AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 20th May, 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 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, Ms D Tomalin, Cllr P Watkins and Cllr L Weatherly

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

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

To receive any declarations made by members of the board relating to items on the agenda

4 Minutes of the Meeting held on 18 March 2015 (Pages 5 - 12)

To agree the minutes of the meeting held on 18 March 2015

5 Workforce (Pages 13 - 30)

To consider issues relating to the health and care workforce required to deliver the Five Year Forward View and the broader changes needed to establish a sustainable health and care sector across Kent

6 Kent and Medway Growth and Infrastructure Framework (Pages 31 - 36)

To note the progress being made to establish a Growth and Infrastructure Framework for Kent and Medway and provide comment on how best to engage with the health sector in debates about growth; about future health provision; and funding for health

7 Commissioning Plans - NHS England, Adult Social Care and Children's Services (Pages 37 - 208)

To discuss and endorse the following commissioning plans:

- NHS England (this plan was included in the printed packs for the meeting of the HWB on 18 March and has therefore not been reprinted)
- Adult Social Care
- Children's Services

8 Assurance Framework (Pages 209 - 236)

To receive a report outlining changes for some of the indicators and highlighting those raising concerns or showing increasing good performance

9 Joint Strategic Needs Assessment Exception Report (Pages 237 - 246)

To note the report

10 Minutes of the Children's Health and Wellbeing Board (Pages 247 - 254)

To note the minutes of the meetings of the Children's Health and Wellbeing Boards held on 3 February and 25 March 2015

11 Minutes of the Local Health and Wellbeing Boards (Pages 255 - 296)

To note the minutes of local health and wellbeing boards as follows:

Ashford – 22 April 2015
Canterbury and Coastal – 25 March 2015
Dartford, Gravesham and Swanley – 15 April 2015

South Kent Coast – 20 January 2015
Swale – 18 March 2015
Thanet – 12 February 2015
West Kent – 20 January 2015

12 Date of Next Meeting - 15 July 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, 12 May 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, 18 March 2015.

PRESENT: Mr R W Gough (Chairman), Mr I Ayres, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Mr B Jones (Substitute for Ms P Davies), Dr N Kumta, Dr E Lunt, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr M Philpott (Substitute for Dr F Armstrong) and Dr R Stewart

IN ATTENDANCE: Ms J Frazer (Programme Manager Health and Social Care Integration), Mr M Thomas-Sam (Strategic Policy Adviser), Mrs A Tidmarsh (Director, Older People & Physical Disability) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

132. Chairman's Welcome
(Item 1)

(1) The Chairman referred to a request from the Assistant Chief Constable Jo Shiner that Kent Police be represented on the Health and Wellbeing Board and said he would seek the views of the board members before responding.

(2) He said the visit by Simon Stevens on 24 February had been constructive and thanked those who had made presentations and other contributions to the event. He said that it would be helpful to consider some of the key issues raised such as estates and workforce at future meetings of the Health and Wellbeing Board and the local health and wellbeing boards.

(3) Mr Carter said that it would be helpful to consider what could be done in Kent to maximise the return on expenditure on health and social care if Kent were offered similar freedoms and flexibilities as Manchester.

(4) Mr Gough said it was intended to consider the commissioning plans for adult social care and specialist children's services at the next meeting of the HWB. He also proposed that consideration of NHS England's commissioning plans also be deferred to that meeting to enable a representative of NHS England to be present. He suggested that NHS England's Commissioning Plan was not reprinted in agenda packs for the next meeting.

133. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr F Armstrong, Dr B Bowes, Cllr A Bowles, Ms P Davies, Mr E Howard-Jones, Dr M Jones and Cllr L Weatherly. Dr M Philpott, Cllr K Pugh and Mr B Jones attended as substitutes for Dr F Armstrong, Cllr A Bowles and Ms P Davies respectively.

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

Dr D Cocker declared an interest in Item 7 – Pharmaceutical Needs Assessment as he was a dispensing doctor and a director of a company that ran a pharmacy.

135. Minutes of the Meeting held on 28 January 2015
(Item 4)

(1) In response to a question about minute 125, Early Years Restructure, it was confirmed that the detail relating to issues such as membership and chairmanship had yet to be finalised. It was also reported that there was general support for the process from the children's health and wellbeing boards and that the district council chief executives had supported the process at a recent meeting.

(2) Resolved that the minutes of the meeting held on 28 January 2015 are correctly recorded and that they be signed by the Chairman.

136. Review of Commissioning Plans
(Item 5)

(1) Dr N Kumta introduced the commissioning plans for Ashford and Canterbury CCGs. He referred in particular to the need to dissolve traditional boundaries between primary care, community services, hospitals, social care and other services in order to meet patients' needs and expectations. He said Ashford and Canterbury CCGs were well placed to deliver against these expectations and drew the Board's attention to the "Strategic Plan on a Page" set out on page 13 of the agenda papers.

(2) Dr D Cocker introduced the South Kent Coast CCG's commissioning plan. He said the plan was building on a solid foundation from 2014/15 and that it included £6.3m savings, prioritised mental health and parity of esteem, aimed to consolidate early work on out of hospital services and to support the hospital trust with the development of strategies for improving cancer diagnosis and treatment times and musculo-skeletal and integrated dermatology pathways. He explained the links between the commissioning plan and the Kent Health and Wellbeing Strategy and set out the structure of integrated care in the South Kent Coast CCG area.

(3) Dr T Martin introduced Thanet CCG's commissioning plan by setting out the vision for Thanet and the priority areas for 2015/15. He said the priorities for 2015/16 were to ensure patients received: high quality, equitable and integrated GP services and out of hospital care; timely, clinically appropriate and high quality care in hospital; high quality mental health care in the most appropriate setting; and to ensure high quality children's services.

(4) Mr Carter said he thought the East Kent CCGs had received a poor financial settlement both for growth and basic need. If this was the case across the county he suggested that collective representations were made to redress this.

He also said that the County Councils' Network had commissioned a report looking at the capitation allocations across the country against demographic and relative needs.

(5) It was suggested that in about 12 months' time the board considers the impact of initiatives in Thanet to address health inequalities and the impact of the development of community hubs (multi-speciality community provider (MCP) model). It was also suggested that safeguarding aims should be as specific as possible and should include appropriate references to child sexual exploitation which now had "national threat" status.

(6) Mr Ayres introduced the West Kent Plan by saying it was year 2 of a five-year plan and much of year 1 had been spent unpacking inherited contracts, getting quality systems in place and building leadership and organisational capacity. He said the West Kent Vision and plans were similar to the recently published NHS Five Year Forward View and referred to a number of initiatives already underway or planned in West Kent including: coaching clinical micro systems, the integration of GP out of hours services with home care services, building teams based around practices, the purchase of software to assist care plan management and secondary care referrals, work with Maidstone and Tunbridge Wells NHS Trust to develop a clinical strategy, new models for contracting, the development of treatment pathways, total place budgets and workforce training particularly in relation to the training of doctors and nurses.

(7) Mr Jones and Dr Lunt gave a presentation on the commissioning plans for Dartford, Gravesham and Swanley CCG and Swale CCG. Mr Jones said that, in addition to the aims set out in the presentation, it was intended to build on the previous year's successes such as the integrated discharge teams at the Darent Valley and Medway Maritime hospitals and the integrated primary care teams developed around groups of GP practices.

(8) He drew attention to the "plans on a page" and said that 11,000 new homes by 2030 were planned for Ebbsfleet resulting in a population increase of 27,000 over and above the normal projected growth of 21,000. He said the CCG was working with NHS England to highlight the potential shortfall in funding and had made submissions for funding for infrastructure to the DCLG and the Urban Development Corporation. He said the development of the Paramount Theme Park would attract 5,000 construction workers and 40,000 visitors per day by 2020 but as this population would be considered to be transient additional demand was unlikely to be funded.

(9) Mr Jones also referred to the Better Care Fund, the North Kent Education, Research and Innovation Hub and initiatives with further education colleges to develop courses and qualifications to provide opportunities for local people to qualify in health and social care.

(10) Dr Lunt drew particular attention to the commissioning intentions in relation to urgent care and long term conditions; a new community dermatology service; the implementation of an emotional and wellbeing service with KCC; the emphasis on reducing health inequalities in primary care as well as plans to review the neurodevelopmental pathway for autism/ADHD across Kent and to review services for disabled children with KCC.

(11) During the discussion there was general support for: the prominence being given to dealing with health inequalities; the emergence of innovation hubs in North and West Kent; and the plans for emotional health and wellbeing and autism services. It was suggested that workforce development initiative with further education colleges in North Kent be shared more widely.

(12) In response to a question about supporting and motivating patient participation groups to enable them to contribute to the resolution of challenges being faced by GPs, Ms Carpenter offered to share a recent report produced in the South Kent Coast area. It was also suggested that more work might need to done to understand more fully how patient participation groups and GP practices could work together.

(13) The Board was told that Ian Dodge, National Director of Commissioning Strategy at NHS England, was visiting Kent on Friday 27 March and the key message to him would be that adequate resources were required to ensure innovation continued at pace and scale regardless of whether sites had achieved Vanguard status or not.

(14) Mr Scott-Clark introduced the Public Health Commissioning Plan. He said much of the last year had been spent dealing with issues arising from the transfer of the public health service from the NHS, there had been no growth in the budget and there were growth pressures from NICE Technology Appraisals, implementing obesity pathways and increasing the number of health checks. He said that better ways of commissioning lifestyle behaviour programmes were being investigated to avoid unnecessary handovers between programmes. Mr Scott-Clark said the Public Health Commissioning Plan had been structured into three areas: starting well; living well and ageing well. He referred in particular to: programmes to reduce obesity in children; provide emotional health and wellbeing services for 0-25 years; reduce premature deaths from vascular disease or poor lifestyles by promoting health checks; support people to remain well and in their own homes, prevent falls and reduce the above average number of neck of femur fractures.

(15) In response to a question about falls and actions following the Kent Fire and Rescue Services presentation to the HWB on 16 July 2014 it was confirmed that: Public Health was working with the KFRS and social landlords to reduce falls and fires; local health and wellbeing boards had been asked to take this forward and efforts were being made to include data from the KFRS in the Year of Care report.

(16) Resolved that:

(a) The CCGs' Commissioning Plans and the Public Health Commissioning Plan be noted;

(b) A report be received at a future meeting of the HWB providing an update on actions taken by local health and wellbeing boards as a result of the KFRS' presentation.

137. Better Care Fund Section 75 Agreement
(Item 6)

(1) The Chairman introduced the report which provided assurance that the Better Care Fund (BCF) Section 75 pooled fund agreement had been through all partners' approval channels in order to be approved for implementation from 1 April 2015.

(2) Mrs Tidmarsh (Director of Older People and Physical Disability) said the HWB had received reports on the BCF at its meetings in September and December 2014.

(3) Ms Frazer (Programme Manager Health and Social Care) thanked the Chief Finance Officers' Group (NHS Area team led group of chief finance officers from the CCGs and Kent County Council) and Robyn Parsons (Graduate Trainee) for their work in bringing this workstream to a conclusion and enabling the agreement to be signed.

(4) Resolved that the assurance provided by the CFO Group that the Section 75 Agreement: ensures delivery of the desired outcomes of the Kent Better Care Fund Plan; has completed the legal process; has been approved through the relevant parties' processes and will be signed to be implemented from 1 April 2015 be noted.

138. Pharmaceutical Needs Assessment
(Item 7)

(1) Mr Scott-Clark introduced the report by saying that in November 2013 the HWB had agreed to the establishment of a steering group to oversee the production, consultation and publication of the Pharmaceutical Needs Assessment (PNA) and in September 2014 had agreed to the formal consultation on the draft PNA.

(2) In response to questions he said there was no evidence that people were not able to access the core dispensing services which formed the basis of the PNA and variations the availability of additional services such as emergency hormonal contraception were addressed as far as possible through the commissioning of services. He also said that details of all additional services provided in pharmacies would be published alongside the PNA.

(3) Resolved that

a) The key strategic findings of the PNA be noted as follows:
- Overall there is good pharmaceutical service provision in the majority of Kent
- Where the area is rural, there are enough dispensing practices to provide basic dispensing pharmaceutical services to the rural population
- There are proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City. This will mean that these areas will need to be

reviewed on a regular basis to identify any increases in pharmaceutical need

- The proposed Paramount leisure site plans in North Kent should be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical
- The current provision of "standard 40 hour" pharmacies should be maintained especially in rural villages and areas such as Romney Marsh
- The current provision of "100 hour" pharmacies should be maintained.

(b) The final PNA be approved for publication subject of final checking with NHS England on any pharmaceutical service application grants made following consultation and final tweaks through proofing and editing;

(c) At the agenda setting meeting for the Health and Wellbeing Board meeting on 20 May, consideration be given to developing a further paper on community pharmacies to address inequalities in access to additional pharmaceutical services outside the PNA and to encourage innovative practice.

139. Revised Protocol on the Working Arrangements between the Kent Health and Wellbeing Board, Kent Children's Health and Wellbeing Board and Kent Safeguarding Children Board
(Item 8)

(1) Mr Thomas-Sam (Strategic Business Adviser – Policy and Strategic Relationships) introduced the report which provided contextual information relating to the revised draft protocol setting out working arrangements between the Kent Health and Wellbeing Board, the Kent Children's Health and Wellbeing Board and the Kent Safeguarding Children's Board.

(2) In response to a comment about the prominence being given to child sexual exploitation it was suggested that it be noted that responsibility for this issue was implicit within the remit of all boards and that an amendment be made to paragraph 3.4 of the protocol to reflect the fact the HWB's role extended to health and care services and was not limited to health improvement and prevention services.

(3) Resolved that the revised draft protocol be agreed subject to the inclusion of specific references to the role of all three boards in relation to child sexual exploitation and an amendment to paragraph 3.4 of the protocol to reflect the KHWB's role in relation to health and care services.

140. Minutes of the Local Health and Wellbeing Boards
(Item 9)

Resolved that the minutes of the local health and wellbeing boards be noted as follows:
Ashford- 21 January 2015
Canterbury and Coastal – 27 January 2015
Dartford Gravesham and Swanley – 17 December 2014 and 11 February 2015
Swale – 28 January 2015 and

141. Date of Next Meeting - 20 May 2015
(Item 10)

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Health Education Kent
Surrey and Sussex

Health Education Kent Surrey and Sussex – Workforce Report

1. Introduction

Health Education (HE KSS), part of Health Education England has responsibility for the leading and supporting the development of the workforce. HE KSS is a provider led organisation working in partnership with service commissioners to determine the future need for workforce and education providers to ensure appropriate education solutions are available. Our vision, determined by our stakeholders including patients and students is:

'Through creative partnerships we shape and develop a workforce that impacts positively on health and well-being for all'.

This paper provides an up to date position on the work of HE KSS to provide an opportunity for discussion and to agree how we can develop the future workforce with the support of the Health and Wellbeing Board of Kent.

2. Five Year Forward View

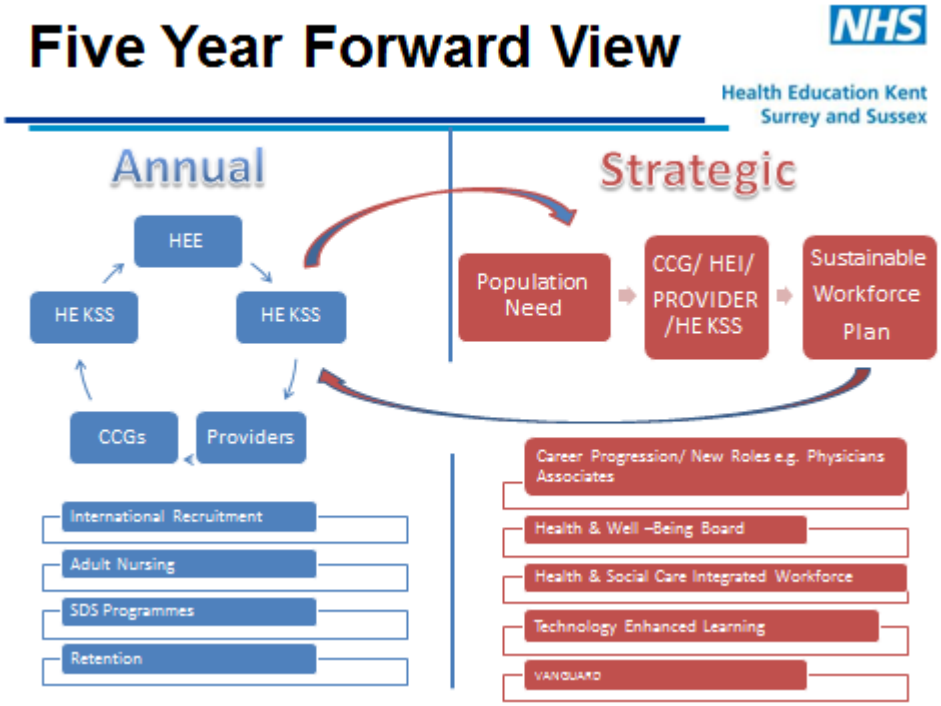
NHS England has recently published its new strategy, 'Five Year Forward View' (5YFV), which has been written in conjunction with and supported by all the arm's length bodies of the NHS, one of which is Health Education England (HEE). Health Education England has its own Mandate from the Department of Health, which is designed to meet this new strategy and to support Local Education and Training Boards to deliver the agenda locally together with their own identified needs. Health Education Kent Surrey and Sussex (HEKSS) has reviewed this new strategy against the current work of the organisation, in order to ensure our strategy and programmes will meet the needs of the 5YFV in support of the population of KSS.

2.1 Review/Map of work – Gaps

The review has shown that there is a significant amount of work already being undertaken within KSS that supports the 5YFV. There are areas which are currently less clear, particularly around the new models of care, Vanguards, and the potential for new organisational forms which may impact on the current model of education and training.

The areas that have been identified require some further work during 2015/16, include Mental Health where we will work with our Mental Health providers to review the current education and training available for mental health to ensure that it is 'fit for purpose', to meet the needs of the population moving forward. Also Learning Disabilities, we are the first LETB to commission a review of Learning Disability workforce planning and education which has now been completed and the Governing Body agreed to action the recommendations at its meeting in March 2014.

3.0 Strategic Planning Framework



The above diagram shows the current annual planning process on the left, together with some examples of short term work being undertaken. The strategic view on the right shows the new work programmes HE KSS is taking forward to enable us to influence the annual cycle with more focus around transformation. The examples on the right hand side show the work we are already developing in areas such as new roles which we have identified as possible solutions of the future.

3.1 CCG –Strategic Workforce Planning

The strategic workforce planning programme shown above has brought together HE KSS, the Universities of Kent and Surrey and the following CCGs, West Kent, Eastbourne Hailsham & Seaford, Hastings & Rother, South Kent Coast and Thanet. This programme is designed to support the CCGs to produce plans to ensure the local workforce is "fit for purpose" for the challenges of today and tomorrow. The work is being led by the CCGs with them determining the areas which they have decided will meet the following requirements:

- How the roles of respective healthcare professionals may need to change to better meet these challenges;
- Ensuring education and training in redesign of patient services and include the curricular requirements for all professionals;
- Ensuring the impact of technology has been considered in service delivery and education and training of all workforce in redesign of the future services;
- The impact of 7 days service closer to home and involvement of social services and third sector in delivery of high quality patient care;
- Ensuring patients are engaged in their own care and active involvement of them in joint decision making;
- Ensuring the impact of service modelling (redesign) on staff numbers, capability/competence;

- Developing agreed core competencies required by a practitioner to be able to be regarded as a safe and competent, which is agreed across the community;
- Determining how existing healthcare professional groups should seek to work together to better meet demands and preferences for the future needs of our population;
- Advising on the development and delivery of education & training to ensure the future workforce is fit for practice to work with patients and other team members in delivery of high quality patient services;
- Creating a pipeline of future healthcare workforce through apprenticeships, widening participation etc. that also helps local economies through job creation and skills development, especially young people.

HE KSS has set up a Steering Group that will meet to report on progress, share work, lessons learned so as to avoid unnecessary duplication. This Steering Group is due to meet in June and will invite additional stakeholders to be part of the group to ensure we take every opportunity of bringing various streams of work together. The outputs will be shared to assist other CCGs in developing the strategic workforce planning capabilities across all Kent Surrey and Sussex CCGs.

3.2 Vanguards

Within the Five Year Forward View there is the opportunity for the development of new models of care. Following an extensive programme of selection one such development was successful within Kent. The Whitstable Vanguard is designed to include:

- Enhanced rehab and intermediate care
- New community hospital
- A new teaching nursing home
- A new extra care facility with day centre

The Vanguard will be staffed by a combination of NHS, Social Care and voluntary and the role of HE KSS is to provide leadership development and workforce expertise in partnership with the NHS England, New Models of Care team.

4.0 Future Workforce Challenges

HE KSS through its County Workforce Summits and its current workforce planning round is working with the clinical leaders in the area to address specific workforce challenges. For the purpose of this paper, Nursing and GPs are selected to provide further information to the Health and Wellbeing Board.

4.1 Nursing

4.1.1 National context

The Royal College of Nursing Safe Staffing Report (Dec 2014) described a worsening picture of nurse vacancies across the UK, in particular London where there are 8,000 vacant nursing posts (14%). NHS England's Chief Nursing Officer Jane Cumming is setting up a national task force with the expectation that stakeholders will work collaboratively to develop local, regional and national solutions. Factors contributing to the shortage are:

- The increase in nursing establishments following the publication of the Francis Report which made a strong link between staffing levels, skill mix and patient safety;
- Pay freeze despite increases in costs of living;
- Issues with retention, especially of nurses trained overseas;
- Increase in complex patients with higher acuity.

4.1.2 Position in Health Education Kent, Surrey and Sussex (HE KSS)

Key points:

- 10% (n=2262) of nursing posts (acute, community and mental health) in Kent, Surrey and Sussex are not filled substantively.
- Of these vacant posts, 5% are filled by temporary staff, 2% by agency, and 3% remain unfilled.
- The highest volume of unfilled posts is in adult nursing (just over 1000 posts).
- The hardest hit areas are Mental Health (20% vacant), Learning Disabilities (16%) and School Nursing (19%).
- There has been significant recruitment from overseas by NHS trusts in the last year, including from Portugal, Spain, Ireland, Italy, Philippines, and Poland. However there are now concerns that this supply is diminishing.

The annual workforce planning takes into account both current and future needs in the context of the Five Year Forward View, and the demographic profile of the current nursing workforce by speciality, and county. The Strategic Workforce Programme with CCGs is looking at alternative solutions and workforce transformation to address the demand, this will identify new roles or opportunities to use other roles differently such as Physicians' Associates and Pharmacists. There are concerns about the impact of London recruitment initiatives on services located in North Surrey and West Kent because of the attraction of London weighting, and the opportunities for nurses to gain experience in centres of excellence.

4.1.3 Agreed Areas of Work within HE KSS

As a result of feedback and consultation, the plan comprises of the following themes:

1. Promoting nursing as a career
2. Education commissioning
3. Supporting students in practice
4. Supporting newly qualified nurses
5. Recruiting qualified nurses
6. Retaining nurses
7. Looking at the role of the nurse – what needs doing and who is best to do it?

These themes are currently being discussed with the County workforce summits and work plans drawn up to address each area.

We will also take into consideration the 'Shape of Care', review of nursing – HEE will consult on the recommendations over the summer. The Five Year Forward View includes the implementation of revalidation for nurses, which is designed to increase public confidence in

nursing. It is in a pilot stage, and is accompanied by a new Code of Conduct to ensure nurses maintain their competence and values.

4.2 General Practitioners

HE KSS has a strong reputation for delivering against national education targets within the GP workforce, however there is of course recognition that there is a gap and it is a challenge that is increasing. The following areas describe the work carried out by HE KSS in more detail.

4.2.1 GP Recruitment

HEKSS has a history of strong recruitment to GP Specialty training. Initiatives include:

- Wide range of Integrated Training Posts (allowing doctors to experience a number of medical specialties);
- Placements in CCGs to develop commissioning skills;
- Opportunities to develop educational and leadership roles through the enhanced ST3 scheme (extra 3 months training);
- Single Employer Model (gives trainees contractual security and good access to HR / occupational health services);
- Access to a comprehensive Indemnity;
- Educational Support programme including access to range of commissioned programmes and courses to help trainees prepare for MRCGP ;
- Broad Based Training Pilot (2 year programme including GP, Medicine, Psychiatry and Paediatrics) to help better develop a doctors generalist skills – trainee exits into one of the 4 specialties ;
- 55% Foundation doctors gain experience in GP.

In addition to the above, HEKSS recruited to 100% of declared (available) programmes for August 2014 entry and has increased the number of programmes from 236 to 247 for August 2015 entry, to support requirements to increase GP recruitment. Nationally there was an increase in recruitment numbers to meet the target produced by COGPED and the Centre for Workforce Intelligence of 3500. HE KSS was successful in round 1 of recruitment, a high fill rate of 88.2% (top 5 in UK). The second round of recruitment is on-going until end May 2015.

4.2.2 GP Workforce 10 point plan

To support the national GP Workforce 10 point plan, HE KSS has a number of programmes currently in operation. The following examples demonstrate the extent of this work:

Retention - Point 3

Retainer Scheme

- Scheme to support doctors in maintaining their clinical skills whilst also focussing on personal commitments that preclude a substantive role as a GP (caring role / personal health) – not intended for doctors developing portfolio careers.
- Doctor can work 1-4 sessions in a practice approved by HEKSS with a nominated GP retainer supervisor
- Doctor on the National Performer List as an unrestricted principal and undertakes NHS appraisal and revalidation

- Scheme runs for 5 years (maximum 10 years in exceptional circumstances) with annual re-approval by HEKSS
- Doctors receive support for CPD activities
- Programme led by Post certification School of HEKSS
- HEKSS currently has 34 doctors enrolled on the scheme 6 in Kent, 9 in Surrey, 19 in Sussex.

Supporting the workforce

Support for sessional doctors (locum / salaried)
- HEKSS peer support learning sets 27 learning sets supporting 300+ doctors
- CPD activities
- Support in developing evidence to meet NHS / revalidation
- Educational support for group leaders.

Newly qualified GPs and Practice Nurses
- Post Completion Training Support Groups
- 6 Groups across HEKSS with membership for up to 120
- Available for those within 2 years of completing GP training or newly qualified practice nurses to support transition to autonomous practice
- Focus on multi-professional approach to management of complex patients and quality improvement activity

Mentoring Scheme
- Network of trained GP mentors to support doctors

Point 8 – New Ways of Working HEKSS Initiatives

Paramedic Practitioners
- Well established programme with SECAMB (7 years) of training to develop paramedics in general practice with enhanced skills in assessment of patients and risk / uncertainty management.
- 40 placements per year (in approved training practices)

Community Pharmacy Pilot
- Placements in general practice for pre-registration community pharmacists
- 1st wave pilot started April 2015 with placements in practices already employing a pharmacist
- 2nd wave April 2016 – placements for 20 in approved training practice with reciprocal placement of GP trainee in community pharmacy.

Physician's Associates
- HEKSS Programme Board established – Lead LEP SASH
- 4 HEIS in HEKSS developing common academic programme to train UK graduates
- Placements in GP throughout the 2 year programme
- 1st wave recruitment anticipated Jan – March 2016.

Post Urgent Care Fellows
- Pilot across London LETBs and HEKSS (Dartford / Medway)

- 1 year programme to develop primary care professionals with skills to transform management of patients across the primary / secondary care interface
- Linked to an academic PG certificate programme and quality improvement activity
- Participants will work in primary care and across SECAMB and Emergency and Medical Assessment Units
- 1st wave multi-professional scheme being piloted in North West London.

Point 9 – Return to Practice

- National I and R Scheme re-launched March 2015
- Streamlined and explicit entry process
- National Application supported by strong links to Local Area Team
- Interview to explore educational needs (HEKSS)
- Objective test of clinical knowledge and professional decision making
- Returner Programme from 6 week – 6 months
- Nominated supervisor
- Revised exit process based on work placed based assessment
- Bursary to support the doctor – supported by NHS England
- No formal identified financial stream to support I and R in previous years
- KSS supported 4 doctors to return through 2014-15
- Currently working with 9 GPs since the new scheme launched.

5.0 Skills Development Strategy - SDS Achievements 2014/15 and Proposals for 2015/16

5.1 Introduction

The HEKSS Skills Development Strategy was developed with stakeholders and approved by the Governing Body in 2012, whilst in shadow form. The Governing Body approved the governance structure of the programmes, with each having a Stakeholder Programme Board, Governing Body sponsorship and where appropriate Clinical or Expert Lead for advice and guidance.

5.2 Background

The Skills Development Strategy began with five major priorities, Dementia, Primary Care, Emergency Care, Children and Young People, Compassion and Patient Safety. During the first two years of implementation the Governing Body recognised the need for three additional enabling programmes: Technology Enhanced Learning, Career Progression including Apprenticeships and Integrated Education. Moving into Year 3 of delivery Compassion and Patient Safety will become the focus for HEKSS' work on Human Factors. The achievements for each programme for 2014/15 together with an outline of plans for 2015/16 are described in sections below.

5.3 Dementia

Achievements 2014/2015

- Foundation Level Dementia Awareness Training - Around 90% of trusts and CCGs engaged. KSS are on target to have 29,065 staff trained by March 2015.

- Empowering Families and Carers - Regional training programme for 50 memory assessment service staff to enable them to deliver carer empowerment and support work to 1250 carers of dementia patients.
- Empowering Practitioners in Training - 'Time for Dementia' longitudinal study has been included in the 2014/15 curricula for the initial cohort of first year nursing and paramedic students at University of Surrey and for second year medical students at Brighton and Sussex Medical School (BSMS). In total four cohorts of undergraduate students will undertake the programme across 3 years.
- Empowering Practitioners in Practice - A 3-module Dementia Fellowship programme was developed by the Centre for Dementia Studies and delivered to a network of 52 primary and community care professionals.
- Empowering Care Home Staff - Delivery and evaluation of an innovative and complementary dementia leadership training programme to 100 healthcare professionals working in nursing homes providing care for older people with dementia to improve compassionate care pathways.

Proposals 2015/2016

- Evaluation of Foundation Level Dementia Awareness Training.
- Empowering Families and Carers - Delivery and evaluation of programme.
- Empowering Practitioners in Training - A comprehensive evaluation of the 'Time for Dementia' longitudinal programme by a clinical research fellow to generate information and guide on outcomes and costs to support the implementation of the model more widely.
- Empowering Practitioners in Practice -Delivery of Dementia Fellowship to a network of 30 healthcare professionals working within general hospitals including emergency care doctors and nurses, ward managers.

5.4 Primary Care

Achievements 2014/2015

- Recruited 20 Primary Care Workforce Tutors across all 20 KSS CCGs to target staff and teams in respect of skills and competencies for professional development.
- Developed and delivered a 'system leadership course' to link together education enablers with their locality including the Primary Care Workforce Tutors, GP Tutors and Programme Directors.
- Increased Practice Nurse mentorship capabilities within KSS to support pre-registration nurse student placements.
- Developed and commissioned an introduction to practice nursing course with the four KSS nursing Universities that is now being accessed by 40 recently employed practice nurses
- Funded the NHS Local Area Teams to enable adoption of a GP workforce tool across all of their general practices to provide workforce data.

Proposals 2015/2016

- To support the development of planning capabilities within CCGs to deliver future workforce plans based on known staff numbers, skills and competencies.
- To develop and deliver a regional educational framework for community pharmacies across KSS.

- To develop placements for pre-registration pharmacy trainees in general practice and GP trainees in pharmacy.
- To develop Community Education Provider Networks (CEPNs) functions through placements and/or shared learning activities that include Pharmacists/Optometrists and Dentists.
- To develop local sustainable models for placement and training activities that include all staff groups in general practice.

5.5 Emergency Care

Achievements 2014/2015

- Emergency Medicine SAS Upskilling Programme - 14 non-training EM doctors completed training to work as senior decision makers in KSS Emergency Departments. Development for second cohort due to commence in March 2015
- Dementia Fellowship – 10 Emergency Medicine practitioners (6 doctors, 3 nurses and 1 manager) have been accepted on the course which is due to commence on 4th February 2015
- Integrating community pharmacy into Urgent and Emergency Care pathways – commissioned AHSN to work on increasing pharmacies contribution and capabilities to emergency and urgent care, particularly in the GP out of hours periods
- Development and testing of Phase 2 'Transforming Urgent and Emergency Care' generic competence framework in collaboration with Canterbury Christ Church University
- Initiation of In vivo training with a focus on Mental Health for combined clinical teams
- Confirmed plans to develop a team of Research Paramedics into SEC Ambulance Trust over the next 2 years
- Confirmed plans to commission SEC Ambulance Trust to develop 36 Advanced Level Paramedic roles over the next 2 years.

Proposals 2015/2016

- Fund a second cohort for Emergency Medicine SAS doctors
- Fund year 2 of the Advanced Level Paramedics role
- Develop a sub-speciality training programme in Paediatric Emergency Medicine
- Support Phase 2 of the Integrated Community Pharmacy project
- Develop a pre-hospital Emergency Medicine sub-specialty training programme working in collaboration with KSS Air Ambulance
- Through training and education develop the potential for ex- military personnel to address emergency medicine workforce challenges.

5.6 Children and Young People

Achievements 2014/2015

- Continued to work both locally and nationally with colleagues to in response to the National Health Visitor Implementation Plan 2011.
- Working with Local Authority colleagues to support them as they take on commissioning of children's services to help them understand workforce issues and how to influence these
- Worked closely with the Maternity, Children & Young People Strategic Clinical Network to identify how we can help improve outcomes. This has led so far to us:
  - Facilitating 6 paediatric asthma training workshops which 140 staff attended in March

- Leading on local and national sonography working groups to develop the capacity of the diagnostic workforce and improve outcomes.

Proposals 2015/2016

- Continuing our health visiting, paediatric asthma and sonography work.
- Support and fund specialist perinatal mental health training.
- Research children's mental health with a view to supporting specialist education and training
- Scope high dependency unit care of children within the region to see if education and training needs can be identified and carried forward.
- Supporting the new PACESetter award – new Quality Award for CYP services in Primary Care called PACE (Patient and Carer Engagement, Accessing Services, Clinical Pathways Implementation and Education) introduced by the SCN.
- Supporting care closer to home.

5.7 Compassion and Patient Safety

Achievements 2014/15

- Schwartz Rounds - following a competitive bidding process, all nine sites have now commenced Rounds and feedback is generally positive. There is an emerging feeling that the Rounds provide the opportunity not only to strengthen teams and understanding of different roles but also to initiate compassionate conversations
- East Kent Hospital NHS Trust - Teams Improving Patient Safety (TIPS) - the Project Manager was appointed in February and this project is due to commence in March 2015. Rosie Courtney is the HEKSS representative on the project board to monitor progress and link with the Human Factors agenda
- Cultivating Compassion Project - University of Brighton, University of Surrey (UoS) & Brighton and Sussex Medical School (BSMS) (and some CCG involvement)
- Cultivating compassion Tool kit completed and ready to hand over on 6 May 2015 to participating organisations. New tools and new website devised, Faculty trained up via monthly facilitated workshops set up at BSUH, SABPT and ASPH to provide ongoing support for the compassion leads and trainers. Conference 'Cultivating Compassion' to be held 6/5/15 at UoB Conference Centre the hub. Key note speaker Peter Carter CE of RCN
- St Catherine's hospice compassion awareness training sessions - two sessions per month started in June 2014, now over 550 staff have been trained. All hospices continue to advertise sessions/dates on their websites. St Catherine's Hospice facilitated a session for 25 local GP trainees on request from a local GP practice. Trying to target more Trust staff going forward
- Mapping support for newly qualified practitioners in Kent, Surrey and Sussex - final report received at successful completion of project. Knowledge Exchange Conference held in December 2014 in Brighton. Generation and verification of a proposed framework will underpin future HEKSS quality improvement work on preceptorship

Proposals 2015/16

•To establish the Human Factors programme.

5.8 Technology Enhanced Learning (TEL)

Achievements 2014/2015

• Simulated Ambulance - Provision of learning opportunities using our simulated ambulance to educate healthcare professionals in undertaking safe patient transfers and paramedic training.
• Faculty Development Training - Simulation faculty development training offered from many of our providers at both basic and advanced level. Includes opportunities for learners to use this development to contribute towards a PGCE
    - E-Learning Network - Establishment of an e-learning network group and provision of e-learning hosting and development support accessible for all NHS providers in KSS
    - Development and launch of e-learning and on-line learning tools:
    - Lottie - raising awareness about sexual exploitation of children and young people
    - Gender variance
    - Pathways for ill children
    - Pain in Dementia
• Human Factors - Commissioned simulation programmes to educate healthcare professionals in human factors in each county
• Commissioned education programmes using simulation to educate healthcare professionals in managing risk in mental health and dementia related illnesses
• Learning Technologies conference in conjunction with London.

Proposals 2015/ 2016

• Expand the education programme using the simulated ambulance
• Evaluate faculty development provision and continue to commission training to develop simulation faculty
• Re-establish the Simulation Network to share best practice
• Review simulation facilities, identify any gaps and fund appropriate development
• Commission education using simulation in priority areas
• Re-develop and move the content from the ETFT platform to the national eLfH platform
• Review the available eLearning to support statutory and mandatory training
• Review available e-learning for diabetes training and the safe use of insulin and develop where appropriate
• In collaboration with London LETBs establish where best practice can be maximised and duplication reduced through network groups and resources
• Explore opportunities to pilot the use of technology (such as Open Badges) to transfer records of skills and training e.g. Care Certificate.

5.9 Career Progression Bands 1-4

Achievements 2014/2015

• Careers Advice Workshops - 2 delivered at Frimley Park and Western Sussex
• Pre-employment Programmes - 2 Princes Trust programmes delivered at Medway Community Healthcare and a joint programme between Brighton & Sussex Universities Hospitals and Sussex Community Trust; Education Business Partnership Pre-employment Programme delivered with Frimley Park NHS Foundation Trust
• Apprenticeships - 351 started at Quarter 3 on target for 549 at end of Quarter 4; regional Apprenticeship Awards 9th March; 3 Rotational Apprenticeship Schemes established across health & social care; 3 Simulation Technicians in post; Dental Apprentice pilot at Brighton, linking in with hospices and GP surgeries

- Care Certificate - 12 organisations in KSS involved in the pilot; peer review group established; HEKSS presented at National Event 17th February; supporting other NHS providers to implement and organising the Skills for Health Quality Mark assessment for organisations
- Surrey Health and Social Care Careers Collaborative - Model developed and bid being written; recruiting a Project Manager; match funding agreed; Initial contact established with Local Enterprise Partnership

Proposals 2015/2016

- Apprenticeships - Working with NHS providers, GP surgeries, social care and hospices to hit a target of 1373; Rotational Apprenticeship Schemes across health & social care rolled out in conjunction with all county councils in the region; delivery of 4 more Pre-employment Programmes linked to apprenticeship opportunities, including Sussex Partnership; further Careers Advice Workshops
- Careers Collaborative model rolled out to other parts of the region
- Implementation of the Care Certificate across all NHS providers from 1st April 2015
- Pilot the Pre-nursing HCA Experience
- Further development of Assistant Practitioner roles in the region
- Development of career pathways, including working with HEIs on vocational routes into study
- Implement systems of tracking LETB funded students in their careers
- Talent for Care Framework -support NHS providers to work towards HEE's top ten strategic intentions to develop the healthcare support workforce
- Inspiring the Futures -increase the number of health ambassadors and staff registered ; development of a regional approach to work experience; building health and social care careers into the school curriculum; recruitment of 3 Youth Ambassadors, one in each county (match - funding agreed).

Initiatives within the above programmes are being recognised nationally and continue to demonstrate that HE KSS is innovative and progressive and is delivering against its vision statement.

5.10 Integrated education

Working with Local Education Providers to develop integrated education governance processes so that education and workforce funding is used to support the patients pathway and move away from historic arrangements of professions working in silos.

6.0 Conclusion

As described above HE KSS has a number of work programmes to address the following:

Determination of the future workforce – CCGs Strategic Workforce Plans and HEE Annual Planning Process.

Workforce Challenges – Work with providers to improve identified areas such as Nursing and to develop new roles such as Physicians Associates and Advanced Paramedics.

Workforce Development – Supporting the current workforce to develop and acquire additional skills through the Skills Development Strategy.

There is clearly more work to do particularly around the health and social care integration agenda and how we transform the workforce to meet a shared vision of the future and this is an area where work with support of the Health and Wellbeing board could be progressed at pace.

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

To: Health and Wellbeing Board, 20 May 2015

Subject: **Workforce: Implications of the Five Year Forward View**

Classification: Unrestricted

Summary:

The strategic importance of ensuring we have the right health and care workforce to deliver the Five Year Forward View, as well as the broader changes needed to establish a sustainable health and care sector across Kent, has been acknowledged by the Board. Members of the Board are invite to discuss the paper on the workforce implications of the Five Year Forward View along with the suggestion that a time-limited Task and Finish Group be established to consider workforce issues in more depth to report back to the Board.

Recommendation:

The Board is asked to:

(a) Note the actions set out in the report from Health Education Kent Surrey and Sussex and to agree actions to support the transformation of the workforce to meet a shared vision of the future.

(b) Agree that a Task and Finish Group be established to look specifically at the strategic workforce issue and that the authority to agree the practical arrangements be delegated to the Chairman of the Board, in consultation with other Members of the Board.

1. Introduction

(a) The Kent Health and Wellbeing Board considered Strategic Workforce Issues at its January meeting. This was a welcome beginning to what will be a close relationship between the Board and Health Education England Kent Surrey and Sussex. The paper presented and discussed today will enable the Board to pursue the issue in more depth.

(b) The document produced by the central NHS organisations, *The Forward View Into Action: Planning for 2015/16*,[1] rightly identified that a modern health and care workforce is one of the fundamental means to enable change:

[1] http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf

- "The new models of care described in the Forward View will only become a reality if we have enough staff with the right skills, values and behaviours to deliver them. We need to develop a workforce able to work across acute and community boundaries and beyond traditional professional demarcations, with flexible skills and with the ability to adapt and innovate."[2]

(c) But the strategic importance of ensuring we have the right health and care workforce goes much further than developing New Care Models, essential though this is. Workforce has now been recognised by all the members of the Health and Wellbeing Board to be a priority area of focus and one that needs to be addressed if the health and care system is to remain sustainable going forward. However, there is a limit to how much each individual organisation can achieve on its own. A strategic approach involving all partners collectively needs to be taken. Taking a look at the issue across the whole of the county will ensure that the risks of decisions around workforce made in one part of the county are not undermined by those in another.

2. A Workforce Task and Finish Group

(a) Given the importance of the workforce issue, and being aware that it can take several years to realise changes to the recruitment, training and retention of staff, there would be merit in the Boards taking a more detailed look at it sooner rather than later. However, given the time constraints on regular Board meetings and the need to do justice to the subject, this Board could establish a time-limited Task and Finish Group to investigate the subject and report back to the Board with recommendations.

(b) The following section sets out suggestions around how the Task and Finish Group could operate:

i. <u>Overview</u>

a. The Task and Finish Group conducting the proposed review will operate over a year, with an interim report being produced after six months. It will need to establish clear objectives and retain a sharp focus on them in order to complete the work within the allocated time and therefore it is important that the Terms of Reference and scope are discussed and agreed at the outset. The final Terms of Reference and scope will need to be discussed at the first meeting of the Committee to ensure provider and commissioner viewpoints are reflected.

b. Consideration would need to be given as to how the Task and Finish Group related to fora like the Kent Workforce Summit and other groups where workforce issues are discussed.

[2] Ibid., p.20.

ii. Membership

a. The membership could include:

- CCG representatives
- Providers - DGH, EKHT, MFT, MTW, KCHT, SECAmb, KMPT, LMC
- Dr Robert Stewart
- NHS England
- Health Education England
- Healthwatch
- Chairman of the HWB
- KCC Directors of Social care and Public Health, or their representative

iii. Terms of Reference and Scope: Overview

a. The purpose and objective of the review is to make recommendations to the Kent Health and Wellbeing Board as to how the collective resources for workforce transformation across Kent can best be used to enable the delivery of new models of care and the Five Year Forward View that will achieve the greatest benefit at scale and pace.

iv. Proposed Terms of Reference

a. to determine how health and care organisations in Kent can best respond to immediate service pressures in an aligned manner;

b. to determine how to maintain and expand the future workforce in priority areas;

c. to assess how resources can be best invested in service transformation through the education and training of the existing workforce and the creation of new roles and/or new settings.

v. Scope – The issues to be explored

a. the priority areas for the future workforce in Kent;

b. the strategic context of workforce education and training, with particular reference to the Five Year Forward View and development of New Care Models;

c. the appropriate balance between retraining and reskilling the existing workforce, creating new roles, expanding existing roles and innovative education and commissioning programmes;

d. how workforce planning can be coordinated across Kent in the future; and

e. the financial and systemic barriers to effective workforce planning.

vi. Key Evidence / Meetings

a. It is proposed that written evidence be requested around a core of common questions from a variety of stakeholders – providers, commissioners, Royal Colleges, staff groups, etc. Key themes will be developed from an analysis of this written evidence and a series of half-day hearings arranged around these themes to be arranged, with relevant witnesses invited to each.

3. **Recommendation(s):**

3.1 The Board is asked to:

(a) Note the actions set out in the report from Health Education Kent Surrey and Sussex and to agree actions to support the transformation of the workforce to meet a shared vision of the future.

(b) Agree that a Task and Finish Group be established to look specifically at the strategic workforce issue and that the authority to agree the practical arrangements be delegated to the Chairman of the Board, in consultation with other Members of the Board.

Background Documents

None

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From: **Barbara Cooper, Corporate Director of Growth, Environment and Transport**

Paul Crick, Director of Environment, Planning and Enforcement

To: **Health and Wellbeing Board 20 May 2015**

Subject: **Kent and Medway Growth and Infrastructure Framework**

Classification: **Unrestricted**

Past Pathway of Paper: Information item for Environment and Transport Cabinet Committee, 9 April 2015 and Cabinet, 27 April 2015

Future Pathway of Paper: Information item for Environment and Transport Cabinet Committee, 21 July 2015

Electoral Division: Countywide

Summary:

The objective of a Growth and Infrastructure Framework for Kent and Medway is to set out the growth planned across Kent and Medway to 2031 along with infrastructure that will be needed to facilitate this growth. The framework will also provide an estimate of the associated infrastructure costs (including health), an assessment of available funding and identify the funding gaps faced by KCC and partners in delivering sustainable growth over the next 20 years.

The purpose of the work is to provide an evidence base for the start of a dialogue with the new Government on how we begin to close this infrastructure funding gap in order for growth to be delivered. It will also provide a valuable tool in the forthcoming debate with London on how the capital plans to meet its future housing growth requirements.

The report also seeks advice on how best to engage with the 'health sector' in the debates both about how health will be delivered in the future and the costs of that provision.

Recommendation:

That the Health and Wellbeing Board note the progress being made to establish a Growth and Infrastructure Framework for Kent and Medway and provide comment on how best we engage with the health sector in debates about growth; about future health provision; and funding for health.

1. Introduction

1.1 KCC commissioned AECOM in December 2014 to carry out the first stage of developing the Kent and Medway Growth and Infrastructure Framework (GIF). This work was completed within a very short timescale of less than 8 weeks and presented an overarching baseline of growth patterns, infrastructure projects and cost requirements and gaps. It was produced drawing upon information obtained through Kent County Council officers in a short time-scale. It was completed as a starting point for wider engagement with Medway, the district local authorities and infrastructure providers and is now subject to further review in order to gain a greater level of accuracy drawing upon different sources of information.

1.2 Through the project process, a number of 'Stage 2' workstreams were identified that will assist in ensuring the framework is completed to a greater level of detail and accuracy. The completion of these tasks will ensure that the GIF is developed into a comprehensive and robust framework that fully represents the infrastructure requirement to support growth across the County. An update on the second stage of this work is provided below.

1.3 The areas of work are nearing completion with a view to the document being finalised by mid May 2015. The workstreams include:

Stage 2 Workstreams	Overview of Tasks
Partner Validation and Engagement	13 x Local Planning Authority (LPA) verification meetings KCC Departments and Officers to review Topic Specific Details Wider Infrastructure partners: NHS, Highways England, Network Rail etc.)
Data / Documents Verification	Data gathering completion Integration of latest Integrated Development Plans and Integrated Development Strategies from Local Plans Housing and employment trajectories and specific sites verified to match latest LPA position and sense checked.
Population Forecast Review	Baseline Population forecast Update – Integrated Infrastructure Funding Model (IIFM) Forecast to be re-run based on latest verified housing trajectories and sense checked Review of latest Office for National Statistics population forecasts and Communities and Local Government household forecasts at LPA and County level. Forecast comparisons with rest of South East Counties (Total population growth / migration / age profile change etc.).
Migration and Wider Growth Review	Historic Growth pattern and planning policy review (South East Plan, 2006 Structure plan etc.) Greater London Authority Further Alterations to the London Plan Review and potential impacts on growth across Kent. Options for a 'green belt' type policy for Kent to protect countryside from urban sprawl. Commercial space planned for each district.
Infrastructure Analysis Review	Detailed Scrutiny of KCC Strategic Project Update Database (SPUD) to sense check and remove duplications / inapplicable / delivered projects.

	Identification of gaps in project list for all services and districts. Modelling for longer term infrastructure requirements.
Infrastructure Cost Review	Continuation of stage 1 costing approach of projects where possible. High level costing sense check exercise across topics and districts based on typical development benchmark costs.
Viability Consideration	Consideration of potential developer contributions across Medway and Districts (where data allows) and geographical variation in land values / developer costs.
Infrastructure Funding & Delivery	Review existing project funding assumptions (differentiating developer contributions and other funding sources). Present the existing delivery/funding landscape and emerging changes. Set out the potential funding sources outside developer contributions to bridge the funding gap. Highlight alternative / emerging infrastructure delivery models.
Document Finalisation	Draft Document production and review by client group. Local Authority specific spreads to be shared for review and comment. Document finalisation.

AECOM have engaged with KCC's Public Health team and have shared their technical work at senior management level; good levels of engagement to date.

Engagement has been sought with the CCGs and is important to develop further.

District IDPs have also been used to inform the healthcare provision within the GIF where these identify specific healthcare projects as agreed with service providers.

The subsequent sections refer to emerging figures as follows

2 Health Infrastructure – Primary Care Services

2.1 The Health and Social Care Act 2012 has radically changed the way that primary care services are planned and organised. This has facilitated a move to clinical commissioning, a renewed focus on public health and allowing healthcare market competition for patients. The work undertaken by AECOM to date has provided the following headlines:

2.2 GP's – 1040 across Kent and Medway

- Tunbridge Wells has greatest surplus in patient capacity with 32,000 surplus spaces
- There is additional surplus in Ashford, Canterbury, Dover, Maidstone, Sevenoaks, Shepway
- Medway has a 32,000 space deficit in patient capacity
- There are significant capacity issues in Dartford and Gravesham
- There is a lack of provision in proposed growth areas

2.3 Dentists – 833 across Kent and Medway

- The poorest provision in Kent is in Swale with 2,800 people per dentist. Dover also has limited capacity
- Medway has most capacity at present with 1,680 people per dentist. Canterbury, Dartford, Shepway and Tunbridge Wells also have good provision

2.4 Future requirements to meet growth

- 105 additional GP's and associated premises
- 91 additional dentists and associated premises

2.5 Costs and funding

AECOM has estimated costs based upon a standard multiplier and benchmark costs. This assumes all costs will be met by the NHS. It identifies the following costs (February 2015) for Kent and Medway: **£40,870,000**

3 Health Infrastructure – Hospitals and Mental Health

3.1 Kent and Medway include nine acute NHS trust hospitals, 12 community hospitals, one NHS independent sector hospital, nine private hospitals and seven A&E departments. These are all commissioned by NHS England and the eight CCG's, except the private hospitals. Mental health trusts provide community, inpatient and social care services for psychiatric and psychological illnesses. The work undertaken by AECOM to date has provided the following headlines:

3.2 Hospitals and Mental Health – 3,115 NHS and 502 mental health hospital beds across Kent and Medway

- West Kent has the most acute hospital beds (30%), followed by East Kent (28%), North Kent (23%) and South Kent (18%)
- 96% of hospital and mental health beds were utilised in Kent and Medway according to 2014 data, compared to 90% in England and Wales
- Dartford, Gravesham and Canterbury are all near capacity in bed provision, despite facing significant housing growth
- Higher capacity of beds appears to be available in Sevenoaks, Tunbridge wells and around Faversham

3.3 Future requirements to meet growth

- 455 additional hospital beds required for Kent and Medway, with 73 additional mental health beds
- Dartford will require 98 additional hospital and mental health beds
- Additional requirements largely match future housing growth across the county

3.4 It is acknowledged that the health service is in the process of change and that future secondary care is more likely to be provided away from acute settings and within the community at local points of contact such as primary care and intermediate facilities. This will have major implications on local healthcare infrastructure.

3.5 Costs and funding

AECOM has estimated costs based upon a standard multiplier and benchmark costs. This assumes all costs will be met by the NHS. It identifies the following costs (February 2015) for Kent and Medway: **£68,240,000**

3.6 In order to achieve a robust assessment of the health needs to accommodate growth to 2031, greater engagement of the many parts of the health sector needs to occur. The Health and Wellbeing Board are asked to consider and advise on the most effective ways to achieve this, either through CCG's, by local Health and Wellbeing Boards, on a geographical basis or a combination of these.

4 Financial Implications

4.1 The work to produce the Kent and Medway Growth and Infrastructure Framework is funded through existing revenue budgets. This work is important as it will identify future pressures for KCC funding of essential infrastructure such as schools and transport.

5 Policy Framework

5.1 The Kent and Medway Growth and Infrastructure Framework is relevant to all 3 strategic outcomes in KCC's Strategic Statement 2015-2020: Increasing Opportunities, Improving Outcomes, but in particular Strategic Outcome 2: Kent communities feel the benefit of economic growth by being in work, healthy and enjoying a good quality of life.

5.2 In addition, the work contained within the GIF will be integrated and aligned with the emerging Kent and Medway Growth Strategy.

6 Next steps

6.1 Once completed, the document will paint a strategic picture of the price of, and risks to, growth. It aims to:

- Collate and summarise population / housing growth projections across districts within Kent.
- Set out a combined understanding of capacity within current infrastructure provision and pipeline infrastructure projects being taken forward by KCC and other infrastructure providers.
- Highlight cumulative costs, funding streams and gaps in infrastructure funding.

6.2 The GIF has been produced for the following audiences:

- Officers and Members within KCC.
- Government and infrastructure providers – to demonstrate the requirement and distribution of growth, infrastructure requirements and funding gaps
- Medway council, district and parish councils and communities to provide a countywide view of development and infrastructure requirements and the opportunities and challenges in delivering infrastructure across the county.

6.3 In addition, the GIF takes into consideration external factors affecting growth and infrastructure provision in Kent in relation to the wider London and south east growth requirements.

6.4 Of particular relevance is the recent Inspector's Report on the Further Alterations to the London Plan which highlighted the lack of capacity in Greater London to meet growth requirements with some of the identified 6,300 homes per annum shortfall likely to be met in areas outside London, including Kent and Medway.

7 Conclusions

7.1 The objective of a Growth and Infrastructure Framework for Kent and Medway is to set out the growth planned across Kent and Medway to 2031 along with infrastructure that will be needed to facilitate this growth. The framework will also provide the associated infrastructure cost, an assessment of available funding and identify the funding gap we face in delivering sustainable growth.

7.2 The purpose of the work is to provide an evidence base for the start of a dialogue with the new Government on how we begin to close this infrastructure funding gap. It will also provide a valuable tool in the forthcoming debate with London on how the capital plans to meet its future growth requirements.

8. Recommendation:

That the Health and Wellbeing Board note the progress being made to establish a Growth and Infrastructure Framework for Kent and Medway and provide comment on how best we engage with the health sector in debates about growth; about future health provision; and funding for health.

9. Background Documents

9.1 Kent and Medway Growth and Infrastructure Framework discussion draft February 2015, AECOM

10. Contact details

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NHS England

NHS England (Kent and Medway)

Direct Commissioning Strategy and Two Year Operational Plan

2014 to 2016

THE NHS CONSTITUTION
the NHS belongs to us all

CONTENTS

SECTION 1: INTRODUCTION

1. This paper provides information about NHS England (Kent and Medway)'s commissioning plans for 2014/15 and 2014/15.
2. NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government. Through its twenty-seven local area teams, NHS England is responsible for directly commissioning:
    - primary care services (GP, dental, optometry and pharmacy services);
    - secondary care dental services;
    - specialised healthcare services;
    - healthcare services for offenders and those within the justice system;
    - a range of public health service on behalf of Public Health England (e.g. covering pregnancy to age five public health programmes, screening and immunisation programmes, sexual assault referral centres); and
    - some healthcare services for the armed forces.
3. NHS England (Kent and Medway) is the local arm of NHS England (also known as the Kent and Medway Area Team).
4. In regards to its direct commissioning functions, NHS England's focus is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.
5. NHS England also works closely with local clinical commissioning groups (CCGs) to support them to use their local knowledge and understanding of the needs of local patients to commission a wide range of other community and hospital services.
6. Work is taking place to develop five year commissioning plans. It is important that this two year plan, which needs to be submitted to an earlier timescale is also presented within the context of, and fits within, the overarching strategic direction of travel. Therefore, this document contains information on the strategic direction for the services directly commissioned by NHS England (Kent and Medway) and this document should also be read in conjunction with NHS England (Kent and Medway)'s Strategic Framework for Primary Care.

The national context

7. Each year the Government publishes the NHS mandate setting out ambitions for the National Health Service. This can be viewed at https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015. The mandate details the outcomes that the Government wants the NHS to achieve for patients but gives clinical commissioning groups (CCGs) and NHS England (through its direct commissioning role) flexibility on how these are delivered.

8. Much of the basis for the Government's mandate originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

   a. We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.

   b. We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.

   c. We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.

   d. We want to ensure patients have a **great experience** of all their care.

   e. We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

9. Delivering these identified long-term ambitions will require transformational change across health and care systems and in the way health services are delivered. That is why in July 2013 NHS England (along with our national partners) launched *A Call to Action* which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. We need to find ways to raise the quality of care for all in our communities to the best international standards, while closing a potential funding gap of around £30 billion by 2020/21.

10. On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled Everyone Counts: Planning for Patients 2014/15 to 2018/19. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to ***make high quality care for all, now and for future generations*** into a reality. The planning guidance can be viewed at http://www.england.nhs.uk/2013/12/20/planning-guidance/ and will be used to inform the development of local health services in Kent and Medway.

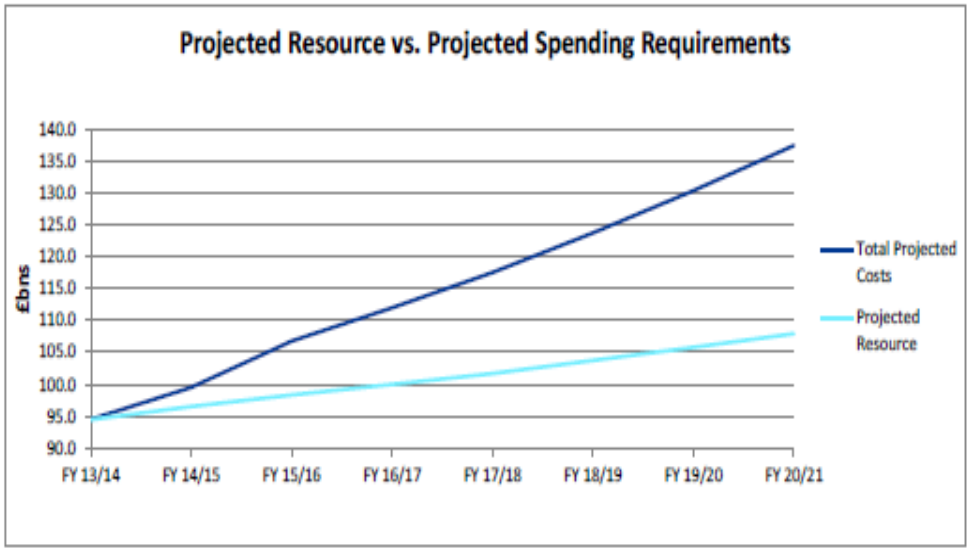
11. Change will need to be achieved through:

- Listening to patient views
- Delivering better care by realising the benefits of the digital revolution
- Transparency and sharing data about local health services
- Transforming primary care services
- Ensuring tailored care for vulnerable and older people
- Delivering care in a way that is integrated around the individual patient
- Ensuring access to the highest quality urgent and emergency care
- A step change in the quality of elective care
- Providing specialised services concentrated in centres of excellence
- Improving access to services (e.g. moving to seven day service provision)
- Supporting research and innovation
- Developing an integrated training model

12. NHS England is focused on ensuring equity and consistency of provision but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally. The following sections provide information on the development of commissioning plans and intentions for those services that NHS England directly commissions for the population of Kent and Medway, taking account of the national planning guidance and commissioning intentions.

The financial challenge

13. Nationally there is a forecast national financial gap of circa £30 billion by 2020/21. This is shown on the graph below. This details projections around the raising costs of NHS healthcare, largely due to an aging population (described later in this document) and projected resources (i.e. funding) that will be available to meet this demand.



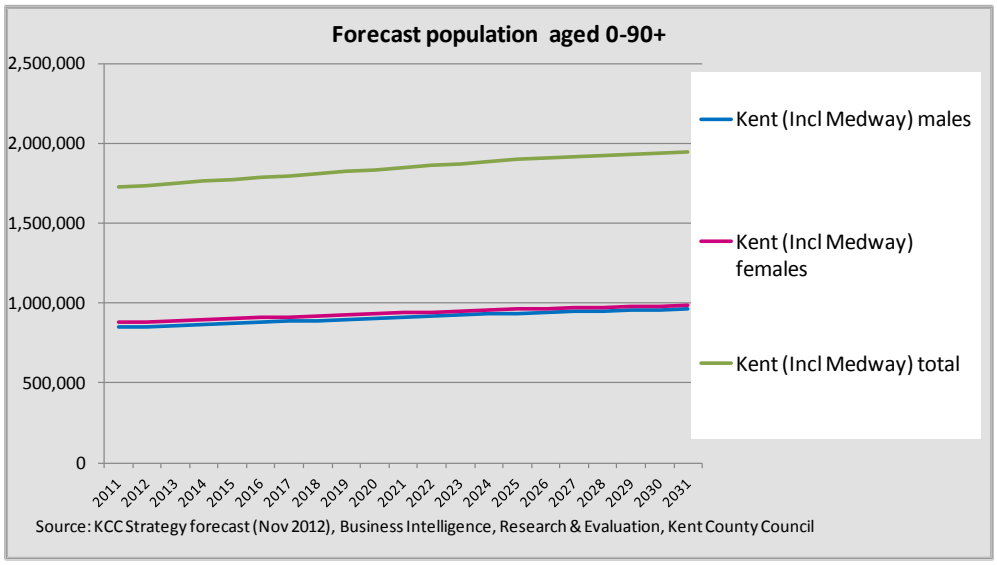
14. As a crude approximation the Kent and Medway weighted population is 3.14% of the national population, so our financial challenge is circa £1 billion of the £30 billion call to action challenge across all NHS commissioners.

15. The affordability challenges (or more accurately the demand challenges) in 2014/15 and 2015/16 are real and urgent. The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases, presents a significant challenge to the way we currently commission and provide care.

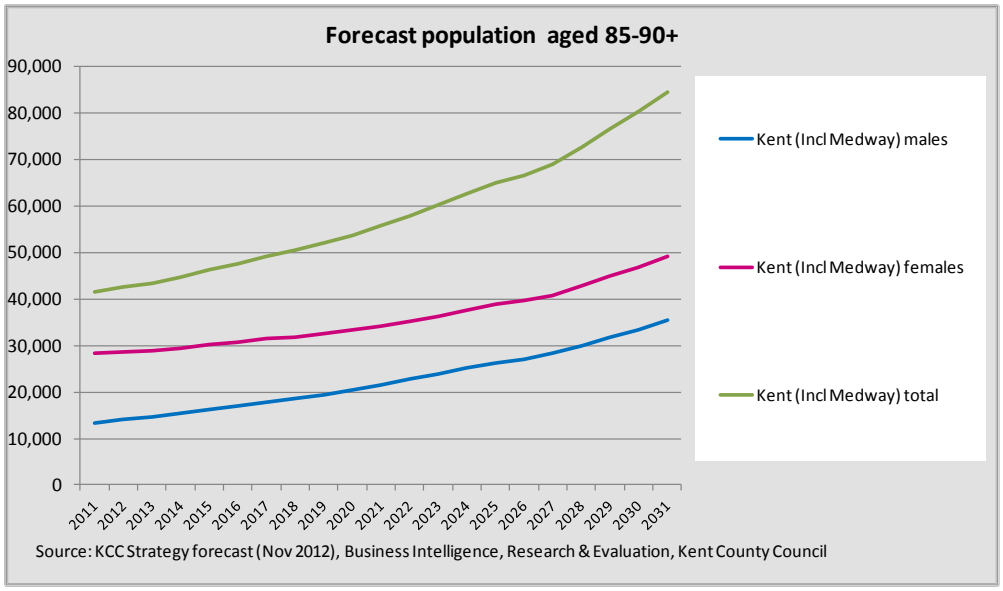
SECTION 2: THE KENT AND MEDWAY POPULATION

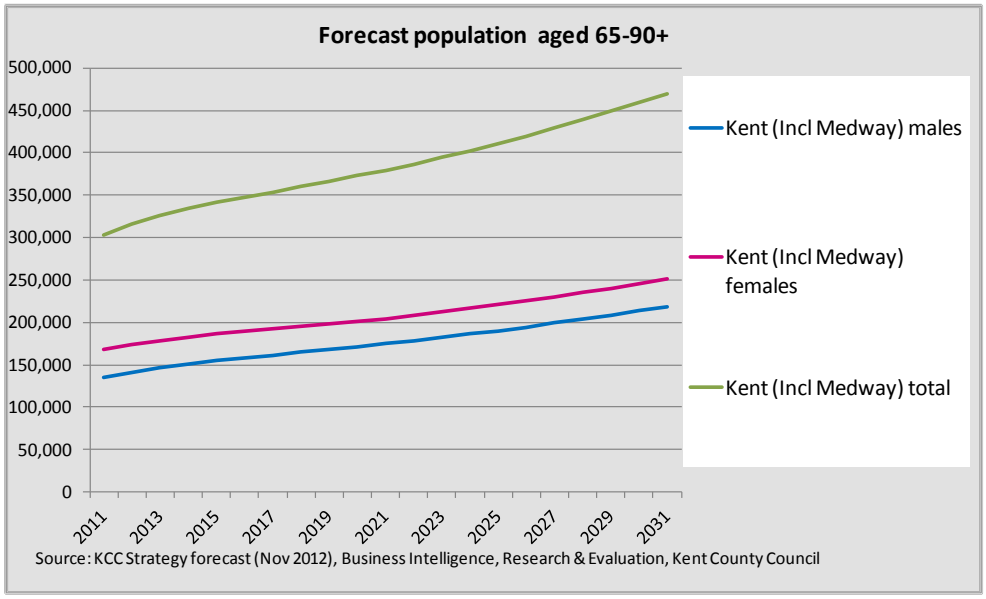
A changing population

16. By 2021 it is projected there will be a 5.4% increase in the total Kent and Medway population, which is shown on the following graph:



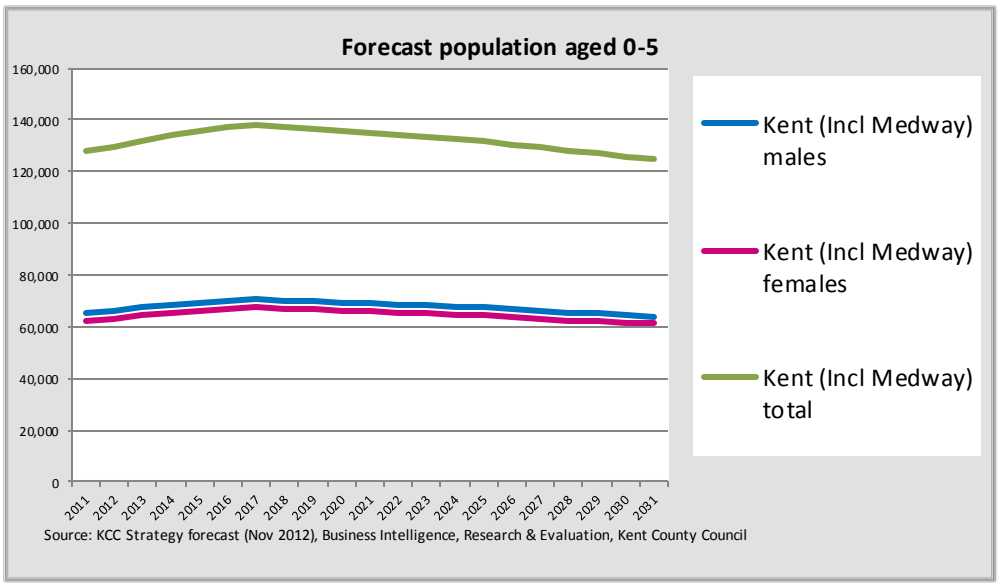
17. Whilst this increase in total population in itself is significant, it masks a more significant issue in that it is projected that over the same time period there will be a 25.5% increase in number of people aged over 65 years and a 34.1% increase in number of people aged over 85 years. This is shown on the following graphs:





18. In practice this means the percentage of older people in the total population is increasing; this is often referred to as "an aging population". This presents two challenges in that older people generally require more health and social care support, plus the percentage of the population who are of working age and paying taxes diminishes (i.e. there is less income from taxes to fund public services). It is this situation that is driving the financial challenge that was outlined earlier in this plan.

19. The area team, through its public health commissioning functions, also has specific responsibilities for children aged 0 to 5 years old. The change in this population is shown on the next graph. Whilst there is a short term increase projected in the number of 0 to 5 year olds, this growth is expected to plateau in the next 3 to 4 years (although further modelling is needed to assess the impact of immigration), after which this population will start to decrease.

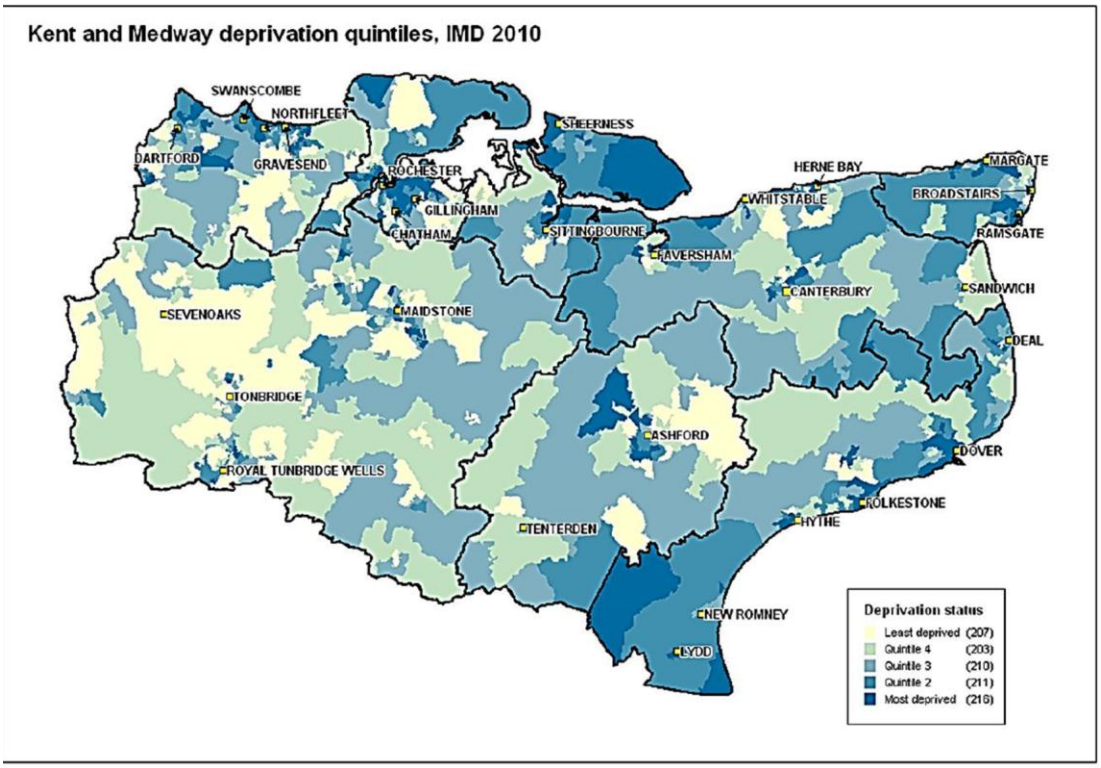


Inequalities

20. Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared with the rest of the population.

21. Health inequalities start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a top governmental and local priority for NSH England, as well as for our partners. Tackling health inequalities is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall.

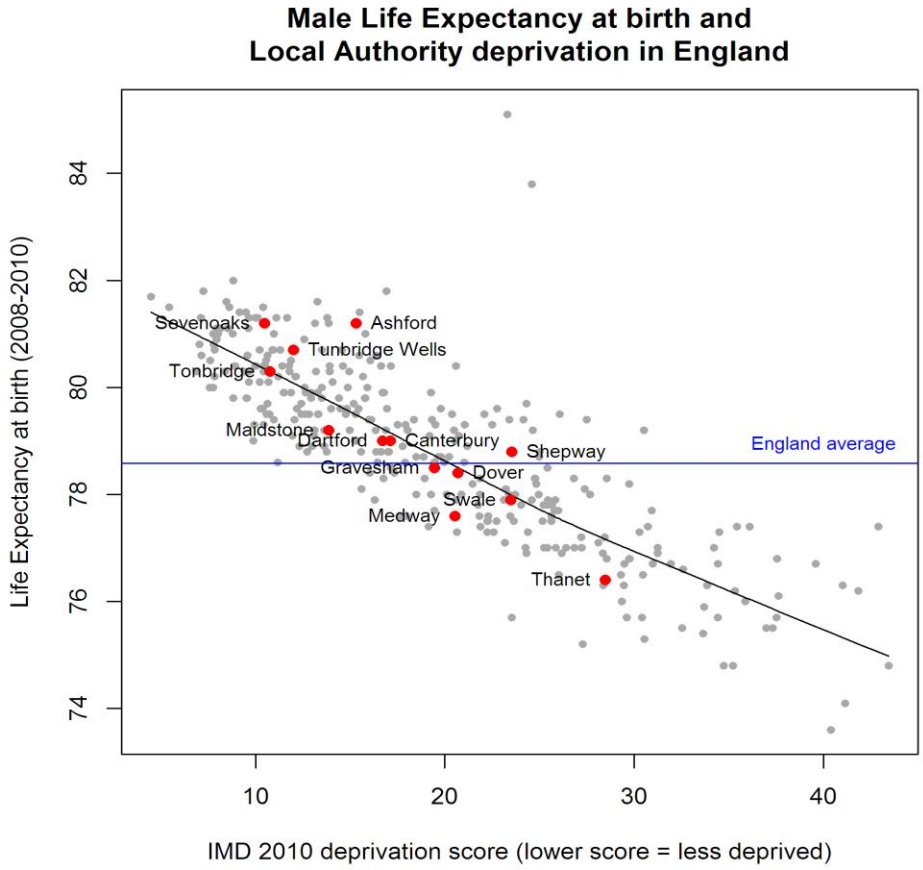
22. Within Kent and Medway there are significant health inequalities. The following map gives an overview of deprivation across the area. The darkest areas are the most deprived.



23. Whilst many areas of Kent and Medway are affluent, with higher levels of "wellbeing" (this includes indicators on life satisfaction, how worthwhile life is considered to be, happiness and anxiety) there are also a significant number of areas in the most deprived quartile of the population This is illustrated in the following table which shows life expectancy and the "slope of index inequalities" (a measure of deprivation) by CCG.

Clinical Commissioning Group	Average Life Expectancy	Slope index of Inequalities (SII) (is calculated by taking into consideration Indices of Multiple Deprivation (IMD) and Life Expectancy at birth and is an indicator of the gap between the most and least deprived).
Ashford CCG	82.6	3.0
Canterbury And Coastal CCG	81.6	4.6
Dartford, Gravesham and Swanley CCG	80.9	5.8
Medway CCG	80.3	4.9
South Kent Coast CCG	80.7	5.0
Swale CCG	79.8	5.5
Thanet CCG	79.4	7.1
West Kent CCG	82.3	4.2
Kent and Medway	81.1	5.6

24. This variation in health inequalities is further illustrated by the following chart that shows a correlation between deprivation and male life expectancy (i.e. this shows the link between deprivation and reduced life expectancy).



25. Whilst the information above shows a difference of about 5 years in life expectancy between the least and most deprived areas (e.g. between Thanet and Sevenoaks), this data is presented at CCG or district council level and hides

the greater disparity between the least and most deprived wards. More information on this is in CCG and local authority plans (including the Annual Public Health Report and the Joint Strategic Needs Assessment).

SECTION 3: MAINTAINING A FOCUS ON QUALITY

26. Knowing that patients are safe in our care is of paramount importance and one of the main categories from the NHS Outcomes Framework relates to keeping patients safe and protecting them from avoidable harm.

27. Everyone Counts describes the key components of quality (effectiveness, patient experience and safety). This focuses on the fundamental principles of the:

    - Francis report and the need to improve high quality, safe care.
    - Berwick report and the need to foster a safety culture
    - Winterbourne report describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.
    - Transforming Care: A national response to the Winterbourne review describes core specifications for commissioners and providers to improve quality and safety standards for patients with learning disabilities.
    - Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework: Promote partnership working to safeguard children young people and adults at risk of abuse at all levels. Ensuring professional leadership and expertise including the responsibility of named professionals for safeguarding children and adults, recognising that safeguarding is everybody's business. Lead with partner agencies to implement national policies to prevent child sexual exploitation, female genital mutilation, sexual violence and domestic abuse.
    - Clwyd-Hart report on NHS complaints

28. In response to the need to continuously improve patient safety and reduction of avoidable harm we will continue to:

    - develop the Quality Surveillance Group oversight across Kent and Medway;
    - implement the new patient safety alerting system;
    - drive to reduce the incidences of Healthcare Associated Infection (HCAI);
    - implement of the new Patient Safety Collaborative Programme;
    - implement the new patient safety thermometers;
    - promptly action Care Quality Commission notices and enforcement notices;
    - learn from Serious Incidents and Death in Custody reviews; and
    - innovate and utilise national models to support safe staffing delivery

29. Intelligent, collaborative commissioning will be undertaken with partners, including regulators of health care services. Within Kent and Medway we will manage a quality work programme for Health and Justice and Primary Care. Through this we will promote a positive experience of care, ensuring the patient's voice is heard, listened to and acted upon. This includes timely responses to and learning from complaints.

30. Wherever possible we will support people in maintaining their own health and thus not requiring healthcare services but where necessary. We want to ensure that every patient has a positive experience of health care and we will continue to:

- be proactive in response to complaints;
- ensure the patients voice in heard, listened to and responded to;
- improve the experience of carers;
- support Friends and Family Test (FFT);
- develop the concept of no decision about me without me and implement patient centred approach;
- implement the Compassion in Practice and methodology of the six Cs;
- safeguard those patients who are the most vulnerable working collaboratively with multi-agency partners;
- enhance the ability of patients and the public to care for their own health;
- ensure full respect for patient autonomy in decision making and ensure patients can access advanced care planning options; and
- ensure our systems are simple and straightforward to access and that appropriate choices and option are clearly signposted.

31. The quality and nursing team are concentrating on three areas of work for the next two years:

- Quality governance
- Health improvement
- Safe workforce

Quality Governance

32. Many of the organisations that we directly commission can be placed into one of four levels of development in quality governance:

Level zero	The Organisation is working in isolation, tends not to engage in local programmes or Area activities. They do not have any quality governance meetings and only report incidents if requested by commissioners.
Level one	**Foundation level** Multiple and disparate action plans in place, basic clinical governance meetings held intermittently with poor attendance and no clear outcomes. The organisation reports only Serious Incidents when a death in custody occurs or a death on the premises in primary care. No reports into clinical governance for incidents and no risk register is presented. No identification of changes to practice as a result of root cause analysis investigations.

Level two	**Intermediate Level** Strategic action plan starting to be developed and quality governance meeting reviewed and in place attended by all partners delivering care. Risks are starting to be identified and a process for mitigation is in place. The organisation is starting to show an open and transparent reporting culture. The organisation engages with area and local events and networks.
Level three	**Mature Organisation** The quality governance meeting is well organised, attended by all partners, receives regular appropriate reports and proactively monitors the review and implementation of the strategic action plan. Clear safety reporting structure is in place and reporting is encouraged by the organisation. There is a clear open safety culture with the organisation proactively assessing the culture at least annually. The organisation routinely examines and where necessary implements changes to policy and practice as a result of incidents reported, complaints or from staff and patient survey analysis. Dynamic process of identifying, reviewing and mitigation identified risks. They are a system leader for improvement programmes.

33. The aim is to have all directly commissioned organisations to be at level 2 by March 2015 and 75% of organisations starting to or achieving level three by the end March 2016.

Health improvement programmes

34. Existing data collection methodologies (e.g. friends and family test, safety thermometer, healthcare acquired infection returns) will be used to establish dynamic health improvement programmes initially focused on pressure ulcers, healthcare acquired infection. A serious incident learning network will also be established by July 2014 led by a CCG and or a local provider by July 2014. In addition:
    - by March 2015 there will also be improvement programmes for venous thromboembolism, medication errors and sepsis; and
    - by March 2016 there will be an improvement programme for the emerging safety thermometer work streams of mental health and maternity harms.
35. The aim is these will all have the overall impact of achieving zero avoidable harm in patient care. This work is also a precursor to the Patient Safety collaborative being established.

Safe Workforce

36. Francis and Berwick both highlighted the importance of a well- trained and well-staffed establishment to ensure safe patient care. We will work with our partners in health education England Kent Surrey Sussex, to ensure there are sufficient learning opportunities for staff in our directly commissioned services.

37. We will also ensure that safe staffing is reviewed within the service specification and commissioning process and will seek opportunities to work nationally in the assessment and review of such staffing levels.

38. The Kent and Medway area team will pursue a longer term strategy for work force development and work with national professional organisations to commission specialist education in order to raise standards and quality of care.

39. Throughout the work of the Nursing and Quality team we will work under the principle of collaboration with our own internal partners within NHS England, CCGs and local providers to ensure stronger engagement for quality throughout the commissioning cycle.

Quality in primary care

40. We intend to support clinicians to provide optimum care for patients by facilitating the development of a strong governance culture throughout the area. This will include more integration to prevent clinical isolation and the development of stronger processes to identify variation in performance and offer early support and intervention. We have taken learning in this area from our work in clinical governance and from incidents that have occurred in primary care. To improve the quality of primary care and to keep patients as safe as possible from avoidable harm, our areas of focus are to:

- improve the way that safeguarding training is implemented to ensure that all clinicians who need training have been trained. In addition, to improve the way the safeguarding training is embedded in practice so that people really understand what it means and how and when to raise a concern;
- improve the complaints systems for primary care. We need to ensure that verbal complaints (not just written ones) are recorded, considered and acted upon, and reported to identify trends that need to be addressed;
- improve the way in which informed consent is given by patients for procedures performed in primary care;
- empower all clinical staff to challenge inappropriate or questionable behaviour;
- embed better two way communication about concerns with Care Quality Commission;
- ensure that GPs with Special Interests (GPwSI) are appropriately monitored for the work that they do; and
- improve practice manager's skills and core competencies.

41. In order to mitigate risks the Medical Directorate actively leads the Quality Hub and ensures appropriate links are made both internally and externally. Complaints are also actively monitored and reviewed to see if there are any performance concerns.

42. In relation to raising the quality of primary care in general, we are aware that Kent and Medway struggles to attract the best applicants to work in the area. There are many reasons for this, one key problem is the lack of a University with a Medical and Dental school as quality applicants tend to live post-qualification in the area in which they trained. Poor quality applicants are more likely to be of concern later on in their careers. NHS England (Kent and Medway) is looking to work with Health Education England, CCGs and the local Medical Committee to develop a primary care workforce plan for general practice. We are also working with CCGs, including utilising the Better Care Fund (BCF), to look at skill mix, using a range of skills in primary care, and a health and social care workforce plan.

43. Professional isolation is a significant factor in poor performance. In General Practice, this risk can be ameliorated by federation of practices and premises and co-location of primary care services. We have agreed a set of principles with the CCGs to support this direction of travel.

44. We believe that we have a robust system of appraisal and revalidation in place in Kent and Medway, which we will continue to develop in conjunction with our lead appraisers. The system is appropriately quality assured and assists with raising quality of primary care and in triangulation of any concerns that are raised.

45. In summary, our quality ambitions for primary care focus on ensuring a more positive experience of [integrated] care for patients by:

Ambition	**Date**
Full implementation of the Friends and Family Test (FFT) in primary medical, dental, optical and pharmacy services; ongoing improvement in the proportion of positive recommendations to friends and family by people receiving NHS treatment for the place where they received this care.	Mar-15
Use of the FFT to drive improvement in patient experience, both at the relevant touch points in primary care, but also as part of a higher systematic approach, linked to QSG, to support identification and action required to improve patient experience along pathways.	2015/16
Improved satisfaction with the quality of consultation, overall care and access to primary medical services as measured by the annual GP Survey]	2015/16
Reduction in the incidence of avoidable harm attributed to primary care services; HCAIs, medication errors, delayed diagnosis, etc.. • Open and honest cultures across primary care • Reduction in complaints	2014/15 – 2015/16

• Improvement in the proportion of positive recommendations to friends and family by people receiving NHS treatment for the place where they received this care • CQC compliant primary care services	
• Competent primary medical care workforce that has accessed multi-agency safeguarding training • A primary care workforce that is fully engaged in, and learns from, Serious Case Reviews and Domestic Homicide Reviews • Reduction in safeguarding incidents • CQC compliant primary care services	2014/15 – 2015/16
All reviews required by Winterbourne Concordat are undertaken and people are appropriately placed	June 2014

Quality in health and justice

46. To improve the quality of health and justice services and to keep patients as safe as possible from avoidable harm, our areas of focus are to:

- Improve the governance of health care in health and justice settings, including all providers and prison authorities to ensure high quality care pathways.
- Continue to ensure that the quality of health and justice is well governed by the area team, including the continued development of the Health and Justice Quality Group.
- Improve the provision of continuous professional development for all professionals in health and justice settings working with RCGP, national clinical reference group for Health and Justice and Health Education England.
- Ensure robust systems for the appointment of clinical reviewers, which include training, are in place.
- Support providers in the reporting of incidents and serious incidents to promote safety and learning.
- Actively influence the quality specifications for all health and justice commissioning especially the new NHS commissions.
- Ensure a timely and robust process is in place for the investigation of deaths in custody

47. In summary, our quality ambitions for health and justice commissioning will focus on:

Ambition	**Date**
All prisons we commission from have partnership quality governance meetings that include all healthcare providers and prison governors to ensure safety and	All be in phase 2 by March 2015

quality.	
All prison settings report incidents and serious incidents; share investigations and learning. Learning forum for serious incidents in place, to support the development of a culture of learning and improvement.	For all health and justice directly commissioned services by March 2015
Future ambition zero tolerance for death in custody due to suicide for prisoners on ACCT The bank of Clinical reviewers for death in custody is increased and linked to standards for clinical review.	December 2014
The RCGP secure environment group revised guidelines are considered for inclusion as quality standard	2015/16
Improvement in quality of care in Sexual Assault Referral Centres (SARCs), including improvements in the timeliness and availability for all relevant assessment treatment (e.g. paediatric assessment, safeguarding, self-referrals and HIV and hepatitis prophylaxis).	March 2015
Ensure appropriate healthcare skill mix and competency levels in custody suites, with clear service pointers / triggers for public health intervention i.e. alcohol abuse support	2015/16

Quality in public health

48. To improve the quality of the public health services commissioned by NHS England (Kent and Medway) and to keep patients as safe as possible from avoidable harm, our areas of focus are to ensure that:

- All services are commissioned in line with revised national service specifications and monitored through robust clinical governance frameworks (i.e. Kent and Medway Programme specific clinical committees),
- Programmes participate in the national public health quality assurance programme and that learning and feedback from national Quality Assurance team is acted upon.
- Any quality concern identified through the screening and immunisation committees and the national quality assurance report are acted upon and information shared appropriately – i.e. Kent and Medway Quality Board, relevant CCG and Local Authority.
- All providers use Serious Incident reporting frameworks and that incident reporting and investigation is robustly managed with findings and lessons learned acted upon to improve services and programmes.
- Incident reporting and investigation involves all relevant organisations, Public health England, commissioners, Local authority and providers.

- Joint working strengthened cross directorates and teams within NHS England (Kent and Medway).
- The Health Visiting Programme is delivered in collaboration with providers, improving outcomes for children and families as part of the transition towards responsibilities being passed to local authorities in October 2015.

SECTION 4: PUBLIC HEALTH SERVICES (e.g. national screening and immunisation programmes, public health services 0-5 years)

49. Responsibility for the commissioning of public health services is split between Public Health England (PHE), local authorities and NHS England.

50. It is NHS England's responsibility to commission a number of public health services as agreed with the Department of Health and built into the Government's Mandate to the NHS and the NHS Outcomes Framework. An agreement between the Secretary of State for Health and NHS England, made under Section 7a of the National Health Service Act 2006, details the public health commissioning functions that are carried out by NHS England. Known as the '7A agreement', these services sit within a number of programmes:

    a) Immunisation programmes
    b) Screening programmes
    c) Cancer screening programmes
    d) Children's public health programmes (Healthy Child Programme pregnancy to age five)
    e) Child health information systems
    f) Public health services for people in prison and other places of detention including those held in the young people's secure estate
    g) Sexual assault services

51. These programmes are nationally mandated supported by thirty-two national service specifications.

Strategic intent

52. NHS England's ambition is that everyone has greater control of their health and their wellbeing. We want everyone to be supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and continually improving.

53. The summary plan for public health is included as Attachment 1. The public health services commissioned by NHS England directly support the achievement of the NHS outcomes framework domains and ambitions, in particular:

Domain 1 - Prevent premature deaths and increase life expectancy	The preventative immunisation and screening programmes enable interventions to stop people from dying prematurely, securing additional years of life for people with treatable conditions (outcome ambition 1).
Domain 2 - People with LTCs get the best possible quality of life	Screening programmes support the early identification of health conditions, enabling people to receive treatment and support much sooner, improving their quality of life (outcome ambition 2). Immunisations (such as the flu vaccine) can also improve the quality of life for those in particular at-risk groups. In addition, early diagnosis can

	ensure more planned and integrated care can be put in place, reducing avoidable hospital stays (outcome ambition 3).
Domain 4 - Patients have a great experience of their care	Continual performance management, working with providers and other partners, ensures the highest standards of patient experience from the public health services we commission.
Domain 5 – Patients in our care are kept safe and protected from all avoidable harm	Keeping patients safe from avoidable harm is the core purpose of our public health services.

Roles and responsibilities

54. Responsibility for commissioning public health services is commissioned by a number of key bodies:

NHS England	Is accountable for letting contracts and ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. We are responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.
Public Health England(PHE)	Develops the national standards and operational guidance and provides expert leadership and advice to NHS England teams. They also play a leading role in collecting and sharing data and monitoring quality assurance.
Local authorities	In addition to leading the local public health system, they provide information, advice and scrutiny on the public health arrangements of NHS England, PHE and providers through local programme boards and health and wellbeing boards. They also commission sexual health services where some cervical samples are taken and public health programmes for children and young people aged 5-19 years, including the school nursing service which carry out school based immunisations. From October 2015 commissioning responsibility for public health programme covering pregnancy to five years old will transfer to local authorities.
CCGs	Are responsible for quality improvement in services delivered by GP practices, such as immunisation and screening services. As commissioners of treatment services for patients who receive positive screens, they have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen-positive patients and meet quality standards. CCGs also hold the contracts for maternity services which provide antenatal and newborn screening.

Partnership working

55. The *Immunisation and Screening National Delivery Framework and Local Operating Model* sets out clear guidance for the commissioning of the 7A public health programmes. It also covers working arrangements between the embedded Public Health England Screening Immunisations Teams and NHS England. Alongside this guidance, there continues to be a need for continual close working between all the organisations responsible for public health at a local level. The implementation of the national service specifications needs to be carried out in collaboration with CCGs and local authorities to reflect local need.

56. The complex public health commissioning arrangements mean that effective partnerships and continual collaboration between all organisations responsible for public health at a local level, including CCGs, are essential in order to ensure that implementation of national service specifications reflects local need.

57. Joint working is between area teams, local authorities and CCGs to identify areas of inequalities and address variation in uptake and coverage across communities will be critical to success in increasing access, information and choice, in particular for disadvantaged communities.

58. While the commissioning of all national immunisation and screening programmes is undertaken by NHS England, certain elements (such as antenatal and newborn screening services) are included in contracts led by primary care contracting, CCGs, specialised commissioners and in some cases local authorities (e.g. sexual health service contracts). Strong links are needed between area teams and these contract leads to ensure the strategic commissioning requirements of immunisation and screening programmes are addressed through these contractual routes.

59. Joint working is also important with the commissioners of treatment pathways (e.g. paediatric services for children identified with congenital hip dysplasia or ophthalmology outpatients in the case of the diabetic eye screening programme) to ensure that any changes through re-tendering of services do not adversely affect the referral pathway for screen-positive patients.

Priorities

60. Everyone Counts sets two overarching ambitions for public health commissioning:

- to increase the pace of change for the full implementation of the national service specifications; and
- to set performance 'floors' to address unacceptably low performance by local providers.

61. The guidance sets out the following priorities to achieve these ambitions:

- New trajectories for roll out of the family nurse partnership and the health visitor programmes
- A revised specification for pneumococcal vaccination
- The roll out of the pilot introduction of HPV testing in women with mild/borderline changes in their cervical screening
- Revised performance baselines for bowel and diabetic eye screening
- The extension of the bowel screening programme for men and women up to age 75

- A minor change to the service specification for seasonal flu
- A meningitis C catch up programme for university entrants
- The continuation of a time-limited MMR campaign for people over 16 and a catch-up campaign for teenagers
- The continuation of the temporary programme for pertussis for pregnant women
- The implementation of DNA testing for sickle cell and thalassemia screening
- A shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds
- Developments for sexual assault referral centres to develop the service and make it more equitable

62. In addition, NHS England intend to extend flu vaccinations to all children over time. Plans are subject to an assessment of NHS England's commissioning capacity and the development of robust workforce models for delivery of the programme which will be completed in early 2014 and will be confirmed through a variation to the section 7A agreement. Prior to this, NHS England shares the ambition to offer vaccines to all children between 2 and 4 years old and as many secondary school aged children as possible in 2014/15.

63. Attachment 1 provides details of the local commissioning intentions that relate to these national requirements.

64. *Everyone Counts* identifies a number of key performance indicators for public health commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
EF1	Do the plans ensure that Dtap / IPV / Hib (1 year old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19.	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF2	Do plans ensure that MenC (1 year old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19	The planned performance level is above the 93% threshold set in the *Everyone Counts* technical guidance
EF3	Do plans ensure that PCV vaccination coverage (1 year old) will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF4	Do plans ensure that Dtap / IpV / Hib (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

EF5	Do plans ensure that PCV booster (2 years) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF6	Do plans ensure that Hib / MenC booster (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF7	Do plans ensure that MMR for one dose (2 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF8	Do plans ensure that MMR for one dose (5 years old) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF9	Do plans ensure that MMR for two doses (5 years old) vaccination coverage will meet the national standard throughout 2014/15 and 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF10	Do plans ensure that Hib / Men C booster (5 years) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF11	Do plans ensure that Hepatitis B (1 years old) vaccination coverage will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance. However, it should be noted that there are significant data accuracy issues. However, locally we are confident we will hit the target threshold as we have developed a local monitoring system.
EF12	Do plans ensure that Hepatitis B (2 years old) vaccination coverage will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance. However, it should be noted that there are significant data accuracy issues. However, locally we are confident we will hit the target threshold as we have developed a local monitoring system.
EF13	Do plans ensure that HPV vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF14	Do plans ensure that PPV vaccination coverage will meet the national standard throughout	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

	2014/15 to 2018/19?	
EF15	Do plans ensure that Flu (aged 65+) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF16	Do plans ensure that Flu (at risk individuals) vaccination coverage will meet the national standard throughout 2014/15 to 2018/19?	Delivery of this target remains a challenge and alternative means of delivering these vaccinations are being established (e.g. beyond reliance on the patients GP). Plans are informed by timely acquisition of data and analysis and understanding of the position is improving.
EF17	Do plans ensure that the percentage of pregnant women eligible for infectious disease screening who are tested for HIV will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF19	Do plans ensure that the percentage of pregnant women eligible for antenatal sickle cell and thalassemia screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF20	Do plans ensure that the percentage of babies who are eligible for newborn blood spot screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF21	Do plans ensure that the percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks or 5 weeks will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF22	Do plans ensure that the percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth will meet the national acceptable standard throughout 2014/15 to 2018/19?	There is currently no reliable data collected across most of England against this target. Therefore, it is not possible to offer assurance that this target will be achieved, However, it is part of the local workplan to implement this programme in line with national guidance and work with providers, maternity commissioners, national and local colleagues to improve data

		collection.
EF23	Do plans ensure that the percentage of those offered screening for diabetic eye screening will meet the national acceptable standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF25	Do plans ensure that breast cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF26	Do plans ensure that cervical cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?	The planned performance level is currently not indicating that the threshold set in the *Everyone Counts* technical guidance will be met. Performance dipping below the 80% threshold is part of a long term downward trend nationally. Despite local actions this trend has not altered for Kent and Medway. In order to improve this there will need to be significant resource deployed in media campaigns, health promotion and publicity and targeting of GP surgeries. NHS England (Kent and Medway) will seek to work with national and local colleagues to address this under-performance.
EF27	**Do plans ensure that bowel cancer screening coverage will meet the national standard throughout 2014/15 to 2018/19?**	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EF28	What number of family health service visitors are planned from 2014/15 to 2018/19?	The planned level of performance is in line with agreed trajectories: **Year** — **No. of Full Time Equivalents (FTEs)** 2014/15 — 421 2015/16 — 421 2016/17 — 421 2017/18 — 421 2018/19 — 421

65. The financial context for public health commissioning is covered next in this plan. Significant financial pressures remain in the public health budget and these have the potential to disrupt service provision and the delivery of the performance trajectories outlined in the above table. The planned performance detailed in this document is subject to the financial pressures being resolved.

Financial context

66. By commissioning effective screening and immunisation programmes with improved coverage and up-take, the public health programme will contribute to delivering financial efficiencies across the health economy by disease prevention, reduced incidence and early identification of cancers (e.g. breast bowel and cervical cancers) and life threatening disease e.g. abdominal aortic aneurisms.

67. The public health team will ensure that all commissioned programmes demonstrate value for money and that high quality, evidenced based cost effective services are delivered including:

    - introducing relevant public health CQUIN (Commissioning for Quality and Innovation payments) targets to new contracts, including reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease;
    - identifying risk of disease and disability early through the commissioning of safe and effective screening programmes;
    - working with providers to demonstrate the value of the universal Healthy Child Programme to improve life chances and access to services for children and families through Health Visiting and Family Nurse Partnership Programmes;
    - ensuring commissioned services represent best value for money and are evidence based;
    - benchmarking the payment and contracting mechanisms of our commissioned services within our Area Team and beyond to ensure and equity of provision;
    - reprocurement of schools based immunisation teams for Kent and Medway; and
    - using revised data sets to ensure screening programmes (e.g. newborn blood spot first and second line testing) is costed on the basis of accurate birth data.

68. In 2013/14, a surplus of £0.5m is projected. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent deficits are carried forward.

69. There are a number of cost pressures arising out of national directives, funded by new allocations. This includes meningitis C (University) and childhood influenza programmes. The expansion of the Family Nurse Partnership (FNP) scheme, the full year costs of the increase in health visitors and the additional cohorts in 2014/15 have also been fully funded. Funding has been received for delivering an extension to the bowel screening programme. However, the funding received is less than the expected costs of these programmes and the shortfall has been included as an unfunded risk.

70. The costs of the 15 % QOF previously chargeable to public health is now included under primary care, for which a transfer of allocation has been made.

71. The overall effect of these cost pressures and changes is to generate a deficit of £2.4m, which reflects a movement of £2.9m from the 2013/14 outturn. This is attributed to the cost of vaccines charged by the NHSBSA which were deducted from CCG budgets by the Department without passing the funding on to Area Teams. The target position is to break even.

72. The summary financial position is shown below:

Public Health		
	2014/15	**2015/16**
Previous year outturn	51,516	53,966
Part year effects	-3,733	-980
Sub total	47,783	52,986
Inflation uplifts	908	1,343
Growth	442	317
Provider Efficiency	-365	-1,483
Service Investments	5,198	1,841
QIPP	0	0
Total	**53,966**	**55,003**
Notified Allocation	51,314	51,314
Deficit carried forward	209	-2,443
Total Resources	**51,523**	**48,871**
Variance Surplus (+) / Deficit (-)	**-2,443**	**-6,132**

SECTION 5: HEALTH AND JUSTICE HEALTHCARE SERVICES (e.g. healthcare services provided in secure estate settings such as prisons)

73. NHS England (Kent and Medway) commission healthcare services for people in prison and other justice settings across Kent, Surrey and Sussex.

74. We are also working to ensure the timely and effective transition of commissioning responsibility for healthcare in Immigration Removal Centres, Police Custody Suites, Children and Young Peoples Secure Training Centres, Secure Children's Homes (welfare only) and Sexual Assault Referral Services is moving apace. On-going work is underway to develop and implement national service specifications and key Performance Indicator (KPI) monitoring data suites covering the delivery of healthcare services in secure estate settings, such as prisons.

75. Identifying and responding to issues of quality and safety for patients has been a resource intensive element of this programme of work. Resulting in some necessary reprocurements. The successful implementation and 'bedding in' of new contracts into some settings are a priority – particularly where delivery of healthcare services by the Prison Service has recently been transferred to a new healthcare Provider.

76. Increasing coverage of the Police and Court Liaison and Diversion Service across Kent, Surrey and Sussex remains a priority and the need to embed the patient voice and their involvement in our commissioning cycle continues to require dedicated time and planning.

77. Implementation of new IT systems for prescriptions, smart cards and the refresh of national systems (e.g. System1) are important to maintain infrastructure in our prisons and manage risk.

78. Maintaining a visible presence in the settings that we commission services for has added valuable and provides visible leadership for our partners and helps us as commissioners gain real insight into how services are delivered and experienced by users.

Strategic intent

> *"True justice for the most vulnerable is about pulling people into treatment, not pushing them away from the support they need. People should get the same quality of services in prison as they do in the community...we have to do more in early intervention, to support children and young people before they reach crisis point...we need diversion services to be a cornerstone of better care and support for offenders with mental health problems"*
>
> The Secretary of State for Health, speaking about health and justice commissioning at a joint event with the Ministry of Justice, March 2011

79. NHS England aims to commission services that offer care of the very highest standard and the best health outcomes for people in prisons and other justice

settings. Ensuring that these people receive the same standards of care that they would in the community is a core principle that underpins our approach. In addition, we want to drive quality improvements in the care and outcomes delivered. The summary plan for health and justice is included at Attachment 2.

80. Through the services we commission, we want to make progress towards the government's objectives of reducing violence - in particular by improving the way the NHS shares information about violent assaults and supports victims of crime - and developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community.

81. People in prison and other justice settings tend to have poorer health and worse health outcomes than the average population. We will work, together with out partners, to commission services in ways that will help to tackle these inequalities. In addition, we will continue to develop our commissioning approach in response to the *Bradley Report*'s recommendations to address the over-representation of people with mental health problems in prisons.

82. Through a single operating framework (developed jointly with the National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) we are responsible for commissioning health services in the following places:

- Prisons
- Young offender institutes
- Secure children's homes
- Immigration and removal centres
- Police custody suites
- Court liaison services

Roles and responsibilities

83. Responsibility for commissioning health and justice services is shared between the NHS England, CCGs and local authorities:

NHS England	Responsible for the direct commissioning of health services for people who are detained. Also responsible for some public health services (such as substance misuse services) for prisons. Area teams may devolve this responsibility to existing local joint commissioning arrangements in order to support more joined up services and continuity of care where they are satisfied that this will deliver their required outcomes.
CCGs	Responsible for commissioning health services for people engaged with the justice system but not in detention. Have a duty to co-operate in multi-agency youth offending teams. CCGs also responsible for commissioning emergency care services for "every person present in its area" including those in detention.
Local	Responsible for commissioning many public health services for people in their

authorities	area including those engaged with the justice system. Local authorities also commission sexual health services that may be used by victims of sexual assaults.

Partnership working

84. Effective partnerships are crucial to enable us to achieve our aims of commissioning excellent, equitable, integrated health services that deliver the best outcomes for people engaged with the justice system.

85. Partnership working already exists through local prison partnership boards and health and criminal justice boards, bringing together NHS England, CCGs, prisons, the police, local authorities and NOMS. These partnerships are able to ensure the effective use of resources, support continuity of care during the transition from custody to the community and can monitor and support equity of access.

86. These partnership approaches need to be further developed and expanded to ensure they are able to reflect the increased focus on the integration of services and the inclusion of reducing re-offending rates and other related indicators in the public health outcomes framework. However, it is also important to streamline governance arrangements to reduce the number of meetings that take place in recognition of the reduced management resource.

87. The NHS England, CCGs and local authorities (public health, children's services and social services) need to work together to commission integrated pathways of equitable health and social care for people whose lives intersect with justice services and to develop outcomes aligned to local joint strategic needs assessments and health and wellbeing strategies.

88. For the majority of people in prisons and other justice settings, their engagement with these services is temporary. Most will transition back to the community, although some will go back and forth. To ensure the best, most equitable health and outcomes for them, it is essential that health and justice services are not commissioned in isolation, but are seen as part of a continuum with the services these individuals would receive in their local community.

Priorities

89. The key priorities in commissioning for health and justice from 2014/15, set out in the Everyone Counts, are:

- To ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of resettlement prisons.
- To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
- Promotion of continuity of care from custody to community and between establishments, working closely with probation services, local authorities and CCGs.

- Development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs.
- Continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.
- A number of developments for sexual assault referral centres to develop the service and make it more equitable (listed as a public health ambition in the *Everyone Counts* five-year strategy planning guidance).

90. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice. For example, changes in the use of the custodial estate (for example from a prison to an immigration and removal centre) can happen at short notice, leading to a fundamental change in the health needs profile of the people who will be accommodated there.

91. Commissioners also need to consider the on-going development of the market for the provision of healthcare in justice settings, ensuring that there are sufficient providers able to offer quality, innovation and value for money.

92. Commissioners need to commission innovative solutions to challenging problems, seeking solutions in a different way. Locally this will mean exploring the potential use of telemedicine within prisons in order to reduce the need for costly and timely escorts and bed watches and in term reduce delays in receiving secondary healthcare out-patient care.

93. Attachment 2 provides details of the local commissioning intentions that relate to health and justice services.

94. *Everyone Counts* identifies a number of key performance indicators for health and justice commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
EG1	Do plans ensure that the national standard for health commissioned services for long term conditions will be delivered throughout 2014/15 to 2018/19?	Each prison now has a Health Improvement Plan (HIP) shared across all Providers and reported on at quality meetings. The development of a bespoke long term condition strategy for each prison forms part of the HIP. We are confident of delivery within the required standards.
	Do plans ensure waiting times will be delivered throughout 2014/15 to 2018/19	NHS England (Kent and Medway) has indicated this standard around waiting times for treatment for individuals in secure estate will not be met. Enabling prisoners to access secondary care is a significant challenge nationally due to the number of escort and bed

		watches cancelled by prisons due to staff availability. A number of streams of works are in place to support the delivery of this target including : - We have commissioned a review of telemedicine to support the delivery of this target but this will not report until summer 2014. - We will liaise with regional and national colleagues to explore the feasibility of a national MOU between NOMS and NHS England to reduce cancellations (e.g. by improving the availability of escorts and bed watches). - We are also sharing data and concerns directly with NOMS as impacting on delivery of timely healthcare. - We are discussing with Acute Providers appointment times for prisoners that best match the prisons 'core day' regime to maximise opportunities for attendance. - Ensuring providers have formal call back processes if prisoners fail to attend appointments.
EG3	Do plans ensure that the national standard for patients with a learning disability will be delivered throughout 2014/15 to 2018/19?	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance
EG4	Do plans ensure that the national standards for patients under Section 117 will be delivered throughout 2014/15 to 2018/19	The planned performance level is above the threshold set in the *Everyone Counts* technical guidance

Financial context

95. In 2013/14, a surplus of £1.7m is projected, arising from a combination of delayed starts to schemes, reduced demand for substance misuse services and other savings. The surplus from 2013/14 is not carried forward into 2014/15, although subsequent surpluses are carried forward.

96. The service has received an increase in allocation, including 2% for growth and additional funding for developing liaison and diversion services, sexual assault referral centres (SARCs) and prison reconfigurations. In addition to these developments, there are also improvements in the provision of primary care in some prisons and the responsibility for some services in immigration removal

centres (IRCs) is expected to transfer from the Prison Service, although no funding has yet transferred. The cost of these services is marginally less than the growth funding received and savings identified, hence the surplus increases to £2.0m, achieving a surplus in excess of the 1% target.

97. The summary financial position is shown below:

Health & Justice		
	2014/15	**2015/16**
Previous year outturn	44,521	47,079
Part year effects	0	-246
Sub total	44,521	46,833
Inflation uplifts	870	1,358
Growth	8	392
Provider Efficiency	-129	-111
Service Investments	2,623	257
QIPP	-815	0
Total	**47,079**	**48,729**
Notified Allocation	49,111	49,338
Surplus carried forward	0	2,032
Total Resources	**49,111**	**51,370**
Variance Surplus (+) / Deficit (-)	**2,032**	**2,642**

SECTION 6: PRIMARY CARE SERVICES (e.g. core services from general practitioners, community pharmacies, dentists and optometrists)

98. The delivery of core primary care services is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy).

99. Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping recovery from episodes of ill health and injury. Primary care professionals are best placed to make effective preventative interventions and to impact positively on the quality and efficiency of the whole health service.

Strategic intention

100. NHS England's ambition is to deliver, through excellent commissioning:

- A common, core offer for patients of high quality patient-centred primary care services.
- Continuous improvements in health outcomes and a reduction in inequalities.
- Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda.
- The right balance between standardisation/consistency and local empowerment/flexibility.

101. This document should be read in conjunction with NHS England (Kent and Medway)'s draft Strategic Framework for Primary Care.

102. The recently published "Improving General Practice - A Call to Action Phase1 Report" sets out 5 ambitions for general practice and wider primary care. The ambitions are:

- Proactive, coordinated care
- Holistic, person centred care
- Fast, responsive access
- Health-promoting care
- Consistently high quality care

103. We can achieve this ambition and vision through our new commissioning arrangements, our approach to engaging with and understanding our patients, strengthened primary care clinical leadership and by developing innovative approaches that challenge the ways of the past.

104. A clear case for change, coupled with a desire from general practice to transform services, has emerged and has been reinforced through the *Call to Action* on

primary care:

- Population changes - including an aging population, an increase in people living with multiple long term conditions and changing public expectations – are increasing demand for health services.
- Improving our primary care services will improve patient care and will cost less. Better care, closer to home is the only way to maintain quality of care in the face of increasing demand and limited resources.
- Addressing inequalities in access, quality and outcomes will require new and innovative ways of coordinating services.
- Action is needed to address emerging workforce pressures including recruitment and retention problems for GPs and practice nurses.

105. NHS England (Kent and Medway) believes the areas discussed in this plan (and in our Draft Strategic Framework for Primary Care) can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review.

106. A federated model of general practice, delivering integrated primary care services to large populations and communities, would appear to be a potential solution to the future configuration and role of general practice. This is an emergent approach that has been proposed by the RCGP and others within the profession.

107. It is suggested that general practice is on a journey that will take it along a development path, progressing through a number of stages:

    i. Current state
    ii. An extended skill mix in practices and across a range of primary care providers
    iii. Federation of practices
    iv. Co-location of practice / merger of practices to form larger partnerships / primary care units
    v. Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations)

108. The Everyone Counts sets out the following key characteristics of high-quality care in primary care:

- Proactive coordination of care, particularly for people with long-term conditions and more complex health and care problems.
- Holistic care: addressing people's physical health, mental health and social care needs in the round.
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing.
- Involving patients and carers more fully in managing their own health and

care.

- Ensuring care is of a consistently high quality: effective, safe and with a positive patient experience.

109. The following table provides more detail of the strategic intentions for the key primary care services:

General practice	General practice is the cornerstone of the NHS. Improving the nature of services provided outside hospital and supporting the public in self-care will be key ingredients for a sustainable NHS. Transformation in general practice must seek to maintain the internationally recognised strengths of the general practice model. Improving access is a priority, ensuring prompt access to GP services through 111, services that are available from 8am to 8pm seven days a week, and more rapid response to patient concerns through the use of telephone consultation. There will also be more personalised care and equality of access to services for everyone irrespective of where they live or their social status. We will work with CCGs, providers and other partners to identify and address inequalities. To achieve these ambitions will require a more scaled-up approach to general practice. This will mean working towards fewer, larger practices or federations or groupings of smaller practices where expertise is pooled and there can be increased focus on efficiency and innovation. This will enable patients to have seven-day-a-week access to a greater range of high quality primary care services. There will also need to be increased capacity in general practice and workforce plans need to include realistic projections for the number of GPs and practice nurses required, taking consideration of the presently aging workforce and changes in the career aspirations and expectations of newly qualified staff. Data and information are fundamental to providing high-quality, personalised care, improving productivity and empowering patients and clinicians to transform local services. It will be essential that GPs are supported by effective, efficient and integrated information technology systems. Patient access to electronic health records has been shown to improve health outcomes and reduce workload and costs so in line with the national strategy this will be supported. Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing costs so will be facilitated. Primary care services operate within communities and have strong links with the voluntary sector and community services. Strengthening and further integrating these can ensure resilient healthy communities addressing the root causes of ill health.
Community pharmacy services	Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E.

	Working with the LPC to ensure that we have the right number of pharmacists, with the right roles, working from the right locations will be important if we are to take advantage of the opportunities to provide a wider range of professional services from community pharmacies. Call to Action has also identified with the LMC an opportunity for pharmacists to undertake a more clinical role as part of the primary care team. Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions.
Dentistry	NHS England commissions dental services in both primary and secondary care, providing an opportunity to commission services across the whole patient pathway. We will look to move work such as minor oral surgery out of secondary care to primary care where we can so it is closer to home and more convenient for patients. We will also work with primary care dental providers and through the LPC to ensure that referrals continue to be made and handled appropriately.
Optometry	Many services provided in secondary care ophthalmology, such as for glaucoma and special needs optometry, could be carried out more efficiently and conveniently in high street optometry services. Core contracts for optometry will be developed and refined with the LPC and we will work with CCGs to co-commission services that can be moved from secondary to primary care.

Partnership working

110. Our aim is to create sustainable NHS services that provide more integrated care for patients, built around the registered populations served by groups of practices. To do this NHS England is developing joint arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.

111. It is important that this co-commissioning approach is developed to ensure the right balance between standardisation and flexibility in order that local primary care services can be planned in the context of CCGs' commissioning strategies, health and wellbeing strategies, JSNAs, PNAs and so citizens and communities can influence and challenge how services are provided.

112. Local professional networks (LPNs) for pharmacy, dentistry and eye health have been established and chairs appointed. As the committees' work gets underway it is essential that they support NHS England in commissioning these services by ensuring representative and robust clinical input to decision making and leading the profession in peer review and support, maximising performance, addressing inequalities and driving continuous improvement.

113. We will work with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment.

Primary care support services

114. NHS England is responsible for primary care support (PCS) services and wants all practitioners to have access to a standard range of modern, efficient and effective PCS services without the current variations in quality and cost. NHS England is continuing to work with staff and stakeholders to achieve the required changes in PCS services.

Secondary care dental

115. National criteria and care pathways are currently being developed by NHS England for all dental specialties following which commissioning of secondary and primary care services will be reviewed. Until these are in place steady state commissioning will continue with existing providers.

116. There are currently no CQUIN specifically for dentistry and these are to be developed at a national level; the 2014/15 CQUIN indicators that Kent and Medway will be using relate to collection of the relevant data flows to enable these to be developed.

117. Referral management arrangements are in place for oral surgery and endodontic treatment as ongoing QUIP delivery. Once national care pathways are in place, it is anticipated that further referral management will be introduced for other dental specialties.

Priorities

118. For general practice services a number of changes have been agreed to the national GMS contract, including:

- **Having a named, accountable GP for people aged 75 and over.** As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care.
- **Out-of-hours services.** There will be a new contractual duty for GPs to monitor and report on the quality of out-of-hours services and support more integrated care, e.g. through record sharing.
- **Reducing unplanned admissions.** There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

- improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission;
- ensure that other clinicians and providers (e.g. A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions;
- carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management;
- provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator;
- work with hospitals to review and improve discharge processes; and
- undertake internal reviews of unplanned admissions/readmissions.

- **Choice of GP practice.** From October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits. This will give members of the public greater freedom to choose the GP practice that best meets their needs. NHS England's area teams will need to arrange in-hours urgent medical care when needed at or near home for patients who register with a practice away from home.
- **Friends and Family Test.** There will be a new contractual requirement from December 2014 for practices to offer all patients the opportunity to complete the Friends and Family Test and to publish the results.
- **Patient online services.** GP practices will be contractually required from April 2014 to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online. The current enhanced service for patient online services will cease and the associated funding transfer into global sum payments for local GP practices.
- **Extended opening hours.** The extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access to services.
- **Patient participation.** The patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.
- **Transparency of GP earnings.** The British Medical Association's General Practitioners Committee (GPC) will join a working group with NHS England and NHS Employers to develop proposals on how to publish (from 2015/16 onwards) information on GPs' net earnings relating to the GP contract. The first published data would be based on 2014/15 earnings and publication of this information will be a future contractual requirement.

- **Diagnosis and care for people with dementia.** There will be changes to this enhanced service to promote more personalised care planning and allow greater professional judgement in which patients should be offered assessment to detect possible dementia.
- **Annual health checks for people with learning disabilities.** There will be changes to this enhanced service to extend its scope to young people aged 14-17 to support transition to adulthood and to introduce health action planning.
- **Alcohol abuse.** There will be changes to this enhanced service to incorporate additional assessment for depression and anxiety.
- **Support for innovation: Innovation pioneer hub** (Robert Stewart's work which we can share)

119. Locally, NHS England (Kent and Medway) is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), reprocure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2016). The following APMS contracts are scheduled to end during the next two years are:

Practice Name	CCG Area
DMC Sheppey Healthcare Centre	Swale
DMC Walderslade Surgery	Medway
College Health-Boots	Medway
College Health –Sterling House	Medway
DMC Medway Healthcare Centre	Medway
The Broadway Practice	Thanet
White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

120. NHS England (Kent and Medway) has a relatively high percentage of general practices on General Medical Services (GMS) contracts. In this respect 82% of GP contractors across Kent and Medway hold GMS contracts with only 13% of practices holding Personal Medical Services (PMS) contracts and a further 5% holding APMS contracts. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

121. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of

PMS contracts was undertaken throughout 2012/13 by the former Cluster PCT. This resulted in the vast majority of PMS contracts being successfully reviewed. A further review of PMS contracts across Kent and Medway will be undertaken in three phases:

- Phase 1 will be to facilitate any transfer back to a GMS contract that PMS contractors wish to make.
- Phase 2 will be to comprehensively review those contracts where the previous review was not concluded to the satisfactions of the NHS England.
- Phase 3, which will be undertaken in 2015/16, will be to review the objectives of other PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

122. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Reviewing and, if appropriate, reprocuring the occupational health service for GPs and other primary care contractors.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Extending the delivery of flu vaccinations in community pharmacies in order to help boost take up of the vaccine amongst at risk patients.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.
- Reviewing and where appropriate reprocuring interpreting services to support patients in accessing primary care contractor services.

123. *Everyone Counts* identifies a number of key performance indicators for primary care commissioning. The planned performance against these is as follows:

	Description of target	**Planned performance level**
ED1	What is the planned satisfaction with the quality of consultation at GP practices throughout 2014/15 to 2018/19?	Satisfaction with GP consultations, care at surgery and access to primary care is expected to continue deteriorating to 2016/17 before recovering. This is felt to be a realistic position reflecting the national trend and the challenges facing general practice in which the current experience of recruitment difficulties, locum utilisation and expected practice closures/mergers which are not necessarily popular with patients and communities. Some structural change is necessary and expected
ED2	What is the planned satisfaction with the overall care received at the surgery throughout 2014/15 to 2018/19?	
ED3	What is the planned satisfaction with access to primary care throughout 2014/15 to 2018/19?	

		and consequently we anticipate it taking 2-3 years to halt the existing downward trajectory in patient experience before we start to see some marginal improvement).
ED5	What is the planned of flu vaccination coverage for those at risk throughout 2014/15 to 2018/19?	
ED6	What is the planned distance between expected depression prevalence and reported depression prevalence from 2014/15 to 2018/19?	This indicator looks at depression prevalence and a trajectory has not yet been set due to data collection problems. This is a national issue and NHS England (Kent and Medway) is working with national colleagues to agree how this should be tackled and the indicator monitored.
ED7	What is the planned percentage of the population which have seen a dentist in the past 24 months for years 2014/15 to 2018/19	The planned level of performance is: Year — % of population who have been seen by a dentist in the past 24 mths 2014/15 — 51.0% 2015/16 — 51.5% 2016/17 — 52.0% 2017/18 — 52.5% 2018/19 — 53.0%
ED8	How many dental courses of treatment are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	Dental treatment rates are unlikely to increase without increased expenditure and this is not built into the plan at this point and, as such, delivery against this target is a risk.
ED9	What is the planned level of positive responses on dental services from the GP Survey from 2014/15 to 2018/19?	The planned level of performance is: Year — % of positive responses 2014/15 — 81.2% 2015/16 — 81.2% 2016/17 — 81.2% 2017/18 — 81.2% 2018/19 — 81.2%
ED10	How many sight tests are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	The local trajectory for sight test shows a very marginal increase in activity volumes per 100,000 population. Detailed plans will be developed in 2014/15 to address this
ED11	How many sight tests are planned to be delivered per 100,000 population from 2014/15 to 2018/19?	This projects a roll-forward of historic activity.

ED12	How many repairs and replacements per voucher are planned to be delivered throughout 2014/15 to 2018/19?	This projects a roll-forward of historic activity.
ED13	How many prisms per voucher are planned to be delivered from 2014/15 to 2018/19?	This projects a roll-forward of historic activity.

General Practice Information Technology

124. General Practice Information Technology (GP IT) covers a broad spectrum of areas. The GP IT operating model 2013/14 provided by NHS England breaks GP IT into three areas:

1. Core and mandated service provision	This includes the following and the hardware required to deliver the services: • GP Clinical systems – new provision and upgrade • GP Extraction Service • Nationally mandated systems e.g. Electronic Prescription Service • Software licenses required – new provision and upgrade • Underpinning Information Governance • Networking and connectivity services required • Hardware required – provision and replacement • Hardware and System maintenance, along with the provision of a service/help desk • Registration Authority services • Core administrative services to underpin the service • Clinical safety and assurance required
2. Local strategic and discretionary service provision	GP IT provision to support local strategic initiatives to improve service delivery and support local commissioning objectives and any items provided under discretionary funding.
3. General Practice business systems service provision	GP IT funded by the general practice or other funding services to support corporate business delivery functions in the GP.

125. Further national guidance on GP IT has just been received and needs to be considered. However, it is highly likely that the capital allocation will not cover the required capital refresh (especially noting that Microsoft will stop supporting Windows XP and a large volume of computers are using this operating system).

This means a key priority is to develop a robust IT strategy for primary care that both enables the benefits of technology to be exploited whilst managing a difficult financial position. In addition, further developing the service support arrangements (e.g. from the Commissioning Support Unit).

126. The desired outputs from the GP IT strategy work have been identified as follows:

- a GPIT strategy document that provides strategic road map for the development and deployment of IT to support General Practices, and underpinning framework(s) for the strategy; and
- a costed actionable plan that describes the strategy in terms of annual priorities and potential programme of work.

Financial context for secondary care dental

127. This service is currently over-performing, although demand management controls are in place to try to contain expenditure. This trend is likely to continue into 2014/15 and this is reflected in the summary financial position shown below:

Secondary Dental		
	2014/15	**2015/16**
Previous year outturn	21,464	21,576
Part year effects	0	-91
Sub total	21,464	21,485
Inflation uplifts	480	623
Growth	214	214
Provider Efficiency	-673	-859
Service Investments	91	88
QIPP	0	0
Total	**21,576**	**21,550**
Notified Allocation	20,480	20,880
Deficit carried forward	-2,260	-3,356
Total Resources	**18,220**	**17,524**
Variance Surplus (+) / Deficit (-)	**-3,356**	**-4,026**

128. Although the 'headline' allocation has increased over 2013/14 levels, the need to absorb the previous year's deficit has led to an increased deficit in the following year. Therefore the forecast outturn in 2013/14 of a £2.2m deficit has increased by approximately a net million pounds in subsequent years.

Financial context for primary care

129. In 2013/14, a surplus of £1.7m is projected. This surplus is carried forward into 2014/15, as are future surpluses and deficits.

130. There are a number of significant changes to reporting of expenditure between 2013/14 and 2014/15. Expenditure on GP IT was included in the spend and allocation in 2014/1. However, the allocation has not been included in 2014/15 and the expenditure has, therefore, been excluded. The public health element of general practice Quality Outcome Framework (QOF) of £5.4m was reported under public health in 2013/14, but is now to be reported under primary care matched by a transfer of allocation.

131. Primary care services are most directly affected by changes in population. GPs' income is largely based on list sizes and demands for pharmacy, dental and ophthalmic services also change as the population changes. Kent & Medway is projecting a 1% annual growth in population and this creates a cost pressure of £2.7m per year. There are also a number of cost pressures arising out of national directives. For example, an Enhanced Service is proposed for a named GP for those aged 75 and over, and there is to be greater choice of GP practice with Area Teams responsible for any in-hours urgent medical care. These initiatives are expected to cost £0.3m per year.

132. Primary care services are subject to annual pay and price increases. The Doctors and Dentists Review Body has recently announced the pay increases for 2014/15. A 1% increase had been assumed, costing £3.3m. Although the overall package is expected to increase income by 1% the actual change to GP fees is an increase of 0.28% and to dental fees is an increase of 1.6%. This has increased the surplus on primary care services by £1.040m.

133. Despite including all these cost pressures there are a still a number of risks which sit outside of the expenditure plans. The principle risk relates to property charges. The rents charged during 2013/14 by Property Services reflected the values included in baseline. Moving to actual rents, plus increased costs since the baseline was calculated, could add a further £1.2m to costs.

134. The allocation has been increased in 2014/15 by 2.42% growth. However, since the carried forward surplus in 2013/14 is greater than that projected to be carried forward into 2014/15, there is a reduction of £1.7m in allocation for this factor. The net increase in allocation is £15.7m. Comparing this to the identified cost pressures produces a surplus of £6.8m.

135. The summary financial position is shown below:

Primary Care		
	2014/15	**2015/16**
Previous year outturn	343,222	348,035
Part year effects	1,818	-2,048
Sub total	345,039	345,986
Inflation uplifts	2,198	2,211
Growth	2,772	2,775
Provider Efficiency	-1	-1
Service Investments	1,082	1,914
QIPP	-3,056	-1,900
Total	**348,035**	**350,985**
Notified Allocation	352,896	359,888
Surplus (+) / Deficit (-) carried forward	1,977	6,838
Total Resources	**354,873**	**366,726**
Variance Surplus (+) / Deficit (-)	**6,838**	**15,742**

SECTION 7: PRESCRIBED SPECIALISED SERVICES AND SERVICES AND ARMED FORCES HEALTH

Prescribed specialised services

136. NHS England (Surrey and Sussex) is responsible for commissioning prescribed specialised services on behalf of the populations of Kent and Medway and Surrey and Sussex. Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Specialised services provided by Kent and Medway providers include:

- East Kent University Hospital NHSFT (£65m, Renal, Cardiovascular Services, Haemophilia)
- Maidstone & Tunbridge Wells NHST (£52m, Cancer Services)
- Kent and Medway Social Care partnership Trust (£18 secure and forensic Mental Health)

137. In addition, to the above Kent and Medway residents access a range of other specialised services in other areas, particularly London.

138. NHS England is committed to ensuring that such services are commissioned on behalf of patients in a nationally coherent and equitable way. Commissioning intentions for specialised services have therefore been developed nationally and can be viewed at: http://www.england.nhs.uk/wp-content/uploads/2013/10/comm-intent.pdf.

139. Six key strategic strands are identified as part of these commissioning intentions:

a. Ensuring consistent access to effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.

b. A Clinical Sustainability Programme with all providers, focused on quality (this includes the need to achieve and maintain compliance with full service specifications and to keep these specifications under review in order to deliver a continuous improvement in health outcomes for patients).

c. An associated Financial Sustainability programme with all providers, focussed on achieving better value in the use of NHS resources.

d. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.

e. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients in particular services and care pathways.

f. A systematic rules-based approach to in-year management of contractual service delivery.

140. Locally, these strategic intentions have been translated into a number of service priorities:

Consolidating cardiovascular expertise	Secure additional years of life by consolidating acute cardiovascular expertise in a reduced number of emergency care centres (e.g. primary PCI and interventional cardiology)
Addressing avoidable admissions / reducing lengths of stay	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, specifically by reducing the need for inappropriate high cost specialised treatment by working with primary care and public health to reduce demand through increasing capacity in primary care to detect and refer people at an early stage.
Efficiency targets	Efficiency targets needs to be set at around 4.5% (£23m) given expected allocation for 2014-15 with the 2015-16 level on a par with 2013-14 outturn without investment
Commissioning for quality and Innovation (CQUIN)	Focusing of local CQUIN schemes on fewer initiatives with clear opportunities for local improvement and performance management. Contract performance management remains challenging without comparable historic and granular current activity data being consistently reported by providers and analysed by Commissioning Support Units

Armed forces health

141. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) commission armed forces health services on behalf of all areas in the South of England, including in Kent and Medway. The identified vision of the team is to provide high quality and safe care for armed forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

142. Armed forces healthcare is for serving members of the armed forces, reservists, veterans and all of their families who form part of a larger 'armed forces community'. In terms of the armed forces population:

- 51% of the population is aged under 30;
- 82% is aged under 40;
- 9.7% of the serving population is female;
- 58% of the serving population is in the army, 20% in the Navy or Royal Marines and 22% in the RAF;
- 17% of the serving population are officers (14% army to 22% RAF); 83% other ranks (78% RAF to 86% army); and
- overall 7.1% of the serving population are from a BME group (2.4% of officers, 8.1% of other ranks).

143. Whilst armed forces healthcare is commissioned by NHS England there are a range of commissioning responsibilities that sit with different statutory bodies:

- **NHS England** – NHS England is responsible for the direct commissioning of secondary and community health services for Armed Forces and families registered with the Defence Medical Service (DMS) Medical Centres. It assumes responsibility for commissioning some public health services through a Section 7 agreement with the Secretary of State, which Armed Forces and their families will be able to access.
- **CCGs** - CCG's are responsible for commissioning health services for veterans and families of members of the armed forces registered with NHS GP practices. CCG's are also responsible for the commissioning of emergency care services for 'every person present in its area', which includes for members of the Armed Forces and their families. It is also recommended that the responsibility for hosting Armed Forces Networks transfer from NHS England by agreement to appropriate lead CCG's to sustain the work of the 10 Armed Forces Networks currently in place. Given the strong focus on veterans and armed forces family healthcare, CCGs are well-placed to lead Armed Forces Networks, with support from NHS England. Further discussions will be needed with Armed Forces Networks to agree their transition and leadership arrangements for the future.
- **Local Authorities** – Local authorities are responsible for commissioning the majority of public health services for people in their area including members of the armed forces, their families and veterans. The exceptions to this are screening services, immunisations, public health services for children aged 0-5 years, public health services for prisoners and other detainees and Sexual Assault Referral Centres (SARCs). These services will be commissioned directly by NHS England. Local authorities will also commission open access sexual health clinics and genito-urinary clinics.

144. Members of the armed forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculoskeletal injury. Combat-related injuries aside, armed forces healthcare needs can usually be met by standard NHS services.

145. The families and dependants of serving armed forces members have health needs typical of their age and gender. Maternity services and children's health services, in particular, must be planned and commissioned with the needs of military families in mind where they are present in large numbers in a community.

146. Members of the armed forces may also have specific health needs that relate to their occupation or employment and require extensive occupational health support. Where the services needed for occupational health exceed the normal NHS services or standards, they will remain the responsibility of Defence Medical Service to commission, pay for or deliver.

147. There is a public perception that the Armed Forces community have a range of mental health problems and in particular suffer from Post-Traumatic Stress Disorder (PTSD). In 2009 the Academic Centre for Defence Mental Health undertook a useful review of evidence on the health and social outcomes - and

the health service experiences - of UK ex-service personnel. Their findings highlighted that:

- the ex-service population has comparable health to the general population and a broadly similar prevalence of mental health-related conditions;
- current UK military personnel have higher rates of heavy drinking than the general population;
- the most common mental health issues experienced by ex-service personnel are alcohol misuse, depression and anxiety disorders;
- military personnel with mental health problems are more likely to leave the armed forces and are at increased risk of adverse outcomes in post-service life;
- the minority who leave the military with psychiatric problems are at increased risk of social exclusion and ongoing ill health;
- the overall rate of suicide is no higher than for the general UK population, with the exception of male veterans aged 24 or younger who are at increased risk compared to their general population counterparts;
- early service leavers are more likely to have adverse outcomes and carry out risk taking behaviours than longer serving veterans; and
- deployment to Iraq or Afghanistan is associated with adverse mental health outcomes for some groups, particularly those with pre-service vulnerabilities, those who experience a high level of combat and reservists.

148. Armed forces commissioning will have a particular focus on those patients with the most complex care needs. NHS England will work to ensure that:
    - a modern model of integrated care is in place;
    - the date of discharge from the armed forces has no impact on the care decisions made, regardless of how far in the future the date may be;
    - area teams facilitate and support a multi-disciplinary team (MDT) approach for those service leavers that have complex health needs or are considered to be a seriously Wounded Injured or Sick (WIS) individual (this may include organising for continuing health care assessments to be made);
    - WIS individuals have an agreed personal health plan prior to service discharge and are clear as to the NHS offer and their rights and responsibilities; and
    - CCGs understand the needs of WIS individuals and their rights under the Armed Forces Covenant.
149. Access to urgent and emergency care. We will work with DMS, Clinical Networks and local CCGs and providers to ensure that:
    - the armed forces community is able to access appropriate services and cost effective out of hours primary care services;
    - the armed forces community is able to access appropriate out of hours services for those in mental health crisis;

- appropriate services are included in NHS 111 directories;
- the views and needs of DPHC are represented at Urgent Care Working Groups, where there is a sizeable Population at Risk (PAR) within the community;
- where there is a sizeable PAR their needs are reflected in the plans that CCGs and Health & Wellbeing Boards agree for the Better Care Fund; and
- the redesign of emergency care systems where there is an associated movement of DMS staff does not result in a destabilisation of providers.

150. NHS England will also be working with DMS, local authorities and colleagues in Public Health, both Public Health England and within NHS England, on the health inequalities agenda. Specific areas of focus are:
    - access to national screening programmes;
    - access to the child health information system;
    - smoking cessation;
    - alcohol misuse;
    - maternity - vulnerable & disadvantaged families; and
    - access to mental health services during and after transition.

151. It is recognised that military personnel put themselves in harm's way in the service of their country, risking risk injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were recently set out in the *Armed Forces Covenant*, a framework for the duty of care Britain owes its armed forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation.

SECTION 8: SUMMARY OF NHS ENGLAND (KENT AND MEDWAY) FINANCIAL POSITION

152. The following tables provide a summary of the projected financial position for 2014/15 and 2015/16:

Kent & Medway Summary Financial Position

2014/15				
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Target Surplus £'000**
Primary Care	354,873	348,035	-6,838	-3,549
Secondary Dental	18,220	21,576	3,356	-182
Public Health	51,523	53,966	2,443	0
Health & Justice	49,111	47,079	-2,032	-491
Total Kent & Medway	**473,727**	**470,655**	**-3,072**	**-4,222**

2015/16				
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Target Surplus £'000**
Primary Care	366,726	350,985	-15,742	-3,667
Secondary Dental	17,524	21,550	4,026	-175
Public Health	48,871	55,003	6,132	0
Health & Justice	51,370	48,729	-2,642	-514
Total Kent & Medway	**484,492**	**476,267**	**-8,226**	**-4,356**

154. The plans for the different direct commissioning areas had certain financial targets to meet, and the initial targets, are shown above. However, over time, and in response to the emerging national position, these have been moderated, such that collectively primary care, secondary dental and public health are now required to show breakeven plus £1.040m savings arising from the DDRB pay award. Health & Justice was required to show improvement upon the 2013/14 outturn to produce a £2.0m surplus.

155. NHS England (Kent and Medway) has used the outputs of the issued finance planning templates to drive the financial position shown above, and this plan is

consistent with those finance templates. The position above is therefore potentially impacted by the issues that are now described in this section.

Allocations

156. NHS England has issued allocations to NHS England (Kent and Medway) for each service but the source and content of each does vary. Whilst most use the allocation as at September 2013, that for public health is based on April 2013.

157. The allocations are adjusted for recurrent transfers made since September 2013 and growth has been added in all except public health, although funding for health visitors and meningitis C (four month dose) has been provided. . The allocations are adjusted for recurrent transfers made since September 2013, and growth has been added in all except Public Health, although funding for Health Visitors and Meningitis C has been provided.

158. Allocations for 2015/16 have also been issued. Those for primary care and secondary dental show a 2% uplift, whilst that for health and justice shows a 0.5% uplift and public health is the same as for 2014/15.

159. The difference in approach and content leads to different impacts on the financial position for each service.

Balances brought forward

160. The financial templates automatically adjust for balances brought forward. All surpluses and deficits generated in 2014/15 onwards are automatically carried forward, and, particularly in the case of deficits, unless the deficits are corrected either by reduced expenditure or allocation adjustments (whichever is most appropriate), there is a multiplier effect in subsequent years.

161. However, there is inconsistent treatment of carried forward balances in 2013/14. Surpluses generated in primary care are carried forward, but those in health and justice and public health are not; deficits generated in secondary dental are carried forward.

Outstanding allocation Issues

162. There are a number of service developments and changes which have not been matched by allocation adjustments:

- In 2013/14, CCGs received a central deduction to their allocations for drugs prescribed for services commissioned by local authorities and NHS England. However, the Area Team did not receive the allocation to pay for these drugs. An allocation was received late in 2013/14 to offset these costs. The net additional allocation required is £ 2.9 million.

- The responsibility for some health and justice services is expected to transfer from the Home Office to NHS England, mostly relating to Immigration Removal Centres. The costs of the services have been included in plans as a risk, but no allocation transfer has been assumed. The cost in 2014/15 is £0.4 million.

Cost pressure to be funded from central reserves

163. There has been an increase in public health allocations for the increase in health visitors employed and the Family Nurse Partnership (FNP) programme. However, as yet there is no increase for meningitis C (University), HPV vaccine and childhood influenza. Some funding, for example for bowel screening and FNP, appears to be less than is required to fund the increased level of service, and the balance is shown as a risk.

Section 7a public health agreement

164. The realignment of public health costs between public health and primary care has meant that £5.4 million of costs and allocation are shown under primary care in 2014/15, whereas they were included under public health in 2013/14.

Expenditure

165. The plans have been drafted assuming that the expenditure outturn for each year will be the total sum spent for that service. As such, this drives a current position which includes all significant risks.

166. NHS England (Kent and Medway) has made a number of assumptions regarding cost pressures impacting on 2014/15 spend. These will be reviewed with the aim of achieving consistency with other area teams in the NHS South area where necessary.

167. The plan reflects the savings which have been identified to date. Work will continue in-year to identify further opportunities, for example, by taking account of wider bench-marking across NHS England.

168. NHS England (Kent and Medway) is expected to identify 2.5% non-recurrent expenditure ("Headroom"). Given the challenges apparent in the current financial planning templates, the area team is currently applying this resource to the reported expenditure and is not expecting to declare unapplied Headroom.

SECTION 9: SUMMARY OF KEY RISKS

169. There are a number of risks and assumptions that are inherent within this plan. These are outlined in this section and are under ongoing review.

170. The following table highlights the key risks that are inherent in this document:

Area	Risk	Mitigation
Corporate	Management capacity is constrained and further financial savings needs to be delivered in 2014/15 and 2015/16. This constraint may limit the ability to deliver this plan.	Plans are being developed to deliver required efficiencies and ensure core functions can be maintained.
Corporate	Further development of the complaints function is critical to ensure that "hidden" complaints are formalised and used to inform a complete picture of provider performance.	Local plans to further develop the complaints function to be identified and presented to QSG
Clinical advice	The availability of clinical advisors presents a risk to a number of core activities. This includes determining the employment model for clinical advisors and ensuring appropriate indemnities are in place.	Discussions taking place with national policy colleagues on how to ensure clinical advisor capacity is in place
Commissioning Support	Business intelligence support has been put in place but arrangements are still immature and a number of data accuracy issues have been identified (e.g. public health trajectories, secondary care dental, secondary care health and justice services). These impact on the ability to robustly commission and monitor delivery.	Work taking place to further develop business intelligence support.
Public health	Significant financial pressures remain in the public health budget and these have the potential to disrupt service provision and the delivery of the performance trajectories outlined in the above table. The planned performance detailed in this document is subject to the financial pressures being resolved.	Ongoing work is taking place with regional and national colleagues to address allocation issues. Work is also taking place to review this within the mandate of 7a agreement.
Commissioning Support	NHS England has only had limited access to information governance support, which has presented risks around information governance compliance.	A service level agreement has been established with Kent and Medway Commissioning Support
Health and justice commissioning	The development of the Kent and Medway Sexual Assault Centre has been priotised in 2013/14 following the previous service coming to an end. However, work now needs to focus on	Interim protocols are now in place and joint working group in place to determine the

	putting in place robust arrangements for paediatric victims of sexual assault and abuse.	commissioning pathway
Health and Justice	Cancelled secondary care appointments impacting on access to secondary care due to prison staff not being available to escort patients or undertake bed watches	Under discussion locally and nationally with a view to putting in place agreements between agencies / organisations to improve performance
Primary care	Lack of capacity and capability in primary care services to support a shift from secondary to primary care (including a range of workforce issues such as recruitment and skill-mix)	To be addressed in 5 year plans
Primary care	The GP IT capital allocation will not cover the required capital refresh (especially noting that Microsoft will stop supporting Windows XP and a large volume of computers are using this operating system).	Development of a robust IT strategy for primary care that both enables the benefits of technology to be exploited whilst managing a difficult financial position.
Primary care	Limited scope for efficiency saving, partly due to the predominance of GMS contract in Kent and Medway (85%) and as PMS reviews have already been undertaken.	Other savings opportunities identified but these largely relate to ensuring robust contract management.
Primary care	Sustainability of general practice is at risk in some areas as we anticipate a number of practice closures over the next 2-5 year period as a result of decreasing margins, increased regulation, ageing workforce and difficulty in recruiting new GPs.	To be addressed in 5 year plans
Primary care	Patient experience has been decreasing year-on-year while expectations have increased. Improving patient experience is likely to require some significant changes to be made in some areas. This means improvements in patient experience are unlikely to be seen immediately in all services.	To be addressed in 5 year plan.
Primary care	Primary care support (PCS) services (provided by Kent Primary Care Agency) are subject to a significant change programme, dependent on approval of plans by the NHS England Board. This introduces business continuity risks (e.g. in relation to payments, management of patient note, etc...)	Mitigations being established through the PCS programme

Secondary care dental	Current secondary care dental contracts are over-performing and the ability to address this is partly constrained by poor business intelligence and partly by the ability to invest in community dental services.	Plans to be developed.

171. The risks in this plan will be reviewed and migrated to the NHS England (Kent and Medway)'s risk register to ensure they are robustly managed on an ongoing basis.

SECTION 10: SUMMARY

172. This paper details the commissioning plans of NHS England (Kent and Medway). Comments from stakeholders and partners are welcomed.

173. It is important that this plan is not read in isolation and should be read in conjunction with:

- Kent and Medway CCG two year operational plans
- The NHS England (Kent and Medway) strategic framework for primary care
- The Kent Annual Public Health Report
- The Medway Annual Public Health Report
- The Kent Joint Strategic Needs Assessment
- The Medway Joint Strategic Needs Assessment
- The Kent Health and Wellbeing Plan
- The Medway Health and Wellbeing Plan

174. These plans will continue to be refined and in particular there will be a focus on working with the three local planning footprints (e.g. the East Kent CCG Federation, the North Kent CCG Alliance and West Kent CCG) to develop five year strategic plans for submission in June 2014.

175. For Health and justice healthcare commissioning and public health commissioning the strategic direction will largely be determined through national work programmes. Local plans will be shaped around these national documents but local strategic focus in the five year plans prepared with CCGs are likely to focus on:

a. addressing any ongoing service performance issues;

b. through the gateway services for prisoners being released from prison back into the community; and

c. secondary care services for the health and justice population.

176. The strategic development of primary care is also being considered at a national level, building on the engagement that has taken place through the Call to Action, and further information on the strategic development of primary care services will be released during 2014/15. However, the development of local plans is also necessary and NHS England (Kent and Medway) has produced a strategic framework for the development of primary care. This will now be built upon to support the development of local strategic plans.

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN

NHS England

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities

- Promote a healthy start in life through universal delivery of the national Healthy Child Programme from pregnancy to - 5 years , including Health Visiting and Family Nurse Partnership and robust Ante Natal Newborn (ANNB) screening
- Deliver national Immunisation Programmes and improve uptake to increase herd immunity and reduce the risk of infectious outbreaks
- Deliver the National Cancer Screening Programmes to help improve early diagnosis of breast, bowel and cervical cancer
- Deliver the non-cancer screening programmes (e.g. diabetic eye screening, abdominal aortic aneurism (AAA) screening.
- Improve support to victims of sexual assault , enabling timely access to care, prevention/prophylaxis treatment and recovery support.
- Working with Health and Justice Teams to improve access to public health programmes in the prison population

Strategic Context and Challenges

- Using improved data sets Identify variation in immunisation and screening coverage
- Review all provider contracts benchmarking against national services specifications and strengthening contract and performance monitoring systems
- Ensure safe transition of universal healthy child programme to Local Authorities commissioning
- Implementation of new programmes and work with partners to take account of pace of change across wider systems
- Improving uptake of section 7a commissioned services for marginalised and at-risk groups.
-

QIPP Improvements

- Introduce relevant CQIN targets to new contracts
- Reviewing variation in performance and coverage across immunisation programmes to reduce incidence and impact of infectious disease.
- Identify risk of disease and disability early by commissioning of safe and effective screening programmes
- Work with providers to demonstrate the value of the *universal* Healthy Child Programme
- Ensure commissioned services represent best value for money and are evidence based
- Benchmarking the payment and contracting mechanisms of our commissioned services to ensure and equity of provision.
- Reprocurement of schools based immunisation team

Organisational Development

- Continued work with the PHE embedded Screening and Immunisation team to maximise skills , expertise and resources, define roles, accountabilities to deliver the work programme
- Develop and implement a programme management approach to the public health commissioning programme to ensure an integrated approach to the programme
- Build collaboration across wider other Area Team commissioning and contracting teams (Primary Care, Specialised Commissioning, Armed Forces, & Health and Justice) in order to maximise resources, nursing and quality directorates and operational delivery.
- To continue to develop relationships with CCG and local authority commissioners and providers in the local health economy
- To provide training and development opportunities to the Public Health team to develop skills and improve team resilience
- The continuation of the partnership approach developed with the local authority and Health & Well-being boards.

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN

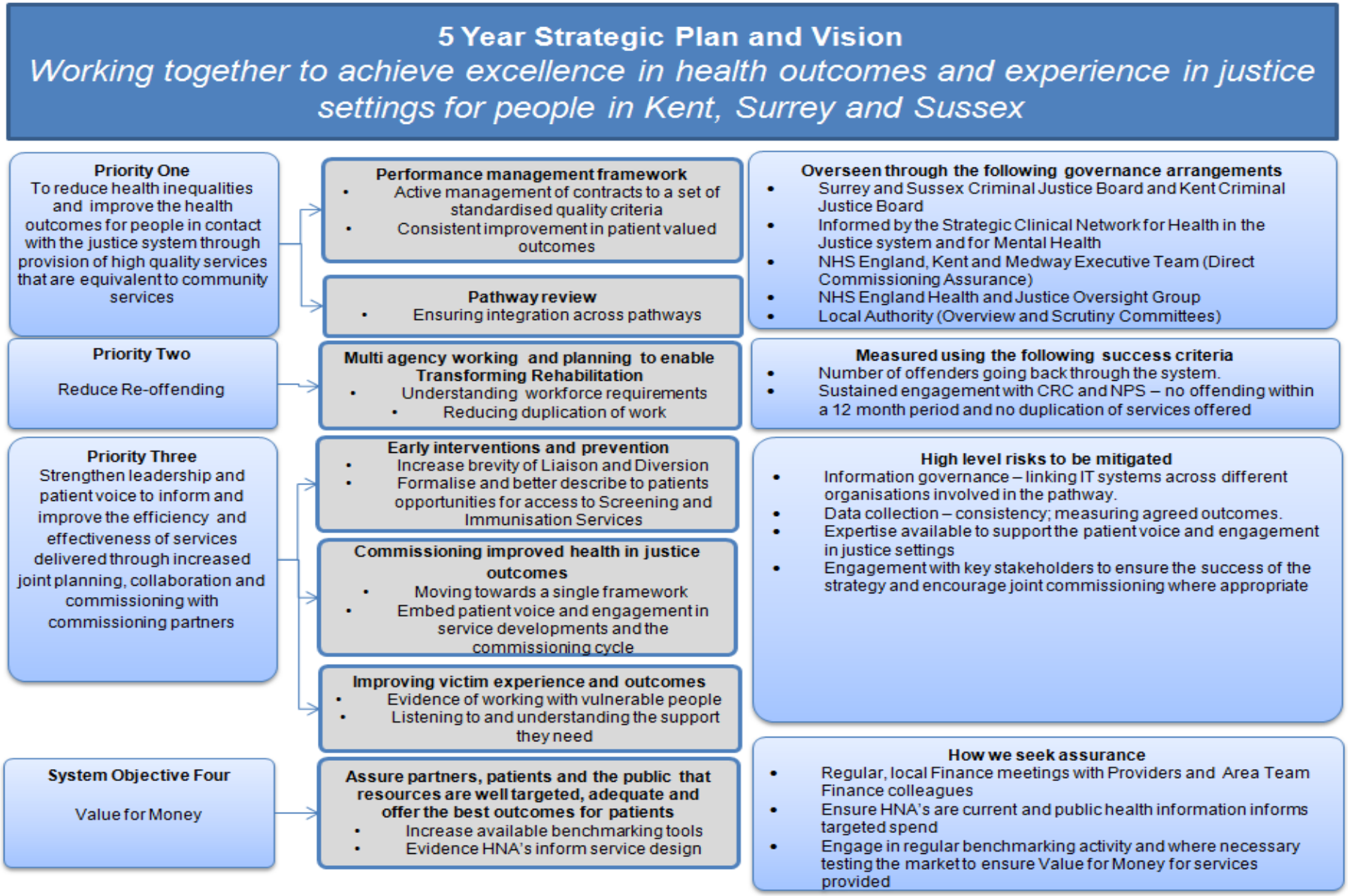
	National Priorities 2014-15	Expected Outcomes of Implementing National Guidance locally in 2014-15	End State Ambition 2015-16	Additional Local Priorities 2014-2018
Immunisation	• Seasonal Flu Programme for children is to be further rolled out to include 4 years olds with piloted programme for year 7 children. • Embed the Men C adolescent booster programme in school immunisation programme • Commission the extension of Men C immunisation for University entrants, • Continuation of MMR catch up, Pertussis in pregnant women, Shingles in 70/79 year olds • Continued improvement of flu vaccinations in healthcare workers, at risk children, pregnant women and at risk over 65s' • Implement pneumococcal vaccination specification	• Increased participation in the flu vaccination programme, reduction in avoidable hospital admissions and severe complications in at-risk patients. • Improved immunisation uptake particularly for at risk and marginalised groups. • Increased herd immunity and reduction in improvements in public health as a result of the extension of the childhood flu programme	• High uptake levels and reduction in variation in up-take • Reduction in vaccine avoidable disease. • Improved timely data available at GP practice level with national benchmarking and trend analysis • Systems in place for fully auditable immunisation payment mechanism in primary care	• Alignment of health visiting programme to support improved childhood immunisation up-take • Evaluate performance and set local improvement targets for new and existing programmes • Review and revise all local contracts and contracting mechanisms to improve performance • Access the school-age immunisation provision against capacity and other competing targets • Implement CQRS as a mechanism for data collection and payments for primary care

Screening Programmes (Non-Cancer)	• Review existing services to identify areas of non-compliance to national specifications and risks to programme delivery. Develop action plans to ensure full delivery to national specifications by March 2015 • Introduction of the new performance baselines for Diabetic Eye Screening • Implementation of the DNA test as part of the Sickle Cell and Thalassemia Screening Programme • Ensure that the payment for the antenatal and new-born screening and immunisation programmes are recognised within the Maternity Pathway Payment and that there is not a subsequent reduction in activity or quality. • Changes to QOF points in relation to diabetic eye screening	• Increased participation in screening programmes with reduced variation between local populations • Review of the participation in antenatal and new born screening services, analysis of the root causes of variation and the spreading of identified best practice • Benefits across of early detection and diagnosis of disease and disability.	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and early detection of disability, and an overall more positive experience from the health service • Full participation in screening programmes to support goal of giving every child a healthy start in life	• Continue to develop governance process for assuring improvements in non-cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary • Benchmark programmes across the region with a view to standardise payments and improve VFM

Screening Programmes (Cancer)	• Review existing services to identify areas of non-compliance against national specifications and risks to programme delivery (to ensure compliance by March 2015). • Age extension for existing Bowel Screening Programme (men and women 75 years) • Introduction of HPV testing as part of the Cervical Cancer Screening Programme for women with mild / border line changes • Age extension for breast screening (randomisation by GP practice) all women who 70-73 or 47-50.	• Full rollout of age extension bowel and breast screening programme with sustained timely access to diagnostics and subsequent treatment • Increased participation in screening programmes with reduced variation between local populations • Benefits across the health system of early detection and diagnosis of cancer	• Full participation in screening programmes so that earlier detection leads to prevention of premature death, help to recover from ill health and an overall more positive experience from the health service	• Continue to develop process for assuring improvements in cancer screening uptake • Improve coverage of screening programmes particularly hard to reach groups • Assess existing contractual arrangements and review the need to retender as necessary • Re-commission the cervical screening programme for armed forces personnel to represent a fair and equitable programme across the system.
NHS England and PHE agreements	• Develop common strategies to improve outcomes • Continue to strive for improved and timelier data collection and better commissioned 7a services.	• Close partnership working with coordinated and integrated commissioning intentions	• Full utilisation of Public Health Advice Service by public to measurably improve domain outcomes	• Continue to develop governance arrangements • Ensure local prison services have appropriate access to public health services

0-5 years Programme (including HV and FNP and Child Health Information System)	• Implement the 14/15 workforce trajectory for Health Visiting Call to Action, and continue to review and report performance on a monthly basis. • Continue to collect and monitor the quarterly data in relation to Healthy Child Programme Outcomes • To plan and work towards the transition of the Healthy Child Programme (0-5) to local authority. Transition Boards/Groups will provide regular updates to all stakeholders • Implement the new trajectory for Family Nurse Partnership expansion	• Increase in Health Visiting workforce and resultant improvements in service delivery • Expansion of Family Nurse Partnership to improve outcomes for young vulnerable first time mothers and their families. • Healthy child programme (0-5 year olds) transition to local authorities with commitment to sustain programme	• In October 2015, commissioning responsibility for this aspect will transfer to Local Authorities (the aim is for the expected service capacity and all national standards to be sustainably delivered prior to transfer).	• Ensure safeguarding and quality arrangements in place reported through Quality Surveillance • Commissioning and implementation of existing and planned new Family Nurse Partnership Programmes.

ATTACHMENT 2: HEALTH AND JUSTICE SUMMARY PLAN



ATTACHMENT 3: PRIMARY CARE SUMMARY PLAN

NHS England

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Primary care: current landscape

1. *Variation in quality and performance*
2. *Some patients have difficulty accessing primary care services*
3. *Some patients struggle to navigate the health care system*
4. *Patients using hospital services inappropriately*
5. *Significant number of premises fail to meet required standards*
6. *Significant number of small practices managed by sole practitioner contractors*
7. *Uneven distribution of resources between practices and across CCGs*
8. *Community pharmacy plays limited role*

General practice in Kent & Medway: current landscape

1. *Registered population of circa 1.4 million*
2. *8 CCGs, covering populations ranging from circa 106,000 to 460,000*
3. *262 GP contractors, 34 PMS 13, APMS. 85% of practices are GMS – unusually high and limits scope of local QIPP*
4. *3 GP-led health centres . Their future is the subject of review by CCGs and the local area team*
5. *Some practice premises do not meet minimum standards*
6. *There are significant GP recruitment issues in parts of Kent and Medway.*

Primary care: future landscape

1. *Consistent levels of high quality performance*
2. *Robust patient and public engagement informing commissioning*
3. *Comprehensive range of services provided in primary care settings including a wide range of diagnostic tests and treatments*
4. *Services are available at times and places that are convenient to patients and appropriate to need*
5. *The highest risk patients identified and patient-focussed pathways put in place*
6. *Premises of consistent quality and meeting minimum standards*
7. *Sustainable provider landscape with services delivered at-scale*

Key challenges

- *Large geographical footprint with many contractors.*
- *Legacy of predecessor organisations and the history and relationships forged with contractor groups*
- *Nationally negotiated contracts leave limited scope for savings.*
- *Large number of small practices*
- *Significant number of elderly sole practitioner contractors.*

Improvements

- *Driving up quality by reducing variation and tackling unacceptable levels of service*
- *Improved access to GP services*
- *Wider range of services provided in community pharmacy and general; practice*
- *Increases in flu vaccination coverage*
- *Improvement in the prevalence of depression compared to estimated model*
- *Post payment verification and audit activities*
- *Review of discretionary payments*

ATTACHMENT 3: PRIMARY CARE SUMMARY PLAN

	Priority objectives	Key Area Team outputs in: 2014-16	End State Ambition 2019-20
1.	QIPP	• PMS reviews • Procurement of APMS contracts that will come to an end • Tackling list inflation • Probity program • Review of minor surgery and anti-coag' DES/LES schemes • Ensuring all practices are being charged appropriately for occupation of NHS PS premises • Dispensing patient review	• Reduced variation in spend on primary care across CCG areas and between GP practices • Unacceptable levels of PMS premiums removed • More consistent set of commercial terms across APMS contract
2.	Drive continuous quality improvement	• Quality of care can be measured and benchmarked • Definition of what good looks like agreed with public, CCGs and other key stakeholders • A continuous quality improvement strategy & delivery plan overseen by ATs Primary Care Quality Hub • Agree a consistent, rigorous and risk-based approach to monitoring quality through practice inspections and deep dive reviews • Maintain and further develop Local Professional Networks (LPNs) and produce work plans and support delivery of key strategic objectives	• Reduced level of variation • Numerous examples of where unacceptable levels of quality have been addressed successfully • CCG facilitated learning networks supporting peer-to-peer challenge and learning • LPNs leading strategic change and improvement

3.	Developing infrastructure and reconfiguring primary care	• Address short-term pressures in workforce • Promote improvements in primary care premises by completing a stocktake of general practice premises and developing an strategy for premises/estates in conjunction with patients, public and other key stakeholders • Improve use of IT systems to improve primary care in collaboration with CCGs • Review of Minor Surgery DES/Les service specification • Review of anti-coagulation LES and use of PGD/development of pharmacy prescribers • Roll out EPS in general practice • On-line booking, access to medical records on-line, order repeat prescriptions on-line	• General practice delivered from fewer premises and reduced number of practices operating from premises that do not meet minimum standards • Much wider range of services delivered in community pharmacy and general practice
4.	Improving access and services	• Methods for engaging patients and the public in contracting changes and procurements enacted by the Area Team • PMS review to be completed in collaboration with CCGs • Procurements for a number of existing APMS contracts, OH services, interpreting services and clinical waste. • Piloting innovation e.g.: 8am – 8pm working, 7 days per week, e-consultations • Ways of enabling registration at GP practice of choice are introduced	• QSGs are successfully identifying and addressing quality issues in a whole systems, collaborative and supportive manner • A robust system for managing contracts and performers whose performance gives rise to concern is well established • Methods for patient and public engagement in contracting changes and procurements are robust and well established • PMS & APMS contracts reflect strategic direction • Improved choice, and access to and satisfaction with general practice

5.	Perform assurance role	• Maintaining up-to-date contract documentation • Annual GP practice reports received and reviewed • Work closely with CQC in responding to evidence of poor quality • QoF assurance program • Self-funded probity function established and program agreed • Effective management of counter fraud activity • Review contractors' business continuity arrangements and ensure that these are robust at both individual service and whole system levels	• Robust and effective counter-fraud mechanisms well established • Targeted QoF visits and self funded probity program • All contractors have clear and up-to-date business continuity arrangements

ATTACHMENT 4: SPECIALISED COMMISSIONING SUMMARY PLAN

NHS England

Values and Principles	Services are patient centred and outcome based	Improved outcomes delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves
Domains	Prevent premature death	Quality of life for patients with Long Term Conditions	Help recover from ill health / injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 13/14	Strategic Context and Challenges	QIPP Improvements	Organisational Development
• Implementation of national service specifications • Resolution of derogation programme with a focus on commissioner led derogations • Provision and modernisation of radiotherapy capacity to improve access for patients and to improve outcomes for patients • Continuing review of vascular services to ensure compliance with national standards • Compliant rare cancer services, e.g. specialised urology • Delivery of compliant major trauma centre in Sussex in regard to neurosurgery • Implementation of recommendations from Winterbourne Review	• Review the implications at a local level of the financial challenge of operating within a deficit budget • Support national review of single operating model for specialised services ensuring local effective engagement • Engage proactively with the Call To Action strategic planning, being clear on local implications • Supporting good access to mainstream specialised services for Kent, Surrey and Sussex patients • Continue to strive for effective relationships with key partners, Patient and Public, Clinical Reference Groups, CCGs, other Area Teams, Health & Wellbeing Boards, HOSCs, providers, Strategic Clinical Networks, ODNs, PHE and clinical senate	• Review and adoption of national and local QIPP/Productivity and Efficiency schemes to meet the challenge of 9% over 2 years front loaded in 14-15 • Input into national process for procurement of high cost drugs and devices • Implementation of nationally agreed clinical access policies • Support clinical and patient engagement with the innovation, health and wealth ambition	• Continue to develop contract management skills and expertise within the team • Support development of matrix working and networking of teams, across national, regional and local landscape • Continue to support staff to embrace NHS England vision and values • Work with SCN colleagues embedding local process to support patient and public voice through engagement and participation • Support provider engagement, in particular regard to strategy, for specialised services, contracting and data quality improvement

ATTACHMENT 4: SPECIALISED COMMISSIONING SUMMARY PLAN

	National and Local Priorities 2014-15	Expected Outcomes of Implementation in 2014-2015	End State Ambition 2015-16 and onwards to 2018-19
Internal Medicine	• Cardiac – Review of TAVI audit and implement recommendations • Review specialised cardiology provider landscape • Implementation of vascular reviews in Sussex and Surrey, commence review of Kent & Medway services	• Achievement of core clinical and quality requirements • All cardiac and vascular services to meet national service specification	• All services compliant with national standards and achieving improved outcomes for patients • Safe and sustainable services with clear patient pathways understood
Cancer and Blood	• Implementation of national recommendations for radiotherapy and increased access to IMRT and IGRT • Work with region and providers to ensure compliance with e-prescribing for chemotherapy • Ensure compliance to national specifications of specialised cancer services • Cancer Drugs Fund – support Wessex with implementing national process and policies • HIV/AIDs - review provider landscape following sexual health reviews working with Public Health and Local Authorities	• Implementation of locally agreed plans to improve quality and access to radiotherapy for patients • Working with Brighton & Sussex University Hospitals Trust (BSUHT) to review provision of radiotherapy and integrated chemotherapy service at Western Sussex Hospital's Trust • E-prescribing operating effectively across all providers as relevant • To be clear on HIV/AIDs treatment and care pathways supported by adequate resources	• Improved access to radiotherapy • Consistent national tariffs in place • Patients to receive optimum care • Consistent and equitable provision of chemotherapy and cancer drugs • High quality HIV/AIDs services in place

Trauma	• Support Major Trauma Centre (MTC) at BSUHT , ensure all codependent services are meeting national service specifications through derogation as required • Work with regional lead to review the implications of the national service specification for Queen Victoria Hospital • Oversee the outputs of the Operational Delivery Networks (ODN) for adult critical care in relation to specialised services	• MTC to be fully compliant with national service specification, standards and quality requirements • London and SE consensus on the configuration of burns services • Effective ODN in place for adult critical care (specialised)	• Safe and sustainable services in place • Burn care services compliant with the national model • Effective network model of adult critical care for specialised services in place
Women and Children	• Oversee the outputs of the Operational Delivery Networks (ODN) for neonatal providers • Implementation of networks for Children's Safe and Sustainable Review (Cardiac and Neurosurgery) • Review paediatric shared care model across Kent, Surrey and Sussex, working with other ATs as relevant	• Effective Operational Delivery Network (ODN) in place for neonatal care • Neonatal services to achieve national service specifications, standards and quality requirements • Implement outputs of the paediatric cardiac surgery review • Implement prime contractor model for paediatrics as relevant	• Improved network and pathway management • Safe and sustainable services
Mental Health	• Embed secure service and CAMHS Case Management and gate keeping • Review of compliance to service specifications and clinical polices • Assess capacity in low & medium secure services	• Continued focus on these areas to manage demand • Improved quality and consistency of services • Review of identified priority areas • Local assessment of capacity • Provision of high quality, clinically safe services	• Case management in place for all specialised MH services • Compliant services • Improved access to and egress from secure services

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
School based immunisations	To commission a school immunisation team for Kent and Medway to provide school based immunisation programmes. Current provision is through Medway NHS Foundation Trust (MFT) and Kent Community Health NHS Trust (KCHT) who provide a mixed model of school based immunisation programmes, i.e. via school nursing service in the east of the county and a standalone immunisation team in the west.	Review the need to decommission the current programme and procure a single school based Kent and Medway immunisation service in order to ensure consistency in delivery of vaccinations across the county.	KCHT and MFT	Costs are not identified at present. Reference costs are being sought from providers to inform service redesign.	School based immunisations are part of a block contract at present. Both providers have been extracting costs of current provision. This commissioning intention has implications for school nursing services which are currently commissioned by Medway Council and Kent County Council. An immunisation team is already in place for West Kent.
Meningitis C (MenC) immunisation programme MenC adolescent booster school year 9 - starting January 2014	Current school nursing team to be commissioned to provide MenC at 14-15 years, with GP's immunising children that did not receive vaccine via school nursing.	Commission KCHT and Medway NHS Foundation Trust (MFT) school nursing team to deliver Men C adolescent booster. Issue Local Enhanced Service for MenC to GP's for those that did not receive vaccine via school nursing.	KCHT & MFT school nursing and GPs	National guidance proposes that funding to deliver the adolescent Men C programme will be transferred from primary care where the second dose (now ceased) has been funded within GP contract/global sum.	To enable Men C to be commissioned from current providers we are currently seeking reference costs from Medway providers and will benchmark against KCHT and other areas to ensure VfM in the commission.

MenC catch up for first time university entrants under the age of 25	From mid-August 2014 there will be a catch up programme of limited duration (possibly up to 5 years) to offer the vaccine to first time university entrants under the age of 25.	Likely to be commissioned via a GP Local Enhanced Scheme (LES); further national guidance awaited	GPs - this programme will be mainly delivered through primary care.	Further information will follow relating to funding and vaccine supply arrangements for the catch-up.	Awaiting further information relating to the funding and vaccine supply.
Men C Removing 2nd 4 month dose	Childhood immunisations are classified as additional services in the GP contract and the infrastructure costs of delivering these are covered by the GP practices global sum payment or baseline PMS funding. GPs are also eligible for target payments if they have vaccinated 70% to 90% of their 2 year cohort.	Decommission 2nd MenC dose in line with national policy around clinical effectiveness	GPs (with a need to inform other providers who provide patients with advice and information)	NHS England plans an adjustment to those target payments to reflect the change from 2 doses to 1 dose, however this adjustment will not be made until 2015/16, reflecting that vaccination status is not assessed until children reach 2 years.	
Human papillomavirus (HPV) - Local Enhanced Service contract ended in August 2013. This service is for children who were not vaccinated under the school programme	Area Team to issue an HPV local enhanced scheme (LES) for general practice to reflect new commissioning arrangements for Jan 2014	Specification to be written	GPs	£9.00 per item	

HPV - School Nursing Team	School nursing team to be commissioned to provide HPV at 14-15 years (with GPs immunising children that did not receive vaccine via school nursing - see the row above).	Revised contract in year	KCHT and MFT school nursing teams		
Additional childhood flu vaccination	The national Joint Committee on Vaccination and Immunisation (JCVI) has recommended that the seasonal influenza programme be extended to all children from aged two up to the age of 17. This programme has been rolled out to all healthy two and three year olds in the 2013/14 flu season as part of a gradual step to full implementation. This programme is in addition to the existing routine seasonal influenza programme.	Service redesign and service specification. Make provision for 4 year olds. Commence delivery of childhood flu vaccination to as many children of secondary school age as reasonably possible.	Best vaccination uptake among 5-16 year olds is likely to be achieved through a school based programme – involving school nursing teams and GPs.	Awaiting further information and funding from NHS England.	

ATTACHMENT 5: PUBLIC HEALTH COMMISSIONING INTENTIONS

Health visiting	NHS England (Kent and Medway) and Health Education England Kent, will work together to increase the number of health visitors as required by the national programme, monitored by the Department of Health. In Kent and Medway the increase in the number of health visitors is planned to be in line with the nationally agreed trajectory of 421 whole time equivalent (wte) health visitors by April 2015. This represents 342.2 wte employed within Kent Community Health NHS Trust (KCHT) and 78.8 wte for Medway Community Healthcare (MCH). This equates to an increase of 68.2 wtes for KCHT and 7.7.wte for MCH in 2014-15.	A national service specification is in place with local trajectories in term of delivery of the new model aligned to the Healthy Child Programme (HCP 0-5 years)	KCHT and Medway Community Health (Social Enterprise)	Additional costs of £1,544,190 for 2014/15.	Mandated programme in line with Department of Health
Family Nurse Partnership (FNP)	Expansion of FNP by one team in both Kent and Medway, thus increasing the number of places by 100 for each area. Kent and Medway are both on the national expansion plan and will therefore contribute to the Department of Health planned increase to 16,000 places nationally. Linked to Public Health Outcomes Framework.	Nationally driven programme aligned to the Health Visitors Programme using a sub license. There is therefore no service change, but just an increase in the number of FNP places	KCHT and MCH	Awaiting costs	Awaiting confirmation of funding

Child Health Information System (CHIS)	The current Careplus CHIS will be replaced by the new SystmOne system during 2014. This system is being deployed across the entire South of England region. This will provide an integrated IT system across Kent and Medway. Work is needed to integrate the Medway Child Health Record Department (CHRD) with the Kent team under a single management structure. This will provide: • a strengthened governance arrangements for CHRD with improved performance monitoring process; • the potential to increase opportunities for learning and development within the team; • efficiency and streamlining as a result of having one single, larger team; and • support robust project plan for implementation of SystmOne.	The service charge relates to the integration of the CHRDs in Kent and Medway.	KCHT and MFT	Full costs to be confirmed following regional and national review of associated costs of new system procurements	
Diabetic Eye Screening service re-procurement.	Continue with and complete the diabetic eye screening re-procurement. The service is being reprocured as the existing contract for the local diabetic eye screening service is nearing the end of its period of operation and under procurement rules, NHS England's Kent and Medway Team is required to re-tender. The objective is to ensure that appropriate services are in place to support the prompt identification and effective treatment of sight threatening diabetic retinopathy. The priorities are to: - ensure effective contract transition processes are in place;	Re-commissioning	Pending outcome of tendering process	Costs to be confirmed subject to the procurement	The new contract is due to be let at the end of May 2014.

	- identify transition risks and ensure mitigating actions are implemented; - ensure services are delivered in line with national service specifications; and - any gaps in service provision are addressed in order				

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Paediatric Sexual Assault Referral Service (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassure of quality of care pathway and service in Surrey by April 2015	The key stages of the work are service design, development of an options paper, consultation and procurement of Paediatric SARC services	Services delivered on a cost per case basis, anticipate there will be a limited impact on current providers due to low volume	Funding has been identified for the health element of the paediatric SARC from budget uplift received	National funding arrangements, roles and responsibilities across Partners to be clarified
Sussex Sexual Assault referral Centre (SARC)	Re-procure Sussex SARC Phase 1 (health element) by June 2014, Part 2 (social care element) by April 2015	Re procure service	Tascor	Sussex Police and local authorities transfer their budgets to NHS England	Further development of Forensic Medical Examiner (FME) service necessary
Kent Sexual Assault Referral Centre (SARC)	Re procure Kent SARC Forensic Medical Examiner (FME) and Forensic Nurse Practitioner (FNP) element by June 2014 and deliver FME and FNP training programmes . Extend service to be able to receive self-referrals by Autumn 2014.	Re procure FME / FNP element Review Kent SARC care pathway	FMEs paid on a retainer, no contracts in place	Kent Police confirmed financial envelope available, NHS England anticipating contributing to uplift	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.
Kent Sexual Assault Referral Centre (SARC)	Agree development plan for the new Kent and Medway SARC, including the move to self-referral January 2015	Review service specification and review care pathway	Kent and Medway Partnership Trust, Family Matters, East Kent Rape Line and Kent Police	Uplift received will ease any cost pressures that the review and further development of an excellent Kent SARC may require.	Partners, with NHS England need to commission a fit for purpose SARC that reflects national best practice and excellence.

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Surrey Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (Kent and Medway) for 1st April 2015	Transfer of commissioning responsibility anticipate novation of contract to NHSE	Tascor	None known	Preparing Statement of Readiness
Kent Police Custody Healthcare Commissioning Transfer	Re procure FME provision into Kent and Medway police custody suites and prepare for transfer of commissioning responsibility of FNP service to NHS England (Kent and Medway) for 1st April 2015	Implement a re procured FME service into police custody by Summer 2014	FMEs paid on a retainer, no contracts in place	None known	Market testing underway
Sussex Police Custody Healthcare Commissioning Transfer	Support Sussex Police to uncouple FME and FNP element of block custody contrac by July 2014	Activity on-going to extrapolate health element of contract in order to re-procure	Tascor	None known	Preparing Statement of Readiness
Surrey Prisons - Virgin Healthcare	Review and redraft service specifications, key performance indicators (KPIs) and service delivery improvement plans (SDIPs) for healthcare provision for each of the four Surrey prisons. Incorporating a formal review of in-patient services at HMP Highdown by June 2014	Service specification, KPI's , Quality Dashboard and SDIP	Virgin	None anticipated	NHS England (Kent and Medway) working to embed partnership working with the provider
Surrey Prisons - Surrey and Borders NHS Foundation Trust	Review and redesign of mental health Service and contractual supporting documents September 2014	Service specification, KPI's , Quality Dashboard and SDIP	Surrey and Borders Partnership Foundation Trust	Commissioner may seek uplift in funding if identified as necessary for a comprehensive mental health service i.e. improving access to psychological therapies (IAPT) service	Provider aiming to being a Phased implementation from 1st April 2014
Surrey Prisons - Virgin Healthcare	Re procure clinical and psycho-social elements of substance misuse services across Surrey Prisons fro implementation by 1st May 2014.	Re procurement completed, contract awarded and announced	Virgin	A saving of no more than 3100,000.00 per annum is anticipated	Contract transition and mobilisation planning underway.

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Review of Discipline Officers enabling healthcare functions across all Kent, Surrey and Sussex prisons	Review the role and function of Discipline Officers who enable healthcare functions across all Kent, Surrey and Sussex prisons and plan with Governors for the transfer of funding responsibility from 1st April 2014	Novate commissioning responsibility from NHS England to Prison Service	Prison Service / National Offender Management Services (NOMS)	Cost pressure for NOMS, release of funds for NHS England to reinvest in clinical services	National programme of work but adopting a local delivery plan
HM Prison Lewes and Ford health services re procurement	Re procurement of healthcare services for 1st April 2015	Re procurement	Sussex Partnership NHS Foundation Trust	Unknown until procurement complete	Current Provider and NOMS advised of intention.
HM Prison/ Young Offenders' Institute (YOI) Rochester and HMYOI Cookham Wood reprocurement	Re-procurement of primary healthcare, pharmacy and child and adolescent mental health services (CAMHS) (Cookham only) for 1st April 2014	Re procurement	Prison Service	Anticipated this will be cost neutral	New ways of working fully implemented at Rochester, Cookham operational capacity increase and Rochester re-roll to 70% adults. Procurement completed and contract awarded and announced.
Telemedicine	Develop a business case and feasibility test regarding the introduction of telemedicine in the Kent, Surrey and Sussex prison estate. Report expected Autumn 2014.	Service innovation	Miscellaneous	Anticipate it will be cost neutral	NHS England (Kent and Medway) need to progress development work with key stakeholders
HM Prison Bronzefield - primary healthcare and psycho-social substance misuse services	Close partnership working with NOMS to support the prison to review its existing service specifications and associated contract document suite i.e. key performance indicators (KPIs), service deliver improvement plans (SDIP), quality dashboard, adopt serious incident reporting framework, complaints process and Prison Health Performance and Quality Indicators (PHPQI) framework	Review and refresh of Service specs, KPIs, SDIP, Quality Dashboard, intro of use of PHPQI's, serious incident reporting framework, NHS complaints process	Sodexo	None	NOMS retain the budget, commissioning and contract management responsibility for the delivery of primary healthcare and psycho-social services at HMP Bronzefield. NHS England is working to support Sodexo and NOMS to prepare to transfer commissioning responsibility to the NHS when negotiations with

					Sodexo regarding uncoupling of healthcare element of main budget is completed.
Mental health services across Kent and Medway prison estate	Re-procurement of mental health services across all Kent, Surrey and Sussex adult prisons for 1st July 2014	Re procurement	Oxleas	Anticipated this will be cost neutral	Re-procurement well advanced
Gatwick Immigration and Removal sites (3 sites)	Transfer commissioning responsibility from UK Border Forces (UKBF) to NHS England and re procure health services by Sept 2014	Transfer commissioning responsibility and re procure	G4S	Anticipate will be cost neutral for NHS England	NHS England's London Area Team are taking the lead on a multi-site procurement, Kent and Medway actively supporting
Secure Children's Homes (SCH) – welfare only	Formalise East Sussex and West Sussex local authorities retaining commissioning responsibility for SCH whilst NHS England (Kent and Medway) take accountability through a formal memorandum of understanding (MOU). Contractually implement service uplift September 2014	Service uplift due to increase in residents and in response to refreshed health needs assessment (HNA). Area Team commissioners to confirm budget transfer value for commissioning transfer to Area Team from 1st April 2014.	Local authorities and local healthcare providers to SCH in East and West Sussex	Increase in available resources for comprehensive health services. NHS England (Kent and Medway) may need to incorporate local authority commissioning service costs into service baseline (if required by local authorities).	Local authority commissioners keen and content to carry on their local commissioning function of these bespoke placements and services for individualised packages of care

ATTACHMENT 6: HEALTH AND JUSTICE COMMISSIONING INTENTIONS

Medway Secure Training Centre (STC)	Provide on-going support in preparation for transfer of commissioning responsibility to NHS England from 1st April 2015 anticipating a re procurement of health services by 1st April 2015	Re procurement by April 2015, transfer of commissioning responsibility December 2014	G4S	Anticipate no cost pressures to NHS England	Position regarding transfer of commissioning responsibility to NHS England still fluid as is reprocurement timetable
Surrey Police Court Liaison and Diversion Service (PCLDS)	Commission Phase 2 of Surrey PCLDS to include some court coverage and enhance existing police custody coverage April 2014	Commission	Surrey and Borders Partnership NHS Foundation Trust	Planned for service uplift	Surrey is the last PCLDS to become established across Kent, Surrey and Sussex

ATTACHMENT 7: ARMED FORCES HEALTH AMBITIONS

NHS Outcomes Framework	Outcome Ambition for AF Health	How Outcome will be monitored
Domain 1 Prevent people from dying prematurely, with an increase in life expectancy for all sections of society	**Outcome ambition 1** Mortality of the armed forces population is currently split (roughly equally) between operational causalities, accidents and other illnesses. Therefore only a very small percentages are within the powers of NHS England to affect – but we will seek additional years of life for these. We will work with the MoD to increase screening and immunisation coverage	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify Potential Years of Life Lost (PYLL) data to look at PYLL rates: • From causes considered amenable to healthcare (adult and children) • The rate per 100k population
Domain 2 People with LTCs, including those with mental illnesses get the best possible quality of life	**Outcome ambition 2** There are very few in the armed forces population who have LTCs as this will normally preclude military service. Any measures are likely to be statically meaningless Mental Health conditions are managed by DMS for serving personnel however, we will look to reduce the impact of transition from service life to civilian life and avoid discontinuity of care issues	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify average health status (EQ5D) score for individuals who identify themselves having a LTC Easy & rapid access to appropriate mental health services

ATTACHMENT 7: ARMED FORCES HEALTH AMBITIONS

NHS Outcome Framework	Outcome Ambition for AF Health	How Outcome will be monitored
Domain 3 Ensure patients are able to recover quickly and successfully from episodes of ill health or following an injury	**Outcome ambition 3** Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, in for example Regional Rehabilitation Units (RRUs)	NHS England will seek to work with Public Health England and MoD to secure baseline and comparable data to identify emergency admissions for acute conditions that should not usually require hospital admission
	Outcome ambition 4 Increasing the proportion of older people living independently at home following discharge from hospital	NHS England will work with the MoD to develop as alternative measure around discharge of veterans
Domain 4 Ensure patients have a great experience within all of their care	**Outcome ambition 5** Increasing the proportion of people with physical and mental health conditions having a positive experience of hospital care	Armed Forces health team will work with Nursing Directorate and P&I to develop measures and baseline for AF population. Seek to benchmark against CCG patients Links to 15 questions from the national inpatient survey Rate of responses of a poor experience of inpatients care 100 patients
	Outcome ambition 6 Increasing the proportion of people with physical and mental conditions having a positive experience of care outside hospital, in general practice and the community	We will work with DPHC to reduce poor patient experience of primary care (GP and OOH services) where the NHS is in a position to influence patient experience Rate of responses of a fairly poor or very poor experience across GP and OOH services per 100 patients
Domain 5 Ensure patients in our care are kept safe and protected from all avoidable harm	**Outcome ambition 7** Working with co-commissioners in making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	NB: small dispersed population which may make information and trends statistically not significant. Monitored through SI reports

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NHS England

NHS England (Kent and Medway)

Direct Commissioning Strategy and Two Year Operational Plan

2015/16 Addendum vs 0.6

May 2015

THE NHS CONSTITUTION
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CONTENTS

SECTION 1: INTRODUCTION

INTRODUCTION

1. NHS England (Kent and Medway) prepared a Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015. This was prepared in March 2014. It was updated in July 2014 to take account of a number of changing national priorities and to update the financial agreements that had been reached. This plan remains current and should be read in conjunction with this short paper that updates the document to take account of the 2015/16 annual planning round.
2. This document consists of:
    - Updated plans on a page for the key direct commissioning areas
    - A short narrative / commissioning intentions for each area
    - An updated financial position

PUBLIC HEALTH 7A SERVICES

3. The national ambition is to improve and protect health and wellbeing for the population. Specifically, the aim is to improve not only how long we live but also how well we live and to ensure that we support the whole community to live healthily, reducing health inequalities.
4. The Public Health Direct Commissioning Team working with Public Health England, Clinical Commissioning Groups and Local Authorities will contribute to the national ambition by improving accessibility and uptake of:
    - Immunisations that reduce the risk of infectious disease outbreaks targeting areas of lower uptake, working with providers to improve performance to achieve national targets by 2018/19
    - Screening programmes that help improve the early diagnosis of major disease, disabilities and death such as Cancer, Aortic Aneurism and diabetic retinopathy to improve coverage for more vulnerable, harder to reach groups to bring them in line with the rest of the population by 2019 and thus address inequalities
    - Services that improve the health and life chances of children and families to ensure that we transfer robust and sustainable services delivering the nationally agreed outcomes to Local Authorities in 2015
5. A number of aims and objectives have been identified by the public health team in relation to the services they are responsible for, these include:
    - Focus on improving data quality to ensure that the reported achievement of national targets are robust (particularly immunisations)
    - Work jointly with commissioning partners including CCGs and Local Authorities to implement coherent integrated commissioning plans along care pathways.
    - Work with all providers of Section 7A services to ensure service delivery complies with standardised core national service specifications. Where

service providers are not currently working to the national specifications, then services and programmes will be benchmarked against the national service specifications and action plans jointly agreed that clearly outline any gaps in provision, service developments proposals and timescales for alignment.

- Work with partners to apply specific CQUIN schemes to incentivise service improvement for Section 7A related services, focusing on initiatives that improve access for the entire population of Kent and Medway (including those in offender institutions) to tackle inequalities and address parity of esteem. Where appropriate 'stretch' targets will be introduced to improve coverage and uptake
- Ensure that all services clearly demonstrate how they are delivering improved outcomes for patients. This will include the systematic application of national and locally agreed outcome measures and KPIs.
- Work with providers and other stakeholders including the South East Coast Strategic Clinical Networks to demonstrate effective patient engagement and user experience informing continuous improvement.
- Ensure that all commissioned programmes demonstrate value for money in line with QIPP, delivering high quality, evidenced based cost effective services. This will include the systematic application of robust financial and contract performance monitoring and review processes. We will prioritise work with partners to implement pathway/system wide re-design.

6. The following are appended to this plan:
   - **Attachment 1:** Public Health Summary Plan
   - **Attachment 2:** Public Health Commissioning Intentions (NHS South / National)
   - **Attachment 3:** Public Health Commissioning Intentions (Kent and Medway)
   - **Attachment 4:** Public Health Programme and Population Risks
   - **Attachment 5:** Public Health Financial Risks
7. The services included in Section 7a are national programmes with the allocations coming under the agreement from Public Health England. Screening and immunisation programmes across Kent and Medway are based and delivered on a population base. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes (as outlined in Attachments 4 and 5).

8. The focus for the public health team is to ensure that these national programmes are delivered according to the national specification and that they deliver good outcomes (protection from infectious disease or early diagnosis of significant disease). The purpose of the service reviews in 15/16 will be to ensure the services are not only good quality but also represent value for money.

9. During 2014/15 there have been a number of cost pressures arising out of national directives, funded by new allocations, including:

- Meningitis C (University)
- Childhood Influenza
- Expansion of the FNP scheme
- Full year costs of the increase in Health Visitors
- The extension to the Bowel Screening Programme

10. The overall effect of these cost pressures and changes was to generate a deficit of £2.4m for 2014/15. This is attributed to the cost of vaccines charged by the NHSBSA which were deducted from CCG budgets by the Department without passing the funding on to Area Teams. This underlying deficit continues into 2015/16. As the total Public Health budget is only circa £54 million, to deliver savings of this magnitude would require a reduction in expenditure of around 4.4%. In addition, the true addressable spend within the public health budget is significantly less than the total £55 million budget as the budget includes expenditure on health visitors, which is effectively ring-fenced, and a significant portion of the remaining budget is locked into contracts where the price has been fixed through recent procurements. However, a range of cost saving QIPP initiatives, including procurement opportunities are being explored but there is a high risk these will not be able to address the underlying deficit.

11. The following table details the investment in Kent and Medway Section 7a programmes:

Investment into Section 7a Services for Kent & Medway	2015/16 Proposal
Immunisation programmes	£14,815,000
Cancer Screening (Bowel, Breast and Cervical)	£8,980,000
Non-cancer screening programmes (Diabetic Eye Screening and AAA)	£2,825,000
Healthy Child Programme (0-5)*	£14,627,000
Family Nurse Partnership*	£434,000
Child Health Information Systems	£218,000
Reserves/Contingency	£202,000
Grand Total	£42,101,000

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Public Health	51,523	53,966	-2,443		39,677	42,101	-2,424

N.B. It should be noted that the 2015/16 expenditure reduces from that in 2014/15 due to the transfer of the 0 to 5 programmes to local authorities, with an associated transfer of funding, from October 2015.

12. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for primary care commissioning. These indicators and the planned performance identified in the plan remain valid.

HEALTH AND JUSTICE HEALTHCARE

13. NHS England (South East) commission healthcare services for people in criminal justice and secure welfare settings across Kent, Surrey and Sussex. Work also continues to ensure the timely and effective transition of commissioning responsibility for healthcare in Police Custody Suites by April 2016.

14. The following are appended to this plan:

- **Attachment 6:** Summary of South East Criminal Justice Services and Settings
- **Attachment 7:** Health and Justice Summary Plan
- **Attachment 8:** Health and Justice Commissioning Intentions (National / NHS South)
- **Attachment 9:** Health and Justice Commissioning Intentions (Local)

15. The implementation of the national, standard Health and Justice indicators of Performance (HJIPs) in all of our prisons has been successful. We have agreed to pilot the new draft children and young people's HJIPs for the national team in our YOI with development of specific suites for Police custody, SARCS and IRCS just beginning.

16. Identifying and responding to issues of quality and safety for patients has been resource intensive element of this programme of work. Resulting in some necessary re procurements where new service specifications now reflect national standards and expectations, particularly in Sexual Assault Referral Centres and our local Youth Offender Institution. The successful implementation and 'bedding in' of new contracts into some settings are a priority.

17. Increasing coverage of the Police and Court Liaison and Diversion Service across Kent, Surrey and Sussex remains a priority as Surrey and Kent move into Wave 2 of the national pilot. The need to embed the patient voice and their involvement in our commissioning cycle continues to require dedicated time and planning.

18. Implementation of new IT systems for prescriptions, smart cards and the refresh of national systems (e.g. System1) are important to maintain infrastructure in our prisons, Immigration Removal Centres (IRC's) and Secure Training Centre (STC) and Secure Children's Homes (SCH's). The implementation of these new IT systems is well underway and our focus now moves to our IRC's, STC and SCH's. E-prescribing is now live in one of our prisons and we have a tight programme to roll E-prescribing out across the Kent, Surrey and Sussex prison estate.

19. Maintaining a visible presence in the settings that we commission services for has added value and provides visible leadership for our partners and helps us as commissioners gain real insight into how services are delivered and experienced by users.

20. NHS England, working with Health Education Kent and Surrey and Sussex and local Universities are developing an educational framework to support health and care staff working within the justice sector. This aims to improve the health outcomes for people in custody by aiding improved recruitment and retention of staff through professional and service development to meet the changing needs of this population.

21. For the majority of people in prisons and other justice settings, their engagement with these services is temporary. Most will transition back to the community, although some will go back and forth. To ensure the best, most equitable health and outcomes for them, it is essential that health and justice services are not commissioned in isolation, but are seen as part of a continuum with the services these individuals would receive in their local community.

Priorities

22. The key priorities in commissioning for health and justice from 2015/16, some of which remain the same as those set out in the Everyone Counts, are:

- Improve the response to managing detained people at risk of serious harm and support the reduction of self-inflicted deaths in detention
- To support sustainable recovery from addiction to drugs and alcohol and improved mental health services.
- Promotion of continuity of care between establishments and from custody to community working closely with Community Rehabilitation Companies, national probation services, local authorities and CCGs.
- Continued close collaboration with our partners in the successful implementation of Wave 2 of the Liaison and Diversion Programme in Surrey and Kent.
- To ensure timely and effective transition of commissioning responsibility for healthcare in immigration removal centres, secure training centre and police custody suites.
- Procure effective, timely Paediatric Sexual Assault Services in Sussex and Kent that reflect the national Paediatric SARC Service Framework

- Improve the proactive detection, surveillance and management of infectious diseases, blood born viruses, outbreaks and incidents in criminal justice settings
- Continue to implement and closely monitor national standards of excellence in the delivery of healthcare services to detained Children and Young People
- Stimulating and supporting Provider development and market engagement in the provision of health and justice settings particularly in preparation for the transfer of responsibility for police custody healthcare services across the South East from the Police Forces.

23. Commissioning plans for the next five years need to address these priorities. They also need to be flexible, with contracts capable of being adapted to meet changing circumstances and any shifts in the policy directions of the various external bodies and agencies involved in health and justice. For example, changes in the use of the custodial estate (for example from a prison to an immigration and removal centre) can happen at short notice; leading to a fundamental change in the health needs profile of the people who will be accommodated there.
24. Commissioners also need to consider the on-going development of the market for the provision of healthcare in justice settings, ensuring that there are sufficient providers able to offer quality, innovation and value for money.
25. Commissioners need to commission innovative solutions to challenging problems, seeking solutions in a different way. Locally this will mean exploring the potential use of medical technology within prisons in order to reduce the need for costly and timely Escorts and Bed watches and in term reduce delays in receiving secondary healthcare out-patient care. Integration of street triage with liaison and diversion services in support of mental health crisis concordat work is also being considered.

Parity of Esteem

26. The active pursuit of Parity of Esteem for people with mental health problems who come into contact with the criminal justice system is a key driving factor influencing commissioning activity. This is evidenced by £550,000.00 increased investment in Liaison and Diversion services from 1st April 2015 in Kent and Medway and Surrey, £200,000.00 increased investment in Surrey Prison Mental Health Services and the ring fencing of funds to support access to Talking Therapies for victims / survivors of sexual assault across Kent, Surrey and Sussex who come into contact with Sexual Assault Referral Centres. The review and redesign of mental health services across the Kent and Medway prison estate has really helped to reinforce the need for equivalence of care and access to NICE approved practice for people with mental health problems similar to standards experienced by people with physical health problems. In particular Cookham Wood YOI now provide for Speech and Language Therapy support for those who have difficulties in expressing their thoughts and feelings positively and access to more Talking Therapy group and individual work.
27. Tackling the 20 year gap in life expectancy experienced by people with severe mental illness is being proactively tackled by ensuring, through contract

performance monitoring, that annual physical health checks are given to prisoners who have severe and enduring mental illness and counting the activity provided by the prisons' IAPT (Improving Access to Psychological Therapies) services with particular focus on individuals with medically unexplained symptoms and for prisoners who have mild / moderate depression and anxiety with chronic health conditions. Making sure GP's working in our prisons know how to refer their primary care patients into our local, primary mental healthcare services early on will help to support early intervention. Mental Health Promotion activities like 5 Ways to Mental Health and Well-being are important activities targeted at reducing health inequalities experienced by people with severe and enduring mental illness and offering group activities in our Resource Centres on healthy eating, self-esteem, sleep hygiene all work hard to demonstrate a commissioning approach targeting Parity of Esteem and reducing the 20 year gap in mortality rate for people who experience severe and enduring mental illness.

Prisons / YOI's / Secure Training Centre

28. Surrey Prisons will have a new GP service and Mental Health service starting 1st April 2015 and HMP Lewes will have new primary care and GP Provider from 1st April 2015; ensuring effective implementation and transition is key alongside robust performance management against services specified.
29. Transfer of commissioning responsibility from Youth Justice Board to NHS England on 1st April 2015 for Secure Training Centres will require the re-procurement of existing health services at Medway STC during 2015.
30. Health & Justice Indicators of Performance are a requirement of all adult prison contracts now across the South East and therefore each contract will be monitored using these indicators alongside our local KPI Suites.
31. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Reduced Prison Officer availability for Escorts and Bed watches and enabling prisoner access to internal healthcare appointments	Escorts for all Prisoners who require a hospital appointment	Reduce the number of escorts by bringing services into the prison, develop medical technologies. Continue dialogue with NOMS	18 and 2 weeks waits for treatment met
Workforce; Clinicians and Medics not applying for jobs in prisons	To have a workforce that is fit for purpose	Assist providers in thinking creatively about staff models and recruitment approaches	Les reliance on Locums and agency provision
Aging prisoner population	Social care and healthcare needs for all prisoners are met or equivalence with the community	Estate capital adjustments required (NOMS requirement) to enable Health & Social care to provide a package of care	Equivalence with the community
Access to Consultation and Clinical Rooms at	Clinicians getting access to patients and then being	Formal notification of impact to the YJB	Reduced DNA's and cancelled appointments due

YOI Cookham Wood	able to see patients in an appropriate setting		to access to patients / room availability
Commissioning a Provider of high quality healthcare services into Medway Secure Training Centre	Provision of high quality, integrated healthcare provision	Market development and Provider stimulation. Re-procurement of existing health services	Delivery of excellent healthcare services for children and young people at Medway STC
Highly complex Children within the Secure Estate	To work with Secure Commissioners to ensure rapid access for those requiring CAMHS tier 4	Continue in dialogue with Specialist Commissioners	The most vulnerable children accessing appropriate services

Sexual Assault Referral Centres (SARCs)

32. The South East will continue its involvement in the national programme of Sexual Assault Services development and the coordination of the South East response to the national work commissioned by NHSE examining pathways and 'who pays' for which elements of the SARC services offered. This relates to both the acute / forensic provision and the aftercare services.

- Liaison and close working with colleagues at Police & Crime Commissioners Office in order to support their continued engagement in and funding of both Adult and Child ISVA provision.
- Liaison with Providers, Police colleagues, Local Authorities and Service Users to develop local KPI are that reflect qualitative issues rather than quantitative data with regard to SARC services.
- Implementation of sustainable, efficient and effective Paediatric SARC s across the South East which reflect the National Paediatric SARC Framework.

33. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	Aspirations	Operation actions	Outcomes
Lack of clarity regarding commissioning responsibility for different element of the victims' journey.	To get a clear understanding of who is responsible for commissioning different aspects of the victims pathway and work in partnership with other agencies to ensure appropriate and relevant services e.g. Talking Therapies.	To await national guidance. To understand the impact and requirements for each SARC within the South East and the aftercare services in partnership with Providers and other Commissioners. To liaise with other agencies e.g. LA, CCG & Police to ensure appropriate services are accessible to victims.	National Guidance is implemented across the South East area. Victims have a choice of services to meet their individual needs. Multi Agency relationships are in place and effective.
Availability of	To provide timely	To complete an	Provision of

Paediatric Sexual Assault Examiners to delivery best practice service to victims	access to high quality, specialist, age appropriate Paediatric Sexual Assault Examinations and aftercare services	engagement exercise with Paediatricians and Clinicians to inform Service Models for each of the 3 geographical areas, co-development of model and service specification following wider stakeholder engagement on proposed Clinicians model. Followed by procurement of 3 Paediatric SARC services.	Paediatric SARC services across the South East that reflect national guidance and best practice.

Police and Court Liaison & Diversion (PCLD)

34. The scaling up of the PCLD programme within the South East to meet the national service specification requirements and will predominantly involve for Wave 2 sites (Kent and Surrey):-

- Widening the range of vulnerabilities beyond mental health (i.e. covering learning difficulties, substance misuse and other health and social care vulnerabilities
- Developing an all age service (youth and adult provision)
- Providing a service across all police custody suites and courts (with a core team of staff in place in both police custody suites and courts to identify and screen vulnerable offenders)
- Delivering a 24/7 service where need is indicated

35. The following identifies key challenges / risk and the actions being taken to address these:

Challenges	**Aspirations**	**Operation actions**	**Outcomes**
Recruitment of workforce to deliver the national service specification	To recruit high quality, permanent staff into all roles	To continue to work closely with Providers on developing local workforce and encouraging Practitioners into the court and police custody environment	Implementation of an equivalent liaison and diversion service across the South East by April 2015

Procurement Plan

36. The South East Health and Justice Commissioning Team intend to undertake the following procurements during 2015/16. The following table gives an indication as to the procurements required and the timeline. Continued resources for

procurement are required from 1.4.2015 for the project management and procurement advice to ensure delivery.

	Procurement	Process to commence	Anticipated Contract Start Date
1	Surrey SARC	March 2015	April 2016
2	Medway STC	March 2015	October 2015
3	Surrey / Sussex / Kent Police Healthcare	May 2015	April 2016
4	HMP Bronzefield SMS	April 2015	April 2016
5	HMP Ford SMS	October 2015	October 2016

Financial context

37. In 2014/15, a surplus of £2.0m is projected in line with submitted plan. This surplus will be carried forward into 2015/16.

38. The service has received an increase in allocation, including a net 0.6% for growth adjusted for efficiency and additional funding for the Gatwick Immigration Removal Centres.

39. The service is planning new investments in Paediatric Sexual Assault Services in Sussex and Kent and increasing its investment in Mental Health provision in Surrey. Responsibility of healthcare in Secure Training Centres transfers to NHS England in 2015/16 and funding is anticipated from the Youth Justice Board. There will be increasing coverage of Police and Court Liaison and Diversion Services as Surrey and Kent move into Wave 2 of the national pilot. Funding for this currently sits within the central team and is still to be allocated.

40. Planned Surplus for 2015-16 is £2.3m in line with business rules.

41. The summary financial position is shown below:

Health & Justice		
	2014/15	**2015/16**
Previous year outturn	44,521	47,079
Part year effects	-1,511	267
Sub total	43,010	47,346
Inflation uplifts	870	922
Growth	8	199
Provider Efficiency	-129	-666
Service Investments	4,034	3,646
QIPP	-715	0
Total	**47,079**	**51,446**
Notified Allocation	49,111	51,730
Surplus carried forward	0	2,030
Total Resources	**49,111**	**53,760**
Variance Surplus (+) / Deficit (-)	**2,032**	**2,314**

42. The following table summarises the investment in Kent and Medway Section 7a programmes:

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Health & Justice	49,111	47,079	2,032		53,760	51,446	2,314

43. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for health and justice commissioning. These indicators and the planned performance identified in the plan remain valid.

PRIMARY CARE SERVICES

44. The delivery of core primary care services is largely covered through nationally negotiated contracts (e.g. general medical services (GMS) contracts) or nationally determined regulations (e.g. regulations governing the process for reviewing applications to open a new community pharmacy).
45. NHS England's ambition is to deliver, through excellent commissioning:
    - A common, core offer for patients of high quality patient-centred primary care services.
    - Continuous improvements in health outcomes and a reduction in inequalities.
    - Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda.
    - The right balance between standardisation/consistency and local empowerment/flexibility.
46. Further information is included at:
    - Attachment 10: Primary Care Summary Plan
    - Attachment 11: Primary Care National Commissioning Intentions.

47. NHS England believes the areas discussed in this plan can be used to draw some conclusions on the future configuration and role of general practice. These conclusions are emerging and will need to be kept under ongoing review.
48. It is suggested that general practice is on a journey that will take it along a development path, progressing through a number of stages:

i. Current state

ii. An extended skill mix in practices and across a range of primary care providers

iii. Federation of practices

iv. Co-location of practice / merger of practices to form larger partnerships / primary care units

v. Development of large integrated primary and community services hubs, incorporating social care (covering populations that are generally significantly larger than most current practice populations), many operating as accountable care organisations

49. The following table provides more detail of the strategic intentions for the key primary care services:

General practice	General practice is the cornerstone of the NHS. Improving the nature of services provided outside hospital and supporting the public in self-care will be key ingredients for a sustainable NHS. Transformation in general practice must seek to maintain the internationally recognised strengths of the general practice model. Improving access is a priority, ensuring prompt access to GP services through 111, services that are available from 8am to 8pm seven days a week, and more rapid response to patient concerns through the use of telephone consultation. There will also be more personalised care and equality of access to services for everyone irrespective of where they live or their social status. We will work with CCGs, providers and other partners to identify and address inequalities. To achieve these ambitions will require a more scaled-up approach to general practice. This will mean working towards fewer, larger practices or federations or groupings of smaller practices where expertise is pooled and there can be increased focus on efficiency and innovation. This will enable patients to have seven-day-a-week access to a greater range of high quality primary care services. There will also need to be increased capacity in general practice and workforce plans need to include realistic projections for the number of GPs and practice nurses required, taking consideration of the presently aging workforce and changes in the career aspirations and expectations of newly qualified staff. Data and information are fundamental to providing high-quality, personalised care, improving productivity and empowering patients and clinicians to transform local services. It will be essential that GPs are supported by effective, efficient and integrated information technology systems. Patient access to electronic health records has been shown to improve health outcomes and reduce workload and costs so in line with the national strategy this will be supported. Online consultations in selected situations are also proving safe, effective and can improve patient confidentiality while reducing

	costs so will be facilitated. Primary care services operate within communities and have strong links with the voluntary sector and community services. Strengthening and further integrating these can ensure resilient healthy communities addressing the root causes of ill health.
Community pharmacy services	Community pharmacy will be increasingly used for urgent minor complaints, as part of an integrated urgent and emergency care system, reducing the pressure on general practice and A&E. Working with the LPC to ensure that we have the right number of pharmacists, with the right roles, working from the right locations will be important if we are to take advantage of the opportunities to provide a wider range of professional services from community pharmacies.. Increased mechanisation of dispensing will be supported to free up time for more proactive health interventions.
Dentistry	NHS England commissions dental services in both primary and secondary care, providing an opportunity to commission services across the whole patient pathway. We will look to move work such as minor oral surgery out of secondary care to primary care where we can so it is closer to home and more convenient for patients. We will also work with primary care dental providers and through the LPC to ensure that referrals continue to be made and handled appropriately.
Optometry	Many services provided in secondary care ophthalmology, such as for glaucoma and special needs optometry, could be carried out more efficiently and conveniently in high street optometry services. Core contracts for optometry will be developed and refined with the LOC and we will work with CCGs to co-commission services that can be moved from secondary to primary care.

50. Our aim is to create sustainable NHS services that provide more integrated care for patients, built around the registered populations served by groups of practices. To do this NHS England is developing joint and co-commissioning arrangements for commissioning with CCGs and also with local authorities who hold some primary care contracts.

51. It is important that this co-commissioning approach is developed to ensure the right balance between standardisation and flexibility in order that local primary care services can be planned in the context of CCGs' commissioning strategies, health and wellbeing strategies, JSNAs, PNAs and so citizens and communities can influence and challenge how services are provided.

52. We will work with Health Education England to ensure a more integrated approach to training of health care professionals in particular with respect to mental health and patient empowerment. This includes supporting the rollout of national and local workforce tools to support workforce planning.

53. In particular, during 2015/16 NHS England will work with CCGs in the active pursuit of Parity of Esteem for people with mental health problems. This includes

in relation to ensuring CCGs are commissioning effective Increasing Access to Psychological Therapies (IAPT) services, as well as exploring a range of other initiatives. This not only includes direct service provision through the national contract but training and awareness raising activities.

Primary care support services

54. NHS England is responsible for primary care support (PCS) services and wants all practitioners to have access to a standard range of modern, efficient and effective PCS services without the current variations in quality and cost. NHS England is continuing to work with staff and stakeholders to achieve the required changes in PCS services, through a market testing exercise.

Secondary care dental

55. National criteria and care pathways are currently being developed by NHS England for all dental specialties following which commissioning of secondary and primary care services will be reviewed. Until these are in place steady state commissioning will continue with existing providers.

56. Referral management arrangements are in place for oral surgery and endodontic treatment as ongoing QUIP delivery. Once national care pathways are in place, it is anticipated that further referral management will be introduced for other dental specialties.

Commissioning Intentions

57. Attachment 9 details the 2015/16 national and NHS South primary care commissioning intentions.

58. Locally, NHS England is committed to ensuring patients can access high quality GP services that meet the needs of our local communities. We will work with CCGs and other stakeholders to review and either extend (where there is flexibility to do so), re-procure or decommission those existing Alternative Provider of Medical Services (APMS) contracts and services which are scheduled to end at various points during the next two years (up to 31st March 2016). The following APMS contracts are scheduled to end during the next two years are:

Practice Name	**CCG Area**
DMC Sheppey Healthcare Centre	Swale
DMC Walderslade Surgery	Medway
College Health-Boots	Medway
College Health –Sterling House	Medway
DMC Medway Healthcare Centre	Medway
White Horse Surgery and Walk-In Centre	Dartford, Gravesham and Swanley
Minster Medical Centre	Swale
The Sunlight Centre	Medway

59. NHS England (Kent and Medway) has a relatively high percentage of general practices on General Medical Services (GMS) contracts. In this respect 82% of GP contractors across Kent and Medway hold GMS contracts with only 13% of practices holding Personal Medical Services (PMS) contracts and a further 5% holding APMS contracts. GMS contracts are nationally negotiated contracts in which price and service requirements are determined through discussions between NHS Employers (on behalf of the Department of Health and NHS England from 2014/15) and the General Practitioners Committee (on behalf of the BMA).

60. NHS England is committed to a comprehensive review of PMS contracts to ensure these offer value for money and deliver services that are aligned to patient need, as well as CCG and NHS England strategies. A local review of PMS contracts was undertaken throughout 2012/13. The final phase of this review will be undertaken in 2015/16, will be to review the objectives of other PMS contracts to ensure they reflect the needs of their population, are delivering value for money and are aligned to CCG and NHS England priorities.

61. Other local priorities for 2014/15 include:

- Reviewing the minor surgery Directed Enhanced Service, which covers specific types of procedures carried out by GPs.
- Reviewing and, if appropriate, re-procuring the occupational health service for GPs and other primary care contractors.
- Working with local authorities to support them to develop more healthy living pharmacies to provide local people with health and wellbeing advice, thus helping to promote healthy lifestyles and to reduce health inequalities.
- Extending the delivery of flu vaccinations in community pharmacies in order to help boost take up of the vaccine amongst at risk patients.
- Reviewing access to NHS dentistry and improving this for local patients where necessary.
- Reviewing and where appropriate re-procuring interpreting services to support patients in accessing primary care contractor services.
- Creation of one new primary care and public health direct commissioning team for NHS South East to deliver both Surrey and Sussex and Kent and Medway direct commissioning 2015-16 plans

62. A significant proportion of the primary care budget is accounted for through the national contracts, which means a large amount of the expenditure is pre-determined. However, a range of QIPP initiative will continue to be progressed including:
    - The continuation of the successful list cleansing programme that was put in place in 2014/15;
    - Vigorous contract management and taking opportunities to rationalise services (e.g. to reduce rent costs)
    - PMS review (see above)
    - Re-procurement of APMS contracts (see above)

63. The Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, prepared last year, identified a number of key performance indicators for primary care commissioning. These indicators and the planned performance identified in the plan remain valid.

Financial investment

64. The following table details the investment in Kent and Medway primary care services:

	2014/15				2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**		**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Primary Care	373,093	369,611	3,482		384,352	376,304	8,048

The allocation for Primary Care is thought to be over-started by £2.123m; if this allocation is removed, the surplus on Primary Care services reduces to £5.925m

PRESCRIBED SPECIALISED SERVICES AND SERVICES AND ARMED FORCES HEALTH

65. Please see NHS South regional return for prescribed services and armed forces health. A summary specialised commissioning plan for NHS England South (South East) is included at Attachment 12**.**

SUMMARY

66. This paper is an addendum to the Direct Commissioning Strategy and Two Year Operational Plan for 2014 to 2015, and updates the plan to take account of 2015 /16 planning requirements.

67. The following table shows the total planned funding for the direct commissioning services that have been the responsibility of the Kent and Medway Area Team:

	2014/15			2015/16		
	Allocation £'000	**Expenditure £'000**	**Variance £'000**	**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Primary Care	373,093	369,611	3,482	384,352	376,304	8,048
Public Health	51,523	53,966	-2,443	39,677	42,101	-2,424
Health & Justice	49,111	47,079	2,032	53,760	51,446	2,314
Total Kent & Medway	**473,727**	**470,655**	**3,072**	**477,789**	**469,851**	**7,938**

The allocation for Primary Care is thought to be over-started by £2.123m; if this allocation is removed, the surplus on Primary Care services reduces to £5.925m.

68. It is important that this plan is not read in isolation and should be read in conjunction with:

- Kent and Medway CCG two year operational plans
- The NHS England (Kent and Medway) strategic framework for primary care
- The Kent Annual Public Health Report
- The Medway Annual Public Health Report
- The Kent Joint Strategic Needs Assessment
- The Medway Joint Strategic Needs Assessment
- The Kent Health and Wellbeing Plan
- The Medway Health and Wellbeing Plan.

69. For Health and justice healthcare commissioning and public health commissioning the strategic direction will largely be determined through national work programmes. Local plans will be shaped around these national documents but local strategic focus in the five year plans prepared with CCGs are likely to focus on:

i. addressing any ongoing service performance issues;

ii. through the gateway services for prisoners being released from prison back into the community; and

iii. secondary care services for the health and justice population.

70. The strategic development of primary care is also being considered at a national level and through the establishment of co-commissioning arrangements with primary care.

2015/16 Public Health Work Plan with Milestones

Objective	Success criteria: How will you know you have achieved the objective? What evidence will you need?	Actions	Milestones	Date	Achievement
Immunisation – improved coverage and uptake to reduce the incidences of outbreaks and avoidable disease	Coverage and uptake of childhood and adult immunisations meets national targets • 95% uptake of childhood immunisation programmes to ensure herd immunity • 75% uptake of flu vaccination in over 65 and under 65 at risk • Achievement of agreed targets for new programmes for childhood flu, adolescent Men C/university entrants, Shingles.	**Maternal Flu and Pertussis** Implementation of maternal flu and pertussis by community midwifery teams across Kent	Work with screening and immunisations team, CSU and maternity providers to deliver within community midwifery	June 2015	
		Immunisations:			
		Childhood Flu Implementation of school based programme 15/16 (subject to funding)			
		Options appraisal for establishing service.	Mini procurement of existing service or vary existing contracts to include in immunisation teams delivering schools based programme	Sept 15	
			Work with providers to ensure service models are robust	Apr – Sep 15	Awaiting funding announcement
		School Based Imms Review in year of school based Imms.	Work with key stakeholders to review full Imms and school nursing programmes	April 2016	
		Adult Flu Establish service models with pharmacies and maternity			

		Men B introduction	Work with providers to ensure programme fully understood and implemented	TBC	Awaiting funding announcement
		Co-commissioning – impact on immunisation and screening services	Awaiting national guidance	TBC	
Screening – improved coverage and uptake to support early diagnosis and intervention and reduce avoidable ill-health	Ensure all screening programmes achieve national targets Ensure that the programmes achieve value for money and reach all the relevant screening populations including those hard to reach who traditionally don't access screening services	**Cervical Screening** Undertake an in-depth systematic review of the cervical screening programmes to identify existing provision, review costs and quality targets and make recommendations for commissioning in 15/16. Include access through CASH and women in the military.	Undertake review of services, identify where current contracts and resources are Identify where future investment maybe required and look for opportunities for re-commissioning.	Jun15 Sep 15	
			Undertake Joint Strategic Investigation with NW Surrey CCG to identify options for future for both the symptomatic and national screening services. Review existing pathways for military services Identify where future investment maybe required and look for opportunities for re-commissioning.	Dec 14 Apr 15	In progress Awaiting review GS

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN 2015/16

Healthy Child Programme including Family Nurse Partnership Developed to ensure effective handover to Local Authority	Achieve trajectory target • 421 health visitors across Kent and Medway Commissioning responsibility ready to be transferred by October 2015.	Continue working with providers and Health Education England, to increase the number of health visitors as required by the national programme and to achieve consistently good outcomes as part of the Healthy Child Programme Ensure contracts are in place jointly with LA for the transfer of commissioning responsibility can happen by Oct 15 Handover of commissioning responsibility	Review Transition Board ToR Develop Transition Board Plans for transfer to ensure systems and processes in place ready for commissioning transfer by October 2015 Monthly review of provider workforce plans to ensure on track to hit trajectory Working with LA to ensure all legal requirements are met Jointly manage contracts with LA until Oct 15	Jan 15 Jan 15 On-going Feb 15 Apr – Sep 15	Achieved Achieved In process In process

ATTACHMENT 1: PUBLIC HEALTH SUMMARY PLAN 2015/16

Improved Child Health information systems and data quality	**Complete and robust data sources for children covering the entire child population in Surrey and Sussex**	**Work with Child Health Information Systems providers to ensure the data is accurate and the benefits maximised.**	**Programme Board to be established across all providers** **Deep dive reviews to identify gap in ability to deliver national spec** **Action plan to be developed based on new service specification**	**Jun 14** **March 15** **Mar 16**	**Achieved** **In progress**
Collaborative Working with CCGs on improving uptake and coverage for immunisation and screening programmes	Improved uptake of screening and increase in early diagnosis of disease particularly cancers	Ensure collaborative working with CCGs in line with CCG plans to improve early diagnosis of cancers	Establish working links with CCGs to identify how we can work collaboratively on specific issues across the area	Apr 16	In progress
6-8 NIPE Checks	Review delivery of 6-8 week checks undertaken by Kent and Medway GPs	Ensure 6-8 week checks are delivered and data reported to CHIS in a timely manner	Establish working links with GP leads, LAs and providers	April 16	In progress

ATTACHMENT 3: 2015/16 PUBLIC HEALTH COMMISSIONING INTENTIONS (LOCAL)

In 2015/16 NHS England is focusing on

- Improving access to public health screening programmes overall, and with a specific focus on improving access and uptake for people with learning disabilities, and women in the military.
- The transfer of commissioning responsibilities for the Healthy Child 0-5 Programme (Health Visitor and Family Nurse Partnership Services) to Local Authorities by October 2015.
- Working with stakeholders to develop a strategic approach to the future of the Child Health Information System to support the commissioning and delivery of services to children.
- Planning to use the national procurement framework for childhood flu. For adult flu we will increase delivery channels, e.g. pharmacies. Work with maternity providers to deliver clinics for pregnant women.
- We will also work with maternity providers to improve the uptake of pertussis.
- Engage with key stakeholders around access to cervical screening e.g CASH clinics.
- Review in year the delivery of school based immunisations, service model, outcomes and finances.
- Review NIPE 6-8 week check to ensure all GPs are appropriately trained and supplying data to CHIS.
- Ensure parity of esteem which is defined as making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems.2 *Source: NHS England, 'Everyone counts'.* Parity extends to dementia or learning disabilities within the wider context of health inequalities.

Introducing Additional Services

- New Born Blood Spot Screening (NBBS) - expanded to screening for 4 more conditions. Completion of full national rollout was in Jan 2015
- Continuation of the temporary programme for maternal pertussis
- Meningococcal B – if vaccine procured at cost effective price
- Childhood flu vaccination programme extended to include 5,6 and 7 year olds (Key Stage 1)
- Rollout of cervical screening to women in the military

ATTACHMENT 3: 2015/16 PUBLIC HEALTH COMMISSIONING INTENTIONS (LOCAL)

The following are the key priorities for the Kent and Medway areas

- Immunisation
    - Data Quality
    - Childhood Flu – implementation of school based programme 15/16
    - Men B introduction
    - Co-commissioning
- Screening Programme Reviews –
    - Cervical Screening
- Transition of commissioning responsibility for Healthy Child Programme to Local Authority
- Child Health Information Service and Record Departments implementation of national specification
- Working with stakeholders to improve the delivery of the 6-8 week NIPE checks delivered by GPs across Kent and Medway
- Collaborative working with Clinical Commissioning Groups and CSU to improve uptake and coverage of immunisations and screening programmes and improve early diagnosis of disease particularly cancer

ATTACHMENT 4: PUBLIC HEALTH PROGRAMME AND POPULATION RISKS 2015/16

Risk Identified	Description	Gross Risk Assessment (Pre-Controls)			Key Controls	Net Risk Assessment (Post-Controls)			Proposed Mitigation Measures	Target Risk Assessment (Post-Mitigation Measures)			Key Risk Indicator to be Monitored	Financial Impact Forecasts		
		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Pessimistic	Most Likely	Optimistic
Immunisation	Delivery of existing programmes not achieving herd immunity resulting in disease outbreak	4	4	16	A review of data collection processes identified data quality issue.. Potential solutions identified to improve quality of data	3	4	12	Once data quality is established, targeting support to providers struggling to deliver to national standards	2	2	4	Roll out and coverage of existing immunisation programmes Implementation plans to be reviewed and monitored by the Kent and Medway Immunisation and Vaccination Committees	£ to deliver better data transfer to improv e data quality	£K	£K
Immunisation	Delivery of new programmes not achieving required levels of immunity resulting in disease outbreak	4	4	16	Investigation of which providers are not achieving target immunity levels through analysis of robust information	3	4	12	Targeted support to providers struggling to deliver to national standards	2	2	4	Roll out and coverage of existing immunisation programmes	£	£K	£K

ATTACHMENT 4: PUBLIC HEALTH PROGRAMME AND POPULATION RISKS 2015/16

NHS England

Risk Identified	Description	Gross Risk Assessment (Pre-Controls)			Key Controls	Net Risk Assessment (Post-Controls)			Proposed Mitigation Measures	Target Risk Assessment (Post-Mitigation Measures)			Key Risk Indicator to be Monitored	Financial Impact Forecasts		
		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Likelihood	Impact	Risk Score		Pessimistic	Most Likely	Optimistic
Cervical Screening - Cytology.	Review of cytology as part of cervical screening pathway	2	4	8	A review needs to be carried out in 2015 to identify potential increase in activity within CASH clinics for Kent and Medway women who present for call and recall screening	2	4	8	Discussion will be needed with LAs to understand commissioning and financial implications	2	4	8		£	£	£
Healthy Child Programme (0-5) Family Nurse partnership safe transfer of commissioning responsibility	Local Authorities fail to agree financial envelopes as part of the transfer of commissioning responsibility	4	4	16	Review of workforce and education plans, monthly and quarterly reporting to NHS England Close working with Local Authority	3	3	9	Regular review meetings are held with providers on workforce and service planning. Close working with LA on plans, finance and legal issues	2	2	4	Numbers through monthly monitoring of Electronic Staff Records Audit of workforce to ensure all involved in delivery of HCP (0-5) Quality measures of service performance	£	£	£

ATTACHMENT 5: PUBLIC HEALTH KEY FINANCIAL RISK 2015/16

Key Financial Risks

- Screening and immunisation programmes across Kent and Medway are based and delivered on a population base. Increases or decreases in the populations receiving screening or immunisation will inevitably impact on the cost of delivering the programmes.
- Over the next 3 years (2015-2018) the predicted changes in population age groups will have the following impacts requiring investment (or disinvestment):

Programme	Age Group	Predicted Change	Impact on commissioning
Cervical Screening Programme	25-49 years (female) 50-64 years (female)	?% increase 10% increase	Some investment is likely to be needed in the short term but this will reduce as HPV vaccination and testing takes effect.
Bowel Screening	60-69 years 70+ years	2% decrease 17% increase	Any reduction in the 60-69 age groups will be offset by increase in age extension. New developments in initial screening process that increases sensitivity & specificity of testing and for bowel scoping will require investment
AAA Screening programme	65 year (males)	15% decrease	Steady state (possible disinvestment)
Diabetic Eye Screening	All Ages	4% increase in population also increase in prevalence	Investment required
HPV vaccination programme	12 year (females)	10% increase	Investment required
Childhood Immunisation	Children up to 12 years	4% increase	Investment required
Flu immunisation	Over 65 years	10% increase	Investment required
Shingles	70 years 79 years	25% increase 11% increase	Investment required

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

NHS England

Prisons

1. As of March 2015 the prison population in the South east was 8,865. This is not a static population; it ranges from those in custody on remand for a matter of days to those in prison for life with associated long term needs.

   - Nationally 70% of adult prisoners said they had used illicit drugs prior to entering prison;
   - In a survey of prisoners released from custody, 12% of prisoners said they had a mental illness or depression as a long-standing illness and 20% reported needing help with an emotional or mental health problem.
   - The age profile of a middle aged prisoner reflects that of someone 10 years their senior in the community. Thus there is a high prevalence of long-term conditions. The older prisoner population is generating emerging social care needs.
   - Female prisoners are more than three times as likely to self-harm as male prisoners.
   - The rates of smoking, drinking and use of illegal drugs are substantially higher among young offenders than among young people who do not offend.

2. Within the South East there are 15 prisons:

Prison	Type	Provider
HMP Elmley HMP Swaleside HMP Standford Hill	Cat C; Op Cap 1252 Cat B; Op Cap 1112 Cat D; Op Cap 464	IC24 – Primary Care Nursing GP - Minister Medical Practice Oxleas – Mental Health, Pharmacy RaPT – Substance Misuse
HMP/YOI Rochester	Cat C; Op Cap 658	Oxleas – Primary Care Nursing , GP, Mental Health, Pharmacy RaPT – Substance Misuse

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

HM YOI Cookham Wood	Cat B Local; Op Cap 200	Oxleas – Primary Care Nursing , GP, Pharmacy CNWL – Mental Health KCA – Substance Misuse
HMP Maidstone HMP East Sutton Park HMP Blantyre House	Cat C Foreign Nationals; Op Cap 650 Cat C / D; Op Cap 100 Cat C / D; Op Cap 122	Oxleas – Primary Care Nursing , GP, Mental Health, Pharmacy RaPT – Substance Misuse
HMP Lewes HMP Ford	Cat B; Op Cap 750 Cat D; Op Cap 557	Sussex Partnership Trust – Primary Care Nursing, Mental Health, Pharmacy CRI – Substance Misuse MedCo – GP Sussex Partnership Trust – Primary Care Nursing, , Mental Health, Substance Misuse, Pharmacy Dr Robertson / Dr West - GP
HMP High Down HMP Down View HMP Send	Cat B Local; Op Cap 1103 Cat C /D; Op Cap 355 Closed Female; Op Cap 282	Virgin – primary care nursing, Pharmacy CNWL – Mental Health RaPT / KCA – Substance Misuse Acor –GP *As above but different GP Provider* Cheam Practice – GP

HMP Coldingley	Cat C Trainer; Op Cap 513	Cheam Practice – GP Studholme Practice - GP
HMP Bronzefield	Cat B Female; Op Cap 527	NOMS Commission Sodexo for healthcare, NHSE commission; CNWL – Mental Health Sodexo Justice Services – Clinical Substance Misuse

Police Custody

3. HNAs have been undertaken in both Sussex and Kent and Medway custody suites. The same will be undertaken in Surrey over 2015/16. The number of detentions in custody across the South East is declining as the police continue to use alternatives to arrest including community disposals, restorative justice and voluntary attendances. However, the following is of note:

    - Approximately 37.1% of individuals in Kent and 40% in Sussex are seen by the healthcare provider whist in custody. This is comparable to other forces nationally.
    - The largest issue facing healthcare providers in Kent & Medway and Sussex custody settings is substance misuse. 34% of contacts in Sussex and 38.1% of contacts in Kent and Medway related to substance misuse. However using the same methodology on current performance indicates closer to 54% - nothing that this figure will include multiple contacts with the same DP.
    - Mental Health concerns are also a significant issue in forces representing 16% of contacts with healthcare provider in Sussex and 8.2% of detainees in Kent presenting with an issue.

4. The following number of police custody suites in each area:

Force Area	Number of Custody Suites	Provider

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Kent	7	Kent Police
Surrey	3	Tascor
Sussex	6	Tascor

Sexual Assault Services

5. Across the South East there are 3 Sexual Assault Referral Centres. All of the SARC's are jointly commissioned with Police. The key points of note are as follows:

- Analysis by the MOJ statisticians revealed that of the estimated 78,000 victims of rape or attempted rape each year, 9,000 are men, equating to 1 in 10 victims being male. They also revealed that 72,000 males were recorded as being victims of sexual offences annually.
- Although reporting of sex crimes against males is evidentially on the increase, academics and professionals in the field of interpersonal violence agree that sexual abuse and rape of males is one of the most under reported crimes worldwide. In 2012/13 only 1,550 incidents of male rape were recorded by the Police in the UK, equating to a staggering 7,450 rape or attempted rapes of males going unreported. These figures are reflected in both Kent where only 11% of reporting rape victims were men and in Sussex where on 4.2% of victims accessing the SARC were men.
- Over 90% of referrals to the SARCs in Kent and Medway and Sussex are made by the Police.
- The NSPCC's 2011 report indicated that:
    - 0.6% of under 11s and 9.4% of 11–17s had experienced sexual abuse including non-contact offences in the past year
    - 65.9% of the contact sexual abuse reported by children and young people (0-17s) was perpetrated by other children and young people under the age of 18
    - Teenage girls aged between 15 and 17 reported the highest past-year rates of sexual abuse.
- Data from individual SARCs suggest that between 22% and 50% of clients seen are young people under 18 years old (NHS England, 2013, op. cit.).
- Sexual violence and abuse can cause severe and long-lasting harm to individuals across a range of health, social and economic factors. The effects of sexual violence on victims can include depression, anxiety, post-traumatic stress disorder, drug and

substance misuse, self-harm and suicide. In Sussex 53% of victims accessing the SARC were identified as having mental health concerns

6. The following details the Sexual Assault Referral centres in each of the three counties:

Force Area	**Sexual Assault Referral Centre**	**ISVA Provider**
Surrey	Care UK	RaSAC
Sussex, East Sussex and Brighton & Hove West Sussex	Mountain Healthcare Limited	Survivors Network Worth Services
Kent	Mountain Healthcare Limited	East Kent Rape Line / Family Matters

Children and Young People's Settings - Secure Children's Homes

7. There are two welfare only - SCHs in the South East Region and health needs assesments have been completed in each in 2014. Key findings are as follows:

- Children and young people in contact within the secure estate have more-and more severe – unmet health and well-being needs than other children of their age. They have often missed out on early attention to health needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems (Healthy children, safer communities, DH, 2009;Evidence of needs paper, Ryan M and Tunnard J, 2011).

- The children and young people who find themselves placed in SCH's have often taken high risks which will have had a detrimental effect on their health. This group of young people have often experienced significant abuse and/or are likely to have been a substance misuser, In addition to this they are likely to have engaged erratically with health services and have often missed significant health appointments.
- Physical health needs are generally minimal and well contained/managed
- Children now in SCHs are increasingly complex and have multiple unmet health needs. The reduction of the numbers of young people in custody nationally means that only the most vulnerable are now in secure environments.

8. The following identifies the secure children's homes within the South East:

Area	**Secure Children's Home**	**Provider**
West Sussex	Beechfield Secure Childrens Home, Copthorne	Sussex Community Health – Primary Care Sussex Partnership Foundation Trust – CAMHS CRI – Substance Misuse Services
East Sussex	Landsdowne Secure Childrens Home, Hailsham	East Sussex Healthcare – Primary Care Sussex Partnership Foundation Trust – CAMHS East Sussex County Council Substance Misuse

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

Children and Young People's Settings - Secure Training Centre

9. Medway STC is the only STC in the South East and has an operational capacity of 76 young people, both girls and boys. G4S are currently the provider of healthcare services and a re procurement for health services at the Centre is underway at the time of writing this document. A recent health needs assessment has indicated the following findings:

    - Since 2012 there has been a marked increase in the number of children and young people placed at Medway STC who have committed violent offences. There has also been an increase in the number of young people in the STC who have committed sexual offences and an increase in the number subject to MAPPA arrangements. In terms of the age of the cohort, there are more 17 year olds at Medway than previously, the data showing a year on year upward trend. Together these changes may mean a more challenging, complex and older group of children for staff to care for in 2014 than the cohort who were present in the STC in 2012.
    - The data provided by the YJB placements team shows higher than expected numbers of children and young people placed at Medway with a 'serious medical or health complaint' (7.54% in September 2014)
    - Youth Justice Board statistics appear to show an increase in the number of children and young people demonstrating a risk of self-harm or suicidal behaviour, now over double the figure reported in April 2013. There remain high levels of lower mental health need in combination with a concerning increase in the number of children and young people placed at Medway with severe mental health problems.
    - Data quality has been a significant issue in the collation of this report. SystmOne (or a parallel cohesive clinical IT system) is not yet in place in Medway. The number of late receptions into STC is currently impacting on the ability of staff to carry out the initial Comprehensive Health Assessment Tool (CHAT) screening within 2 hours of admission. This requires monitoring and further discussion at YJB/NHS England level; it is not a Medway specific issue but difficulty across a number of secure settings for children and young people at the moment.

Immigration Removal Centres

10. There are 3 IRCs and 1 Pre-Departure Accommodation (PDA) in the South East and recent health needs assessments have identified the following key findings:

    - Detainees require access to a full range of Mental Health services that are commensurate with the needs of those being detained, pending removal. Ensuring early interventions are available to ensure Mental Health issues are dealt with as early as possible.
    - People with Mental Health problems are likely to stay in detention for almost twice as long as those who do not.

- Health promotion activities be delivered to ensure increased knowledge is available prior to departure.

11. The detainee population is unique and presents particular challenges for commissioners and providers in identifying and meeting health and wellbeing needs. The picture of health needs that emerges from the individual health and wellbeing needs assessments is of a population that is highly stressed due to their particular circumstances and the fact of being in detention. The following is also of note:

- The potential for communicable diseases to spread or go unchecked due to the likelihood of detainees not having received childhood immunisations;
- Aggravation of long term conditions e.g. diabetes due to detainees having avoided contact with formal healthcare services prior to being detained and/or the lack of access to appropriate health services in their home country;
- High levels of stress resulting in poor mental health and associated physical problems e.g. skin disorders, lack of sleep etc.;
- Risk factors associated with poor health including smoking, alcohol and drug use;
- Cultural and religious barriers making early identification and treatment of sexual and blood borne viruses problematic in particular HIV/AIDS

12. The following details the IRCs within the South East:

Area	**Immigration Removal Centre**	**Provider**
Sussex (Gatwick)	Tinsley House – Op Cap: 448 Brook House – Op Cap: 153 Cedars Pre-PDA for family units – Op Cap: up to 54 (9 units holding max of 6 detainees)	G4S – primary care and GP service Sussex Partnership Foundation Trust – mental health
Kent	Dover – Op Cap: 380	IC24 – primary care and GP service Oxleas – mental health and Pharmacy RaPT – Substance misuse

ATTACHMENT 6: SUMMARY OF SOUTH EAST CRIMINAL JUSTICE SERVICES AND SETTINGS 2015/16

NHS England

Police and Court Liaison & Diversion

13. Police and Court Liaison and Diversion (PCLD) services exist to identify offenders who have mental health, learning disability, substance misuse and/or other vulnerabilities when they first come into contact with the criminal justice system.

14. The need for greater consistency and coverage of Criminal Justices Liaison and Diversions services was highlighted in the Bradley report. The ambition is to have 100% coverage of the country by L&D services by 2017, subject to final approval by HM Treasury.

15. In the South East PCLD services were being commissioned historically but have benefited from being Wave 1 and Wave 2 pilot schemes where additional resources have been received to ensure that pre-existing services now meet the national specification requirements for the service.

16. The National Programme commenced in April 2014 with ten trial sites across the country implementing the national, standard service specification and standard, Sussex was one of these sites. The trial sites were selected on their perceived readiness and ability to scale up their existing PCLD provision to meet the new National Service Specification for L&D.

17. A further wave of trial sites has been announced which will receive 1-year funding from April 2015 to do the same. By April 2016 this means that over 50% of the country will be covered with L&D services that are working to the National Specification.

18. The following shows the healthcare providers that provide services in the police custody suites in the three counties and their status against national service specifications:

Area	Provider	Meets National Specification
Kent Force Area	Kent and Medway Partnership Trust	Yes – from 1.4.15 Wave 2
Surrey Force Area	Surrey and Borders Partnership Trust	Yes – from 1.4.15 Wave 2
Sussex Force Area	Sussex Partnership Foundation Trust	Yes – from 1.4.14 Wave 1

ATTACHMENT 7: HEALTH AND JUSTICE SUMMARY PLAN 2015/16

NHS England

5 Year Strategic Plan and Vision

Working together to achieve excellence in health outcomes and experience in justice settings for people in Kent, Surrey and Sussex

Priority One
To reduce health inequalities and improve the health outcomes for people in contact with the justice system through provision of high quality services that are equivalent to community services

Performance management framework
- Active management of contracts to a set of standardised quality criteria
- Consistent improvement in patient valued outcomes

Pathway review
- Ensuring integration across pathways

Overseen through the following governance arrangements
- Surrey and Sussex Criminal Justice Board and Kent Criminal Justice Board
- Informed by the Strategic Clinical Network for Health in the Justice system and for Mental Health
- NHS England, Kent and Medway Executive Team (Direct Commissioning Assurance)
- NHS England Health and Justice Oversight Group
- Local Authority (Overview and Scrutiny Committees)

Priority Two

Reduce Re-offending

Multi agency working and planning to enable Transforming Rehabilitation
- Understanding workforce requirements
- Reducing duplication of work

Measured using the following success criteria
- Number of offenders going back through the system.
- Sustained engagement with CRC and NPS – no offending within a 12 month period and no duplication of services offered

Priority Three
Strengthen leadership and patient voice to inform and improve the efficiency and effectiveness of services delivered through increased joint planning, collaboration and commissioning with commissioning partners

Early interventions and prevention
- Increase brevity of Liaison and Diversion
- Formalise and better describe to patients opportunities for access to Screening and Immunisation Services

Commissioning improved health in justice outcomes
- Moving towards a single framework
- Embed patient voice and engagement in service developments and the commissioning cycle

Improving victim experience and outcomes
- Evidence of working with vulnerable people
- Listening to and understanding the support they need

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Data collection – consistency; measuring agreed outcomes.
- Expertise available to support the patient voice and engagement in justice settings
- Engagement with key stakeholders to ensure the success of the strategy and encourage joint commissioning where appropriate

System Objective Four

Value for Money

Assure partners, patients and the public that resources are well targeted, adequate and offer the best outcomes for patients
- Increase available benchmarking tools
- Evidence HNA's inform service design

How we seek assurance
- Regular, local Finance meetings with Providers and Area Team Finance colleagues
- Ensure HNA's are current and public health information informs targeted spend
- Engage in regular benchmarking activity and where necessary testing the market to ensure Value for Money for services provided

ATTACHMENT 8: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (NATIONAL / NHS SOUTH)

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Implement Best Practice Mental Health Pathways of care in Prisons and YOIs that link with community mental health services	Review existing mental health services in prisons and YOI's to ensure they offer primary care mental health services which reflect the Stepped Care Model reflected in 'Improving Access to Psychological Therapies' (IAPT) services in the Community. Ensure that secondary care mental health services reflect standards of best practice in care. Embed patient outcome monitoring. Monitor timely Section 47 and 48 transfers under the Mental Health Act for prisoners experiencing a mental health crisis who meet criteria under the Act	Review existing service specifications to include primary mental health care services and patient outcomes monitoring.	All Providers of mental health services in prisons and YOI's	Where there is an absence of primary care mental health service Commissioners will need to either move existing resources to promote early intervention and prevention or identify new resources.	Recent ministerial interest has indicated a political drive to improve mental health services in prisons and uptake in Treatment Orders (CTO's, MHTR's) in the community.
Transfer of commissioning responsibility from Police Forces to NHS England	Implementation of the transfer of commissioning responsibility from Police Forces to NHS England by 1st April 2016 – this is reflected in the completion of the Statement of Readiness documentation And its requirements	By 1st April 2016, where contractually possible implementation of the new, standard, national service specification for healthcare services provided into Police Custody Suites. Budgetary and commissioning responsibility for healthcare services into Police Custody transfer to NHS England by 1st April 2016.	All Providers of Healthcare into Police Custody Suites	Should be cost neutral but relies on negotiations between Department of Health and the Home Office	Transfer of commissioning responsibility delayed by 12 months in order to enable all Forces to be ready and able to transfer to NHS England and provides time for cost and budget negotiations to be completed between DH and HO.

Implement effective co-commissioning of Sexual Assault Services for children aged 12 years and under and young people and adults aged 13 years and over.	The effective provision of SARC services relies on effective co-commissioning relationships between a number of Agencies; NHS England, Police Forces, Police and Crime Commissioners, CCG's, Local Authorities. Proactive engagement with Agencies by NHS E will be essential in their role as lead commissioner for the service.	Implementation of the Service Framework for Paediatric SARC Services and implementation of the 13 years and over National Service Specification for SARCs with supporting KPI Suite. This may result in the need to retender some SARCs during 2015/16,	All Providers of SARC's and their associated services.	Uplift provided by DH to support improved service provision od SARC's nationally – particularly for Paediatric provision.	On-going work confirming the financial responsibilities of each co-commissioning agency will provide greater clarity around funding responsibility when partners review existing services.
Implementation of National Health and Justice Performance Indicators	Ensure Providers of health services in criminal justice settings implement the national HJIP Framework for their particular setting when they become available. A national suite of HJIPS for prisons is available and being implemented; HJIPS for IRC's, YOI's and STC's and Police Custody are being developed.	Requires IT systems and templates to populate the indicators	All Providers of healthcare services in criminal justice settings.	Providers may have to resource time in training their staff in populating the HJIP template, learning READ codes., collating data returns and putting the HJIP template onto their computers.	Implementation of the national suite of HJIPs for adult prisons is well underway. Other settings are developing their own, bespoke data suites for implementation during 2015 / 16.
Providers continue to improve the coverage and uptake of health checks	Commissioners continue to review and monitor the delivery of Health Checks in prison	Implementation of Service Specification for Health Checks in prison.	All Providers of primary health care services in prisons.	Cost neutral as built into existing primary care contracts as a requirement.	Training needs of staff and ensuring consistency of what services are offered within the Health Check and how they are recorded is an important feature.
Strengthen the integration and continuity of care between custody	Healthcare Providers in criminal justice settings work with new Community Rehabilitation Companies to deliver continuity of care for prisoners on release –	Sharing of the service specification and model of provision being offered by	All Providers of healthcare services in prisons and	Cost neutral as an expectation within existing Provider contracts.	A national policy that will require close partnership working across a variety of local Agencies. Prison

and the community	reflecting 'Transforming Rehabilitation' agenda and 'Through the Gate' national policies Police and Court Liaison and Diversion Services continue to develop in line with the national service specification.	CRC's to enable prison healthcare Providers to engage and support the 'Transforming Rehabilitation' agenda.	YOI's.		based Providers must learn to be 'outward' facing.
Improve the proactive detection, surveillance and management of infectious diseases, outbreaks and incidents	Services will review and improve systems for the detection of TB, implement care pathways and processes for the screening, diagnosis and treatment of Hep B, Hep C and HIV, enabling the full roll out of opt out BBV testing by 1st April 2017.	Performance management of existing contracts by Commissioners to ensure delivery and review of specifications to ensure adequate purchasing of services.	All Providers of primary health care.	Potential cost implications where robust services and level of provision do not meet national expectations.	A phased roll out of BBV opt out is active nationally. Commissioners have undertaken local stock takes of their current positions against this requirement in order to determine any local additional resource implications.
Support the delivery of the Social Care Act in prisons.	Commissioners and Providers will support the prison and Local Authorities in the development of systems and services that deliver integrated health and social care.	Provision of social care assessments and interventions for prisoners commissioned by Local Authorities from April 2015.	Providers who may want to be delivering social care assessments and interventions by LA's	None	Variable approaches to provision of social care services to prisoners by Local Authorities nationally i.e. some will provide the service directly; some LA's will commission the services from existing prison Providers of healthcare.
Management of medicines and new psychoactive substances	Prescribers will proactively and continually review their prescribing practice and will introduce the new national formulary for pain management in prisons when published. Implementation of Best Practice Guidance in management of medication queues	Where not already in place implementation of national formulary and best practice guidance.	All Providers of Pharmacy services and Substance Misuse Services working with New Psychoactive	Expected to be cost neutral to NHS England	Close partnership working with Prison Service colleagues will be essential in delivering responses to NPS, reducing the use of some addictive medicines for the treatment of pain and enabling of safe medicine queues.

	Implementation of Best Practice Guidance regarding new psychoactive substances		Substances.		
Improved response to managing prisoners at risk of serious self harm	Insist that Providers; ensure that Risk is highlighted and early intervention offered and available. Improve management of prisoners at risk of serious self-harm by implementing lessons learnt from Near Misses, local review of ACCT interventions and implementation and repeated monitoring of the implementation of Death in Custody recommendations consistently across Agencies	Reviewing with Partners how effective ACCT implementation is in each establishment, workforce training needs, quality of mental health services offered(i.e. timeliness of access, range of interventions offered) and how robust implementation of Lessons Learnt and PPO recommendations is will influence future service specifications for services and strategies for reducing the likelihood of self-harm and self-inflicted deaths.	All Providers in prisons and YOI's	None anticipated.	This intention is one that can only be delivered in partnership with stakeholders and is far reaching in identifying and supporting improvements in services which minimise the likelihood of serious self-harm and suicide.
Reduce the levels of smoking amongst prisoners	Ensure the consistent implementation of both Smoking Cessation courses, equipment, aids and peer support programmes in secure settings.	Review of service specifications to ensure compliance with expected national standards. Close working with Public Health colleagues to support the increased number quitters.	All Providers of primary care services in prisons and YOI's.	Some additional costs may be experienced where services are not adequate to meet the range of interventions needed ie peer support, NRT.	Preparing for and working closely with PHE will support prisoners and prisons when the settings move to totally smoke free environments.

Ensure Excellence in Delivery of Healthcare Services for Children and Young People	Continue to ensure that the Comprehensive Health Assessment Tool (CHAT) , AssetPlus (an end to end youth justice assessment framework) and SystemOne is implemented in Secure Training Centres and Secure Children's Homes Ensure robust Clinical Substance misuse services are in place in YOI's, SCH's and STC's Ensure the implementation of Standards of Care for CYP in Secure Settings is implemented, audited and actively reviewed	All service specifications should now reflect these requirements and all Providers of CYP services should be actively delivering the expected national standards	All Providers of CYP healthcare in secure settings.	Some additional costs may be experienced where services are not adequate to meet the range of interventions needed or standards expected.	Implementation of the standards for CYP services is being delivered throughout 2015/16

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Work Programme	Brief description of Commissioning Intention 2014 / 15	Service Change - Service Specification, redesign, decommission, etc.	Provider affected	Financial Implications	Comments
Service User Story	Development of a Service User Story with poem / art work and a short film to use alongside recruitment campaigns for healthcare professionals into Criminal Justice Settings	A new product to use alongside mainstream recruitment campaigns to address workforce shortages in the criminal justice setting	All Providers in Criminal Justice Settings	Funding identified and planned for in 2015/16	A service User in Recovery from active addiction after 17 years has been released from prison and tells their experience of health services within criminal justice settings.
Implementation of Recommendations made by User Voice	Implementation of Recommendations made by User Voice who are undertaking a stock take of how South East H&J Commissioning supports the involvement, engagement and active inclusion of people who use health services in the criminal justice system can inform, influence and help deliver the local Commissioning Programme of Work	Service User and Patients by Experience lead our work plan development and help deliver its outcomes.	All Providers in Criminal Justice Settings in the South East.	Funding identified and planned for in 2015/16	Report with Recommendations expected by May 2015.
Sexual Assault Referral Service for children under 13 years (SARC) Kent, Surrey and Sussex	To commission fit for purpose Paediatric SARC Services in Kent and Sussex and seek reassure of quality of care pathway and service in Surrey To commission bespoke HNA's for Paediatric Sexual Assault in each of the 3 geographical areas	The key stages of the work are service design, development of a Kent and Sussex specific options paper, consultation and procurement of Paediatric SARC services. Sussex Paediatric SARC Services have progressed into developing a bespoke	Services delivered on a cost per case basis, anticipate there will be a limited impact on current providers due to low volume	Funding has been identified for the health element of the paediatric SARC from budget uplift received	National funding arrangements, roles and responsibilities across Partners to be clarified

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

		service specification and Kent Paediatric Service is to start engagement with Clinicians in service design.			
Surrey SARC	To re procure Surrey SARC	To meet national service specification , KPI and Quality measures	Care UK	Cost neutral	Existing Providers contract requires a procurement during 2015 for new service delivery April 2016
Surrey and Sussex Police Forces Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (South East) for 1st April 2016 and the re-tendering of services for 1st April 2016.	Transfer of commissioning responsibility to NHSE requiring a re-tendering of existing services across Surrey and Sussex Forces. Requiring a proactive Market Development and Provider Stimulation event to ensure new services are in place from April 2016	Tascor	National Team confirming service value and transfer value of services from Police Forces to NHSE to ensure adequate resources are transferred to enable re-commissioning of services.	Preparing Statement of Readiness and organising Market Development and Provider Stimulation Event in early Summer 2014.
Kent Police Custody Healthcare Commissioning Transfer	Prepare for transfer of commissioning responsibility of FME and FNP service to NHS England (South East) for 1st April 2016 and the re-tendering of services for 1st April 2016.	Transfer of commissioning responsibility from Kent Police Force to NHS England requiring a re-tender of existing services which meet national specification requirements.	Kent Police are the Provider of the FNP service, FME's are employed on an individual contract	National Team confirming service value and transfer value of services from Police Forces to NHSE to ensure adequate resources are transferred to enable re-commissioning of	Preparation for procurement underway whilst confirming OPCC and Kent Police agreement to go out to competitive tender due to change in law not allowing Police Forces to be direct employers of healthcare staff.

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

			basis by Kent Police.	services.	
Surrey Public Prisons – mobilisation of 2 new contracts	Mobilisation of new GP Contracts and new Mental Health Service Contract across the 4 Surrey public Prisons	New Service specifications, KPI's , Quality Dashboard	CNWL Foundation Trust, Cheam Practice, Studholme Practice and Ancor Practice.	As a result of procurements savings will be made from April 2016.	Mobilisation of new services and ensuring fidelity to the new service specifications.
HMP Lewes	Mobilisation of new GP Contract and new healthcare contract	New Service specifications, KPI's , Quality Dashboard	Sussex Partnership NHS Foundation Trust MedCO	As a result of procurements savings will be made from April 2016.	Mobilisation of new services and ensuring fidelity to the new service specifications.
HMPs Kent and Medway : Clinical Substance Misuse Service	Mobilisation of new clinical substance misuse service across the Kent and Medway prisons Estate	New Service specifications, KPI's , Quality Dashboard – particularly new clinical approach to methadone maintenance / detox	RaPT	Cost neutral	New Provider of Clinical SMS Services – close monitoring required by Commissioner required – need to ensure best practice in methadone prescribing is followed
Secondary Care Technology HMPS	Use medical technology in prisons to enable access to pathways for secondary care treatment and assessment. To be trialled and developed with existing secondary care Providers at the Isle of Sheppey and Surrey prisons.	Service innovation and reduce demand for external hospital visits and improve timeliness of intervention	Local Acute Trusts	Cost neutral	Innovative work with partners which will develop capacity and commitment from Acute Clinicians to engage in this approach

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Secure Children's Homes (SCH) – welfare only	Implement new CAMHS contract Review primary care services model in light of national expectations and implementation of CHAT Review of substance misuse support in light of national expectations	Service uplift to meet Royal College standards and national specification expectations	Sussex Partnership Trust Crawley Downs practice Sussex Community Trust, E. Sussex Healthcare CRI	Increase in available resources for comprehensive health services.	
Medway Secure Training Centre (STC)	Transfer of commissioning responsibility to NHS England from YJB for health services at the STC from 1st April 2015. Need to re procure health services.	Aim to re procure health services by April 2015 in line with commissioning responsibility transfer.	G4S	Anticipate no cost pressures to NHS England	Unsuccessful procurement of services in January 2015 now requires a re tendering exercise to ensure new service specification is in place as soon as possible after 1st April 2015.
Surrey and Kent and Medway Police and Court Liaison and Diversion Service (PCLDS)	Implementation of Wave 2 of the National Pilot of Surrey and Kent and Medway PCLDS	Uplift existing services to meet the national service specification requirements	KMPT and SABPT	Financial uplift to existing services for a 12 month Pilot from 1st April 2015	PCLDS exists across all of the South East – Wave 2 additional monies allows all 3 services to meet national requirements from 1st April 2015
Roll out E-prescribing across the Secure Estate	In line with national requirements roll out E-prescribing across the secure Estate in the South East	Paperless prescriptions, improved Information Governance	All Providers who Prescribe	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable alongside training for Providers funded by NHS E and delivered by North London CSU

ATTACHMENT 9: 2015/16 HEALTH AND JUSTICE COMMISSIONING INTENTIONS (LOCAL)

Provision of new IT Hardware across Secure Estate	To provide all secure settings with a hardware refresh during 2015	New equipment enabling more timely use of information and data reporting and storing	All Providers in Secure Settings in South East	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable developed and live.
Implementation of System One (TPP) into; Secure Children's Homes, Immigration Removal Centre's and Medway Secure Training Centre	Implementation of System One (TPP) Electronic Patient Record system into all secure settings which Health and Justice Commission services into.	Allowing electronic record keeping that reflects national standards and requirements in these settings – similar to all other Secure Settings	Providers in SCH's, STC and IRC's	Cost of implementation during 2015/16 planned for in budget	Programme of work with timetable developed and live.
Implementation of standard Information Governance Audit Recommendations across HMPS in the South East	Implementation of recommendations provided to each HMPS site across the South East following an IG audit	Reduce the risks associated with non-compliance with legal Information Governance requirements. New expectations and new method of assessing Providers compliance.	All Providers of healthcare services in HMPS.	Cost neutral for NHS England – may require some investment from Providers e.g. staff training	Implementation of a Memorandum of Understanding (MOU) developed in information sharing between health Providers and non-health Providers in HMPS supports the audits findings

ATTACHMENT 10: 2015/16 PRIMARY CARE SUMMARY PLAN

NHS England

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Primary care: current landscape

1. *Variation in quality and performance*
2. *Some patients have difficulty accessing primary care services*
3. *Some patients struggle to navigate the health care system*
4. *Patients using hospital services inappropriately*
5. *Significant number of premises fail to meet required standards*
6. *Significant number of small practices managed by sole practitioner contractors*
7. *Uneven distribution of resources between practices and across CCGs*
8. *Community pharmacy plays limited role*

General practice in Kent & Medway: current landscape

1. *Registered population of circa 1.4 million*
2. *8 CCGs, covering populations ranging from circa 106,000 to 460,000*
3. *262 GP contractors, 34 PMS 13, APMS. 85% of practices are GMS – unusually high and limits scope of local QIPP*
4. *3 GP-led health centres . Their future is the subject of review by CCGs and the local area team*
5. *Some practice premises do not meet minimum standards*
6. *There are significant GP recruitment issues in parts of Kent and Medway.*

Primary care: future landscape

1. *Consistent levels of high quality performance*
2. *Robust patient and public engagement informing commissioning*
3. *Comprehensive range of services provided in primary care settings including a wide range of diagnostic tests and treatments*
4. *Services are available at times and places that are convenient to patients and appropriate to need*
5. *The highest risk patients identified and patient-focussed pathways put in place*
6. *Premises of consistent quality and meeting minimum standards*
7. *Sustainable provider landscape with services delivered at-scale*

Key challenges

- *Large geographical footprint with many contractors.*
- *Legacy of predecessor organisations and the history and relationships forged with contractor groups*
- *Nationally negotiated contracts leave limited scope for savings.*
- *Large number of small practices*
- *Significant number of elderly sole practitioner contractors.*

Improvements

- *Driving up quality by reducing variation and tackling unacceptable levels of service*
- *Improved access to GP services*
- *Wider range of services provided in community pharmacy and general; practice*
- *Increases in flu vaccination coverage*
- *Improvement in the prevalence of depression compared to estimated model*
- *Post payment verification and audit activities*
- *Review of discretionary payments*

ATTACHMENT 11: Primary Care Services Commissioning Intentions

Priorities for 2015-17
Strategy ▪ Work with CCGs in the co-commissioning of primary care services ▪ Work with CCGs in the development of local Primary Care Strategies to reflect national priorities ▪ Work with CCGs in developing local Primary Care Estates Strategies to support improved access and the provision of primary Care at scale including new models of care
Quality ▪ Implementation of the quality improvement strategy for primary care ▪ Implementation of the web based tool for GP quality indicators has been developed and adopted locally ▪ Work with the central team to develop the performance assessment frameworks for each provider group ▪ Work with the central team to develop further a robust reporting system is in place for reporting quality concerns SUIs, never events in primary care ▪ Ensure Safeguarding systems are embedded in primary care and there is evidence they are operating across all independent contractor groups ▪ Ensure there is demonstrable evidence of improved patient satisfaction of primary care services ▪ Working with CQC in relation to the inspection of independent contractors and support for failing practices
General Practice ▪ Continue with implementation of the Single Operating Model across all provider groups ▪ Continue to work with CCG and CSU to develop SCR into patient accessible electronic record ▪ Work with practices to roll out online services, such as access to appointments , prescribing and e.consultations ▪ Continue implementation of equalisation of contracts ▪ Implement 7 day working in General Practice as part of the Primary Care Strategy ▪ PMS – Align PMS contracts with local emerging Primary Care Strategy to achieve better outcomes and value for money ▪ APMS – Align APMS contracts with local emerging Primary Care Strategy to achieve better outcome and value for money

- **Align premises development plan with emerging Primary Care Strategy**
- **Implementation of changes agreed as part of the annual contract negotiations (see next slide)**
- **Work with CCGs to ensure that a comprehensive premises development plan is developed to assist investment and planning**

Dental Services

- **Work with central team on the development of the Assurance management framework for Dental services**
- **Further embed the single operating model for dental services**
- **Prepare for the implementation of the new Dental Contract**
- **Fully operational LPNs in place**
- **Ensure contracts are in place with acute providers for secondary and community care dentistry**
- **Implement specialty pathways for dental as they are developed**
- **Implement the Assurance Management Framework for Primary care dentistry**
- **Review of care pathways to decrease the number of referrals into secondary care**
- **Review case mix in specialised services and develop new pathways**
- **PDS – rationalise and align KPIs with local priorities**
- **Contribute to national Orthodontic review – resulting in extension of contracts or procurement**
- **Ensure robust OOH /7 day service is in place**
- **Promote access to dentistry ensuring rate of new patient relates to need**

Community Pharmacy

- **Ensure the revised Control of Entry regulations adopted by AT and operational**
- **EPS programme being developed through CCG /CSU**
- **Established LPN in place for Pharmacy and Optometry**
- **Development of the Pharmacy needs assessment working with Local Authority**

ATTACHMENT 11: Primary Care Services Commissioning Intentions

Optical services

- **Work with the central team on the development of the assurance management framework for Optical services**
- **Further embed the single operating model for Optical services**

Family Health Services

- **National re negotiation of the FHS / SBS Contracts**
- **Ensure contracted out FHS service meeting all quality, service and financial KPIs**

Other services

- **Work with the central team to develop the Single Operating for translation and interpretation services**
- **Work with the central team to develop the single Operating model for Occupational Health services**
- **Contribute to National review of clinical waste and prepare for tender in 2015/16 – new service in place 2016/17**

South Region Operational Plan 2014/16 refresh
South East Specialised Commissioning Hub

Background

This report is to be read in conjunction with the two year operational plan developed in 2014/15 and the refreshed strategic "plan on a page", enclosed at Appendix 1, which articulates the service priorities at a programme of care level. The report is a refresh of the key areas from the two year operational plan with the benefit of a year's operation and further national guidance on specialised services.

Environmental Context

The Kent, Surrey and Sussex (KSS) geography covers a population of 4.5million based on an area of 4000 sqm. We have 20 clinical commissioning groups across KSS footprint. We hold contracts for specialised services with 12 acute NHS providers and 2 NHS Mental Health providers, with a small number of national contracts for a range of independent sector specialised mental health providers; this will decrease to 11 acute NHS provider contracts in 15-16 as we look to handover the Frimley Park Foundation Trust Hospital contract to the Wessex team.
There are significant cross-boundary flows of patients into London providers and smaller population flows to Portsmouth and Southampton from the West Sussex locality, and close working relationships are in place with the London and Wessex teams to support joined up working on patient pathways.
Brighton and Sussex University Hospitals NHS Trust is our largest provider of specialised services, and has secured a capital investment for its 3Ts (Tertiary, Teaching and Trauma) full business case of circa £500m. The revenue consequence for specialised care is a small percentage of this overall and relies on repatriation from London for a range of specialities which has been supported in principle by the London regional team.

Our priorities

Our priorities reflect the specialised (prescribed) services 15-16 commissioning intentions, the Five Year Forward View with specific reference to the development of Collaborative Commissioning arrangements with CCGs as key strategic partners, and are outlined by programme of care in Appendix 1.

Our key priorities for 2015/16 therefore are:

- Highest quality safety, outcomes and patient experience in all services provided;
- Achieve NHS Constitutional requirements;
- Ensuring an integrated approach in commissioning of pathways with our CCG colleagues through Collaborative Commissioning;
- Reduction in inequalities in outcomes;
- Securing services within the resources available and best possible value for money;
- Services are as close to home as well as high quality as possible across all specialised services;
- Ensuring service transfers between CCGs and NHS England and vice versa are enacted within the national guidelines, and

- Delivery the contractual requirements within the central guidance on tariffs and contracting, inclusive of the reinvestment plans required through the marginal rate emergency threshold.

We aim to deliver these priorities through continued adoption of the national service specifications and clinical and commissioning polices, working in partnership with our CCG colleagues through the formal Collaborative Commissioning structure that we have established. We view this as being a critical step in delivery of an integrated commissioning system within the South East to support the delivery of these priorities

Patient safety and quality

Within the past 12 months a great deal has been achieved in operationalising the processes to ensure there is a whole system view of patient safety and quality with our partners. This has worked well and will continue to be refined and developed throughout 2015/16. Some key aspects will be:

- Continue with NHS South process for quality reviews of derogation application plans, taking into consideration the revised structural arrangements;
- Continue to operate quality governance framework with our Clinical Commissioning Groups to ensure there is a system wide of patient safety and quality;
- Continues support and adoption of recommendations for the post Winterbourne (now Transforming Care) Care and Treatment Reviews;
- Review the newly forming quality metrics and monitoring for specific quality intelligence on specialised services.

Engaging with the Public and Stakeholders

The South East team support the National Patient Public Voice Assurance Group, through the Assistant Director role. Local delivery of patient and public engagement takes place through a range of mediums, including the strategic clinical network, operational delivery networks and service specific work programmes. The team engage with the Health Overview and Scrutiny committees through attendance at a Kent, Surrey and Sussex group, where the work programme is discussed. We are looking to strengthen patient and public engagement through the collaborative commissioning joint committee structure.

Risks

- Delivery of QIPP for 2015/16, note the reliance on transactional QIPP, recognising requirement through collaborative commissioning to move to more transformational and sustainable schemes as we move into 16-17 and beyond;
- Achieving national service specification/national standards compliance where issues are complex and service reconfigurations are potentially indicated and specific cross boundary flow issues, internal to the South East and on our borders including vascular, specialised cancer (urology/oesophageal), radiotherapy, and interventional cardiology services;
- Reducing the number of service providers in line with national strategy where it is not possible to reconcile factors such as drive time and activity thresholds;

- Availability of appropriate specialised mental health placements, specifically following the outputs of care and treatment reviews and for CAMHS placements, complicated where pathways from tier 3 to tier 4 are broken;
- Referral to treatment times (RTT) for specialised services in order to meet the NHS Constitutional requirements is a challenge in terms of identifying early at a patient level and receiving supporting contract data. However we are working closely with CCGs to ensure that their elements of pathways do not impact on specialised RTT and working with the strategic clinical network for cancer waiting times to support no patients waiting over 52 weeks. At BSUHT specifically working with the provider and CCGs in reviewing the RTT for spinal/neurosurgery for adults. The Trust is extremely challenged on RTT in general, and work will continue in collaboration with the local CCGs to ensure improvements to the whole system, of which spinal surgery is a part.
- In addition we have the challenge of the considerable increase in workload of gender reassignment surgery at Nuffield Brighton as one of only two providers in England to ensure we deliver parity of esteem in terms of RTT.
- Financial balance; working with our CCG partners to understand the spend at a per head of population level across England will support the wider work of needs assessment and capacity across key service areas. Continuing to embed good principles of contract management will support delivery, however support with transformational change to ensure longer term safe and sustainable services will be key.
- Organisational capacity to deliver all of this and specifically at a time of organisational realignment.

Performance

QIPP

Building upon both the success and learning of the QIPP programme during 2014/15 the South Region have developed a regional approach to the planning of QIPP for 2015/16. This is aimed at ensuring both consistency where it benefits and building a stronger delivery platform through a single PMO function within the South with executive oversight through the regional governance arrangements. All national schemes have assessed for local benefits and are integrated within the plans.

ATTACHMENT 12: 2015/16 NHS South (South East) PRESCRIBED SPECIALISED SERVICES SUMMARY PLAN

NHS England

Values and Principles	Services are patient centred	Improved outcomes are delivered across	Fairness and Consistency – patients have access to services		Productivity and efficiency
Domains	Prevent premature death	Quality of life for patients with	Help recover from ill	Ensure positive experience of	Care delivered in a safe

Pre-existing Priorities

- Implementation of Safe and Sustainable Paediatric Cardiac and Paediatric Neurosurgery Services through Network implementation
- Supporting the PCT/Cancer Network legacy planning and provision of radiotherapy capacity Reviewing equipment replacement/modernisation to improve access for patients and to improve outcomes for patients
- Continue to implement the review of vascular services to ensure compliance with national standards
- Continue to support the development of Neonatal Services in line with DH toolkit and national metrics and products

Strategic Context and Challenges

- Implementation of single operating model for specialised commissioning underpinned by principles of 5 Year Forward View and Collaborative Commissioning
- All specialised activity covered by one national contract with each provider based on 'place based' treatment, with 'place based' budget allocation
- National core specifications/clinical policies in place for all services or derogations applied for (provider derogation), or led by commissioners (Commissioner led derogation)
- Requirement to establish effective relationship with key partners, Clinical Reference Groups, CCGs, other Area Teams, Health & Wellbeing Boards, OSCs, providers, Strategic Clinical Networks, ODNs, PHE, PPV and clinical senate

QIPP Improvements

- Review and adoption of national and local QIPP/Productivity and Efficiency schemes to meet circa £14-17m challenge
- National process for review and procurement of excluded drugs and devices
- Implementation of nationally agreed clinical access policies and commissioning through evaluation
- Review national service specifications and quality dashboards to identify areas for improvement in conjunction with NPoCs
- Support clinical and patient engagement to deliver implementation, working in partnership with SCNs, ODNs to support

Organisational Development

- Integration of specialised services function into the new structure for specialised commissioning as a regional structure with close working relationships with the local NHS England office with specific regard to quality, and whole system management
- Continue to prioritise the development of contract management skills and expertise within the team
- Support development of matrix working and networking of teams across the South landscape
- Lead the team to work to NHS England vision & values
- Support provider engagement to embed new operating model and clinical engagement

By Programme of Care (PoC)	South East Priorities 2015-16 • Implementation of national service specifications • Adherence to National Clinical Policies and Circular Guidance • Benchmark local prices to ensure efficiency and productivity • Delivery of QIPP schemes to support Commissioning Strategy	Expected Outcomes in 15-16	End State Ambition
Internal Medicine	•Deliver compliance of KSS vascular surgery services to national service specification •Implementation of recommendations of SCN review of interventional cardiology, through 15-16 contracts •Review PPCI in NW Surrey and West Kent	•Vascular services to meet national specification •Achievement of core clinical and quality requirements	• All services compliant with national standards to achieve improved outcomes • Safe and sustainable services with clear patient pathways and improved outcomes
Cancer and Blood N.B. this will be split into 2 separate PoC	•IOG /Service Specification/QIPP compliance for cancer and radiotherapy services •Review of Urological cancer services, Kent, Surrey & Sussex •Implement long term strategy for Oesophageal Cancer Surgery for K&M • Cancer Drugs Fund – support Wessex with implementing national process and policies •HIV/AIDs - Identify activity and money for the current integrated outpatient services. Work with local authorities to identify HIV costs and ensure there are contractual arrangements that ensures patient experience doesn't suffer and these services remain integrated	• Implementation of locally agreed plans to improve access to radiotherapy, seek to resolve Sussex issues on expansion/modernisation of linacs • Reduction in differential pricing and variations in service • Development of cancer services and designation of providers in line with national clinical policies and service specifications/ IOGs • Compliance with cancer drug fund guidelines •Implementation of Blue Teq to support good clinical practice with high cost chemotherapy drugs	• Improved access to radiotherapy • Consistent national tariffs in place • Patients to receive optimum care • consistent and equitable provision of chemotherapy and cancer drugs
Trauma	• Sussex Major Trauma centre compliance of neurosurgery support delivered through derogation • Implement the designated burns facility model and review the implications of the national service specification for local provider •Provider specialised T&O & spinal surgery review to understand provision & need •Work with Operational Delivery Network (ODN) on adult critical care delivery of QIPP and resilience •Support the provider implementation of action plans for Augmentative and Assisted Communication (AAC) Aids	• MTC to be fully compliant with national standards and quality requirements • London and SE consensus on the configuration of burns services • Achievement of national standards and improved waiting times • Functioning ODN in delivery of specialised adult critical care compliant and efficient services •Patients will have access to AAC equipment in a timely manner appropriate to need	• Burn care services compliant with the national model • Safe and sustainable spinal surgery services •Improved access to spinal surgery and care pathway management •Patients with AAC requirements will be fully met
Women and Children	• Work with ODN on neonatal QIPP & review neonatal services against BAPM/Specification/national products • Implementation of networks for Children's Safe and Sustainable Cardiac and Neurosurgery •Work with CCGs on level 2 HDU provision and implications on PIC and pathways	• Functioning ODN in delivery of neonatal services that are compliant and efficient • Neonatal services to achieve national standards	• Improved network and pathway management • Safe and sustainable services •Ensure PIC networks and retrieval are sustained with import to out of geography providers
Mental Health	• Specialised MH identified as a collaborative commissioning priority topic area with CCGs • Focus on CAMHS pathways, implementation of increased case manager support • Support review and procurement of low & medium secure services •Focus on Care and Treatment Reviews	• Continued focus on these areas to manage demand • Improved quality and consistency of services • Review of identified priority areas •Local assessment of capacity •Provision of high quality, clinically safe services for people with LD	• Case management in place for all specialised MH services • Compliant services •Improved access to and egress from secure services •Provision of high quality, clinically safe services for people with a LD

ATTACHMENT 12: 2015/16 NHS South (South East) PRESCRIBED SPECIALISED SERVICES SUMMARY PLAN

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By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director – Social Care, Health and Wellbeing
To:	Kent Health and Wellbeing Board
Date:	20 May 2015
Subject:	Kent County Council Adult Social Care Commissioning Priorities
Classification:	Unrestricted

Summary: This report provides a summary position of Adults Social Care commissioning priorities, in the context of Kent County Council's 5 year vision '*Increasing Opportunities, Improving Outcomes',* the whole Council Transformation agenda '*Facing the Challenge*', and specifically the Adults Transformation Portfolio.

These priorities will support effective commissioning and transformation of Adults services to deliver improved outcomes, meet statutory duties and deliver savings. The priorities will also support the implementation of the Joint Health and Wellbeing Strategy and the key objectives of:

- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
- 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 health issues are supported to 'live well'
- People with dementia are assessed and treated earlier, and are supported to 'live well'.

The delivery of the priorities will involve working in partnership with the NHS, voluntary, community and private sector. Adult Social Care has established a Portfolio Management Office which will be able to support implementation and work with partners to ensure effective delivery against objectives.

FOR COMMENT

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Kent Adult Social Care Commissioning Priorities

April 2015 – March 2016

Final v 1

1. Introduction

1.1 Our aim is to ensure that Kent's population of older people, people with physical disabilities, people with learning disabilities and people with mental health issues and their carers live healthy, fulfilled and independent lives and are socially and economically included in the community. We consider that individuals should be at the heart of joined up service planning, and be empowered to make choices about how they are supported.

1.2 Adult Services has the lead role in discharging KCC's statutory responsibilities for social care. The principal responsibilities of the service include undertaking needs assessment, commissioning and the provision of a range of services and safeguarding vulnerable adults

1.3 KCC's newly adopted Strategic Statement, 'Increasing Opportunities, Improving Outcomes 2015-2020' sets out the Council's vision: *''Our focus is on improving lives by ensuring every pound spent in Kent is delivering better outcomes for Kent's residents, communities and businesses."*

The Social Care, Health and Wellbeing Directorate vision is ambitious and aims to promote and ensure:

- Every child and young person in Kent achieves their full potential in life, whatever their background
- People with care and support needs in Kent live independent and fulfilled lives safely in their local communities
- We protect and improve the health of the population of Kent
- That those most in need will receive the best possible service by ensuring that we have the workforce, the leadership and the systems and processes.

2. Current Position

2.1 In connection with the main responsibilities described above, Adult Services

- provide care for over 6000 people enabling them to live safely in their own homes,
- enable over 3000 older people and those with disabilities and mental health issues, choice and control over their care needs through personalised budgets and direct payments,
- support 400 people a month following discharge from hospital with enablement services,
- support over 3000 adults with telecare services, maintaining independence and reducing hospital admissions,
- provide day care services to over 2000 adults, including social and educational activities enabling people to live healthy and fulfilled lives,
- support over 1500 adults with a learning disability live independent lives in their own homes or with family carers
- have increased the proportion of people with mental health needs who live in a stable environment, on a permanent basis to 82%

- have reduced admissions to permanent residential or nursing care to 127 per month; ensuring people can continue to live safely in their own community.
- Supported over 5000 carers

3. Supporting Frameworks

3.1 **Increasing Opportunities, Improving Outcomes: Kent County Council's Strategic Statement 2015 – 2020.** This sets out three Strategic Outcomes for the council (see appendix 1):

- Children and young people in Kent get the best start in life;
- Kent Communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life;
- Older and vulnerable residents are safe and supported with choices to live independently

The main focus of the Adult Social Care activities is geared to support with the achievement of these outcomes.

3.2 **A Commissioning Framework for Kent County Council**: KCC, in common with other local authorities, is moving to becoming a commissioning authority. The Commissioning Framework is underpinned by the following principles:

Principle 1: Focused on outcomes for our residents
Principle 2: A consistent commissioning approach to planning, designing and evaluating services
Principle 3: The right people involved at the right stage of commissioning
Principle 4: Open-minded about how best to achieve outcomes
Principle 5: High-quality, robust evidence informing our decisions
Principle 6: Hold all services to account for the delivery of KCC's strategic outcomes
Principle 7: Customers at the heart of our commissioning approach
Principle 8: A commitment to building capacity
Principle 9: We will maximise social value
Principle 10: Our supply chains will be sustainable and effective

3.3 **Commissioning for Better Outcomes** was designed to support local authorities improve their commissioning practice in line with new duties under the Care Act. It provides a framework for councils to self-assess their progress and identify areas for further improvement, and is relevant to all aspects of commissioning, service design and decommissioning. The KCC principles set out above in para 3.2 also complement this framework. The framework is made up of 12 standards which were co-produced by local authorities, service providers, people who use services and a steering group overseen by Think Local Act Personal.

The standards are grouped into four main domains. The domains are:

- Person-centered and outcomes-focused
- Inclusive
- Well led
- Promotes a sustainable and diverse market place.

The 12 standards are:

1. Person-centred and focused on outcomes
2. Promotes health and wellbeing
3. Delivers social value
4. Coproduced with local people, their carers and communities
5. Positive engagement with providers
6. Promotes equality
7. Well led
8. A whole system approach
9. Uses evidence about what works
10. A diverse and sustainable market
11. Provides value for money
12. Develops the workforce

3.4 The **Care Act 2014** brings together a number of new duties and powers which define the responsibilities of Adult Social Care and it will impact on both our partners as well as the people we support. The changes which have been introduced include a new national minimum eligibility for meeting care and support needs and a separate eligibility criteria for carers eligible support. The Care Act, for the first time, puts carers on equal statutory footing as the people they support.

Above all, Adult Social Care is focused on building on peoples' strengths and capabilities and promoting their independence to improve their health and wellbeing. We are also assisting people to achieve outcomes that matter to them and working with statutory and non-statutory partners to protect the most vulnerable children and adults in our area.

3.5 **Integration – The Better Care Fund**: Adult Social Care takes an active role in the current work being taken forward under the Better Care Fund and Pioneer programme. As outlined in Kent's plan using the Better Care Fund the citizens of Kent can expect:

- Better access – co-designed integrated teams working 24/7 around GP practices.
- Increased independence – supported by agencies working together.
- More control – empowerment for citizens to self-manage.
- Improved care at home – a reduction for acute admissions and long term care placements, rapid community response particularly for people with dementia.

- To live and die safely at home – supported by anticipatory care plans.
- No information about me without me – the citizen in control of electronic information sharing.
- Better use of information intelligence – evidence based integrated commissioning.

As part of delivering the Better Care Fund, Adult Social Care will deliver services seven days a week. We will increase enablement services, supported by integrated rapid response and neighbourhood care teams. Further emphasis on delivering effective self-management and dementia pathways are essential to working to reduce hospital readmissions and admissions to residential and nursing home care.

4. Key Priorities and Outcomes for 2015/2016

4.1 Within the Directorate Strategic Priorities Statement 2015/16, Adult Social Care has identified the following as priorities:

Older People and Physical Disability:

1. Transform and modernise service with effective management and control of resources.
2. Implement the Integrated Care and Support Pioneer Programme and Delivery Plan, integrating Health and Social Care commissioning and service delivery (including Better Care Fund).
3. Improve social care practice, keeping vulnerable adults safe, promoting independence and fulfilling lives for all.

Disabled Children and Adults Learning Disability and Mental Health:

1. Keep vulnerable people safe through robust and effective safeguarding procedures.
2. Work in partnership across health and social care to encourage innovation, improve efficiency and support healthy and productive lives for people in Kent.
3. Ensure that there is a smooth transition for vulnerable young people from health, education and Disabled Children's Services into Adult Social Care Services.

Commissioning in 2015/16:

1. To ensure that Social Care, Health and Wellbeing develop safeguarding services which wherever possible stop abuse, prevent harm and reduce risk.
2. 'Facing the Challenge' – Transformation.
3. Contribution to the delivery of the Corporate Outcomes Framework – Supporting Independence and Opportunity and the Commissioning Framework.

4.2 The Strategic Priorities are translated into a number of objectives and key areas of activity for 2015/16 which are outlined below with their intended outcomes. The activity is presented in the context of the vision

for Adult Social Care – prevention, promoting independence, support for complex/specialist needs and accommodation solutions.

4.3 The delivery of the priorities will involve working in partnership with the NHS, voluntary, community and private sector. Adult Social Care has established a Portfolio Management Office which will be able to support implementation and work with partners to ensure effective delivery against objectives.

Prevention – First contact capability to enable self-management and ensure people receive the right level of response.

Objective	15/16 Activity	Outcomes
Information Services To continue to improve the information provided to support people to make informed choices about their care and support at the appropriate point in the customer journey.	• Improve information provided through Kent.gov and other channels.	• Improved access to the right information at the right time. • Support demand management to reduce people being drawn into formal care system.
Integrated Community Equipment and Digital Care Service Providing high quality digital care and telecare services, working with the Council, CCGs, partner agencies and the service user, their carers' and nominated responders.	• Ensuring equity of access for service users. • Increasing the range of options that practitioners have to use. • To further develop preventative solutions which will keep people out of social care system.	• Improve access to and speed / responsiveness of support. • Support more people to live independently. • Prevent hospital admissions or support timely discharges.
Community Capacity Building To continue to ensure that all commissioned and/or grant funded services are strategically aligned to KCC vision and outcomes and are supporting people to live healthy and independent lives.	• Explore cost / benefit analysis models to develop evidence of impact of preventative services. • Deliver DCLG Delivering Differently in Neighbourhoods Project investigating models of community budgets. • Continue to support Kent's journey to be	• Fewer people entering the formal care system and requiring assessment and ongoing support. • Delay or prevent need for domiciliary or residential care.

Objective	15/16 Activity	Outcomes
Understand opportunities to manage demand for statutory services through better utilisation of voluntary and community sector resources Encourage and support collaboration and diversification in the voluntary and community sector.	Dementia Friendly. • TLAP Making it Real Plan developed and implemented. • Begin engagement with older people about the outcomes that matter to them and co-produce new models of care and support. • Work with GET Directorate investigating role of Community Warden in supporting vulnerable people to access timely advice and support. • Deliver Cornwall integrated Care Model in partnership with AGE UK, Ashford and Canterbury CCGs and KCHT • Continue as Arts Council Partner in Cultural Commissioning Programme with PH and GET colleagues.	• New models of care co-produced and implemented • Improved evidence base for preventative services. • Two pilot communities supported to take more control of the care of their residents. • More communities working towards being Dementia Friendly. Recruit more Dementia Champions to train more Dementia Friends. • 500 older people proactively case managed / reduce hospital admissions and reduce need for ongoing care / support.
Carers Support Continuously improve Carers support services, through assessment and short breaks contracts to support Carers and to embed care act requirements in relation to Carers' Services	• Understanding impact of Care Act on Carers offer which will also inform recommissioning of carers services strategy 2016-17 • Joint commissioning with CCGs.	• Development of carers commissioning strategy.

Promoting Independence – Outcome based support with a 'relentless focus on maximising people's independence'

Objective	15/16 Activity	Outcomes
Acute (Phase 2) To improve long term outcomes for people leaving hospital.	• Ensuring the right services are both available and selected during hospital discharge to promote independence after a stay in hospital. • Reduction of inappropriate placements in STBs. • Reduction of direct placements in LTBs as well as after a STB.	• 200 fewer Long Term Residential placements starting in year. • Improved outcomes and increased level of independence promoted on leaving hospital.
Enablement Outcomes and process (Phase 2) To improve the outcomes for service users leaving KEaH and to deliver the service in a cost effective way.	• Improved planning processes in KEaH ensuring more service users have access the service. • Increased efficiency ensuring the service becomes more cost effective for KCC. • Sharing of best practice and input from Senior Practitioners and Occupational Therapists to help standardise and improve outcomes.	• Access to enablement service for a greater percentage of those referred to the service. • Improved and standardised effectiveness across the service.
Alternative Models of Care (Phase 2) Ensuring that Service Users are in settings that best meet their needs and lead to improved independence.	• Reduction in number of current and ongoing Residential Placements. • Improved decision making at assessment and review ensuring more service users are in receipt of appropriate package of care. • Improved planning and placement process with Supported Living providers • Development of requirements for any future	• Improved visibility of supported living options provided greater choice and making it easier to identify most appropriate setting. • Greater independence for service users. • Development of strategic

Objective	15/16 Activity	Outcomes
	Support contracts.	relationships with housing and support providers. • Improved decision making at assessment and Review.
Kent Pathways Service (Phase 2) Development of short term and intensive support packages to improve independence of Service Users.	• Sharing of best practice and input from Pathways workers to help standardise and improve outcomes for service users. • Improved decision making at review point including standardised process for approving changes to packages.	• More active support to develop independence of current and future Service Users. • Improved and standardised review process to ensure ongoing packages of care meet needs of service users.
Recommission Advocacy Services for Vulnerable adults	• Commission a service that supports vulnerable adults to take a central role in decision making and leading their own care and support.	• Aligns with Care Act requirements. • Supports independence. • Supports safeguarding process.

Complex/Specialist in the Community – Outcome based support to cater for more complex requirements

Objective	15/16 Activity	Outcomes
Commissioning Community Mental Health and Wellbeing Service in partnership with Public Health and all Kent CCGs Commission a service that challenges the stigma of mental illness and creates the environment for people with mental health needs will recover, thrive and are accepted within their communities.	• New service is commissioned to deliver a network of supply that encourages and incentivise providers to work together to achieve better outcomes for people needing support and makes best use of resources.	• More people access early preventative help • Less people end up in Mental health crisis • Less people use secondary mental health services • More people are discharged from secondary mental health services
Learning Disability Integrated Commissioning	• To develop a LD integrated health & social care commissioning model.	• Integrated LD Commissioning strategy • Integrated pooled budget with clear governance arrangements. • Integrated LD Commissioning Team Structure.
Learning Disability Day Care Services (private)	• Understand current provision. • Design new model of service and internal processes for payment. • Procure new services that offer value for money and support independence and choice.	• Updated model that is value for money, offers choice to individuals and supports independence.

Objective	15/16 Activity	Outcomes
Further develop Home Care Market to ensure sufficiency of supply and quality of care	• Understand patterns of delivery including areas that are difficult in which to secure supply. • Use evidence to extend or amend current contracts to ensure sufficiency of supply. • Work with all providers to monitor performance using KPIs contained in contract and quality information from complaints, SGVA alerts and CQC intelligence. • Work with providers and operational colleagues to develop new and different models of delivery that support the journey from time and task to outcome based commissioning.	• Contract extensions / amendments completed and in place by June 1st 2015. • All providers compliant with KPIs and performance monitoring regime.
Commission new Community Meals service	• Deliver new community meals service to ensure sufficiency of supply and new pricing strategy.	• New service commissioned

Accommodation – High quality accommodation options for target client groups

Objective	15/16 Activity	Outcomes
Deliver the Accommodation Strategy	• Encourage and actively support the development of extra care housing for older people. • Encourage and actively support the development of Alternative Models of Care for People with a learning Disability. • Scope the evidence base for future accommodation models for people with autism, physical disabilities and mental health needs.	• Provide more choice to individuals requiring care. • Provide savings to KCC.
Re-let the Older Persons residential and nursing care contracts To align with Care Act requirements from 2016.	• Identify commissioning and procurement plan. • Tender and award contracts.	• To include short term care. • To include the findings of Phase 2 Acute Demand project.
Quality in Care To provide a framework that links to Safeguarding with overall reporting programme for operational staff and strategic commissioning across the health and social care economy.	• Review findings of Learning Disability pilot • Understand scope for Older People • Roll out	• To provide a clear framework between Quality issues and Safeguarding issues.
LDMHPD Cost Model	• Review the model.	• To provide an updated

Objective	15/16 Activity	Outcomes
Understand and standardise costs for people with a learning disability, physical disability and mental health needs.	• Understand changes required and implement.	model to reflect current pricing, market factors and operational issues.

5. Background Documents

Increasing Opportunities, Improving Outcomes 2015-2020

Kent County Council Commissioning Framework

Kent Better Care Fund Submission, 2014

Adult Social Care Transformation Programme Blueprint and Preparation Plan, 2012

Social Care, Health and Wellbeing Directorate Strategic Priorities Statement 2015/16 (draft)

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Taken from

Increasing Opportunities, Improving Outcomes:
Kent County Council's Strategic Statement 2015 – 2020

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By:	Peter Oakford, Cabinet Member for Specialist Children's Services
	Andrew Ireland, Corporate Director – Social Care, Health and Wellbeing
To:	Kent Health and Wellbeing Board
Date:	20 May 2015
Subject:	Kent County Council Children's Commissioning Priorities
Classification:	Unrestricted

Summary: This report provides a summary position of Children's commissioning priorities, in the context of Kent County Council's 5 year vision '*Increasing Opportunities, Improving Outcomes',* the whole Council Transformation agenda '*Facing the Challenge*', and specifically the 0-25 Portfolio.

These priorities will support effective commissioning and transformation of children's services to deliver improved outcomes, meet statutory duties and deliver savings.

There is a significant and increasing amount of partnership work taking place as we seek to ensure that services are aligned around the needs of children and families.

FOR COMMENT

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Kent Children's Commissioning Priorities

April 2015 – March 2016

Draft v.01

Introduction

1.1 The council will deliver sustained changes to children's services in the year ahead. 2015/16 will see us deliver on our 0-25 Transformation Programme, move toward integration with health commissioners in the north of the county, and commission a range of new services to meet needs and improve outcomes.

1.2 This report sets out the areas in which we are making the most significant changes during the year, and the changes that we are expecting to the way that we work together as partners to deliver them.

2. Background

2.1 The council's new Strategic Statement *"Increasing Opportunities, Improving Outcomes"* establishes the Strategic Outcomes that will be the focus of our efforts in the next five years. Whilst each of the outcomes is cross-cutting, the first "Children & young people in Kent get the best start in life" will drive prioritisation and business planning for children's services.

2.2 There are seven Supporting Outcomes that provide the detail behind the strategic outcome. These are:

- Kent's communities are resilient and provide strong and safe environments to successfully raise children and young people
- We keep vulnerable families out of crisis and more children and young people out of KCC care
- The attainment gap between disadvantaged young people and their peers continues to close
- All children, irrespective of background, are ready for school at age 5
- Children and young people have better physical and mental health
- All children and young people are engaged, thrive and achieve their potential through academic and vocational education
- Kent young people are confident and ambitious with choices and access to work, education and training opportunities

2.3 The 0-25 Portfolio was established in 2013 to ensure consistency across children's services in the council and create a seamless service offering that places the needs of children at its core. This has seen a substantial amount of change in the past year, including the establishment of the Early Help & Preventative Services Division and the integration of the Children with Disabilities Service into a new all-age disability service.

2.4 In addition to the specific priorities outlined in this document, there will be a particular focus on Child Sexual Exploitation (CSE) in the year ahead. The importance of preventing CSE through identification and early reporting of risks, and of providing support to victims will be considered and prioritised within all of the activities the council undertakes.

3. Key Areas of Activity for 2015/16

3.1 Implementation of the 0-25 Programme

3.1.1 Throughout 2014/15 the council has been working on plans for the transformation of early help and social care through a single programme that aims to introduce a systemic approach across the service. The programme began with a diagnostic assessment that identified potential for significant operational benefits alongside improvements to outcomes for children and their families.

3.1.2 The improvements identified focus on improving outcomes for children and families though provision of more effective services that meet needs early and so reduce demand. This is to be achieved through service re-design that creates the environments for our practitioners to consistently deliver excellent practice. These were tested in a live environment in 2014, during which practitioners were delivering, reflecting and refining approaches.

3.1.3 The key changes that we will see in roll-out are:

1. New Early Help units will bring together professionals from a range of backgrounds, working together as a team, based on reflective practice and outcome focused working
2. New children's social work teams, implementing assessment and support to children in need, using new processes to deliver focused and timely support
3. Introduction of a county wide "edge of care" service to identify adolescents are risk of entering care and provide timely interventions
4. A more proactive approach to placements and accommodation for young people, ensuring we have the provision we need to meet the needs of each child in care and care leaver

3.1.4 A full Business Case for Implementation was approved in early 2015, with delivery of changes across Kent between March 2015 and July 2016. Implementation will see the roll-out in phases, initially in Maidstone, before changes are made more widely. The expected timeline is:

- April 2015 – Implementation begins in West Kent
- June/July 2015 – Conclusion of the West Kent rollout. Moving counter-clockwise across the county, Implementation begins in South Kent as the Early Help restructure is completed.
- August 2015 – Early Help Triage and the Central Referral Unit join together and co-locate.
- September/October 2015 – Implementation begins in North and East Kent; scheduled to continue into early 2016.

Engagement with partners

3.1.5 During the initial phases of transformation the council has been primarily focused on refining internal process and functions. We have engaged HWB partners through regular updates to the Children's Health & Wellbeing Board.

3.1.6 As we move into implementation we expect to significantly increase the level of engagement activity with partners. We plan a presentation for the KSCB Board, and will look to utilise refreshed Children's Operational Groups as forums to discuss implementation on a district to district basis.

3.2 Disabled Children

3.2.1 April 2015 saw the integration of the Childrens Disability Social Care Team into a newly formed Disabled Children, Adults Learning Disability & Mental Health Division. This is a key step in developing a whole-life pathway for people with disabilities.

3.2.2 The emphasis for the year ahead will be on integration and seamless working. Commissioning activity will focus on the system of services for children with disabilities, including social care, health, education and special needs – as well as transitions into adulthood and adult services between 18 and 25 years.

3.2.3 Following the alignment of adult and children's disability services we will undertake work targeted to reducing barriers to successful outcomes for young people in transition to adult life. This will involve joint work with commissioners responsible for commissioning services for adult with learning disabilities, autistic spectrum conditions, sensory impairments and physical disabilities.

3.2.4 A key area of focus will include the development of joint commissioning between KCC and Dartford, Gravesham & Swanley and Swale CCGs. This will see a Joint Commissioning Manager post established and recruitment of a KCC hosted Disability Commissioning Officer. The aim of the project is to create a more seamless pathways across services and ultimately to benefit from pooled funding and aligned strategies.

3.2.5 We will continue work across Kent on joint commissioning for SEND and implementation of the requirements of the SEND Code of Practice 2014. This will involve greater joint working with commissioners of services for children with special educational needs and/or complex health needs in particular those with neuro developmental disorders such as ASC or ADHD.

3.2.6 During 2015 we will be procuring new arrangements for Short Breaks respite services. These will be three year agreements with a range of voluntary and community sector providers designed to ensure equity of access and opportunity across the county.

Engagement with partners

3.2.7 Partnership working is central to work with disabled children, and has become increasingly important since the introductions of Education Health and Care Plans. A standing group of the Children's Health & Wellbeing Board, chaired by Patrick Leeson provides leadership and direction for this partnership work.

3.2.8 The development of integrated commissioning during 2015 is an exciting step that has potential to enhance systemic working that places children at it's core. It will be important to balance this work with north Kent CCGs, with working alongside other CCGs in seeking to develop a consistently high quality service across the county.

3.3 Accommodation

3.3.1 We will be undertaking a programme of work to ensure that young people leaving care have the skills they require to live independently, and are able to access suitable accommodation. In the past the council's approach has not been aligned, leading to a fragmented accommodation and support offer.

3.3.2 Reporting to the 0-25 Portfolio Board the programme is seeking to co-ordinate the accommodation and support provision for young people aged 16 -25 aligning Supporting People activity with Children in Care and Care Leavers. This will bring together a number of projects seeking to resolve/improve accommodation and support and deliver efficiencies and replace contracts for support and accommodation that are due to end during 2015.

3.3.4 A key part of this work is a Care Leaver Pathway project, which is focused on ensuring young people develop the skills they need to live independently during their time in our care. The work follows our transformation principles, including the establishment of a live test environment for practitioners to establish the best approaches.

3.3.5 The programme aims to deliver a number of outcomes including the following:

- Children in Care, Care Leavers and Vulnerable Young People aged 16-25 are self-supporting and living independently as early as possible
- Children in Care, Care Leavers and Vulnerable Young People aged 16-25 are housed in suitable accommodation that meets their needs in line with their pathway
- The Council's is supported to meet its sufficiency duty

Engagement with partners

3.3.6 There is a substantial level of engagement with partners in looking to provide effective support and accommodation to young people. This includes a series of meetings chaired by the Leader of the Council to bring partners together to identify solutions.

3.3.7 In addition to the regular Joint Policy and Planning Board in which partners discuss housing issues, we have established a multi-agency steering group to oversee the programme of work of the programme.

3.4 Emotional Wellbeing Strategy

3.4.1 The council is working in partnership with colleagues from the health service to develop a new Emotional Wellbeing Strategy, as a sub-strategy of Kent's Health & Wellbeing plan.

3.4.2 The aim of the strategy and action plan is to establish a new systemic approach to meeting emotional needs of young people across all tiers of need. A key element of this work is for the procurement of a suite of services, from August 2016, at the point that current contracts for Child & Adolescent Mental Health Services, and emotional well-being services come to an end. We will move from service design to procurement activity, and implementation of agreed actions during 2015.

3.4.3 A key emphasis of this strategy is on providing support for children who are at risk from, or have been victims of Child Sexual Exploitation. The actions outlined in the delivery plan will include procurement activity to ensure we have the right specialist interventions in place to support children who have been victims, along with wider workforce activity to ensure staff working with children with all tiers of need have the skills to identify and respond to risk.

Engagement with partners

3.4.4 The development of the strategy and plan are examples of true partnership working. The Steering Group has been led by individuals across health, public health, and social care. Regular updates have been provided to both the Children's Health & Wellbeing Board and full Health & Wellbeing Board.

3.5 Early Help Commissioning Intentions

3.5.1 Alongside the development of our internal Early Help & Preventative Service we will design and implementing new externally contracted early help services. This will replace a wide range of contracts and grants that have been in place for a number of years, and commissioned through a range of different processes.

3.5.2 Our Early Help commissioning intentions will be developed through a series of workshops, designed to establish need across the council, prioritise areas of focus and then to design the system and services we will procure. The focus will be on working alongside internal services and partner agencies to ensure that we are utilising the whole resource available in the most effective way.

3.5.3 Another priority will be to establish more locally based innovative arrangements for supporting children and families. In keeping with the council's social value focus we will be seeking to utilise voluntary sector agencies including those in the arts, sport and recreation to deliver early help opportunities tailored to the specific needs and interests of families.

3.5.4 A wide range of contracts, covering support across a range of levels of needs and ages from birth to adolescence are due to end in March 2015. We expect to have new contracting arrangements in place to replace these from April 2016.

Engagement with partners

3.5.5 The first multi-agency workshop to consider and prioritise needs took place on April 28th. This involved staff from across the public sector and provider organisations, considering data and intelligence on a district by district basis.

3.5.6 Two further events are planned for May. We will continue to keep partners informed of progress through the Children's Health & Wellbeing Board and Children's Operational Groups.

4. Developing stronger partnership working

4.1 As identified in the priorities outlined, partnership working has continued to improve during 2014/15, within a stronger Children's Health and Wellbeing Board and a range of sub-groups to tackle the key priorities of the partnership.

4.2 A key area of further development during 2015/16 will be the strengthening of Children's Operational Group, such that they represent a meaningful and effective means of delivering improvements to children's outcomes in each district of Kent.

4.3 A workshop on 2nd June 2015 will focus on how to ensure we have the right arrangements in place. The aim is that we will then have groups working in all districts by September 2015.

5. Summary

5.1 This report has provided a summary position of the Children's 0-25 Transformation Programme Plan and the Children's Commissioning Team Business Plan. These documents will be available upon request.

5.2 There is a significant and increasing amount of partnership work taking place as we seek to ensure that services are aligned around the needs of children and families.

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By:	Roger Gough Cabinet Member for Education and Health Reform
To:	Kent Health and Wellbeing Board
Date:	20th May 2015
Subject:	Assurance Framework
Classification:	Unrestricted

Summary:

This paper provides an overview of the indicators contained within the Kent Health and Wellbeing Strategy, with a more detailed look at the acute and urgent care services in Kent.

Recommendations:

The Health and Wellbeing Board is asked to:

1. Continue to raise reporting and recording concerns on breastfeeding rates with the relevant partners.
2. Seek assurance from NHS England on actions for improving the uptake of 2 dose MMR vaccination amongst 5 years olds
3. Seek assurance from NHS England for improving the uptake of flu vaccination in the target population
4. Seek assurance from CCGs and Social Care on plans for ensuring capacity and capability of the local systems to address potential demands during winter of 2015/16.

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. This report continues to focus on the acute and urgent care stress metrics as presented in the previous report, this can be seen in Appendix 1.

2. Key developments

There were no major changes in metrics for Outcome 2 and 5 that need to be raised in this current report.

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

Breastfeeding rates for both initiation and continuation, where available, show lower than national performance for Kent; data quality concerns continue to surround the recording and reporting of breastfeeding continuation rates both in Kent and nationally.

The proportion of 5 year olds having the MMR 2 dose vaccination (Indicator 1.5) has decreased and is now both below the 90% target and the National proportion.

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

The proportions of Kent adults who are receiving secondary mental health services on the care plan approach recorded as in stable and appropriate accommodation remains considerable higher than national levels, however all three aspects of the metric have decreased from the previous year for Kent (Indicator 3.6).

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

The rate of male suicides in Kent has slowly been increasing from 2008-10, the most recent reporting period now shows Kent with a slightly 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 with the exception of East Kent Hospital University Foundation Trust (EHHUFT) experienced increases in the bed occupancy rate in Q3 2014/15. EKHUFT was the only Trust to reduce its occupancy rates to just below the recommended operating level of 85%.

For the week ending 12/04/2015, Dartford and Gravesham NHS Trust (DG NHS) and Medway NHS Foundation Trust (MFT) had their proportions of A&E attendances within 4 hours (all) from arrival to admission transfer or discharge above both National and the target of 95%. Maidstone and Tunbridge Wells NHS Trust (MTW) and EKUFT remain below both National and the target for this time period. Overall the performance of the Trusts has increased from the lower proportions consistently experienced by all the Trusts in December and January. Further analysis is needed locally into the other factors influencing this metric outside of the number of attendances and admissions.

Although the acute delayed days continue to form the majority of delayed days in Kent, there has been a noticeable increase in the number of non-acute delayed days; with 1,287 non-acute delayed days in February compared 1,710 acute. Both NHS and Social care attributed delayed days have increase, with Social Care experiencing the highest number of delayed days in February 2015 at 947 since reporting from April 2013.

Please refer to Section 5 of Appendix 1 for a detailed outline of bed occupancy, A&E discharges, admissions or transfers within 4 hours, and delayed days.

3. Recommendations

The Health and Wellbeing Board is asked to:

1. Continue to raise reporting and recording concerns on breastfeeding rates with the relevant partners.
2. Seek assurance from NHS England on actions for improving the uptake of 2 dose MMR vaccination amongst 5 years olds
3. Seek assurance from NHS England for improving the uptake of flu vaccination in the target population
4. Discuss the reporting of NHS 111 performance in Kent, and make suggestions on alternate metrics
5. Seek assurance from CCGs and Social Care on plans for ensuring capacity and capability of the local systems to address potential demands during winter of 2015/16.

4. Background Papers

Joint Kent Health and Wellbeing Strategy

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Key to KPI Ratings used in Appendix 1

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.

Appendix 1. 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 MMR uptake of 2 doses at age 5 (1.5) school readiness (1.6) excess weight in children (1.7 & 1.8) and CAMHS (1.11 – 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)	24.3% national	25.9 (a)	22.9 (a)	⇧	2013
1.5 Improving MMR vaccination uptake of two doses at 5 years old (PHOF)	90%	92.2% (g)	87.1% (r)	⇩	2013/14
1.6 Increasing school readiness: all children achieving a good level of development at end of Year R (% of all eligible children. PHOF)	60.4% national	63.4% (g)	68.5% (g)	⇧	2013/14
1.7 Reducing the proportion of 4-5 year olds with excess weight (PHOF)	22.5% national	21.7% (a)	20.8% (g)	⇧	2013/14
1.8 Reducing the proportion of 10-11 year olds with excess weight (PHOF)	33.5% national	32.7% (a)	32.7% (g)	⇔	2013/14
1.9 Increasing the proportion of SEND assessments within 26 weeks (**Stress indicator**. KCC MIU)	90%	92.9% (g)	92.4% (g)	⇩	August 2014***
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***

Indicator Description	Known Target	Previous status	Recent status	DoT	Recent time period
1.11 Reducing CAMHS average waiting times to routine assessment from referral (**Stress indicator.** South East CSU)	tbc	5 weeks	6 weeks	⇩	February 2015
1.12 Reducing the number waiting for routine CAMHS treatment (**Stress indicator.** South East CSU)	tbc	262	279	⇩	February 2015
1.13 Having an appropriate CAMHS caseload for patients, open at any point during the month (**Stress indicator.** South East CSU)	8,408	8,662 (r)	8,381 (g)	⇧	February 2015
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

Data quality concerns continue to surround the recording and reporting of breastfeeding continuation rates (at 6-8 weeks) nationally not all Local Authorities have had figures published for 2013/14; both Kent and national as a whole do not have published figures. Work continues between KCC, NHS England Area Team and Providers to find local solutions.

The proportion of 5 year olds having the MMR 2 dose vaccination has decreased to 87.1%; this now places Kent as both below the target of 90% and the England proportion of 88.3%.

Indicator 1.8 on excess weight in children has changed its RAG from Amber to Green; this is due national data refresh as a result of which the national proportion of excess weight has increased consequently placing Kent in a better position by comparison.

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

There have been updates to the following metrics, life expectancy at birth (2.1) and slope index of inequality (2.3) smoking cessation services (2.5) and NHS Health Checks (2.6).

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
2.1 Increasing life expectancy at birth (PHOF):					
Male (years)	79.4 national	79.9 (g)	79.9 (g)	⇔	2011-13
Female (years)	83.1 national	83.4 (g)	83.6 (g)	⇧	2011-13
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)	9.1 national	7.1	7.1	⇔	2011-13
Female (years)	6.9 national	4.8	5.1	⇩	2011-13
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%	50% (a)	51% (a)	⇧	Q3 2014/15
2.6 Increasing the proportion of people receiving a NHS Health Check of the eligible population (KCC Public Health)	50%	36.1% (r)	50.6% (g)	⇧	2014/15
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

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
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

As outlined in the previous report, cancer screening for both breast and cervical cancer has decreased from 2013 to 2014; this is an ongoing decrease for both measures from 2010; however both currently remain above national coverage rates.

2014/15 saw an increase in the proportion of the eligible population in Kent receiving an NHS Health Check, from just 36.1% in 2013/14 to 50.6%; The actual numbers receiving a check went from 32,924 to 45,623.

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

Updates have been made to metrics on telecare/telehealth (3.2) permanent admissions to residential care (3.4) adults with learning disabilities living in their own home (3.5) adults who are receiving secondary mental health services recorded as living independently (3.6) and recorded diabetes (3.7).

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

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
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)	3,740	4,234 (g)	4,332 (g)	⇧	December 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	51 (g)	63 (g)	⇩	December 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	74.8% national	70.1%	70.0%	⇔	2013/14
Male	74.5% national	68.7%	68.2%	⇩	2013/14
Female	75.3% national	72.0%	72.7%	⇧	2013/14
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	60.9% national	81.5%	77.9%	⇩	2013/14
Male	59.5% national	79.8%	76.9%	⇩	2013/14
Female	62.5% national	83.5%	79.1%	⇩	2013/14
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)	6.2% national	6.0%* (a)	6.2% (a)	⇧	2013/14
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 proportions of Kent adults who are receiving secondary mental health services on the care programme approach recorded as living independently, with or without support, remain considerably higher than national levels, however all three aspects of the metric have decreased from the previous time period (3.6)

Overall there is a decreasing trend on the admissions to permanent residential care for older people (3.4) and the increase experienced in December 2014 is still below the maximum of 110 admissions.

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

There have been updates made to the two substance misuse treatment metrics (4.4 & 4.5) adults and social isolation (4.10) and responses to the annual population survey (4.12).

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
4.3 Increasing access to IAPT (Increasing Access to Psychological Therapies) services	Kent value not available				
4.4 Increasing the number of adults receiving treatment for alcohol misuse (ndtms.net)	tbc	1,808	1,937	⇧	2013/14
4.5 Increasing the number of adults receiving treatment for drug misuse (ndtms.net)	tbc	2,931	2,807	⇩	2013/14
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

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
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)	44.5% national	44.0% (a)	45.8% (a)	⇧	2013/14
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)	5.6% national	5.6% (a)	5.4% (a)	⇩	2013/14
Low Worthwhile (score 0-4)	4.2% national	4.0% (a)	4.1% (a)	⇔	2013/14
Low Happiness (score 0-4)	9.7% national	9.9% (a)	9.0% (a)	⇩	2013/14

As outlined in the previous report, 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 males to 4.1 per 100,000 females. 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 services 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.

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.

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

Metric 5.6 on patients aged 75 and over admitted as an emergency, has been updated 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)		tbc	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)		tbc	25.0	25.1	⇔	2013/14
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)		tbc	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)		tbc	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)		tbc	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	tbc	91%	94%	⇧	Q3 2014/15
	(b) who are appropriately assessed	tbc	100%	100%	⇔	
	(c) and, where appropriate, referred on to specialist services in England	tbc	98%	98%	⇔	
East Kent Hospitals University NHS Foundation Trust	(a) identified as potentially having dementia	tbc	99%	100%	⇧	Q3 2014/15
	(b) who are appropriately assessed	tbc	93%	96%	⇧	

Indicator Description		Target	Previous status	Recent status	DoT	Recent time period
	(c) and, where appropriate, referred on to specialist services in England	tbc	100%	100%	⇔	
Maidstone and Tunbridge Wells NHS Trust	(a) identified as potentially having dementia	tbc	99%	98%	⇩	Q3 2014/15
	(b) who are appropriately assessed	tbc	100%	99%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	tbc	100%	100%	⇔	
Medway NHS Foundation Trust	(a) identified as potentially having dementia	tbc	91%	93%	⇧	Q3 2014/15
	(b) who are appropriately assessed	tbc	94%	93%	⇩	
	(c) and, where appropriate, referred on to specialist services in England	tbc	100%	98%	⇩	
5.7 Decreasing the percentage of people waiting longer than 4 weeks to assessment with Memory Assessment Services (South East CSU)		tbc	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)		tbc	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 or out of county schools (indicator 1.10 KCC MIU)	-	604	599	⇧	August 2014***
Children's: Reducing CAMHS average waiting times from routine assessment from referral (indicator 1.11South East CSU)	tbc	5 weeks	6 weeks	⇩	February 2015
Children's: Reducing the number waiting for routine CAMHS treatment (indicator 1.12 South East CSU)	tbc	262	279	⇩	February 2015
Children's: Having an appropriate CAMHS caseload for patients, open at any point during the month (indicator 1.13 South East CSU)	8,408	8,662 (r)	8,381 (g)	⇧	February 2015
Public Health Increasing the population Flu vaccination coverage for those aged 65+. (PHOF)	75%	71.4% (r)	71.1% (r)	⇩	2013/14
Public Health Increasing the population Flu vaccination coverage for those at risk individuals. (PHOF)	75%	48.7% (r)	49.3% (r)	⇧	2013/14
Acute/Urgent Bed Occupancy Rate – Overnight (NHS England)					
Dartford and Gravesham NHS Trust	tbc	93.6%	96.1% (r)	⇩	Q3 2014/15
East Kent Hospitals University NHS Foundation Trust	tbc	87.6%	84.5% (g)	⇧	
Maidstone and Tunbridge Wells NHS Trust	tbc	91.6%	93.7% (r)	⇩	
Medway NHS Foundation Trust	tbc	88.9%	93.0% (r)	⇩	
Kent and Medway NHS and Social Care Partnership	tbc	92.4%	94.3% (r)	⇩	
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%	95.6% (g)	97.4% (g)	⇧	Week ending 12/04/2015
East Kent Hospitals University NHS Foundation Trust (all)	95%	86.3% (r)	90.4% (r)	⇧	

Indicator Description	Target	Previous status	Recent status	DoT	Recent time period
Maidstone and Tunbridge Wells NHS Trust (all)	95%	92.4% (r)	90.3% (r)	⇩	
Medway NHS Foundation Trust (all)	95%	93.0% (r)	96.9% (g)	⇧	
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)	-	2,605	2,997	⇩	February 2015
Acute days	-	1,599	1,710	⇩	
Non-acute days	-	1,006	1,287	⇩	
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	51 (g)	63 (g)	⇩	December 2014

Both Flu vaccination metrics remain below the target of 75%; there has been a slight increase in the proportion of those at risk individuals receiving the vaccination, with an increase from 48.7% in 2012/13 to 49.3% in 2013/14.

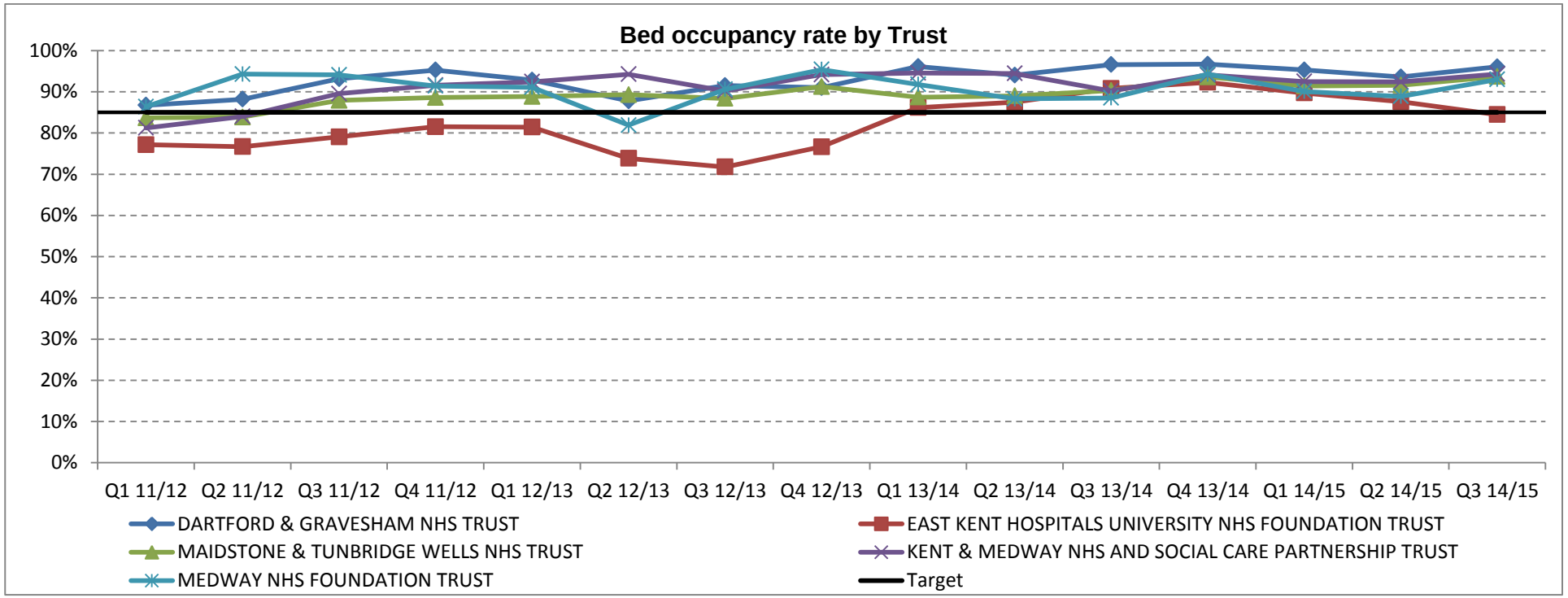
The report continues to be unable to report Kent NHS 111 performance.

Better Care Fund (BCF) Metrics: Awaiting notification of BCF Performance Dashboard.

Stress indicators

It has been requested that this extended section on Acute/Urgent services presented in the previous report remain for this report with an update to the published figures; these metrics 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. April 2015)

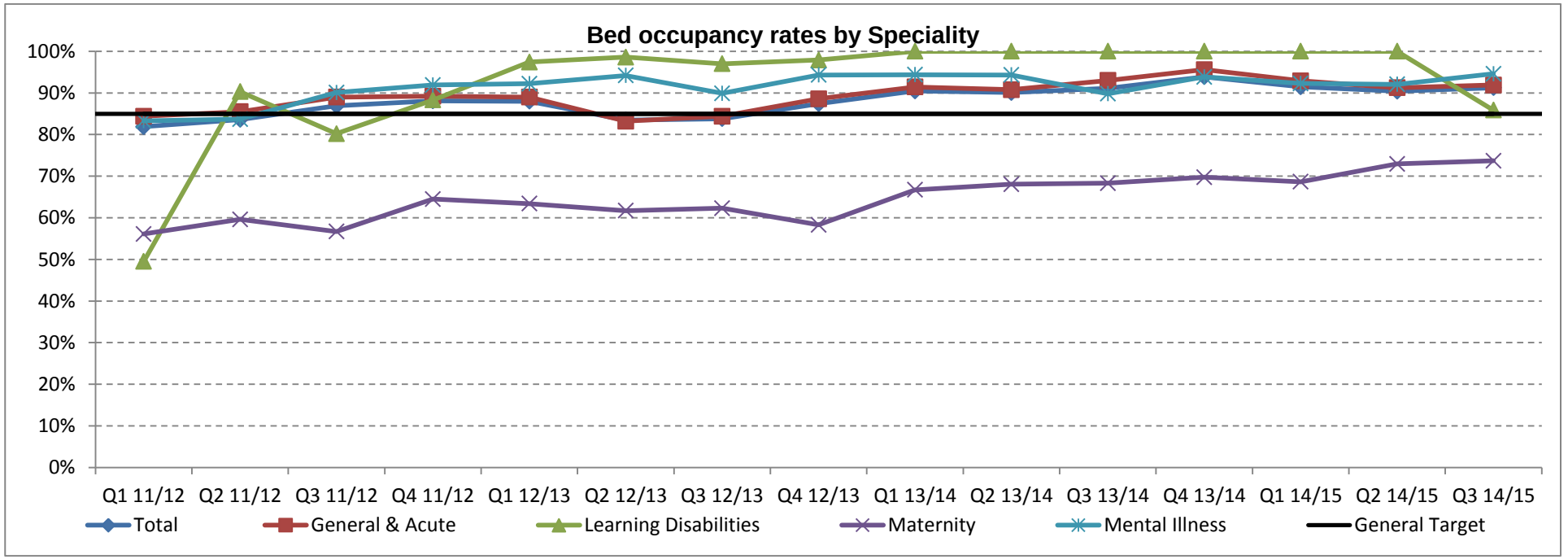


Bed occupancy rates look at the number of available beds open overnight and the percentage that are occupied by Trust and speciality.

All Trusts with the exception of EKHUFT experienced increases in the bed occupancy rate in Q3 2014/15. EKHUFT was the only Trust to reduce its occupancy rates to just below the recommended operating level of 85%.

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

In total there were 3,368 beds available in Q3 2014/15, the majority of which were for General & Acute Speciality (2,639 beds), 13 beds were available for Learning Disabilities, 192 Maternity and 523 for Mental Illness.

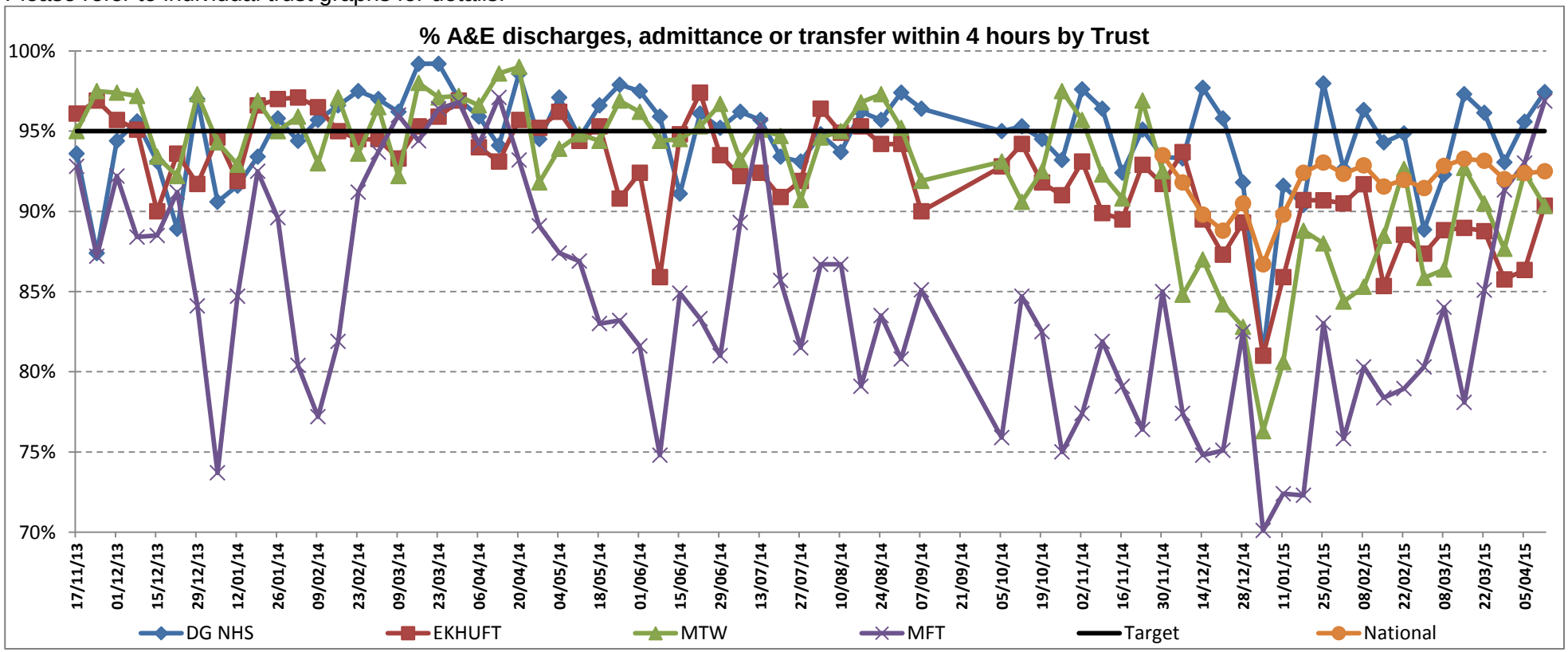


Acute/Urgent A&E attendances within 4 hours (all) from arrival to admission transfer or discharge
(Source: NHS England. April 2015)

For the week ending 12/04/2015, DGS and MFT had their A&E % within 4 hours above both National and the target of 95%. This is consistent with previous performance at DGS but is a positive direction for MFT who have not been above 90% since July 2014.

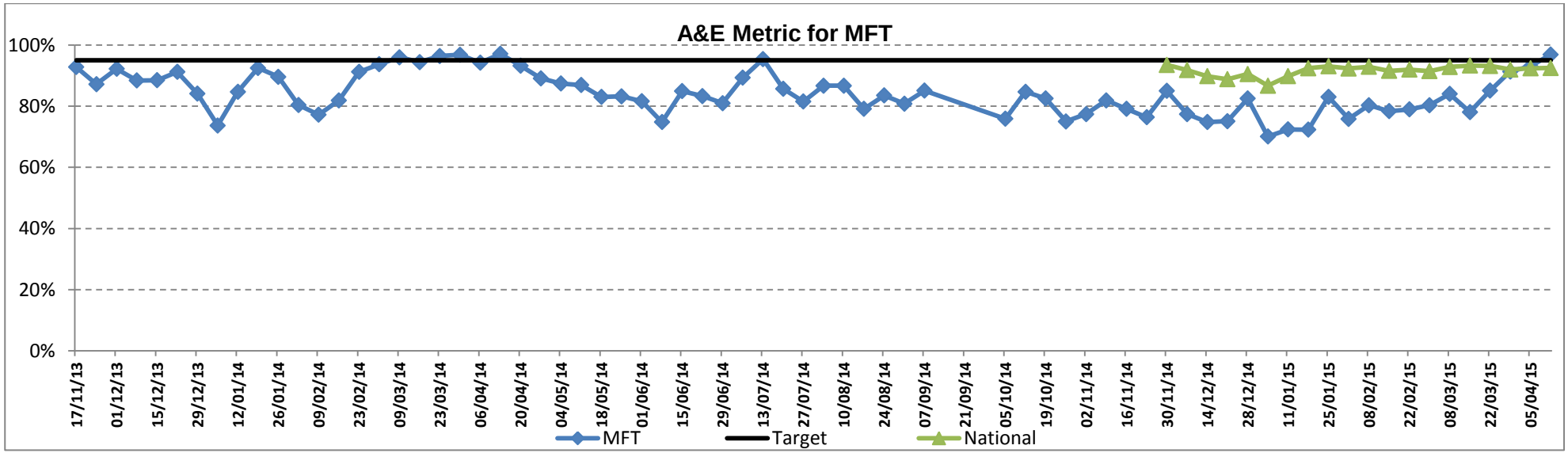
MTW have been steadily improving from the beginning of January 2015 where they experienced their lowest percentage of 76%.

Please refer to individual trust graphs for details.



Medway NHS Foundation Trust (MFT):

MFT have improved since the week ending 15/03/2015, and at the week ending 12/04/2015 met and exceeded the target of 95% and national performance at 97%.



The table below outlines the figures on attendance and admissions from the week ending the 7th December 2014 to the week ending 12th April 2015. Although MFT have not experienced a decrease in the number of attendances in the final 3 weeks of published data, they did increase week on week those that were dealt with within 4 hours. On their emergency admissions, they significantly decreased the actual number of patients spending greater than 4 hours from decision to admit to admission; this reduced from 124 in week ending 22nd March to 11 in week ending 12th April.

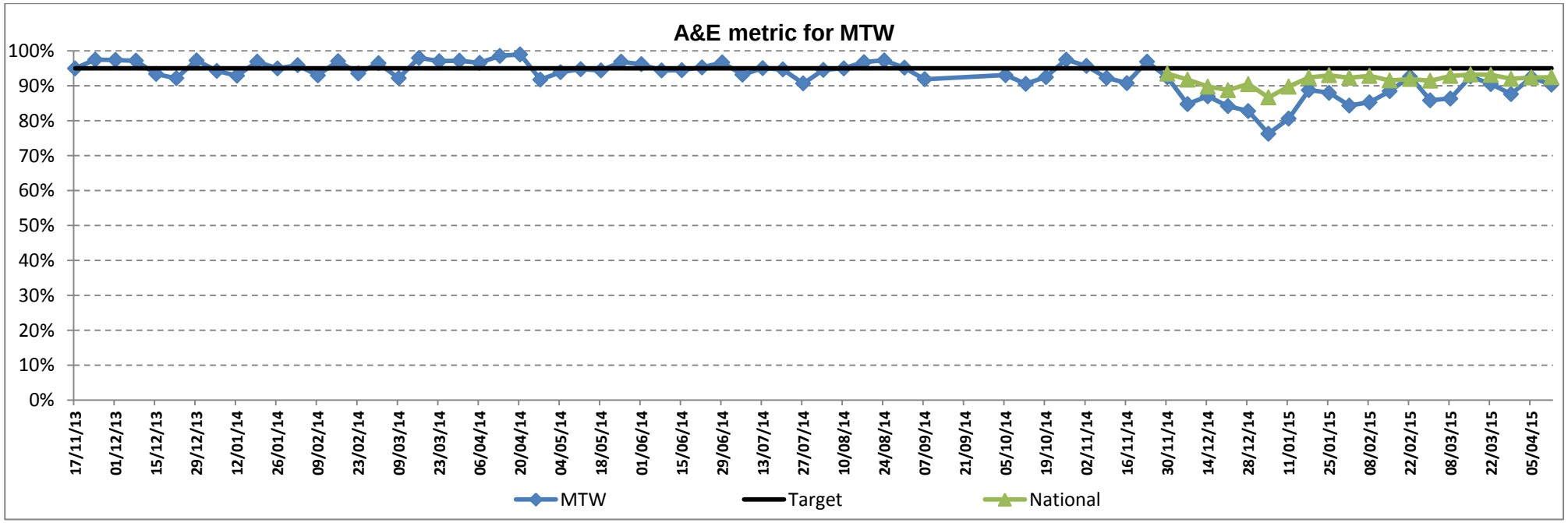
A&E attendances and emergency admissions – MFT

Week Ending	Total Attendances	A&E attendances Percentage in 4 hours or less (all)	Emergency Admissions		
			Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	Number of patients spending >4 hours from decision to admit to admission
07/12/2014	2,001	77.4%	341	203	179
14/12/2014	1,972	74.8%	318	195	159
21/12/2014	1,961	75.1%	336	310	189
28/12/2014	1,820	82.5%	329	214	66
04/01/2015	1,870	70.1%	382	221	182
11/01/2015	1,798	72.4%	384	218	147
18/01/2015	1,732	72.3%	378	198	188

Week Ending	Total Attendances	A&E attendances Percentage in 4 hours or less (all)	Emergency Admissions		
			Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	Number of patients spending >4 hours from decision to admit to admission
25/01/2015	1,739	83.0%	315	212	93
01/02/2015	1,779	75.8%	369	208	204
08/02/2015	1,879	80.3%	345	214	168
15/02/2015	1,943	78.4%	276	229	155
22/02/2015	1,900	78.9%	317	215	140
01/03/2015	1,940	80.3%	329	221	134
08/03/2015	1,871	84.0%	336	217	148
15/03/2015	1,953	78.1%	373	206	168
22/03/2015	2,026	85.1%	381	224	124
29/03/2015	2,008	91.3%	359	273	49
05/04/2015	1,973	93.0%	320	301	40
12/04/2015	1,985	96.9%	342	201	11

Maidstone and Tunbridge Wells NHS Trust (MTW):

MTW began a noticeable decrease in proportions within 4 hours from the end of November (23/11/2014) and experienced their lowest proportions in January 2015 compared to any week as far back as November 2013. From the end of November they also operated below national proportions. MTW have slowly been increasing in their performance since January 2015 however they still remain below target and national.



The table below outlines the figures on attendance and admissions from the week ending the 7th December 2014 to the week ending 12th April 2015. There does not appear to be any trend data here to explain the increasing performance; wider actions would need to be considered which are outside of the scope of attendance and admission figures alone.

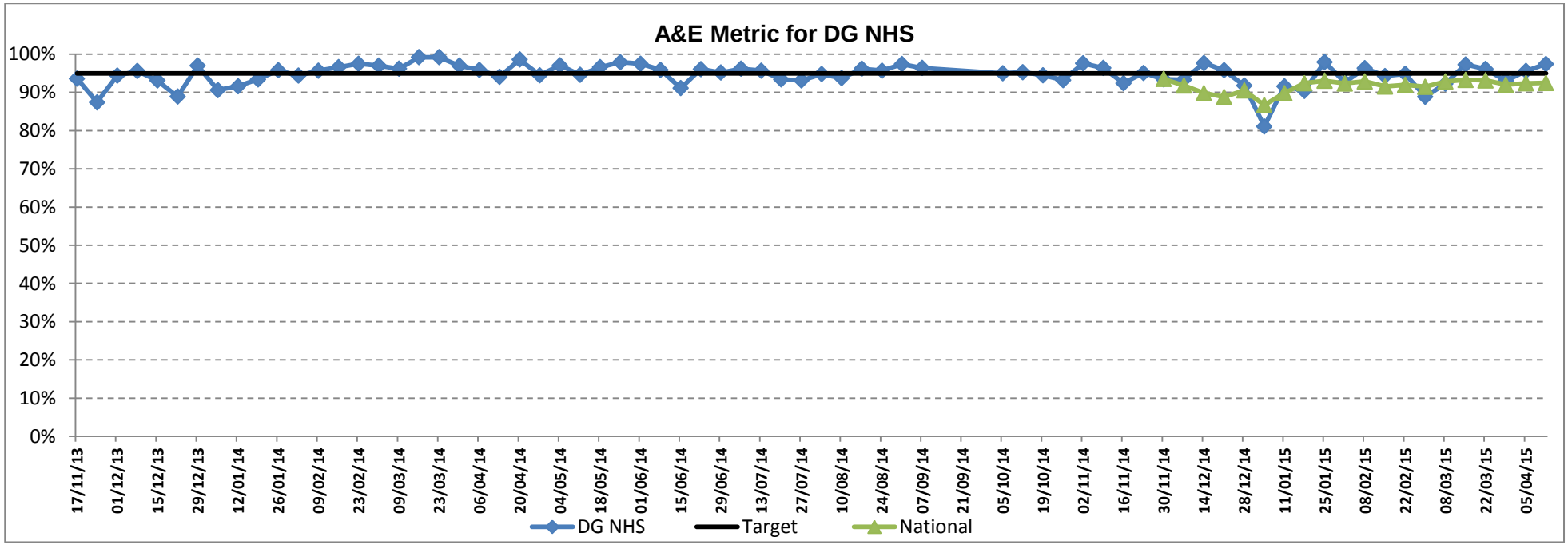
A&E attendances and emergency admissions – MTW

Week Ending	Total Attendances	A&E attendances Percentage in 4 hours or less (all)	Emergency Admissions		
			Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	Number of patients spending >4 hours from decision to admit to admission
07/12/2014	2,406	84.8%	691	63	122
14/12/2014	2,515	87.0%	711	57	87
21/12/2014	2,661	84.2%	729	66	125
28/12/2014	2,455	82.8%	762	45	104
04/01/2015	2,382	76.3%	758	50	246
11/01/2015	2,254	80.6%	677	61	153

Week Ending	Total Attendances	A&E attendances Percentage in 4 hours or less (all)	Emergency Admissions		
			Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	Number of patients spending >4 hours from decision to admit to admission
18/01/2015	2,205	88.8%	663	60	73
25/01/2015	2,167	88.0%	655	61	98
01/02/2015	2,336	84.4%	640	60	164
08/02/2015	2,339	85.3%	661	49	148
15/02/2015	2,378	88.5%	691	79	115
22/02/2015	2,300	92.7%	680	71	63
01/03/2015	2,467	85.9%	714	71	152
08/03/2015	2,495	86.4%	745	63	118
15/03/2015	2,454	92.7%	705	66	52
22/03/2015	2,674	90.5%	790	56	64
29/03/2015	2,561	87.7%	704	52	113
05/04/2015	2,585	92.4%	691	48	33
12/04/2015	2,567	90.3%	716	54	71

Dartford and Gravesham and NHS trust (DG NHS):

DG NHS is the only Trust to consistently vary around the 95% target; it did experience a dip in performance in the week ending 4th January 2015, however it has returned to previous levels.



The table below outlines the figures on attendance and admissions from the week ending the 7th December 2014 to the week ending 12th April 2015.

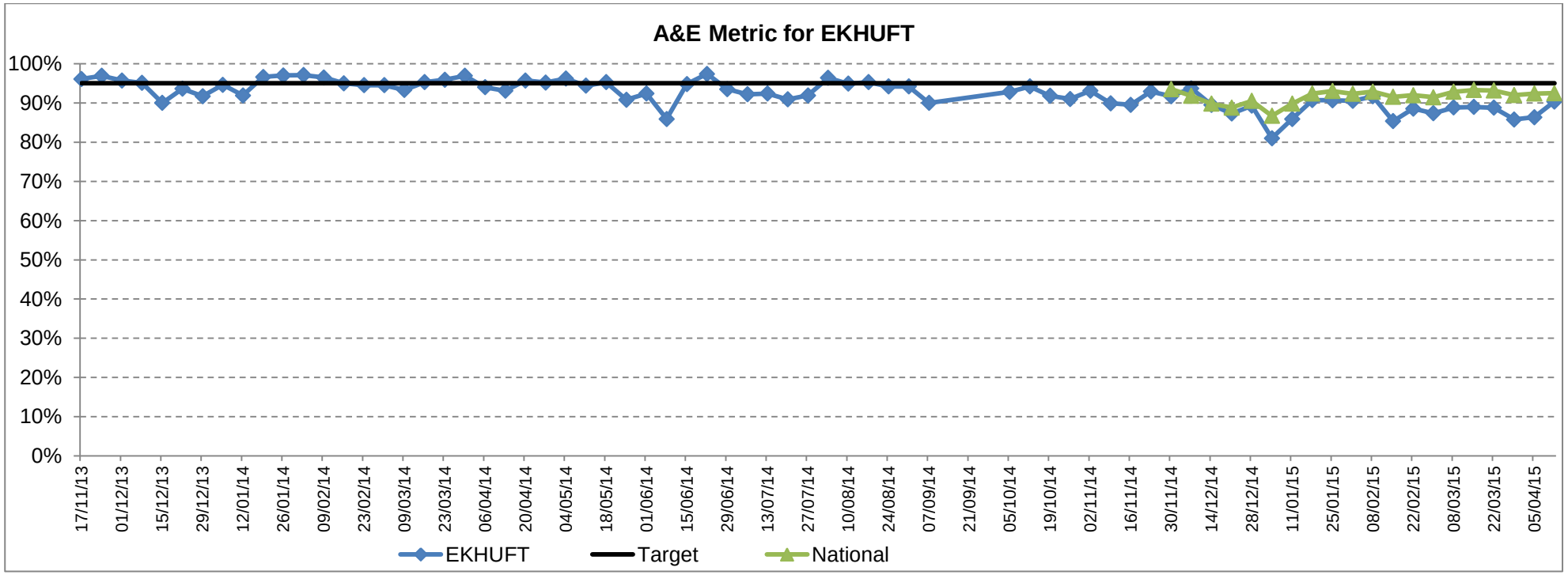
A&E attendances and emergency admissions – DG NHS

Week Ending	Total Attendances	Percentage in 4 hours or less (all)	Emergency Admissions		
			Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	Number of patients spending >4 hours from decision to admit to admission
07/12/2014	1,906	93.3%	574	17	1
14/12/2014	1,942	97.7%	582	22	0
21/12/2014	1,974	95.8%	600	26	0
28/12/2014	1,850	91.8%	552	13	7
04/01/2015	1,826	81.1%	552	22	51
11/01/2015	1,718	91.6%	510	17	23
18/01/2015	1,653	90.4%	489	27	18
25/01/2015	1,675	98.0%	499	18	3

Week Ending	Total Attendances	Percentage in 4 hours or less (all)	Emergency Admissions		
			Emergency Admissions via Type 1 A&E	Other Emergency admissions (i.e not via A&E)	Number of patients spending >4 hours from decision to admit to admission
01/02/2015	1,726	92.6%	541	22	15
08/02/2015	1,712	96.3%	543	18	12
15/02/2015	1,858	94.3%	545	19	20
22/02/2015	1,732	94.9%	509	23	9
01/03/2015	1,839	88.9%	571	18	34
08/03/2015	1,959	92.3%	530	27	19
15/03/2015	1,746	97.3%	540	27	4
22/03/2015	1,814	96.1%	522	19	7
29/03/2015	1,945	93.1%	521	23	26
05/04/2015	1,856	95.6%	538	15	9
12/04/2015	1,874	97.4%	531	16	2

East Kent Hospitals University NHS Foundation Trust (EKHUFT):

EKHUFT remains below both national proportions of within 4 hours and the target of 95%.

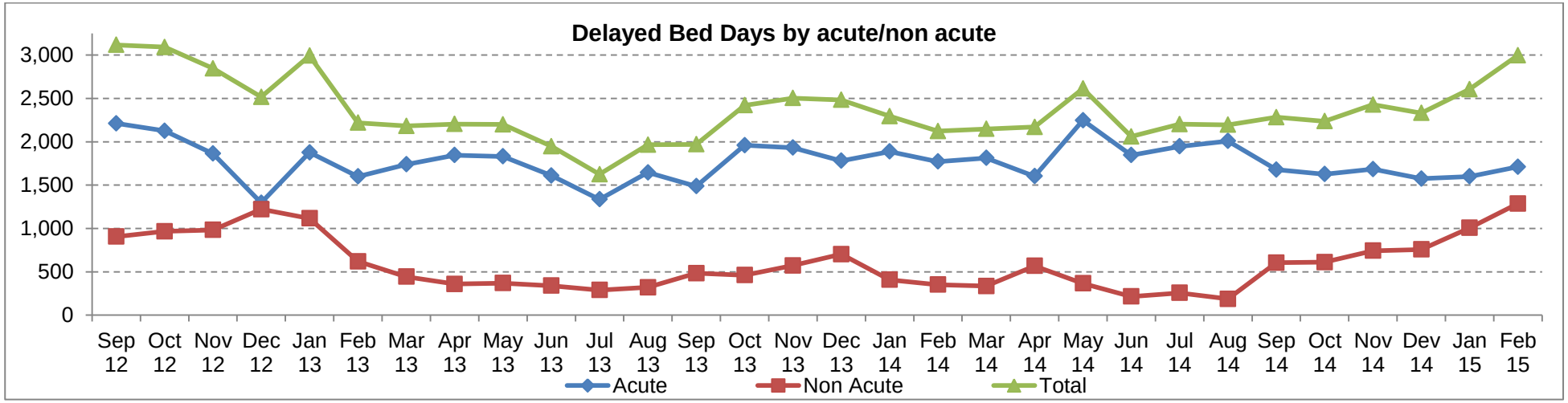


The table below outlines the figures on attendance and admissions from the week ending the 7th December 2014 to the week ending 12th April 2015. During the weeks ending the 29th March and the 5th April EKHUFT experienced its highest number of attendances during this time frame at over 4000 each, the proportion within 4 hours dipped slightly but not to the point experienced at the beginning of January.

A&E attendances and emergency admissions – EKHUFT

Week Ending	Type 1 Departments - Major A&E Attendances	Total Attendances	% in 4 hours or less (all)	Emergency Admissions			
				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)	Number of patients spending >4 hours from decision to admit to admission
07/12/2014	2,789	3,817	93.7%	791	387	329	16
14/12/2014	2,720	3,785	89.5%	772	406	290	18
21/12/2014	2,781	3,847	87.3%	826	409	311	20
28/12/2014	2,574	3,548	89.3%	823	402	242	50
04/01/2015	2,708	3,672	81.0%	796	398	265	24
11/01/2015	2,414	3,480	85.9%	742	441	281	24
18/01/2015	2,431	3,415	92.9%	738	360	293	15
25/01/2015	2,546	3,588	90.7%	779	372	273	23
01/02/2015	2,635	3,663	90.5%	819	346	276	14
08/02/2015	2,657	3,682	91.7%	816	375	280	4
15/02/2015	2,739	3,862	85.3%	834	383	291	40
22/02/2015	2,615	3,716	88.5%	770	364	329	29
01/03/2015	2,731	3,828	87.4%	777	390	304	46
08/03/2015	2,715	3,869	88.8%	779	359	311	36
15/03/2015	2,754	3,945	89.0%	720	389	336	23
22/03/2015	2,840	3,998	88.8%	784	366	321	25
29/03/2015	2,902	4,094	85.8%	779	385	312	24
05/04/2015	2,923	4,107	86.3%	760	394	295	22
12/04/2015	2,837	3,900	90.4%	735	363	265	18

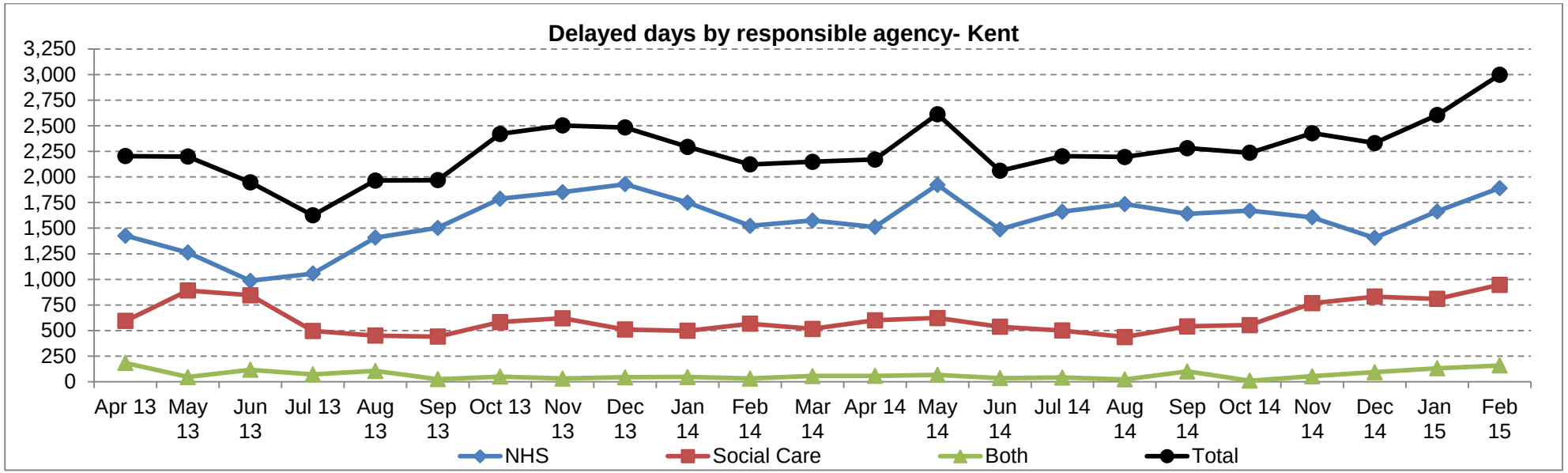
Social / Community Care Decreasing the number of delayed days
(BCF. Source: NHS England. April 2015)



Published figures on the number of delayed days currently is to February 2015.

Although the delayed days labelled as Acute (type of care the patient receives) continue to form the majority of delayed days in Kent there has been a noticeable gradual increase in the number of Non-acute delayed days since September 2014; with 1,287 non-acute delayed days, this was just below the acute days at 1,710.

The chart below 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, following a plateau, the days have increased from December 2014 through to February 2015; Social care has too followed this and been increasing from August 2014. For Social Care, the highest number of delayed days was experienced in February 2015 at 947 since reporting from April 2013.



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/

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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Roger Gough, Chairman – Health and Wellbeing Board

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

Date: 20th May 2015

Subject: JSNA Exception Report

Classification: Unrestricted

Electoral Division: All

Summary:
The Kent JSNA is a set of reports, chapter summaries, interactive maps and needs assessments which are regularly reviewed and updated as per the development process agreed by the Kent Health & Wellbeing Board in 2013. All JSNA chapter summaries have been refreshed for 2014/15, to reflect the latest policy, guidance and data trends. Alongside this, the JSNA exception report highlights only key excerpts of this refresh, described in this paper. Most excerpts are reported for Kent, describing variation at a sub-Kent level where information is available.

Recommendations:
Kent Health & Wellbeing Board Members are asked to note the contents of the report.

1. Changes in population

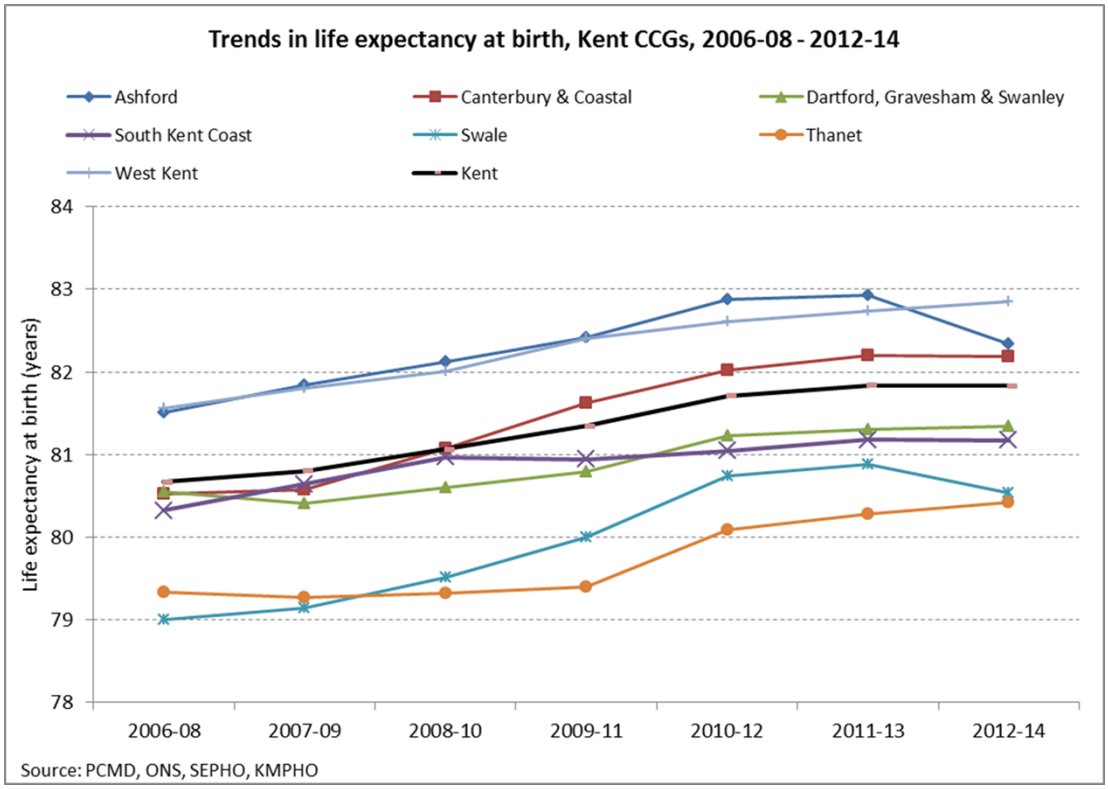
1.1 In mid-2015, the Office for National Statistics (ONS) population estimate for Kent was a little over 1.5 million persons. This is expected to rise to 1.77 million in 2035 a rise of nearly 17%.

1.2 The highest percentage increase would be that of Swale CCG (20.8%) and the lowest in Canterbury (13.1%).

2. Life Expectancy

2.1 Life expectancy in Kent continues to increase over time, although there appears to be a slight decrease in Ashford and Swale CCGs but this is statistically not significant.

2.2 The 'Health Gap' between the most deprived and least deprived areas stays constant at around five years of life difference (between the respective populations). Closer examination reveals that while this gap is shrinking in East Kent and in West Kent, these reductions are counterbalanced by an increasing gap in North Kent, resulting in no appreciable net change.



3. Premature mortality for long term conditions

3.1 'Kent's 'Health Gap' between most and least deprived for premature mortality in long-term conditions fell by 4% between 2012 and 2013. This was the result of a reduction in the health gap for this indicator in East Kent; North Kent and West Kent remain relatively unchanged.'

3.2 People with cancer living in areas in the most deprived quintile are persistently around 50% more likely die from cancer under the age of 75 than those living in the least deprived areas. Whilst there have been improvements in terms of the overall level of premature mortality from cancer, the gap between the most and least deprived has remained relatively static.

4. Physical Activity

4.1 The percentage of adults in Kent currently classed as physically inactive is 28.1%, meaning almost 3 in 10 adults fail to achieve at least 30 minutes of physical activity in one week.

4.2 Currently 56.3% of the adult population meet the physical activity guidelines of 150 minutess per week to improve or maintain health.

4.3 Programmes to systematically address physical inactivity are in development by Kent County Council Public Health for 2015 onwards and will follow current guidance on programme design and commissioning.

5. Smoking

5.1 There were 7,285 premature deaths related to smoking mortality between 2011 and 2013. In 2014 the overall smoking prevalence reduced to 19% in Kent in line with, but slightly above, the national rate of 18.4%. District wise, the highest prevalence was in Dover and Thanet, particularly in routine manual skilled workers.

6. Health Checks

6.1 Latest figures show that clusters of GP practices located in more deprived areas have lower uptake levels. These include Thanet, parts of Swale and Maidstone. More focussed targeting and promotion of the NHS Health Check is necessary from a Health Inequalities perspective.

7. Teenage Pregnancy

7.1 There are significant differences in progress to reduce rates across the districts of Kent, with Shepway having achieved the best reduction, of 55.9%, and Dartford having shown the lowest increase, of 17.6%. Significant improvement has been made in Maidstone, from a 4% increase to a reduction of 38.8%, giving an overall improvement of 42.8%.

7.2 Thanet and Swale had the highest teenage conception rates in 2012/2013; the lowest rates were in Tunbridge Wells and Sevenoaks. Dartford, Dover, Gravesham, Swale and Thanet districts all had teenage conception rates above the national average in this period.

8. Maternity and Child Health

8.1 The number of live births in Kent has fluctuated over the past 3 years for which data is available with an average of just over 17,600 births per year. There has been no distinct upward or downward trend.

8.2 In 2012/13 Gravesham had the highest rate of terminations of pregnancies amongst Kent districts whilst Tunbridge Wells had the lowest rate. Rates tend to be higher in districts within East Kent compared to West Kent. It is interesting to note that although Maidstone district hosts the only terminations clinic in Kent the rate of terminations for women in this district is below the Kent average.

8.3 Dover has the highest infant mortality rate of Kent districts and Dartford the lowest. Dover, Sevenoaks, Canterbury, Gravesham Swale and Thanet districts all have infant mortality rates higher than the South East average although it is not currently known if any of these differences are statistically significant.

8.4 Swale CCG has the highest percentage of mothers smoking at the time of delivery at just over 20%. South Kent Coast, Swale and Thanet CCGs all have higher smoking rates at delivery than the Kent and Medway average. The percentage of women smoking at the time of delivery is lowest in West Kent CCG at just under 10%.

8.5 According to these statistics breastfeeding continuation at 6-8 weeks (12/13) is highest in West Kent CCG and lowest in Swale CCG.

9. Late diagnoses of HIV

9.1 Latest figures for 2011-13 indicate considerable differences in proportion of HIV cases that were diagnosed late across Kent districts, ranging from 46.7% in Gravesham to 66.7% in Swale.

10. Stroke

10.1 Latest Quality Outcomes Framework (QOF) data indicated that in Kent & Medway, 30,500 people were recorded as having a Stroke or Transient Ischaemic Attack (TIA). This is a prevalence of 1.7% across Kent and Medway (same as the national average). The lowest prevalence of stroke was seen in Swale with 1.4% of the population appearing on a stroke register, the highest prevalence of 2.1% is seen in South Kent Coast CCG area.

10.2 Thanet CCG area has the second highest prevalence with 2.0%, followed by Canterbury & Coastal CCG (1.9%), Ashford CCG (1.8%), West Kent CCG (1.8%) DGS CCG (1.6%) and Swale CCG (1.4%). The national prevalence from the quality and outcomes framework (QOF) is 1.7%. Latest PHE figures show national comparison of premature mortality and prevalence for stroke /

TIA and other risk factors in which Kent has been rated better than average for most except Atrial Fibrillation.

10.3 Latest analysis of Quality Outcomes Framework (QOF) data related to CHD, stroke and hypertension suggest similar patterns in indicator achievement across all CCGs (eg. higher case ascertainment rates in stroke and higher proportion of patients with recorded blood pressure of 150/90mmhg or less) with minimal variation across them.

10.4 Stroke care quality was analysed in a special report by Public Health. The table below shows the three hospital sites in East Kent performing relatively better than the acute sites in other areas.

Domain	Darent Valley	Kent and Canterbury	Queen Elizabeth the Queen Mother	William Harvey	Maidstone District General	Tunbridge Wells	Medway Maritime
Scanning	C	A	A	A	D	D	C
Stroke unit	E	C	C	C	E	E	D
Thrombolysis	E	A	B	B	E	E	D
Specialist assessment	D	A	A	B	E	D	E
Occupational therapy	C	D	C	C	C	C	Insufficient records
Physiotherapy	D	D	B	C	D	D	Insufficient records
Speech and language therapy	E	E	E	E	E	E	Insufficient records
Multi disciplinary team working	E	D	C	D	D	E	D
Standsards by discharge	C	C	B	D	D	D	Insufficient records
Discharge process	D	E	D	E	E	D	Insufficient records
All Domains combined	E	D	C	D	E	E	D

A = Over 80% B = 70-80%
C = 60 -70% D = 40 – 60%
E = less than 40%

Source: Royal College of Physicians, Sentinel Stroke Audit, 2014
http://www.rcplondon.ac.uk/projects/ssnap-clinical-audit/SSNAP

11. Coronary Heart Disease (CHD)

11.1 As per previous estimates, CHD prevalence in Kent overall still appears to be increasing in line with national trends, largely due to higher reporting and case finding rates. Thanet district appears to have relatively higher Coronary Heart Disease mortality rates compared to the rest of Kent while Tonbridge and Malling have relatively lower levels.

11.2 Latest 2013/14 estimates show admissions for heart failure have shown some increase in Thanet and West Kent CCGs but these have reduced slightly in Canterbury, DGS and South Kent Coast CCGs.

11.3 The rates for revascularisation (angiogram/Percutaneous Coronary Intervention (PCI) procedures) procedures in 2013 show higher proportion of activity being repatriated from London to local centres in Kent and slightly reduced numbers of Coronary Arterial Bypass Graft (CABGs) alongside increased angioplasties.

12. Cancer

12.1 Over the last 15 years, there have been significant improvements in Kent in one-year survival rates across all cancers. However, both the overall one-

year survival index and the rate of improvement varies markedly across CCGs.

12.2 This analysis particularly highlights Swale CCG, and to a lesser extent Thanet CCG, as having a concerning combination of low baseline survival rates and low rates of improvement. This implies that these areas are likely to fall further behind in terms of one-year survival rates.

12.3 More effort is required to promote early diagnosis and awareness of signs and symptoms of cancer

13. Dementia

13.1 Based on 2013 estimates, the observed prevalence of dementia (number of dementia patients on QOF registers) is approximately 44% of the expected prevalence across Kent or 9221 which is an improvement from 37% based on estimates made in 2011. However this falls short of the revised new target of 67% that GP practices are obliged to meet by March 2015.

13.2 NHS England (NHSE) has published a second Direct Enhanced Service known as Dementia Identification Scheme In addition to identifying and referring those individuals at high risk of dementia, this enhanced service also requires practices to work with nursing and care homes to identify patients in their care who may have symptoms of dementia and offer a dementia assessment.

14. Falls

14.1 Falls related admissions amongst the over 65's (with an injury-related primary diagnosis) continue to increase steadily, with the age-standardised rate having increased by 30% between 2006/07 and 2013/14. This upward trend is evident in all CCGs except Swale, where admission rates have decreased year-on-year since 2010/11.

15. Excess Winter Deaths

15.1 Kent also showed a reduction from 933 excess winter deaths in 2012/13 to 655 in 2014/15. In contrast to national figures, the reduction was not as significant as past years, in particular for the winter periods of 2006/7 and 2007/8 (473 and 454 respectively).

15.2 Kent has continued to develop partnership referral pathways to try to reach those most at risk in cold weather. Emergency support is available at a population level and Public Health co-funded housing retrofit interventions with the Kent County Council Warm Homes programme, to provide sustainable interventions such as insulation and heating repairs for those over 65 with a long term health condition, particularly respiratory and heart. In the

winter period of 2013/14 almost 11,000 people received a home visit resulting on over 3,000 interventions.

16. Looked After Children

16.1 A needs assessment completed in 2014 highlighted the following:

16.2 A 25% increase in the number of Kent children in care in the last five years (but a 16% decrease in children from other local authorities). Thanet district has the highest number of children in care. Most children in care are in the age group 12-18 years old. A decrease in the age group 0-4 years old has been observed in 2013-14.

16.3 Higher levels were reported for fixed school exclusions, Special Education Needs, educational attainment and SDQ score. Lower levels were reported annual health assessments completed compared to rest of England, however the number of review health assessments performed by nursing staff for looked after children in east Kent has increased sharply in 2013/14.

17. Learning Disabilities

17.1 A needs assessment for adults with Learning Disabilities was completed in 2014. It highlights a number of gaps in access to health improvement programmes such as Health Promotion for patients and their carers, health activity groups such as weight management, cancer screening. Kent Public Health team is working with NHSE, CCGs and Kent Community Health Trust to improve the uptake of annual health checks for people with learning disabilities.

18. Domestic Abuse

18.1 During 2013/14 there were 25,365 domestic abuse incidents reported to Kent Police. This is an increase of 8.4% from 2012/13.

18.2 During 2013/14, 1862 high risk cases were referred to Multi Agency Risk Assessment Conferences, with 2,394 children living in those high risk households. This is an increase of 32% on the previous year.

18.3 During the first two quarters of 2014/15 (the second year of the service) the Kent and Medway Independent Domestic Violence Advisor service received 1,411 referrals. This amounts to a 64% increase on the same period in 2013/14.

18.4 Between July 2013 and June 2014, 1,835 people were assisted at domestic abuse one stop shops across Kent. This is an increase of 46% on the previous year.

18.5 In light of the increasing demand for services and reduced budgets, discussion is required about whether to combine the provision of domestic abuse services into a single commissioned integrated service.

19. Offenders

19.1 Latest anecdotal reports indicate a higher than expected number of suicides (or suspected suicides) in Kent Prisons – 11 in total - between December 2013 and December 2014. A comprehensive health needs assessment of the prison population in Kent should be undertaken, particularly highlighting suicide prevention.

20. Mental Health – Adults

20.1 The National Wellbeing Index shows that overall Kent's population feels slightly more anxious then the UK population average. There has been considerable work done to tackle psychosis and urgent and early help via the Mental Health Crisis Concordat. Many partners are signed up to this agreement across Kent and Medway. Latest needs assessment work continues to highlight the problems in the provider services data, an issue that CCG commissioners as well as NHS England are looking into.

20.2 There is a comprehensive public health and social care prevention plan for mental wellbeing across Kent. This includes promoting good mental health via asset development and resilience building (6 ways to Wellbeing), supporting access and vulnerable groups (Kent Sheds and Community Link Workers), preventing suicide (Mental health first aid training) and helping recovery via the forthcoming 'primary care mental wellbeing and recovery service' which will empower voluntary and community agencies to tackle stigma, support employment and re-integrate people into community life after illness.

20.3 Each CCG area has particular priorities highlighted by their needs assessment. However many issues are shared across all areas with differential impact. Some of the most important are listed below:

- Ensuring joined up community asset development is linked to accessing primary care and psychological therapy.
- Tackling the rise in self harm and dual diagnosis by ensuring better transition between CAMHS and AMHS as well as focusing on schools and raising awareness (particularly in Canterbury).
- Understanding more fully the nature and extent of depression in local areas (particularly Ashford).

20.4 Increasing areas of concern are anti-social personality disorder, Attention Deficit Disorder (around 7000 people in Kent), eating disorders (around 26,000 in Kent particularly in females) and post natal depression (around 1800 women across Kent).

21. Suicide and Self Harm

21.1 A Kent and Medway Suicide and Self Harm Strategy is currently out for consultation in 2015. The strategy aims to strengthen data surveillance via working with Coroners and the police.

21.2 In 2013 there were 182 deaths from suicide across Kent. Men are far more at risk of suicide then women. The rate of suicide across Kent is 9 deaths per 100,000 people (2011-13). This is slightly higher than the England rate of 8.8 per 100,000. This amounts to just over 4000 years of life lost across Kent (2011-13). DGS, SKC and Thanet CCGs had the highest rates in 2013.

21.3 Latest estimates suggest that almost 15,000 young people between 16-24 years have self-harmed in Kent. Overall, trends of self-harm in Kent are falling for people aged 20-24 but increasing for those aged <19 years. South Kent Coast CCG had highest self harm rates in 2013/14 in those aged 10 – 24 years, followed by Ashford, Thanet and Canterbury CCGs.

21.4 A key recommendation for tackling self-harm in young people (particularly those who repeatedly self-harm) is to discuss distress and risky behaviours in schools settings and also support parents and young people to discuss emotional problems together.

22. Mental Health – Children and Young People

22.1 Latest estimates indicate 11-16 years are the riskiest ages for developing mental health problems in young people. There are over 5,500 children in need in Kent due to family dysfunction, abuse and neglect. Kent also has higher rates of hospital admissions for mental health conditions than the England average, particularly eating disorder and self-harm.

22.2 Approximately 45% of Children In Care are at risk of mental illness, compared with 9% in the rest of the population but only half of the expected number of children in care in Kent are getting CAMHS services, particularly Tier 2 (preventative /early help) services reflecting similar problems nationally. It is hoped that the new Children's Emotional Well Being Strategy – linking Headstart / Early Help, Troubled Families, resilience and public health services together may address this situation.

22.3 Self-harm and Obsessive compulsive disorder and witnessing domestic abuse are some of the main reasons for referral to CAMHS therapy services. Given these issues, transition between children's and adult mental health services needs to be planned carefully to improve care continuity.

23. Recommendations

23.1 Members of the Committee are asked to:

a. Note the contents of the report
b. Make recommendations to the Cabinet Member for Adult Services and Public Health to approve the report.

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Relevant Director:
Andrew Scott-Clark, Director of Public Health
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Children's Health and Wellbeing Board

3rd February
Council Chamber Sessions House, Sessions House

MINUTES

In attendance:

Andrew Ireland (AI)	KCC – Corporate Director – Social Care, Health & Wellbeing (Chair)
Peter Oakford (PO)	KCC - Cabinet Member SCS
Margaret Crabtree (MC)	For Roger Gough KCC - Cabinet Member Education and Health Reform
Debbie Stock (DS)	NHS – Dartford, Gravesham and Swanley CCG Chief Operating Officer
Philip Segurola (PS)	KCC - Acting Director Specialist Children's Services
Florence Kroll (FK)	KCC - Director Early Help and Preventative Services
Karen Sharp (KS)	KCC - Head of Public Health Commissioning
Thom Wilson (TW)	KCC - Head of Strategic Commissioning (Children's)
Colin Thompson (CT)	KCC Interim Public Health Consultant Children and Young People
Sue Mullin (SM)	For Hazel Carpenter - NHS - South Kent Coast CCG & NHS Thanet CCG, Accountable Officer
Abdool Kara (AK)	Kent District Councils Chief Executives
Gill Rigg (GR)	Kent Safeguarding Children Board Independent Chair
Ian Darbyshire (ID)	Senior Commissioning Manager, CAMHS, NHS
Dave Holman (DH)	West Kent CCG - Head of Mental Health Commissioning
Amy Merritt (AM)	KCC – Commissioning Officer
Jennifer Maiden Brooks (JMB)	KCC – Policy Manager
Jill De Paolis (JDP)	KCC - Commissioning Officer

Apologies:

Patrick Leeson	KCC – Corporate Director – Education and Young People's Services
Hazel Carpenter	NHS – Sue Mullin substituting
Mark Lobban	KCC - Director of Strategic Commissioning
Michael Thomas-Sam	KCC - Strategic Business Adviser

		ACTION
1.	**Minutes of the last meeting and Matters Arising:** Accuracy of minutes agreed. **CAMHS contract:** TW confirmed the contract had not been extended at the time of the last meeting. This was a misunderstanding. Members have now been consulted and Children's Social Care and Health Cabinet Committee agreed it should be extended subject to some modifications to the contract which are being drafted. **OfSTED inspection:** KCC's Improvement Journey narrative is currently being drafted. TW will share with partners KS confirmed the required action on the Emotional Health Strategy had been carried out and GR confirmed her action **Teenage Pregnancy Strategy:** CT confirmed this will come to the next meeting of this board	TW JDP/CT
2.	**Emotional Well Being Strategy Delivery Plan**:	

	AI reported that the event at the Kent Showground was very successful in moving things on and was particularly pleased about the involvement of the young people. DH briefed the Board that following approval of the draft strategy a public consultation had taken place. There were 134 responses most of which gave full support to the proposed approach. Subsequent to this Amy Merritt developed the Delivery Plan with partners. DH recommended the strategy goes for Scrutiny as this is a major service. He further recommended the Task and Finish group continue to ensure delivery of the delivery plan. Amy Merritt talked the Board through the Delivery Plan, the different levels of support and how they are envisaged working as part of a holistic service. She underlined that the Task and Finish group would need to drive forward implementation across all the relevant services and that implementation would not just be about commissioning. PS asked about tier 3.5 ID clarified this is because there are currently 2 different services in specialist CAMHS; tier 4 being commissioned by NHS England and this helps to differentiate between them (crisis service in Tier 3 and Tier 4 outreach) DH agreed to take forward work to align the services and the resource. It was agreed that the Task and Finish group would continue and would ensure progress of the Delivery Plan, reporting back to this Board any barriers to progress as necessary. AI outlined the next steps: • CHWBB approve the strategy and it goes to HWBB for final approval. • The delivery plan needs to include the procurement process with clearly mapped out milestones, including agreeing the specification and finance. If 'invest to save' decisions need to be made then the case must be clearly made. • Communicating and engaging partners, especially schools and GPs in particular will be a challenge and this needs to be clarified in the plan. • Need to check it 'sits well' with the thresholds for SCS referrals. FK: We need to think about linking up eg to the Headteacher Forum. The above points were agreed. The Task and Finish group were asked to work up the points above into the plan and circulate to the members of the CHWBB for the March meeting. The high level strategy was agreed and it was further agreed it should go to Health Scrutiny by AI and PO. AI thanked AM for all her work to take forward the strategy and action plan and wished her well in her new post.	T&F Group T&F Group
3.	**Update on COGs and CHWBB Plan** A paper which had previously been discussed and agreed at the HWBB, was shared. TW talked through the paper to help Board members understand the complexity of integration of services for children and young people. The 5 recommendations (below) were discussed: **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. **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. **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. **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. **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. It was agreed that a workshop should be held to look at how we work together with CCGs, Districts and KCC represented both at this Board and locally. It was agree that 1 event may not be enough and it was essential the District Council chiefs are engaged in a conversation. AK agreed to draft a paper to the District Chiefs before the workshop. It was agreed there should be areas of focus rather than 'motherhood and apple pie' and that thought could be given to the JSNA and the current priorities in the HWB Strategy. AK said the governance must be right and we need better communications - eg reorganisations need to be communicated to partners as well as internally and we need to think about what our shared model for change is. AI said we need to resolve CCG boundary issues with Districts and what is missing locally that these groups need to be delivering and achieving. TW agreed to attend the Joint Chiefs meeting on March 12th and to meet AK first. PO said once we are clear what the COGs are for then we can decide who should sit on them. We won't get it right from day 1, there needs to be a process. If KCC wants them to happen we need to put in the resource and make sure they are held accountable and report on their progress. DS, DH, FK volunteered to help TW and AK to take this work forward AI asked for an update at the next meeting. FK to send AK information on the new Early Help arrangements and key contacts to share across the Districts	TW KS FK/KS TW/AK TW FK/AK
4.	**Update on protocol on the working arrangements between HWB, KSCB and CHWB** JMB introduced her paper. It was approved to go forward to the next stage of the approval process, but board members underlined the fact that the test will be in how we translate it into reality, what difference it makes to outcomes for children and families.	

5.	**Outcome 1 of the HWB Strategy: Every child has the best start in life** DS said we must think about the way we do things differently and move away from medicalising things such as support for speech and language, developing models like that for the Emotional Wellbeing Strategy. After discussion as to the best way to take forward the review it was agreed that the CHWBB planning group should start this work. All partners were asked again to confirm members of this group.	TW
6.	**Update and Plan on Speech and Language and Behaviour services in Kent NHS** TW reported that Martin Cunnington (MC) was not able to attend the meeting but he had sent an email. AI said he expected MC to produce a paper and attend the next meeting of the Board as this is an extremely important area of work; the Board needs to understand and discuss the issues fully in order to help move things forward.	TW/JDP
8.	**AOB:** It was agreed that the May meeting date be changed as it is during half term. JDP to add DS to mailing list for this Board **Date of next meeting:** 25th March 2015 Darent Room, 2.00 – 4.30	JDP

Children's Health and Wellbeing Board

25th March 2015
Medway Room, Sessions House, Sessions House

MINUTES

In attendance:

Andrew Ireland (AI)	KCC – Corporate Director – Social Care, Health & Wellbeing (Chair)
Peter Oakford (PO)	KCC - Cabinet Member SCS
Debbie Stock (DS)	NHS – Dartford, Gravesham, Swanley and Swale CCG Chief Operating Officer
Philip Segurola (PS)	KCC - Acting Director Specialist Children's Services
Florence Kroll (FK)	KCC - Director Early Help and Preventative Services
Karen Sharp (KS)	KCC - Head of Public Health Commissioning
Sue Mullin (SM)	For Hazel Carpenter - NHS - South Kent Coast CCG & NHS Thanet CCG, Accountable Officer
Jennifer Maiden Brooks (JMB)	KCC – Policy Manager
Jill De Paolis (JDP)	KCC - Commissioning Officer
Patrick Leeson (PL)	KCC – Corporate Director – Education and Young People's Services
Rebecca Walker (RW)	For Abdool Kara, Interim Strategic Housing and Health Manager, Swale District Council
Lee Russell (LR)	T/Supt Kent Police
Colin Thompson (CT)	Consultant in Public Health (Children)

Apologies:

Hazel Carpenter (HC)	NHS – Sue Mullin substituting
Abdool Kara (AK)	Kent District Councils Chief Executives
Thom Wilson (TW)	KCC - Head of Strategic Commissioning (Children's)
Gill Rigg (GR)	Kent Safeguarding Children Board Independent Chair
Mark Lobban (ML)	KCC - Director of Strategic Commissioning
Roger Gough (RG)	KCC - Cabinet Member Education and Health Reform
Michael Thomas-Sam (MTS)	KCC - Strategic Business Adviser

		ACTION
1	**Minutes of the last meeting and Matters Arising:** Accuracy of minutes agreed. DS asked the minutes be changed to add Swale to her job title	 JDP
2.	Speech and Language and Behaviour (ADHD and ASD) update. It was confirmed that Martin Cunnington had not progressed this work and that the CCGs are all withdrawing from the arrangements with the Health Commissioning Support Unit. DS said her understanding is that each CCG will look at SALT and behaviour. This was confirmed by SM. AI expressed concern about equity across Kent and said the CHWB would want to track this work. DS confirmed it is an area of priority for the CCGs.	
3.	**Update on Locality Working**  Microsoft PowerPoint 97-2003 Presentation JDP gave a short presentation on behalf of TW. Slides attached. DS said it's important there is no duplication. Purpose and prioritisation are critical and they must work on what cannot be done by others means. SM talked about the work of the COG in Thanet. She felt a clear mandate would be helpful	

	and developing a plan locally to deliver the mandate. She felt the group was essential for effective multi agency working with children and young people across the District. AI said we need to resolve whether there is central direction of the local groups. Independent chairs are part of that; also members may have views on their importance as core members of the groups. We'll probably need to agreed broad parameters and structure. Would we want to have a review and monitoring role and tighter targets etc. for these groups? It was agreed that the workshop needs to take place as a matter of urgency and the target start date for the new arrangements is September 2015. SM said HC had asked that senior leaders are invited to the workshop. TW to share list of invitees with AI. PL suggested that if Thanet and any other COG is particularly effective perhaps the workshop could look at what the crucial factors are to make this happen and that might be a good starting point for the workshop. FK expressed an interest in attending Thanet COG. PS suggested Dartford COG is also be worth a visit.	TW TW
4.	**Children's JSNA Update - CT** CT explained that the JSNA is not a single document, but a series of documents and a summary document, although currently there is not a summary for the children's JSNA. CT has met PL & TW to discuss what would be helpful and has been meeting with data people, but will now set up a group of key managers to "steer" the JSNA for children. The additional chapters will be completed by June. FK asked about particular groups or communities which may be vulnerable - e.g. gypsies & Roma. PL asked about Speech and Language and said it would be helpful to have specific recommendations. (e.g.: resources targeted to earliest years.) We need to have recommendations to help commissioners and suggested each section has a summary of key points or priorities for commissioners. LR welcomed the areas covered in CT's paper and felt that findings would be helpful for multi-agency work for CYP. DS reemphasised the importance of tackling Speech and Language in the same sort of way as Emotional and mental health; with a multi agency strategy including preventative work with parents. AI asked about ASD & ADHD – CT said this will come under disabilities. CT said he would make sure members of the Board got future Children's JSNA proposals and outlines for approval by the Board before being taken forward.	CT
6.	**0/25 Transformation Update – Plans for Implementation.**  Microsoft PowerPoint 97-2003 Presentation Presentation from FK and PS. Slides attached. They described the challenge of transformation whilst continuing to deliver business as usual. Work is being staggered to help with this.	
7.	**Sub Group Updates: -** **Disabilities** The group has renamed itself "Children and Young People Health and Well Being Board sub group on Disabilities". It also suggests that this Board change its name to reflect the fact that it covers some young people up to the age of 25	

	when they are no longer children. The group has been very active ensuring delivery of the requirements of the Care Act and KCC's own SEND Strategy. Effective joint commissioning is the aspiration. PL said good progress is being made but this is hampered by issues with the Health commissioning and links with all the Kent CCGs needs to be addressed with the decommissioning of the Health commissioning arrangements. The following work needs to be developed and agreed: • Seamless pathways for children and young people • Ways in which parents and CYP can be heard to influence this work. • Extending the dashboard to consider views of CYP and parents as their perception is now a PI. • More consistent approached via MASHs and any other arrangements (PL emphasized that MASHs are a good vehicle to achieve aspirations for seamless pathways) • Neurodevelopmental pathways: ASD diagnosis – good progress has been made but not on the delivery of support yet. • ADHD pathways are next. DS said it would be helpful if plans and issues were written up for the CCGs so they can understand them and take appropriate action to ensure the right people are represented on the sub group. DS suggested Speech and Language would be a good piece of work for the group to progress using the EHWB strategy development as a model. **Emotional & Mental Health** KS reported that the group continued to focus on delivery of the Strategy through development of an Action Plan. The needs assessment should come to the next board meeting. Delivery plan – being set in motion – workforce development. Also looking at aligning processes for access to CAMHS and Early Help. Lots of work is going on to ensure key points from the consultation are carried forward. The Strategy and Action Plan are also going through Governance processes with Cabinet Committee and HOSC. KS will bring a further report to next meeting of CHWB.	PL KS
8	**Kent Teenage Pregnancy Strategy** CT described how the strategy has been developed. If approved an Action Plan will be developed. The document was welcomed. It was felt it could be further improved with more local data and by clarifying what has worked well in Kent and what still needs further effort. Perhaps links to key documents as an appendix. KS also suggested local data would also be needed on range of issues for the new District COGs.	CT
9	**AOB:** None **Date of next meeting:** June 2nd, 2-4.30, Sessions House, Swale 2	

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Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **22nd April 2015.**

Present:

Councillor Michael Claughton – Chairman – Cabinet Member, ABC;
Navin Kumta – Vice-Chairman – Clinical Lead Ashford CCG;
Tracey Kerly – Head of Communities and Housing, ABC;
Philip Segurola –Director Specialist Children's Services, KCC;
Paula Parker – KCC Social Services;
Faiza Khan – Public Health, KCC;
Sheila Davison – Head of Health, Parking & Community Safety, ABC;
Simon Perks – Accountable Officer, CCG;
Neil Fisher – Head of Strategy and Planning, CCG;
Caroline Harris – HealthWatch Representative;
Martin Harvey – Patient Participation Representative (Lay Member for the CCG);
Tracy Dighton – Voluntary Sector Representative;
Mark Lemon – Policy and Strategic Partnerships, KCC;
Stephen Bell – Local Children's Trust;
Christina Fuller – Cultural Projects Manager, ABC.
Emma Hanson – Head of Strategic Commissioning and Community Support, KCC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;
Belinda King – Management Assistant, ABC;
Renu Sherchan – Environmental Health, ABC.

Also Present:

Councillor Paul Clokie

Apology:

Diane Aslett – Age UK.

1 Notes of the Meeting of the Board held on the 21st January 2015

1.1 Tracy Dighton referred to paragraph 4.12 and advised that her suggestion that the Chief Executive of Kent and Medway NHS and Social Care Partnership Trust be invited to a future meeting was supported by the Board.

Subject to the above comment, the Board agreed that the notes were a correct record.

2 Chairman's Report – Overview of Opportunities and Activity during the Year

2.1 The Chairman explained that his report represented a review of the past 12 months' activity. He believed it presented a positive view of the work

undertaken by the Board and recognised its importance in terms of improving services for the residents of Ashford. He considered that the profile of Health and Wellbeing Boards would increase and play a more strategic role following the General Election and he believed that this Board was travelling in the right direction.

The Board supported the Chairman's report.

3 Focus on Independent Living and Self-Management

3.1 Included with the Agenda papers was an introduction and covering report which set out details of the presentations the Board would receive and included recommendations for consideration.

(a) Building Community Capacity

3.2 Emma Hanson, Head of Strategic Commissioning and Community Support, KCC gave the above presentation. The presentation covered the Community Capacity Building Programme which explored the role that Community Support played in preventing or delaying the need for statutory services. It would support KCC in developing a commissioning approach for building community capacity including a core offer or menu of services to support wellbeing, social inclusion and independence across the County. The presentation also explained the work KCC were undertaking with the community of Wye which was a project about testing new models of care and support that were more commonly focused and accountable through working with local residents to co-design alternative models of care and support.

3.3 During the presentation Emma Hanson had mentioned that KCC currently commissioned services in Wye that supported 28 residents of Wye. Tracey Kerly asked what outcomes were expected if these funds were subsequently transferred to be allocated locally. Emma Hanson said that there were would be a reduction in costs and any surplus would be ploughed back in to the community allowing further work to be undertaken. She hoped that the initiative would reduce the number of emergency admissions to hospital and as part of the work, she would be working with both General Practitioners and the hospital on this initiative. Funding was available for one year for the pilot study. Paula Parker advised that KCC were utilising community wardens in enabling them to fulfil their community role in this area. The establishment of community agents would also allow them to work within the community and there was currently one of them for each CCG area.

3.4 In response to a question, Emma Hanson said that the funding for the services commissioned to support these residents had not been given to Wye but the discussions with them were talking about how this could be used in a different way to be of a mutual benefit to the community and also to KCC. KCC would not be looking for Parish Councils or the Borough Council to meet a shortfall in any provision and she emphasised it was about making sure that the services met the needs. Emma Hanson explained that if people at risk were identified at an earlier stage it would allow steps to be taken to put solutions in place prior to it reaching a point where it had to be treated as an emergency and an admission to hospital.

3.5 Emma Hanson provided details of the STAMP Programme which was supported by KCC, Public Health and the CCGs with a remit to help Kent Charities and social enterprises, manage the transition from grants/funding to commercial contracts. This organisation would work with partners in a different way and would feed in to the overall community strategy.

3.6 Emma Hanson made reference to the Community Wardens and a desire to increase their focus on health and social care. Sheila Davison emphasised that their community safety work already contributed significantly to health and welfare and therefore this needed to be treated with caution. Tracey Kerly explained that the sheltered housing scheme in Wye could be involved in developing this initiative and the Chairman suggested that this be taken forward outside of the meeting.

3.7 As part of the establishment of a Strategic Partnership Group, Emma Hanson said that she would welcome the appointment of an Ashford Borough Council representative on the Group.

3.8 Tracy Dighton referred to the difficulties, for example, of Managers in Children's Centres in drawing down additional funds to provide extra services. Emma Hanson explained that under the proposed model the Partnership would be tasked with sorting out the desired outcomes. They would work with other agencies to deal with the issue. In terms of courses run by STAMP, she advised that they did levy a charge for attendance at their events as it was considered preferable to charge a nominal amount rather than offer free spaces as this resulted in more people actually attending the events.

3.9 In terms of the pilot exercise, Emma Hanson considered that the work undertaken in Newington, Thanet could have relevance to Ashford's urban wards.

(b) Age UK Integrated Care Programme

3.10 Paula Parker, KCC Social Services gave a presentation on behalf of Diane Aslett of Age UK. The covering report explained that the purpose of the Age UK Integrated Care Programme was to co-develop with local partners new and innovative services that aimed to reduce the risk of and prevent vulnerable old people being admitted to hospital. The services would focus on maximising the independence and self-reliance of older people using a range of approaches including promoting self-management, peer support, building and maintaining social networks and practical support alongside existing health and social care interventions. Paula Parker drew attention to the link to a video set out within the presentation and encouraged members of the Board to view it outside of the meeting.

3.11 Caroline Harris said she had concerns in that there were less and less volunteers available and for those that did volunteer, their time was becoming stretched. She asked what could be done to help support the voluntary sector. Emma Hanson said that they were currently looking at the establishment of "spice credits" which could be earned and be used for example in gyms or for local attractions. She explained that she would

arrange for invitations to the launch of the Spice Credit Scheme to be sent to members of the Board. Councillor Clokie commented that if the credits were used to gain access to Local Authority run swimming pools then the Local Authority was subsidising the programme. Emma Hanson accepted this point but said that generally the credits could be used off peak and the other benefits from the use of the swimming pool were for example on the sales of food or beverages by that visitor. Emma Hanson encouraged all to come to the presentation and said that there was a strong evidence base that such a credit scheme would help in terms of supporting volunteers.

3.12 Tracy Dighton said she was aware of a pilot scheme entitled “Rother St Mary’s” and she agreed to forward the details to Emma Hanson.

3.13 In terms of the recommendations, Councillor Clokie referred to (d) and advised there had been concern expressed in Tenterden that the development at Danemore could involve three storeys. He therefore suggested an amendment to the wording of recommendation (d).

The Board recommended that:

(a) the detailed briefings on the projects be noted.

(b) consideration be given to how the projects can be supported by stakeholders and commissioners especially through the life of the projects.

(c) the update and outcomes be brought to future meetings.

(d) details of the redevelopment of the sheltered scheme at Danemore, Tenterden are yet to be confirmed and an update be brought to a future meeting.

(e) Ashford Borough Council be invited to appoint a representative to join the Strategic Partnership in Wye.

(f) more information be provided to the Ashford North Network.

(g) an invite be issued to Board members to the launch of the Spice Credit Scheme.

4 Planning for Tomorrow, Delivering Today – Strategic Commissioning Plan 2014-2019

4.1 Included within the Agenda papers was a summary of the above document, together with a copy of the full document. Neil Fisher explained that last year the Board had received a report on the five year Commissioning Plan which included the first two years’ Operation Plan. He said that the document before the Board was a refresh of year 2 and involved no strategic changes. He referred to certain targets and in particular to the fact that the target of 66.7% for Dementia diagnosis had not been achieved and was in the region of 52%.

4.2 In response to a question, Neil Fisher explained that the targets were not included within the document as the figures were not available to show the full year's performance. He said for the most part, the targets missed were not by a huge amount.

4.3 Simon Perks said he thought it would be useful for the Board to consider at a future meeting a report on the Constitutional Standards within which the CCG worked and which also identified the timescales when national targets had to be achieved. In terms of the target for patients being admitted, transferred or discharged within four hours from the arrival at the A & E Department, Simon Perks explained that the target was 95%, however, the current performance was around 90%. He said there was no one single answer as to why performance was at this level and advised that it had been included in the Hospital Trust's published improvement plan.

4.4 With reference to Dementia diagnosis, Simon Perks explained that the Canterbury CCG had achieved the target therefore further work was needed to be undertaken with Ashford's GP's to improve on performance. In terms of the William Harvey Hospital, Simon Perks explained that the CQC would return in July to undertake an assessment of improvements stemming from the Trust's improvement plan and at that time it may become clear as to whether the Hospital would be taken out of special measures. A new temporary Chief Executive was in post who wished to move beyond the current improvement plan and improve further. The Board agreed that it would be appropriate to invite the Chief Executive of the Trust to a future meeting of the Board.

The Board recommended that:

(a) the Strategic Commissioning Plan 2014-2019 be supported.

(b) a report be submitted to a future meeting of the Board on the CCGs Constitutional Standards.

(c) the Chief Executive of the East Kent Hospitals University NHS Foundation Trust be invited to the meeting of the Board to be held in October 2015.

5 Ashford Local Performance Plan

5.1 The report explained that the Ashford Local Performance Plan was a live document which illustrated the range of activities and programmes delivered in the Ashford Clinical Commissioning Group area, organised under the five Kent Health and Wellbeing Strategy outcomes. Faiza Khan took the Board through the report and asked whether the Board wished to concentrate on fewer of the outcomes rather than all of them.

5.2 Sheila Davison said that the Board would be refreshing its own priorities at its meeting in October 2015 and advised that currently the Board had five priorities it was currently working on.

5.3 Mark Lemon explained that the County Council had organised an event to be held on the 17th June 2015 at the County Showground to undertake a stocktake of the work undertaken to date on the health and wellbeing strategy and he asked that any members of the Board who wished to attend to let him know and he would arrange for an invitation to be sent.

The Board recommended that:

(a) the contents of the Ashford Local Performance Plan be noted.

(b) it be agreed that the Ashford Lead Officers Group raise any specific concerns and/or good practice that arise from the plan to the Ashford Health and Wellbeing Board.

(c) a number of key priority activities be identified and regular updates and reports be received on the progress of these activities.

(d) the plan be endorsed as an information resource to update the Kent Health and Wellbeing Board on Ashford's local achievements in relation to the Kent Health and Wellbeing Strategy priorities and outcomes.

(e) Board members be invited to contact Mark Lemon direct for invitations to the KCC Joint Health and Wellbeing Strategy event on the 17th June 2015 at 10am the County Showground, Maidstone.

6 Kent Health and Wellbeing Board Meeting and Strategy Update

6.1 Set out on the cover of the Agenda was a link to the Agendas and Minutes of the Kent Board.

6.2 Navin Kumta said that the most important item dealt with by the Kent Board was the Commissioning Plan of the CCG and the plan for Public Health. He also explained that a report on the Better Care Fund would be submitted to the next meeting of the main Kent Board.

The Board noted the report.

7 Partner Updates

7.1 Included with the Agenda were A4 templates submitted by Partners:-

(a) Clinical Commissioning Group (CCG)

Simon Perks said that in terms of A & E there were a number of initiatives in progress to improve the performance.

(b) Kent County Council (Social Services)

Noted.

(c) Kent County Council (Public Health)

Faiza Khan drew attention to the report and in particular to the initiatives involving smoke free parks and play spaces; the Alcohol Strategy; tobacco control; CAMHS; and breast feeding. She also explained that the contract would shortly be awarded to provide sexual health services for East Kent and that this will be the subject of a consultation process to determine location of services.

(**d) Ashford Borough Council**

Tracey Kerly gave an update and explained that the Little Hill Extra Care Scheme was on target, however, the project at Farrow Court was delayed with the first phase now due for initial completion by early July 2015 and the second phase by early 2017. It was also noted that the previous week the Council had supported the acquisition of the Park Mall shopping centre and Wilko store premises. She also explained that she had attended the launch of the Smoke Free Play Spaces scheme and she advised that the play spaces were being well used.

(e) Ashford Children and Young Persons Health and Wellbeing Committee

Stephen Bell explained that in terms of mental health, the provision for these services for young people should involve only a six week maximum wait. With reference to NEETS he advised that in terms of school leavers his organisation was unaware of what 12% of them were currently doing.

(f) Case Kent/Voluntary Sector Representative

Tracy Dighton explained that at the next Community Network meeting in Ashford, Neil Fisher from the CCG had agreed to speak and furthermore a representative from Kent County Council had agreed to attend to talk about the issue of contracting.

With reference to the Charing Gardening Club, the Chairman explained that at a recent Grants Gateway Panel £7,000 had been awarded to the organisation. He explained that at the Grants Panel Meeting it had been suggested that the Club undertake a disabled audit and he was pleased to report that this had now been done and the recommendations had been acted upon. The Chairman also said he was pleased that the organisations which had to be relocated from International House had all now successfully moved to new premises.

(g) HealthWatch Kent

Caroline Harris explained that their report on support received from GP's by mental health patients had been published on their website.

8 Forward Plan

8.1 The Board noted the Forward Plan of subsequent meetings of the Board.

9 Next Meeting

9.1 The next meeting would be held on the 22nd July 2015.

9.2 The Chairman explained that this was his last meeting of the Board and said he wished to thank everybody who had been involved with its work for their support. The Chairman also said that he was concerned about the future of the Board and advised that he had met with the Leader of the Council and the Chief Executive to discuss this issue. If it was not possible to identify another Chairman for the Board from the partners, it was possible that an independent Chairman could be appointed. He said that he would be willing to take on this role if asked.

9.3 Sheila Davison also said that the Board wished to give thanks to Councillor Claughton as Chairman for all his work.

(KRF/AEH)

MINS: Ashford Health & Wellbeing Board - 22.04.15

Queries concerning these minutes? Please contact Keith Fearon:
Telephone: 01233 330564 Email: keith.fearon@ashford.gov.uk
Agendas, Reports and Minutes are available on: www.ashford.gov.uk/committee

CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Wednesday, 25th March, 2015
at 6.00 pm in the The Guildhall, Westgate, Canterbury

Present: Velia Coffey (Chairman for the meeting)

Faiza Khan
Amber Christou
Neil Fisher
Mr Gibbens
Councillor Gilbey
Councillor Howes
Mark Lemon
Paula Parker
Simon Perks
Councillor Pugh
Jonathan Sexton
Sari Sirkia-Weaver
Hilary Clayden
Jayne Faulkner
Debbie Smith

1 APOLOGIES FOR ABSENCE
Mark Jones
Mark Kilbey
Cllr Sue Chandler
Cllr Andrew Bowles
Anne Tidmarsh
Steve Inett

2 MINUTES OF THE MEETING HELD ON 27 JANUARY 2015 AND ACTIONS
The minutes were approved as an accurate record.
All actions were reported as complete.

3 MATTERS ARISING
Item 4 Dementia Friendly Communities
Peter Marsh has made contact with Canterbury City Council and work is progressing.

Item 10 Children's Operational Group
A letter has been received from KCC and will be circulated with the minutes. A discussion was held at the Kent Health and Wellbeing Board (KHWB) around how the KHWB, Kent Children's Health and Wellbeing Board and the Children's Safeguarding Group relate. The KHWB will continue to review how the local Children's Health and Wellbeing Boards (CHWB) operate and relate across the district and it is likely that they will be established on a district basis. This has also been discussed at the Kent Council Leaders meeting.

4 LOCAL RESPONSE TO HEALTH AND WELLBEING STRATEGY - FAIZA KHAN

Faiza Khan gave a presentation and advised that she had used different sources of data to show areas where Canterbury is rated red against local or national standards.

It was highlighted that the key theme running through all the measures was to reduce inequalities within communities and improve access for all.

Faiza Khan invited questions and asked the Board to identify the key priorities for future focus.

A request was made to break the alcohol admissions statistics into age ranges.
Action: Neil Fisher to speak to the Community Safety Partnership (CSP) alcohol group to get more specific age related statistics on alcohol admissions.

A query was raised regarding the violent crime statistics as Canterbury is not usually flagged as problem area in this respect. It was noted that the CSP will deal with these issues so there may not be a need for the Health and Wellbeing Board to focus on it.

It was stated that primary care under diagnosis is a common problem and is often a result of over demand. There may be a need to look at health promotion services to help support primary care services and improve this situation rather than rely on improvements in primary care services which are already over stretched.

It was suggested that it may be useful to target specific GP practices where improvements can be made and that this approach may also help address inequalities of access within specific communities. Simon Perks reported that practices are encouraged to be more proactive and to compare themselves to their peers and to challenge themselves on areas where they feel they can improve.

It was noted that prevention should be included in any care pathway rather than starting the pathway at diagnosis.

The Board discussed the priorities and agreed to delegate identifying the priorities to the Core group.
Action: Core group to agree the priorities for the local response to the health and wellbeing strategy.

5 NHS CONSTITUTIONAL STANDARDS - SIMON PERKS

Simon Perks stated that the NHS constitution sets out what the NHS will do and to what standard. It forms part of Clinical Commissioning Group (CCG) performance framework however delivery of these standards has not been a high focus for the CCG and 4 standards now need to be improved upon. These will be a focus for the CCG for the near future

There are four key areas where standards have not been met:

- Referral to treatment – waiting times for routine surgery. Compliance is required by April 2015 but this will not be achieved until 2015/16.
- Diagnostics – diagnostic tests within 6 weeks. An improvement plan is in place and the CCG has been compliant since December 2014 so this is now being monitored.
- A&E waiting times – the CCG has performed poorly since the first quarter of 2014. There is whole system work being undertaken to try and address this situation.
- Secondary care mental health – Significant work is going into this.

Significant resource is being put into these standards and solutions are wide ranging and varied however there are some internal processes that need to be reviewed at East Kent Hospitals University NHS Trust (EKHUFT) to help streamline discharge processes and provide social care support packages to free up beds in a timely way and smooth the patient flow through the hospital.

It was noted that EKHUFT had had to respond to a Care Quality Commission inspection and this will have diverted some resource. There is now greater joint working between agencies such as social care, primary care etc and the CCG is looking at jointly commissioning services.

This is a less positive report to the one given Stuart Bain at EKHUFT last year. It was noted these are health economy issues rather than just local hospital issues and that changes in management at EKHUFT mean that things are improving now and EKHUFT is taking these issues very seriously.

6 CCG OPERATIONAL PLAN 2015/16 - NEIL FISHER

Neil Fisher gave a presentation on the Operating Plan for 2015/16. It was noted that this is still being developed of the nine strategic objectives, seven are set as part of the operating framework and are broken into three groups, effectiveness, experience and safety.

Action: The slides to be circulated with the minutes.

It was reported that the timeline for the post implementation review for dementia has not yet been set.

Simon Perks commented that business case timetables and post implementation review timetables are important steps forward and encourage focus on specific projects, their delivery, outcomes and financial implications.

7 CHILDREN'S OPERATIONAL GROUP (TO INCLUDE CAMHS) - SARI SIRKIA WEAVER

Sari Sirkia-Weaver presented the paper and invited questions from the floor or by e-mail following the meeting.

The following comments were made:
The KHWB recognises the importance of the work of the Childrens Operational Group (COG).
Encouraged to see work that being done on speech and language.
Dover COG are working well and within the district boundaries.

Action: Core Group to consider whether to ask Rick Bradley from KCA to present the Mind and Body Programme

8 REVIEW OF CURRENT STRUCTURE AND FUNCTION OF THE HEALTH AND WELLBEING BOARD - VELIA COFFEY / NEIL FISHER

Velia Coffey presented the structure charts for the Canterbury HWB and how it related to other groups. It was reported that these structures are in place to deliver on the priorities set by the Board.

Neil and Velia had updated the charts to show that the five key outcomes were each allocated to a working group but that some gaps had been identified and two other groups had now been included relating to KCC Public Health (as they commission on

behalf of the CCG) and also the Community Safety Partnership and its work on the Alcohol Strategy
Action: The structures to be circulated with the minutes.

It was noted that the CSP has a very important role to play in providing an overall picture of community health with regards to alcohol abuse, violence etc.

A query was raised as to the role of the HWB in the transformation of services, the level of complexity involved in these changes, and the expertise of the Board. It was agreed that the Core Group would decide whether these complex issues should be brought to the Board. It was noted that the HWB is not a decision making group and currently has no agreed Terms of Reference therefore had no powers to make decisions on these issues.

9 ANY OTHER BUSINESS
None.

10 DATE OF NEXT MEETING
26 May 2015 at 18.00 in the Canteen at Canterbury City Council Offices.

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 15 April 2015 at Gravesham Civic Centre.

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

Tania Smith	Dartford Borough Council
Matt Roberts	Dartford Borough Council
Lesley Bowles	Sevenoaks District Council
Melanie Norris	Gravesham Borough Council
Tristan Godfrey	Kent County Council
Terry Hall	Kent County Council
Anne Tidmarsh	Kent County Council
Natalie Brown	Kent County Council
Mark Walsh	Kent County Council
Dr Elizabeth Lunt	Clinical Commissioning Group
Su Xavier	Clinical Commissioning Group
Debbie Stock	Clinical Commissioning Group
Mike Gilbert	Clinical Commissioning Group
Cecilia Yardley	Healthwatch
Ed Shorter	West Kent Recovery Service - CRI

65. APOLOGIES FOR ABSENCE

The meeting opened with Councillor Ann Allen in the Chair due to the late arrival of Councillor Gough.

Apologies for absence were received from Sheri Green and Graham Harris, (Dartford Borough Council), Sarah Kilkie (Gravesham Borough Council), and Andrew Scott – Clark and Stuart Collins (Kent County Council).

An apology for lateness was received from the Chairman, Councillor Roger Gough.

66. DECLARATIONS OF INTEREST

There were no declarations of interest received.

67. MINUTES OF THE MEETING OF THE DARTFORD, GRAVESHAM, AND SWANLEY HEALTH AND WELLBEING BOARD.

The Minutes of the meeting of the Dartford, Gravesham and Swanley Health and Wellbeing Board, held on 11 February 2015 were confirmed as a correct record of that meeting.

Arising from the Minutes Cecilia Yardley reported that it was now proposed that Healthwatch would report its findings to the Kent HWB at their meeting in July. (Minute 55 refers)

68. KENT HEALTH AND WELLBEING BOARD AND MATTERS ARISING.

Councillor Gough took the Chair from this point forward in the meeting.

The Chairman explained that the Kent Board meeting on 18 March 2015 had mainly considered the Commissioning plans for the County, and that while these were important there was little of relevance for our Board to consider.

69. URGENT ITEMS

The Chairman reported that there were no urgent issues for the Board to consider but that in view of the time necessary to consider items 7 and 9 on the agenda he had agreed to defer consideration of item 8, Progress Against Board Priorities, to the meeting scheduled for 17 June 2015.

70. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS.

The Board received a position statement on actions arising from previous Board meetings.

Arising from this some concern was expressed at the delays in organising workshop events involving Kent Fire and Rescue (KFR), agreed at the meeting held on 29 October 2014.

It was noted that Councillor Ann Allen was to meet with KFR in the near future and would remind officers that this was still outstanding. It was therefore agreed that this should be progressed as a matter of urgency.

71. KENT ALCOHOL STRATEGY - LOCAL ACTION

The Chairman welcomed Mr Ed Shorter of the West Kent Recovery Service – CRI – the local Drug and Alcohol Treatment service, who gave the Board a briefing on his organisation's work in the local area aimed at lessening the effects of alcohol consumption.

He firstly outlined the aims of the Kent Wide Strategy, as set out below and explained that arising from these aims, his group had developed a six point pledge which addressed the local issues arising from the Strategy.

- 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.

He further explained the detail of the Pledge (set out below), explored the relevance of each point and considered the actions currently underway to deliver each point.

- Improve Prevention and Identification
- Improve the Quality of Treatment
- Co-ordinate Enforcement and Responsibility
- Tailor the plan to the local community
- Target Vulnerable groups and Tackle Health Inequalities
- Protect Children and Young People

Mr Shorter stressed the importance of training for health Care professionals, the development of robust links between CRI, local action groups and local commissioning groups, and the use of innovative approaches when dealing with street drinkers.

He went on to explain the importance of targeted approaches to diverse population groups and the development of links with mental health services, local interest groups victim support providers relating to domestic violence.

He also reiterated the need to target vulnerable groups and involve providers of support for troubled families in the support alcohol programme.

Finally Mr Shorter closed his presentation with requests for Commissioning Group attendance on the alcohol strategy and substance misuse task groups, and for the development of an alcohol liaison team in Darent Valley Hospital.

Ms Xavier asked if it were possible to extend the work currently underway in south and East Kent through into our Board area?

Mr Shorter responded that he was not sure if that were possible but stressed that the service currently provided by Darent Valley hospital was of the highest quality.

Cecilia Yardley asked if training was undertaken in mixed service groups as it was felt that this would foster higher levels of joint working following the event.

Mr Shorter confirmed that training groups were normally mixed, though more by accident than design.

Terry Hall enquired if the work undertaken in implementing the Strategy had any impact on issues relating to the use of so called “legal highs”?

Mr Shorter explained that this fell outside the remit of the Strategy although Mr Roberts confirmed that this was addressed by the Community Safety Teams and that initiatives were being explored to deal with this matter.

The following matters were raised and Mr Shorter agreed to respond on them direct:

- the interaction of the local strategy with the Public Health service (Dr Lunt)
- the development of links between Mental Health Services for children in families where drinking is a problem (Dr Lunt)
- risk analysis by Kent Fire and Rescue Officers (Dr Lunt)
- a query whether Swanley was receiving sufficient input from the Alcohol service (Lesley Bowles)
- training for early help staff (Mark Walsh)
- the level of access to services by older people (Anne Tidmarsh)

Councillor Gough thanked Mr Shorter for his presentation commenting that it was extremely informative and useful to Board Members. He added that the Board would be pleased to receive an update on the work of the Strategy in around six months time.

72. PROGRESS AGAINST DGSHWB PRIORITIES.

Further to item 69 above Members noted that consideration of this matter was to be deferred to the Board meeting on 17 June 2015.

73. UPDATE ON SERVICE PROVISION IN RESPONSE TO DEMOGRAPHIC CHANGES

Mr Mike Gilbert and Dr Su Xavier updated the Board on work which is being undertaken by the Clinical Commissioning Group (CCG) to understand and prepare the provision of medical services and facilities in the light of projected population growth in the Dartford, Gravesham and Swanley Board area.

Mr Gilbert reported that the CCG had established an analytical group comprising of the key stakeholders and that this was looking at

- Population projections (indigenous growth & Ebbsfleet specific)
- Predicted impact of growth on existing health services
- Predicted need for future health services
- Wider determinants of health

He added that the implications of the London Paramount Development had not yet been considered but were to be added in at a later stage.

Mr Gilbert gave an outline of the major development areas and informed the Board about the format of the model that was being used to project the scale of population growth being predicted in the Board area.

Dr Su Xavier explained how the shape of the predicted population would impact on the demand for health care in future years, and how the geographic and environmental outcomes arising from the developments would impact on the health of the population in the future.

Dr Xavier outlined current problems being experienced in health care provision, and considered the requirements of the current system to respond to that need, together with current reviews and strategies being pursued by the CCG.

Mr Gilbert returned to explain the current financial structure in which the CCG is functioning and the implications for the future which this has. He stressed that there was a significant gap in funding given population growth and that major investment would be required in capital infrastructure to support the growth identified in population.

Mr Gilbert concluded by explaining the following programme of work which it was planned to undertake as the next steps in the planning process.

- Analysis of specialty data
- Develop healthcare models – may include existing facilities development to accommodate new population
- Ongoing meetings with local authority planners to determine future community solutions
- Financial costings with providers for proposed models
- Meeting with developers

Arising from the presentation Board Members raised the following matters

- It would be good to see the scope of developments in the physical environment and infrastructure arising from the Garden city development

- There is a need to look at the placing of green spaces across the numerous developments to ensure that they are fit for purpose, and thought is given to the ideas of designing out crime when they are laid out.

- The marketing of the housing units could have a major impact on the client base for health services in the area.

At the conclusion of the presentation, the Chairman introduced Tania Smith from Dartford Borough Council, Planning division. Mrs Smith gave the Board an overview of the planning issues arising from new developments and the introduction of the Urban Development Corporation and highlighted the following points

- Development in Dartford was well underway
- Some developments will have impacts on service provisions outside the immediate area, and vice versa
- Dartford Planning Policy will still apply to ongoing developments – this requires a 30% open space provision in some of the larger developments
- Existing planning consents will dictate the shape of the infrastructure for Ebbsfleet Garden City and other developments in the Board area.
- There is currently liaison between local planners and the new Urban Development Corporation, and a number of matters have been re visited including the Master Plan for the Garden City and health provision in the area.
- It should not be forgotten that there is Government funding for the Garden City and thus there is a commitment to make it work.

Arising from this overview Mr Gilbert raised two points, firstly that it was important not to underestimate the impact of residents from adjoining areas on the service provided by Darent Valley Hospital, and that individual developers should not be allowed to select where they built, as the scenario could emerge where little or no open space was ever provided.

In drawing this whole matter to a close the Chairman proposed that

The Board meeting in June receives details of the Review of Health and Social Care being undertaken by the CCG, and other plans be reported when appropriate

That proposals on the new shape of service provision be added to the work plan for the Board

74. INFORMATION EXCHANGE

Ceclia Yardley informed Members of a number of issues relating to dementia which were relevant to the Board.

75. BOARD WORK PLAN

The Board received and noted a report on its work plan for the future and on a number of amendments which were made arising from this meeting.

The meeting closed at 5.10pm

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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, 20 January 2015 at 3.00 pm.

Present:

Chairman:	Councillor Dr J Chaudhuri (Vice-Chairman in the Chair)
Board:	Ms K Benbow S S Chandler P G Heath Councillor J Hollingsbee Mr M Lobban Councillor M Lyons Ms J Perfect Mr D Reid (as substitute for Councillor Mr S Inett)
Also Present:	Councillor P M Beresford (Dover District Council) Ms A Davis (Kent County Council) Mr M Mellor (Shepway District Council) Mr I Rudd (Kent County Council) Mr M Thomas-Sam (Kent County Council)
Officers:	Head of Leadership Support Leadership Support Officer Team Leader – Democratic Support

41 APOLOGIES

Apologies for absence were received from Mr S Inett (Healthwatch Kent) and Councillor G Lymer (Kent County Council).

42 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the agreed Terms of Reference, it was noted that Mr D Reid had been appointed as substitute for Mr S Inett.

43 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

44 MINUTES

It was agreed that the Minutes of the Board meeting held on 25 November 2014 be approved as a correct record and signed by the Chairman.

45 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

(a) Matters Raised On Notice By Members of the Board

There were no matters raised on notice by members of the Board.

(b) Matters referred by the Scrutiny (Community and Regeneration) Committee

The Board was advised that the Scrutiny (Community and Regeneration) Committee had requested that the Board include the issue of Suicide Prevention in its work programme.

Ms M Farrow stated that the work programme would be reviewed to see if an update could be provided to a future meeting of the Board.

RESOLVED: That updates be provided to the Board on the outcomes of the Kent Suicide Prevention Strategy at appropriate points.

46 SOUTH KENT COAST HEALTH & WELLBEING BOARD WORK PLAN REVIEW

Ms M Farrow advised the Board that a Development Day would be arranged for Board Members. The Development Day was needed as there had been a number of recent legislative changes that needed to be discussed and due to the volume of work undertaken by the Board's sub-groups.

RESOLVED: That a Development Day be arranged.

47 NHS FIVE YEAR FORWARD VIEW / INTEGRATED CARE ORGANISATION

The Board received a presentation from Ms K Benbow, Chief Operating Officer of the South Kent Coast Clinical Commissioning Group (SKCCCG) and Ms A Davis, Integration Programme, Kent County Council.

NHS Five Year Forward View

The NHS Five Year Forward View, published in October 2014, set out the vision for the NHS over the next five years including priorities for NHS operational delivery and new models of care to support better, more flexible working across traditional organisational boundaries. This supported existing work being undertaken by the SKCCCG in respect of integrated working.

There were four new models of care promoted by the strategy:

- Multi-specialty community providers – The CCG was looking to develop this model.
- Integrated primary and acute systems – This was more relevant to the Thanet CCG due to the presence of Queen Elizabeth the Queen Mother Hospital in Margate.
- New approaches to creating smaller viable hospitals – East Kent Hospitals were working with the clinical strategy to right size services with an emphasis on more treatment at home where appropriate.
- Enhanced health in care homes – The importance of integrated working with other partners such as social services to deliver improved care in care homes.

Integrated Care

Integrated Care was defined as hospital and community based services (social services, primary care, voluntary sector, health education, etc.) working together to provide a single care plan for the patient. In contrast, the current situation was one of a complex system with lots of boundaries and multiple care plans for the patient.

For the patient, integrated care would appear to be one cohesive, co-ordinated service (regardless of which organisation providers worked for) with one budget for the patient's care.

The components of Integrated Care were:

- Levels – Empowerment and self-care
- Person centred – Care delivered around a person's needs
- Data sharing – Integrated information used to develop shared care planning and anticipatory care planning
- Integrated community teams – Including GP's, specialist nursing, social care, mental health and consultants
- Integrated access – That 'no door should be the wrong door'
- Integrated skill mix – Generic skills across workforce with one assessment
- Integrated equipment and use of technology – The use of telehealth and telecare
- Crisis response and rapid response – quick action for patients and carers
- Integrated discharge teams – To reduce hospital admission and facilitating discharge
- Community capacity and community agents/navigators – Providing advice and support and building community networks

A central 'hub' formed an important part of delivering Integrated Care. While, Dover, Deal and Folkestone all had local hospitals that could service as hubs there still needed to be further work undertaken for Hythe and Romney Marsh for identifying a potential hub.

The Board was advised that there were still challenges to be resolved before Integrated Care could be delivered as this was only at the initial vision stage and there was still a 3 - 5 year programme of work to be undertaken. However, subject to the details being developed SKCCCG was keen to be a pioneer of this approach.

The role of the Health and Wellbeing Board was to provide oversight and encourage the integration of services in the development of Integrated Care.

The consensus view of the Board was that the Integrated Care approach was to be welcomed and links with other strategies, such as the Kent County Council Accommodation Strategy were highlighted.

RESOLVED: That the presentation be noted.

48 BETTER CARE FUND UPDATE

The Board received an update from Ms K Benbow, Chief Operating Officer of the South Kent Coast Clinical Commissioning Group (SKCCCG).

The Board was advised that the Kent-wide Better Care Fund Plan, which included the SKCCCG Plan, had been approved by NHS England and funding would be made available subject to the following standard conditions being met:

- That the Fund must be used in accordance with the approved Plan through a Section 75 pooled fund agreement; and

- That CCG's were only able to release the full value of the funds linked to non-elective admission reduction if the target was met in accordance with the Technical Guidance.

In response to a question over staff recruitment and retention, the Board was advised that no problems had been encountered to date, although primary care capacity was scarce.

RESOLVED: That the update be noted.

49 UPDATE ON THE A&E SITUATION LOCALLY

The Board received a verbal report from Ms K Benbow, Chief Operating Officer of the South Kent Coast Clinical Commissioning Group (SKCCCG) in response to a request from Councillor P A Watkins that the Board be updated on the situation.

The Board was advised that East Kent Hospitals had failed to meet the 95% target on Accident and Emergency (A&E) waiting times although despite this, East Kent Hospitals had been the best performing trust in Kent. A plan was in place to ensure the trust achieved the 95% target and as part of this an exercise called 'Perfect Week' would be undertaken to focus on the effective discharge of patients.

In addition, media was being used to encourage attendance at A&E only where necessary as a significant number of cases seen at A&E would have been more appropriately dealt with by primary care or minor injury units.

RESOLVED: That the update be noted.

50 CARE ACT 2014 IMPLEMENTATION

The Board received a presentation from Mr M Thomas-Sam, Strategic Business Adviser Social Care, Kent County Council on the implementation of the Care Act 2014.

The Care Act had a significant legislative impact, replacing or repealing a number of pieces of primary and secondary legislation. The key changes in the Act from April 2015 were:

- A duty to assess and meet the eligible needs of individuals with care and support needs and the eligible needs of their carers;
- A national minimum eligibility criteria – (a) needs related to physical or mental impairment; (b) inability to achieve at least two outcomes; and (c) significant impact on wellbeing.
- The power to charge for all types of care and support unless prohibited by law, although in practical terms no changes will take effect until 2016.
- The introduction of a new national Universal Deferred Payment scheme intended to prevent people from having to sell their homes in their lifetime in order to pay for their care. Instead, eligible people would have their care home bills paid for by the council until they chose to sell their home or upon their death.

- A duty to promote wellbeing, a duty to provide information, advice and access to independent financial advice and a duty to promote a diverse and high quality market of care and support services.

A further set of changes would be implemented from 2016 to establish new rights for residential self-funders, extend means-testing, and introducing a financial cap on care costs.

The Board was advised that in order to deliver these changes, a Care Act Implementation Programme had been set-up to identify the additional activity required (such as in providing assessments) and the estimated cost of delivering the Care Act's changes. A grant of 12.1 million had been provided by the Government towards the costs of implementing the Act.

There was concern expressed that in some individual circumstances it would be possible to spend more than the financial cap value before the cap itself came into effect and that as the Kent County Council care package costs were cheaper than the cost of commercial providers' packages, there would still be a financial burden for self-funders.

RESOLVED: That the presentation be noted.

51 CHILDREN'S OPERATIONAL GROUP UPDATE

Councillor S S Chandler advised that a 3rd stakeholder group meeting would be held in February and that an update would be provided to the next meeting.

RESOLVED: That the update be noted.

52 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 5.26 pm.

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Health and Wellbeing Board – Seventh Formal Meeting

Meeting held on Wednesday 18 March 2015 at 09:30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present	**Cllr Andrew Bowles (AB), *Leader, SBC (Chair)*** **Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC*** **Abdool Kara (AK), *Chief Executive, SBC*** **Amber Christou, *Head of Service Housing and Health, SBC*** **Cllr John Wright (JW), *Cabinet Member for Housing and Lead Member for Health, SBC*** **Colin Thompson (CT), *Public Health, KCC*** **Terry Hall (TH), *Public Health, KCC*** **Su Xavier (SX), *Swale CCG*** **Megan Philpott (MP), *Swale CCG*** **Helen Stewart (HS), *Kent Healthwatch***	**Tristan Godfrey (TG), *Policy Manager, KCC*** **Chris White (CW), *Swale CVS*** **Cllr Chris Smith (CS), *Deputy Cabinet Member Adult Social Care & Public Health, KCC*** **Steve Furber (SF), Vice-Chair, *Swale Mental Health Action Group*** **Becky Walker (BW), *Interim Strategic Housing and Health Manager, SBC Housing*** **Carol O'Maley (COM), *Family Nurse Partnership*** **Christy Holden (CH), *Head of Strategic Commissioning – Accommodation Solutions, KCC***
Apologies	**Patricia Davies (PD), *Accountable Officer, Swale CCG*** **Dr Fiona Armstrong (FA), *Chair, Swale CCG*** **Debbie Stock (DS), *Chief Operating Officer, Swale CCG*** **Paula Parker (PP), *Commissioning Manager, KCC***	**Penny Southern (PS), *Director Learning Disability and Mental Health, KCC*** **Alan Heyes (AH), *Community Engagement Lead, Mental Health Matters***

NO	ITEM	ACTION
1.	**Introductions**	
1.1	AB 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.1, 2.2: PP to share a list of respite/support services for dementia carers – to be carried forward ▪ p.2, 3.1: TG advised wording on point two to be amended to read "The	**PP**

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	national eligibility criteria will ***be on a par*** with KCC's existing criteria, which is set at ***moderate***;" ▪ p.4, 7.1: AC advised the ToR is being revised ▪ p.4, 9.1: AK advised the COG will not be established prior to June 2015 ▪ p.5, 10.4: SF apologised for the delay in providing the Wellbeing Café update, and advised this should be ready in the next few days. SF to provide to BW.	**SF**
3.	**KCC Accommodation Strategy**	
3.1	CH introduced a presentation on KCC's Accommodation Strategy focusing on older persons housing. The key points were: ▪ the strategy was launched in July 2014 and is available on-line; ▪ this strategy is required to secure better accommodation outcomes, make savings, and provide modern fit-for-purpose accommodation; ▪ the strategy is district-based, with analysis going up to 2021; ▪ placement patterns were looked at and it was found that there are many cross-district placements; ▪ 2,500 units are required across Kent, with the need to increase extra care provision in particular; ▪ there is a requirement to increase nursing care by 2,000 units, and a need to increase the workforce to support this; ▪ the national vacancy rate for older persons schemes is 7% compared with Kent which is 3%; ▪ there is a 30% increased need for accommodation for those aged 85yrs+; ▪ there is a need to review care provision after hospital discharge; and ▪ the Isle of Sheppey is a priority where there is a case to incentivise build of accommodation.	
3.2	Points made in the discussion included: ▪ need to get homes inspected in plenty of time before discharge to ensure they are fit and adequate. Requires multi-agency approach to discharge; ▪ adaptations should be carried out as early as possible to avoid the use of nursing homes in the short term. Adaptations works should be 'up-streamed' to ensure completion prior to discharge. This can be managed by Swale BC's HIA; ▪ there are rehabilitation facilities at Sheppey Hospital that are not being fully utilised, and cottage hospitals could also be used for respite care; ▪ requirement for a matched workforce to patient needs; ▪ there is a working group looking at all issues raised, which will be escalated through the CCG Executive Board; ▪ the community service review is critical to driving the needs outlined in the strategy forward. Community hospitals are not directly under the	

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	CCGs, although they are being reviewed and this may enable them to be utilised to avoid bed-blocking and provide respite beds on the Island; ▪ a request was made for the presentation slides to be emailed out; and ▪ a request made for a synopsis of the discussion to be sent to AB.	 **RW** **RW**
4.	**Falls Prevention**	
4.1	PP was unfortunately unable to attend to present on this item. It was agreed to reschedule for a future meeting.	**RW**
5.	**Family Nurse Partnership**	
5.1	COM introduced a presentation on the FNP. The key points were: ▪ available to first time mums under the age of 20 years and until their child turns two; ▪ focuses on increasing breastfeeding rates, reducing smoking during pregnancy rates, increase father involvement, increase employment and reduce welfare dependency, better antenatal health, reduce substance misuse, increase school readiness, and prolong time between subsequent births; ▪ use of a client-focused behaviour changing model; ▪ two FNPs working in Swale with capacity for 25 clients each - at the end of January 2014 had 44 cases, although aware there are 114 clients who could access the service; and ▪ referrals are via midwife, but also welcomed from other agencies at kcht.FNP@nhs.net.	
5.2	Points made in the discussion included: ▪ reiterated that the clients must be 20 years or younger to participate as this is a licence requirement of the programme and is only available to first time mums; ▪ the programme is looking to be expanded across all Kent districts; and ▪ FNP work closely with children centres, assessing client's readiness to engage in other service provision. Handover to health visitor when child turns two years old.	
6.	**Swale Health & Wellbeing Improvement Partnership Update**	
6.1	CT gave an overview of the KH&WIP priorities: ▪ Eight priorities were suggested by KH&WIP which were presented to PSB last week for feedback. This resulted in six priorities being recommended: 1. Reduce obesity through physical activity and healthy nutrition 2. Reducing increased and higher risk alcohol use, substance misuse and legal highs 3. Prevent and reduce mental ill health and improve identification and diagnosis rates	

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	4. Promote and increase dementia services and diagnosis rates 5. Reduce the number of falls within the home amongst over-65 and work to reduce length of hospital stay of those who have fallen 6. Reduce smoking across all groups ▪ The action plan will be populated through KH&WIP. The final draft will be signed off at the next Swale H&WB.	**RW**
6.2	Points made in the discussion included: ▪ social isolation should be included as a priority - it was noted that this links across priorities 2, 3, 4 and 5, although we can consider making it the seventh priority; ▪ access to services was also discussed, and it was noted that this links across all priorities; and ▪ require short, medium, and long term gains, and agreed action target dates should be measured at one year to allow for review and adjustment.	**RW**
7.	**Better Care Fund**	
7.1	TG provided an update on the Better Care Fund (BCF). A short paper to be taken for sign off to Kent H&WB 18 March meeting.	
7.2	Points made in the discussion included: ▪ Chief Finance Officers group changing to an overarching monitoring group, and exploring local options for sub groups; ▪ focus on integrated discharge or primary care teams with increased work around dementia pathway, reducing admission and increasing successful discharge; ▪ no more than three sub groups should be in place with prevention plan/ strategy beyond care and health and focusing borough-wide; and ▪ may require a parent and early intervention sub group.	
8.	**Kent Health & Wellbeing Board**	
8.1	AC updated on Kent Health & Wellbeing Board. The key issues was the revised draft Protocol, setting out the working arrangements between the KHWB, Kent Children's Health and Wellbeing Board (CHWB), and Kent Safeguarding Children Board (KSCB).	
8.2	A communications plan will be discussed at the KHWB meeting 18 March.	
9.	**Partners' Update/AOB**	
9.1	**Swale Borough Council** ▪ SBC went Live with Universal Credit on 16 March for single claimants only. Two clients processed to date. ▪ Planning permission for the Town Centre regeneration granted at Planning Committee on 16 March - start on site summer 2015.	

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	▪ The pre-election period commences 20 March.	
9.2	**Kent Healthwatch** ▪ Healthwatch held a Swale public engagement event on 11 March. ▪ Overview provided of the Healthwatch Kent Care Home Programme that examined provision in three homes across the county, and suggested recommendations. ▪ Overview provided of the report undertaken on Mental Health and GP support, with the aim to work with commissioners, NHS England and GPs to improve the experiences of mental health patients.	
9.3	**Public Health** ▪ Andrew Scott-Clark has been appointed as the Director of Public Health at KCC.	
9.4	**Mental Health Matters** ▪ Many organisations remain unclear about funding for mental health services 2015 and into 2016.	

Next meeting date: **Wednesday 20 May 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):

15 July 2015

16 September 2015

18 November 2015

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 12 February 2015 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Councillors Johnston (Thanet District Council), Hazel Carpenter (Thanet Clinical Commissioning Group), Esme Chilton (Future Creative), E Green (Thanet District Council), Madeline Homer (Thanet District Council) and Mark Lobban (Kent County Council)

In Attendance: Jonathan Bates (Thanet Clinical Commissioning Group); Penny Button (Thanet District Council); Linda Smith (Kent County Council)

1. APOLOGIES FOR ABSENCE

Apologies were received from Andrew Scott-Clark, for whom Linda Smith was present as substitute. Apologies were also received from Mark Elliot and Councillor Gibbens.

2. DECLARATION OF INTERESTS

No declarations of interest were received.

3. MINUTES OF THE PREVIOUS MEETING

Esme Chilton noted that the second to last paragraph of page two which referred to safeguarding children, should be moved to the end of the agenda item to avoid confusion with hip fractures.

The minutes of the previous meeting held on 13 November 2014 were agreed subject to the amendment.

4. ALCOHOL STRATEGY: LOCAL PLAN PROGRESS REPORT

Linda Smith, Public Health Specialist, Kent County Council, provided a progress update on the Thanet Alcohol Plan (2014-16) which implemented the Kent Alcohol Strategy (2014-16) at a local level.

In response to comments and questions, it was noted that:

- the plan was in an early stage of design and was publically available. The document would be updated and developed as a result of feedback.
- it was the intention to develop electronic scratch cards which, like the paper versions, would encourage people to think about how much they drank. The electronic scratch cards could be available on intranet sites for access by employees.
- an important element of the alcohol strategy for Kent was early intervention with a focus on partnership working.
- while progress had been made in the under 25's age category, the age group drinking the most appeared to be the over 55's. It was suggested that this could be for a number of reasons including bereavement and loneliness.

The report was noted.

5. INTEGRATED CARE ORGANISATION

Hazel Carpenter, Accountable Officer, Thanet Clinical Commissioning Group, presented the report noting that the need for change was generated from a number of pressures including an increasing demand for care, reduced funding and fragmented services. Hazel added that depending on the result of the upcoming general election, the Health and Wellbeing Board may take a more active role in the future.

In response to questions and comments Hazel responded that:

- integrated care included in hospital and out of hospital care, as well as long and short term care;
- there was acknowledgement that mental health support was not always available when needed;
- patients would have access to their own medical notes from 1st April 15, this would be a complex process to put in place, and there were concerns about how patients would use the information;
- it was recognised that whilst there is a shared vision, every component within the organisation would have their own challenges in reaching that goal.

The report was noted.

6. BETTER CARE FUND

Jonathan Bates, Chief Finance Office, Thanet Clinical Commissioning Group, gave a report noting that the Government wished to further integrate health and social care. In order to encourage this, the budgets for health and social care would be merged from the 1st April 2015, and as a result, legal and financial frameworks had been produced.

Jonathan added that Local Health and Wellbeing Boards should look at how services could work together to reduce gaps and duplication in service provision. While legal oversight would remain with Kent County Council and the Clinical Commissioning Group, in practice local Health and Wellbeing Boards would drive and formulate the change.

A Member suggested that some training or a workshop might be useful for THWB Members in order to prepare for this.

7. DEVELOPMENT OF THE THANET HEALTH AND WELLBEING BOARD

Madeline Homer, Acting Chief Executive and Director of Community Services, Thanet District Council, advised that there would be an executive group that would support the Thanet Health and Wellbeing Board. Feedback from this executive group would be provided at the next THWB meeting.

8. AGENDA TOPICS FOR THE NEXT MEETING

It was suggested that the following items be included on the next Thanet Health Wellbeing Board meeting agenda:

- Development of the Thanet Health and Wellbeing Board.
- Report on the work of the Children's Board.

- Report on Dementia.

Meeting concluded : 11.30 am

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WEST KENT CCG HEALTH AND WELLBEING BOARD

DRAFT MINUTES OF THE MEETING HELD ON TUESDAY 17TH MARCH 2015

Present:

Cllr Roger Gough (Chair)	Chair of Kent Health and Wellbeing Board
William Benson	Chief Executive, Tunbridge Wells District Council
Cllr Annabelle Blackmore	Leader of Maidstone Borough Council
Lesley Bowles	Chief Officer for Communities & Business, Sevenoaks District Council
Hayley Brooks	Health and Communities Manager, Sevenoaks District Council
Alison Broom	Chief Executive, Maidstone Borough Council
Cllr Alison Cook	Sevenoaks District Councillor
Nick Fenton	Head of Service (West), Early Help and Prevention, Education and Young Peoples Directorate, Kent County Council
Mark Gilbert	Public Health, Commissioning and Performance Manager (Public Health) Kent County Council
Wayne Gough	Business Planning and Strategy Manager (Public Health)
Christine Grosskopf	Kent County Council
Mark Lemon	Kent County Council
Louise Matthews	Deputy Chief Operating Officer, WK CCG
Mark Raymond	Tonbridge and Malling Borough Council
Cllr Mark Rhodes	Tonbridge and Malling Borough Council
Dr Andrew Roxburgh	GP Governing Body member, WK CCG, (Sevenoaks locality)
Penny Southern	Director of Learning Disability and Mental Health, Kent County Council
Malti Varshney	Consultant in Public Health, Kent County Council

In attendance:

Francesca Guy (minutes)	Deputy Company Secretary, WK CCG
Sophie Lyon	South East Commissioning Support Unit

1. WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting. Apologies had been received from the following:

Dr Bob Bowes (Cllr Roger Gough chaired the meeting on his behalf)
Gail Arnold, Chief Operating Officer, WK CCG
Julie Beilby, Chief Executive , Tonbridge and Malling Borough Council
Jane Heeley, Tonbridge and Malling Borough Council
Fran Holgate, HealthWatch
Dr Caroline Jessell, NHS England
Dr Tony Jones, GP Governing Body member, WK CCG
Reg Middleton, Chief Finance Officer, WK CCG
Dr Sanjay Singh, GP Governing Body member, WK CCG

Cllr Lynne Weatherly, Tunbridge Wells Borough Councillor

2. MINUTES OF THE MEETING HELD ON TUESDAY 20TH JANUARY 2015

RESOLVED: That the minutes of the meeting held on Tuesday 20th January 2015 be approved as a correct record.

3. MATTERS ARISING

The following actions were discussed:

4.15: Louise Matthews reported that it had not been possible to present the performance report for the Better Care Fund as the inaugural meeting had only taken place last week. It was anticipated that the first performance report could be presented to the May meeting of the West Kent Health and Wellbeing Board (WKHWB). **Action: Louise Matthews/Reg Middleton**

5.15: Malti Varshney reported that a task and finish group for the healthy weight programme had been established and progress would be reported to the WKHWB.

Malti Varshney agreed to check whether there were any outstanding actions from previous WKHWB meetings. **Action: Malti Varshney**

4. BEHAVIOURAL CHANGE CAMPAIGNS

4.1 Public Health Campaigns

Malti Varshney opened this discussion by stating that a coherent and systematic approach towards public health campaigns was needed which brought together actions from across the system.

Wayne Gough gave an overview of recent public health campaigns delivered by Kent County Council (KCC) and noted that there were broadly three approaches: service promotion; education and awareness raising; and social marketing campaigns. Examples of recent campaigns were flu vaccinations for pregnant women and HIV.

Dr Roxburgh commented that hepatitis B and C represented a similar risk to that of HIV and suggested that this could be an area of focus for a future campaign.

Alison Broom asked how campaigns could be used specifically to address health inequalities. Wayne Gough responded that smoking during pregnancy was an example of a campaign which targeted health inequalities. The focus of these types of campaigns was to understand the communities and the motivators for behaviour. Campaigns targeted at reducing health inequalities tended to use the social marketing approach.

Alison Broom asked whether there was an opportunity to link with healthy business initiatives eg if vaccinations could be administered in the work place, whether other options could be considered.

Alison Broom also asked whether people could be captured through children's centres. Wayne Gough agreed that there was more work to be done to develop relationships with children's centres.

Wayne Gough agreed to explore the above ideas further. **Action:** Wayne Gough

4.2 Approaches to changing behaviour and achieving better health

Mark Lemon presented his paper on approaches to changing behaviour and the factors that influenced the success of campaigns. The evidence highlighted the importance of understanding both the communities targeted and the motivation of the individuals within the community. It was also important to understand how best to deliver these messages, to understand the product offered and why people would want it. Social marketing had been shown to be an effective approach in delivering behavioural change messages.

Learning from other sectors

Alison Broom gave an overview of learning from other sectors and noted that the key themes were the importance of understanding the attitudes and behavioural preferences of individuals and developing a method to extrapolate this information to a whole-population approach. An example of a successful behavioural change campaign was the campaign by local government to promote recycling. Loyalty cards used by the retail sector also highlighted the importance of obtaining data on your customers.

The Chair commented that the starting point should be the data that was already available to identify the areas in which West Kent was an outlier. The next step would be to consider the campaign approach and to identify the assets available. The Chair added that this should include those areas within West Kent that were outliers, even if West Kent as a whole was not an outlier. The Chair added that the methodology to be applied to these groups should also be identified.

Mark Lemon commented that the data should be supported by soft intelligence and he emphasised the importance of testing the approach to ensure that it resonated with communities.

Cllr Alison Cook commented that she personally found campaigns that highlighted negative behaviours or that focussed on the cost to the NHS to have little impact. Cllr Cook suggested identifying best practice from other countries.

Cllr Annabelle Blackmore suggested obtaining feedback from campaigns across the country and identifying what had been successful.

The Health and Wellbeing Board agreed to trial this process with child obesity and to present the findings to the May WK HWB. Malti Varshney agreed to take forward the following:

- Identify what data was already available and to identify those areas where West Kent was an outlier;
- Drill down into the data to identify specific areas within West Kent that were outliers, even if West Kent as a whole was not an outlier;
- Gather soft intelligence to support the data;
- Agree the methodology.

Action: Malti Varshney

5. TOWARDS TOTAL PLACE

Financial and Service Overview of the Better Care Fund

Louise Matthews gave a presentation on the Better Care Fund, the funding that was available in West Kent and how this aligned to Mapping the Future.

Alison Broom asked what mechanism would need to be in place to start this conversation and how the WKHWB would make connections with what other services delivered eg Age UK and the British Red Cross. Louise Matthews responded that it would rely on joined up working.

The Chair noted that this was an opportunity to review what was working, even though the budgets had already been allocated. There was also an opportunity to learn from best practice in other areas eg the integrated discharge system in North Kent.

William Benson asked whether the membership of the board should have a representative from the acute trust to facilitate better partnership working.

Public Health Spending in West Kent

Mark Gilbert gave an overview of public health spend by programme area and the outcomes against each activity. Alison Broom asked whether there was any scope to develop the commissioning plan in a collaborative/co-designed way. Mark Gilbert confirmed that this was the intention going forward, however it would likely be by involvement rather than consultation. Malti Varshney added that there needed to be a population-level and lifestyle approach to commissioning, rather than a programme approach, and a paper to that effect was going to the Kent Health and Wellbeing Board the following day. Prevention should form part of various pathways and should not be a standalone programme. Alison Broom reiterated that future design and commissioning of public health services should involve partners. Malti Varshney and Mark Gilbert agreed to present the public health commissioning plan to the May meeting of the West Kent Health and Wellbeing Board.

Action: Malti Varshney/Mark Gilbert

A discussion followed about the fact that some services would need to be commissioned county-wide and therefore the WKHWB would need to understand what money was available in West Kent and what type of services were required.

William Benson and Cllr Alison Blackmore left the meeting.

Scope of future integrated commissioning

Alison Broom gave a presentation on approaches to commissioning and the next steps. The Chair commented that the starting point of a joint commissioning plan in West Kent was the continual review of the Better Care Fund.

Malti Varshney suggested setting up a sub-group comprising finance officers from each of the partners, in order to develop a common understanding of the total assets and resource available in West Kent and to develop a commissioning methodology. Alison Broom suggested that this approach would be too broad and instead suggested focussing on one particular outcome. Alison Broom and Malti Varshney agreed to discuss this further outside of the meeting. **Action: Alison Broom/Malti Varshney.**

Spending on out of hospital care in West Kent

The Health and Wellbeing Board noted that it was not yet clear how much was spent on out of hospital care in West Kent. Penny Southern commented that it was possible to give a breakdown of spend in certain areas eg mental health. Penny Southern agreed to discuss this further with Anne Tidmarsh and Malti Varshney outside of the meeting. **Action: Penny Southern.**

6. CHILDREN'S DEVELOPMENT INCLUDING TROUBLED FAMILIES

6.1 Local state of play and proposed governance arrangements

Hayley Brooks gave an update on progress against her action to work with all districts to understand what gaps there were in the governance arrangements for children's development. Ms Brooks reported that she would be convening a meeting of all chairs and local authority representatives to identify the common themes from the strategic plans and to ensure that the Children's Operational Groups (COGs) were working towards the same priorities. This would ensure that there was consistency in terms of reference and local objectives. Ms Brooks agreed to report back to the next WK HWB on the progress made. **Action: Hayley Brooks.**

Lesley Bowles commented that the Children's Operational Groups would be based on district boundaries rather than CCG boundaries and that some groups were already in place.

6.2 Update from Kent County Council Children and Young People's Services

Nick Fenton gave an update on the new structure of the Early Help and Prevention, Education and Young Peoples Directorate at Kent County Council. The department was

keen to support the work of the Children's Operational Groups which were at different stages of development. Mr Fenton gave an example of the reporting tool used by Dartford, Gravesham and Swale COG. The Health and Wellbeing Board agreed that this would be a useful tool.

Malti Varshney noted that children's and young people's health could be another key area of focus in terms of the total place perspective.

7. WEST KENT STRATEGIC NEEDS ASSESSMENT

RESOLVED: That a West Kent strategic needs assessment is undertaken for the use of the West Kent Health and Wellbeing Board.

Malti Varshney agreed to set up a group to take this action forward. **Action: Malti Varshney**

8. SYSTEM LEADERSHIP

Louise Matthews reported that the System Leadership document had been updated to reflect the comments made at the last meeting.

RESOLVED: The West Kent Health and Wellbeing Board approved the System Leadership Structure as outlined in the paper.

9. CARE ACT 2014

Christine Grosskopf joined the meeting to give a presentation on the Care Act 2014 and the impact this would have on service users.

Malti Varshney commented that these services needed to link with the CCG self-care strategy and other prevention services that had already been commissioned by the CCG.

10. ANY OTHER BUSINESS

There were no items of other business.

11. DATE OF NEXT MEETING

The date of the next meeting is Tuesday 19th May at Tunbridge Wells Borough Council, Committee Room B, Town Hall, Tunbridge Wells TN1 1RS.