 2015.

2.5. A significant change is the transfer of commissioning of the Health Visiting service in October 2015 from NHS England to KCC Public health. KCC and NHS England are already working closely together to review progress in relation to the Health Visitor workforce targets and the performance of the service.

2.6. The new commissioning arrangements offer further opportunity to review the Health Visiting service as a core programme of work during 2015. In particular, to look at the coordinating role that Health Visitors play in leading the delivery of the Healthy Child programme during the early years. It is an opportunity to review services from a whole system perspective, ensuring that health visitors are best placed to work across provision, effectively linking with both General Practice and Early Help & Preventative Services to ensure that families are supported at the right time in the right setting.

3. Early Help & Preventative Service Opportunities

3.1. Early Help is a core area in which integrated working across a range of partners is essential to success. Early Help services for children, young people and families are commissioned and provided across a wide range of agencies including schools, CCG, the council, health providers, the voluntary sector and the police and fire services.

3.2. A significant amount of work is already underway in this area, notably following the development of a dedicated Early Help & Preventative Services Division within Kent

County Council. The first phase of the council's 0-25 programme is due to be implemented in 2015. This will see a full restructure of the service and a range of systems and process implemented to ensure that the service is able to effectively identify the families that most need their help, and to support them in an effective, outcome focused way. The restructure is designed to enable a coterminous approach with children's social care, and close alignments with districts. A key aspect of implementation will be to work with CCGs to identify the most effective means of ensuring early help practitioners work effectively together regardless of the provider or commissioner.

3.3. Organisations represented across the Health and Wellbeing Board are engaged in a transformation agenda, aimed at improving outcomes within reducing budgets. Related initiatives provide a significant opportunity for the Health & Wellbeing Board to have a greater opportunity to shape the way that services work together – but they also present a risk if partners are not able to take this chance to plan in partnership, and align strategies around the needs to the community. We know that families want seamless care and do not want to repeat their needs to multiple services.

4. Conclusion & Recommendations

4.1. We believe that there are significant opportunities to improve outcomes and efficiency by more effectively working together both strategically and operationally. The agreement and implementation of a coherent approach to the development of service models, to communication and to decision making would enable partners to establish an integrated framework, providing the maximum opportunity to support children and families across Kent.

4.2. This will not be a straightforward objective to achieve, but we would propose the following recommendations as the next stage on the journey:

Recommendation 1: All partners review the membership of the Children's Health & Wellbeing Board and identify appropriate representatives to ensure they are able to effectively represent them and help to steer the strategic direction for children's services in the county.

Recommendation 2: Review Outcome 1 of Kent's Health and Wellbeing Strategy – Give Every Child the Best start in Life. We propose that the Children's Health & Wellbeing Board review this Outcome to ensure that it meets the strategic priorities of the organisations involved, and can be used to drive the delivery of the most important priorities for the county.

Recommendation 3: Work in partnership across the Districts, CCGs and KSCB to review the arrangements for working together at a local level. We believe that the current system requires improvement to work effectively, and would want partners to work together to quickly establish a way to establish local governance which is meaningful and effective for all partners.

Recommendation 4: Public Health commissioners, in partnership with all colleagues across the Health and Wellbeing Board, refresh and re-develop the model for Health Visiting to deliver an integrated service for families with young children.

Recommendation 5: Working together Early Help & Preventative Services & Health Commissioners will agree the actions and programme of work to achieve the priorities of the Healthy Child Programme.

Report Authors

Thom Wilson

Head of Strategic Commissioning, Children's, Families and Social Care, Kent County Council

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By: Dr Robert Stewart, Chair Integration Pioneer Steering Group

To: Kent Health and Wellbeing Board, 28 January 2015

Subject: **Integration Pioneer and vision re the Five Year Forward View.**

Classification: Unrestricted

Summary: In line with the NHS Five Year Forward View, Kent as a Pioneer site was requested to provide information on the seven models of care described in the forward view on those with which our pioneer programme overlaps. The information requested in relation to the Forward View models of care will be the basis for pioneer expressions of interest to become test bed sites.

Kent was asked to complete the taxonomy report (Appendix 1) by the National Pioneer Programme to show where we are delivering against the elements laid out in the Five Year Forward View document. Further details about what this will entail are expected from the DH this week. Kent has updated the taxonomy report further with provider input after the Integration Pioneer meeting on the 19th. Test bed sites will be determined on the quality of their intentions not the size of the area. Pioneer sites will still receive the same support, commitment, information and tools if the decision is made not to progress to a new model of care. Funding will be allocated to successful test bed sites according to the needs of the business case.

The Integration Pioneer Steering Group has taken place Monday 19 January; the meeting consists of all key stakeholders including providers as well as commissioners. The meeting agenda covered the 5 Year Forward View and included table discussions on proposals for the next 5 years and how these link into Simon Stevens' visit.

A short power point slide will be available for the board reflecting the meeting of the 19/1/15.

For Information

1. Recommendation

The Kent Health and Wellbeing Board is asked to:

1.1 Note the update of integration pioneer and vision re the 5 Year Forward View

2. Contact details

Report author:
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07917473593

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Pioneer programme – Interface with Forward View new models of care

Below are the seven models of care described in the Forward View. Please can you provide information on those with which your pioneer programme overlaps, or for which you would like to be considered as a test bed. We anticipate that as you may overlap with a number, please can you provide a sense of phasing or interdependencies, for example which models you are seeking to implement first, and when.

For convenience the Forward View document can be accessed here: http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

New model of care	Pioneer perspective - Kent	Order of phasing (ie 1 = top priority; 2 = second priority etc)
Multidisciplinary community providers (horizontal integration around GP networks with MSTs covering wide service range including up to community hospital)	**South Kent Coast & Thanet** Thanet and South Kent Coast CCG's are currently developing their model of integrated health and social care around natural communities with the aim of developing an Integrtaed Care Organisation. The model includes horizontal integration of teams including GP, mental health, care management, community nursing and intermediate care services (health/social care/mental health/domiciliary /voluntary care/access to community beds across the system by both health and social care to accommodate step up and step down)with the person at the centre.	1
	Ashford & Canterbury The framework for commissioning community-based services is to ensure that health, social care and voluntary services are based around individuals and the communities in which they live and work. The framework has been termed Community Networks and will be focussed around our clustering of GP practices and the local communities that they serve. Selection and design of these services will be carried out in partnership with local patients, services users, provider and partner organisations. Consequently the services will be based on the needs of our local population. Examples of services that may form part of the community networks include: some outpatient services, neighbourhood care teams (which provide care to people in their own homes), GP care, consultants who provide care for the elderly, community and voluntary sector support and mental health services. One of the key enablers for successful delivery is the development of our Primary Care Strategy which underpins the Community Network approach. There may be one or two networks that are slightly more developed in their thinking and design models for local services that would enable them to be considered as	1
	West Kent West Kent BCF is underpinned by the West Kent Mapping the Future which introduces a new model of Primary Care focusing on three distinct but interlinked areas of care (prevention, proactive and reactive) creating larger scale GP led multi-disciplinary health and social care teams which are wrapped around a suitably sized group of practices to ensure a suitable skill mix balanced against critical mass of population need. This will be our interpretation of multidiciplinary community provider models.	1* part of the same project in different parts of the West Kent Health system
	DGS & Swale	1
Primary and acute care systems (vertical integration across GP, hospital, mental health and community care)	**South Kent Coast & Thanet** Thanet and SKC CCGs are developing an integration model that includes some integration of primary and acute systems,enagagement across the health and social care system has been in progress for the last couple of months and it is expected that a proposed model will be ready in early January for implementation as part of the organisation of integrated care model.	1
	Ashford & Canterbury Development of Community Networks is the key enabler to our Strategic Vision.	1
	West Kent During 2015, we will redesign and then procure ophthalmology services in West Kent to integrate our extended and enhanced opticians services (including rapid eye clinics), our current opthalmology GPWSI services, our current community opthalmology team and all opthalmology currently delivered by the Acute Trust which does not depend on an Acute Hospital facility for its delivery. It is anticipated that all this activity will be provided outside an acute hospital building.	2
	DGS & Swale	
Urgent and emergency care networks (integration of A+E, urgent care centres, ambulance, 111, out of hours GP, community health teams and pharmacies)	**South Kent Coast & Thanet** There is an Urgent Care Strategy(Integrated Urgent Care Centre Model- IUCC) in place that covers the whole of east Kent (which includes both SKC and Thanet CCGs)and is being tested as part of the resilience funded schemes in addition the OOH and 111 service design is taking place to include the IUCC in preparation for the procurement exercise due to take place in 2015	
	Ashford & Canterbury We are currently implmenting our vision of Integrated Urgent Care Centres, for this to be fully effective the Community Network model needs to be in place.	2
	West Kent In 2015/16 West Kent intends to reprocure as one bundle the following: GP in A&E (primary care and A&E minors work), Enhanced Rapid Response Service, and GP Out of Hours Service to achieve a single provider solution focused at delivering as much urgent care activity outside of admission to an acute hospital. It is anticipated that there will be colocation which will allow the system to better manage peaks in activity in any of these areas.	1* part of the same project in different parts of the West Kent Health system
	DGS & Swale	1
Viable smaller hospitals (shared services or full integration with larger hospital, or specialisation)	**South Kent Coast & Thanet** SKC CCG is developing the Deal community hospital as a hub for services across health, social care and voluntary organisations, ensuring full utilisation of the inpatient beds for both step up and step down for the use by both health and social are for the appropriate patients. In addition seeking to provide accessible out patient follow up services in areas such as rheumatology and orthopaedics and investigating the use of technologies and other health are professionals in this provision across acute and primary care. Thanet and SKC CCG are working in collaboration with the Hospital Trust around the shift of acute care into the community as part of the integrated care model in addition to identifying implications for the main acute hospital sites and the redesign of the site in Thanet.	
	Ashford & Canterbury This is a much longer project which can only be implemented once the Community Networks are delivering reductions in attendances and admissions	4
	DGS & Swale	3
Specialised care (concentration in centres of excellence)	**South Kent Coast & Thanet** SKC and Thanet CCGs are involved in Kent & Medway level work starting looking at stroke and vascular services working from a centre of excellence	
	Ashford & Canterbury This is our lowest priority and can only be completed after reduction in admissions and attendances brought about through the Community Networks. However, we have already begun rationalising the outpatient services.	5
	DGS & Swale	3
Modern maternity services (following review, test new models including wider choice and more midwifery-run services)	**Ashford & Canterbury** This has already been completed following an public consultation.	6
	DGS & Swale	3
Enhanced health in care homes (shared health and care models of in-reach services)	**South Kent Coast & Thanet** Model in place for quality improvement, support and education to care homes in order to reduce unnecessary attendance at A&E, this works across community health and social care services (older peoples nurse specialist and social care) and incudes a community geriatric supporting the care homes via the nurse specialist or GP, in addition, a model of additional support via the community night nursing service is being tested - a proactive approach to support the care homes by making nightly contact with them and addressing any issues that may escalate over night. Integrated discharge team will incorporate the care home specific pathway	
	Ashford & Canterbury This is part of our better care fund and Community Networks model of care. We have already been increasing the level of support however this can only be fully effective following introduction of the Community Networks model of care	3
	West Kent In 2015/16 we intend to contract with GP practices to provide medical support to care homes in West Kent. This will include anticipatory care plans for high intensity users in the top 20 targeted homes. It is anticpated that the coordination of care for vulnerable people in West Kent through an effective multi-diciplinary team approach and a focus on anticipatory and end of life planning with help prevent crisis and unplanned acute hospital admissions. This will be complemented by a focused High Impact Support Team to work specifically with care homes.	2
	DGS & Swale	2
Are there are elements of your model which are relevant but missing from the above options?		

The Forward View also speaks to a range of enablers and approaches which are integral to integrated care models and change programmes. Please provide information on any aspects your programme exemplifies.

Enabler/approach	Pioneer perspective
Prevention and early intervention (healthier behaviour, public health leadership, targeted prevention, employment support, workplace health)	**South Kent Coast & Thanet** SKC CCG has an Integrated commissioning group in place that reports to the local health and wellbeing group, identified areas of work that are linked to the Better care Fund work for example - CVD, diabetes, falls, housing. In addition SKC are developing an inequalities pilot focused around 3 practices using Health Trainers developing a pro active approach to Health and Wellbeing with the aim of reduction in the use urgent care services. Both thanet and SKC CCGs plans focus on self management, self care and prevention is an integral part of the model of integrated care.
	Ashford & Canterbury We are engaging with the Public Health Team in KCC to explore opportunities for preventative services to be commissioned and driven at network level, linking to both sections below.
	DGS & Swale Obesity prevention and smoking prevention
Patient empowerment (access to information, self-care, patient choice)	**South Kent Coast & Thanet** There is work being progressed regarding patient self care - 'Patients in Control'. There are plans for a focus on self management, self care and prevention is an integral part of the model of integrated care in Thanet and SKC
	Ashford & Canterbury Our community networks are being codesigned and coproduced by local stakeholder groups. Public engagement is implicit in everything we are trying achieve
	DGS & Swale integrated IT systems
Community engagement (carer support, community volunteering, VCS partnership, NHS as employer)	**South Kent Coast & Thanet** Have undertaken patient and public engagement across both SKC and Thanet CCG areas to seek views on how services should be designed and gaps identified and to test the integrated care ideas with them. In addition as part of the integration plans both CCG localities have developed a "building community capacity"model
	Ashford & Canterbury Our community networks are being codesigned and coproduced by local stakeholder groups. Carers, the voluntary sector etc are key stakeholders and are engaged in our codesign teams.
	DGS & Swale working with vol sector on community agents etc

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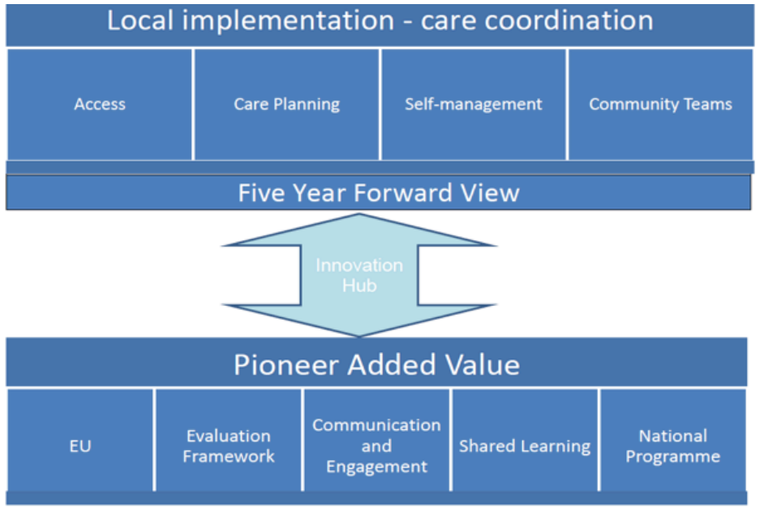
Kent Innovation - Putting the Citizen at the Centre

Ashford & Canterbury

- Neighbourhood Care teams – providing care to people within their own homes
- Community Based services to ensure that health, social care and voluntary services are based around individuals and the communities in which they live and work
- Development of a shared care plan
- Creating community networks, meeting local need and providing support and advice to people that need it.

Thanet

- Integration of teams including GP, mental health, care management, community nursing and intermediate care services
- Development of an integrated care organisation, that will not be solely medical model but will focus on reducing inequalities
- Focus on Self management, Self care and prevention and Thanet's communities will be enabled to support health and wellbeing
- Development of a community capacity model
- Thanet has an Acute site on its patch and is developing a model moving towards a possible hybrid PACS.



Sharing and Disseminating Learning

- *Kent Innovation Hub* – Innovate Communicate Disseminate - A central communication network, with most activity hosted virtually through Tweet chats and webinars with additional workshops and conferences, focusing on themes that support the Integrated Care and Support
- *Kent Innovation Labs* - A physical space that allows for collaboration between public and private sectors, academia and populations, working together to solve difficult problems & develop solutions
- *European Work* - Benefiting from the experience with similar issues across Europe: bringing the best practices and lessons learned to Kent through our CASA and Engaged Programmes.

Pioneer Added Value

- *Distributed leadership:* training and development to enable people to transcend organisational boundaries
- *Creative space*: the importance of maintaining focus and securing engagement of staff, users, patients and citizens
- Agreeing strategic commissioning needs
- Financial modelling to help build transparency and trust.

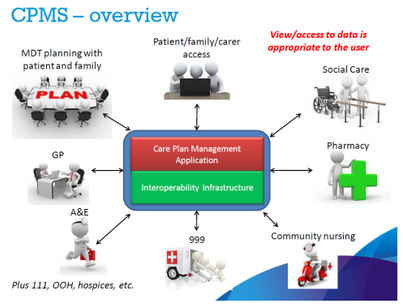
North Kent - DG&S & Swale

- Integrated Primary Care teams, providing needs led person centred care
- Full development of Integrated Discharge Team that will focus on admission avoidance and appropriate discharge
- Development of Integrated Dementia teams
- Developing shared care plans and IT that supports data sharing and care coordination.

South Kent Coast

- Prime Ministers Challenge Fund
- Development of a shared care plan
- Development of an integrated care organisation, including the horizontal integration of teams that put the citizen at the centre
- Development of multidisciplinary community hubs
- Development of a MCP model.

West Kent



- Integrated Care Plan Management System
- Cross organisational shared IG agreement
- Integrated shared care plan
- Enhanced Rapid Response Service.

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By:	Roger Gough Cabinet Member for Education and Health Reform
To:	Kent Health and Wellbeing Board
Date:	28th January 2015
Subject:	Assurance Framework
Classification:	Unrestricted

Summary: This section outlines changes for some of the indicators and highlights those raising concerns or showing increasing good performance.

Outcome 1: Every child has the best start in life.

- There has been a decrease in the proportion of **women with a smoking status at time of delivery**; from 15.2% (2011/12) to 13.0% (2013/14) Kent is now 1% higher than national proportions. (Indicator 1.1)

- **Breastfeeding initiation** rates have continued to decrease to 71.3% in 2013/14 and remain worse than national who are at 74%. (Indicator 1.2)

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

- The proportions of women having **Breast and cervical cancer screenings** continues to decrease; however both remain above national coverage rates. (Indicators 2.8 & 2.9)

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

- Indicator 4.6 measures the number of all people entering **prison who are identified as having a substance dependence**, and of these people how many had not accessed community substance misuse treatment services prior to entry. For Kent nearly 60% of those entering prison with an identified substance dependence had not previously accessed community treatment services. Nationally it was nearly 50%.

- The rate of male **suicides** in Kent has slowly been increasing from 2008-10, the most recent reporting period now shows Kent with a higher rate (14.6 per 100,000) than both the national male suicide rate (13.8 per 100,000) and the Kent female suicide rate (4.1 per 100,000). (Indicator 4.9)

Stress Indicators

All trusts have experienced decreases in the proportion of people being either discharged, admitted or transferred within four hours of arrival at A&E during December 2014.

All Trusts in December were below the 95% target, with just Dartford & Gravesham NHS trust operating above national levels.

No Trusts reported any patients with greater than 12 hours between decision to admit and admission.

Please refer to Section 5 for a detailed outline of bed occupancy, A&E discharges, admissions or

transfers within 4 hours and delayed days.

For Decision: The Health and Wellbeing Board is asked to

- Discuss the contents of this report and implications at local levels
- Discuss areas of joint working to avoid further crisis in the health and social care system
- Ask members to report back at the next meeting their findings and key learnings from the above.

1. 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 arranged on the 5 Outcomes with additional stress indicators.

2. Progress since the last report

Since the previous report a new Health and Wellbeing board Strategy report has been produced, new metrics were included and there have been added into the report.

Key to KPI Ratings used

GREEN	Target has been achieved or exceeded, or in comparison to National
AMBER	Performance was at an acceptable level within the target or in comparison to National
RED	Performance is below an acceptable level, or in comparison to National
⇧	Performance has improved relative to the previous period
⇩	Performance has worsened relative to the previous period
⇔	Performance has remained the same relative to the previous period

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

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3. Indicator executive summary

The following tables provide a visual summary of the indicators within each outcome domain. Where an indicator has not been RAG rated this indicates that there is no current specified target at this stage or there has not been a National RAG comparison made in the Public Health Outcomes Framework (PHOF).

Outcome 1: Every child has the best start in life

There have been updated published figures since the previous report for the number of pregnant women with a smoking status at time of delivery (1.1) breastfeeding Initiation rates (1.2) SEN figures (1.9 & 1.10) and CAMHS (1.11, 1.12 & 1.13).

Indicator Description	Known Target	Previous status	Recent status	DoT	Recent time period
1.1 Reducing the number of pregnant women with a smoking status at time of delivery (PHOF)	12.0% (national)	15.2% (r)*	13.0% (r)	⇧	2013/14
1.2 Increasing breastfeeding initiation rates (PHOF)	73.9% (national)	72.1% (r)	71.3% (r)	⇩	2013/14
1.3 Increasing breastfeeding continuance at 6-8 weeks (PHOF)	47.2% (national)	**	40.8% (r)	-	2012/13
1.4 Reducing conception rates for young women aged under 18 years old (rate per 1,000. PHOF)	27.7% (national)	31.0 (a)	25.9 (a)	⇧	2012
1.5 Improving MMR vaccination uptake of two doses at 5 years old (PHOF)	90%	90.5% (g)	92.2% (g)	⇧	2012/13
1.6 Increasing school readiness: all children achieving a good level of development at end of Year R (% of all eligible children. PHOF)	51.7% (national)	-	63.4% (g)	-	2012/13
1.7 Reducing the proportion of 4-5 year olds with excess weight	22.2% (national)	21.7% (g)	21.7% (a)	⇔	2012/13
1.8 Reducing the proportion of 10-11 year olds with excess weight	33.3% (national)	32.7% (g)	32.7% (a)	⇔	2012/13
1.9 Increasing the proportion of SEND assessments within 26 weeks (**Stress indicator**. KCC MIU)	90%	92.9% (g)	92.4% (g)	⇩	August 2014***

Indicator Description	Known Target	Previous status	Recent status	DoT	Recent time period
1.10 Reducing the number of Kent children with SEND placed in independent of out of county schools (**Stress indicator.** KCC MIU)	-	604	599	⇧	August 2014***
1.11 Reducing CAMHS average waiting times from routine assessment from referral (**Stress indicator.** South East CSU)	to be confirmed	13 weeks	12 weeks	⇧	November 2014
1.12 Reducing the number waiting for routine CAMHS treatment (**Stress indicator.** South East CSU)	to be confirmed	380	170	⇧	November 2014
1.13 Having an appropriate CAMHS caseload for patients, open at any point during the month (**Stress indicator.** South East CSU)	8,408	8,470 (r)	8,683 (r)	⇩	November 2014
1.14 Reducing unplanned hospitalisation rates for asthma (Primary diagnosis) in people aged under 19 years old (rate per 100,000. KMPHO)	-	14.8	14.6	⇧	2013/14
1.15 Reducing unplanned hospitalisation rates for diabetes (Primary diagnosis) in people aged under 19 years old (rate per 100,000. KMPHO)	-	7.6	7.3	⇧	2013/14
1.16 Reducing unplanned hospitalisation rates for epilepsy (Primary diagnosis) in people aged under 19 years old (rate per 100,000. KMPHO)	-	9.4	8.8	⇧	2013/14

*Refers to 2011/12 as 2013/14 figures for Kent were suppressed. ** Figures suppressed for Kent. *** Rolling 12 month figures

For Kent, the percentage of women with a smoking status at time of delivery has decreased from 15.2% (2011/12) to 13.0% (2013/14) this has led to a reduction in the gap between Kent and national rates with Kent 1% higher in 2013/14.

Breastfeeding initiation rates have continued to decrease from 2011/12 to 2013/14 from 72.5% to 71.3% and remain worse than national which consistently are at 74%.

Partnership work is continuing between the NHS Area Team and Public Health Kent to improve recording mechanisms surrounding breastfeeding continuation rates; the current focus is on identifying where problems occur in the system and finding mid to long term solutions

Indicators 1.7 and 1.8 on excess weight in children have changed their RAG from Green to Amber even though the proportions have not changed as the national figures have both decreased making the difference between Kent and National no longer better (green) but similar (amber).

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

New indicators have been added on life expectancy from the Public Health Outcomes Framework, the 3 indicators are split by gender and are on life expectancy and birth, health life expectancy and the range in years of life expectancy across the social gradient within each local authority from most to least deprived (Slope Index of inequality).

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
2.1 Increasing life expectancy at birth (PHOF):					
Male (years)	79.2 (national)	79.4 (g)	79.9 (g)	⇧	2010-12
Female (years)	83.0 (national)	83.2 (g)	83.4 (g)	⇧	2010-12
2.2 Increasing healthy life expectancy at Birth (PHOF):					
Male (years)	63.4 (national)	63.6 (a)	63.5 (a)	⇩	2010-12
Female (years)	64.1 (national)	65.5 (g)	66.0 (g)	⇧	2010-12
2.3 Reducing the slope index for health inequalities (PHOF):					
Male (years)	9.2 (national)	7.8	7.1	⇧	2010-12
Female (years)	6.8 (national)	4.7	4.8	⇩	2010-12
2.4 Reducing the proportion of adults with excess weight (PHOF)	63.8% (national)	-	64.6% (a)	-	2012
2.5 Increasing the proportion of people quitting having set a quit date with smoking cessation services (KCC Public Health)	52%	57% (g)	51% (a)	⇩	Q1 2014/15
2.6 Increasing the proportion of people receiving a NHS Health Check of the eligible population (KCC Public Health. The target is for the specific quarter)	12.7% (Q2)	11.2% (g)	14.8% (g)	⇧	Q2 2014/15

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
2.7 Reducing alcohol related admissions to hospital (per 100,000. PHOF)	637 (national)	557 (g)	565 (g)	⇩	2012/13
2.8 Increasing the proportion of eligible women screened adequately in the breast cancer screening programme (PHOF)	75.9% (national)	78.2% (g)	77.6% (g)	⇩	2014
2.9 Increasing the proportion of eligible women screened adequately in the cervical cancer screening programme (PHOF)	74.2% (national)	77.2% (g)	77.1% (g)	⇩	2014
2.10 Reducing the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000. Local Tobacco Control Profiles)	288.7 (national)	285.2 (g)	281.8 (g)	⇧	2011-13
2.11 Reducing the under-75 mortality rate from cancer considered preventable (rate per 100,000. PHOF)	83.8 (national)	80.5 (g)	78.2 (g)	⇧	2011-13
2.12 Reducing the under-75 mortality rate from respiratory disease considered preventable (rate per 100,000. PHOF)	17.9 (national)	16.6 (a)	16.7 (a)	⇩	2011-13
2.13 Reducing the under-75 mortality rate from cardiovascular disease considered preventable (rate per 100,000. PHOF)	50.9 (national)	52.3 (a)	49.3 (a)	⇧	2011-13

Healthy life expectancy at birth is a new measure both in this report and reported nationally and under development, currently there are only 2 times frames of figures available, however for males, this is the measure within life expectancy where Kent is Amber compared to national with a very slight decrease.

Cancer screening for both breast and cervical cancer has decreased from 2013 to 2014; however both remain above national coverage rates. At district level, all districts have higher coverage rates than national on cervical screening, however for breast screening, Sevenoaks and Thanet have worse levels than national at 75% for both districts compared to Kent at 78% and national at 76%, both districts have had year on year decreases.

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

New metrics have been added concerning adults with learning disability (3.5 & 3.7) and adults accessing mental health services (3.6). Metrics surrounding adult social care are currently being reviewed by the directorate working in collaboration with South East CSU to move reporting to cover both those adults supported by KCC and by other means.

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
3.1 Increasing clients with community based services who receive a personal budget/ direct budget (ASC KCC)					
Learning Disability Clients	95%	93.2% (r)	93.1% (r)	⇔	November 2014
Mental Health Clients	95%	78.9% (r)	82.6% (r)	⇧	November 2014
OPPD Clients	95%	73.9% (r)	73.7% (r)	⇔	November 2014
3.2 Increasing the number of people using telecare and telehealth technology (ASC KCC)	3,978	4,041 (g)	4,088 (g)	⇧	September 2014
3.3 Increasing the proportion of older people (65+) 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 (**Stress indicator**. **BCF.** ASCOF)	82.5% (national)	-	83.8%	-	2013/14
3.4 Reducing admissions to permanent residential care for older people **Stress indicator**. **BCF.** ASC KCC)	110	85 (g)	101 (g)	⇩	September 2014
3.5 Increasing the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (PHOF, no published RAG)					
Persons	73.5% (national)	71.4%	70.1%	⇩	2012/13
Male	73.2% (national)	-	68.7%	-	2012/13
Female	74.0% (national)	-	72.0%	-	2012/13
3.6 Increasing the percentage of adults who are receiving secondary mental health services on the care programme approach recorded as living independently, with or without support (aged 18-69 years. PHOF, No published RAG)					
Persons	58.5% (national)	65.6%	81.5%	⇧	2012/13
Male	57.3% (national)	63.8%	79.8%	⇧	2012/13

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
Female	59.8% (national)	67.6%	83.5%	⇧	2012/13
3.7 Reducing the gap in employment rate between those with a learning disability and the overall employment rate (% point gap. PHOF, No published RAG)	65.1 (national)	66.5	66.1	⇧	2013/14
3.8 Increasing the early diagnosis of diabetes – Recorded Diabetes (registered GP Practice aged 17+. PHOF)	6.0% (national)	5.8% (a)	6.0%* (a)	⇧	2012/13
3.9 Reducing the number of hip fractures for people aged 65 and over (rate per 100,000. PHOF)	568.1 (national)	599.0 (a)	544.0 (a)	⇧	2012/13

* Estimated value

The new metrics published in the Public Health Outcomes Framework surrounding adults with a learning disability and receiving secondary mental health services are presented without comparison to national and therefore remain without a RAG status in this report.

However, it should be noted that for Kent adults with a learning disability who are known to the council recorded as living in their own home or with family is just below national proportions in 2012/13 for all three categories of person, males and females (3.5)

In contrast, the proportions of Kent adults who are receiving secondary mental health services on the care programme approach recorded as living independently, with or without support, are considerably higher than national levels (3.6)

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

New metrics have been added concerning self-reported wellbeing of adult social care users, carers and general population (4.10, 4.11 and 4.12) and the proportion of people entering prison with substance dependence issues who are not known to community substance misuse services has published figures for the first time (4.7).

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
4.1 Increasing the crisis response of A&E Liaison within 2 hours	-	82.1%	75.5%	⇩	Q2 2014/15
4.2 Increasing the crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	100%	100% (g)	100% (g)	⇔	Q2 2014/15

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
4.3 Increasing access to IAPT (Increasing Access to Psychological Therapies) services	A Kent value is not available but will be reported at CCG level in Local Assurance Reports				
4.4 Increasing the number of adults receiving treatment for alcohol misuse (ndtms.net)	To be confirmed	-	1,945	▬	2013/14
4.5 Increasing the number of adults receiving treatment for drug misuse (ndtms.net)	To be confirmed	3,364	2,931	⇩	2012/13
4.6 Reducing the number of people entering prison with substance dependence issues who are previously not known to community treatment (PHOF)	46.9% (national)	-	57.4% (r)	▬	2012/13
4.7 Increasing the successful completion and non-re-presentation of opiate drug users leaving community substance misuse treatment services (PHOF)	7.8% (national)	10.9% (g)	10.3% (g)	⇩	2013
4.8 Increasing the employment rate amongst people with mental illness/those in contact with secondary mental health services (ASCOF)	7.0% (national)	7.4%	6.2%	⇩	2013/14
4.9 Reducing the number of suicides (rate per 100,000. PHOF)					
Persons	8.8 (national)	8.1 (a)	9.2 (a)	⇩	2011-13
Males	13.8 (national)	12.6 (a)	14.6 (a)	⇩	2011-13
Females	4.0 (national)	4.0 (a)	4.1 (a)	⇩	2011-13
4.10 Increasing the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users survey (PHOF)	43.2% (national)	37.5% (r)	44.0% (a)	⇧	2012/13
4.11 Increasing the percentage of adult social carers who have as much social contact as they would like according to the Personal Social Services Carers survey (PHOF)	41.3% (national)	-	33.9% (r)	▬	2012/13
4.12 Decreasing the percentage of respondents who according to the Annual Population survey have (PHOF):					
Low Satisfaction (score 0-4)	5.8% (national)	6.5% (a)	5.6% (a)	⇧	2012/13

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
Low Worthwhile (score 0-4)	4.4% (national)	4.6% (a)	4.0% (a)	⇧	2012/13
Low Happiness (score 0-4)	10.4% (national)	11.0% (a)	9.9 (a)	⇧	2012/13

There has been a decrease in the number of adults receiving treatment for drug misuse in Kent from 2011/12 to 2012/13, this is an ongoing trend and is being monitored by Kent Drug and Alcohol Action Team who commission substance misuse services in Kent.

The number of people entering prison with identified substance dependence issues is monitored in indicator 4.6 which looks at the number of those with identified dependence at entry into prison who have not previously accessed community treatment services. This indicator looks at unmet need. Kent is showing as having a higher proportion (57.4%) unknown to community services compared to national proportions (46.9%). This is the first time the metric has been published and will need further analysis and monitoring to develop the right actions to take.

The rate of male suicides in Kent has slowly been increasing from 2008-10, the most recent reporting period now has Kent as higher than the national rate and the Kent female rate as 14.6 per 100,000 to 4.1 per 100,000. Public Health has a suicide prevention strategy and wellbeing programmes specifically targeting men in Kent, an example is the Kent Sheds programme. There has been an equity audit conducted into IAPT which has highlighted that men are not accessing psychological therapies as much as women are, from this, wellbeing programmes are further targeting men, specifically in the workplace.

Outcome 5: People with dementia are assessed and treated earlier and are supported to "live well"

Metrics 5.8 to 5.12 are new to the assurance framework and work is ongoing with Adult Social Care KCC and South East CSU to define and report these figures in future reports. There have been no updates since the previous report.

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
5.1 Increasing the reported number of dementia patients on GP registers as a percentage of estimated prevalence (South East CSU)	To be confirmed	39.4%	41.5%	⇧	2012/13
5.2 Reducing rates of hospital admissions for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1,000. South East CSU)	To be confirmed	25.0	25.1	⇔	2013/14

Indicator Description		Target	Previous status	Recent status	DoT	Recent time period
5.3 Reducing rates of hospital admissions for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000. South East CSU)		To be confirmed	49.9	50.5	⇩	2013/14
5.4 Reducing total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000. South East CSU)		To be confirmed	231.8	225.7	⇧	2013/14
5.5 Reducing total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000. South East CSU)		To be confirmed	464.0	452.5	⇧	2013/14
5.6 Increase the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been (South East CSU):						
Dartford and Gravesham NHS Trust	(a) identified as potentially having dementia	To be confirmed	93%	92%	⇩	Q4 2013/14
	(b) who are appropriately assessed	To be confirmed	100%	100%	⇔	
	(c) and, where appropriate, referred on to specialist services in England	To be confirmed	97%	100%	⇧	
East Kent Hospitals University NHS Foundation Trust	(a) identified as potentially having dementia	To be confirmed	99%	100%	⇧	Q4 2013/14
	(b) who are appropriately assessed	To be confirmed	95%	94%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	To be confirmed	100%	100%	⇔	
Maidstone and Tunbridge Wells NHS Trust	(a) identified as potentially having dementia	To be confirmed	99%	99%	⇔	Q4 2013/14
	(b) who are appropriately assessed	To be confirmed	99%	99%	⇔	
	(c) and, where appropriate, referred on to specialist services in England	To be confirmed	100%	100%	⇔	

Indicator Description		Target	Previous status	Recent status	DoT	Recent time period
Medway NHS Foundation Trust	(a) identified as potentially having dementia	To be confirmed	69%	78%	⇧	Q4 2013/14
	(b) who are appropriately assessed	To be confirmed	97%	88%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	To be confirmed	85%	91%	⇧	
5.7 Decreasing the percentage of people waiting longer than 4 weeks to assessment with Memory Assessment Services (South East CSU)		To be confirmed	21.0%	23.4%	⇩	Q4 2013/14
5.8 Increasing the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months/12 months (South East CSU)		To be confirmed	76.0%	79.7%	⇧	2013/14
5.9 Reducing care and nursing home placement, especially those made at a time of crisis and/or from an acute setting		Under development with Adult Social Care KCC and South East CSU				
5.10 Increasing numbers of carers assessments and carers accessing short breaks						
5.11 Increasing attendance at Dementia Peer Support Groups						
5.12 Increasing number of Dementia Champions						

Stress indicators

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
Children's: Increasing the proportion of SEND assessments within 26 weeks (indicator 1.9 KCC MIU)	90%	92.9% (g)	92.4% (g)	⇩	August 2014***
Children's: Reducing the number of Kent children with SEND placed in independent of out of county schools (indicator 1.10 KCC MIU)	-	604	599	⇧	August 2014***

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
Children's: Reducing CAMHS average waiting times from routine assessment from referral (indicator 1.11South East CSU)	to be confirmed	13 weeks	12 weeks	⇧	November 2014
Children's: Reducing the number waiting for routine CAMHS treatment (indicator 1.12 South East CSU)	to be confirmed	380	170	⇧	November 2014
Children's: Having an appropriate CAMHS caseload for patients, open at any point during the month (indicator 1.13 South East CSU)	8,408	8,470 (r)	8,683 (r)	⇩	November 2014
Public Health Increasing the population Flu vaccination coverage for those aged 65+. (PHOF)	75%	73.1% (r)	71.4% (r)	⇩	2012/13
Public Health Increasing the population Flu vaccination coverage for those at risk individuals. (PHOF)	75%	46.3% (r)	48.7% (r)	⇧	2012/13
Acute/Urgent Bed Occupancy Rate – Overnight (NHS England)					
Dartford and Gravesham NHS Trust	to be confirmed	95.3%	93.6%	Refer to section 5	Q2 2014/15
East Kent Hospitals University NHS Foundation Trust	to be confirmed	89.7%	87.6%		
Maidstone and Tunbridge Wells NHS Trust	to be confirmed	91.4%	91.6%		
Medway NHS Foundation Trust	to be confirmed	90.1%	88.9%		
Kent and Medway NHS and Social Care Partnership	to be confirmed	92.5%	92.4%		
Acute/Urgent A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge (NHS England)					
Dartford and Gravesham NHS Trust (all)	95%	95.8% (g)	91.8% (r)	⇩	Week ending 28/12/2014
East Kent Hospitals University NHS Foundation Trust (all)	95%	87.3% (r)	89.3% (r)	⇩	
Maidstone and Tunbridge Wells NHS Trust (all)	95%	84.2% (r)	82.8% (r)	⇩	
Medway NHS Foundation Trust (all)	95%	75.1% (r)	82.5% (r)	⇧	

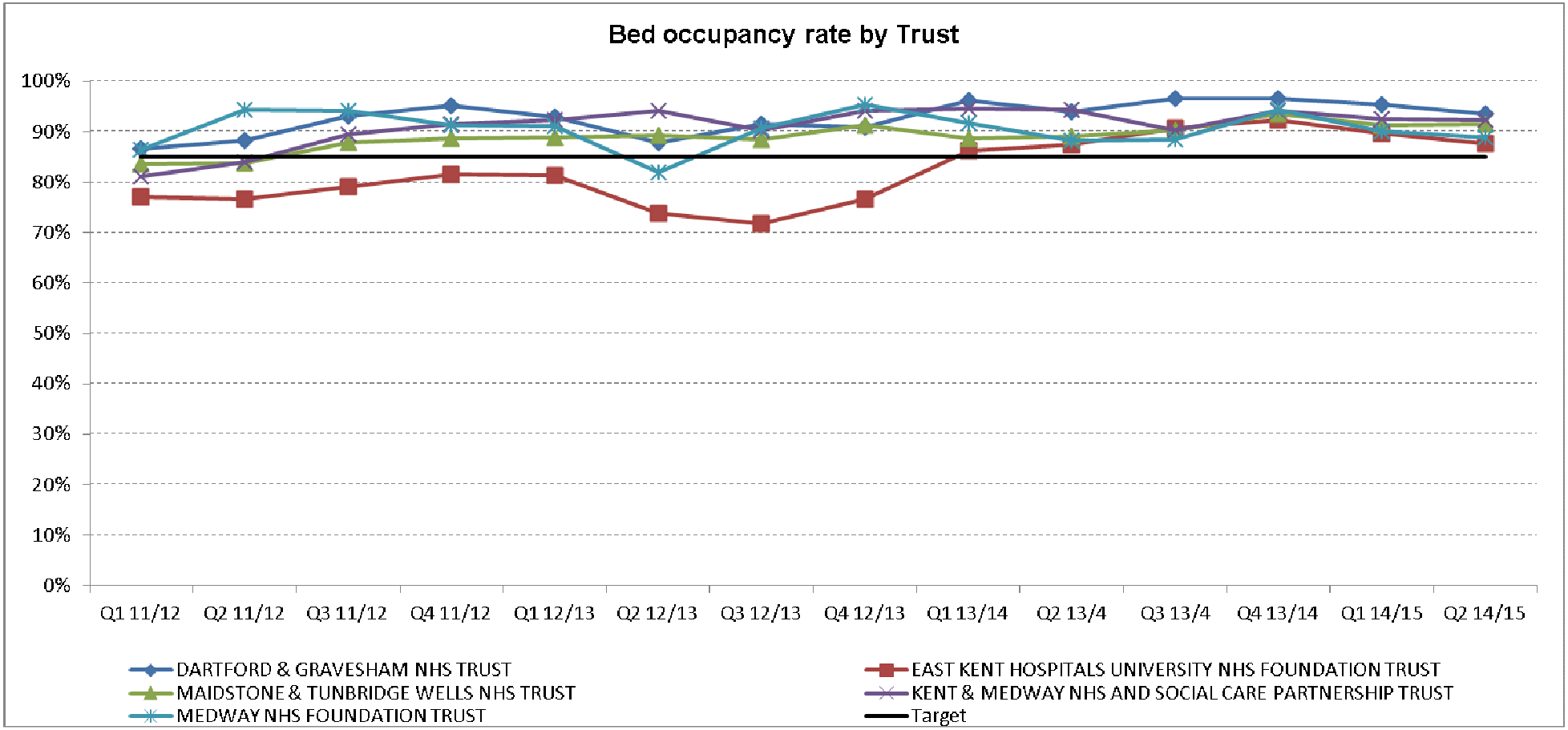
Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
Acute/Urgent Emergency admissions **BCF**	Awaiting alignment with BCF definitions				
Primary Care GP Attendances	To be defined and developed with South East CSU				
Primary Care Out of Hours activity					
Primary Care 111 NHS Service	Figures only available at Kent, Medway, Surrey and Sussex Level				
Social / Community Care Increasing the proportion of older people (65+) 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 **BCF** (indicator 3.3 ASCOF)	82.5% (national)	-	83.8%	-	2013/14
Social / Community Care Decreasing the number of delayed bed days **BCF** (NHS England)	-	2,236	2,427	⇩	November 2014
Acute days	-	1,626	1,684	⇩	
Non-acute days	-	610	743	⇩	
Social / Community Care Infection control rates	Continuing to be sources with Public Health England				
Social / Community Care Reducing admissions to permanent residential care for older people (aged 65+) **BCF (**People**.** Indicator 3.4 ASC KCC)	110	85 (g)	101 (g)	⇩	September 2014

4. Better Care Fund (BCF) Metrics: BCF Metrics will be referenced in the next Assurance Framework report

5. Stress indicators

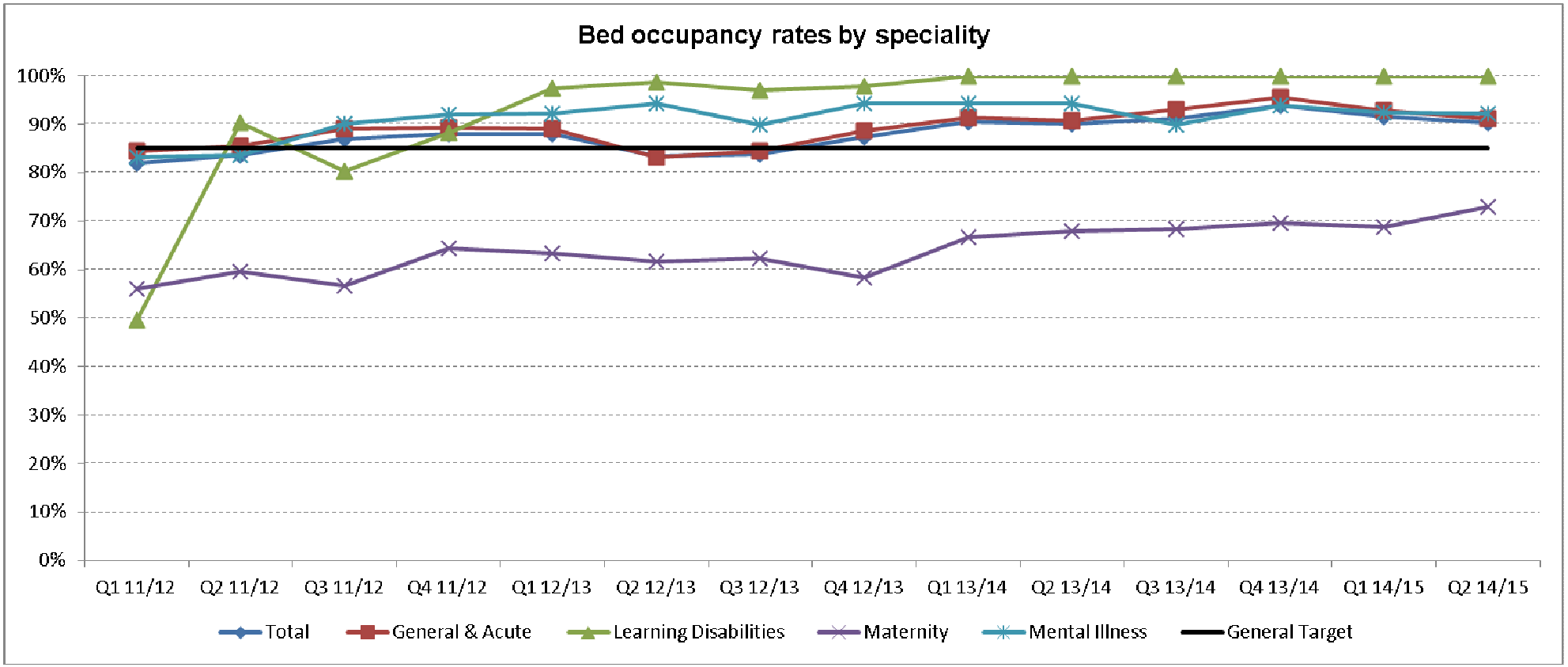
Due to the winter pressures on the NHS Acute/Urgent services, the focus of the detailed section of the assurance framework will be on the core metrics which focus on these services; these are bed occupancy rate, A&E attendances within 4 hours discharged, admitted or transferred and delayed days.

Acute/Urgent Bed Occupancy Rate – Overnight (Source: NHS England. 7th January 2015)



Bed occupancy rates look at the number of available beds open overnight and the percentage that are occupied by Trust and speciality.

All five Trusts have not experienced great variances over the previous 3 quarters published however all Trusts continue to operate above the recommended level of 85%; In Q2 2014/15 the occupancy rates varied from between 88% (Medway NHS Foundation Trust) and 94% (Dartford and Gravesham NHS Trust). Q3 2014/15 had not been published at time of writing this report and therefore the effect winter pressure effect for Q3 is not presented here.

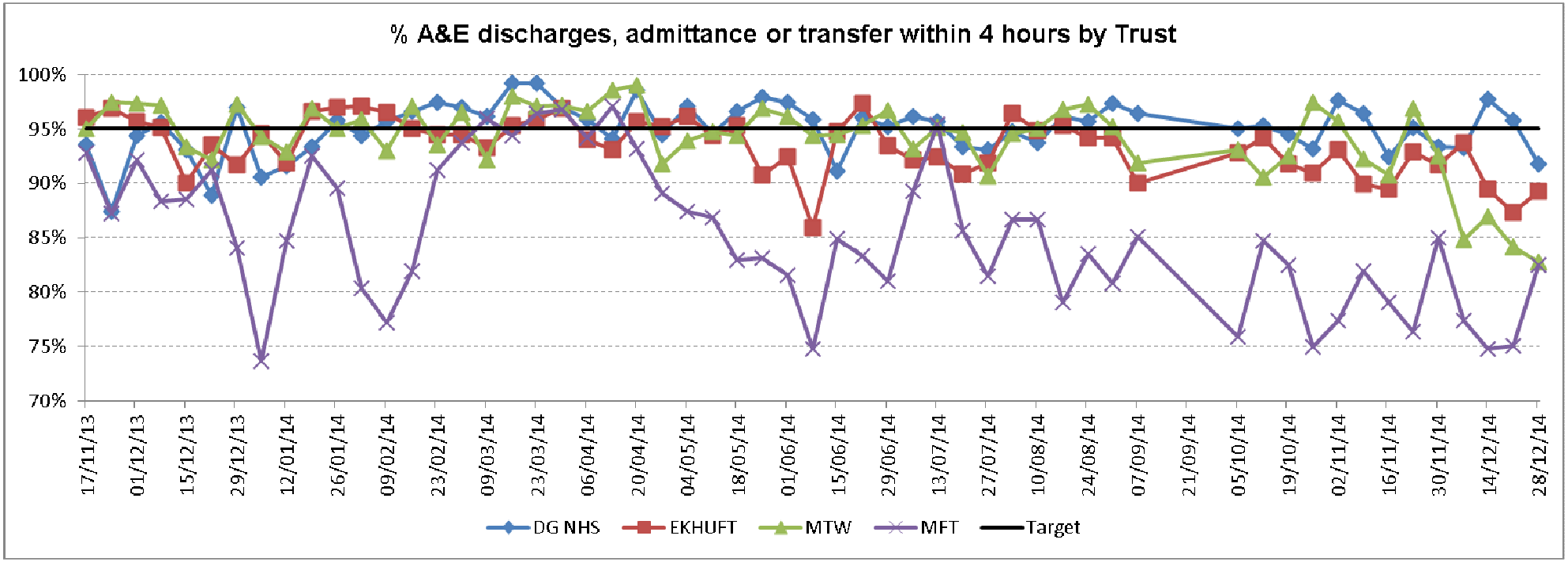


Maternity is the only speciality operating under the 85% recommended level; however this speciality is gradually increasing on capacity since Q1 2011/12.

Learning disabilities is consistently operating at 100%, it should be noted that this equated to only 23 beds available in Q2 2014/15 and operates at a much smaller number than the other specialities.

In total there were 3,380 beds available in Q2 2014/15, the majority of which were for General & Acute Speciality (2,642 beds).

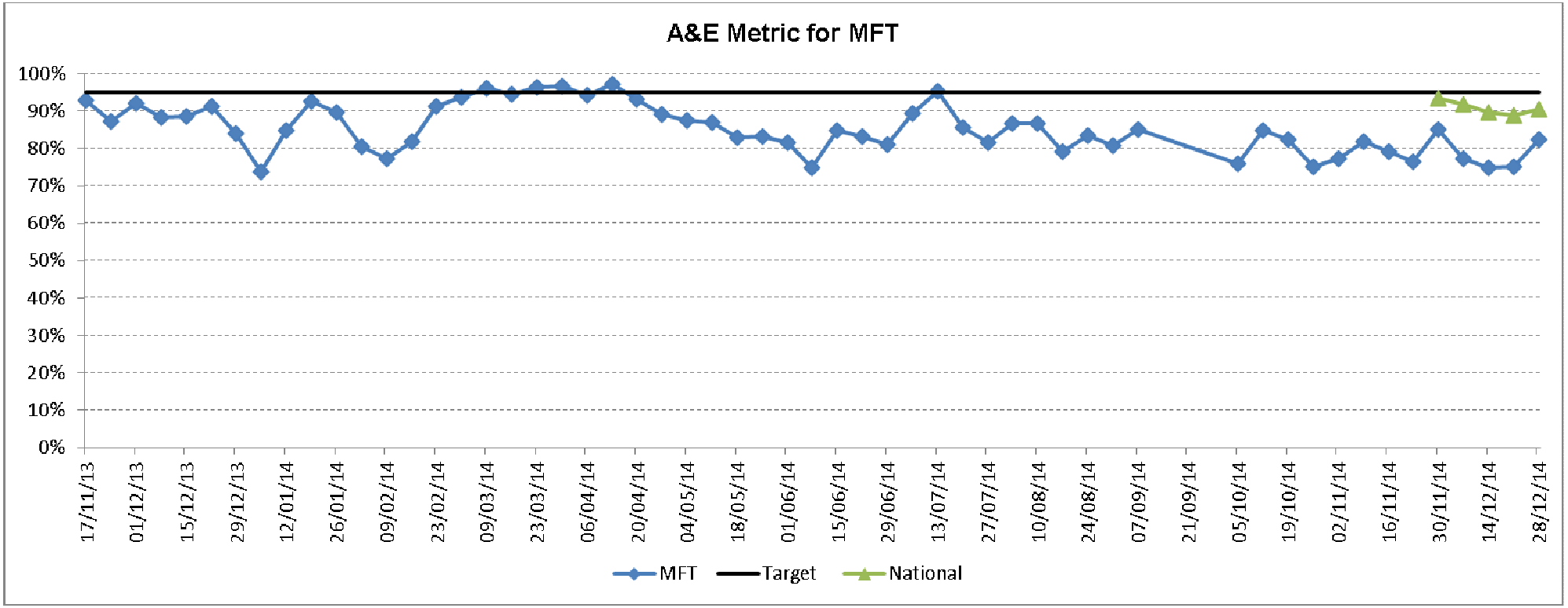
Acute/Urgent A&E attendances within 4 hours (all) from arrival to admission, transfer or discharge (Source: NHS England. January 2015)



All trusts have experienced decreases in the proportion of people being either discharged, admitted or transferred with four hours of arrival at A&E during December 2014. None of the Trusts reported any patient spending more than 12 hours from decision to admit to admission.

National proportions for the end of November and December have been added to the individual figures below to provide a comparison of the Trusts against National.

Medway NHS Foundation Trust (MFT):
MFT continues to see less than the targeted 95% within 4 hours and is operating below current National proportions at the end of November and December. The week ending 14th December experienced the lowest proportion within 4 hours at 74.8%, the lowest since the week ending 8th June 2014 and lower than the same time period in 2013.



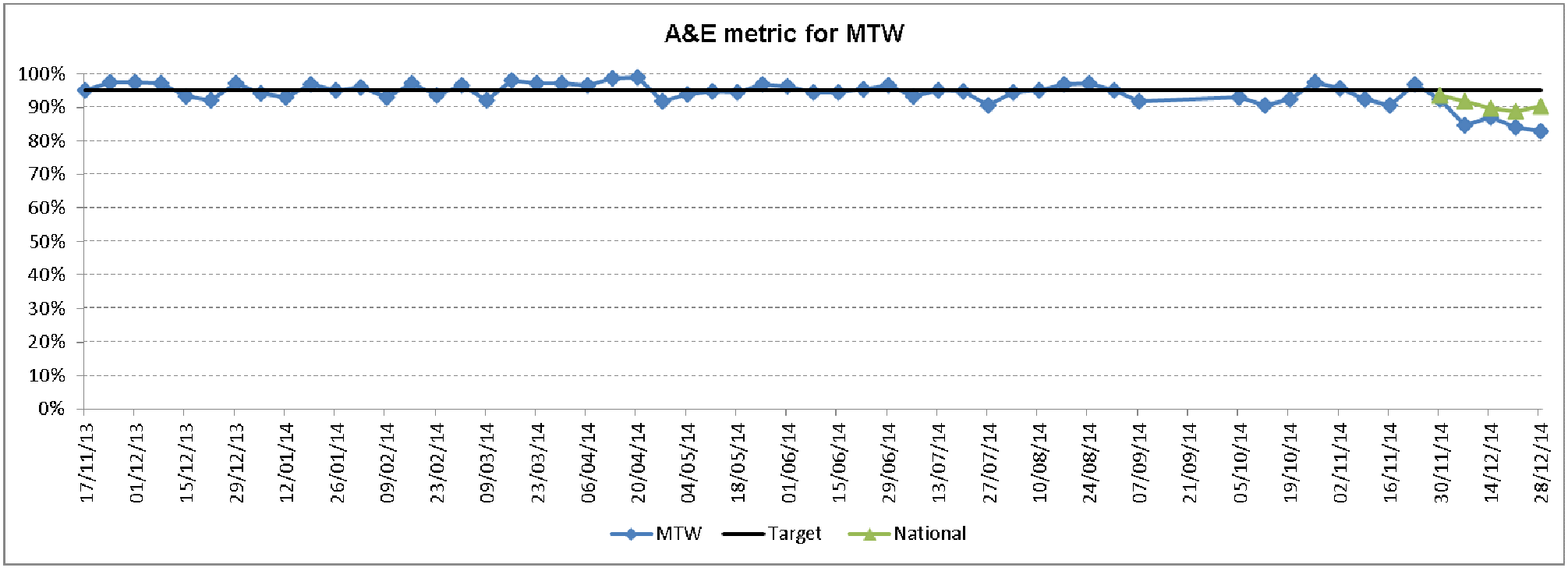
The table below outlines the figures on attendance and admissions from the week ending the 16th November 2014 to the week ending 28th December 2014.

- Although the week ending the 14th December had the lowest proportion within 4 hours, it was the week before (week ending the 7th December) that experienced the highest number of attendances.
- The longest number of patients waiting for between 4 and 12 hours was in the week ending 21st December where 189 patients waited.
- Improvements were made in the final week of December with a decrease in the number of attendances.

A&E attendances and emergency admissions – MFT

Week Ending	A&E attendances		A&E attendances > 4 hours from arrival to admission, transfer or discharge		Emergency Admissions		
	Type 1 Departments - Major A&E	Total attendances	Type 1 Departments - Major A&E	Percentage in 4 hours or less (all)	Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	No. of patients spending >4 hours but <12 hours from decision to admit to admission
16/11/2014	1,970	1,970	411	79.1%	346	203	147
23/11/2014	2,006	2,006	474	76.4%	347	269	147
30/11/2014	1,906	1,906	285	85.0%	317	269	79
07/12/2014	2,001	2,001	453	77.4%	341	203	179
14/12/2014	1,972	1,972	496	74.8%	318	195	159
21/12/2014	1,961	1,961	489	75.1%	336	310	189
28/12/2014	1,820	1,820	319	82.5%	329	214	66

Maidstone and Tunbridge Wells NHS Trust (MTW):
MTW began a noticeable decrease in proportions from the end of November (23/11/2014) within 4 hours and experienced their lowest proportions in December 2014 compared to any week as far back as November 2013. From the end of November they also operated below national proportions.



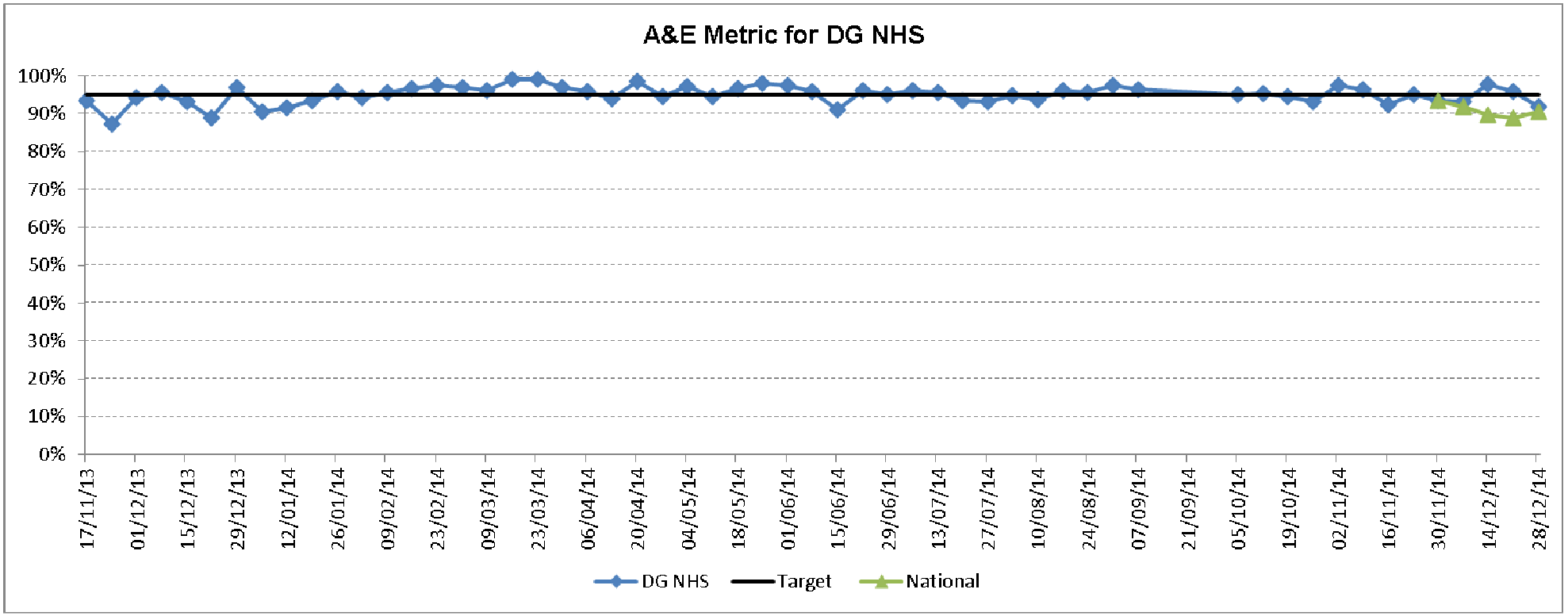
- The week ending the 28th December had the lowest proportion within 4 hours, it was the week before (week ending the 21th December) that experienced the highest number of attendances.
- The longest number of patients waiting for between 4 and 12 hours was in the week ending 21st December where 125 patients waited (same week as MFT).

A&E attendances and emergency admissions – MTW

Week Ending	A&E attendances		A&E attendances > 4 hours from arrival to admission, transfer or discharge		Emergency Admissions		
	Type 1 Departments - Major A&E	Total attendances	Type 1 Departments - Major A&E	Percentage in 4 hours or less (all)	Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	No. of patients spending >4 hours but <12 hours from decision to admit to admission
16/11/2014	2,513	2,513	230	90.8%	669	62	73
23/11/2014	2,466	2,466	76	96.9%	745	74	19
30/11/2014	2,580	2,580	193	92.5%	728	83	46
07/12/2014	2,406	2,406	366	84.8%	691	63	122
14/12/2014	2,515	2,515	326	87.0%	711	57	87
21/12/2014	2,661	2,661	420	84.2%	729	66	125
28/12/2014	2,455	2,455	423	82.8%	762	45	104

Dartford and Gravesham and NHS trust (DG NHS):

DG NHS has not varied greatly from the 95% target, albeit at times below this and tends to have the highest proportions compared to the other Trusts; it has however experienced decreases in the 4 hour target from the week ending 21st December into 28th December.

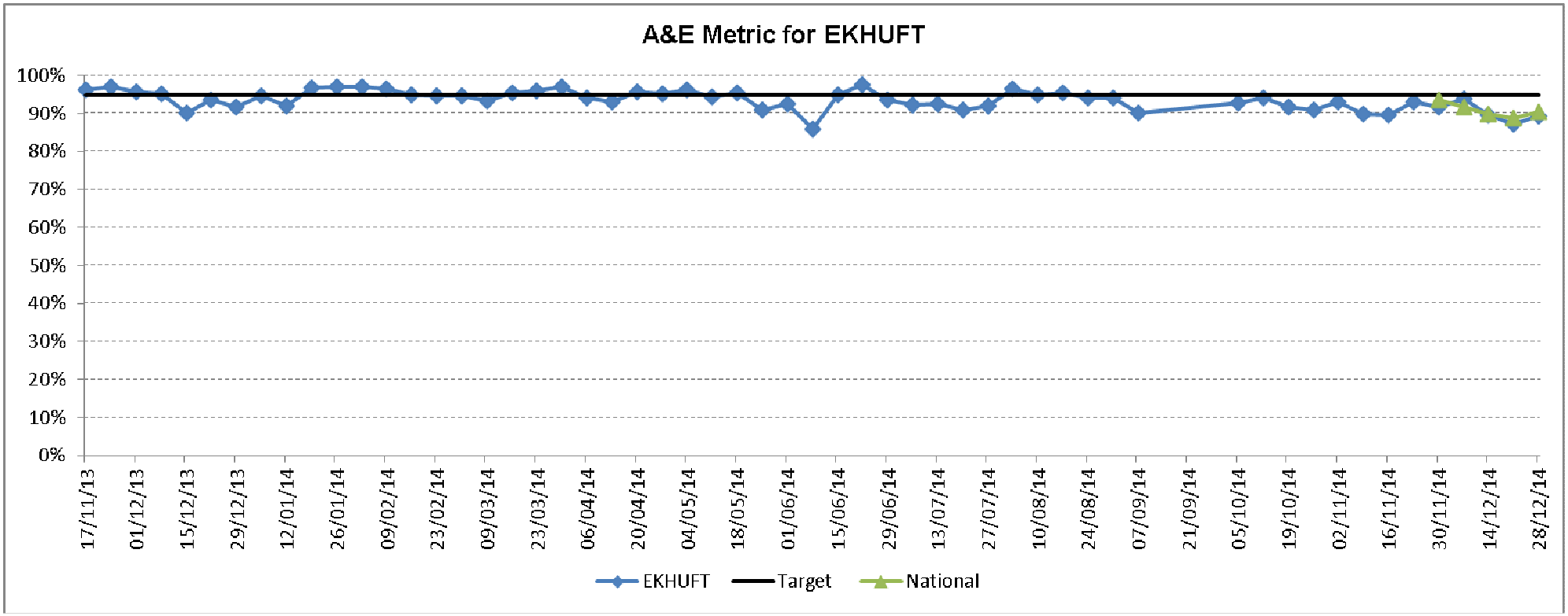


- The highest number of attendances for DG NHS was the week ending the 21st December (the same as MTW) with the lowest percentage in 4 hours the next week of the 28th December.
- DG NHS had very minimal numbers of patients waiting between 4 and 12 hours for admission even though it had higher numbers of people being admitted compared to MFT.

A&E attendances and emergency admissions – DG NHS

Week Ending	A&E attendances		A&E attendances > 4 hours from arrival to admission, transfer or discharge		Emergency Admissions		
	Type 1 Departments - Major A&E	Total attendances	Type 1 Departments - Major A&E	Percentage in 4 hours or less (all)	Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	No. of patients spending >4 hours but <12 hours from decision to admit to admission
16/11/2014	1,847	1,847	141	92.4%	573	28	<5
23/11/2014	1,925	1,925	94	95.1%	560	21	0
30/11/2014	1,888	1,888	125	93.4%	564	25	0
07/12/2014	1,906	1,906	128	93.3%	574	17	<5
14/12/2014	1,942	1,942	45	97.7%	582	22	0
21/12/2014	1,974	1,974	82	95.8%	600	26	0
28/12/2014	1,850	1,850	151	91.8%	552	13	7

East Kent Hospitals University NHS Foundation Trust (EKHUFT):
EKHUFT also decreased in December, following a very similar pattern to the national proportion in December.

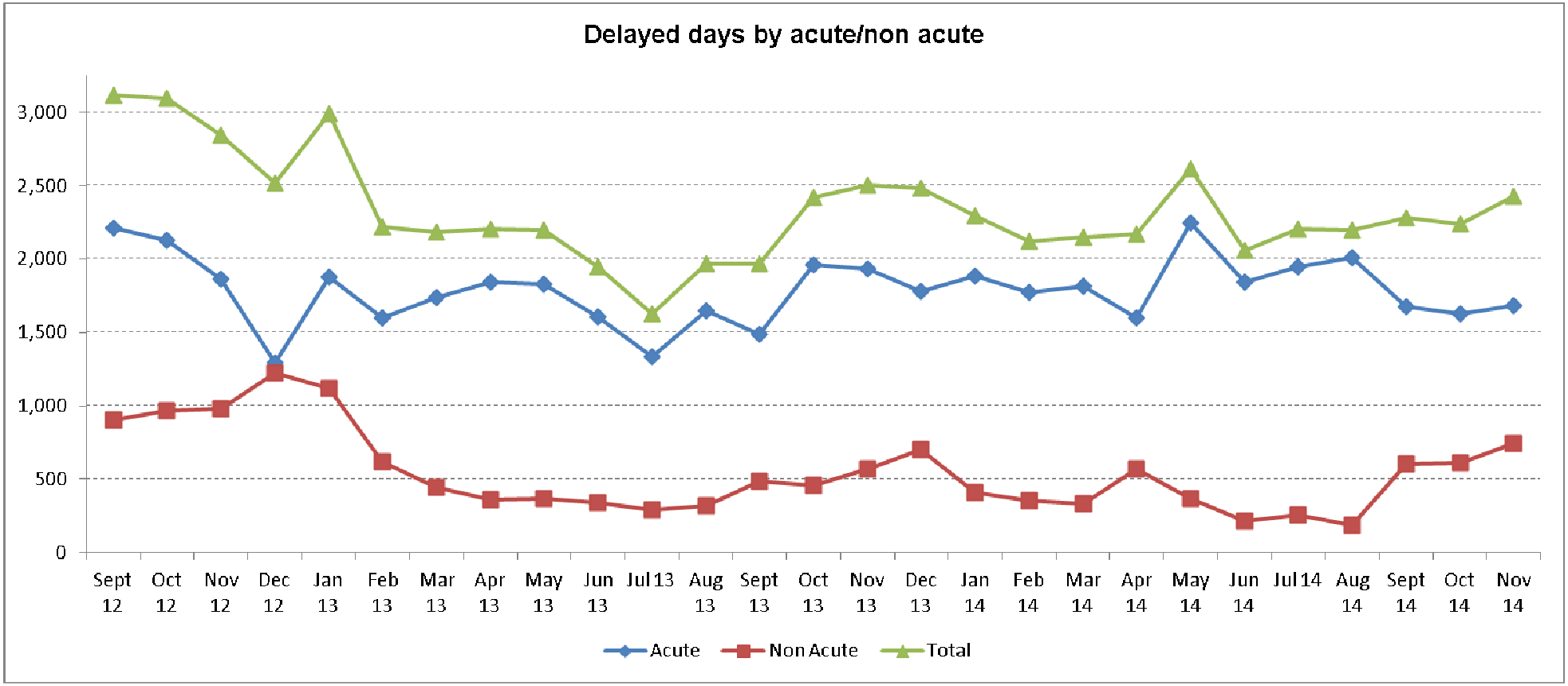


- EKHUFT experiences the highest number of attendance compared to the other Trusts in Kent and Medway, it also has Type 3 attendances. The week ending the 16th November was where EKHUFT experienced the highest number of attendances.
- The week ending the 21st December, as with MTW and DG NHS, was the week where the lowest proportion of patients was seen within 4 hours.
- Although EKHUFT experienced the highest number of admissions across the Trusts, its numbers of patients waiting between 4 and 12 hours was lower compared to the other trusts (except DG NHS)

A&E attendances and emergency admissions – EKHUFT

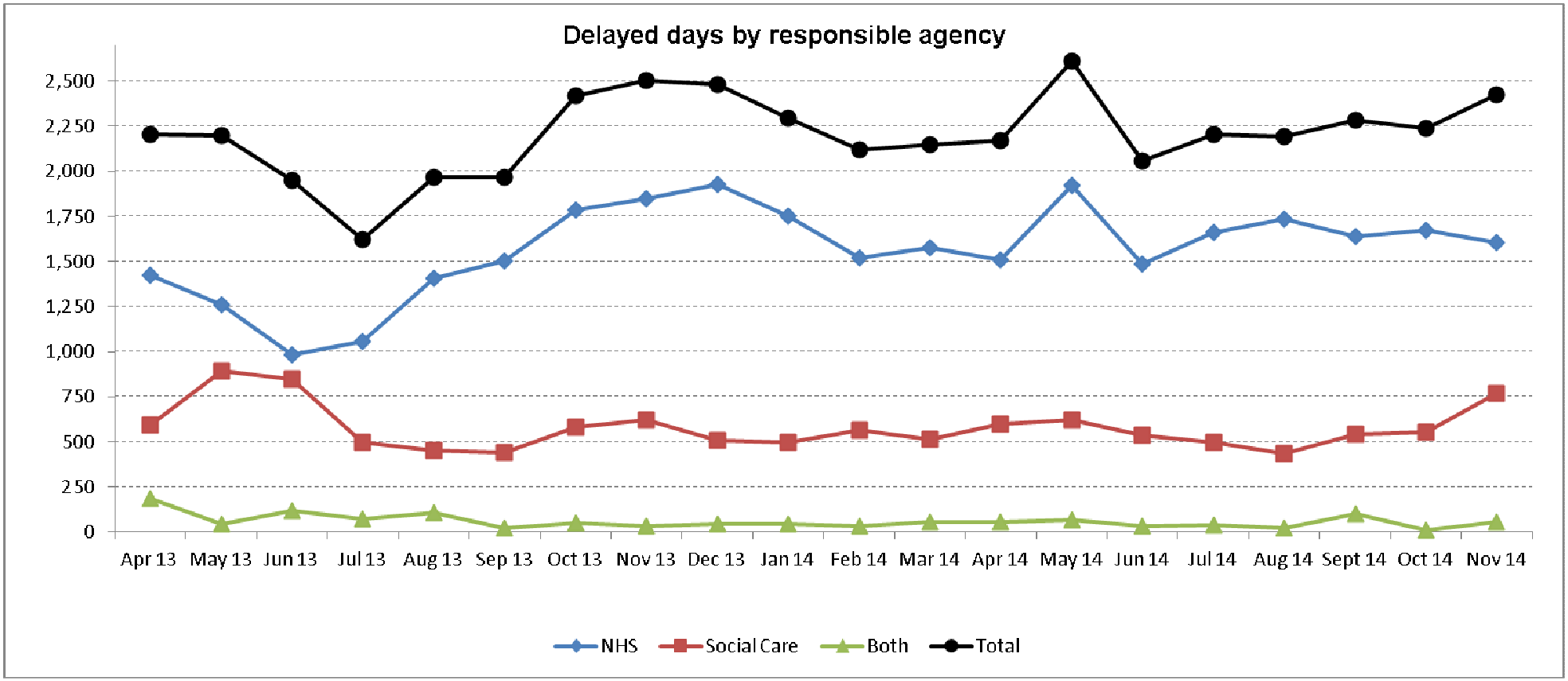
Week Ending	A&E attendances			A&E attendances > 4 hours from arrival to admission, transfer or discharge				Emergency Admissions			
	Type 1 Departments - Major A&E	Type 3 Departments - Other A&E/Minor Injury Unit	Total attendances	Type 1 Departments - Major A&E	Type 3 Departments - Other A&E/Minor Injury Unit	% in 4 hours or less (type 1)	% in 4 hours or less (all)	Emergency Admissions via Type 1 A&E	Emergency Admissions via Type 3 and 4 A&E	Other Emergency admissions (i.e not via A&E)	No. of patients spending >4 hours but <12 hours from decision to admit to admission
16/11/2014	2,805	1,187	3,992	378	41	86.5%	89.5%	790	412	301	6
23/11/2014	2,711	1,100	3,811	257	15	90.5%	92.9%	760	386	360	7
30/11/2014	2,769	1,052	3,821	306	13	88.9%	91.7%	845	361	333	13
07/12/2014	2,789	1,028	3,817	217	22	92.2%	93.7%	791	387	329	16
14/12/2014	2,720	1,065	3,785	344	54	87.4%	89.5%	772	406	290	18
21/12/2014	2,781	1,066	3,847	468	20	83.2%	87.3%	826	409	311	20
28/12/2014	2,574	974	3,548	357	22	86.1%	89.3%	823	402	242	50

Social / Community Care Decreasing the number of delayed days (**BCF**. Source: NHS England. January 2015)



Published figures on the number of delayed days currently is to November 2014, as with Bed Occupancy rates December figures are not available for reporting.

The delayed days labelled as Acute (type of care the patient receives) continue to form the majority of delayed days in Kent; for November 2014 this was 2,427. Non-acute delayed days have been increasing since August 2014, however this increase is not of significance compared to previous months and for November was only 743 days.



The chart above shows the delayed days each month by the responsible agency for the delay, this is split by NHS, Social care and then both. The majority of the delayed days were attributable to the NHS, however these are currently plateauing; the delayed days attributable to Social Care have increased in November to 767 from 554 in October. The number attributable to both also increased from 11 in October to 54 in November.

The table below outlines the reason categories for delayed days and which responsible agency they can be attributed to.

Delayed Days Reasons and attribution	Attributable to NHS	Attributable to Social Care	Attributable to both
A. Awaiting completion of assessment	✓	✓	✓
B. Awaiting public funding	✓	✓	✓
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	×	×
D i). Awaiting residential home placement or availability	✓	✓	×
D ii). Awaiting nursing home placement or availability	✓	✓	✓
E. Awaiting care package in own home	✓	✓	✓
F. Awaiting community equipment and adaptations	✓	✓	✓
G. Patient or Family choice	✓	✓	×
H. Disputes	✓	✓	×
I. Housing – patients not covered by NHS and Community Care Act	✓	×	×

Source: http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

By: Roger Gough, Cabinet Member for Education and Health Reform
Steve Inett, Chief Executive Healthwatch Kent

To: Health and Wellbeing Board, 28 January 2015

Subject: **Update on Quality and the Health and Wellbeing Board**

Classification: Unrestricted

Summary:

This paper updates the Board on progress regarding producing a Quality Report that fulfils the requirements set out in the Francis report and gives an overview of quality issues in Kent.

Issues affecting the quality of health and social care service to the public are often complex and rely on effective partnership working with other parts of the system. Whilst issues for individual services are addressed by their commissioners, there is a potential role for the Board in addressing the complex issues that affect the experiences of patients and service users.

Many of those issues are already known and there is activity to address them. This report would identify the highest priority issues, what activity is happening to address them, and how this could be enhanced by involvement from the Board.

The Board is asked to agree:

(a) The Quality Report highlights the complex systemic issues that have the most impact on providing quality services in Kent

(b) Healthwatch Kent contact representatives from commissioners, providers and working groups to gather feedback on main issues of concern

(c) Healthwatch Kent present a further report analysing the issues and identifying key trends

1. Introduction

The quality of health and social care service members of the public receive can be impacted by a range of complex factors. A paper was presented to the Kent Health & Wellbeing Board (KHWBB) in September 2014 recommending a regular report coordinated by Healthwatch Kent (HWK) that fulfilled the requirements set out in the Francis report and gave an overview of quality issues in Kent.

The aim of the report is to assist forward planning by Board membership organisations and agree priorities for consideration by the Board.

Discussions at the Board meeting in September raised concerns about the risk of duplication of existing performance management processes and getting further clarity about the purpose and format of the report.

Since the Board meeting two further Quality Report meetings have been held involving Healthwatch Kent, KCC Officers, NHS England and Public Health. There has also been a discussion at the Quality Surveillance Group. The outcome of these discussions is described below.

2. Intelligence Approach

At the meetings it was agreed that the report should not use existing performance data as it was agreed the accuracy and performance management implications were already being addressed in existing commissioning processes.

It was therefore agreed that the report should draw on intelligence rather than data.

It was also agreed it should not be administratively onerous or duplicate existing work, rather it should be an analysis of existing intelligence.

3. Sources of Intelligence

A key source of intelligence is the Quality Surveillance Group (QSG), whose function was outlined in the September paper. More detail about the QSG can be found here.

Discussions at the Quality Report meetings and the QSG agreed that there may be a role for the QSG to escalate issues that are complex and involve more than one provider or system, or may be a county wide area of concern impacting on provider quality. It was discussed that the Health & Wellbeing Board could be a place where such system issues could be raised.

Similarly wider system issues arising out of the deliberations of the Health Overview & Scrutiny Committee could be fed into the report.

During discussions at the September HWBB meeting members expressed that many of the complex system issues are already known. Providers are also able to identify system issues which are barriers to providing high quality services. The report could incorporate these known issues.

Public Health could feed in concerns arising from areas of underperformance in the Assurance Framework.

The Quality in Care Project is coordinated by Kent County Council and provides a framework to enable local authority staff and partners to monitor quality and practice in the delivery of services, highlight and disseminate good practice, and support services to address identified issues and prevent poor provision in residential and home care services. The partner members of the steering group would be able to identify systemic issues that impact on the quality of those services.

Although the Pioneer Steering Group is addressing longer term challenges to providing quality services, it would be able to contribute issues that it sees but are not within its remit.

Local HWBB understand the quality challenges in their area and are already working on many of them. Getting their feedback on those issues and their activities would be essential.

Frequently Healthwatch Kent raises concerns from the public with commissioners and providers and makes recommendations. Invariably there are recommendations that an organisation can address directly, but other issues involve the cooperation of other organisations within the health and social care systems and cannot be so easily addressed.

HWK would also ensure that the issues raised correlate with concerns raised by the public.

HWK works with soft intelligence and qualitative feedback and so would be well placed to coordinate this report.

4. Format and process

It is proposed that the report be a short document summarising the issues raised from the sources above and identifying the key themes.

These issues would be gathered by Healthwatch Kent via conversations with the appropriate contact in each commissioning organisation, provider or group. It would be made clear that issues raised would be presented at the KHWBB and every effort will be made to ensure that issues cannot be attributed to individuals or organisations.

Discussion at the KHWBB would identify what work is already happening re the issues identified and some will be seen as a greater priority to address.
It is proposed that a very short list of issues be agreed as priorities which the KHWBB feel are having significant impact on the provision of quality services. AND can only be addressed by a cross-county, system-wide approach.

These issues will be very complex and need exploring in more depth including:

- Understanding work currently being undertaken that involves KHWBB members or groups such as QSG, Quality in Care, Pioneer etc.
- What might be needed to enhance that work including how partnership with Local HWBBs could effect change
- Understanding progress made and how progress is measured
- How progress might be reviewed in the future

Healthwatch Kent will report back to the KHWBB regularly with these findings.

5. Value Added by the Health & Wellbeing Board network

As described above, raising these complex system issues with the KHWBB is an opportunity for information sharing by representatives of many aspects of the health and social care system, extending to the insights provided by District Council colleagues.

It is not currently clear how discussions occur regarding these systemic issues and the KHWBB offers an open, transparent and public forum for these issues to be discussed.

The network of Local HWBBs offer an opportunity to coordinate a drill down to local level to explore an issue and how it is being addressed in each Clinical Commissioning Group area, offering an opportunity to share good practice.

6. Conclusion

Recommendation(s)

The Board is asked to agree:

(a) The Quality Report highlights the complex systemic issues that most impact on providing quality services in Kent

(b) Healthwatch Kent contact representatives from commissioners, providers and working groups to gather feedback on main issues of concern

(c) Healthwatch Kent presents a further report analysing the issues and identifying key trends

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By: Roger Gough, Chair Health and Wellbeing Board

Chief Financial Officers, CCG's

To: Health & Wellbeing Board – 28 January 2015

Subject: **Better Care Fund s75 agreement**

Classification: Unrestricted

Summary: This paper presents a summary of progress to date in relation to producing a BCF section 75 pooled fund agreement and summarising the key provisions within the agreement in relation to monitoring, risk and governance

FOR INFORMATION

1. Introduction

1.1 Kent's Better Care Fund (BCF) plan was agreed by the Health & Wellbeing Board in September 2014 and has now been approved through the national assurance process.

1.2 At the same meeting of the Health and Wellbeing Board, it was agreed that the NHS Area team would lead a group with CCG CFO's and other senior KCC finance leads ("CFO Group") to discuss and recommend options for pooled fund arrangements with the ultimate aim of producing a s75 pooled budget agreement(s) to support and deliver the Kent BCF plan.

1.3 The purpose of this report is to update Board members on progress to date given the tight timescales. Funds will not be released unless the s75 agreement is in place (by 31 March 2015). The draft agreement will be presented at the March 2015 Health & Wellbeing Board.

2. Update on progress

2.1 Considerable progress has been made by the CFO group which first met in October 2014. Overall principles were discussed and explored to ensure consensus that the s75 agreement would :

- Cleary articulate the key objectives and vision within the submitted Better Care Fund
- Meet accountability requirements for CCG's and KCC
- Provide practical arrangements that were not overly bureaucratic and sufficiently agile to serve the local community
- Maintain local decision making and accountability with strategic oversight by the Kent Health & Wellbeing Board
- Provide for risk sharing in line with local requirements and circumstances

- Provide a clear framework for monitoring and reporting delivery including financial and operational performance
- Comply with the requirements of the Better Care Fund Revised planning guidance *(issued on 25/07/14)*

2.2 It was agreed that there would be one section 75 agreement with seven CCG specific schedules attached to reflect the slightly different approaches to delivery and governance across local areas. In addition it has been agreed that KCC will act as host for the pooled fund. The draft agreement will reflect this approach.

2.3 The draft agreement is being developed building on a template developed by Bevan Brittain who were appointed by the Better Care Fund Task Force to develop a suggested model that would be acceptable to both CCGs and local authorities (reflecting the joint collaborative working of the group). In addition legal advice is currently being sought by the Council and CCGs to ensure that the agreement adequately reflects the technical guidance, is in accordance with legislation and adequately protects the interests of the relevant partners. Based on progress to date, it is anticipated that this agreement should be ready for approval in time for the go live date of 1 April 2015.

2.4 The legal agreement will need formal approval from the KCC Cabinet Member and the CCG Governing Bodies. However the Health & Wellbeing Board in its role of

> *"strategic lead on improving the health and well being of Kent residents including making arrangements under section 75 of NHS Act 2006* "

will also need to be satisfied that the s75 agreement will ensure delivery of the desired outcomes of the Kent wide Better Care Fund plan.

2.5 The following paragraphs outline the key provisions which will be included within the draft agreement:

3. Flow of funds

3.1 Although the BCF in theory will operate as a pooled budget as required by the technical guidance, there are conditions attached to several of the funding streams which will have to be met e.g. part of the money has been earmarked as disabled facilities grant and may only be used for that purpose. Hence the funding will not entirely lose its identity as more often is the case in pooled budgets.

3.2 Where there are specific conditions, the agreement has been drafted to reflect these requirements. The guidance confirms that the accountable body is the organisation from where the money originated.

3.3 The flow of funds within the agreement is as follows:

Source of Funds	Pooled Fund	Application of funds
KCC £10.640m	£101.404m	KCC Protection of social care £28.254m
CCGs £90.764m		KCC Care Act implementation £3.566 m
Total £101.404m		KCC Social Care Capital grant £3.432 m
		Districts Disabled facilities grant £7.208m
		BCF schemes (Ringfenced CCG out of hospital commissioned services) £18.591m
		BCF Payment for performance £7.641m
		CCG carers' break schemes £3.443m
		BCF schemes £29.269m
		Total £101.404 m

4. Risk share

4.1 In line with the series of meetings hosted by Roger Gough, Chairman of Kent HWB, with the CCGs as well as discussion at the HWB in September 2014 it was agreed not to share risks across CCG's at this time. The agreement is therefore being drafted in light of this as follows:

Performance element - The £7.641m performance payment linked to achievement of the 3.5% target reduction in emergency admissions will be calculated quarterly with no cross subsidy across CCG's for under-performance. Amounts reflecting under-performance will be retained by CCG's to address the resulting pressures (in consultation with the Health & Wellbeing Board).

Over and Underspends - the s75 agreement will ensure that there is no cross subsidy across locality for under or overspends. Overspends will remain the responsibility of the relevant body to which the funds have been applied and the agreement ensures mitigation of this risk to the host and fund as a whole. Proper forecasting of underspends will be required by relevant bodies to ensure that they comply with the necessary regulatory requirements.

5. Commissioning arrangements

5.1 The nature of the schemes within the Better Care Fund plan has meant that the current s75 arrangements are tailored around joint commissioning principles (i.e. two or more commissioning bodies acting together to coordinate their commissioning, taking joint responsibility for how the care is commissioned to meet the agreed list of agreed objectives within the Better Care Fund plan). In the initial year of this agreement physical contracting arrangements are unlikely to change from the current arrangements, however in time, as commissioning plans are reviewed and consulted upon, this approach may change to reflect a more integrated way of commissioning services to achieve the BCF outcomes.

6. s75 Governance arrangements

6.1 Although the pooled budget is created from allocations to CCGs and local authorities, the arrangements do not constitute a delegation of statutory responsibilities. These are retained by the CCG Governing Body and the local authority Cabinet/executive.

6.2 In practice this means CCG Governing Bodies and KCC Cabinet or executive operating through Executive delivery groups reporting to County & Local Health and Wellbeing Boards (or equivalent local groups) for oversight.

6.3 As part of the Kent Section 75 agreement, a core central model has been proposed for the governance structure which establishes local governance that reports to the Kent Health and Wellbeing Board. Final agreement on how these groups are being convened is at a CCG level and is based on existing local governance arrangements which means it will look slightly different within each CCG area. The schedules to the s75 agreement will contain the detail of local arrangements. A draft diagrammatic representation is included at Appendix 1 which can be discussed with all partners over the coming weeks.

7. Monitoring and reporting of spend and performance

7.1 To support the measuring and reporting of performance it is essential that all relevant financial and non-financial data that may be required is collected on a regular basis from the outset. Much of this will be at a local level and for performance data may involve local providers as well as commissioners.

7.2 The draft agreement is being drafted to provide for a minimum of quarterly monitoring and reporting of spend, performance and delivery against objectives at a locality level flowing up to the Health & Wellbeing Board. This will allow the Kent HWB to provide the required strategic oversight during 2015 – 2016 allowing them to

"monitor outcomes and ensure remedial action is taken when required",

as recommended by a Grant Thornton report published in September 2014 which highlighted considerations to be made by Health & Wellbeing Boards.

7.3 Detail of planned spend and outcomes to be achieved is currently set out in the approved Better Care Fund Plan annexes (attached at Appendix 2). Appendix 3 sets out how monies for the protection of social care will be spent.

A summary of identified spend across CCGs for the total Better Care fund is set out in the table below:

WK	£'000	SKC	£'000	Thanet	£'000	NK	£'000	A&C	£'000
New Primary Care - Intermediate Care	1,356	Integrated Teams, Rapid Response and Reablement	3,189	GP Step up beds (care homes)	266	Integrated Discharge Team	-	Community geriatrician	96
New Primary Care - GP Out of Hours/ERRS/A&E front end	1,366	Integrated Teams, Rapid Response and Reablement - social care	2,692	Reducing DTOC - Loan store	754	Integrated Primary Care Team	3,544	Falls prevention and management	125
New Primary Care - Reablement Schemes	540	Enhanced Neighbourhood Care Teams and Care Coordination	5,754	Integrated Health & Social Care teams - Universal nursing	2,227	Community Adult Mental Health	200	Westview (Health and Social Care Housing)	1,422
Protection of Social Care	8,708	Enhanced Neighbourhood Care Teams and Care Coordination	188	Integrated Health & Social Care teams - ICT	1,823	Intermediate Care	193	Health and Social Care Village (Health and Social Care Housing)	-
Self & Informal Care - Carers funding	409	Enhanced Neighbourhood Care Teams and Care Coordination	253	Rehabilitation - Westbrook House (staffing)	832	Community Liaison/Single point of entry	154	Community Nursing (Integrated Health and Social Care Teams/IUCC)	1,552
New Primary Care - KCHT community services	12,143	Enhance Primary Care	592	Carers Breaks	296	Out of Hours Service	1,654	Loan Store (Integrated Health and Social Care Teams/IUCC)	512
New Primary Care - Falls prevention service	296	Enhance support to Care Homes	245	Protection of Social Care	2,631	Dementia Care	500	Protection of social care	2,443
System Enablers - Information systems	165	Enhance support to Care Homes	14	Maximum in hospital spend	870	Palliative Care Grant	1,000	Carer's break funding (Mental Health)	298
Self & Informal Care	1,017	Integrated Health and Social Housing approaches	180			IT/Comms	225	Care Bill (Mental Health)	307
Mobile Clinical Services	94	Falls prevention	150			Joint Commissioning	250	Maximum in hospital spend TBC (Across All Schemes)	566
Self & Informal Care - Elderly Care/End of Life Care	300	Falls prevention	26			3.5% reduction in Non Electives	1,248	Community geriatrician (Care Homes Support)	134
						Carer's Break	584	Community geriatrician (Care Homes Support)	131
						Protection of Social Care Funding	4,792	Falls prevention and management	125

WK	£'000	SKC	£'000	Thanet	£'000	NK	£'000	A&C	£'000
						Care Bill	603	Health and Social Care Village (Health and Social Care Housing)	-
						Integrated Primary Care Team	2,181	Community Nursing(Integrated Health and Social Care Teams/IUCC)	4,957
						Intermediate Care	1,248	Intermediate Care (Integrated Health and Social Care Teams/IUCC)	464
						Carer's Break	252	Loan Store (Integrated Health and Social Care Teams/IUCC)	929
						Protection of Social Care Funding	2,067	Protection of Social Care	3,727
						Care Bill	260	Carer's break funding (Mental Health)	454
						3.5% reduction in Non Electives	548	Care Bill (Mental Health)	469
								Maximum in hospital spend TBC (Across All Schemes)	1,174
Totals	**26,394**		**13,283**		**9,699**		**21,503**		**19,885**
MEMORANDUM	**The total pool of £101,404k also includes £3,432k social care capital grant and £7,208k disabled facilities grant**								

Members of the Health & Wellbeing Board may wish to ask questions in relation to the planned spend at the meeting today. Guidance will be received as to how the Government intends for BCF's to report on performance going forward, however Appendix 4 provides a potential assurance framework for spend that has been put forward by CIPFA/HFMA to give an indication of how this may look.

7.4 Rather than await the national guidance due to the urgent timescales, a finance sub group has been set up to ensure that financial spend information can be gathered and reported across all CCG's and KCC in a consistent manner. In addition CCG's and KCC are developing a local performance dashboard which will form part of the performance reporting framework and inform the HWB Assurance Framework. As previously agreed by the HWB it is proposed to set up a County Wide performance and finance group to ensure timely collation and reporting of this information. Draft terms of reference for such a group are attached at Appendix 5 but will need to be discussed and agreed with all partners over the coming months.

8. Next Steps

8.1 At the time of writing this report an agreement is being drafted and will be reviewed by all relevant parties with the intention of issuing a final draft within the next few weeks. The agreement will then be progressed through the relevant decision making timetable requirements of all partner bodies with a view to final oversight by the Health & Wellbeing Board in March 2015.

9. Recommendations

9.1 It is recommended that: Members note the progress made to date on developing the section 75 agreement to support delivery of the approved BCF plan.

10. Appendices

Appendix 1 Proposed s75 governance arrangements
Appendix 2 BCF Annexes
Appendix 3 Protection of social care spend analysis 15-16
Appendix 4 Spend assurance framework
Appendix 5 Proposed terms of reference for performance and finance group

Authors

Neeta Major, Mark Sage, Jo Frazer **Kent County Council**
Jonathan Bates, CFO **South Kent Coast, Thanet CCG**
Reg Middleton, CFO **West Kent CCG**

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APPENDIX 1

Proposed Better Care Fund Section 75 Governance Arrangements

Kent Health & Wellbeing Board — Kent Oversight

Local Health & Wellbeing Boards — Strategic Oversight

Section 75 Partnership Boards

Strategic Commissioning Group—North Kent / Ashford & Canterbury

Executive Integrated Commissioning Group— SKC / Thanet

Senior Managers Group—West Kent

Decision Making and Management of Section 75

Section 75 Partnership Groups

Executive Delivery Group—North Kent

System Leadership Group—West Kent

Joint Commissioning Delivery Group—Ashford & Canterbury

Executive Integration Programme Board—SKC / Thanet

Delivery of Better Care Fund

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Health and Wellbeing Board Expenditure Plan

APPPENDIX 2

Kent

Please complete white cells (for as many rows as required):

	Expenditure						
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Social Care Capital Grant	Social Care		Local Authority	Local Authority	Local Authority Social Services		3,432
Disabled facilities Grant (DFG)	Other	District Council	Local Authority	Local Authority	Local Authority Social Services		7,208
Care Act	Social Care		Local Authority	Local Authority	CCG Minimum Contribution		3,552
Carers Break	Other	Joint	Joint		CCG Minimum Contribution		3,443
Protection of social care	Social Care		Local Authority	Local Authority	CCG Minimum Contribution	28,254	28,254
Schemes-Ashford CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		4,273
Schemes- Canterbury & Coastal CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		7,914
Schemes-Dartford, Gravesham and Swanley CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		8,968
Schemes-South Kent Coast CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		8,437
Schemes-Swale CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		3,977
Schemes- Thanet CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		6,416
Schemes- West Kent CCG	Other	Detail within local schemes	CCG		CCG Minimum Contribution		15,530
Total						**28,254**	**101,404**

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Community Networks

What is the strategic objective of this scheme?

The fundamental, underlying, principle which reaches across our strategic direction is that the CCG are keen to ensure that care is be delivered as close to where patients live as possible. The consequence of this is that patients will be able to access a variety of services in a number of locations –including their own home, their pharmacy, the optometrist, their GP surgery, community hospitals as well as district hospitals.

Ultimately we anticipate that the outcome of this longer term approach will mean larger practices offering more services, including Social Care, and acting as the central hub for a wider variety of services and with improved access for traditional GP services.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

"Community Networks" is the title given to a number of projects leading towards an overall strategic aim.
The component projects, forming part of the Better Care Fund initiative are detailed individually below

The delivery chain

Kent Adult Social Care
The CCG
Provider Organisations including Voluntary Sector

The evidence base

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

The schemes will ensure that residents received both health and social care using pathways that address all of the issues. Through a coordinated approach this will support the dependence upon health services

SCHEME REQUIREMENTS:

- Core set of community based health **and** social care services, with tailored community based services
- General Practice as the most frequent point of contact for patients and carers;
- Improved GP access - in terms of time waiting for an appointment and telephone access
- More services provided locally, within a community setting e.g. at or via the GP surgery

- More locally based day services for carers and patients
- Improved communication with patients and carers. This could reduce patients' and carers' concerns regarding treatment and disputes regarding decisions about health care provision and support
- Improved communication between health care professionals and across health and social care
- Better information, whether it is about services that are available (accessibility, timings, contacts) in different formats including easy read
- Reduced cost of void space to the CCGs in future
- Improved community bed utilisation
- Voluntary and social services integrated into community-based contracts
- Integrated contracts for defined geographical locations
- Increased emphasis on early interventions and health and wellbeing

Feedback loop

What are the key success factors for implementation of this scheme?

- Reduced emergency admissions;
- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia;
- Improve patient, carers' and relatives' experience;
- Improve health and social outcomes;
- Reduced length of stay across the health and social care economy;
- Improved transfers of care across health and social care;
- Reduced long term placements in residential and nursing home beds;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment
- Improving patients ability to self-manage

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Integrated Urgent Care Centre (IUCC)

What is the strategic objective of this scheme?

This initiative will improve the effectiveness of multi-disciplinary agencies for the following benefits:

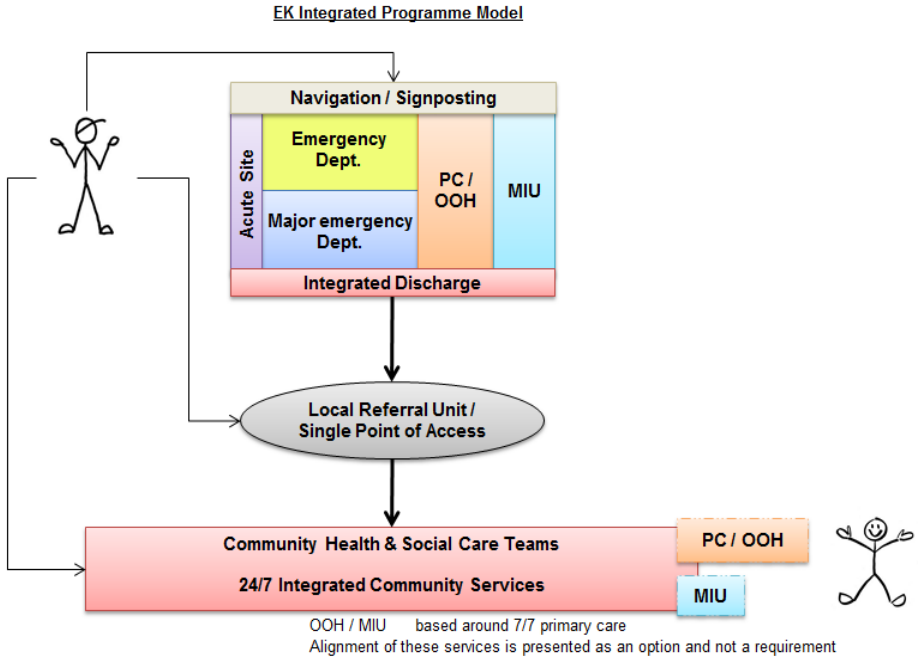
- Enhanced Patient Experience
- Reduced Admissions
- Improved flow of discharges over 7 days a week
- Reduced Acute Hospital Length of Stay

Overview of the scheme

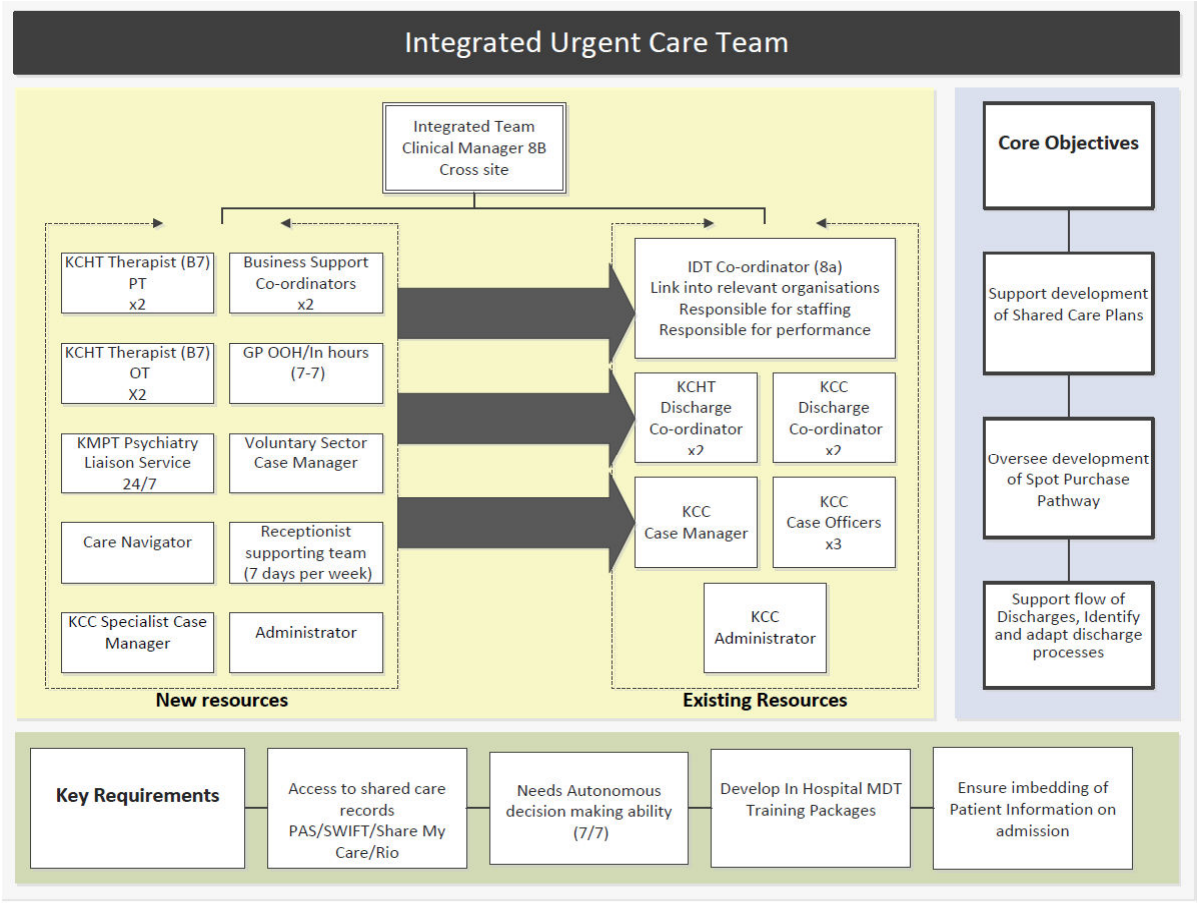
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The IUCC is an initiative which will bring together providers across health and social care settings under one management structure. It aims to reduce administrative burdens and to enhance productivity by creating a team of senior decision makers working towards shared objectives with shared governance arrangements.
The team will be responsible for working both within the Acute aspects of Hospitals (A&E, Clinical Decision Unit and Surgical Assessment Unit) and also the speciality inpatient wards, covering a 7 day per week service provision.
The model is described below



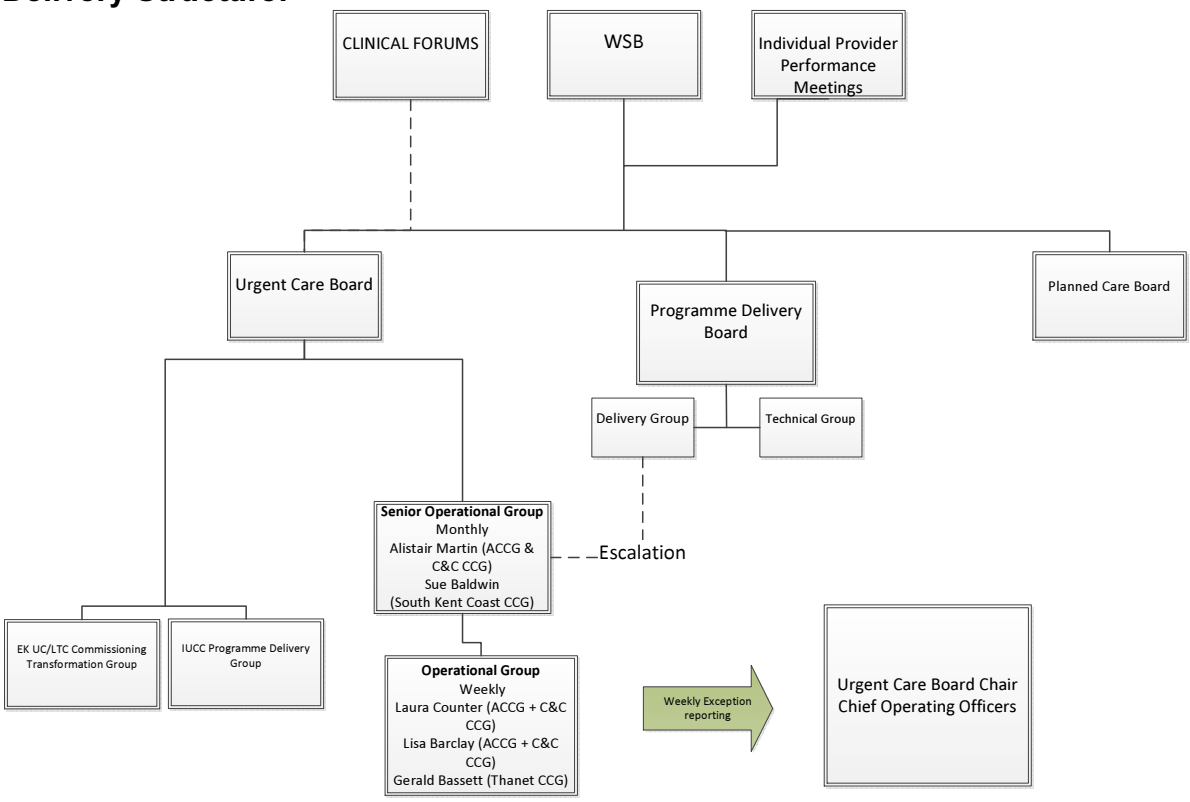
The Team Structure is outlined below:



The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners
Ashford CCG
Canterbury and Coastal CCG
South Kent Coast CCG
Thanet CCG
Providers
Kent County Council
East Kent Hospitals University Foundation Trust
Kent Community Healthcare Trust
Kent & Medway Partnership Trust
South East Coast Ambulance Service
Intermediate Care 24 Ltd
Invicta Health
Delivery Structure:



The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Transforming Urgent and Emergency Care services in England (Sir Bruce Keogh, 2013)
Urgent and Unplanned Care: Operational Resilience and Capacity Planning for 2014/15 (NHS England, 2014)
Costing 7 day Services: The Financial Implications of seven day services for acute and urgent services and supporting diagnostics (Healthcare Financial Management Association (HFMA), 2013)
The Diseconomies of Queue Pooling: An Empirical Investigation of Emergency Department Length of Stay (Harvard Business School, 2014)
East Kent Integrated Urgent Care Centre Strategy (East Kent Hospitals University Foundation Trust, 2013)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Key deliverables:

- Reduction in Admissions: - 3 patients per day per site
- Reduction in Reportable Delayed Transfers of Care (DTOC): - 30% reduction on last year
- Reduction in 0-7 day unplanned re-attendance rate (3% reduction)
- Reduction in <28 day LOS by 0.5 days
- Increase in early morning discharges (plan 10 by 10:00 to ensure throughput to new Medical Assessment area)
- Discharge Rate at Weekends (20% improvement)

Enabling KPI

- GP in A&E Productivity/Utilisation to increase from 1.2 Pts per hour to 4 Pts per hour

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators will feed into a live urgent care dashboard from October 2014

What are the key success factors for implementation of this scheme?

- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia;
- Improve patient, carers' and relatives' experience;
- Reduced spend on medication;
- Reduced duplications across the health and social care system;
- Reduce delays in provision of care
- Reduce long term admissions to care homes
- Reduction in A&E waiting times
- Reduction in Ambulance Conveyances to Hospital
- Improvement of Emergency Access Standard
- Reduction in Acute Hospital Length of Stay
- Reduction in 0-7 day Acute Hospital re-attendances

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Support for Care Homes

What is the strategic objective of this scheme?

To support the reduction in A&E attendances and unplanned admissions for care home residents (nursing and residential).

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?

- Which patient cohorts are being targeted?

The services provide specialist assessment, advice and treatment to older people in care homes (nursing and residential). The models differ slightly in each locality, an overview of each is provided below;

Ashford:

Funding supports the employment of a Community Matron, available 8am-8pm 7 days a week and 8pm-8am 7 days a week via an on call bleep for advice only, and a Community Geriatrician available in office hours (9am-5pm Monday to Friday). The Geriatrician job plan includes the provision of a Community Geriatric Assessment clinic.

New care home admissions, residents who have been discharged from hospital, and those with perceived high risk of unplanned emergency attendance will be identified and referred to the Community Matron Team to arrange a visit, commence assessment and future planning. The Community Geriatrician and Matron Team work together to ensure individuals are assessed in their care home or own home, with a view to assessing their health and care needs and where appropriate initiate anticipatory care plans with clients and relatives. By working with care home staff, it is anticipated that this will continue to improve confidence in managing frail older people in the community.

Fixed, daily sessions of Consultant Geriatrician time will be provided for domiciliary assessments of care home residents

Weekly outpatient clinics will be provided enabling the removal of secondary care outpatient activity into the community. The clinics will be accessible by care home residents and GP referred complex elderly patients living within their own homes providing care closer to home.

Canterbury:

Community Geriatrician is funded to provide joint visits to care homes (nursing and residential) with Community Matrons, GP, Clinical Nurse Specialist for Care Homes and Medicines Management. Medical Management Plans are put in place for patients referred to the service.

There is also a 7 day a week Community Matron on call service. The Community Matrons proactively call the top ten care homes, as identified by the Care Home Dashboard, between 5-7pm to ask if there are any issues the care home needs support with.

Investment has recently been provided to allow the Neighbourhood Care Team to provide locality focused advice and treatment for the care home community 7 days a week, with a pro-active on call service being available for care homes 8pm-8am, Monday to Sunday

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

- Rachel Grout/Lisa Barclay - Commissioning Project Manager Ashford/Canterbury and Coastal CCG
- Sue Luff - Head of Commissioning Ashford CCG
- Dr Caroline Ruaux – GP and Clinical Lead Ashford CCG
- Dr Geoff Jones – GP and Clinical Lead Canterbury and Coastal CCG
- Kirstie Willerton - Commissioning Officer, Accommodation Solutions, KCC
- Francesca Sexton - Commissioning Officer, Accommodation Solutions, KCC
- Paula Parker – Commissioning Manager, Community Support, Strategic Commissioning, KCC

Providers:

- GPs
- East Kent Hospitals University Foundation Trust (EKHUFT)
- Kent Community Health NHS Trust (KCHT)

- South East Coast Ambulance Service (SECAmb)
- Local Care Homes

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Frail older people with multiple comorbidities are at risk of health and functional decline. They have high health and social care requirements that require detailed assessments. Such individuals are at risk of unplanned admission and readmission to hospital. Projections from office for national statistics show a rise in all age groups over the next 5 years with the largest percentage rises occurring in the 65+ age group (16%) resulting in additional pressure on local urgent services.

Analysis of activity data in relation to care homes in 2012 demonstrated that over 40% of patients who were transferred to Accident and Emergency for urgent review were discharged back to the care setting for continuation of their current care package. In addition the majority of transfers occurred out of hours.
The initial investigation highlighted that care homes felt that they had no alternative option due to lack of anticipatory care planning, lack of advice out of hours and whilst GPs were assigned to undertake medical services within the care home they do not necessarily have the depth of knowledge in relation to care of the elderly patients. The community matron did have responsibility for the care homes but did not work beyond 5pm.
There was also evidence that the readmission rate for care home patients was above 20% due to lack of robust care plans.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total expenditure:

Canterbury and Coastal CCG - £135,000
Ashford CCG - £160,000 (Community Geriatrician and Community Matron)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

To improve care for patients in care homes (both nursing and residential)

- Reduction in avoidable A/E attendances in care home residents.
- Reduced admissions for care home residents
- Support and education for care homes in the management of frail older people.
- Improved communication streams between secondary, community and primary care.
- Improved satisfaction and quality of care for care home residents and complex elderly patients living in their own homes
- Support to GPs in managing complex elderly patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A&E and admission data will be reviewed on a monthly basis to identify admission avoidance against pre agreed criteria.
The project reports into the joint CCG and KCC Health and Social Care Operational Group for Care Providers (Adults), this feeds into the Integrated Commissioning Group, a

sub-group of the Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia;
- Improve patient, carers' and relatives' experience;
- Reduced duplications across the health and social care system;
- Reduce unnecessary prescribing;
- Improve patient satisfaction through personalised care planning.

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Falls Prevention and Management

What is the strategic objective of this scheme?

The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service. The overall aim of the proposed 'framework' is to focus on objectives 2 and 3, and improve the quality of life for local residents (particularly over 65yrs of age):

- Objective 2 - respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings
- Objective 3 - early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries

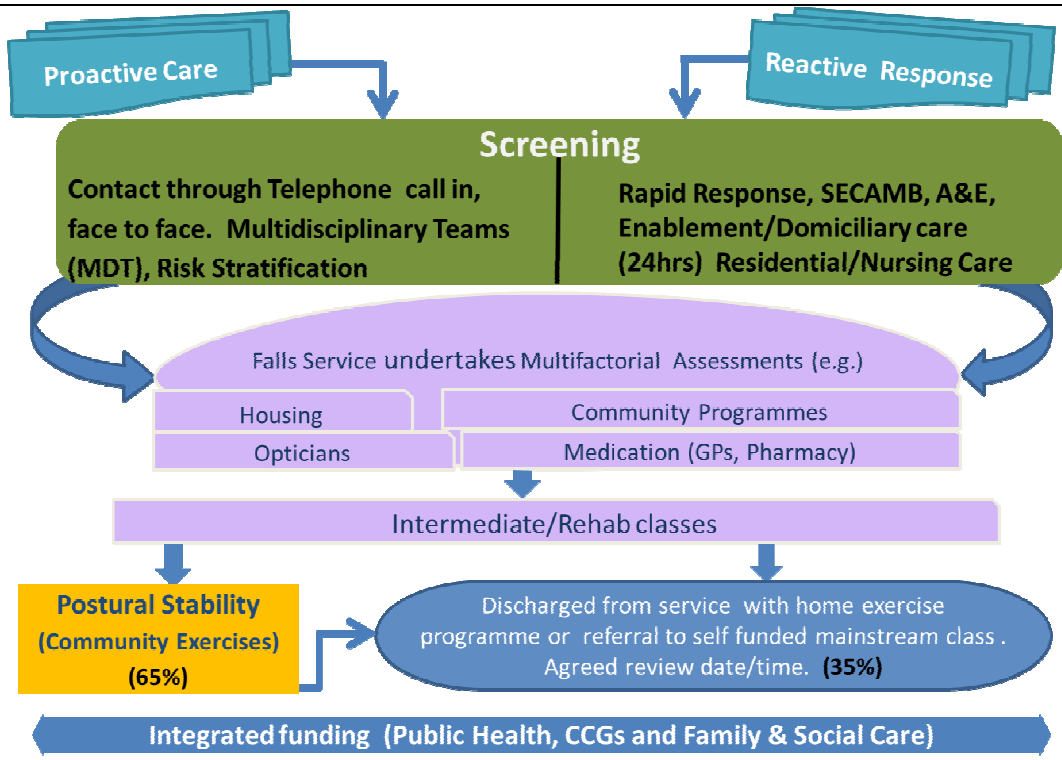
Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The intention is to work with partners to develop an integrated multi-agency, multi-disciplinary falls service across Ashford and Canterbury. This will focus predominantly on those aged over 65 years.

The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service.



The 'framework' covers the entire spectrum across a range of stakeholders including acute trusts, community health trusts, CCGs, adult social services, district authorities and voluntary organisations.
Considering the guidance from NICE and the National Service Framework, the framework recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include:
1. Screening of adults who are at a higher risk of falls
2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures
3. Use of standardised Multifactorial Falls Assessment and Evaluation tool
4. Availability of community based postural stability exercise classes
5. Follow on community support for on-going maintenance closer to home
These interventions should be available as a "core offer" for the population if we are to see a reduction in the number of falls related hospital admissions and reductions in numbers of older people living in residential care as a result of falls.
A scoping exercise has been undertaken to review the existing pathways (re-active and pro-active) and services identifying what works well, what requires further development and gaps in existing provision. The outputs of this will be reviewed by the falls task and finish group to support the move to an integrated service.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

- Rachel Grout – Commissioning Project Manager Ashford CCG
- Laura Counter – Commissioning Manager Canterbury and Coastal CCG
- Dr Neil Pilai, GP and Ashford CCG Clinical Lead
- Paula Parker – Commissioning Manager, Community Support, Strategic Commissioning, KCC
- Dave Harris – Commissioning Officer, Community Support, Strategic Commissioning KCC
- Martin Field - Commissioning Officer, Community Support, Strategic Commissioning KCC
- Karen Shaw – Public Health Programme Manager, Public Health, KCC

Providers:

- GPs
- East Kent Hospitals University Foundation Trust (EKHUFT)
- Kent Community Health NHS Trust (KCHT)
- South East Coast Ambluance Service (SECAmb)
- Integrated Care 24 (IC24)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Both health and social care organisations are facing unprecedented challenges. Evidence has shown that a lot of falls, especially amongst the older population can be prevented provided at risk individuals are identified from the first fall, with infrastructure in place to prevent a second fall.

The current system is uncoordinated and requires integration across stakeholders. The financial constraints which exist across all organisations require an urgent need to use existing resources more effectively.

A scoping exercise identified the following issues and gaps in existing provision:

- Lack of falls prevention pathway
- Lack of Fracture Liaison Service
- Improved integration needed with South East Coast Ambulance Service (SECAmb)
- Improved integration and working needed with Kent Fire and Rescue Service
- Lack of pathway with Housing linking into falls service
- No concrete links to Pharmacies and GPs especially around medication reviews
- No links with Opticians for eyesight reviews
- Low GP referrals into falls services
- Training

Both NICE and National Service Framework (NSF) for older people recommend the prompt delivery of multifactorial assessment and interventions to be delivered by a specialist falls and fracture prevention service working closely with primary care and social care professionals.

Nationally the NHS Confederation (2012) suggests that a falls prevention strategy could reduce the number of falls by up to 30% and that effective falls prevention schemes can be implemented at little cost with the involvement of professionals working in health, social care and in the community. The report further suggests that prevention by one partner can create efficiencies for others and that when addressing falls and fractures, health and social care organisations should be encouraged to align their own budgets to support joined-up working in this area.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overall aim is to improve the quality of life for residents (particularly over the age of 65 years) and to lessen the burden of ill health related to falls.

The outcomes of this service will be to;

- Minimise duplication of existing services, to maximise the use of existing resources
- Ensure service delivery is in line with National Guidance and is evidence based
- Ensure equity of provision
- Improve access to services

- Reduce hospital admissions related to falls by preventing the patient from having a second fall
- To reduce the number of health and social care activity related to falls and fracture in older people
- Improve patient experience of services
- Improve outcomes for patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcome measures will be identified in conjunction with the development of the pathway and supporting business case.
The project reports into, and is monitored by, the Integrated Commissioning Group a sub-group of the Health and Wellbeing Board

What are the key success factors for implementation of this scheme?

- Reduction in hospital admissions related to falls by preventing the patient from having a second fall
- Reduction in the number of health and social care activity related to falls and fracture in older people
- Improved patient experience of services
- Improved outcomes for patients
- Reduction in hip fractures;
- Improve patient experience and levels of self management;
- Reduced A&E attendances.

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Mental Health

What is the strategic objective of this scheme?

Through provision of integrated services patients will be able to access coordinated mental health service provision ensuing that the pathway is designed to have maximum input from prevention to treatment.

Overview of the scheme

We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support:

- Increased schemes to support health minds and early interventions
- Crisis support within all pathway
- Integrated models for all pathways to support patients within range of pathway
- Systematised self-care/self-management through assistive technologies
- Improved care navigation
- The development of Dementia Friendly Communities and,
- To facilitate access to other support provided by the voluntary sector.

SCHEME REQUIREMENTS:

- Street triage services, aligned with Kent Police to ensure earlier assessment of a patient in crisis, thus avoiding the need for hospital admission

- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by General Practice
- We will ensure that patients are supported outside of the hospital environment through “Befriending Services” to address and support the needs of vulnerable people.
- Improved support for carers during periods of “crisis”, including short breaks for carers.
- Improvements to Psychiatric liaison service provided within urgent care facilities
- We will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Pathways which are integrated across health and social care
- Primary care and the integrated team will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community;
- Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies;
- Develop a Health and Social Care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.
- Introduction of an “all-age” earlier identification and intervention for problematic eating behaviours
- Improved discharge pathways for patients with mental health related conditions

The delivery chain

Sue Scammel Mental Health Commissioner KCC
Jacqui Davies Mental Health Commissioner Kent & Medway Commissioning Support Unit
Ian Reason Commissioning Project Manager Ashford CCG
Kent Police
Kent and Medway Partnership NHS Trust
East Kent Hospitals University Foundation Trust

The evidence base

Closing the Gap DOH 2014
Kings Fund Making the Case for Family Networks 2014
Kings Fund Lesson from Mental Health 2014
Kent Health and Wellbeing Strategy

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

The delivery of mental health pathways will incorporate integrated service delivery to manage the full range of the patient’s pathway from prevention to medical intervention. This will support patients with their needs across their support network and social needs

Feedback loop

The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board

What are the key success factors for implementation of this scheme?

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient satisfaction and well-being;
- Increase levels of patient self management of long term conditions;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services.
- Increase in number of patients returning to their normal daily activities

Ashford and Canterbury Clinical Commissioning Groups

Scheme ref no.

Scheme name

Health and Social Care Housing

What is the strategic objective of this scheme?

To ensure that development of Health and Social Care Housing schemes are developed in partnership across the health and social care economy. This will facilitate the ability to maximise the benefits of the facility through access to focused health provision

Overview of the scheme

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment.

There are several housing projects in various stages of development. The largest of these are focused on elderly and homeless patients.

It is proposed that the facility for elderly patients will support the ability to provide site based health delivery to include the primary care, consultant geriatrician and the wider integrated team.

The homeless facility will be supported by the integrated team and will include primary care, social services, mental health and voluntary agencies. The team will ensure that all residents are fully assessed and where required implement a plan to manage the complex care needs of this patient group

SCHEME REQUIREMENTS:

- An integrated approach to local housing and accommodation provision, supported by a joint Health and Social care Accommodation Strategy, to enable more people to live safely in a home environment and other environments.
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to remain in their homes safely;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally;
- More supported accommodation for those with learning disabilities and mental health needs

The delivery chain

Paula Parker Commissioner KCC
Sue Luff Clinical Commissioning Group
Ashford Borough Council
Canterbury City Council

The evidence base
District Council Housing Strategy documents the importance of ensuring that new developments incorporate services to meet the needs of the residents. Kent Health and Wellbeing Strategy
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme
The schemes will ensure that residents received both health and social care using pathways that address all of the issues. Through a coordinated approach this will support the dependence upon health services
Feedback loop
The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board
What are the key success factors for implementation of this scheme?
Delivery of services at point of facility opening. • Reduced A&E attendances; • Reduced hospital admissions and re-admissions; • Improve patient, carers' and relatives' experience; • Reduced duplications across the health and social care system; • Reduce unnecessary prescribing; • Improve patient satisfaction through personalised care planning. • Reduced residential care admissions; • Reduced care packages

Ashford and Canterbury Clinical Commissioning Groups
Scheme ref no.
Scheme name
Integrated Health and Social Care Teams
What is the strategic objective of this scheme?
To implement new ways of working which will ensure that the service delivery is a joint service across health and social care thereby facilitating the ability to shift care from secondary to community.
Overview of the scheme
Through reducing the current division across health and social care this will support the ability to implement services which are delivered by one team sharing their skills and competencies to reduce duplication and unnecessary interventions from multiple agencies. The impact of this is that patients will be supported within their own care environment as the norm • Aligned to geographical areas the support will be accessible 24 hours a day seven days a week and will coordinate integrated management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making; • Each Team will include input from the wider community nursing teams, Health

Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Case Managers as part of the multi-disciplinary approach;

- The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
- The integrated teams will provide continuity of care for patients who have been referred for support and care in the community, including within care homes.
- To ensure continuity for patients with long term needs, the team will provide seamless coordination and delivery of End of Life care;
- There will be a single point of access, the Health and Social Care Co-Ordinator, and single assessment to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Specialist dementia nursing support, through the Admiral Nurses, will be integrated into the teams as part of an approach to maximising the knowledge of the team through the inclusion of specialists.
- Each patient, identified through risk stratification, or as resident of a care home, will have a comprehensive anticipatory care plan to identify their individual needs and to identify possible pressure points so that approaches to the patients care can be identified in advance of the need arising.
- We will ensure that patients are supported outside of the hospital environment through “Befriending Services” to address and support the needs of vulnerable people.
- Improved support for carers during periods of “crisis”, including short breaks for carers.
- Sharing of practice across professionals will improve the quality of care provided to patients and carers
- We will implement a shared IT solution to allow health and social care professionals to access the shared care plan.
- The aspiration is that, where possible, the team will be co-located. We suspect that this may prove to be the optimum model.
- The voluntary sector is seen as having an important role in the delivery of this scheme.

The delivery chain

Paula Parker Commissioner KCC
Sue Luff/ Lisa Barclay Commissioner Clinical Commissioning

The evidence base

Kent Health and Wellbeing Strategy
A New Settlement for Health and Social Care, Kings Fund 2014
Community Services – How they can transform care, Kings Fund 2014

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Delivery of pathways meeting both health and social care needs through an integrated team. Patients will be supported to manage their own needs and where intervention is required this will be delivered through community based services as an alternative to

secondary care
Feedback loop
The projects will report into the Integrated Commissioning Group which is a sub group of the Health and Wellbeing Board.
What are the key success factors for implementation of this scheme?
• Reduced emergency admissions; • Reduced A&E attendances; • Reduced hospital admissions and re-admissions for patients with chronic long term conditions including Dementia; • Improve patient, carers' and relatives' experience; • Improve health and social outcomes; • Reduced length of stay across the health and social care economy; • Improved transfers of care across health and social care; • Reduced long term placements in residential and nursing home beds; • Reduced need for long term supported care packages; • Increase patients returning to previous level of functionality in usual environment • Improving patients ability to self-manage

North Kent Clinical Commissioning Groups

Scheme ref no.

1

Scheme name

Integrated Primary Care Teams – iPCT's

What is the strategic objective of this scheme?

The Joint Strategic Needs Assessment (review at January 2014), and local modelling confirms a number of key issues across North Kent which the development of Integrated Primary Care Teams (IPCT's) are expected to improve:

- There is a significant increase in the older population – by 2020 there will be a 34% increase in people over 85 years in DGS and 22% increase in Swale (with an overall increase in the population by 8% and 4% respectively).
- There is emerging significance of the importance of patients who have multiple morbidities which impact more and more on our health and social care services. The latest risk stratification analyses indicate that the highest intensive users (approximately 5% of the population) of hospital services are mostly elderly patients with complex needs and multiple morbidities. These patients represent almost 60% of the total unscheduled hospital admission spend for the CCG's.
- While the current Kent Health and Wellbeing Strategy is under review, it outlines the following expected outcomes which underpin the rationale for IPCT's:
- Effective prevention of ill health by people taking greater responsibility for their health and well-being – these plans aim to support people to take responsibility by providing appropriate information, advice and signposting.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental ill health issues are supported to live well
- People with dementia are assessed and treated earlier.

These two significant strategy documents underpin the two and five year strategies for the CCG's.

The challenge for health and social care nationally is predominantly 2-fold:

- Resources, both financial and human are finite and require further efficiency gains
- The number and complexity of morbidities within, particularly, the elderly population are increasing year on year. This is however, true for all age groups with long term conditions.

The response to this cannot be to keep doing more of the same and the need to completely revise the way health and care services are offered has been accepted for a number of years. The need has become more acute and real action is required now to facilitate that change.

The challenge across the North Kent health and care economy has been set to reduce non-elective admissions by 10% at Darent Valley Hospital in 2014/15 with a further 5% reduction in 2015/16. Similar aspirations are expected at Medway Hospital. Plans are in place to achieve this target using the Better Care Fund programme to support the change. A number of projects have been established under the BCF banner to achieve the aims associated with it of which integrating primary health care teams is one.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The vision for community based care delivered by integrated primary care teams is that it should be centred round the patient with the GP as the named accountable person. The teams themselves should be grouped around this construct and developed to work in an integrated, multi-disciplinary model. In order to facilitate this, there needs to be a new framework in place for the team, which has the relevant staff 'allocated' to practice populations.

To that end the iPCT's are being developed around a combined practice population or neighbourhood of c20-40,000. This figure enables the team to remain small enough to promote good relationships but to provide the resilience and flexibility needed to operate effectively when dealing with annual leave, sickness and training absences.
Success of the teams will be reliant on the following:

- Effective communication and relationships between all team members
- Core membership commensurate with the demographic and local needs
- Skills and competence of the team members
- Effective coordination and care planning
- Effective and robust operation within pathways for secondary and tertiary healthcare and also out of hours services

Whilst there is no absolute requirement for primary care itself to re-structure or to adopt different organisational structures to support the iPCT's, there are a number of options which may want to be considered by some practices. Work undertaken by the Kings Fund specifically suggests that this may support the development of primary care more generally and improve the quality of care provided. These are detailed in the draft Primary Care Strategy, which is currently in development for DGS CCG and one for Swale CCG. However, for the purposes of developing and testing out the right configuration of the iPCT's, the current plans are proposed around the current practice configuration.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

As the iPCTs will be multi-disciplinary teams the members of the teams will be commissioned by a number of commissioners and from various provider organisations. Essentially it will be delivered as follows and under existing contractual arrangements:
DGS & Swale CCG's will commission:

- District Nurses and Matrons from Kent Community Health NHS Trust
- Community MH Nurses from Kent & Medway Partnership NHS Trust
- Palliative Care Nurses from Ellenor Lions Hospice (DGS only at this stage)
- Outreach acute, specialist services from Dartford & Gravesham NHS Trust and Medway Maritime NHS Foundation Trust
- Paramedic Practitioners from South East Coast Ambulance NHS Foundation Trust

NHS England will commission:

- Primary Care services

Kent County Council will commission:

- Care services
- Voluntary and carer services

DGS & Swale CCG's have jointly secured external consultancy support to lead the project with accountability to the CCG Accountable Officer for delivery. The Programme Manager works within the programme governance and is responsible for presenting

regular reports on delivery of the project plan and the agreed KPI's. The project itself is managed through the iPCT Working Group which reports into the Integrated Operational Commissioning Group and has representatives from all member organisations.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The concept of iPCT's is not new and has been implemented and further developed quite widely nationally and internationally. As such there is a wealth of evidence which supports such an approach and has demonstrated a positive impact in terms of avoided admissions, reduced length of stay and improved patient experience. The models from which local plans have been drawn include those in Torbay, Devon and Canterbury in New Zealand.

References to their work can be located at:

1. March 2011. The Kings Fund. 'Integrating health & social care in Torbay: Improving care for Mrs Smith'
2. September 2013. The Kings Fund. 'The quest for integrated health a social care. A case study in Canterbury, New Zealand'

In addition close watch is being kept on Pioneer projects nationally, in particular the work in inner North West London. As more evaluation becomes available any learning will be applied to the Nth Kent approach.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be measured accordingly to the project KPI's which are listed below Dashboards tracking the local metrics are being developed and will be monitored by the Executive Programme Boards for DGS and Swale:

Category	Group	Sub-group
Pt experience	Improvement in patient reported outcomes	People report system is not as complicated
		People report no delays in referral or assessment
		People report being treated with respect
		People report being involved in the development of their care plan
		People know name of their Care Coordinator
		People know how to access care and advice from team members
		People feel supported in the management of their condition
	Reduced admissions	

	related to their LTC	
Team Operation	Team establishment	Team configuration & establishment agreed
	Referrals made via the SPA	Actual number of referrals
		Reduced time from referral to first assessment visit
	MDT meetings	Dates and times agreed and set
		Evidence of meetings taking place
		Attendance for all members
		Care Coordinator reports access to specialist advice
		Practice based telephone advice line in place & operational – others
	Staff satisfaction	report improved communication within the team
		report improved morale amongst team
		report enhanced ability to provide a good quality service
Clinical Quality	Integrated Care Plans	in place for all patients on the caseload
		shareable and shared across all members of the team
	Risk stratification tool	applied monthly and reports shared with the team
		at risk patients discussed at MDT's

Using a risk stratification approach the 'at risk' patients will be identified enabling proactive management of individuals by all members of the iPCT as appropriate to the care required. This proactive involvement by the team will reduce the number of crises experienced by patients and a resultant early deterioration in their general health and wellbeing.

The contribution of these metrics to the overall BCF Programme for North Kent will be in terms of the contribution to avoiding hospital attendances from which might result an admission and the provision of a community based support infrastructure will enable a speedier discharge. These in turn will enable people to stay supported in their own homes for longer and thus reduce the number of admissions into long term care.

What are the key success factors for implementation of this scheme?

The local and care environment will need to ensure the following for this scheme to succeed:

- strong governance arrangements are in place to ensure senior level commitment and support
- a full and transparent approach to joint working, sharing resources and enabling delegated assessment and decision making powers within teams
- a pooled budget in support of the above
- a joint commitment to developing and retaining good staff to ensure sustainable services in a notoriously 'hard to recruit to' area.

Evidence elsewhere has been that a significant local imperative has been the key to innovative and true joint working. In Torbay it was a severely financially challenged local authority, in Canterbury NZ, it was an earthquake, In North Kent a similar outcome

needs to be achieved based on learning from best practice elsewhere, whatever the catalyst.

North Kent Clinical Commissioning Groups
Scheme ref no.
2
Scheme name
Integrated Dementia Care
What is the strategic objective of this scheme?
To establish an effective integrated care pathway for people with dementia. The ageing population in North Kent will continue to place significant financial challenges on the care system with an increase in the number of people with long term conditions, the concomitant increase in dementia and a subsequent increase in carers and the people they care for experiencing crisis situations. People with dementia and their carers need a range of services, some of which will be dementia- specific and others which will be more mainstream in nature. These services need to respond well to people affected by dementia and in the main meet their needs within the home environment where possible, If people do need a hospital admission effective joint care planning is essential and better cross-organisational and inter-organisational working to improve discharge planning is essential. The development and implementation of an integrated care pathway for people with dementia will see their needs assessed through a framework of care management and coordination that ensures delivery of health and social care services by means of a combined shared care plan. The integrated care pathway is being jointly developed by health, social care and voluntary organisations within North Kent to provide guidance about effective services and interventions that deliver outcomes for people living with dementia and their carers from early diagnosis and throughout the course of the condition. Transformation of dementia care within North Kent to a multi-disciplinary, multi-agency planned approach to the delivery of care and support for people with dementia and their carers will provide improved access to resources and services throughout the course of the disease. Effective joint care planning and crisis management will reduce the use of more intensive, higher cost services and incur a delay in the need for more intensive services in the later stages.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
At the present time there are various aspects regarding service provision for people with dementia that requires changing to ensure continuity of patient care and an effective pathway for patients from earlier diagnosis, integrated service provision within the community, effective crisis management through to end of life care. The dementia programme focuses on three elements of the pathway which will have the highest impact in reducing admissions to acute hospitals, all of which are designed to improve the experience of people with dementia as we progress to establishing a fully integrated care pathway.

Effective co-ordinated care will be introduced by establishing mental health nurses within Integrated Primary Care teams based around practice populations of 30,000 people.

Mental health expertise will become an integral function within Integrated Primary Care teams to provide post diagnostic support and effective case management for people with dementia in the community. The ambition is to treat dementia under the long term condition model of care where a person's needs are treated holistically factoring in physical and mental health needs together where services are responsive to individual need and carers are supported through the journey with dementia. The Integrated teams will support the management of the higher risk stratified population and caseloads for dementia currently in Cluster 18 and 19.

A crisis service for people with dementia and their carers will be jointly commissioned by Kent County Council and North Kent CCGs and procured through the voluntary sector. The service will provide a short term rapid response to a physical and/or mental health crisis through intensive support and home treatment more often than not due to an escalation in difficult behaviour that results in carer breakdown and risks unplanned admissions to hospital or care homes.

This will be achieved by shifting current resources to improve care coordination, improve access to services, and provide greater support to carers by reducing inefficiencies and duplication without significant infusion of financial resources and subsequently reduce the use of more intensive, higher cost services.

An acute hospital bridging service provided by a specialist dementia voluntary sector organisation has been established to work within the Integrated Discharge Team. This will optimise effective client transfer to avoid admissions where it is safe to do so and to facilitate timelier discharge operating a 'pull' system via a single point of case management. The service will support people with dementia or other cognitive impairments by the provision of short term care support services to re-establish the patient in the community, including support to family carers, to allow time for decision making by health and social care for their future long term care needs if required.

All three initiatives are underpinned by integrated working between health, social care and the voluntary sector and the development of the shared care plan.

Commissioners and Providers are working together to develop local policies and protocols embedded within the shared care plan which cross professional boundaries to focus on meeting the needs of people with dementia within the community.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This service will be part of the wider multi-disciplinary iPCT's and the members of the teams will be commissioned by a number of commissioners and from various provider organisations.

Essentially it will be delivered as follows and under existing contractual arrangements:
DGS & Swale CCG's will commission:

- Community MH Nurses from Kent & Medway Partnership NHS Trust

NHS England will commission:

- Primary Care services

Kent County Council will commission:
- Care services
- Voluntary and carer services

DGS & Swale CCG's have jointly secured external consultancy support to lead the project with accountability to the CCG Accountable Officer for delivery. The Programme Manager works within the programme governance and is responsible for presenting regular reports on delivery of the project plan and the agreed KPI's. The project itself is managed through the integrated Dementia Working Group which reports into the Integrated Operational Commissioning Group and has representatives from all member organisations.

DGS CCG has commissioned the Alzheimer's and Dementia Support Service to work with the Integrated Discharge Team based within Darent Valley Hospital. The Integrated Discharge Team is collaboration between DGS CCG, Darent Valley Hospital and Kent Community Healthcare.

A change in approach to crisis management will be required and joint working is already taking place between the CCG and Kent County Council. Kent County Council short breaks for carer's contract started on November 2013 continuing through to 31st March 2016 (18 months plus an additional year extension). The service builds on the objective of the current crisis service and moves to a more holistic and proactive approach to preventing crisis' arising focusing on the capacity and capability of carer to continue their caring role, alongside building greater links with existing services. The CCG can access the contract through expanding the scope of the existing Section 256, allowing CCG transfer of a corresponding allocation to KCC buying into the service outlined in the service specification.

The development of the Integrated Care Pathway for dementia is a collaborative planning process working in partnership with:
- DGS/Swale CCG
- GP Dementia Clinical Leads
- Darent Valley NHS Trust
- Kent and Medway Partnership Trust
- Kent Community Healthcare Trust
- Kent County Council
- Crossroads Care
- Alzheimer's and Dementia Support Services

Dementia Leads from all listed organisations participate and take forward specific tasks within their respective organisations**.**

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are numerous examples of evidence for the improvement and development of consistent high quality care for dementia that has influenced the service transformation within North Kent most notably:

National Strategies
- Department of Health (2009), Living Well with Dementia: A National Dementia Strategy

- Dementia: A NICE–SCIE Guideline on supporting people with dementia and their carers in health and social care, National Clinical Practice Guideline
- National Audit Office (2007), Improving services and support for people with dementia. London: TSO.
- Alzheimer's Society (2008), Out of the Shadows. London: Department of Health.
- Department of Health/Care Services Improvement Partnership (2005), Everybody's Business – integrated mental health services for older adults.
- The National Dementia Declaration (Alzheimer's Society, 2010)

There are a number of areas within the UK that have implemented the same approach to dementia care and the evidence has been recognised nationally as good practice and improving overall outcomes for people with dementia and their carers. Although service provision cannot always be replicated exactly the main driver of integrated care for dementia has provided the catalyst to base our joint plans around the needs of the person with dementia.

The models that have proved beneficial in improving care for people with dementia and influenced service redesign and pathway development are:

- South Devon Partnership Integrated Care Pathway for dementia
- Healthcare for London Dementia Services Guide: Integrated Care Pathway
- Torbay Care Trust – Integrated Care for Older People

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

In North Kent we have a number of active forums that have been the vehicle for delivering changes in the dementia pathway. These are listed below:

- Dementia Strategic Oversight Group (People with dementia and Carers)
- Dementia Forums
- Kent Dementia Action Alliance
- Practice Participation Groups
- Dementia Friendly Communities forums

The feedback from people living with a dementia type illness and people who care for them .gives a valuable insight into the perceptions of the local community as well as their ideas on how to improve things.

Many of those who had either first hand or experience as a carer of someone with a dementia type illness expressed concern about how there is no obvious pathway to guide those affected. Some people had struggled to manage and cope, often only getting assistance at a crisis point.

This is reinforced in the Dementia in Kent 2010, Public Health Annual Report which highlighted that 37% of admissions of patients with dementia resulted from patient and/or carer being unable to cope (in conjunction with fall with no bone injury, poor mobility and/or increased confusion). This is supported by results released by Kent County Council (Personal Social Services Research Unit, 2008) highlighting that carer breakdown was a contributory factor in 31% of all care home admissions.

We will continue to work with these groups and the improvements will be evaluated by

the use of questionnaires to both staff within the hospitals and community services and families of people with dementia.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A range of key performance indicators will be developed for regular monthly reporting, and there will be monthly meetings between the commissioner and provider to monitor performance against these. Baseline measures on all indicators will be collated to accurately measure quantifiable benefits. A central database has been developed to enable regular monitoring of performance and activity against agreed key indicators, assist resource planning, support service audit (e.g. equity of service) and evaluation. The metrics for monitoring the impact of the integrated care pathway are contained in service specifications and information is provided on a monthly basis to measure the success of the contract and to control spend and measure savings. The metrics form part of an overall dashboard measuring achievement against all BCF projects to achieve a 10% reduction in admissions to Acute Hospitals and support the key performance indicators relating to the Integrated Discharge Team and Integrated Primary care teams in reducing unplanned admissions and reducing lengths of stay and includes the following:

Metrics for dementia service improvements include:

- Reduced lengths of stay for non-elective >65s
- Reduction in admissions to Acute Hospital for people with cognitive impairment
- Reduction in the number of patients presenting monthly at A&E with cognitive impairments
- Reduction of crisis episode
- Reduction in people progressed to permanent support (Residential/Nursing care)
- Increase in dementia diagnosis rate to 60% predicted prevalence25% people with confirmed diagnosis of dementia with a shared integrated care plan

To assess the qualitative impact of the service improvements, patients, carers and staff (managerial and clinical) views will be sought to help shape the services, develop the protocols and meet the needs of the community whilst operating to national frameworks and standards. Each provider must complete regular surveys, act upon the results, feedback to the patients and provide opportunities for patients to become involved in service improvement.

Systems are in place to involve the following stakeholders in the ICP development process:

- multi-agency and multidisciplinary workforces (including advocacy services and
- voluntary organisations)
- service users, and
- informal carers.

What are the key success factors for implementation of this scheme?

The development of the Integrated Care pathway follows the 8 pillars of care from raising awareness through to early diagnosis, living well in the community to end of life care. The pathway will be developed in a phased approach with the initial phase focussing on integrated community care establishing mental health expertise in Integrated Primary care teams in the community, effective interventions in times of crisis and timelier discharge from acute hospitals by the provision of home care, night sitting

and support for the carer.

The three areas of initial focus were identified from collaborative working between health, social care, Acute hospitals, Community services and voluntary sector organisations. A process mapping exercise was conducted in the early stages of the ICP development to:

- identify current patterns of service delivery and available resources
- examine the journey of care for service users and informal carers
- establish the strengths and weaknesses of current service provision
- quantify demands on the services
- identify the gaps in services
- identify gaps in staff skills and competencies, and
- identify how the journey of care can be improved

A range of case studies highlighted gaps and fragmentation within the current system
Agreement was reached on a number of service improvement standards and the introduction of revised processes as people move through the care system.
The introduction of a fully operational service user held care plan shared between agencies underpins the development of the integrated pathway.

North Kent Clinical Commissioning Groups

Scheme ref no.

3a

Scheme name

Integrated Discharge Team, Medway and Swale

What is the strategic objective of this scheme?

Our vision for health and care services is to deliver the right care at the right time in the right place, providing seamless integrated care for patients, particularly those with complex needs.

Evidence shows that patients with complex needs often stay longer than necessary in an acute hospital bed. By providing appropriate care outside of the acute hospital setting, patients can be discharged more timely and supported in the community, in or as close to their homes as possible, with effective personalised care plans.

To deliver our vision, the strategic objective of the Integrated Discharge Team (IDT) is to facilitate safe, timely discharge while reducing emergency admissions by working to a 'home is best' philosophy.

The service delivers a multi-agency approach to facilitate discharge for complex patients from acute care whilst ensuring:

- The best possible outcome for the patient
- Timely access to a range of community based health and social care services
- Optimum use of acute/community and social services resources.

By working with the 'home is best' principle, the IDT ensures patients are discharged home, wherever possible, with the appropriate care package to maximise independence and empower people to manage their own health and wellbeing.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Integrated Discharge Team (IDT) was introduced towards the end of 2013 to support complex discharges at Medway Foundation Trust. This is a multidisciplinary team comprising of health and care professionals working together to facilitate safe and timely discharges for patients with complex needs, 7 days a week.

The team brings together the Community Navigation Team, Social Care Teams, Rapid Response, Community Nursing, Hospital Discharge Team, Acute Fragility and the Swale In-Reach Team.

The population focus is mainly, but not restricted to, those over the age of 65 with one or more long term condition, with the aim of facilitating 15 discharges per day. Providing a 7 day service, this equates to 5475 per year.

The aim of the IDT is to:

- deliver a multi-agency approach to facilitate timely discharge for patients whilst ensuring the best possible outcome
- provide optimal care packages in the community to support patients on discharge in retaining independence in their usual place of residence,
- where possible
- avoid premature admission of patients to acute care and transfer them to where care can be delivered in a more appropriate environment that is conducive to patient's need. Admission to acute hospital care will not be prevented, where it is clinically required.
- avoid the premature admission of patients into long-term care, where clinically appropriate.
- reduce the number of re-admissions of patients with chronic long term conditions.

Hosted by Medway Community Healthcare, the IDT sits within Medway Foundation Trust and facilitates the co-ordinated admission, navigation and transfer of care across the Medway and Swale health economy.

The team expedites all complex patient discharges across all hospital wards, Emergency Department (ED) and the assessment/observation units 7 days a week - 8.00am-8.00pm Monday to Friday, 8.00am-4.00pm weekends and Bank holidays.

The IDT is structured in three cluster teams supporting ward staff with discharge planning. A fourth cluster is responsible for the emergency wards, including A&E, Observation ward, CDU, AMU and SAU, focussing on admission avoidance, where appropriate, by assessing and implementing care packages to support a return to home with support. A physiotherapist, occupational therapist and dedicated care manager are part of the forth cluster.

Planned discharges that do not take place are reviewed and shared daily with hospital managers to understand what the delay is attributable to, enabling improvements to be identified and actioned.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The IDT is jointly commissioned by Medway and Swale Clinical Commissioning Groups

and implemented and hosted by Medway Community Healthcare (MCH). The team consists of members of staff from the following organisations:

- Medway Foundation Trust
- Medway Council
- Kent County Council
- Medway Community Health Trust
- Kent Community Health Trust

Kent and Medway Partnership Trust provide in reach mental health support.

The team is overseen by the IDT Clinical Service Lead, employed by MCH with each employing organisation responsible for the management of their staff.

The team operate within agreed criteria ensuring the whole discharge pathway is considered and patients are actively managed post discharge.

All Parties are responsible for meeting the outcomes and Key Performance Indicators set down by the CCG and work together to address all issues that arise.

Overall operational performance is reported weekly by the Operations Director of MCH through the whole system executive conference call. The weekly executive conference call, chaired by the Chief Operating Officer of the Medway Clinical Commissioning Group, has representation from all key provider organisations across Medway and Swale therefore operational issues requiring whole system input or support are addressed at executive level.

KPIs are reported on a monthly basis to the commissioners with the strategic governance of the IDT being led by the Medway and Swale Executive Programme Board.
Any operational issues requiring whole system input or awareness are reported through the weekly executive conference call.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Driven by an increasing number of delayed discharges and transfers of care from Medway Foundation Trust, a whole system discharge process planning workshop was hosted in June 2013 by Medway and Swale CCGs. The aim of the workshop was to bring together the organisations that play a role in facilitating discharge from both the acute and community hospitals. 50 delegates (operational and strategic leads) representing all key stakeholders were involved in the workshop.

Delegates reviewed the existing processes to identify the ‘As Is’, starting from the time a patient presented in the emergency department to the time of their discharge home or transfer to an alternative care setting. From this necessary steps and key actions to support effective and rapid discharge from hospital, for patients deemed medically fit, were determined.

A number of recommendations from the workshop were signed off by the Medway and Swale Executive Programme Board. Priority was given to the rapid development of single integrated discharge team, hosted by Medway Community Health Trust, working within MFT, to support proactive admission avoidance and timely effective discharge planning for complex patients.

In recent months, the Emergency Care Intensive Support Team (ECIST) have undertaken work with the local health economy both at a Trust and whole system level and continue to provide support to improve timely discharges 7 days a week.

The Emergency Care Intensive Support Team (ECIST) have undertaken work with the local health economy both at a Trust and whole system level in recent months and continue to support key whole system pieces of work.

In addition to the work with ECIST, the Oak Group were commissioned in the latter part of 2013 to undertake audits of acute (admissions and beds) and Community (beds) across North Kent. At a headline level the audits demonstrated:

Acute (patients already in a hospital bed)

- 44% of non-qualified admissions could have been prevented by providing a variety of services at home.
- 46% of all continuing days of care could have been provided at home with a variety of services
- A discharge plan was present in 37% of records.
- 95% of these were started post admission and documentation was poor.
- An estimated date of discharge (EDD) was listed for 13% of patient records.
- 41% of patients with an EDD were in hospital beyond the EDD.

Acute admissions (All patients who were admitted though A&E or the assessment units during the prior 24 hours were retrospectively examined)

- 21% could have been prevented with only GP or other routine follow-up.
- 78% of patients came through A&E of which 27% were non-qualified.
- 21% came through GP referral of which 37% were non-qualified.

An audit of A&E attendances was undertaken in August 2014, the results of which will help to identify gaps in community service provision to manage people better in the community in future.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

KPIs have been developed for the IDT which are monitored by the Urgent Care group to measure outcomes of the scheme. The agreed KPIs will enable success in admission avoidance and the discharge planning process to be highlighted and quantified.

The current measures are:

- % of patients with EDD set within 24 hours of admission
- % of patients discharged within 24 hours of planned EDD
- % of patients with DTA who have baseline assessment
- Reduction in the number of patients on the medically stable list
- % patients on medically stable list with a discharge plan Reduction in the

number of patients with a length of stay > 15 days, >30 days
- Reduction in the number of placements into social care
- Reduction in the number of readmissions
- Reduction in the number of high cost packages
- Increase in the number of early discharges facilitated by Continuing Health care

This is existing data, generated automatically, which has been reported on previously through various existing data systems.

Dashboards tracking the local metrics are being developed and will also be monitored by the Executive Programme Boards for DGS and Swale.

What are the key success factors for implementation of this scheme?

For patients, success factors are defined by improved patient experience as a result of high quality, seamless care. Being aware of and supported to work towards an expected date of discharge. Feeling supported to live at home with appropriate enablement services

Success factors for the workforce are defined by improved partnership working which breaks down organisational barriers to enable them to deliver optimum care to patients.

North Kent Clinical Commissioning Groups

Scheme ref no.

3b

Scheme name

Integrated Discharge Team - DGS

What is the strategic objective of this scheme?

The objective of the scheme is to reduce emergency admissions ensuring people are treated in the right place at the right time by the appropriate person.

There is empirical evidence that too many patients are inappropriately staying in hospital beds. It is believed that care can and should be more appropriately delivered in the community rather than in an acute hospital bed, using highly responsive, effective and personalised services outside of hospital and in or as close to people's homes as possible.

The aim of the service is to deliver a multi-agency approach to facilitate discharge for patients from acute care whilst ensuring:
- The best possible outcome for the patient
- Timely access to a range of community based health and social care services
- Optimum use of acute/community and social services resources.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

The IDT is a team made up of Nurses, Doctors, Therapists, Pharmacists, Care Managers and Mental Health Specialists working across the acute and community settings. The team operates 8am – 8pm, 7days a week.

The goal is to ensure that patients receive the most appropriate treatment, delivered by the most relevant health care worker in the most appropriate setting – all the time.

The aim of the IDT is:

- to deliver a multi-agency approach to facilitate timely discharge for patients whilst ensuring the best possible outcome
- ensure timely access to a range of community based health and social care services and optimum use of acute/community and social services resources.
- avoid the premature admission of patients to acute care and transfer them to where care can be delivered in a more appropriate environment that is conducive to patient's need. Admission to acute hospital care will not be prevented, where it is clinically required.
- avoid the premature admission of patients into long-term care, where clinically appropriate.
- reduce the number of re-admissions of patients with chronic long term conditions.

This is achieved through the following objectives:

- that Discharge Planning begins at the point of admission to acute care.
- providing ward staff with support, advice and training regarding discharge planning of both simple and complex patient discharges.
- working collaboratively with community agencies such as Intermediate Care, Continuing Health Care, Therapists, Social Services and Community Matrons to ensure patient needs have been correctly assessed and are appropriately met on discharge.
- ensuring the development of existing discharge services and transfer of care into community settings by developing key relationships with Mental Health, Alcohol Liaison Nurses, Nursing and Residential Homes and Community Nursing Services.
- providing all groups of staff with education and training with regard to discharge planning.
- developing and produce discharge information and literature for patients regarding the discharge process to assist them and prevent delays in their discharge.
- the assessment of complex patients' needs prior to discharge
- development of a "one team" approach

The population focus is mainly over 65's with 1 or more, long term condition although not restricted to.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

There is an SLA in place between all providers – see attached

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Pressure on local hospitals particularly in winter results in substandard care of patients and evidence shows that In the UK up to one million emergency admissions were avoidable last year.

Work carried out for DGS CCG by the Oaks Group in October 2013 identified that within

Darent Valley Hospital:

- 58% of acute admissions could have been avoided by providing a variety of services at home.
- 15% of acute admissions could have been provided for on sub-acute wards.
- 8% of all admissions required supported living environments.
- 36% of continuing stay days were due to discharge planning issues.
- 37% of continuing stay days could have been avoided by providing a variety of services at home.

Examples of successful Integrated Discharge teams and models of provision were identified including, Mid Cheshire, East Cheshire, Nottinghamshire and Glasgow, St Helens.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Comprehensive KPIs have been developed for this scheme and are monitored by the Urgent Care Group. Data is compiled to highlight and quantify the successes in admission avoidance. There are Whole health Economy KPIs and the IDT has a set of proxy measures that have been developed to identify success and also where the delivery model may need changing.

Current measures are:

- % of patients discharged within 24 hours of planned EDD
- Reduce number of patients on medically stable list
- Reduce patients with Length of Stay > 15 days
- % patients on medically stable list with a discharge plan
- % of patients on medically stable list with diagnosis of dementia / Mild Cognitive Impairment
- % of patients with a LoS > 15 days on the medically stable list
- % of patients reviewed by the IDT (exclude IDT GP) in A&E
- % of patients reviewed by IDT (exclude IDT GP) in A&E and discharged back to usual place of residence
- Patients seen by IDT GP
- Total number of patients seen by IDT GP appropriate for Primary Care
- Decrease in readmissions to an acute bed for same condition within 30 days
- Decrease in readmissions to an acute bed with an exacerbation of a Long Term Condition (HF/COPD/Diabetes)
- Numbers admitted to long term care

Dashboards tracking the local metrics are being developed and will be monitored by the Executive Programme Boards for DGS and Swale:

What are the key success factors for implementation of this scheme?

Success factors are defined by patient experience reporting high quality seamless integrated care, a reduction in emergency admissions and admissions to long term care.

Increase in the number of people living at home with enablement services.

South Kent Coast Clinical Commissioning Group

Scheme ref no.

1

Scheme name

Integrated Teams and Reablement

What is the strategic objective of this scheme?

Integrated teams available 24 hours a day seven days a week will be contactable through single access points. Patients will know who they should contact within these teams whenever they need advice and support. The teams will undertake single assessments and coordinate onward referrals and comprehensive care planning and will provide enhanced rapid response to patients at high risk of hospital admission providing intermediate care and rehabilitation in the community. The teams will integrate with the hospital discharge planning and referral processes seven days a week and coordinate post-discharge support into the community linking with the community based Neighbourhood Care Teams, primary care and the voluntary sector.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Integrated Intermediate Care Pathway & flexible use of community based beds

- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care, supported by single access points;
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services ensuring transfer to most appropriate care setting (including patients own home);
- Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- Community hospital beds only to be used for comprehensive assessments, for patients needing 24/7 nursing rehabilitative care and for carer respite;
- Community based beds (in any local setting) will provide 60% step down from hospital and 40% step up to support timely hospital discharge and prevent avoidable hospital admissions and re-admissions. These beds will be used flexibly to effectively respond to changes in demand.

Enhanced Rapid Response – supporting acute discharge/preventing readmission

- Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals;
- The teams will be integrated with Emergency Care Practitioners to ensure enhanced skills are available and supporting the ability to keep sub-acute patients at home;
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home;
- The teams will integrate with the Dementia Crisis Service which can receive

referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions.

Integrated rehabilitation & Non Weight Bearing Pathway

- Integrated approach to support timely hospital discharge, rehabilitation and intermediate care for patients including non-weight bearing patients;
- Proactive case management approach to support timely transfer of patients from acute beds into the community and preventing admissions into acute from the community;
- Integrated step up and step down beds supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

Patient Cohorts (examples of client group this scheme will target)

- Patients requiring sub-acute whose condition has exacerbated in the community (such as a fall or a UTI) or following treatment in hospital, for time limited periods who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential/Nursing care or continuing NHS inpatient care;
- Patients whose carers are in crisis;
- Patients requiring rehabilitation (Occupational Therapy or Physiotherapy) in the community or within a care home/intermediate care facility;
- Adults aged 18 and over, although primarily older people, residing in their own homes or in an intermediate care facility with the ultimate aim of returning to their own home to maximise independence and recovery including patients requiring neurological rehabilitation.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced teams will be developed through workforce reconfiguration across KCHT and secondary care. Scoping of staffing reallocation and cost savings is underway, led by SKC CCG in collaboration with service providers.

Delivered by KCHT, ambulance services, EKHFUT, KCC

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Schemes were selected based on evaluation of high impact schemes identified by the Kings Fund and other best practice evidence, supported by evaluation of Public Health England information on long term conditions and where impact would be most effective in South Kent Coast.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions by 3.5%;
- Reduced A&E attendances;
- Reduced hospital admissions and re-admissions for patients with chronic long term

conditions and Dementia;
- Improve patient experience by 4%;
- Improve health outcomes;
- Reduced length of stay;
- Improved transfers of care;
- Reduced long term placements in residential and nursing home beds by 5%;
- Reduced need for long term supported care packages;
- Increase patients returning to previous level of functionality in usual environment

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 250 through prevention of readmissions.
- Improve the step-down and step-up ratio for community hospital beds (target 60/40).
- Development of cross service clinical audit is in progress. This work will monitor multi-agency contacts to ensure effectiveness of integrated teams.
- Increase in Community Services admission avoidance (targets to be agreed)

These KPIs will be monitored by the Intermediate Care group.

What are the key success factors for implementation of this scheme?

This scheme will build on existing teams, but will redevelop fragmented pathways to create streamlined care from prevention to treatment through to end of life. Integrated enhanced services will be developed with clear and prescriptive deliverables and strengthen definitions of required skills mix within team. Providers and clinicians are currently engaged in agreement of redesigned specifications and pathways.

South Kent Coast Clinical Commissioning Group

Scheme ref no.

2

Scheme name

Enhance Neighbourhood Care Teams and Care Coordination

What is the strategic objective of this scheme?

This model builds a team around the patient who focus holistically on the patients overall health and well-being and pro-actively manages their needs. These teams will be further enhanced to ensure wider integration with other community and primary care based services as well as hospital specialists working out in the community and mental health teams to ensure people can be cared for locally and in their own homes wherever possible and using technology for virtual ward rounds or consultations and remote guidance for GPs rather than patients attending hospital. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Risk Profiling to enable Proactive Care of patients who are at both high and low risk of hospital admission to deliver more coordinated patient care in the community (see section d below for further details of the South Kent Coast Pro-Active Care Programme)

- Aligned to every GP practice the Neighbourhood Care Teams will be accessible 24 hours a day seven days a week and will coordinate integrated proactive care management of patients through a multi-disciplinary approach with patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;
- The Neighbourhood Care Teams function as integrated teams and provide continuity of care for patients who have been referred for support in the community and form the main structure in providing post hospital discharge care and some pre-admission interventions as well as seamless coordination and delivery of End of Life care;
- The Neighbourhood Care Teams will form the main structure in providing post hospital discharge care and some pre-admission interventions and will be integrated with pathways to asses a patients home environment;
- Access into and out of the Neighbourhood Care Teams will be coordinated through clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments. This single point of access will be integrated with social services and will be linked with secondary care via a flagging system to report when patients known to the teams have been admitted into secondary care;
- Each Neighbourhood Care Team will include input from the wider community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, and Social Care Managers as part of the multi-disciplinary approach;
- The teams will support patients with complex needs to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health;
- The Neighbourhood Care Team will be able to access the relevant care package required to support the person for the time required.

Specialists to integrate into community based generalist roles

- The enhanced Neighbourhood Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms (respiratory, diabetes, heart failure and COPD) including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology, such as video conferencing with acute specialists.

Patient Cohorts (examples of client group this scheme will target)

- Adults aged 18 years and over with long term conditions, including respiratory, diabetes, heart failure and COPD, and advising their carers;
- Patients who require general nursing input and those that are housebound.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Enhanced teams will be developed through workforce reconfiguration across KCHT and secondary care. Scoping of staffing reallocation and cost savings is underway, led by SKC CCG in collaboration with service providers.

Provided by KCHT, KCC, and GPs

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Schemes were selected based on evaluation of high impact schemes identified by the Kings Fund and other best practice evidence, supported by evaluation of Public Health England information on long term conditions and where impact would be most effective in South Kent Coast.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient experience;
- Increase levels of patient self-management of long term conditions;
- Improve health outcomes;
- Reduced spend on drugs;
- Reduced duplications across the health and social care system;
- Reduce the needs for long term placements in residential and nursing homes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 108 through proactive care.
- Reduction of long term placements (10)
- Increase in Community Services admission avoidance (targets to be agreed)
- Development of cross service clinical audit is in progress. This work will monitor multi-agency contacts to ensure effectiveness of integrated teams and quality of anticipatory care plans.

These KPIs will be monitored by the Proactive Care & Primary Care Groups.

What are the key success factors for implementation of this scheme?

This scheme will build on existing teams, but will redevelop fragmented pathways to create streamlined care from prevention to treatment through to end of life. Integrated enhanced services will be developed with clear and prescriptive deliverables and strengthen definitions of required skills mix within team. Providers and clinicians are currently engaged in agreement of redesigned specifications and pathways.

South Kent Coast Clinical Commissioning Group

Scheme ref no.

3

Scheme name

Enhance Primary Care

What is the strategic objective of this scheme?

- Integrated community models of care centred on GP practices requires significant change in primary care working patterns.
- Different models need to be developed to ensure the right levels of support and capacity is available within general practice and to support the development of sustainable local communities.
- This will include a primary care hub in each town linking all practices around the local hospitals that will host primary care services 7 days a week from 8am to 8pm and work closely with the existing MIU to develop integrated working.
- A pilot will commence in two towns with a view to including a 'hub' of practices in every community to improve access to a full range of local health and social care services which will support the move from a medical focused model of care and shifting towards a health and well-being focus.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Integration of all GP practices within a community offering extended primary care service 8am – 8pm 7 days per week, linked to the local hospital
- A GP clinical system would be installed at the hospital and consulting rooms established for GP's and nurses.
- The system would be linked via the Medical Interoperability Gateway (MIG) to all local practices and software installed to enable data entry onto multiple systems.
- An integrated telephone system would be installed that enables all practices to have calls re-directed and to offer telephone appointment booking.
- There will be an urgent visiting service provided by paramedics and supported by GP's.
- In some cases patients may be transported to the 'hub' either by paramedics or other local transport services.
- There will be primary care mental health specialist offering assessments either at the hospitals or at home. They will also provide support to GP's with mental health queries.
- The service will be available to all patients within the CCG with an aim of increasing capacity within primary care and reduce burden on acute services

Develop primary care based services with improved access and integrated with other community and specialist services

- GPs have started to undertake proactive case management of patients including regular medication reviews, proactive working with patients to avoid admissions. This will require closer working with social services working with at risk patients to avoid crisis and better use of carer support services. This could also include virtual ward rounds of at risk patients following hospital discharge;
- GP practices to be clustered in hubs and configured in a way that enables different access opportunities for patients to include open access and access to other practices in the hub to improve responsiveness of service provision;

- Develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the Neighbourhood Care Teams as well as stronger links with and signposting to the voluntary sector;
- Integrated primary care provision will have greater support from specialist hospital teams to ensure on-going medical care for patients after hospital discharge by creating shared on-going care plans to avoid hospitals readmissions and stronger links with rapid response services to enable patients to remain out of hospital;
- GP practices to link with the support to care homes pathways to provide more intensive support.

Primary care service will support and empower patients and carers to self manage their conditions

- Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways;
- Primary care and the Neighbourhood Care Teams will increase the use of technology, such as telehealth and telecare, to assist patients to manage their long term conditions in the community.
- The Neighbourhood Care Teams will educate patients about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;
- Patients will be supported by the Neighbourhood Care Teams and primary care to inform and take ownership of their care plans. Care plans have started to be shared via MIG functionality between health and social care professionals and this will be rolled out over the coming months.
- Improved signposting and education and access to signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies. GPs will signpost patients with early signs of mental health concerns to the right services
- Develop a Health and social care information advice and guidance strategy to enable people to access services without support from the public sector if they choose to.
- Plans in place to implement enhancements in care for over 75's which includes anticipatory care planning for a range of cohorts: patients in care/nursing homes, patients in the community that have an ambulatory sensitive condition as well as patients that are housebound with long term conditions.

Patient Cohorts (examples of client group this scheme will target)

- All patients accessing services who have a primary care need, particularly those at risk of hospital admission and those who can self-care in the community setting.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- The providers within this scheme are essentially our GP Practices who work as independent contractors
- The integration aspect of this scheme is being supported by a nationally funded pilot to test this approach within two local communities and if successful will be rolled out across the entire CCG
- Initially this will be delivered by a local Community Interest Company (Invicta Health) and commissioned by NHS England but with support and guidance being inputted by

the CCG
- If the pilot demonstrates the required enhancements to primary care, South Kent Coast CCG will commission the service going forward and with a view to rolling out across the CCG
- Many other providers will be involved as the integration work is accelerated that will include South East Coast Ambulance NHS Trust, East Kent Hospitals NHS Foundation Trust, Kent Community Health NHS Trust, Out of Hours providers, Mental Health providers, 111 as well as social services and voluntary sector providers.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1. mprove the patient experience by:
   - mproving access to general practice by providing 7 day opening
   - nhancing care through service integration
   - roviding more GP input for patients with complex needs

2. ddress GP recruitment and retention issues by:
   - ddressing workload concerns
   - eveloping alternative career structures

3. evelop service and system integration by:
   - rapping GP services around community services
   - ederating models of provision
   - eveloping hub and spoke arrangements (the hubs will be located in two community hospitals and other hubs will be developed in other communities)
   - ntegrating IT systems and shared access to medical records
   - ore patients will be managed at home with greater community support.

The will improve access for patients by providing 7-day primary care and enhance the care for elderly and frail patients by increased availability of GPs and improved co-ordination and continuity. This is intended, in conjunction with other local schemes, to reduce demand on A&E and OOH.

It also allows practices to trial an alternative provision for OOH in collaboration with 111. The introduction of primary care mental health assessments will improve care for patients presenting with urgent mental health needs and reduce demands on secondary mental health.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions;
- Reduced A&E attendances;
- Improve patient satisfaction and well-being;
- Increase levels of patient self-management of long term conditions;
- Increase levels of patients with personal health budgets and integrated budgets;
- Improve health outcomes by better use of prevention services.
- Increased levels of capacity within primary care
- Increased level of integration between healthcare professionals and providers

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions by 259 admissions in year through over 75s schemes impact on ambulatory care sensitive conditions and urinary tract infections.
- Development of cross service clinical audit is in progress. This work will monitor quality of anticipatory care plans.
- Increased GP opening hours
- Medication reviews

These KPIs will be monitored by the Primary Care Development group.

What are the key success factors for implementation of this scheme?

- Creating enhanced access and capacity within primary care
- Integration of services against delivery of certain requirements e.g. MH, IT
- Improved system efficiency to reduce A&E and OOH activity and improve patient outcomes and experiences

South Kent Coast Clinical Commissioning Group

Scheme ref no.

4

Scheme name

Enhance support to Care Homes

What is the strategic objective of this scheme?

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory can plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions and to improve those patients care and support in the community.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

An integrated local community based Consultant Geriatrician and specialist nursing team providing support to care homes

- The integrated team for older people can be referred to directly and is aligned to the Neighbourhood Care Teams and the Integrated Intermediate Care teams to undertake reviews all care home discharges from hospital and A&E and ensure appropriate community based services are in place to support patients as part of their discharge planning. These discharge plans will be in place for every patient and known to all community based teams. The team will also undertake anticipatory care planning with the patients and their carers;
- The consultant works in the community providing advice to GP in the treatment and support for patients and along with the wider team provides additional support, advice and guidance to care homes, primary and community services in the management of older people;
- Access to specialist services such as Dementia Crisis will be available to support care homes, through the integrated working model of, 'Enhanced Support to Care Nursing Homes'

Patient Cohorts (examples of client group this scheme will target)
Adults residing within a care home setting (nursing and residential) including patients with Dementia.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain is managed by CCG Commissioning comprised of clinical commissioner input and commissioning management support.
The CCG has commissioned a Consultant Geriatrician and part of the specialist nursing, element to date from our local Community Provider KCHT and is in process of commissioning two further posts from a CIC Invicta with an agreed start date for one post Nov 1st and the second post within the same timescale. The service specification sets out that the providers will work in a MDT, integrated way building on the existing integrated team structures currently in place.

The CCG has commissioned the Geriatrician Services from an independent organization, with a service specification in place that requires a model of integrated working.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The ratio of care nursing home beds per CCG capita (we have the highest in Kent)
An earlier pilot of the Enhanced support to Care Nursing Homes demonstrated a reduction in A&E attendances and subsequent financial savings. A 54% of all clients reviewed in care homes had their medications reduced or changed and there was an increase in the number of Care Management/ACPs initiated for patients in care nursing homes.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduced emergency admissions from care nursing homes; comparing admission rates before and after the pilot
- Reduced A&E attendances from care nursing homes comparing admission rates before and after the pilot
- Reduce unnecessary prescribing; patients seen by the Consultant Geriatrician reviews medications and stops, reduces or changes prescriptions
- Improve patient satisfaction through personalised care planning; patients (and their families) have improved awareness of understanding of their care, what is required of them and what to expect from the provider(s). Indirectly communication is improved around, capacity and DNAR information.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

• Admissions data feedback loop will be via the established CCG care nursing home dashboard, that sets out nos. of admissions from care homes (rate of beds), top diagnosis rates, HRGs and Primary Diagnosis

• While social care performance monitors individual care nursing home contracts, the CCG and LA meet every 6 weeks to triangulate performance/quality data and information to agree comes to target to provide support, advice and guidance in the care of the patients supported.

These KPIs will be monitored by the Care Homes group.

What are the key success factors for implementation of this scheme?

The following indictors will be used to monitor success of the scheme:

- Reduce unplanned admissions from care homes by 90.
- Development of cross service clinical audit is in progress. This work will monitor quality of anticipatory care plans.
- Medication reviews

Scheme ref no.

5

Scheme name

Integrated Health and Social Housing approaches

What is the strategic objective of this scheme?

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their condition in a safe home environment.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

An integrated approach to local housing and accommodation provision to enable, supported by a joint Health and Social Care Accommodation Strategy, to enable

more people to live safely in a home and other environments and to enable people to be discharged from hospital in a timely manner into the appropriate environment.

- Current bed based facilities (step up and step down) to be flexible and broadened to use housing schemes;
- Promote developments of wheelchair accessible housing to support the reduction of costly adaptations;
- Responsive timely adaptations to housing;
- Preventative pathways to enable patients and service users to return to (following hospital and care home admissions) and remain in their homes safely including full holistic home safety checks;
- Flexible housing schemes locally;
- Increased provision of extra care housing locally, including a facility to support patient rehabilitation or carer respite for short periods of time with clear criteria and processes for accessing such facilities;
- Different types of supported accommodation for those with learning disabilities and mental health needs.

Patient Cohorts (examples of client group this scheme will target)

- Patients who require additional additional support to enable them to remain their own homes or to be rehoused in a suitable facility that meets their needs. This includes disabled patients, those in wheelchairs and those requiring adaptations to support their rehabilitation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

To be delivered by KCC, Shepway and Dover District Council, KCHT, and KMPT.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Plans developed due to evidence of lack of appropriate accommodation facilities resulting in delayed transfers of care and reduced quality of life.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in emergency hospital admissions by 3.5%;
- Reduced A&E attendances;
- Reduced residential care admissions by 5%;
- Reduced care packages;
- Increased personalisation;
- Reduced delayed transfers of care by 25%;
- Increased patient experience by 4% as more people maintain level of independence in their own home.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?

The following indictors will be used to monitor success of the scheme:

- Reduced length of stay
- Reduced delayed transfers of care by 2.5%.

These KPIs will be monitored by the Integrated Commissioning Group.

What are the key success factors for implementation of this scheme?

Improvement in discharge process and improved access to appropriate housing options

South Kent Coast Clinical Commissioning Group

Scheme ref no.

6

Scheme name

Falls prevention

What is the strategic objective of this scheme?

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care teams to undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

The existing falls pathway will be refreshed to reflect the various settings the patient could present, e.g. GP, MIU, Walk in Centres. The pathway will clearly show the appropriate action professionals should take when dealing with a potential faller or patient that has already fallen. The pathway will include signposting to vision screening, hearing tests, medication reviews, exercise groups and environmental such as housing assessments.

- Level of current services across locality will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians, audiologists and the voluntary sector;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

Patient Cohorts (examples of client group this scheme will target)

- Patients who are at risk of or have fallen. Patients at most risk include the elderly, those with muscle weakness, cardiovascular problems, medication education needs and those living in poor housing environments.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

South Kent Coast CCG has been working with colleagues from EKHUFT, KCHT, the voluntary sector, CCG GPs together with patient representative to develop falls pathway. The commissioners involved from the CCG are Sue Baldwin and Hilary Knight.

Investment in specialised falls and fracture prevention service is contingent on savings identified by schemes 1 and 2.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

South Kent Coast CCG has seen a rise in the number of non-elective admissions due to falls over the last 3 years. There were 894 new attendances at the outpatient fracture clinics in East Kent Hospitals University Foundation Trust (EKHUFT) for South Kent Coast patients aged 65+ for the period 1 April 2012 - 31 March 2013. By focussing on falls prevention the CCG hopes to see a decrease in these numbers. The development of a robust falls prevention pathway and scoping of relevant services will inform patients and professionals of what is available to them, e.g. Active for Life, walking groups etc.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in falls and secondary falls by 10%;
- Reduction in hip fractures;
- Improve patient experience and levels of self-management by 4%;
- Reduced emergency admissions by 3.5%;
- Reduced A&E attendances.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The CCG should see a reduction in falls related attendances in secondary care, we will be able to measure this by comparing activity data prior to and after the refreshed pathway. We will engage with patients to understand their experience of the falls prevention service.

The following indictors will be used to monitor success of the scheme:

- Reduce admission from falls by 10%

These KPIs will be monitored by the Falls group.

What are the key success factors for implementation of this scheme?

The main key to success will be for the refreshed pathway to be adopted by the relevant agencies to ensure that patients are signposted appropriately to the correct service, providing the patient with a positive experience and seamless service.

Thanet Clinical Commissioning Group
Scheme ref no.
THA01
Scheme name
Enhanced Primary Care
What is the strategic objective of this scheme?
The strategic objective of this scheme is to improve access to a full range of local health and social care services to support the move from a medical focused model of care and shifting towards a health and social care well-being focus. Integrated community models of care centred on GP practices requires significant change in primary care working patterns. New models need to be developed to ensure that the right levels of support and capacity are available within primary and community care settings. This will include alliances of GP practices working together in every community.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• GP practices will work together in a way that enables different access opportunities for patients to include extended access via access to other practices in the town to improve responsiveness of service provision; • We will develop an approach which increases opportunities for patients to have their wider health and well-being needs supported by primary care. This will require stronger integration with the integrated community care teams as well as robust links with and signposting to a range of services provided by the voluntary sector; • Integrated primary care provision to have greater support from specialist hospital teams and stronger links with rapid response services to enable patients to remain out of hospital. • GP in Accident and Emergency at the acute hospital in Margate will forge links between the acute hospital staff and Primary care colleagues, this will also provide challenges to colleagues where appropriate if the need for hospital admission is questionable. Equally this will also challenge why people may be admitted if primary and community care plan is sufficient to look after the patient in their own home. • The Integrated Discharge Team based on the acute site will also assist in managing attendances at A&E/ Clinical Decision Unit to liaise with primary and community care colleagues to avoid unnecessary admission and facilitate safe discharge at the most appropriate point in the care pathway. • Professionals in primary care will promote the use of integrated personal health budgets for patients with long term conditions and mental health needs to increase patient choice and control to meet their health and social care needs in different ways; • Primary Care and the Integrated Care Teams will increase the use of technology, such as tele-health and tele-care, to assist patients to manage their long term conditions in the community; • Patients will be given the opportunities to be educated about their long term condition as well as about preventative services such as weight management and alcohol services as part of the multidisciplinary assessment;

- Patients will be supported to inform and take ownership of their care plans which includes electronic sharing of care records with the patient and between health and social care professionals;
- Primary Care will work with the local community to ensure the correct information, advice and guidance is available to help manage long term conditions
- Improved signposting and education will be available to patients through care coordinators and Health Trainers to ensure patients are given information about other opportunities to support them in the community, including the voluntary sector, and community pharmacies.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This will be delivered primarily by the 20 GP practices in Thanet.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Self-care interventions can reduce hospitalisations, improve outcomes and reduce costs for the system. For example, one study found that supported self-management had the strongest effect on clinical outcomes of all integrated care interventions, and reduced hospitalisations by 25-30%.

The evidence base highlights the following techniques:

- Involving patients in co-creating personalised self-care plans
- Telephone health coaching
- Tailoring interventions to the condition (e.g. structured education for
- diabetes self-care, behavioural interventions for depression)
- Programmes to encourage lifestyle and behavioural change

Further evidence on self-care:

- Naylor et al (2013) 'Long term conditions and mental health – the cost of comorbidities'
- Purdy S (2012) Avoiding hospital admissions: what does the research evidence say? London: the King's Fund
- De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation
- A NICE Local Practice example is available at: Self-care support for long term conditions
- For guidance on making a local business case for self-care, please see the work done by the NESTA people powered health programme: 'The business case for people powered health'

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes

- Improved ability for patients able to access primary and out of hospital care
- Improved responsiveness of service provision
- More patients seen by the right person in the right place
- Reduced hospital admissions

Metrics

- Access to primary care
- Patient satisfaction
- **%** of patients able to access hospital care in the community

Thanet Clinical Commissioning Group

Scheme ref no.

THA02

Scheme name

Integrated Health and Social Care teams including enhancing community teams and care co-ordination

What is the strategic objective of this scheme?

- The strategic objective is to deliver access to services seven days a week, contactable through a single access point via a Local Referral Unit. Links between services will be facilitated by greater use of technology (BT Cloud, MIG, Share my care) to share clinical information to assist with clinical decision making out of hospital – using a care navigation approach to manage and signpost referrals appropriately.
- Access to a rapid response service will be available to patients at high risk of hospital admission and coordinate intermediate care and support in the community, including the use of community beds. This model builds community care teams wrapped around the patient at the centre to support and pro-actively manage their needs. The teams will be further enhanced to ensure integrated working between GP practice, community and social care with specialist input from hospital, mental health and community services as required in order to keep people in their own homes. The teams will be aligned to every GP practice, will undertake Multi-disciplinary Team meetings and will include designated care coordinators for all patients.
- The team will also develop a robust integrated discharge process and coordinate post-discharge support in the community. Patients will know who to contact in the team whenever they need advice or support.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Aligned to every GP practice the Community Integrated Care Teams will be available 24 hours a day seven days a week and will coordinate the integrated proactive care management of patients through a multi-disciplinary approach with

patient involvement at every stage of the process including the development and access of anticipatory care planning to ensure patient centred care and shared decision making;

- The Community Integrated Care Teams function is to provide continuity of care for patients who have been referred for short term or long term support in the community.
- They will provide post hospital discharge care and rehabilitation and some pre-admission interventions as well as seamless coordination and delivery of End of Life care.
- Access into and out of the Care Teams will be coordinated through a clinically supported single access points. Patients who require assistance by more than one professional will receive coordinated integrated assessments.
- Each Care Team will include input from the community nursing teams, Health Trainers, Pharmacists, Therapists, Mental Health specialists, Social Case Managers and the voluntary sector as part of the multi-disciplinary approach
- The community services nursing model will ensure continuity of care by training the core team as “universal nurses” who will manage the majority of individual patient nursing needs, ensuring that specialist input is appropriate and timely
- Patients with complex needs will be supported to better manage their health to live independent lives in the community, including supporting and educating patients with their disease management by using technology, for as long as possible empowering them to take overall responsibility for managing their own health.
- Integrated pathway to coordinate referral management, admissions avoidance and care coordination across health and social care and voluntary sector, supported by single access point(s) Links between services will be facilitated by greater use of technology (BT Cloud, MIG, Share my care) to share clinical information to assist with clinical decision making out of hospital – using a care navigation approach to manage and signpost referrals appropriately. A single access point for Thanet would streamline access to alternative care pathways for a range of referring professionals ,including GPs, SECAMB, AHPs, IDT .providing a “one stop shop” approach for access and/or referral to a range of community based services including community, care management and voluntary services.
- Care coordination will be in place to co-ordinate appropriate support such as information, advice and guidance, befriending, medicines management, rehabilitative or enablement short term support as appropriate (care co-ordinators will be in place where appropriate to do this)
- Integrated assessments to ensure responsive onward referral to either rapid response services or intermediate care services in patients own home where possible and only if necessary ensuring transfer to most appropriate care setting Rehabilitative or Enablement Intermediate care provision to be provided at patients own home wherever possible by professional carers or by a multidisciplinary team of therapists and nurses;
- The team will support the integrated discharge team in the hospital and ensure that they will be available to support people in their own home in response to patients in A&E within 2-4 hours of referral and initiate a co-ordinated admission avoidance intervention.
- The team will work closely with paramedic practitioners to support care homes to assess, diagnose and treat patients as an alternative to non-elective admission via A&E. Enhanced Rapid Response teams supporting admissions avoidance as part of intermediate care provision as well as respond directly to A&E referrals.
- Integrated discharge teams will be in place in the acute hospital that will link with the community services, this team will know what the patients care plan and wishes are, they will link with primary care to work with the primary care plan.
- Develop a robust integrated discharge referral service to support the patient in the

first 5-7 days post discharge, by integrating with the hospital discharge planning processes and coordinating post-discharge support in the community.

- Medicines use will also be assessed in the first 5-7 days post discharge as this is a major cause of readmission.
- The teams will include medicine management support as well as medical leadership and input from hospital consultants to enable continuous support at home.
- The teams will integrate with the Dementia Crisis Service which can receive referrals 24/7 providing support 24/7 to patients with Dementia and carers of people with Dementia to prevent hospital or care home admissions
- The enhanced Community Integrated Care Team model requires specialist input from acute in the community to enable the management of care for more patients in the community for a range of specialisms including the care of the over 75s, this will include undertaking clinics and reviews of patients in or close to their own homes rather than in hospital. This could include actual and remote approaches supported through the use of technology.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG will commission this through its contracts with EKHUFT, KCHT, and KMPT. KCC will deliver support through Social Care Teams

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Multidisciplinary teams (MDTs) bring together the relevant professionals needed to care for someone with complex needs. MDTs should include everyone required to look after the physical, mental and social health and care needs of the individuals they serve. The aim is to manage the complexity of individual cases and facilitate the delivery of the best possible care.

The evidence base highlights the following techniques:

Multi-disciplinary teams
MDT meetings about every person admitted to hospital
Hire specialists to work in community settings rather than hospitals
Expanded hours for GPs and coordinators
Dedicated housing workers for SEMI/vulnerable groups
Allow nurses or nurse practitioners to prescribe certain drugs
Mental health liaison teams
Direct phone/email access from GPs to MH experts
Further evidence on MDTs:
Holland et al, Heart, 2005, 91, 899-906
Proactive care partnership
http://www.sussexcommunity.nhs.uk/Downloads/services/proactive_care/proactivecare_coastal_leaflet.pdf

Case study examples: NHS North West London, Torbay, Towers Hamlets

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes

- Reduced hospital admissions
- Fully integrated team responding appropriately to the patient's needs

Metrics

- Single access point into the team known to all patients with long term conditions
- Measurement of ability to obtain timely support
- % of care provision undertaken at patient's own home
- Response to known patients presenting to A&E within 2-4 hours of referral
- % patients with long term conditions known to the team
- % of admissions avoided from A&E
- Pre and post evaluation of cardiac rehab programme
- Pre and post evaluation of pulmonary rehab programme

Thanet Clinical Commissioning Group

Scheme ref no.

THA03

Scheme name

Flexible use of Care Homes and Westbrook House

What is the strategic objective of this scheme?

To deliver an improved community solution which offers a flexible service that reduces the need for hospital admission and supports the early discharge of patients from hospital.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Care home beds (previously GP step-up beds) to be used as step-up beds for patients requiring a short-term intervention that would prevent them being admitted to secondary care. These beds will be used flexibly to effectively respond to changes in demand and may also be used as step-down beds to enable maximum occupancy.

- Westbrook house will be further developed as an enhanced step down facility to

support patients for 6-8 weeks post discharge so that they can be returned, where possible, to their own bed and avoid social care placement or re-admission. The Westbrook House team will be supported by a dedicated multi-disciplinary team, including therapists, social care and primary care input, to ensure timely patient flows.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The CCG currently commissions GP step up beds from a number of private sector care homes through contracts with local GP Practices. Westbrook House is a jointly funded facility with KCC

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Health Act 1999 provided the "flexibilities" that allow qualified nursing staff to be seconded into local authority/County Council Registered Care Centres to deliver improved outcomes in nursing care and clinical input to meet the needs of those individuals identified to receive nursing care, in addition to their individual personal care and spiritual needs. The Department of Health (DH) has stated that effective and efficient joined up working between the NHS and Local Government is an essential part of how the care system works to meet patients' needs and public expectations at all times and particularly when increased demands are made of the services.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes
- Reduced hospital admissions
- Reduced hospital readmissions
- Avoidance of long term social care placements

Metrics
- % occupancy of step-up beds
- % occupancy of Westbrook House (Victoria Unit)
- % of readmissions of patients seen by the team
- % patients returning to their own home
- Measure of response times
- Patient satisfaction

Thanet Clinical Commissioning Group

Scheme ref no.

THA04

Scheme name

Falls Prevention

What is the strategic objective of this scheme?

To reduce the number of unplanned admissions due to falls.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Development of falls and fracture prevention services for older people to undertake screening and comprehensive assessment aimed at identifying and treating the underlying causes of falls, such as muscle weakness, cardiovascular problems, medication and housing issues.

SCHEME REQUIREMENTS:

Development of a local specialist falls and fracture prevention service

- This service will work closely with the Neighbourhood Care Teams, Rapid Response and Intermediate Care and will undertake proactive and responsive screening and multi factorial assessments to identify causes of falls and make arrangements for preventative approaches.

Local integrated falls prevention pathways

- Level of current services across locally will be more integrated to include the increased level of input from geriatrician for integrated management and integration with other professionals e.g., pharmacists, chiropodists, podiatrists, opticians and audiologists;
- Develop an Integrated Ambulance Falls Response Service;
- Improve availability and awareness of therapeutic exercise programmes (postural stability classes) via community classes and domiciliary based.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCG and KCC will jointly commission KCHT, EKHUFT, Primary Care and the Voluntary Sector to deliver the proposed Falls Framework.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Falls Prevention a Framework for Kent – Thanet CCG v2.1

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

- Reduction in non-elective admissions due to falls.
- Improved patient outcomes and improved efficiency of care after hip fractures through compliance with core standards.
- Response to a first fracture and prevention of the second – through fracture liaison service in acute and primary care settings.
- Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.
- Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle and reducing unnecessary environmental hazards.

Thanet Clinical Commissioning Group

Scheme ref no.

THA05

Scheme name

Support for carers

What is the strategic objective of this scheme?

To improve the support to carers through a more integrated approach to commissioning.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

KCC and Thanet CCG currently fund a number of carers support schemes through two strands. Carers Support and Carers Short breaks. These include Planned Respite, Crisis Support and Respite for Carers. Through improved integration we intend to:

- Improve the Support to carers of those with dementia.
- Provide Support to carers who are elderly and/ or have their own health needs and for whom the caring role is particularly intensive, for example living with the person they care for, or spending over 100 hours a week caring.
- Support carers within new emerging BME communities.

- Ensuring easy access to information, advice and guidance for both known and unknown carers, particularly in deprived areas.
- Address the predicted decline of female 'mid life' carers when developing services for the future.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Combining resources from KCC and Thanet CCG to commission services from the Private and Voluntary Sector.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Kent Carers JSNA 2013/14

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

- Increased number of carers supported through each of the three programmes.
- Access to crisis support
- Access to planned care respite
- Access to respite for carers

Thanet Clinical Commissioning Group

Scheme ref no.

THA06

Scheme name

Improving End of Life Care

What is the strategic objective of this scheme?

To improve the overall co-ordination of end of life care ensuring that patients' wishes are recorded and patients are given their choice of place of death wherever possible.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A major opportunity to address some of the key issues for EOLC is through adoption of the new Long Term Conditions Agenda that incorporates the themes of risk-stratification, integrated teams and self-care. The vision is for a unified data hub that integrates activity across all health and social care and a fully functional system which will enable early identification for those at risk of death, enable more accurate EOLC planning across a population and ensure health and social care are better coordinated and integrated with each other. End of Life Care (EOLC) should support people to remain independent where possible, allowing the final stages of life to be as comfortable as possible. The preferred location of death should be discussed with family and carers, with the choice being adhered to wherever possible. Many people do not wish to die in hospital and would prefer to die at home, but often this does not happen. Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCG commission services from Pilgrims Hospices, KCHT, EKHUFT and GP Practices.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

East Kent End of Life Strategy May 2014

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance Measurement of agreed KPIs. Regular meetings and reviews with providers

What are the key success factors for implementation of this scheme?

Outcomes
- To enable end of life care in patients own home

Metrics
- To reduce the number of secondary care admissions for patients receiving end of life care
- % of patients dying in their place of choice

West Kent Clinical Commissioning Group

Scheme ref no.

WK001

Scheme name

Joint Health and Wellbeing System Approach

What is the strategic objective of this scheme?

A coordinated whole system approach in which all health and wellbeing partners use their individual and collective efforts to tackle the root causes of health and wellbeing problems.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A coordinated whole system approach for West Kent in which all health and well-being system partners use their individual and collective efforts to tackle the root causes of health and wellbeing problems (including alcohol and tobacco use and addiction and obesity). The change levers include health education, environmental health improvements, housing eligibility and maintenance, trading standards, licensing and the standards and specifications of health and social care contracts and community development support. It includes efforts to encourage and support people so that they take more responsibility for their health and to make the healthy choices easier for people to make. It also includes an asset based approach, enhancing the capacity of communities and individuals to support themselves and each other

Community based support and prevention will be available to residents of West Kent. A core offer will be developed and commissioned which will ensure a comprehensive range of universal support services are available to people. Some will be targeted services for particular populations e.g. smoking cessation, weight management, and employment support.

Other support services commissioned via voluntary sector organisations will help reduce demand on more specialist health and social care services through preventative activities. Some will be linked to care pathways, for example, falls prevention classes, while others will offer universal access e.g. carer support, or dementia support.

NHS 111 will continue to provide advice online and by phone to patients and carers supported by GPs. This will be complemented by an integrated Information, Advice and Guidance service which will enable residents to access information and will enable those working within health, social care and housing services to signpost people to other support available within local communities.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, the following local authorities (Kent County

Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council) as well as the voluntary and community sector. As this programme develops this will be specified further.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£8,708,000 to deliver BCF outcomes

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Campaign team
- Co-ordinating team to reach out to all agencies and to drive for consistency of programmes
- Campaign to increase people's willingness to take on responsibility for own care (culture change)
- Suitable information content and communications channels
- Education/campaign team
- Information materials
- Volunteer and informal carer support

Expected Benefits

- Integrated working and co-commissioning
- Services developed are person centred, are part of integrated provision and procured through integrated commission
- A reduction in health inequalities
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group

providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- Co-ordinated campaigns across health, social care, general public work, with consistent messages
- Consistent prioritisation across all agencies avoiding fragmentation of efforts
- Holistic approach that tackles underlying causes for ill-health
- People become true partners in care: manage parts of pathways themselves, take part in active prevention and make healthy lifestyle choices
- Greater awareness of health/social needs and more looking out for each other in community (neighbours and volunteers helping)
- Increase in patients feeling supported to manage their long term condition
-

West Kent Clinical Commissioning Group

Scheme ref no.

WK002

Scheme name

Self and Informal Care

What is the strategic objective of this scheme?

The Mapping The Future blueprint places self and informal care at the centre, enhancing the capacity of communities and individuals to support themselves and each other. People are fully informed and take part in planning their care helping are supported to stay at home and independent longer.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Self and informal care will be an important part of the new system, with more people and their families being supported to manage their own care and long term conditions through the use of smart technology and the development of a self-care/self-management model. Integrated telecare / telehealth solutions will be backed up, where necessary, by trained staff working in an integrated telecare / telehealth monitoring centre, who will be pro-actively monitoring changes in activity and health condition, alerting integrated community teams where further intervention to prevent increases in care needs

- People are supported to take responsibility for their health and care. This includes intensive education about their conditions and how they can manage them, peer support, information and supported signposting to find appropriate voluntary and community options, fast and easy access to daily living aids
- People are kept fully informed about the need for changes to health and care and are encouraged to take part in discussions about future plans
- People are encouraged to make early decisions about treatment options and end of life preferences: they are active partners in planning their care
- People are supported to stay independent and at home for as long as possible,

e.g., using telehealth, patient held records and personal health budgets

- Supported housing and domiciliary care is commissioned in a way that enables people to remain in the home as long as possible: short term stays are possible for those that have immediate needs
- Local communities and voluntary organisations are encouraged to provide health and care support to people and carers

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.

The providers may include the NHS Acute Provider, the NHS Community Provider, the private sector, the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council) as well as the voluntary and community sector. As this programme develops this will be specified further.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£3,092,000 to deliver BCF outcomes

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- People willing to take on responsibility for own care (culture change)
- Suitable, easily accessible information
- Accessible, responsive and reliable support 24/7 when questions and issues arise
- Incentives (?)

- Easy access to easy-to-understand information
- Access to up-to-date care plans and care records
- Info about EOLC service options
- Cultural acceptance of “natural” death
- 24/7 responsive and reliable support service for crises
- Well-co-ordinated social/domiciliary care services
- Culture of helping each other
- Info/education for volunteers and community at large

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 104 reduction in A&E attendances
- 104 integrated care at home packages provided
- Increase in patients feeling supported to manage their long term condition

Feedback loop

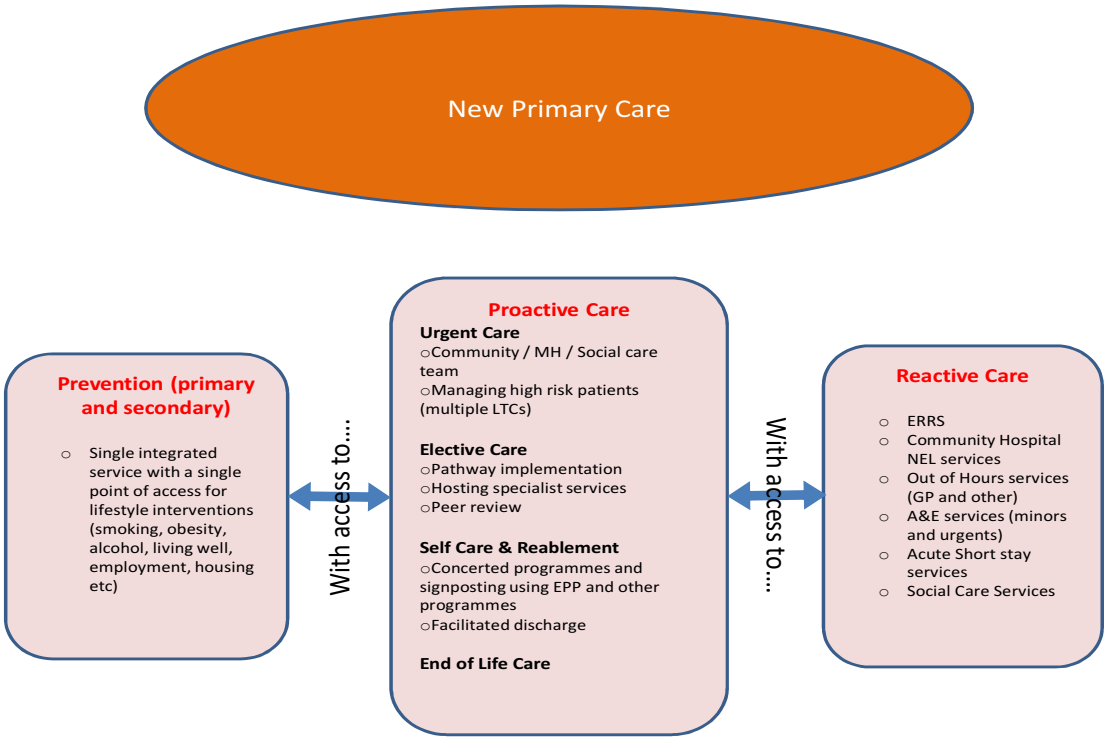
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- People become true partners in care: manage parts of pathways themselves, take part in active prevention and make healthy lifestyle choices
- Avoiding unnecessary and ineffective care
- People take more of their own care decisions
- Earlier discussion on EOL patient preference with reduction of excessively aggressive treatments
- Reduce avoidable hospitalisations
- Ability to receive treatments that otherwise would have needed hospital (greater convenience for patients)
- Avoid unnecessary admissions for “social” reasons
- Healthier homes (e.g., less cold/damp, less falls risk)
- Support at home by neighbours and volunteers and within the community by volunteers
- Overall greater awareness of “look out for each other”
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group
Scheme ref no.
WK003
Scheme name
New Model of Primary Care
What is the strategic objective of this scheme?
A new model of Primary Care focusing on three distinct but interlinked areas of care (preventative, proactive and reactive care) creating larger scale GP led multi-disciplinary teams which are wrapped around a suitably sized group of practices.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?



It supports the provision of more capable and cost effective out of hospital proactive care and brings together elements of urgent care, elective care, self-care, reablement services and end of life care.

The teams will include clinically-led professionals that take a care management and coordination role for patients who are elderly and those with the most complex needs. They will operate within a framework of clear clinical pathways spanning the health and care system and will have access to consultant opinion to enable them to

support patients, most often without the need to send them to hospital.

The focus will always be to support citizens to manage and coordinate their own care whenever possible

This will include:
- Comprehensive New Primary Care responds 24/7
- Practice clusters that offer diagnostics and other extended services
- Easier access 24/7
- Universal electronic record system
- MDT-teams based around health centres, or community hospitals
- Risk profiling and proactive outreach to people at risk of deterioration
- OOH is integral part of New Primary Care
- Dedicated processes for scheduled and unscheduled care
- Population health is part of NPC's responsibilities
- NPC 'owns' their patients along the entire pathway
- NPC can access intermediate care
- Integrated assessments
- Care coordinators for patients with complex needs
- Access to specialist opinion without referral

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.

The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a

greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£14,335,000 to deliver BCF Outcomes

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Call handling protocols
- Call centre
- Sufficiently senior clinicians (e.g., GPs) on call
- Suitable facilities (within some GP practices or community centres?)
- Call handling protocols
- Data protection protocols
- Access to suitable IT system
- Shared record and care plan
- MDT processes
- Risk stratification tool
- Processes and team capacity to respond
- Call handling protocol and call centre
- Access to GP records (IT systems)
- Adequate staffing levels (if GP and community staff deliver part of OOH)
- Dedicated practice capacity for unscheduled care
- Active working with Public Health
- Clinical governance for lead clinicians
- Communications protocols for 'lead'
- Intermediate care beds
- Clinical governance
- Suitable joint protocols and skilled staff
- Skilled care coordinators
- Clinical governance
- "On phone" specialists

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 104 reduction in permanent residential admissions
- 1185 reduction in non-elective (general + acute only)
- 730 reduction in delayed transfers of care
- 104 reduced use of commercial beds
- Reprocurement of an integrated loan and equipment store
- Reprocurement of integrated therapy services
- Increased effectiveness of reablement/104 readmissions avoided
- Increase in patients feeling supported to manage their long term condition
-

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- The new primary care teams comprise GP practices, community services, social work and mental health support working as an integrated team that can respond to patient needs round the clock
- All members of the New Primary Care have a clear understanding of each other's role
- All practices networked into clusters so that patients can receive a consistent range of services wherever they live in West Kent. The clusters have local access to essential diagnostics, where this is cost effective for the population size: quality assurance, calibration and training provided by hospital services reduces the need for tests to be repeated in different settings
- The new primary care teams make it easy for people to see them, e.g., by offering consultations by telephone, longer opening times and efficient appointments systems. For the patient it feels seamless whether they contact during the day or at night, although night and weekend care may be offered by another organisation
- All members of the primary care team use the same unified electronic patient records – these are also available to mobile clinical services and to other specialist services
- The multi-professional and multi-skilled teams may be virtual or based around larger health centres or community hospitals
- Primary and community teams use risk profiling and disease registers to plan the team's work: they are proactive in targeting people at risk of developing conditions or of deteriorations in their condition. They call people who might be at risk in to see them rather than waiting for them to seek help
- The traditional out-of hours services are redesigned and integral to the new primary care rather than a separate element. They may take on a wider range of functions supporting GP practices
- The teams plan their work so that they offer both planned and urgent care - these elements may need to be separately organised to provide greatest efficiency
- The new primary care teams see population health as their responsibility. They 'own' their patients and follow them up when they need specialist care, planning their return home as quickly as possible. They are supported by real time information about available services and system performance
- The teams can access intermediate/step up care where adults or children can get short term observation and treatment
- The teams have advanced skills in the diagnosis and treatment of patients with long term conditions and use agreed pathways of treatment and care to plan the support for individual patients – these are designed around the principles of encouraging self-management and early intervention to prevent conditions from

getting worse
- The MDT enables interdisciplinary overlap and partial substitution so that one professional can cover potentially multiple specialities' services
- Use agreed assessment protocols the teams have reduced duplicated assessments for some conditions
- Within the team there are professionals that take a care management and coordination role for patients with the most complex health needs
- The new primary care teams can access consultant opinion and advice to enable them to support patients without the need to send them to hospital
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group

Scheme ref no.

WK004

Scheme name

Mobile Clinical Services

What is the strategic objective of this scheme?

Mobile clinical services (MCS) will provide direct care to people at the point it is needed by taking care to the patient wherever possible and clinically appropriate to do so. The MCS will work as a complementary workforce to the new Primary Care System using similar pathways, protocols and medical records.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

MCS will be supported to help people remain at home, through the development of a new integrated (health and social care) intermediate care/ reablement service with a workforce trained to deliver comprehensive care that supports independence, recovery, maintenance of existing situation or for some people, quality end of life care. The breadth of these services will be enhanced to include best practice use of assistive technologies to complement hands on care and where appropriate clear referral pathways to non-clinical partners.

Community based integrated care teams will be established to provide targeted, proactive co-ordinated care and support to those people identified as being of highest risk of hospital attendance or increasing use of care services.

- NHS 111 call centre gives helpful advice and is supported by GPs
- Call handlers know what local services are available and when
- See-and-treat by paramedics in the field
- MCS are integrated part of NPC team (same care protocols/processes and medical records), or at least integrated operationally

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, Ambulance Service and the private sector.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£94,000 to deliver BCF outcomes

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Qualified and sufficiently senior staff answering phones
- Call centres and call management protocols
- Clinical governance
- Process to keep directory of services up-to-date and manageable
- Access to medical records and care plans
- Processes to keep Paramedics/MCS clinicians involved
- Integrated care records
- Designed and formally agreed protocols and processes

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 938 journeys avoided
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.
What are the key success factors for implementation of this scheme?
• The NHS 111 number provides valuable advice and help to patients and carers on line and by phone. The call handlers are supported by GPs and well supervised so they feel part of an accountable system not individually responsible • Call handlers have a strong understanding of local services in West Kent and what they can offer: this plus access to the real time information means they are confident in the advice they give • Mobile Clinical Service clinicians (could be paramedics, doctors, specialist nurses, etc.) provide direct care to people at the point where they become ill – this is a more common approach than taking the patient to hospital, or to intermediate beds (e.g., in community hospitals) • MCS clinicians work as a complementary workforce to the new primary care teams. They use similar pathways and protocols, have access to the unified electronic patient records and provide systematic handovers of patients back to the primary care team • Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group
Scheme ref no.
WK005
Scheme name
Urgent Transfer Service
What is the strategic objective of this scheme?
To transfer patients with urgent care needs to the best setting (this may not necessarily only to A&E), to provide a range of treatments and diagnostic tests to patients on the way and to make more use of transport services by voluntary and community organisations.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• Enhanced assessments and diagnostics/start more care enroute • Urgent care protocols the same regardless of care setting

- All care professionals have access to universal records all the time
- A&E is not automatic destination but patients could be taken to GP practice or other community-based care setting
- More non-urgent patient transport to be provided by others than ambulance e.g. volunteer and community support teams

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.
The providers will include the NHS Acute Provider, the NHS Community Provider, the Ambulance Service and the private sector.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

No direct funding identified but included for completeness of Mapping the future vision.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements
- Qualified staff
- Protocols and clinical governance
- Suitable equipment
- Agreed, standardised protocols
- Suitable record system

- Urgent care services outside of A&E
- Clear protocols for triage
- Suitable transport organisations/capacity

Expected Benefits outlined in Part 2 Tab 4 HWB Benefits Plan

- 130 journeys avoided
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- The traditional ambulance services transfer patients with urgent care needs where necessary. They may provide a range of treatments and diagnostic tests to patients on the way, providing effective handover to specialist hospital services
- Protocols accepted and understood across the system guide transfers
- Access to unified electronic patient records enables the paramedics to know which patients have complex conditions who might benefit from taking their prescribed medicines with them to hospital
- The transfer service may not transfer just to acute hospitals, but also to community hospitals or care homes or other appropriate venues
- More use is made of transport services provided by voluntary and community organisations
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group

Scheme ref no.

WK006

Scheme name

New Secondary Care

What is the strategic objective of this scheme?

New Secondary Care will seek to manage urgent and planned care as separate entities for optimum efficiency with some highly specialised services concentrated in larger centres. Hospital based urgent care will work as part of the total system connected with primary and community services and mobile clinical services. Together they will optimise patient flows to deliver the most cost effective service with coordinated care around people with complex needs.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

It is anticipated that this will allow secondary care services to be provided with a more community base model that reduces dependency on beds and buildings.

- Concentration of highly specialised services in larger centres
- Hospital-based urgent care is integrated with NPC and mobile services , providing access to senior clinical input as early as possible when needed and ensuring rapid response and rapid turnaround so that patients can be supported in most appropriate setting
- Specialists and GPs work as one team with one lead clinician
- Ongoing monitoring and rapid learning to adjust care supply to demand so that provider capacity responds to demand, rather than supply inducing demand
- Proactively link physical and mental health, with psych liaison services at hospitals
- Coordinated and simplified care for patients with complex needs

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council.

The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

No direct funding identified but included for completeness of Mapping the future vision.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

System Requirements

- Large enough provider units to keep both scheduled and unscheduled care areas above critical mass
- Sufficient capacity at specialist centres
- Specialist centres at still acceptable distance
- Adequate NPC-based urgent care capacity
- Clinical governance
- Quality monitoring
- Clear protocols
- Close intelligent activity monitoring
- Contractual flexibility
- Adequate expertise and capacity in NPC to take on care
- Referral protocol
- Responsive prevention and health promotion service and capacity
- Psych liaison service
- Agreed referral guidelines
- Clinical governance
- Tertiary advisory service
- Clinical governance
- Competent clinician who can synthesise treatment regimens into one simplified care plan

Expected Benefits

- Greater cooperation across acute and community sectors
- Coordinated and simplified care for patients with complex needs
- Increase in patients feeling supported to manage their long term condition

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows and achievement of the metrics associated with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- Hospital based urgent and planned care services can complement each other

but they are managed as separate entities to provide optimum efficiency
- Some consultant led services are concentrated in larger centres where there is evidence that they can improve quality and offer more cost effective care
- Hospital based urgent care works as part of a total system connected with primary and community services and mobile clinical services. Together they work to optimise patient flows to deliver the most cost effective service
- There are clear agreements between primary care and specialist teams among them about their respective patient care responsibilities and ways of managing organisational and professional risks (agreement is between providers but also with clear transparency to commissioner for quality control)
- Constant analysis of how urgent care demand and service delivery enables fast learning and resources deployed to the right place
- Hospital based MDTs facilitate proactive follow up of patients through explicit handover back to primary and community teams and use unified electronic patient records to track patients and keep each other informed
- Have a health promotion role, using opportunistic encounters with patients to encourage positive changes in healthy behaviour. They are supported by 7 day on site advice services, e.g., smoking and alcohol
- Proactively work together to link physical and mental health treatment and support
- Develop shared understanding between primary/specialist clinicians about when it is clinically appropriate to refer patients to specialist centres outside West Kent
- West Kent specialists develop clear agreements with tertiary centres and can access consultant advice by phone to enable local care for patients
- Develop coordinated care around people with complex care needs such as physically frail older people making the care and support for the individual and carer quicker and simpler
- Increase in patients feeling supported to manage their long term condition

West Kent Clinical Commissioning Group

Scheme ref no.

WK007

Scheme name

System Enablers

What is the strategic objective of this scheme?

- Information sharing protocols as first step towards universal medical records, allowing all care professionals access to real-time patient record and care plans from anywhere.
- Improved communications and relationships amongst professionals of different organisations
- Clear risk management agreements
- Culture of personalised care, collaboration and joint ownership of effectiveness of care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?

- Which patient cohorts are being targeted?

- Data sharing protocols
- Suitable record system
- Remote access to such system
- Communications platform
- Availability of care professionals to respond rapidly
- Communications processes
- Funding model that incentivises best outcomes at minimum costs
- Shared culture and incentives

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioners will include West Kent CCG, Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council. The providers will include the NHS Acute Provider, the NHS Community Provider, the private sector, and the following local authorities (Kent County Council, Maidstone Borough Council, Sevenoaks District Council, Tonbridge & Malling Borough Council and Tunbridge Wells Borough Council).

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Mapping the Future exercise conducted in West Kent CCG has identified the financial impact of expected levels of demand growth arising from the change in demography of West Kent. This has been based upon ONS population growth forecasts by age band. The charts set out in the West Kent CCG Strategic Commissioning Plan show the anticipated growth in expenditure on services as a result of demographic pressures. Significant cost growth is anticipated in the following areas: People who have multiple Long Term Conditions; People who are aged 70 and over; People who would require services in: Urgent care, Community services, Continuing Care and Funded Nursing Care services.

The Mapping the Future programme sets out a planned redistribution of resources across settings of healthcare. Over a five year period, WKCCG aims to deploy a greater share of its resources towards investment in New Primary Care services, and relatively less in the acute care setting.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£165,000 to deliver BCF outcomes

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not

captured in headline metrics below

- Data sharing protocols
- Suitable record system
- Remote access to such system
- Communications platform
- Availability of care professionals to respond rapidly
- Communications processes
- Funding model that incentivises best outcomes at minimum costs
- Shared culture and incentives

Expected benefits

- Introduction of an integrated care plan management system
- Increase in patients feeling supported to manage their long term condition

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Local Health and Wellbeing Boards, whole system boards, CCG Boards, Integrated Commissioning Groups will ensure delivery and the Integration Pioneer Steering Group providing advice and guidance. Commissioners, Providers and the NHS England Area Team are represented within Whole System Boards, the HWB and on the Integration Pioneer Steering Group. At a local CCG, care economy and system wide level there will be monitoring of the financial flows associated and achievement of the metrics with implementation of the Better Care Fund.

What are the key success factors for implementation of this scheme?

- Electronic patient records using a common IT platform may be over ambitious in the short term but information sharing protocols and risk sharing agreements can be a pragmatic first step
- Improved communications and relationships between professionals working in different organisations/sectors
- More use is made of electronic communications (e.g., email, SMS) between professionals and between professionals and people who need health care and support
- Risk management arrangements and agreements that work across the system contribute to more efficient and effective care
- The new system of health care is underpinned by a shift in culture that emphasises personalised care, collaborative working between providers and joint ownership of optimising patient flows and effective care
- Increase in patients feeling supported to manage their long term condition

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Health Money Summary 2015/16

APPENDIX 3

	Ashford CCG (£'000)	Canterbury & Coastal CCG (£'000)	Dartford, Gravesham & Swanley CCG (£'000)	South Kent Coast CCG (£'000)	Swale CCG (£'000)	Thanet CCG (£'000)	West Kent CCG (£'000)	Total (£'000)
Hospital Discharge								
Assessment Beds, Step Down/Up Beds, Purchased per Block Contract	50.0	0.0	0.0	0.0	0.0	0.0	255.5	305.5
Health Commissioned Beds	256.8	0.0	0.0	308.2	0.0	0.0	0.0	565.0
Residential Placements from Hospital	29.2	189.5	209.3	171.5	24.4	131.3	555.5	1310.9
Direct Payments (Domiciliary) from Hospital	40.9	304.5	209.9	124.5	157.1	53.2	234.0	1124.1
Domiciliary Placements from Hospital	81.9	609.0	419.7	249.0	314.1	106.4	468.0	2248.1
Short Term Bed Placements Outside Block Purchased Beds	151.4	323.4	567.9	333.2	62.9	536.9	313.7	2289.4
Enablement	854.7	944.8	1713.4	1358.9	681.0	657.2	3775.2	9985.3
Staffing - Supporting Hospital Discharge/Admission Avoidance	204.4	165.1	197.9	133.4	218.3	327.4	477.4	1723.9
Direct Payments	2.6	4.0	5.1	4.1	2.2	2.8	9.2	30.0
Equipment - Telecare	112.4	171.5	220.5	178.7	95.1	121.1	400.7	1300.0
Self Care & Prevention								
Carers	129.7	197.9	254.4	206.2	109.8	139.7	462.3	1500.0
Befriending	20.8	31.7	40.7	33.0	17.6	22.4	74.0	240.0
Autistic Spectrum Team	40.8	62.2	80.0	64.9	34.5	43.9	145.4	471.8
Postural Stability and Voluntary Sector Support	14.4	21.9	28.2	22.8	12.1	15.5	51.2	166.0
Additional Integration Fund								
Extended Working Hours	167.4	255.5	272.3	196.7	150.6	131.1	422.9	1596.5
Enablement Staffing Capacity	156.3	238.5	306.7	248.5	132.3	168.4	557.2	1807.9
Joint Programme Posts	0.0	0.0	0.0	26.3	0.0	26.3	0.0	52.6
Additional Out of Hospital	129.6	208.0	266.5	224.1	55.3	147.6	505.7	1536.8
TOTAL	**2443.3**	**3727.5**	**4792.5**	**3884.1**	**2067.3**	**2631.2**	**8707.9**	**28253.7**
Total Funding 15/16								**28253.7**

NHS England £90m Apportionment						
Ash CCG	**C&C CCG**	**DGS CCG**	**SK CCG**	**Swale CCG**	**Thanet CCG**	**WK CCG**
9%	13%	17%	14%	7%	9%	31%

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APPENDIX 4

BCF Financial Expenditure Pro-forma

Scheme Name	Plan Value (£'000)	Year to date Expenditure (£'000)	Forecast Outturn Expenditure (£'000)
Community, Equipment and Adaptations			
Telecare			
Integrated crisis and rapid response services			
Maintaining eligibility criteria			
Reablement Services			
Bed-based intermediate care services			
Early supported hospital discharge schemes			
Mental health services			
Housing Projects			
Employment support			
Learning disabilities service			
Dementia Services			
Support to Primary Care			
Integrated assessments			
Integrated records or IT			
Joint health and care team/working			
Overall Totals			

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Kent Better Care Fund – performance and finance group – Terms of Reference DRAFT v0.3

Aims and Objectives
To oversee and coordinate the collation of required performance and finance information to enable Kent's Health and Wellbeing Board to monitor the ongoing delivery of Kent's Better Care Fund plan.

Role and Function of the Group
1) To coordinate and ensure provision of regular required (quarterly /TBC) information by all partners (in agreed format) informing Kent HWB assurance framework on BCF performance data.
2) Provide update as required to national BCF reporting.
3) To develop and agree consistent presentation of key financial and performance data and operational commentary (in line with BCF guidance to be received) for presentation to the Kent Health and Wellbeing Board and other relevant local and Kent wide governance boards.
4) Ensure linkage between Finance and Performance to manage the Pay for Performance element and oversee release of funds as appropriate. Ensure appropriate year end adjustments are made and appropriate audit sign off.

This will be achieved via:

Collation of quarterly performance reports from CCG partnership groups.
Collation quarterly finance reports from CCG partnership groups.
Aggregation of CCG level reports into a Kent quarterly report.
Twice yearly update on Disabled Facilities Grant spend.

Membership (*TBC*)

Organisation	Name	Representing
KCC Finance		
KCC Performance		
KCC Public Health		
CCG Performance		
CCG Finance		
Area Team		
KCC business		
CCG business		
District Rep		

Meeting Arrangements
The meeting will meet quarterly within a cycle to be determined by national reporting requirements.

The meeting will be Chaired by *(TBC).*

Reporting
To be completed when BCF reporting framework agreed

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Children's Health and Wellbeing Board

28th November 2014
Swale 1, Sessions House

MINUTES

In attendance:

Andrew Ireland (AI)	KCC - Director – Social Care, Health & Wellbeing (Chair)
Patrick Leeson (PL)	KCC - Director – Education and Young People's Services
Peter Oakford (PO)	KCC - Cabinet Member SCS
Roger Gough (RG)	KCC - Cabinet Member Education and Health Reform
Rob Price (RP)	Kent Police - Assistant Chief Constable
Karen Sharp (KS)	KCC - Head of Public Health Commissioning
Thom Wilson (TW)	KCC - Head of Strategic Commissioning (Children's)
Stephen Bell (SB)	CXK (VCS Provider rep)
Hazel Carpenter (HC)	NHS - South Kent Coast CCG & NHS Thanet CCG, Accountable Officer
Jo Purvis (JP)	Representing Kent District Councils Chief Executives
Gill Rigg (GR)	Kent Safeguarding Children Board Independent Chair
Jill De Paolis (JDP)	KCC - Commissioning Officer
Jo Tonkin (JT)	Representing KCC - Acting Director of Public Health
Philip Segurola (PS)	KCC - Acting Director Specialist Children's Services
Helen Buttivant (HB)	KCC - Public Health Registrar
Louise Fisher (LF)	KCC – Early Help Locality Manager

Apologies:

Abdool Kara	Kent District Councils Chief Executives Rep
Florence Kroll	KCC – Director of Early Help
Mark Lobban	KCC - Director of Strategic Commissioning
Michael Thomas-Sam	KCC - Strategic Business Adviser

		ACTION
1.	**Minutes of the last meeting and matters arising** • Colin Thomson, Interim Consultant and Children's lead for Public Health will replace Andy Scott Clark on this Board. • Updated MOU between CHWBB and KSCB is still an outstanding action from the last meeting. • JDP confirmed that some items will be carried forward to the next meeting. • JSNA – TW confirmed there will be a children's JSNA. Work is now being taken forward by a group which will report to this Board. • CSE Needs Assessment – As a result of the thematic review a Health Needs Assessment on CSE will be carried out. Timescales to be confirmed.	JDP MTS JDP
2.	**Emotional Well Being Strategy** KS reported that the task and finish group managing this work is meeting weekly to ensure this work stays on track and continues at pace. There has been a discussion at the HWBB. The needs assessment is underway, the draft strategy is out to consultation until January 5th and considerable	

	activity is underway to inform the delivery plan as follows: Workshops with CYP have taken place. Clear messages were: accessibility of services – more drop-ins and less 'clinics', the importance of schools to access services and their role in de-stigmatising mental health issues and also use of services within the school culture. 2 workshops for professionals have also been held looking at Early Help and Specialist provision. A second summit will be held on 18th December to which all Board members have been invited. A new service model is under development which will be brought to the next meeting of this Board. KS also confirmed that she thought the current CAMHS contract had been extended. PL and AI both asked for clarification about the contract extension as KCC contributes £1Mill. TW and KS to discuss with Dave Holman and report back.	TW/KS
3.	**Early Help and Headstart – Patrick Leeson and Louise Fisher** Headstart is a strand of Kent EWB Strategy. Lottery funded £5 mill Kent is 1 of 12 pathfinders and aims to ensure young people aged 10-14 years have access to EWB support in the following ways: Thanet schools – restorative approaches NW Kent schools – Safe Places/time out Canterbury, Ashford and Dartford schools – Resilience Mentor training alongside digital resources. PI confident Kent will get phase 2 funding of £10 mill to roll out successes of year 1. Outcomes expected include a reduction in referrals to specialist services. Kent Family Support Framework (KFSF) is becoming embedded. There has been a big increase in assessments across all age groups and the right level of support is made as a result of timely assessments. Restructuring is continuing as is piloting further improvements as a result of working with Newton Europe. Coordination of services with health, recording of case work, stepping up and down of cases with SCS have all improved. In Sept/Oct 2014 there were 1251 notifications of a wide range of CYP – all ages and varied issues, in particular there were a lot of adolescents. The triage system is reported to be working very well. KS said that it was important the SPA for mental health and the new KFSF become aligned.	KS/FK
4.	**Child Sexual Exploitation (CSE) OfSTED thematic review – AI** AI said OfSTED are now not expected back until after Christmas and KCC's self-assessment will be shared with partners. The CSE review report was published last week and is hard hitting, especially on the lack of urgency LAs have shown in managing this issue. http://www.ofsted.gov.uk/sites/default/files/documents/surveys-and-good-practice/t/The%20sexual%20exploitation%20of%20children%20it%20couldn%E2%80%99t%20happen%20here,%20could%20it.pdf	PS

	Clear issues for Kent were identified which need to be worked on at pace. These include the need for a clear strategic lead; a sub group currently exists but needs to be improved; greater consistency in use of the CSE toolkit and statutory guidance; awareness of CSE across the whole children's workforce; improved tie ups with Community Safety Partnership work in the Districts and greater coordination of effort to tackle CSE. The EWB Strategy needs to refer to support for recovery of survivors. Social Work practice also needs work to raise understanding and the quality of return of runaways interviews. Operation Lakeland was identified as good practice but could not be written up as there is an ongoing criminal investigation. PS said that 14 individual actions have been carried forward to the Improvement Plan for SCS and added that OfSTED considered there was too much fragmentation of commissioning in Kent. SB suggested a short message to share with all partners should be prepared specifying what we all need to do and signposting resources such as training, the toolkit and the importance of really listening to what children and young people are saying whilst being mindful of the impact grooming may have on them. GR said she would put something in the KSCB newsletter. PO raised the question of where adult paedophiles would go for help. RP reported this was currently being looked at by the National Crime Agency but currently the only resources he was aware of are meagre and available only after criminal conviction.	KS to ensure CSE in EWB strategy GR to ensure this is covered in the KSCB newsletter.
5.	**Review of the delivery of the antenatal and postnatal elements of the healthy child programme across Kent – Helen Buttivant KCC Public Health Registrar** Helen gave a presentation outlining the findings of her research and recommendations for improving the Kent 'offer' attached.  Microsoft PowerPoint 97-2003 Presentation AI said he recognised many of the issues Helen had identified which had come out in various SCRs. HC welcomed the report and links made with Health Commissioners. It is important that Public Health research and support are embedded into health commissioning arrangements. It was recommended the report goes to the Collaborative Commissioning Group looking at maternity services across KCC CCGs with NHS England. CCGs will be writing to the SE Commissioning Support Unit to say they no longer wish to continue current arrangements regarding maternity services. AI said this should be carried forward into KCC's work with under 5s when they transfer from Health into KCC next year.	
6.	**Framework and workplan for the CHWBB – Thom Wilson** TW gave a presentation outlining future challenges the CHWBB needs to be mindful of.	

	Microsoft PowerPoint 97-2003 Presentation KS said it was important commissioning and procurement arrangements are better aligned. SB said how important he felt COGs are to underpin collaboration and communication across agencies locally and also to implement decisions of this Board on the ground. AI said it was essential our work is driven by Needs Assessments. HC said it was a pity there are no GPs around the table. Meetings on Friday afternoon are not conducive. The Board needs to influence their thinking and encourage them not to medicalise childhood issues. CCGs are not necessarily cognisant of KCC's responsibilities, what needs to sit at county level and what locally. GPs are interested in talking to Headteachers, but this is not an efficient way to commission services. How we can work more effectively both Kent wide and locally are key questions we need to answer. The Teenage Pregnancy Strategy has just been to the HWBB for ratification and has not come to this board. There is considerable confusion about roles and responsibilities which needs early resolution. HC said it is essential to clarify to Local HWBBs, perhaps through guidance, what this Board does, what we need them to do to support us and how they can communicate with us. KS said we do need to get this right with a clear connection to localities so we can carry out our business efficiently and everyone knows what body to take partnership issues to for agreement. All TW's recommendations were agreed AI agreed to discuss and agree with MTS, TW, PO and RG.	JDP to look for different dates JDP, TW, MTS
7.	**The Care Act – Chris Grosskopf KCC Strategic Policy Manager** CG presented the Care Act verbally. The main focus of interest to this Board are transitions to adult services. Transition protocols need to be in place making reference to the Care Act by April 2015. Therefore all relvant protocols need to be revised and updated. She asked if there should be partnership protocols or single agency ones and what the governance would be for sign-off. AI clarified that the key work areas are around LD and mental health. AI said that the 0-25 Board should agree any changes to single agency protocols. PS said it would be helpful to have 1 protocol across all agencies underpinned by a clear service pathway and asked Chris to come back to this Board with proposals which this Board should probably sign off before it goes to the HWBB for final approval.	CG
8.	**AOB:** None **Date of next meeting:** 3rd February 2015 2.00-16:30 – Medway Room, Sessions House, Maidstone	

CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Tuesday, 25th November, 2014
at 6.00 pm in the The Guildhall, Westgate, Canterbury

Present: Dr Mark Jones (Chairman)

Faiza Khan
Councillor S Chandler
Velia Coffey
Amber Christou
Mr Gibbens
Councillor Gilbey
Councillor Howes
Steve Inett
Mark Lemon Paula
Parker Simon
Perks Councillor
Pugh Jonathan
Sexton Sari Sirkia-
Weaver Chris Ives
Linda Smith
Stuart Bain (present for part of the meeting)

1 APOLOGIES FOR ABSENCE
Cllr Watkins
Anne Tidmarsh
Neil Fisher

2 MINUTES OF THE LAST MEETING AND ACTIONS
The minutes were approved with a minor amendment on page 5 item 10. Paragraph 5 to read;
Jonathan Sexton suggested that further investigation was made into CAMHS in schools as the provision could be funded by the schools from within their baseline funding.

The following action is still to be completed, all other actions are complete,
Cllr Pugh advised that Kent and Medway NHS and Social Care Partnership Trust (KMPT) has recently undergone a review and a meeting will be held next week to discuss the findings.
Action: Cllr Pugh to circulate the report regarding the KMPT review as soon as it is available.

3 CARE QUALITY COMMISSION REPORT REGARDING EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - STUART BAIN
Stuart Bain, Chief Executive of East Kent Hospitals University HNS Foundation Trust (EKHUFT) introduced himself and gave some background information on the Care

Quality Commission (CQC) and their inspection process. He reported that the CQC visited the 3 district hospitals in March 2014 and inspected 8 key areas of service in each hospital against 5 domains. Each hospital was then scored and given a rating out of 4. The reports highlighted a number of concerns and gave the Trust overall a rating of 'inadequate'.

A quality summit was held which included a number of stakeholders and the Trust was given 20 days to produce an action plan. This is a public document and identifies the 'must dos' to address each of the concerns. The actions fall into 3 groups:

- Practical issues eg fire doors do not meet standards, and these are easy to address.
- Wholly agreed challenges eg capacity to deal with the number of incoming patients. These issues are being addressed through a strategy which will be followed by a consultation before implementation.
- Challenging issues which are more difficult to address eg engagement of staff, and addressing these is more of a culture change and takes a significantly longer time to achieve. The CQC report and the publicity around it may have decreased morale and there is concern that there may be a drop in staff satisfaction and engagement in the short term.

The action plan will be used by the CQC to assess whether the actions have been addressed and also Monitor will use it to assess progress on a monthly basis. EKHUFT will continue to engage staff and progress the actions. It was noted that Healthwatch attend the monthly meetings and have met with senior managers to offer their support.

Stuart Bain commented that he felt that the tone of the report over exaggerated some of the problems but recognised that there is work to do.

Cllr Pugh queried whether centralising the outpatient service would increase problems and was advised that the new structure will increase capacity as staff are currently spread very thinly across the district and locations often lack modern diagnostic equipment. The new site will be in 6 purpose built buildings housing all the specialists in one place and will offer a one stop shop approach from 07.00 – 20.00 Monday to Friday with services also available on Saturdays.

It was noted that the positive messages regarding the changes to the outpatient service will be communicated to the public as the changes happen and feedback will be sought from individuals as they access the new service.

Pressures on the Accident and Emergency (A&E) department were discussed and it was reported that pressures are often because of pinch points in other parts of the hospital rather than too many patients coming into A&E. A more structured approach is being taken with regard to discharging patients to ensure they have adequate support when they leave hospital.

A query was raised regarding how staff give feedback and Stuart Bain reported that staff can report problems both anonymously and in person. Senior managers meet regularly with staff however there is still a lack of engagement. A new Director of Human Resources was appointed in September and although they have brought in new ideas it was acknowledged that there is no quick way to bring about a culture change.

A comment was made that one of the challenges was to review the health and social care system so that it could work sustainably, especially in the acute sector. The Board offered their support to the Trust in making the necessary changes to bring them out of special measures and it was noted that supporting the elderly in the community to keep them out of hospital and enabling better end of life care in the community would be a key area where all the Board organisations could be involved.

It was brought to the Board's attention that all the services in the hospital had been rated good for care and compassion and all critical care services rated good. Outcome measures are good and mortality rates are 20% below the average in the country.

Stuart Bain reported that recruitment and staff retention is difficult at nursing as well as consultant levels and staff recruited from overseas often move to the London hospitals although this is thought not to be due to a lack of affordable housing in the District.

It was agreed that partnership working would be key in bringing about the necessary changes in the NHS locally and Simon Perks commented that there is a need to ensure that the Better Care Fund is being implemented locally to support the aim of the Trust to keep people out of hospital through providing better support in the community.
Action: For consideration by the Core Group.

The Chairman thanked Stuart Bain for attending.

4 ALCOHOL STRATEGY DRAFT IMPLEMENTATION PLAN & POSITION STATEMENT FROM CANTERBURY COMMUNITY SAFETY PARTNERSHIP - VELIA COFFEY, LINDA SMITH

Velia Coffey commented that responsibility for undertaking a gap analysis on work already being done around the Alcohol Strategy had been delegated to the Community Safety Partnership (CSP) but that this was not yet complete. A report will be presented at the next meeting.

Linda Smith gave a presentation on the alcohol strategy, the physical and mental health problems associated with alcohol abuse, crime and the financial cost to individuals, organisations and communities. She outlined how the national strategy will address some of these issues and how the Kent Strategy is doing this on a local level through the Kent Alcohol Strategy Pledges.

Linda Smith offered support to the local groups who are leading on this.

It was noted that boundary issues are important here and there is a need to include Faversham and Dover and to share information.

5 MENTAL HEALTH PROVISION UPDATE - NEIL FISHER

Simon Perks presented an update on behalf of Neil Fisher.

- The Discharge service has been re-launched since last year to address quality issues, delays for people moving on from hospital and out of area beds including home visits to ensure everything is set up before discharge
- The out of area treatment panel has been tightened up and people no longer have to wait on the ward for a month until the panel meets. It is very important

that when people are recovered they are discharged when required as they will become more distressed and unwell the longer they are delayed.

- Bed pressure increasing early discharge: Some people do revolve and that can be about finding them the right placement for them. It takes time to find right placement. There will always be a number of patients who do come back but other need to be discharged when they are well or they can deteriorate again by staying on the ward too long. When people are stable they need to be allowed to make their own decisions and mistakes. The acute admission ward sometimes cannot provide what is needed.
- As of 24th October there were no Canterbury patients based in out of area beds. Efforts made to repatriate people in appropriate manner as soon as possible.
- New Faversham Umbrella Centre manager is keen to welcome everyone to the Umbrella Centre and extended an invitation to all to drop in
- Rethink Mental Illness have produced a report on Access to Mental Health Services in Canterbury & Coastal CCG Areas which will be circulated with minutes.
- More planning guidance for 15/16 coming out in December focusing on MH waiting times for initial assessments.

Action: Neil Fisher to give an update on services provided to patients in crisis, triage facilities etc.

It was commented that although the report indicated that fewer patients are cared for out of area the statistics are for just one day and that the figure is probably higher. Simon Perks reported that this is a current focus and progress will be reported as work is done by the commissioners.

6 CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) - NEIL FISHER

Simon Perks gave the following update on behalf of Neil Fisher.

- Task and finish group preparing the Strategy and it has been really positive collaborative.
- Covers both preventative and early intervention aspect and also the emphasis on better involvement of parents which was a concern in the recent Healthwatch report.
- This year there has been huge improvement in CAMHS and SFPT are now out of special measures.
- Waiting times are much better (unlike England generally) and the service is now responsive to urgent requests.
- Kent strategy addresses the remaining shortcomings in children and young persons' emotional health provision and covers the concerns in the report by MPs in the Times recently
- David Grice comment "Looking forward to other areas of children's commissioning working as well as this !"
- Sussex Partnership CQC Visit in January.

Steve Inett advised that feedback from the Sussex Partnership will be shared.

It was recognised that individual reports of experience of the service are not good and there is overall dissatisfaction.

Action: Neil Fisher to liaise with David Grice and children's commissioners.

The need for preventative services was also discussed and it was commented that the Healthwatch report did not emphasise enough the needs of children who do not yet need to access CAMHS.

7 CHILDREN'S HEALTH AND WELLBEING BOARD - SARI SIRKIA-WEAVER

Sari Sirkia-Weaver gave an update on the work of the Children's Operational Group and highlighted the following:

- Reports that she had received indicated that the CAMHS service is not improving sufficiently.
  Action: Sari Sirkia-Weaver is due to meet the Programme Director for CAMHS before Christmas to talk further about this and will report back after that meeting.

- There are no formal lines of reporting from the local Children's Operational Group (COG) to the Kent Health and Wellbeing Board and methods of sharing good practice and learning have not yet been established.
- The Early Help Notification process has now replaced the Common Assessment Framework (CAF) and although this went live in September no referrals were made until November and there is now a large backlog of referrals in the pipeline. There are no assessment tools and staff have had little training.
- The Coastal Children Centre hub was inspected by OFSTED in September 2014 and was rated as good.
- A sub group of the COG has been established for safeguarding issues and will be supported by the Kent Safeguarding Children's Board.
- A group of young mothers supported by the Riverside Children's Centre have made a film about attitudes towards young parents and this has been very well received.
- One of the priorities is around healthy weight for children and a specialist is coming to the next COG to report on obstacles and barriers to delivering this and how the COG can help.

Amber Cristou queried whether the COG had planned to expand to Swale and was advised that there are no plans at the moment.

Grave concern was raised over the implementation of the new CAF system and the evidence that needs are not being addressed in individual cases as they are coming through and this will result in delays and a backlog. It was agreed that it is not acceptable that the new system was put in place without it being adequately resourced. This should be flagged a risk to all organisations as families in crisis are not being helped in a timely way.
Action: Sari Sirkia-Weaver to draft a letter to Andrew Ireland to express the Board's concerns.

Action: Alison Hargreaves to ensure that Simon Perks and Mark Jones take this for the Clinical Commissioning Groups to consider.

8 EMOTIONAL HEALTH STRATEGY - SARI SIRKIA-WEAVER

Sari Sirkia-Weaver brought the Boards attention to the Strategy and encouraged all to comment if they wished. The consultation closes on 5 January 2015. Commissioning intentions will be developed following the consultation.

9 DEMENTIA FRIENDLY COMMUNITIES - VELIA COFFEY

Velia Coffey reported that she had visited Sevenoaks District Council to see how they are working with communities to raise awareness of dementia. Ashford Borough Council also has a specialist scheme which has a more integrated approach. Velia Coffey suggested that as the population is ageing, organisations should be doing more individually and raising awareness as part of their overall strategies and policies.

Paula Parker commented that Kent County Council (KCC) have a dementia friendly programme and work is being done in Herne Bay and Whitstable.

Action: Paula Parker to bring a report outlining the work that is being done around dementia and how this information is disseminated to partner organisations.

10 ANY OTHER BUSINESS

It was agreed that the Core Group would discuss the potential need for written rather than verbal updates at future meetings.

11 DATE OF NEXT MEETING

27 January 2015, 18.00, Guildhall Canterbury.

DARTFORD BOROUGH COUNCIL

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 29 October 2014.

Present:
Councillor Roger Gough – Kent County Council (Chairman)
Councillor Ann Allen - Dartford Borough Council
Councillor Jane Cribbons – Gravesham Borough Council
Councillor Tony Searles - Sevenoaks District Council & Swanley Town Council

Sheri Green	Dartford Borough Council
Melanie Norris	Gravesham Borough Council
Sarah Kilkie	Gravesham Borough Council
John Britt	Gravesham Borough Council
Tristan Godfrey	Kent County Council
Anne Tidmarsh	Kent County Council
Val Miller	Kent County Council
Debbie Stock	Clinical Commissioning Group
Dr Elizabeth Lunt	Clinical Commissioning Group
Jess Muckerjee	Kent County Council

27. APOLOGIES FOR ABSENCE

Apologies for absence were received from Lesley Bowles, Andrew Scott – Clark, Graham Harris, James Lampert, Vicky Wiltshire, Su Xavier, and Cecilia Yardley.

28. DECLARATIONS OF INTEREST

There were no declarations of interest made.

29. THE MINUTES OF THE DARTFORD, GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD: 27 AUGUST 2014

The minutes of the meeting of the Board held on 27 August 2014 were agreed as a correct record although it was recognised that the responsibility for the Community Health nurse service did not lie with Anne Tidmarsh but with Lesley Strong.

The following issues were raised: Increasesinserviceprovisionin

responsetodemographicchanges.
It was noted that discussions were ongoing regarding this and it was agreed that the matter should remain in the Board's work plan for the future.

TheinclusionofHealthneedsinfutures106AgreementsandCIL
Members were unclear on the mechanism for including health requirements in s106 agreements and CIL that were to be attached to forthcoming planning approvals, both by the relevant local Councils and the proposed UDC.

It was agreed that the Chairman would approach KCC planning to ensure that this matter is accorded priority by them and that links are made between the CCG and district planners.

30. THE MINUTES OF THE MEETING OF THE KENT HEALTH AND WELLBEING BOARD: 17 SEPTEMBER 2014

The Chairman summarised the meeting of the Kent Health and Wellbeing Board held on 17 September 2014. He drew Members' attention to the issue of the Better Care Fund submission, which had been forwarded to the Department of Health for approval.

It was noted that feedback from the Department of Health was due but that it was not anticipated that major issues existed with the submission except perhaps relating to governance issues where risk apportionment had yet to be agreed.

Additionally it was reported that Officers had met regarding progress attained by local boards and were to report back to the Kent Board in January on this matter.

31. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS

The Board received and noted a position statement on actions arising from previous Board meetings.

32. BETTER CARE FUND - UPDATE

It was noted that this matter had been dealt with at item 30 of the minutes.

33. KENT ALCOHOL STRATEGY

The Board received a detailed presentation and a report from Jess Muckerjee, on an Alcohol Strategy for Kent.

The Board were informed that increases in the numbers of deaths and illness due to alcohol misuse now exceed those for any other chronic condition, and that misuse is also a major contributory factor in crime, disorder and anti - social behaviour.

It was noted that although the majority of people use alcohol responsibly, the misuse of alcohol is a growing problem both locally and nationally, with cirrhosis of the liver showing a five - fold increase in 33 – 55 year olds in the past 10 years.

It was explained that a new Kent Alcohol Strategy 2014 – 2016 had been adopted to build on the progress made by the previous (2010 – 2013) Strategy and that its primary aims were to:-

Reduce alcohol-related specific deaths
Continue to reduce alcohol-related disorder and violence year on year
Raise awareness of alcohol-related harm in the population
Increase pro-active identification and brief advice at primary care
Increase numbers referred into treatment providers as appropriate

The Board were also informed that the primary tools identified to achieve these aims were the Identification and Brief Advice (IBA) in Primary Care and pharmacies, Training for practitioners, Social Marketing, and the Targeted promotion of alcohol abuse initiatives.

While the delivery of the Strategy was a County wide responsibility it was stressed that local initiatives were extremely important to its success, and the development of local action plans was also recommended.

The Board noted that the Dartford and Gravesham Community Safety Partnership was supported by a local Drug and Alcohol Action Group and that it was appropriate that this Group with the addition of representation from Sevenoaks/ Swanley be responsible for work relating to the Alcohol Strategy.

Discussion amongst Board Members also identified the following list of issues which were of relevance to the Board area:-

The Impact of work currently underway in the Board area:

The addition of information and recommendations from Health professionals when alcohol license applications are being considered;

The practical advantages of the use of social media when publicising information on Alcohol misuse;
The impact that Alcohol abuse has on domestic violence;

The investigation of local publicity and consultation on alcohol related problems;

The promotion of alcohol related education into local schools; and,

The promotion of the use of Identification and Brief Advice (IBA) in Primary Care to aid in the treatment of alcohol misuse.

It was therefore agreed that this be referred to the local Drug and Alcohol Action Group with a request that a report be submitted to the Health and Well Being Board detailing positive ways forward, at the Board's meeting scheduled for April 2015.

34. WALK IN CENTRES

Debbie Stock provided a brief presentation on progress in the re - commissioning process for community health and urgent care services both of which were both due for renewal in 2016.

It was reported that the Darenth Valley trust was the only trust in Kent which had achieved its targets in Quarters 1 and 2 of the current year, and that investigations were under way into the factors which had contributed to this success, in order to assist others.

It was noted that attendance figures at Accident and Emergency were flattening out and that in the main patients were receiving attention within the 4 hour target time.

It was also reported that a review was to be undertaken of Urgent Care provision in the three North Kent areas, that preliminary meetings had taken place, and a timescale for the review had been agreed.

Councillor Roger Gough informed the Board that the details of local consultation undertaken on the review should be provided to the Board and accordingly asked that a further report on this be submitted by Debbie Stock to the Board's meeting scheduled for February 2015.

35. KENT HEALTH AND WELLBEING STRATEGY: LOCAL PUBLICITY

It was noted that there was no further information on this issue.

36. INTEGRATED COMMISSIONING GROUP: FURTHER REPORT

The Board was informed by Anne Tidmarsh that the Integrated Commissioning Group, following consideration of its work plan and progress to date, was proposing to realign itself to take on work relating to the delivery of services in addition to its current area of responsibility.

This realignment would necessitate the formation of a number of new sub groups and the consequent appointment of Officers to swerve thereon.

Arising from this Sheri Green asked that the new role of the Group should be clarified and Terms of Reference and governance arrangements for the new Integrated Commissioning Group and its sub groups be drawn up to enable suitable officer appointments.

37. HEALTH INEQUALITY GROUPS - UPDATE ON PROGRESS ACHIEVED

The Board received a comprehensive report detailing the work, to date, of the three Health Inequalities Groups.

The report identified progress made against the objectives identified by the individual HIG.

In view of the length of the report and the short time available it was agreed that consideration of the item should be deferred to the Board's next meeting where more detailed consideration could be afforded to it.

38. INFORMATION EXCHANGE

There were no items to be reported.

39. BOARD WORK PLAN

The Board noted the content of the Work Plan and the amendments and additions arising from this meeting.

The meeting closed at 5.20 pm

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Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 16 September 2014 at 3.00 pm.

Present:

Chairman: Councillor P A Watkins

Board: Dr J Chaudhuri
Ms K Benbow
S S Chandler
P G Heath
Councillor J Hollingsbee
G Lymer
Councillor M Lyons
Ms J Mookherjee
P Parker (as substitute for Councillor Mr M Lobban)
Ms J Perfect
Mr D Reid (as substitute for Councillor Mr S Inett)

Also Present: Councillor PM Beresford (Dover District Council)
Councillor B W Bano (Dover District Council)
Ms G O'Grady (Local Project Delivery Manager Shepway, Troubled Families)
Ms R Jennings (Turning Point)
Mr S Taylor (Shepway District Council)
Ms M McManus (Shepway District Council)
Mr I Swallow (Kent Police)
Mr A Upton (Public Health)

Officers: Head of Community Safety, CCTV and Parking
Head of Strategic Housing
Head of Leadership Support
Licensing Team Leader
Leadership Support Officer
Team Leader – Democratic Support

14 APOLOGIES

Apologies for absence were received from Mr S Inett (Healthwatch Kent) and Mr M Lobban (Kent County Council).

15 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the agreed Terms of Reference, it was noted that Mr D Reid and Ms P Parker been appointed as substitutes for Mr S Inett and Mr M Lobban respectively.

16 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

17 MINUTES

It was agreed that the Minutes of the Board meeting held on 24 June 2014 be approved as a correct record and signed by the Chairman.

18 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised on notice by members of the Board.

However, with the consent of the Chairman, Councillor J Hollingsbee requested an update on staffing levels in respect of Child and Adolescent Mental Health Services (Minute No, 10).

19 REVISED BETTER CARE FUND PLAN

Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) presented the report on the Revised Better Care Fund Plan.

The indicator for reducing unplanned hospital admissions was highlighted as a key indicator as it was linked to funding distribution. However, even if the number of unplanned admissions was reduced, South Kent Coast Clinical Commissioning Group would need to show a link between this and schemes it had in place.

The importance of the GP referral system and early diagnosis was discussed as part of the framework of system changes required to reduce unplanned admissions.

The Board was informed that the report would be considered by the Kent Health and Wellbeing Board at its meeting on 19 September 2014.Ms P Parker stated that Kent County Council had worked with all Clinical Commissioning Groups in Kent in the development of their Better Care Fund Plans.

RESOLVED: That the Revised Better Care Fund Plan be noted.

20 SOUTH KENT COAST HEALTH AND WELLBEING BOARD WORK PROGRAMME: THE WAY FORWARD

The Head of Leadership Support introduced the Board's proposed Work Programme. It was stated that the work programme was a living document.

RESOLVED: (a) That the proposed work programme be approved.

(b) That a communication and Engagement Plan be developed.

21 EAST KENT HOMELESSNESS PREVENTION STRATEGY

The Board was informed that this item had been withdrawn from the agenda.

22 SHELTERED HOUSING SERVICE REVIEW

The Board received a presentation from Mr K Cane and Ms J Hatcher (East Kent Housing) on the recent Sheltered Housing Service Review undertaken.

The key points of the review were:

- The rebranding of sheltered housing as independent living with an increased emphasis on promoting choices, personal independence and health and wellbeing;

- More tailored as opposed to generic support services;
- More effective and integrated working with health and social care agencies;
- The creation of a new Health and Wellbeing Co-Ordinator post (subject to funding);
- A new support planning process with better and more predictable access to support and advice. As part of this there would be more planned face-to-face meetings with tenants with greater support needs and regular drop-in sessions for all tenants; and
- New arrangements for laundry facilities.

The Board was advised that the proposals had been overwhelmingly supported by those residents who had responded to the consultation.

The Head of Strategic Housing (Dover District Council) stated that measures were being taken to review current sheltered housing provision and anticipate future demands. As part of this, the service was seeking to link with the Kent County Council Accommodation Strategy over the provision of extra care accommodation.

The Board was advised that the report had been to Dover District Council's Cabinet in September 2014 and would be going to Shepway District Council's Cabinet in October 2014.

RESOLVED: That the report be noted.

23 KENT ALCOHOL STRATEGY

The Board received a presentation from Ms J Mookherjee (Public Health Kent, Kent County Council) on the Kent Alcohol Strategy.

The Board was informed that the excessive consumption of alcohol was a growing problem in Kent and the fifth largest cause of death in England. In the South Kent Coast Clinical Commissioning Group area, Dover had the highest rate of male mortality in the locality and Shepway the highest rate of female mortality in the locality.

The key aims of the Alcohol Strategy for Kent 2014-16 were:

(a) To reduce alcohol-related specific deaths.
(b) To continue to reduce alcohol-related disorder and violence year-on-year.
(c) To raise awareness of alcohol-related harm in the population.
(d) To increase pro-active identification and brief advice at primary care.
(e) To increase the numbers referred into treatment providers as appropriate.

The Strategy also had six pledges for its delivery as followed:

(a) Prevention and Identification
(b) Quality of Treatment
(c) Co-ordination of Enforcement and Responsibility
(d) Local Action
(e) Vulnerable Groups and Inequalities
(f) Protection of Children and Young People

The development of the Strategy had commenced in 2013 and a number of measures were already underway.

The Board was advised that alcohol-related issues were not just a health matter but also a crime and disorder matter and would involve a multi-agency approach to achieve the strategies objectives.

RESOLVED: (a) That the report be noted.

(b) That a Local Alcohol Action Plan be developed to implement the Kent Alcohol Strategy.

(c) That the Healthier South Kent Coast Group be given responsibility for addressing the 6 pledge areas of the Kent Alcohol Strategy.

24 CQC INSPECTION REPORT - EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) presented the Care Quality Commission's (CQC) report on the East Kent Hospital University NHS Foundation Trust.

The Board was advised that the next step was for the development of an improvement plan which the Clinical Commissioning Group would a role in supporting.

RESOLVED: That the update be noted.

(Councillor P G Heath declared a Voluntary Announcement of Other Interest (VAOI) by reason of his membership of the Council of Governors of the East Kent Hospital University NHS Foundation Trust.)

25 CHILDREN'S OPERATIONAL GROUP UPDATE

Councillor S S Chandler provided an update to the Board on the Children's Operational Group. It was stated that the first meeting had been held in July 2014 with the next meeting scheduled for October 2014.

RESOLVED: That the update be noted.

26 CONSULTATION AND NEWS UPDATE

RESOLVED: That the update be noted.

27 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 5.37 pm.

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 25 November 2014 at 3.00 pm.

Present:

Chairman:	Councillor P A Watkins
Board:	Ms K Benbow P M Beresford Dr J Chaudhuri Councillor P G Heath Councillor J Hollingsbee Mr M Lobban Ms J Mookherjee Ms J Perfect Mr D Reid
Also Present:	Ms P Beer (NHS England) Mr A Fairhurst (Public Health, Kent County Council) Mr K Fordham (Your Leisure) Mr W Greaves (Shepway District Council) Ms J Hulks (Kent Community Health NHS Trust) Ms H Knight (South Kent Coast Clinical Commissioning Group) Mr R Jackson (Shepway District Council) Mr D Martin (Your Leisure) Mr I Rudd (Public Health, Kent County Council) Ms L Rumbelow (Kent Community Health NHS Trust)
Officers:	Head of Leadership Support Leadership Support Officer Scheme Manager Head of Democratic Services

28 APOLOGIES

Apologies for absence were received from Councillor S S Chandler (Dover District Council), Mr S Inett (Healthwatch Kent), Councillor G Lymer (Kent County Council), and Councillor M Lyons (Shepway District Council).

29 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the agreed Terms of Reference, it was noted that Councillor P M Beresford and Mr D Reid has been appointed as substitutes for Councillor S S Chandler and Mr S Inett respectively.

30 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

31 MINUTES

It was agreed that the Minutes of the Board meeting held on 16 September 2014 be approved as a correct record and signed by the Chairman.

32 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised on notice by members of the Board.

33 DOVER MEDICAL PRACTICE UPDATE

Ms P Beer of NHS England gave the Board an update on the progress of transferring patients from the Dover Medical Practice following Concordia decision to cease delivering the service.

The Board expressed its concern at the number of patients who had yet to register with another practice and sought clarification on the process and timing.

The Board was assured that the NHS policy was being followed and all patients would have access to a GP and that all vulnerable patients had been transferred. Letters had been sent to all patients and drop in sessions with translation services had been arranged. Approximately one third of the 3000 patients had already been allocated another GP with a backlog of several hundred manual applications still to be processed.

The Board questioned why telephone contact had not been made with patients who had yet to register with another GP and were advised that, whilst the Practice has contact numbers, NHS England does not hold this information.

Dover District Council offered to display posters at its offices to advise patients of the surgery of the need to register with another GP and to signpost them.

The Board were advised that NHS Property Services were realigning the accommodation in Pencester to offer better facilities to accommodate additional patients.

It was noted that the recruitment and retention of GPs generally continues to be a problem with many newly qualified medical staff choosing to move abroad.

The NHS England representative agreed to the request of the Board that an update on the numbers that had transferred to another practice at the next meeting together with details of any further action that was being taken and any remaining issues that need to be addressed as a result of the closure of the surgery.

The subject of training, recruitment and retention of medical staff within the Health and Wellbeing Board area be the subject of consideration at a future meeting.

RESOLVED: That the update be noted.

34 CARDIO VASCULAR DISEASE WORKSHOP

The Board received a presentation from Ms J Mookherjee on the positive impact that early diagnosis and behavioural changes can have on patients with Cardio Vascular Disease.

RESOLVED: That the presentation be noted.

35 THE ROLE OF PHYSICAL ACTIVITY IN IMPROVING HEALTH AND WELL BEING & POTENTIAL LINKS BETWEEN YOUR LEISURE AND SOUTH KENT COAST HEALTH & WELLBEING BOARD

The Board received a presentation from Mr K Fordham and Mr D Martin from Your Leisure on the benefits of exercise on reducing ill health and their drive to turn the tide of inactivity. The use of technology with the increasing use of Apps to measure health scores was highlighted.

RESOLVED: That the presentation be noted.

36 NHS HEALTH CHECKS AND HEALTH IMPROVEMENT

The Board received a presentation from Ms L Rumbelow and Ms J Hulks regarding the NHS Health Checks and Health Improvement and how these activities can highlight those with health issues and target actions.

RESOLVED: That the presentation be noted.

37 CURRENT CARDIO VASCULAR DISEASE WORK AND SERVICES AVAILABLE IN SOUTH KENT COAST

The Board noted the report from Ms J Mookherjee and Ms K Benbow regarding the SKC CCG CVD Working Group and the aim to ensure patients are seen in the most appropriate setting and the Public Health work looking at equity across practices and variations across the CVD Pathway.

Mr W Greaves (SDC Sports Development) and Mr R Haynes (DDC 'Up on the Downs') noted the work each are undertaken to encourage participation, noting accessible countryside in close proximity to urban areas and looking at funding opportunities.

RESOLVED: (a) That the South Kent Coast Clinical Commissioning Group Cardio Vascular Disease Working Group and the Healthier South Kent Coast Group (a sub-group of the South Kent Coast Health Wellbeing Board) liaise through Mr I Rudd (Kent Public Health) to identify the services provided in the South Kent Coast area and understand how these could be better co-ordinated and integrated.

(b) That Mr K Fordham to be invited to join the Healthier South Kent Coast Group to understand motivational behaviour to encourage people to increase activity and look at joint opportunities.

(c) That the potential for healthy Living Pharmacies to signpost within the community and for better liaison with GPs around exercise referrals be explored.

(d) That Mr I Rudd report back to the Board through the Healthier South Kent Coast Sub-Group.

38 OPERATION OF SOUTH KENT COAST HEALTH AND WELLBEING BOARD

The Board discussed the need to review the trial of 'Operational' and 'Strategic' meetings and ensure the Boards work plan keeps up with national policy.

RESOLVED: That Ms M Farrow to report at next meeting with suggestions on how to move forward.

39 CONSULTATION AND NEWS UPDATE

RESOLVED: That the update be noted.

40 URGENT BUSINESS ITEMS

There were no items for urgent business.

The meeting ended at 5.35 pm.

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Health and Wellbeing Board – Fifth Formal Meeting

Meeting held on Wednesday 19 November 2014 at 09:30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present	**Cllr Andrew Bowles (AB), *Leader, SBC (Chair)***	**Paula Parker (PP), *Commissioning Manager, KCC***
	Cllr John Wright (JW), *Cabinet Member for Housing and Lead Member for Health, SBC*	**Alan Heyes (AH), *Community Engagement Lead, Mental Health Matters***
	Patricia Davies (PD), *Accountable Officer, Swale CCG*	**Tristan Godfrey (TG), *Policy Manager, KCC***
	Su Xavier (SX), *Swale CCG*	**Jo Purvis (JP), *Strategic Housing and Health Manager, SBC***
	Colin Thompson (CT), *Public Health, KCC*	**Pippa Barker (PB), *KMPT***
	Hannah McKenzie (HM), *Kent Healthwatch*	**Karen Dorey-Rees (KDR), *KMPT***
	Chris White (CW), *Swale CVS*	**Nicola Jones (NJ), *Interim Head of Quality and Safety, Swale CCG***
	Chris Beaney (CB), *Assistant Director LD, KCC*	
Apologies	**Debbie Stock, *Chief Operating Officer, Swale CCG***	**Penny Southern, *Director Learning Disability and Mental Health, KCC***
	Dr Fiona Armstrong, *Chair, Swale CCG*	**Mark Lemon, *Strategic Business Advisor, KCC***
	Bill Ronan, *Community Engagement Manager, KCC*	**Cllr Ken Pugh, *Cabinet Member for Health, SBC***
	Sarah Williams, *Assistant Director, Swale CVS*	**Amber Christou, *Head of Housing, SBC***
	Terry Hall, *Public Health, KCC*	**Abdool Kara, *Chief Executive, SBC***
	Cllr Chris Smith, *Deputy Cabinet Member Adult Social Care & Public Health, KCC*	

NO	ITEM	ACTION
1.	**Introductions**	
1.1	JW welcomed attendees to the meeting.	
1.2	All attendees introduced themselves and apologies were noted.	
2.	**Minutes from Last Meeting**	
2.1	The minutes from the previous meeting were approved.	
2.2	Matters arising:	
	▪ p.2, 2.2: JP to contact Debbie Stock about presentation on Integrated Discharge Teams	**JP**
	▪ p.5, 5.2: PP to share a list of respite/support services for dementia	**PP**

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	carers ▪ p.6, 10.3: TH to confirm if there is still a pharmacy at Teynham Street	**TH**
3.	**KMPT Mental Health Quality Review**	
3.1	AB joined the meeting and assumed the Chair.	
3.2	NJ presented on the CCG quality review into MH provision across North Kent. The key points were: ▪ insight visits were undertaken at four locations in June: Littlebrook; Medway and Swale Crisis Team; Swale Community Recovery Team; and Medway Psychiatric Liaison Service; ▪ the review found high vacancy rates with a high use of agency staff; e-rostering was not being used to its full potential, and staff were feeling under pressure but did feel supported and spoke highly of their colleagues; ▪ there was a lack of consistent communication between teams, particularly the crisis and community teams; and ▪ a number of follow-up visits were carried out and found that many of the recommendations were starting to be implemented. A final report will be going to the CCG Governing Body in January.	
3.3	PP and KDR presented KMPT's response to the review. The key points were: ▪ there is a national issue recruiting registered mental health nurses and the added local issue regarding the proximity of some of the London Trusts, who can pay staff more; ▪ recruitment on the acute wards for vacancies previously filled by agency staff is underway. Where agency staff are used, they are employed for three months to provide some consistency; ▪ integrated working between the crisis and community teams is improving and work is going on with GPs the community team and the local mental health action groups around inappropriate referrals to the crisis team; ▪ KMPT are also looking at the s135 assessment process to see how this can be made smoother, and also how to free up the crisis team to deliver home treatment; ▪ there are frequent admissions to acute wards from Medway and Swale. A panel has been set up to look at this and treatment to prevent admissions; and ▪ Littlebrook will be undergoing a major refurbishment beginning in January, which will add an additional three rooms.	
3.4	Points made in the discussion included: ▪ need a workforce strategy around psychiatric liaison community nurses. If we are trying to prevent acute admissions we need to ensure that we increase staffing levels amongst community teams accordingly; ▪ custody liaison nurses working closely with the police and the street	

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	triage team identify at the first instance if people need a s136 admission; and ▪ Patient/relative feedback was sought on the follow-up visits and the Healthwatch Kent recommendations from their review will be incorporated into the final CCG report.	
4.	**Mental Health Crisis Provision**	
4.1	AH outlined the proposals for MH crisis cafe provision within Swale. The key points were: ▪ they have received winter pressures monies to be able to fund this, although less than they were hoping for due to funds needing to be redirected to Medway A&E; ▪ just started a similar project in Medway; ▪ due to the geographical nature of Swale and lack of evening transport, the proposal is for two cafes, one in Sittingbourne and one on Sheppey. Currently considering the Pulse cafe in Sittingbourne and the Healthy Living Centre in Sheerness; ▪ the cafes will provide support to people over the weekends who are experiencing crisis. Idea is to prevent them from presenting at A&E and to reduce social isolation; ▪ planning to start this in early December and will be running events to encourage people to come along to the service; and ▪ hoping to make a business case around the benefits to A&E to get funding for after the pilot period.	
4.2	Points made in the discussion included: ▪ this will be a very welcome and valuable service - what can partners do to help? Promote service and ensure frontline services are aware and can signpost; ▪ AB would like to visit the service once it is up and running. AH to organise through JP; ▪ Swale CCG looked at the people from Swale presenting at A&E, and around 43% were known to mental health services; ▪ Many people with mental health issues may need other support beyond care i.e. social interaction; and ▪ wellbeing measurements of service users at the beginning and end of the interaction with the service will help to show if it is making a difference to people.	**AH/JP**
5.	**Draft Children and Young People's Emotional Health and Wellbeing Strategy**	
5.1	CT provided an outline of the Draft CYP Emotional Health and Wellbeing Strategy. The key points were: ▪ This is a multi-agency strategy, with a key aim of reducing pressure on Tier 3 services;	

	▪ golden thread running through the strategy of the promotion of emotional wellbeing amongst CYP; ▪ aim is to engage with CYP earlier to prevent the need for Tier 3 services; and ▪ tt is expected that a delivery plan for the strategy will be in place by February next year.	
5.2	Points made in the discussion included: ▪ there is not much in strategy about emotional resilience amongst the under-5s. CT will feed this back; ▪ BR suggested the Board invite the lead for the Head Start programme at KCC to present to the Board. JP to add to Forward Plan; and ▪ the consultation closes on 5 January if organisations wish to feed back directly. The consultation can be accessed here: http://consultations.kent.gov.uk/consult.ti/EWStrategy/consultationHome	**CT** **JP**
6.	**Health and Wellbeing Board Prioritisation**	
6.1	JP outlined the proposed priorities for the Health and Wellbeing Board. The key points were: ▪ priorities have been developed from the local assurance framework for the JSNA and the Kent Joint Health and Wellbeing Strategy; ▪ areas of focus have been identified based on where Swale is under-performing or where it was thought the Board could have the most impact; and ▪ these will be for 12 months and will then be reviewed. The Health Improvement Partnership will develop an action around these and bring back to the Board. The priorities were agreed by the Board	**JP/TH/ CT/SX**
7.	**Integrated Commissioning Group Update**	
7.1	PP outlined that that ICG had been undertaking work around falls prevention and working with KCC on the Accommodation Strategy. A fuller item on this to be brought back to the Board at a future meeting.	**JP/PP**
7.2	PP updated that a decision had been taken to merge the Swale and DGS ICGs into one North Kent Operational Commissioning Group. The purpose of the Group will be to look at ways of aligning more commissioning across organisations.	
7.3	There will be a rotating chair and location between Swale and DGS.	
7.4	PD advised that it was thought that having the single group would make it more focused.	
7.5	JP asked if Public Health would be involved as they were in the ICG but weren't on the ToR for the new Group. PP advised that they would be invited to join. SX also stated that she would be happy to feed in as required.	

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8.	**Better Care Fund**	
8.1	TG updated on the Better Care Fund. The key points were: ▪ the Kent Health and Wellbeing Board agreed to a target of 3.5% reduction in emergency admissions; ▪ the Kent BCF Plan was approved by DoH with support, indicating there are still some issues to iron out; and ▪ a Finance sub-group of the Kent HWB has been set-up to look at governance and accountability and will report back to the Kent HWB in January.	
8.2	PD informed the Board that the Medway BCF Plan had been approved with conditions because of MFT and this could have impacts for Swale patients.	
9.	**Kent Health and Wellbeing Board**	
9.1	The agenda for the Kent HWB was noted with no comments.	
10.	**Partners' Update/AOB**	
10.1	**Swale CCG** ▪ The GP out-of-hours contracts and walk-in centre contracts both expire next April. Undertaking a wholesale review of community services across Swale and DGS to look at provision and need. ▪ Swale CCG are contracting directly with Maidstone and Tunbridge Wells Trust for some elective/planned services to enable MFT to concentrate on urgent and non-elective cases. This will initially be for six months. ▪ The majority of local NHS winter pressure funds will be directed to MFT to support their A&E service over the winter. JW stated that it would be nice if some winter funds could be redirected to housing services such as DFGs and Staying Put. PD reiterated that they had been directed that funds needed to go to MFT.	
10.2	**KCC** ▪ The second phase of KCC's transformation programme is underway. ▪ KCC are reviewing the numbers of people with learning disabilities in residential care and how they can be supported in independent living. Also looking at developing an enablement service for adults with a learning disability. ▪ Similar work is happening around older people, evaluating acute demand and enabling people to remain in their own homes. They are also looking at how they can work closer with the VCS to support people in the community.	
10.3	**Kent Public Health** ▪ The County-wide Teenage Pregnancy Strategy has been agreed. This should naturally sit with the Children's Operations Group (COG) but there are still ongoing discussions with KCC about the role and remit of the COGs.	

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10.4	**Mental Health Matters** ▪ Considering whether there is potential to interlink the Live it Well Hub and the crisis café.	
10.5	**Swale CVS** ▪ Currently undertaking some work around support for trustees. ▪ Board member organisations can use the Swale CVS CEN if they have information they need to share with the VCS.	
10.6	**Kent Healthwatch** ▪ Healthwatch will be looking at the Swale area in February. Keen to link in with any local community groups. All to consider and feed back to Hannah at Healthwatch.	**ALL**

Next meeting date: **Wednesday 28 January 2015***

Time: **9.30am – 11.30am**

Location: **Committee Room, Swale Borough Council**

***This meeting will be in public**

Future Meetings Dates (all 9.30 – 11.30 at Swale House):

18 March 2015

20 May 2015

15 July 2015

16 September 2015

18 November 2015

THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 13 November 2014 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Councillors Johnston (Thanet District Council), E Green (Thanet District Council), Hazel Carpenter (Thanet Clinical Commissioning Group), Dominic Carter (Thanet Clinical Commissioning Group), Esme Chilton (Children's Board), Madeline Homer (Thanet District Council), Mark Lobban (Kent County Council) and Andrew Scott-Clark (Kent County Council)

In Attendance: Anne Charman, Karen Maxted and Margaret Mogentale

1. APOLOGIESFORABSENCE

Apologies were received from Mr Gibbens.

2. DECLARATIONOFINTERESTS

There were declarations received at the meeting.

3. MINUTESOFPREVIOUSMEETING

The minutes of the previous meeting held on 4 September 2014 were agreed.

4. ASPIRATIONSFORTHANET

Andrew Scott-Clark led the discussion on the item with a power-point presentation. He emphasised the need for using more positive data in order to convey a positive message to the public. Mr Scott-Clark requested Board members to agree on the best approach to present statistical data, whether through percentages or the 'thermometer.' He said that life expectancy data showed significant inequalities between Thanet and other areas in the county. There was therefore a need to provide support that was proportionate to the significance of the problem in Thanet.

Aspirations for Children

Mr Scott-Clark said that with regards to the Aspirations for Children, officers were still working on coming up with some of the Key Performance Indicators (KPIs). As regards the Universal Child Programme, not all the mandatory performance indicators were currently being delivered in Thanet and other areas of the county.

Women Not Smoking

Evidence based approach was being used to support an early referral approach for pregnant mothers and first time mothers under 18. The aspiration was to have 95% of women not smoking when pregnant in 4 years' time. CO^2 monitoring has helped identify early on a number of issues/problems not necessarily related to smoking, like a leaking boiler in one of the households. Midwives were engaging expecting mothers and talking to them about smoking up to the point they gave birth.

The Board agreed to aspire to achieve the following target; that 95% of women not smoking when pregnant in 4 years' time.

Women Initiating Breastfeeding
Mr Scott-Clark said that there were challenges regarding the information system. Peer support programmes for midwives to work with individual mothers had been started county wide. He was going to find out the age profile of breastfeeding women in Thanet.

The Board agreed to aspire the following, that 75% of new mothers would be breastfeeding in 5 years' time and maintain at least 50% breastfeeding over six to eight weeks.

Reduce Alcohol Specific Stay in Hospitals
Mr Scott-Clark said that Thanet has the highest admission rates in the county. Madeline Homer said that TDC had previously directly funded pastoral street persons in Thanet. Mr Scott-Clark advised the meeting that work was in progress on some initiatives that would increase children resilience to say no to peer pressure in relation to alcohol use.

The aim to reduce alcohol related stays in hospitals from 58.3% per 100,000 to 40% in 5 years' time. Board members suggested that more discussions be conducted that would look at approaches that the Licensing function of Council could play to the health and wellbeing of the local residents.

Reduce Teenage Pregnancy
Thanet's aspiration was to reduce the rate to below 30% in the next 5 years.

Reduce Prevalence of Adult Smokers/Adults Not Smoking
Members were concerned that currently the advertisements that were being put out by companies selling cigarettes were sending the wrong messages to the public. Mr Scott-Clark said that discussions were on-going about the national policy on e-cigarettes.

The Board agreed to aim for a 20% reduction in smoking in 5 years' time.

NHS Health Checks
Mr Scott-Clark said that letters were sent out to individuals in the 40-74 age groups who were not on the register for health checks of vascular diseases. However the challenge was to get some of those individuals who would have received the letters to actually attend appointments. Thanet statistics were not yet available.

The Board agreed to aim for 100% population invitation for a health check. And that by the end of the current financial year 50% of eligible cohort would have received an NHS Health Check.

Early Deaths From Heart Disease & Stroke
Mr Scott-Clark said that the current mortality rate due to cardio-vascular disease was 95% in Thanet. The aim was to reduce it to 50% in the next 5 years.

Hip Fractures
The meeting was advised most falls occurred in people's own homes and that landlords were being encouraged to ensure that their properties had appropriate facilities to ensure that hazards were kept to a minimum.

Esme suggested that safeguarding children information should be added to that monitoring report. A report will be brought to the next Board meeting.

Thanet aspiration was to reverse the current trend hip fracture rate from 523 for the over 65yrs to below 450 in the next 5 years.

5. ASSURANCEFRAMEWORK

Andrew led discussion on the item. He gave a brief overview of the framework for monitoring of the agreed indicators. He said that county targets will be used to report back at a local level.

The report was noted.

6. KENTTEENAGEPREGNANCYSTRATEGY2015-2020

Andrew advised of the need to conduct extensive consultation with stakeholders through stakeholder engagement events with district representatives, teachers and young people in order to implement the county strategy on preventing teenage pregnancy. In order to successfully implement the strategy, joined up working was required. There should be universal access to services for young people. The services should be friendly. The challenge was how schools could be engaged effectively to break the cycle of teenage pregnancy. Part of the aspiration was to find ways to get young women into employment or back to school. The strategy now required to be translated into an action plan for implementation and monitoring in Thanet.

The report was noted.

7. NHSSTATEMENTOFSUPPORTFORTOBACCOCONTROL

Andrew indicated that the report sought the support of the NHS and the Thanet Board for the initiative that sought to stop tobacco smoking. He said part of the strategy to stop young people from smoking was to work with families. The approach had to be pragmatic; with an initial target being to lead individuals to gradually stop smoking but later on move to permanently abstinence.

Andrew suggested that Thanet District Council appoints a representative to attend the meetings of the Tobacco Anti-Smoking Alliance. He was going to provide the minutes of the last meeting of the Alliance held on 12 November 2014. Thanet CCG, TDC and the board should sign up to the 'Stop Tobacco Smoking' Campaign.

The Board agreed that Andrew Scott-Cark would draft a letter that would be signed by the TDC Leader and Board Chairman signing up to the Campaign.

8. RECOMMENDATIONSOFKCCHEALTH&WELLBEING BOARD ATITSMEETING ON16 JULY14

(a) Engagementwith theKent FireandRescue Service, particularlyinrelation tofalls anddementia

Madeline Homer outlined how engagement was taking place with the Kent Fire & Rescue Service (KFRS) through the Margate Task Force. Support of vulnerable persons was a high priority, illustrated by the fact that the Task Force now had its own dedicated Vulnerable Person Officer. Going forward, work would take place with KFRS in relation to health related issues such as dementia, slips, trips and falls. Penny Button, Head of Safer Neighbourhoods (Thanet Council) had spoken to Sean Bone-Knell, KFRS Director of Operations, and would be meeting with the KFRS Strategic Lead to discuss how this could be taken forward and broadened to the rest of Thanet. An update on progress would be brought to the next meeting of the Board.

The report was noted.

(b) Ensure that the Kent Joint Health and Wellbeing Strategy is reflected in all public engagement activities

Hazel Carpenter reflected on the meetings of the Board since its inauguration one and a half years ago, and the various debates that had taken place, particularly through the offices of Andrew Scott-Clark, on matters developed within the Kent Health and Wellbeing Strategy. There was undoubtedly synergy between the joint strategy and the work of the Board.

However, what has been done implicitly rather than explicitly was anything around engaging with the public on issues specifically relating to the Strategy; for example, the various Summits which had been organised by the CCG and supported by the Board.

Hazel referred to the need for the Board to develop a strategy on communications and public engagement.

Esme Chilton suggested that consideration should be given to how public engagement takes place online.

The report was noted.

(c) Demonstrate how the priorities, approaches and outcomes of the Joint Strategy will be implemented at local levels

It was noted from Andrew Scott-Clark that all of the aspirations agreed by Thanet Board fitted into the Kent Joint Strategy. Clearly, Thanet Board was localising Kent-wide priorities and ensuring delivery.

Hazel concurred that key elements of the joint strategy were in action, and some in development. The Board needed to be sharp, however, on how these were put together through the Thanet Plan.

She added that it was important to reflect, in the near future, on what a good health and wellbeing board for Thanet should look like and what the next developmental step should be to ensure that public engagement and communications were right, and that measures and outcomes were right in reflecting the County Strategy.

Tony Martin stated that he would circulate the results of an online benchmarking exercise that had recently been undertaken by the clerk in relation to Health & Wellbeing Boards in Kent. It was important to assess where that Board was delivering and where it was not delivering and to ensure that it added value.

The report was noted.

9. THE THANET PLAN

Hazel Carpenter led the discussion. She said that all the six work streams were now active. The focus has been on ‘beefing up’ the care support outside the hospital. Madeline Homer suggested that the roles played by Thanet District Council and Kent County Council ought to be made clear in the Thanet Plan. Madeline and Hazel were going to talk about that issue outside the meeting.

Members noted the report.

10. AGENDA TOPICS FOR THE NEXT MEETING, TO BE HELD AT 10.00 AM ON THURSDAY,12FEBRUARY2015

The Chairman confirmed that the next Board meeting would be on Thursday, @ 10.00am on 12 February 2015.

Meeting concluded: 12.15 pm

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WEST KENT CCG HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON TUESDAY 18 NOVEMBER 2014

Present: Dr Bob Bowes (Chairman), and Gail Arnold, William Benson, Councillor Annabelle Blackmore, Alison Broom, Councillor Alison Cook, Councillor Roger Gough, Jane Heeley, Fran Holgate, Dr Caroline Jessel, Dr Tony Jones, Mark Lemon, Councillor Mark Rhodes, Dr Sanjay Singh, Malti Varshney and Councillor Lynne Weatherly

24. APOLOGIES FOR ABSENCE

It was noted that apologies for absence had been received from Linda Southern.

25. DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS

There were none.

26. MINUTES OF THE MEETING HELD ON TUESDAY 16 SEPTEMBER 2014

RESOLVED: That the Minutes of the meeting held on Tuesday 16 September be approved as a correct record.

27. DISCUSSION AND DECISION ON ACTIONS TO BE TAKEN FROM CHILDHOOD OBESITY TASK AND FINISH GROUP.

Malti Varshney, Consultant in Public Health with Kent County Council, introduced the report of the West Kent Childhood Obesity Task and Finish Group. The remit of the Group included development of a sound common understanding of the issues related to childhood obesity, understanding of cross organisational issues, and the articulation of how different organisations link up to resolve the issue.

A number of conclusions were reached which included the following:

The need to commission a pathway and associated services for childhood obesity that represented a whole system approach across the early years of the life course;

The need to develop a coherent lead to work with commissioners on the workstream to ensure that action bridges differences in practice and contracting;

The importance of communication, such as promoting awareness of available programmes, contact between different parts of the

system, communicating referrals and results, and communicating with children and families about obesity.

Barriers were identified within the report from among which the following were noted:

The lack of comprehensive services for pregnant women with a high BMI;

The lack of consistency in breast feeding support across West Kent;

Gaps in data collected on childhood obesity.

During discussion the Board decided to appoint a childhood obesity lead to work with commissioners to address recommendations of the report, and instigate and cultivate productive relationships between members to tackle issues.

It was suggested that data from the report of the National Child Measurement Programme could prove informative once released.

RESOLVED: It was agreed that:

1. Jane Healey be appointed as the officer lead for obesity

2. The report of the Childhood Obesity Task and Finish Group be noted, with feasible recommendations to be taken forward

28. INTERACTIVE WORKSHOP SESSION ON ADULT OBESITY

Laurie McMahon, Professor in Health Policy at City University, London facilitated a group discussion which included the Board and invited guests from public sector and voluntary organisations.

The meeting heard that the pressures on health funding in conjunction with a rise in public expectations had created a gap between funding and demand. Options discussed had included localisation, investment in prevention, profiling and targeted interventions, and generating citizen responsibility.

During discussion the following points were made:

Foresight modelling in 2007 projected a substantial increase in obesity by 2050. A raised BMI denoted an increase in disability affected life years, characterised by conditions such as musculoskeletal disorders, sleep apnoea, and type II diabetes.

Modelling of prevalence described how, by 2034, 50% of 50-79 year old men would be obese, and 50% of 70-79 women would be obese, and that this would create increased dependency.

Programmes such as Change for Life had demonstrated that awareness did not necessarily instigate engagement. There were a number of small projects to tackle obesity in progress, but in order to create a widespread affect an industrialisation of intervention would need to be created. These could be brief interventions, and include methods such as motivational interviewing, as per current interventions for smoking and alcohol. Inactivity constituted less than 30 minutes of activity per week, and so individuals who fell within this category needed to be located and motivated to change behaviour.

Convenience food had become an issue, and Local Authorities had a the ability to control licensing for fast food establishments, however a message that communicated the need for balance with moderation should be prioritised over a bad food/good food message. This message would need to be consistent across all services to inspire change and reduce confusion.

Interventions could be implemented using local, drill down data on obesity to target interactions and disseminate through communities. School and pre-Schools could have a major role within this through physical education and Healthy Schools Pilot. Staff within organisations, as members of the community, could be supported with programmes such as work place challenges and the support of in house Champions. Interventions would need to encompass a life course message and make contact with women prior to pregnancy, and through maternity and post-natal services.

Making a habit socially unacceptable was considered the most effective way to change behaviour. This would suggest that concentration on social and cultural changes would affect change laterally and virally. Financial levers could be explored for educating and raising awareness, such as the impact of high BMI on matters such as insurance premiums and mortgages borrowing. Research had been conducted into the kind of messages that change behaviour. Borough Councils and District Councils experienced in local educational campaigns could lend expertise to disseminating the message.

There could be an opportunity to create a model for a healthy town approach based upon research conducted by other towns and cities, which could then be adapted to localised areas.

RESOLVED:

1. That a task and finish group be set up by Malti Varshney and Jane Healey to produce further information and recommendations on child and adult obesity

2. That Maidstone BC, Tonbridge and Malling BC, Sevenoaks DC and Tunbridge Wells BC discuss the potential for a cycle of agenda setting

meetings, with each authority taking in turn in conjunction with the Clinical Commissioning Group and Kent County Council

29. DATE OF NEXT MEETING

The next meeting would be held at Maidstone Borough Council Officers on 20 January 2015 starting at 4 p.m.

30. DURATION OF MEETING

5.02 p.m. to 6.51 p.m.