AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 16th September, 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 F Cox, Ms P Davies, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Dr N Kumta, Dr E Lunt, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr S Phillips, Dr R Stewart, Cllr P Watkins and Cllr L Weatherly

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

UNRESTRICTED ITEMS

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

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes

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

To receive any declarations of interest by Members in items on the agenda for this meeting

4 Minutes of the Meeting held on 15 July 2015 (Pages 5 - 10)

To agree the minutes of the meeting held on 15 July 2015

5 Healthwatch Kent - Strategic Priorities 2015 and Annual Report for 2014/15 (Pages 11 - 44)

To note reports summarising Health Watch Kent's priorities for 2015 and the annual report which summarises activities for 2014/15

6 JSNA Recommendations Report (Pages 45 - 54)

To receive a report that outlines key recommendations from the Kent JSNA and related needs assessments that may be considered by CCGs and other commissioners represented on the Board for their next commissioning plans in 2016/17

7 NHS England South (South East): Preparations for winter 2015/16 (Pages 55 - 58)

To receive a report on the state of preparedness for winter

8 Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years)- (CAMHS) (Pages 59 - 72)

To receive a progress report on the development of the Emotional Wellbeing and Mental Health Service for Children, Young People and Young Adults in Kent

9 Kent Health and Wellbeing Board and Local Health and Wellbeing Boards Relationships and Future Options (Pages 73 - 86)

To discuss the recommendations set out in section 7 of the report

10 Developing the relationship between Kent's Health and Wellbeing Board and the voluntary sector (Pages 87 - 94)

To consider options for the board's strategic and local relationship with the VCS and identify next steps

11 Health and Social Care Integration (Pages 95 - 116)

To receive a report on the current status of the health and social care integration programme and a report on the progress made on the Kent Health and Social Care Integration Test Bed Site submission

12 Minutes of local health and wellbeing boards (Pages 117 - 166)

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

Ashford – 22 July
Canterbury and Coastal – 9 July
Dartford, Gravesham and Swanley – 19 August
Swale – 20 May and 15 July
Thanet – 11 June
West Kent 21 July

13 Dates of meetings for 2016-2017

To agree that meetings of the Health and Wellbeing Board will take place at 6:30pm on the following dates:

28 January, 16 March, 25 May, 20 July, 21 September, 23 November 2016 and 25 January and 22 March 2017.

14 Date of Next Meeting - 18 November 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, 8 September 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, 15 July 2015.

PRESENT: Mr R W Gough (Chairman), Mr I Ayres, Mr G K Gibbens, Mr M Gilbert (Substitute), Mr S Inett, Mr A Ireland, Dr M Jones, Dr N Kumta, Dr E Lunt, Dr T Martin, Ms J Mookherjee (Substitute), Cllr K Pugh (Substitute), Dr R Stewart, Mrs D Tomalin (Substitute) and Cllr P Watkins

IN ATTENDANCE: Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

154. Chairman's Welcome
(Item 1)

(1) The Chairman made announcements relating to the Health and Wellbeing Strategy event in June and the Charter for Homeless Health.

(2) He said that the Joint Health and Wellbeing Strategy event on the 17 June had been attended by over 100 colleagues from the health and social care system and that it had been an interesting morning with a stimulating debate led by Noel Plumridge.

(3) He also said the workshops at the event had generated ideas for improving ways of working together and a report on how they might be implemented would be made to the Health and Wellbeing Board later in the year.

(4) He thanked those who had attended and said a similar event was planned for 2016.

(5) The Chairman referred to the briefing note about the Homeless Health Charter that had been circulated to members of the board and said he would sign it, on behalf of the board, if members were happy for him to do so.

(6) The Chairman said links to Police training DVDs had been circulated in advance of the meeting and that they were useful background information for item 6 on the agenda – Mental Health- Mental Health Responding to a Crisis.

155. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr Armstrong, Dr Bowes, Cllr Bowles, Mrs H Carpenter, Mr Carter, Dr Cocker, Ms F Cox, Ms Davies, Mr Oakford, Mr Perks, Mr Scott-Clark and Cllr Weatherly. Cllr Pugh, Ms Tomalin, Mr Gilbert and Mrs Mookherjee attended as substitutes for Cllr Bowles, Ms Cox, Ms Davies and Mr Scott-Clark respectively.

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

There were no declarations of interest.

157. Minutes of the Meeting held on 20 May 2015
(Item 4)

Resolved that the minutes of the meeting held on 20 May 2015 are correctly recorded and that they be signed by the chairman.

158. One Public Estate Initiative
(Item 5)

(1) Rebecca Spore (Director of Infrastructure) and Ros Adby (Property Asset Strategy Manager) introduced the report which asked the board to review the benefits and examples of how the One Public Estates (OPE) initiative had supported health and social care integration in other parts of the country, and to consider whether this should be explored further in relation to the delivery of health and social care in Kent. The report also asked the board to consider the establishment of an asset collaboration sub-group.

(2) Ms Spore described the OPE initiative and circulated a diagram from the Department of Health's Local Estates Strategy that had been published in June 2015 and required all CCGs to have plans in place by the end of 2015 covering the primary care estate, community care and non-clinical estate.

(3) In response to questions and comments Ms Spore said that: the OPE initiative in Kent was bringing together public sector partners including NHS Property Services and some acute trusts; estate requirements needed to be driven by commissioning and service needs; KCC retained the freehold of schools run as academies; and was well placed to maximise opportunities to make more effective and efficient use of the public estate locally.

(4) During discussion concerns were raised about: committing resources to another initiative when organisations, particularly those not present, were "lean" and were facing challenges to deliver strategies and services within existing resources, as well as the complexity of primary care ownership and the ownership of all the estate used to deliver public services.

(5) Interviews carried out by Healthwatch had identified premises and estates as an issue.

(6) A pilot project to identify opportunities and to consider how the OPE might be implemented locally was suggested.

(7) Resolved that:
(a) Proposals for a pilot scheme to answer specific questions relating to estates be developed using an existing local project(s);

(b) Consideration be given to how the Department of Health's Local Estate Strategy and the requirement to establish local estates forums might fit with wider collaboration and integration of service commissioning and to possible links with the local health and wellbeing boards and the Health and Wellbeing Strategy.

159. Mental Health- Responding to a Crisis
(Item 6)

(1) The Chairman welcomed Dave Holman (Head of Mental Health Commissioning), DS Ann Lisseman, (Head of Criminal Justice Department, Strategic Partnerships Command - Kent Police), Penny Southern (Director of Disabled Children, Adults Learning Disability and Mental Health - KCC), Tim Woodhouse (Public Health Programme Manager - KCC), Malcolm McFrederick (Director of Operations – Kent and Medway NHS & Social Care Partnership Trust), Inspector Wayne Goodwin (Kent Police), Debbie Wade (Kent Police) and Sue Scamell (Mental Health Commissioning Manager - KCC) and invited them to give a presentation. A copy of the presentation is available on-line as an appendix to these minutes.

(2) In response to questions and comments the presenters gave the following further information.

(a) One of the keys to reducing the number of detentions under Section 136 of the Mental Health Act 1983 was communication with and training for police officers as well as having systems in place with partners.

(b) The Concordat was aiming for a consistent approach to crisis care while simultaneously recognising local needs and priorities. For example, West Kent had commissioned a Crisis Café in response to local need and the local community safety partnership had considered the Concordat.

(c) Work was underway to bring services for the treatment and management of Personality Disorders together with a view to reducing the number of detentions under Section 136, the numbers presenting at A&E and the numbers repeatedly phoning 111 as well providing appropriate and timely interventions to those in need.

(d) A mental health nurse was on duty in the Kent Police Control Room to give advice to officers on the ground. It was anticipated that in the future nurses and unmarked ambulances would be deployed to ensure individuals received appropriate health assessment and service.

(e) All front line police officers received mandatory training in dealing with people with mental health issues annually.

(f) Using a reduction in the Section 136 detentions was a crude measure and it was intended to develop and refine the indicators within the Concordat as data improved.

(g) Service users had requested a single point of contact.

(h) In response to a comment about the need for regular updates and specific data on improvements to and development of services, Mr Holman said the development of mental health services to avoid crisis and aid recovery was seen as an incremental process. The Concordat provided strategic direction and a mandate to work through specific issues resulting in specific outcomes.

(i) An action plan for every Crisis Concordat nationally was available on the Crisis Concordat website and the action plan for Kent was currently being refined.

(4) Resolved that:

(a) The work of the Kent and Medway Mental Health Crisis Care Concordat be supported;

(b) The governance framework of the Concordat group reporting progress annually to the Kent Health and Wellbeing Board be agreed;

(c) A report tracking the progress and impact of the Concordat be considered by the Health and Wellbeing Board within the next 6-9 months;

(d) Outcome 4 – People with Mental Health are supported to live well – of the Health and Wellbeing Strategy be reviewed.

160. Update on Quality and the Health and Wellbeing Board
(Item 7)

(1) Steve Inett (Chief Executive – Healthwatch) introduced Libby Lines (volunteer with Healthwatch) and paid tribute to the work she had done in conducting interviews and collating the information. He then gave a presentation, a copy of which is available on-line as an appendix to these minutes.

(2) During the discussion the importance and value of the public voice was recognised particularly in relation to finance, workforce and local engagement.

(3) The need to avoid duplication and ensure any workplan focussed on areas where the patient and Healthwatch perspective added value to the work of the board was acknowledged.

(4) The board was reminded of the work being undertaken by the Integration Pioneer Group to bring providers into the discussion and to support the Workforce Task and Finish Group to ensure no omissions or duplication. The Board was also informed that the Kent Integration Pioneer was part of various bids including an EU bid to become a test bed site to service local sites of innovation.

(5) The role of Healthwatch in: challenging assumptions about what should be communicated; retaining focus on key messages; and advising about the methods of communication and engagement was acknowledged.

(6) Resolved that:

(a) The priorities identified in the Quality Report form the priorities for the board;

(b) Healthwatch be asked to prepare a further report on messages to be communicated to the public in conjunction with the Integration Pioneer Communications Group;

(c) A regular report on progress, co-ordinated by Healthwatch, be received by the board.

161. Minutes of the Local Health and Wellbeing Boards
(Item 8)

Resolved that the minutes of local health and wellbeing boards be noted as follows:
Dartford, Gravesham and Swanley – 17 June 2015
West Kent – 19 May 2015.

162. Date of Next Meeting 16 September 2015
(Item 9)

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From: **Steve Inett, Chief Executive Healthwatch Kent**

To: **Health and Wellbeing Board – DATE**

Subject: **Healthwatch Kent – Strategic Priorities 2015**

Classification: **Unrestricted**

Summary
This report summarises Healthwatch Kent's Priorities for 2015 and includes details of how these priorities were decided upon.
Also included is Healthwatch Kent's Annual Report which summarises its activities for 2014/15.

Recommendation
The Health and Wellbeing Board is asked to note the reports.

1. Introduction

1.1 Healthwatch Kent has published a document which details its Priorities for 2015 and explains how these priorities were decided upon. Many of the priority areas will be relevant to Health & Well Being Board Members. Healthwatch will continue to update this group about their progress and work with relevant Members on individual project areas.

1.2 Healthwatch Kent's Annual Report is also enclosed which details their work for the 2014/15 timeframe. The reporting framework is determined by the Department of Health and the Care Quality Commission.

2. Recommendations

The Health and Wellbeing Board is asked to note both documents and to liaise directly with Healthwatch should you have any comment or wish to be involved.

3. Background Documents

3.1 There are no background documents.

3.2 Healthwatch Kent Strategic Priorities document is at Appendix 1
The Healthwatch Kent Annual Report is Appendix 2

4. Contact details

Steve Inett
Chief Executive Officer, Healthwatch
Tel: 07702911143
Email: steve@healthwatchkent.co.uk

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healthwatch
Kent

Healthwatch Kent
Annual Report 2014/15

Contents

Our vision, mission and values

Our mission

To raise the public's voice to improve the quality of local health and social care services in Kent.

Our vision

You, the public, are listened to, and involved in, improving our health and social care services in Kent.

We achieve this by

Listening to you about your experiences of health and social care services and taking those experiences to the people who commission health and social care services in Kent.

Our values

- Open and transparent
- Volunteer led
- Objective and balanced
- Working in partnership with organisations – no surprises
- Critical friend
- Balancing positive and negative, loud and quiet, many and few
- Truly represent residents of Kent

Foreward from our Chief Executive

This time last year, I was reflecting on the end of our first year and the progress we had made in setting up a new organisation, recruiting and training new volunteers. Now another year on, and Healthwatch feels very grown up.

We have nearly 70 volunteers all of whom are actively involved in supporting us in different aspects of our work. Together with our volunteers, we have embarked on a number of detailed projects and reviews of Kent's services. This work is already delivering changes for people who are receiving services right now or improving services for the future.

We passionately believe that by working in partnership with other organisations we can achieve more together. Although we have nearly 70 volunteers, we remain a small organisation covering a huge geographical area with vast differences and priorities from district to district. We continue to invest time in our relationships with the organisations who provide and commission health & social care services in Kent. These relationships mean that we are regularly approached for our input and advice on how best to engage with, and listen to the public. For example, we have recently completed some work in West Kent which saw us involving 215 people and organisations in the plans to improve stroke services. We are currently working in East Kent to ensure the public are involved in plans to change and improve hospital services. These relationships also mean that when we regularly request in-depth information from providers and commissioners about aspects of their work all of them have responded, and willingly work with us in our bid to improve services.

As we move into our third year we are conscious that we are not yet hearing enough from young people. We are planning a new project that looks to build our relationships with youth groups and engage better with young people. We are also looking to invest in new ways to build more meaningful relationships with the voluntary sector and people who are traditionally harder to reach.

This report details just some of the highlights from this year. We hope you find it useful. Do please get in touch if you would like to be involved in any way or would simply like more information.

You can reach us anytime on 0808 801 802 or via email on info@healthwatchkent.co.uk

Steve Inett
Chief Executive, Healthwatch Kent

Our volunteers

Our volunteers are essential to us. They are the life blood of Healthwatch Kent. They are involved in every single aspect of Healthwatch from making decisions about our priorities, through to helping us stuff envelopes. We simply could not function without them.

We asked one of our volunteers, Helen Stewart what it's like to be a volunteer with Healthwatch Kent.

Why did you become a volunteer?
I recently retired from social services but I still wanted to play an active role in improving services for people.

What do you do for Healthwatch?
All sorts! The time I have available varies so some weeks I do more than others but that is the great thing as Healthwatch is flexible and fits round my life.

I represent Healthwatch at meetings which means I update the meeting about the work that Healthwatch does. I also relay information back to Healthwatch about the work of the meeting group which in this case is the Swale Health & Well Being Board. My meeting report is used along with similar reports from lots of other volunteers as a source of information by our Information Gathering Group (IGG). I also sit on the IGG group which is one of Healthwatch's key Governance groups.

We are a mixture of volunteers and staff and we review and analyse all the information that comes to Healthwatch either from the public, from voluntary groups, meetings reports from people like me and intelligence from surveys and reports. We then make recommendations up to the Healthwatch Deliberations & Directions Group (DaDs) about what we think Healthwatch should be focusing on. The DaDs group is again made up of volunteers and they look at all the recommendations alongside the resources that we have and determine what our priorities and projects should be going forward.

I have been trained to do Enter & View visits. I am due to visit a mental health ward in Canterbury very soon and I have already completed a number of visits to hospitals and care homes. I've also been trained to be a facilitator which means when we meet with the public I know how best to gather their experiences and thoughts on services.

What does it mean to be a volunteer with Healthwatch?
I very much value the work I do with Healthwatch. It is so varied but we have already achieved so much. I am proud to be making a difference to the community I live in.

We have a huge variety of volunteer roles to suit all interests and availability. Give us a ring and find out more. Call our Volunteer Co-ordinator, Theresa on 0808 801 0102 or email theresa@healthwatchkent.co.uk

How do we work for you?

Feedback from people about their experiences of health and social care services is the information we use to do our job. We can't work to improve a service, if we don't know the issues, so we make it as easy as possible for people to talk to us:

- The Information and Signposting freephone line is the easiest way to contact us on **0808 801 0102**, Monday to Friday 10am to 4pm. We work hard to ensure we immediately answer any call received in the opening hours but if you have to leave a message we will ring you back within one working day.
- You can email us on **info@healthwatchkent.co.uk** and we will respond within two working days.
- You can text us on **07525 861639** and we will respond within two working days. You can request a British Sign Language Interpreter via our text service and they will arrange to meet with you.

The phone line cannot deal with complaints but can provide information about how to complain to the relevant organisation. We will continue to respond urgently to cases where people are potentially at risk or the quality of a service is extremely poor. We will continue to have quarterly liaisons with the main providers of health and social care services to share the anonymised feedback we have received from the public.

We also ensure that we meet people face to face:

- Anyone can go into their local Citizens Advice Bureau (CAB) and be helped to contact us.
- We hold four public meetings a year, in venues across the county, to update people on our work and gather feedback.
- We visit a different district council area each month and visit libraries, CABs, community groups and events. During these 'public voice' sessions we raise awareness of Healthwatch Kent and the freephone line, give information about patient rights and gather feedback of people's experiences of local services.
- We work with other organisations to deliver events to gather public views
- We work with voluntary organisations who feed us the views of their service users.
- We capture people's feedback via our website and social media. We also have a range of printed materials including a Speak Out form which people can complete and send back to us for free. Our leaflet is available in six languages.

We have proactively taken Healthwatch to many different communities this year. For example, we have visited the deaf community along with our British Sign Language Interpreter to gather experiences of people with hearing loss. We have also worked with our colleagues at Healthwatch Medway and Healthwatch East Sussex on joint projects as we recognise that Kent residents use services outside of the county borders. Equally, many East Sussex residents use Kent services.

In 2015/16 we will improve our accessibility to the most disadvantaged groups to ensure their voice is heard by commissioners and providers. We will continue to raise awareness of Healthwatch Kent amongst the public. You've told us that you want to see Healthwatch raising our profile so we are touring the Healthwatch Big Red Bus in June 2015 which will visit every district in Kent to raise awareness of Healthwatch Kent and gather feedback. We hope to see you there!

Every Comment Counts

What do we do with the information you share with us?

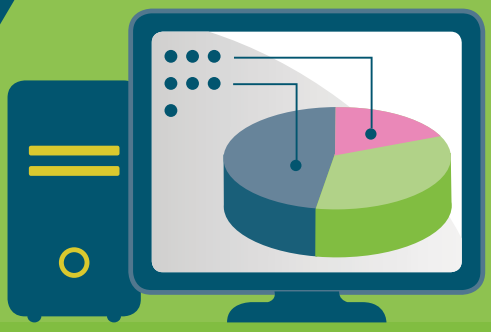
1 **Healthwatch Kent receives comments from the public (anonymously if you want).**

An example of a comment we have received: "My elderly aunt is in a care home and has a fortnightly chiropody appointment. The patient transport often turns up late. It's making her very worried about missing her appointments and not getting the treatment she needs"

We may signpost you to other organisations where appropriate (e.g. complaints department)

We will take immediate action over comments causing serious concern (e.g. safeguarding)

2 **The comments are put onto our database and reports of all comments are sent to health and care service managers.**



We check the comments on the database and look for areas with common themes, and of people who are experiencing a good or poor service.

For some big issues, we publish reports with findings and recommendations. This helps health and care service managers to understand what works best from the public's point of view.

3

Using our legal powers we can ensure that health and care managers respond, saying what action they will take.

4

You can read our reports on our website and find out more about current projects.

5

You can sign up for our regular newsletters, with news from around Kent

Information & signposting service

With all the changes to health and care services it's not always clear where you should go to report an urgent issue, to make a complaint, or for further information.

Healthwatch Kent can help you find the right services to suit your needs through our FREE Information & Signposting Service.

Although we can't give you advice or make specific recommendations, we can help you make an informed decision in finding the right health and social care service whether it is provided by the NHS, the Council, a voluntary or community organisation.

We know how complicated it can be to find your way around the health and social care system. Our team of trained staff can take the worry away and find the answers for you. Call us!

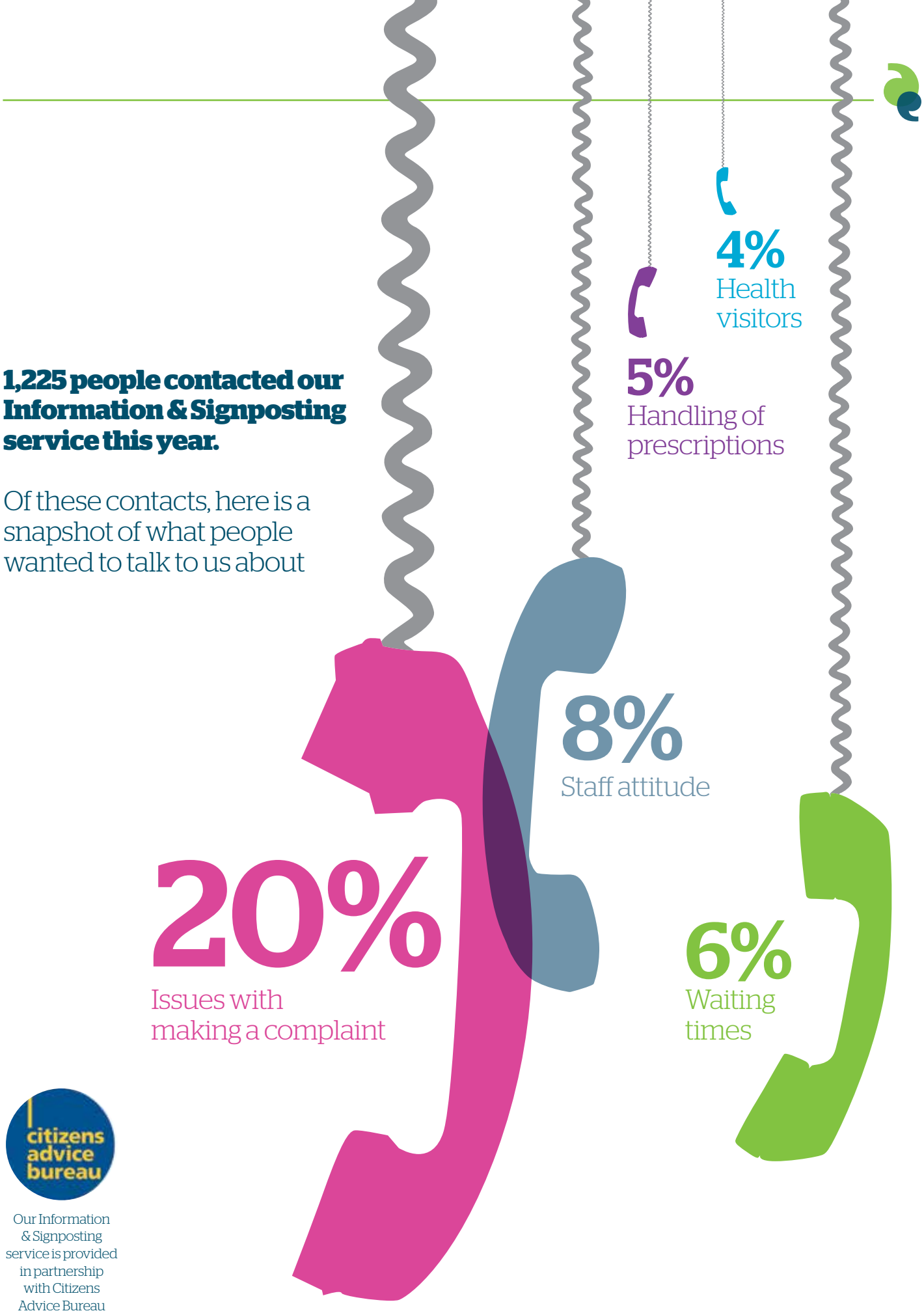
Call us for FREE on
0808 801 0102

Calls answered from
10am - 4pm every weekday

Messages welcome anytime and responded to next working day
Email us at **info@healthwatchkent.co.uk**
or pop into any Citizen Advice Bureau to speak to someone face to face

1,225 people contacted our Information & Signposting service this year.

Of these contacts, here is a snapshot of what people wanted to talk to us about



Our Information & Signposting service is provided in partnership with Citizens Advice Bureau

How we decide our priorities?

We are always analysing the feedback we receive from the public to identify trends and issues. We combine this information with feedback from our volunteers who attend a variety of meetings on our behalf. All these issues are brought to our Intelligence Gathering Group (IGG) each month which is made up of volunteer readers.

Mental Health

We undertook a project to talk in-depth to patients, carers and their families from across Kent about their experiences of mental health services. As part of our project we conducted an Enter & View visit to Little Brook Hospital in Dartford. The results of this visit, plus the findings of our project culminated in a series of actions and recommendations. We have been working alongside carers, patients and the mental health trust to make a number of improvements including the completion of a Carers Charter, free wifi for patients at Little Brook, a free bus service for families visiting from Medway to Dartford. Mental health remains an important priority for us in the year ahead.

Quality of Care in Nursing & Residential Homes

We have escalated three concerns for patient safety to the Care Quality Commission and Kent County Council following information we have received from the public. We would urge anyone with worries to contact us for free anytime. In addition we have visited a number of Care Homes across Kent as part of our Enter & View programme. We will continue to plan visits to Care Homes for the coming year.

Complaints systems

People ring us with questions and issues about making a complaint more than anything other issue. This has triggered us to undertake a project to look in-depth at the systems and process that our hospital trusts use to handle and manage complaints. We are also scrutinising the system for people wishing to complain about social care services. We are actively working alongside Healthwatch England, who are campaigning for a total reform of the complaints system at a national level.

Our volunteers further research around these issues to determine what is already being done to avoid duplication. If we feel the issue needs further investigation, and that the views of patients and the public have not been heard, the decision of whether it becomes a priority for further work is made by our Deliberations & Directions (DaDs) group. This year, our DaDs group have agreed on a number of priorities and projects for Healthwatch.

All our reports can be found on our website

Nursing Care at Home

Working in partnership with Kent Community Health Foundation Trust we have invited patients from Thanet & Canterbury to take part in a pilot project to gather the experiences of people who are receiving nursing care at home. We gathered experiences through home visits, telephone interviews and written feedback.

Children and Adolescent Mental Health service

We heard from a number of families about their experiences of this service. This prompted us to undertake a detailed project talking to families who use this service and identifying the key issues that they face. Our report has made a number of recommendations which we are keen to see implemented. We will be working with the organisations that commission and provide this service in the year ahead and revisiting the families to understand if their experience has improved.

Access to services by the Eastern European community

Healthwatch has become concerned about how the Eastern European community is accessing health and social care services, particularly in East Kent. To explore this concern further and to identify the issues, Healthwatch has been working on a project to investigate. We have held a number of focus groups and worked closely with existing support groups and voluntary organisations. Coupled with a detailed literature analysis we have identified a number of issues and will be making a number of recommendations.

Enter & View

Part of Healthwatch Kent's remit is to carry out Enter and View visits. Trained volunteers carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement.

The Health and Social Care Act allows Healthwatch Kent authorised representatives to observe services and talk to service users, patients, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

This year we have completed 17 Enter & View visits. Copies of all our Enter & View reports are on our website. If you require printed copies just let us know by ringing 0808 801 0102.

Darent Valley A&E, Dartford
Purpose of the visit: Concerns had been raised with us about services at A&E by the Health Overview & Scrutiny Committee.
Outcome: Patients on the day were broadly positive. We will revisit once the new A&E building is finished.

Faversham Minor Injuries Unit, Faversham
Purpose of the visit: We had heard strongly from local residents about the importance of the Unit following news that it may be closed.
Outcome: patients were receiving a good service. Signage and promotion of the Unit should be improved to ensure local people knew where to go should they need it.

Tunbridge Wells Hospital, Pembury
Purpose of the visit: As part of a nationwide inquiry into Hospital Discharge we wanted to talk to patients who were being discharged that day. This visit was in conjunction with Healthwatch East Sussex.
Outcome: the new pilot system was making progress at Pembury and the relevant teams were working well together to ensure quick and seamless discharge of patients. Some concerns raised about discharge of mental health patients and challenges about where they could be discharged too.

William Harvey A&E, Ashford and Queen Elizabeth the Queen Mother Hospital, Margate
Purpose of the visit: As part of our work to support East Kent University Hospital Foundation Trust (EKUHFT), following their Inadequate rating by the Care Quality Commission we undertook a number of visits to East Kent services. The purpose was to establish a baseline of patient experience during this initial visit. Return visits are planned for May/June 2015 to hopefully see improvements.
Outcome: Patients on the day broadly had a positive experience.

Outpatient Clinic at:
- **Kent & Canterbury Hospital, Canterbury**
- **Royal Victoria Hospital, Folkestone**
- **Buckland Hospital, Dover**

Purpose of the visit: As part of our work to support East Kent University Hospital Foundation Trust (EKUHFT), following their Inadequate rating by the Care Quality Commission we undertook a number of visits to East Kent services. The purpose was to establish a baseline of patient experience during this initial visit. Return visits are planned for May/June 2015 to hopefully see improvements.
Outcome at Kent & Canterbury Hospital, Canterbury: The signage has been improved to help patients navigate their way but also to highlight services such as the water dispenser. Whiteboards have been instated to help communicate with patients about any delays and the reasons why. The appointment system is being reviewed.
Outcome at Royal Victoria Hospital, Folkestone: They will explore interim options to help patients find their way in advance of a full scale Way Finding project which is currently being planned. Also planning a new centralised reception to better support patients. Our return visit will examine both of these elements.
Outcome Buckland Hospital, Dover: The new Dover Hospital should address some of the issues around accessibility and signage that we found. In the meantime, they are exploring interim solutions to the signage issues to help patients find their way.

Care Homes:

- **Barnetts Residential Home, Tunbridge Wells**
- **Broad Oak Manor Nursing Home, Dartford**
- **Sonia Lodge Care Home, Deal**

Purpose of the visit: this was part of a number of visits to Care Homes. Homes were selected on the basis of previous CQC reports which had raised concerns about the quality of care that residents were receiving.

Outcome at Barnetts Residential Home, Tunbridge Wells: Continue to make improvements to the physical elements of the home.

Outcome at Broad Oak Manor Nursing Home, Dartford: Residents told us that they felt their calls bells were not answered as quickly as they liked. We recommended that the Manager investigates this further and involves residents and families in the solutions.

Outcome at Sonia Lodge Care Home, Deal: Positive changes have clearly been implemented over the past two years.

Learning disabilities day centres and residential services:

- **Folkestone Independent Living Service, Hythe**
- **Future Home Care & The Birches Respite Facility, Tonbridge**
- **Martha Trust Centre, Deal**
- **Rosecroft Care Residential Home, New Romney**
- **Whiterose Care, Canterbury**
- **Little Brook Hospital, Dartford**

Purpose of the visit: Healthwatch Kent undertook a series of visits to learning disabilities day centres and residential services, as part of a Kent wide observation of provision within the county. Care homes were selected on recommendation from Kent County Council.

Outcome at Folkestone Independent Living Service, Hythe: The transformation of the service from a traditional day centre to a Community Hub has clearly been welcome and well used by clients.

Outcome at Future Home Care & The Birches Respite Facility, Tonbridge: The clients and staff we spoke to on our visit clearly had a good rapport and clients seemed relaxed and comfortable.

Outcome at Martha Trust Centre, Deal: Staff have created a Family Forum. They work with the Forum to look at ways to continually improve the service. The management try to resolve any issues by regular contact with parents individually and through the Family Forum and are constantly looking at ways to improve the service they offer. The CEO has developed a Parent's Representative.

Outcome at Rosecroft Care Residential Home, New Romney: The Trust demonstrated a good relationship with parents and families.

Outcome at Whiterose Care, Canterbury: The residents we met had a positive experience of the service provided by Whiterose.

Outcome at Little Brook Hospital, Dartford: Free wifi for residents was installed almost immediately after our visit, allowing patients to communicate more freely with their families. A free bus service has been established for relatives wishing to visit from Medway. Improvements have been made to the outside area and the number of activities for patients has been improved.

What difference have we made?

1,225 people have directly contacted us this year either by phone, email, through our website or by talking to us face to face at events and community meetings. We have helped each of them with information and signposting to the right service or support.

Hundreds of people have shared their experiences of services with us and we have taken those experiences directly to the people who commission and provide them in order to improve them for the future.

Other ways we have made a difference is through our projects and Enter & View visits. Our visits give people a voice. By talking to us and voicing their experiences we can help to make a difference to services. So for example, **mental health patients** and their families told us about how difficult it was to stay in touch and visit loved ones when the mental health hospital was so far from home. As a result free Wi-Fi has been installed at Little Brook Hospital in Dartford and a free bus service is now provided for families from Medway wishing to visit patients in Dartford.

We have attended meetings to help plan the move of another ward from Medway, this time to Maidstone. In response to our work visiting Sapphire Ward in Dartford this year, we were asked to contribute to the plan for the move of Emerald Ward to Maidstone to ensure issues such as travel for relatives and activities on the ward were planned effectively.

Our visits to **care homes** led to changes being instigated re menu choice and staff training, as well as improving the decoration.

We facilitated a meeting between a **Fibromyalgia** support group and a GP practice where there were concerns from the group about the approach of the practice to fibromyalgia. The meeting was very successful and the practice have agreed to display information about the condition and the support group.

Following every Enter & View visit we make a number of recommendations. On visiting **Outpatients** in East Kent we made a number of suggestions for improvement to their appointment systems and waiting rooms. Most of our recommendations have now been implemented and we are planning a follow up visit to ensure patients are enjoying a better experience.

Similarly by working with mental health **carers** and other voluntary organisations we have helped to raise the voice of mental health carers. We've worked collectively together to ensure a Carer's Charter is now in place and a regular communication with carers across Kent has recently started. Carers have been trying for many years to make these relatively simple changes.

Working with the **Deaf community** we have heard about the extreme difficulties that have in making appointments and securing British Sign Language Interpreters to support them. We've been working jointly with Kent Community Health Foundation Trust, Kent County Council and East Kent University Hospital Trust to create a free credit card which they can present to any health or social care professional to indicate that they require a translator. These cards will be available shortly. Linked to this, we have created a new text service for people with hearing loss who want to contact us. The text service allows people to share their experiences or ask for information. It is also a route for people wishing to set up an appointment with our BSL interpreter to have a more in-depth conversation.

Other examples of our impact are related to **safeguarding** issues. We regularly share our intelligence with the Care Quality Commission and we have escalated three issues this year which we deemed to be serious safeguarding concerns. These issues have been dealt with swiftly by either Kent County Council or the relevant Clinical Commissioning Group.
Through our feedback to organisations about the quality of their previous consultations we have worked closely with hospital trusts to ensure a robust engagement takes place with the public going forward. This work has been on stroke services with Maidstone & Tunbridge Wells NHS Trust which spoke to over 200 people. We are also in the process of working with East Kent University Hospital Trust to ensure the public are fully involved in their clinical strategy.

We have also been an integral part of the **integration** of health and social care services. We took over as chair of the communication and engagement working group of the Kent Integration Pioneer and worked with partners to develop a shared language to be used by organisations across the county when talking about integration.

We are one of the first Healthwatch in England to speak to **people in their own homes** about the services that come to them. Although it is not part of our powers such as Enter & View, many people receive care at home. We found many people received a good service but we fed back to the community trust the areas patients felt they could improve.

The year ahead?

Together with our volunteers, we have identified the following strategic priorities for 2015/16

Improvement of Mental Health Services
We will work with patients and carers to establish if they feel services have changed following our work to improve services

Improvement in Children and Adolescent Mental Health Services (CAMHS)
We will work in partnership with commissioners to ensure the voice of young people is heard in the redesign of CAMHS, now known as Children and Young People's Services (ChYPS)

Health & Social Care Complaints
We will follow up our evaluation of complaints processes in health and social care with an evaluation of the improvements that have been made from complaints, and how those improvements are maintained.

End of Life Care
We will get feedback from patients on the effectiveness of new end of life care pathways in the hospital and community trusts in Kent.

Dentists
We will speak with patients of dental practices in Tunbridge Wells to understand their experiences, and work with those practices on evaluating their services.

Focus on Social Care Services
We will ensure we have equal focus on social care services and health services.

Children & Young Peoples Services
Working with existing networks we will ensure that the voice of children, young people and their families are heard in setting strategic priorities and developing new services.

Integration of health & Social Care services
Healthwatch Kent has already been heavily involved in the strategies for integrating services and we will continue to monitor the impact of the Better Care Fund. We will actively gather experiences of people who are moving between services such as from a hospital to a care home.

Public Consultations
We will work in partnership with organisations to ensure they actively engage communities when consulting on service changes. We will act as a critical friend, setting out our expectations of good practice.

We will also be continuing to raise our profile amongst the general public. If you can help by placing posters and leaflets within your local community do please let us know.

You can follow the progress of these projects through our website or sign up for our monthly newsletter. If you are particularly interested in any of our priority areas or would like more information, do please get in touch.

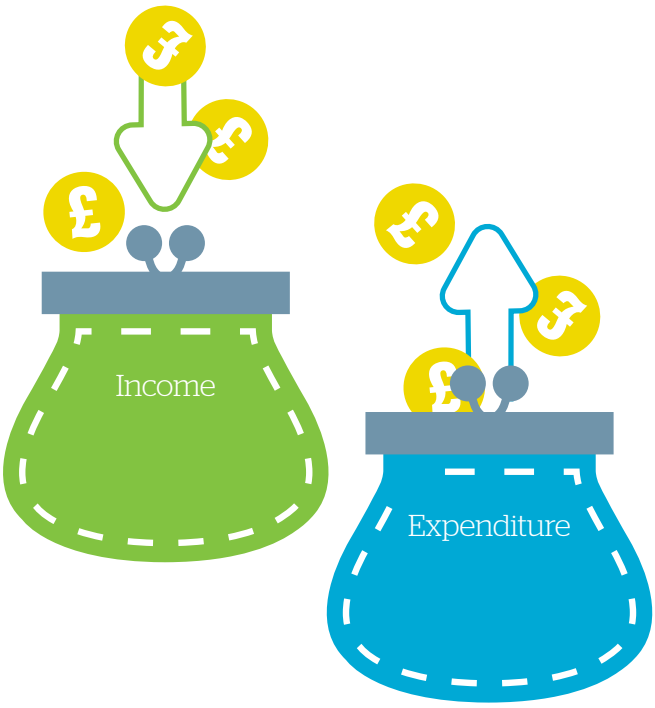
Finances

Table heading showing statement of activities for the year ending 31 March 2015

Income	Total
KCC Contract	£411,555
KCC Business case projects	£122,213
Project income	£13,940
Total income	**£547,708**

Expenditure	Total
Engaging Kent	£15,601
Staff employment costs	£170,587
Staff recruitment / training	£2,395
Staff and volunteer expenses	£17,978
Projects and research	£287,277
Professional fees	£5,667
Office related costs inc Insurance	£25,345
Total expenditure	**£524,850**

Surplus on activities before taxation	£22,859
Surplus on activities after taxation	£18,287



Balance sheet as at 31st March 2015

Fixed assets	
Tangible assets	£3,981

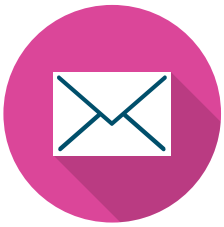
Current assets	
Debtors	£104,337
Cash at bank	£154,341
Total current assets	**£258,678**
Creditors (amounts falling due within one year)	(£243,576)
Net current assets /(liabilities)	£15,102
Total assets less current liabilities	£19,083
Provisions for liabilities Deferred tax	(£796)
Net assets	£18,287
Capital and reserves	£18,287

Notes
Tangible assets, based on ICT equipment purchases minus a depreciation charge.
Cash at Bank - funds allocated to current projects
Creditors - trade creditors, taxation and social security, deferred income and accruals.

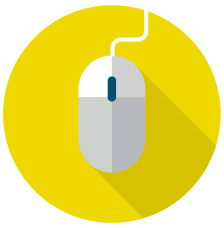
Your voice counts
We want to hear from you

Tell us your experiences of health & social care services in Kent

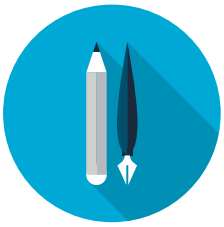
By Telephone:
Healthwatch Kent
Freephone 0808 801 01 02



By Email:
Info@healthwatchkent.co.uk

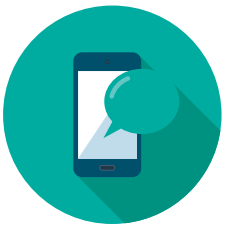


Online:
www.healthwatchkent.co.uk



By Post: Write to us or fill in and send a Speak out form. **Freepost RTLG-UBZB-JUZA**
Healthwatch Kent, Seabrooke House,
Church Rd, Ashford TN23 1RD

Face to Face:
Call 0808 801 01 02 to arrange a visit



By Text: Text us on **07525 861 639**.
By texting 'NEED BSL', Healthwatch's British Sign Language interpreter will make contact and arrange a time to meet face to face.

Healthwatch Kent
Seabrooke House, Church St. Ashford, TN23 1RD
Tel 0808 801 0102
Twitter @HealthwatchKent
Facebook hwkent
info@healthwatchkent.co.uk
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healthwatch
Kent

Healthwatch Kent
Strategy 2015/16

Chief Executive Officer's foreword

This strategy sets out how Healthwatch Kent works and how we intend to continue working in 2015-16.

After a troubled beginning in 2013/14 Healthwatch Kent achieved a huge amount in 2014/15.We recruited, inducted and trained over 60 volunteers and two additional staff. We produced project reports on:

- Mental health inpatients
- Mental health carers
- Eastern European patients in East Kent
- Children & adolescent mental health services (CAMHS)
- Complaints in health and social care

Our project reports can be found here: http://healthwatchkent.co.uk/projects

We also undertook Enter and View visits to:

- an acute inpatient mental health ward
- 5 older person's care homes
- 5 learning disability services
- 3 A&E departments and 1 minor injuries unit
- 3 Outpatient departments

In addition to this a review of discharge arrangements in an acute hospital was completed.

We held events across the county to speak to the public about a variety of topics. We also built links with the voluntary sector, Patient Participation Groups and GP practices.

We have developed ways of working which empower our volunteers to represent Healthwatch at strategic meetings and forums across the county. We are committed to ensuring Healthwatch Kent is a partnership of volunteers and paid staff working in an open, transparent way, agreeing how we work and the issues we work on.

We have built our relationships with organisations and stakeholders via regular liaison and through our work at Kent's eight Health and Wellbeing Boards. We are seen as an objective, credible partner; this allows us to challenge poor quality services and acknowledge good practice. We are now being proactively approached by organisations to help them ensure the public are involved in service redesign.

We have a come a long way in the last year which is a huge credit to the volunteers and paid staff team. This strategy describes the way we work and identifies the areas **we will** develop in 2015/16.

Steve Inett, CEO, Healthwatch Kent

About Healthwatch Kent

What is Healthwatch Kent?
Healthwatch Kent was established in April 2013 as the new independent consumer champion created to gather and represent the views of our community.

Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use health and social care services are taken into account.

What do we do?
Healthwatch Kent took over the role of Kent Local Involvement Network (LINk) and also represents the views of people who use services, carers and the public to the people who commission plan and provide services. Healthwatch provides a FREE signposting service for people who are unsure where to go for help. Healthwatch Kent can also ask Healthwatch England and the Care Quality Commission to take action on concerns raised about the quality of health and social care.

Our Mission Statement
Our mission is to raise the public's voice to improve the quality of local health and social care services in Kent. We listen to you about your experiences of health and social care services and take your voice to the people who commission these services.

Our FREE Information and Signposting service can help you navigate Kent's complicated health and social care system to ensure you can find and access the services that are available for you. Call us on 0808 801 0102 or email info@healthwatchkent.co.uk

Our Values
- Partnership of volunteers and paid staff (over 60 volunteers, 7 staff)
- Information and intelligence based
- Support and guidance for services
- Two way communications
- Partnerships and relationships – achieving more in partnership than alone
- Honest, accountable and transparent

Equality & Diversity

Healthwatch Kent recognises that many people in our society experience discrimination or lack of opportunity for reasons that are not fair.
Healthwatch Kent challenges discrimination and lack of opportunity in its own policy and practice and encourages other organisations and individuals to do the same.

Healthwatch Kent aims to create a culture that respects and values individual differences. Healthwatch Kent sees these differences as an asset to our work as they improve our ability to meet the needs of the people and organisations we serve.

In 2015/16 **we will** continue to build on our understanding of the diverse communities within Kent and proactively engage with them to gather their views about the health and social care services they receive. **We will** continue to ensure all the information and services we provide are fully accessible to all Kent residents. **We will** complete Equalities Impact Assessments for all our projects to ensure we hear the voices of those most affected. We have a programme of gathering public feedback where we focus on a different district council area each month. Before carrying out our engagement with the public in a district, **we will** have undertaken and Equalities Impact Assessment and prioritised the communities we want to ensure we speak to.

Our responsibilities

In 2015/16 we will continue to use our position as a voting member of the Kent Health & Wellbeing Board to amplify the voice of the public.
Our volunteers will continue to represent the public's voice at the seven local Health & Wellbeing Boards across the county. **We will** also engage fully in agreeing the Joint Strategic Needs Assessment (JSNA), Health & Wellbeing Strategy and Pharmaceutical Needs Assessment (PNA) to ensure the public are actively engaged in setting strategic priorities and Healthwatch Kent is a credible partner of the Health & Wellbeing boards.

We will scrutinise and contribute to the Quality Accounts of the main health and social care providers.

We will use our statutory power to Enter and View services to understand people's experiences of places like A&E, Outpatients departments and care homes and publish the results.

We will use our attendance at the Kent Health Overview & Scrutiny Committee to give feedback from the public and contribute to investigations they undertake.

Partnership of volunteers and paid staff

Healthwatch Kent is not a membership organisation. It exists to serve the whole population of Kent regardless of whether individuals have signed up as a member.

To be actively involved members of the public can sign up as a volunteer. There are a variety of roles volunteers can undertake, and the organisation could not achieve its aims without them.

We work proactively with the general public in Kent to gather their feedback and Healthwatch Kent holds a database of people who have asked to keep up to date or contribute to what we do. Networking with other voluntary sector groups and membership groups allows us to cascade Healthwatch information to a further group of people who may not wish to register with Healthwatch directly.

Healthwatch Kent ensures that volunteers represent the public and patients of Kent, supported and partnered by a small team of paid staff. Volunteers are fully inducted and trained and understand that their role is to be the conduit for the feedback Healthwatch Kent receives, they do not use it as a platform for their own concerns.

Our volunteers are involved at every level of what Healthwatch Kent does. They:

- help agree priorities
- gather intelligence and information
- plan and carry out Enter & View visits
- represent Healthwatch Kent at meetings and forums
- liaise with stakeholders
- gather feedback from the public
- promote Healthwatch
- work together in their locality to improve services

In 2015/16 **we will** undertake a targeted volunteer recruitment campaign to ensure our volunteers are representative of the localities and diversity within Kent. **We will** develop our induction and training and provide regular updates on agreed topics. **We will** continue to improve our internal information sharing systems to ensure volunteers feel informed and engaged.

How we work with others

We always aim to work in partnership and an open, transparent manner to ensure we are a credible partner to organisations and stakeholders.

We will strive to maintain an open, two way relationship to develop understanding and negotiation. However when we raise a concern with a statutory organisation they are required to respond to us. We avoid duplication of the work of others and aim to understand and enhance that work. We work with Kent organisations and stakeholders in a variety of ways.

Commissioners

We will continue to liaise closely with the organisations that fund services. In Kent there are seven Clinical Commissioning Groups (CCGs) who have GPs as their members and commission many community and hospital services. We meet with the CCGs regularly, sharing intelligence and informing their evaluations of the quality of services. We support them in ensuring the public are fully consulted on planned services. **We will** also work closely with NHS England who hold the contracts with GPs and specialist services.

We are a key partner in Kent County Council's strategy for improving the cost effectiveness of services and how they work more closely with health services to offer seamless service to the public.

Providers

We have strong relationships with the three hospital trusts in Kent as well as the community health trust, the community mental health trust and the ambulance trust. We update them regularly on the feedback we receive from the public about them, alert them to serious quality issues and we are supporting many of them with engaging with the public.

We will continue to visit care homes, day services and talk to the public about services they receive at home. We always raise any concerns and good practice directly with the provider before anyone else. **We will** continue to publish reports on our findings that are balanced and objective to ensure we continue to be seen as credible representatives of the public. **We will** work hard with providers to ensure recommendations are acted upon.

Inspectors

We have monthly liaison with the Care Quality Commission (CQC), who inspect all health and social care services in England. We provide intelligence on services about to be inspected and assist the CQC with listening events prior to large inspections where the public are invited to give feedback. Following inspections we are invited to 'Quality Summits' where all partners hear the outcome of the inspection before it is published and confirm what support can be given with the action plan to improve the service. We have worked with East Kent Hospitals University Foundation Trust and Maidstone & Tunbridge Wells Hospital Trust following their inspections and worked in partnership with Monitor who ensure NHS services are meeting targets and are financially viable. In 2015/16 **we will** continue to work with organisations following their CQC inspection such as the mental health trust Kent & Medway Partnership Trust. Where there are serious concerns raised about a service **we will** inform the CQC who will then decide whether to inspect.

Voluntary Sector

We recognise that voluntary organisations work with the groups most disadvantaged by the way health and social care services are delivered. **We will** continue to work in partnership with those organisations to utilise their relationships with those groups so we can help ensure their views are heard. **We will** increase the number of voluntary and community groups that have a Healthwatch Kent Community Champion and ensure every group is aware of how to link with Healthwatch Kent.

Elected members

Healthwatch Kent is an independent organisation and so does not take part in party political activities or campaigns. We recognise the importance of those who are democratically elected to represent the public and **we will** continue to develop our relationships with MPs, county, district and parish councillors. The feedback they receive from the public is valuable intelligence to understand their experiences of health and social care services.

Patient engagement

We work closely with many patient and public engagement networks and forums and **we will** support them to continue to develop and be essential parts of engagement with the public:

Patient Participation Groups (PPGs) are based in GP practices and are a vital network in listening to the public's views on health and social care services. We have met with many of them but **we will** ensure every PPG understands how to work in partnership with Healthwatch Kent.

The Mental Health Action Groups are regular forums for patients, carers, providers and commissioners to discuss service issues in mental health. We attend the Kent forum and are nominating Healthwatch Kent representatives on the others.

We ensure we keep in touch with carers groups and forums and will ensure we have more representatives attending. **We will** also continue to link with other patient and public engagement activities across the county.

Healthwatch England and neighbouring local Healthwatch

We are part of a network of 152 local Healthwatch organisations. The network is supported by a national organisation;

Healthwatch England. Healthwatch England (HWE) provide support to local Healthwatch and collate the work being done by them to look at the national picture. **We will** continue to work closely with HWE and share the outcomes of the work we do.

Where an issue can only be addressed on a national level **we will** escalate it to HWE who have a direct relationship with the Department of Health, NHS England and Care Quality Commission nationally, and can also lobby parliament behalf of the public.

We have worked closely with neighbouring Healthwatch in East Sussex, Bexley and Medway and in 2015/16 continue to work closely on projects that affect our residents. **We will** also continue to meet regularly with all Healthwatch in the South East to see what we can achieve on a regional level.

How we work with the public

Feedback from people about their experiences of health and social care services is the information we use to do our job, so we make it as easy as possible for the public to talk to us:

- The Information and Signposting freephone line is the easiest way to contact us on **0808 801 0102**, Monday to Friday 10am to 4pm. We work hard to ensure we immediately answer any call received in the opening hours but if you have to leave a message **we will** ring you back within one working day.
- You can email on **info@healthwatchkent.co.uk** and **we will** respond within two working days.
- You can text us on **07525 861639** and **we will** respond within two working days. Use this service if you require a British Sign Language Interpreter.

The phone line cannot deal with complaints but can provide information about how to complain to the relevant organisation. **We will** continue to respond urgently to cases where people are potentially at risk or the quality of a service is extremely poor. **We will** continue to have quarterly liaisons with the patient experience departments in the main providers to share anonymised feedback we have received from the public and ensure we can contact the correct person urgently if necessary.

We also ensure that we meet people face to face:

- Anyone can go into their local Citizens Advice Bureau (CAB) and be helped to contact us.
- We hold four public meetings a year, in venues across the county, to update people on our work and gather feedback.
- We visit a different district council area each month and visit libraries, CABs, community groups and events. During these 'public voice' sessions we raise awareness of Healthwatch Kent and the freephone line, give information about patient rights, gather feedback of people's experiences, and recruit new volunteers.
- We work with other organisations to deliver events to gather public views
- We work with voluntary organisations who feed us the views of their service users

In 2015/16 **we will** ensure we are easily accessible to the most disadvantaged groups in each district to ensure their voice is heard by commissioners and providers. **We will** also increase the activities our volunteers undertake in their local area to engage with the public and understand local issues re health and social care services. **We will** continue to raise awareness of Healthwatch Kent amongst the public; it is now a requirement for health services to display our information and **we will** be monitoring that this happens. We are also touring with our big red bus in June 2015 which will visit every district in Kent to raise awareness of Healthwatch Kent and gather feedback.

How we decide our priorities

From the feedback we receive from the public we look at trends in services to see what issues are affecting people the most.

We also look at the issues being discussed with commissioners and providers around the county. Healthwatch Kent have a network of volunteer representatives who attend meetings and forums throughout Kent and report back the main issues that are being discussed. We also respond to urgent issues such as the outcome of Care Quality Commission inspections and closures of services. All these issues are brought to our Intelligence Gathering Group (IGG) each month which is made up of volunteer readers.

Once we have gathered the issues volunteers read and research to understand what work might already being done in those areas to avoid duplication. This involves looking at commissioning plans and speaking with commissioners and providers to understand the current situation. If we feel the issue needs further investigation, and that the views of patients and the public have not been heard, the decision of whether it becomes a priority for further work is made by our Deliberations & Directions (DaDs) group. The DaDs group is made up of volunteers and paid staff who consider the evidence provided by IGG. If something is agreed as a priority, Healthwatch Kent will undertake further work as described in the section **how we improve services.**

In 2015/16 we anticipate the amount of feedback we receive will increase as it has in 14/15. **We will** implement systems to manage the increased amount of feedback effectively and be clear about the main themes and areas of concern.

We will continue to listen to our external representatives and the issues they discuss at meetings and forums giving them feedback on how the information has been used.

How we improve services

We can influence and improve services in a number of ways. These include:

- Under Events & Workshops section
- Change sentence to read

We will continue to host events and workshops for the public to share their experiences and to discuss ways to improve services. The people that commission and provide services will always be part of these discussions.

- **Discuss with the provider or commissioner concerned.**
  This might be done by the Healthwatch Kent Chief Executive Officer or the local Area Team of volunteers. In 2015/16 **we will** continue to work in a transparent way with stakeholders to understand the issues, agree the value of the public feedback and gain assurance that the issue is being addressed.

- **Undertake an Enter & View visit to speak to patients face to face and make recommendations.**
  In 2015/16 **we will** continue with our programme of Enter & View visits to social care services such as care homes and day services to speak to service users, carers, family and staff about their experiences and feed this back to the organisations involved. These reports will have recommendations which the organisations are required to respond to and are published on our website.

- **Agree to undertake a project.**
  In 2015/16 **we will** continue to use some of our funding to commission community organisations and specialists in exploring issues and making recommendations. Project reports are published for the public to review what we have done.

- **Events and workshops.**
  We will continue to host events to allow the public to agree actions for our projects.

- **Action plans and follow up.**
  We have worked hard to ensure we follow up on our projects and monitor how actions are completed.

- **Ongoing liaison.**
  We developed regular liaisons with organisations to monitor our action plans and have already seen organisations using that liaison to proactively involve us in upcoming service changes.

Where we are not able to effect improvements alone, we escalate to Healthwatch England or the Care Quality Commission.

Strategic priorities 2015/16

Below is a list of the priorities agreed by our DaDs group as described in the section **How we decide our priorities.** This list is not exhaustive and **we will** continue to respond to issues brought to our attention as described in the same section.

Improvement of Mental Health Services
We will undertake an evaluation to establish whether actions taken in response to reports published by Healthwatch Kent in 2014 have led to improvements in services for service users and carers.

Improvement in Children and Adolescent Mental Health Services (CAMHS)
We will work in partnership with commissioners to ensure the voice of young people is heard in the redesign of CAMHS, now known as Children and Young People's Services (ChYPS).

Health & Social Care Complaints
We will follow up our evaluation of complaints processes in health and social care with an evaluation of the improvements that have been made from complaints and how those improvements are maintained.

End of Life Care
We will also continue to link with other patient and public engagement activities across the county.

Dentists
We will speak with patients of dental practices in Tunbridge Wells to understand their experiences, and work with those practices on evaluating their services.

Focus on Social Care Services
We will ensure we have equal focus on social care services and health services.

We will continue to work in partnership with commissioners in ensuring public participation in planning and procurement.

Children & Young Peoples Services
We will work closely with existing networks that gather feedback from young people and families. **We will** work closely with Children's Health & Wellbeing Boards to ensure that the voice of children, young people and their families are heard in setting strategic priorities and developing new services. **We will** gather feedback on the challenges faced by children and their families in accessing health and social care services, in particular the experiences of schools referring children into services.

Integration of Health & Social Care Services
Healthwatch Kent has already been heavily involved in the strategies for integrating services.

We will monitor the impact of the Better Care Fund but recognise that new services put in place for this fund may need to be reviewed in 2016 for evaluation to be meaningful. In the meantime Healthwatch Kent will gather the experiences of people, in particular older people, who are moving between services e.g.

- From hospital to a care home
- From hospital to the community
- From the community to hospital

We will undertake this work where short term improvements in services can be made, without needing to wait for integrated services to become effective.

We will employ our statutory power to 'Enter & View' services to speak to service users, carers, family and staff about their experiences and feed this back to the organisations involved. These reports will have recommendations which the organisations are required to respond to.

Consultations
We will work in partnership with organisations to ensure they actively engage communities when consulting on service changes. **We will** act as a critical friend, setting out our expectations of good practice.

Governance

The funding for Healthwatch is provided by the Department of Health and passed to local authorities to administer. Kent County Council (KCC) manage the funding and Engaging Kent CiC were awarded the contract to deliver Healthwatch Kent. KCC and Engaging Kent have agreed an outcomes framework to measure the performance of Healthwatch Kent.

There are two types of governance in relation to Healthwatch Kent:

Corporate Governance:
A framework of rules and practices by which the Engaging Kent Board ensures accountability, fairness and transparency in its relationships and stakeholders with regard to Healthwatch.

Organisational Governance:
The process of overseeing of the direction, running and effectiveness of an organisation, in this case Healthwatch. This is undertaken by the Chief Executive Officer (CEO), the Deliberations & Directions Group and the Intelligence Gathering Group.

Engaging Kent CIC role and function
Directors of the Engaging Kent CIC are not directors of Healthwatch. Their responsibility is to oversee the delivery the contract and ensure the highest standards of quality and adherence to best practice. It is the employer of staff working within Healthwatch.

Engaging Kent CIC has a duty to ensure that the governance structure and processes in place to deliver Healthwatch are robust and that the service meets its contractual and statutory obligations. This is done via the line management of the Healthwatch CEO and delegated areas of responsibility. It provides assurance that Healthwatch Kent's priorities and activity cohere with the Outcomes Framework and local stakeholder and national bodies' expectations of best practice. It assesses and manages risks to Healthwatch Kent.

Deliberations and Directions Group (DaDs) Role and Function
The Deliberations and Directions Group (DaDs) is the body which determines the direction, content, format and schedule of work that reflects Healthwatch Kent's priorities and goals. Its remit is to define, shape and implement what Healthwatch Kent wants to achieve. The DaDs group is a core part of the governance arrangements through which Healthwatch Kent can deliver its operational and strategic objectives.

The DaDs members make decisions based on their knowledge and expertise; and from the evidence based information they receive from the Intelligence Gathering Group (IGG). IGG captures information and data from multiple sources – large and small organisations, public, community and professional bodies, official and lay individuals – and sorts, refines and presents it to the DaDs group.

DaDs reviews the intelligence received and determines what to act on, how to act and to whom it should award grant pot money. It is helped in this choice by testing each issue against the priority setting tool. This is a simple weighting and multiplier system that selects and assesses the potential impact of each proposed project. Transparency, rigour and objectivity are the basis for DaDs effective and successful working.

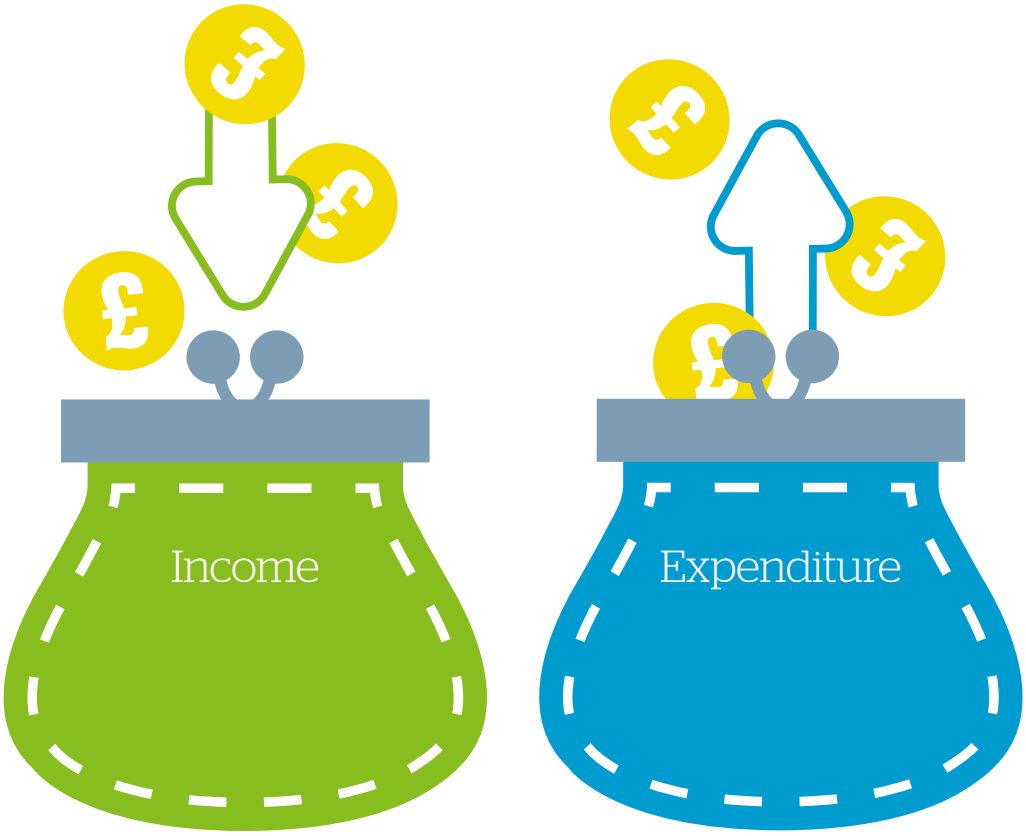
The DaDs group also receives project reports, analyses and data from the 'Enter and View' projects.

The group operates by discussion and consensus and is chaired by the CEO, who has the ability to veto any activities they consider to be contrary to the Outcomes Framework, the contract or best practice. It is empowered to take agreed actions forward within the allocated budget lines and available resources and determine delivery timeframes.

Ensuring value for money

In 2015/16 Healthwatch Kent will continue to be open and transparent about the funding it receives and how it is spent by undertaking the following actions:

- **We will** publish our accounts each year in our annual report.
- **We will** ensure funds are used effectively in the day to day operation of Healthwatch Kent.
- **We will** ensure we offer opportunities for funding for project work as widely as possible and select organisations based on the quality of the proposals as well as value for money.
- **We will** undertake value for money evaluations of project work to demonstrate robust monitoring of the use of funds.
- **We will** ensure volunteers are not left out of pocket by working with us and pay expenses according to our agreed policy.



By: Graham Gibbens, Cabinet Member for Adult Social Care and Public

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

Date: 16th September 2015

Subject: JSNA recommendations report

Classification: Unrestricted

Summary:
This paper outlines key recommendations from the Kent JSNA and related needs assessments that may be considered by CCGs and other commissioners represented on the Board for their next commissioning plans in 2016/17. The recommendations follow a life course approach and summarises some of the key findings from the latest JSNA exception report which was noted at the May 2015 Kent Health & Wellbeing Board.

Recommendations:
Kent Health & Wellbeing Board members are asked to:

1. Consider how areas identified in this report reflect the priorities of the Health and Wellbeing Strategy

2. Consider the focus that these areas should have in the commissioning plans

3. Ask local health and wellbeing boards to develop their priorities based on the discussion at this Health and Wellbeing Board

1.1. The purpose of this paper is to ensure that annual CCG commissioning plans reflect important changes in population need. Therefore, in addition to the annual JSNA exception report tabled earlier this year, a short report listing key recommendations, at a Kent level, could be considered before the commencement of the next CCG commissioning round, starting in March 2016.

1.2. The recommendations have been broadly listed using a life course approach, focusing on key programme areas. An additional section has been written particularly around the infrastructural requirements around the better use of

information and intelligence affecting the success of future health and care service planning by commissioners.

2. Early Years

The following key points should be included in commissioning plans:-

2.1. A Kent-wide maternity service specification to include the ***Healthy Child Programme***, particularly the universal delivery of full conception to first week of birth element, and reflect all relevant NICE Guidelines for maternity care.

2.2. Commissioners need to oversee the delivery of ***NHS England Stillbirth Care Bundle*** (which includes reducing smoking in pregnancy) to reduce stillbirth and early neonatal death. Reducing deaths in babies and young children; specifically neonatal mortality and still births is a key NHS indicator in the NHS Outcomes Framework.

2.3. There is a need to improve capacity and with ***Unaccompanied Asylum Seeking Children*** to cope with the considerable increase in demand. There is also a need to improve data about the health needs of children in care.

2.4. ***The commissioning of speech, language and communication services*** should be less fragmented across the county resulting in an inconsistency of approach and risks inequity. A detailed assessment of need and provision using a nationally validated method needs to be undertaken. This should allow a service specification to be developed which can inform a joint commissioning strategy going forward.

2.5. There is a need to have a greater impact on families suffering from ***the toxic trio (domestic abuse, mental health and substance misuse).***

2.6. It is important to ***increase breastfeeding rates*** in Kent, particularly in areas of deprivation. Health and social care professionals and the third sector should evidence they are working collaboratively to provide women with a fully integrated service in line with the national breastfeeding pathway.

2.7. ***Increase childhood vaccination rates*** via closer working between the immunisation and vaccination coordination service and GP practices, utilising a targeted approach to those practices and vulnerable population groups where uptake is lowest. Social marketing campaigns and improved monitoring systems need to be used.

3. Improving lifestyles

Sexual Health

3.1. ***Termination of pregnancy services*** need to be commissioned as per the guidelines which offer and undertake testing for HIV, syphilis, gonorrhoea and chlamydia with all clients and provide contraception; signpost to sexual health services for discussion and implementation of long acting methods of contraception and give clear advice on how information about positive Sexual Transmitted Infections (STI) tests and treatment will be communicated.

3.2. Commissioners need to incorporate ***HIV testing*** as a routine test for all patients discharged from active services in the forces, all patients with TB, Hepatitis C, Hepatitis B, all new registrants, all patients who present with HIV clinical indicators.

3.3. Commissioners commit to undertake to promote and offer ***chlamydia screens*** to all contacts aged 15-24.

3.4. Clinicians in primary care to offer a full range of contraception including ***Long Acting Reversible Contraception (LARC).***

Smoking

3.5. ***Carbon Monoxide (CO) screening*** should be part of routine care. CCGs should include a requirement in service specifications that midwives discuss smoking status at booking with all women and that all women are screened for CO. Midwives should give very brief advice on cessation to identified smokers and promptly refer a minimum of 90% of those with CO score of 4 or higher to local stop smoking services.

3.6. Commissioners should include requirements to ***reduce smoking*** within Key Performance Indicators (KPIs) in contracts with secondary care. The KPIs should include:

- Identifying and coding all smokers on admission and referring to stop smoking services
- Mandatory training for all front line staff so confident/competent in raising the issue and signpost/make referrals
- Nicotine Replacement Therapy readily available and seven day 24 hour service
- An electronic referral system in place
- Services available to provide support as and when needed

3.7. Every Kent clinician including ***GPs knows the smoking status of each patient*** they care for and has the competence and the commitment to encourage and support that patient to quit through direct action and referral.

3.8. ***Future commissioning plans should include Quit smoking interventions*** delivered by GPs and pharmacies building on the current success of 4-week quit stop smoking services in GP surgeries and pharmacies. New models of commissioning will be designed in line with NICE guidance and consultation with Public Health and CCGs.

Physical Activity

3.9 The Kent population is becoming less active over time. Almost 3 in 10 adults fail to achieve at least 30mins of physical activity over the course of a week and over 4 in 10 adults do not currently meet the recommended levels of 150mins of physical activity per week.

3.10 Primary and secondary care practitioners are well placed to identify and signpost individuals who will benefit by increasing their physical activity. C should use commissioning opportunities to influence behaviour change through service providers by contractually implementing programmes such as ***Making Every Contact Count***. CCGs to also work with Public Health who are currently developing programmes to improve physical activity based on current guidance from NICE and Department of Health on local programme design and commissioning.

Healthy Weight

3.11 ***Education and training*** as part of on-going Continuous Professional Development (CPD) is required to a range of professional and non-professional staff including developing confidence in raising the issue of weight, offering brief advice and more intensive training including motivational interviewing and nutrition to identified staff who will be local champions.

3.12 Further work is required to ensure that both adult and children ***weight management pathways have adequate capacity*** to meet specialist dietetic and weight management services.

4 Long Term Conditions – Early Diagnosis and Treatment

Health Checks

4.1 Inequity patterns exist across key Long Term Conditions particularly linked with deprivation on indicators such as recorded and expected prevalence, hospital admission rates, premature mortality rates and vascular health checks.

4.2 ***Estimated volumes of undetected disease prevalence should be monitored alongside health check performance*** and in the wider context of avoidable admissions, profiling for cardio-vascular admissions considered amenable to health check intervention.

4.3 Patients identified at risk of cardio-vascular disease through the health check programme should be supported with the ***appropriate range of adjunct primary and secondary prevention interventions.***

Cancer

4.4 A recent cancer equity report highlighted marked outcomes inequalities by gender, deprivation and emergency presentation rates. Variation across CCGs exist for early stage diagnosis, one year survival and urgent GP referral rates. Additionally, lung cancer mortality rates are increasing quickest amongst the most deprived groups.

4.5 Action is required to ***target health promotion/prevention and cancer risk awareness messaging among the male population and deprived areas.*** Consideration should also be given to ensuring that such action is delivered in ways that are likely to be effective among at risk male groups.

4.6 ***Reinforce the importance of early diagnosis and urgent referrals in primary care*** towards achieving improved survival rates, particularly in Swale and Thanet.

Stroke

4.7 Commissioners need to ***map out and understand in detail the care journey of stroke patients*** in order to identify potential areas for improvement, where resources can be utilized more efficiently.

4.8 Further improvements are required in the ***management of key risk factors*** for stroke in primary care, ***targeting particular groups ie. Black African and***

Caribbean in North Kent region. This should be part of the wider prevention agenda by Public Health to promote healthy lifestyles and reduce poor diet, obesity, smoking, physical inactivity and excessive alcohol consumption.

4.9 ***The Stroke Review Programme Board should consider the above factors towards the commissioning of hyperacute and subacute stroke beds.***

Mental Health

4.10 National reports and local needs assessments as well as the JSNA exception report already highlight the growing burden and importance of tackling mental ill health both in children and adults, particularly domestic violence, self-harm and suicides.

4.11 Commissioners should contribute to the current pathway to ***improve outcomes to issues such as self-harm (particularly in relationship to liaison psychiatry)*** to reduce hospital admissions and consider how to improve equity to psychological therapy in particular risk groups eg. new mothers, Lesbian Gay Bisexual & Transexual, and isolated men and some BME communities (regarding suicide risk).

4.12 ***Further audit, evaluation and needs analyses*** is required in a number of areas such as a 'serious incidents / lessons learnt process' for patient suicides, benzodiazepines and opiate prescribing, treatment of high risk groups such as veterans and offenders and services such as Community Mental Health Teams.

4.13 ***Further integration and service transformation work is required*** in joining up pathways for treatment pathways for personality disorder, dual diagnosis (consider use of incentives such as 'CQUINS'), screening (both physical and mental health) and brief interventions for alcohol misuse, and a multiagency partnership approach towards domestic abuse.

4.14 A ***Kent-wide perinatal mental health pathway*** with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent. The pathway should be developed with reference to the national maternal mental health pathway.

Learning Disabilities

4.15 With respect to ***annual health check assessments*** for persons with learning disabilities, commissioners need to work with local GPs to improve the measures need to be taken to ***improve uptake rates*** for the same. To address variation in health outcomes of people with learning disability attention should also be given to the quality of health checks. This can be done through service audits in primary care.

4.16 With regards to national screening programmes commissioners need to ***work collaboratively to improve quality of data recording*** particularly for identification of those eligible for various national screening programmes. Attention should be paid to improving the uptake of cancer screening amongst people with Learning Disabilities.

5 Shifting care out of hospital

5.1 Based on forecasts by the Office of National Statistics, the older population (65 years and over) in Kent is expected to increase by another 30,000 (10%) to 330,000 by the year 2020. This will have considerable impact on health care services caused by higher old age dependency, chronic disease management particularly multiple morbidities and increased care needs.

5.2 Work is required to understand how to bring key programmes for older people's health together for ***service integration and transformation***, particularly in three areas – ***dementia, falls prevention and end of life care (EoLC).***

5.3 Further work is still required to ***improve the completeness of dementia prevalence*** registers in primary care to meet national targets, and review impact of the referrals for dementia identification and assessment particularly from care and nursing homes. Commissioners may need to consider how they wish to take part in local Dementia Action Alliance and their role in the population approach to raising awareness about dementia and voluntary services and other organisation that are part of Dementia Friendly Communities.

5.4 Kent overall appears to be on target for consistent reduction in falls related hospital admissions, however in West Kent and Swale CCGs, the rate of decrease is currently lower than their respective targets. Commissioners should ***continue their efforts in falls prevention, integrate services in the community for rehab and postural stability for maintaining***

independence.

5.5 Alongside this, commissioners need to consider ***the impact of sensory impairment services*** such as eye health treatment provided by primary care optometrists eg. management of Acute Macular Degeneration, Glaucoma and Cataract. There is a universal requirement for the availability of communication support for the deaf, blind and deafblind people in all health settings.

5.6 ***In EoLC, completeness of palliative care registers need to be improved*** with a view to find the missing 'one per cent'. Adequate training of frontline staff and raising awareness to minimise access to EoLC services between cancer and non-cancer patients.

5.7 As part of the ***Kent Pioneer and Vanguard work***, commissioners should continue their respective efforts in service integration, multi-disciplinary team approach to chronic disease management, evaluate the use of technology to support direct care such telehealth and telecare, as well as sharing of medical records and care plans.

6 Embedding Sustainability

6.1 There is a clear interdependency between public health, health and social care, sustainability and wellbeing. Workplaces impact significantly on population health, and good quality employment has been shown to increase wellbeing, whilst at the same time reducing conditions such as anxiety and depression. ***CCGs should develop plans to promote their staff health and wellbeing.***

6.2 CCGs also have responsibility for promoting environmental sustainability and should develop programmes to promote sustainable practices in their procurement processes.

7 Improving the access to and use of informatics for planning health and care services

7.1 National policy shift emphasizes the need for redesigning payment contracting mechanisms to incentivize service integration and integrated care. However, the evidence based approach for whole system transformation within current financial resources is still not yet determined, owing to a lack of suitably designed information and intelligence systems that can deliver this.

7.2 Commissioners must appreciate the urgent need for the ***right infrastructure and resources required in the development and design of whole population person level linked datasets*** and work with Public Health to design a whole system strategy on the use of health and care informatics for planning purposes.

7.3 Commissioners need to be adequately aware of the benefits and uses of linked datasets particularly around ***capitated funding model development, predictive modelling and 'system modelling', and accurately estimate future service demand and costs.***

7.4 A key example would be linked datasets that can effectively plan Child and Adolescent Mental Health and disability services, particularly understanding impact on vulnerable groups such as Children in Care comparing to the rest of the population.

8 Recommendations

Kent Health & Wellbeing Board members are asked to:

1. Consider how areas identified in this report reflect the priorities of the Health and Wellbeing Strategy
2. Consider the focus that these areas should have in the commissioning plans
3. Ask local health and wellbeing boards to develop their priorities based on the discussion at this Health and Wellbeing Board

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From: Matthew Drinkwater, Head of EPRR, NHS England South (South East)

To: Kent Health and Wellbeing Board

Subject: **NHS England South (South East): Preparations for winter 2015/16**

Recommendations

The Health and Wellbeing Board is asked to:

1 Note the report

2 Comment on the state of winter preparedness in their areas

1.0 Introduction

1.1 Historically the effects of winter have been shown to place additional pressures on health and social care services across Kent and Medway. This is caused by a number of issues including an increase in respiratory illness, increased slips and falls and the impact of seasonal influenza.

1.2 This report provides a briefing to the Kent and Medway Health and Wellbeing Board which describes the actions that are being taken by the health service across Kent and Medway to prepare for winter. The key vehicle for winter planning activities is the four Systems Resilience Groups (Dartford Gravesham and Swanley / Swale Executive Programme Board; East Kent Whole System Performance Delivery Group; West Kent Urgent Care Board; and Medway / Swale Executive Programme Board) of which Kent County Council and Medway Council are core members.

2.0 System Resilience Group Assurance

2.1 NHS England expects all Systems Resilience Groups in Kent and Medway to have in place robust plans to deliver the urgent care standards and to ensure that plans are in place to effectively manage winter pressures. Therefore ahead of winter 2015/16 NHS England South (South East) has circulated an assurance toolkit to each Systems Resilience Groups which asks them to provide assurance that they have put in place preparations for the winter period. This includes key actions being taken to improve on last year's plan, delivery of the national eight high impact interventions (see appendix 1), the flu programme for staff and patients and work on Delayed Transfers of Care.

3.0 South Surge Management Framework and Systems Resilience Group Surge Management & Capacity Plans

3.1 NHS England has circulated a South Region Surge Management Framework which has been agreed by the South Region Tripartite of NHS England, Monitor and the NHS Trust Development Agency. All Systems Resilience Groups are expected to prepare Surge Management Plans that are aligned to this Framework. NHS England South (South East) has requested that these be tested via exercise ahead of winter.

4. Systems Resilience Groups Surge Capacity Exercises

4.1 NHS England South (South East) has written to each Systems Resilience Groups to conduct a Surge Capacity exercise ahead of winter 2015-16. A debrief report from each exercise will be prepared and presented to the Systems Resilience Groups to ensure that lessons identified are learned ahead of winter.

Appendix 1 - Eight High Impact Interventions

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

2. Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.

6. Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

7. Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess

models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

NHS
West Kent
Clinical Commissioning Group

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years) (CAMHS)

Kent Health and wellbeing board

16th September 2015

Patient focused, providing quality,

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years)

Summary

This paper provides a progress report on the development of the Emotional Wellbeing and Mental Health Service for Children, Young People and Young Adults in Kent.

Historically, children and young people's services have been fragmented, disjointed and confusing to navigate with services working in silos. This has often resulted in the child or young person having to 'start over' with each new service they come into contact with and a 'revolving door' culture in which the health and wellbeing needs of the child or young person are not being adequately met.

The new Model, which draws together all the current service provisions throughout Local Authority and Healthcare, outlines a whole system approach to emotional wellbeing and mental health in which there is a Single Point of Access, clear seamless pathways to support ranging from Universal 'Early Help' through to Highly Specialist care with better transition between services. Work is already taking place to implement the associated Delivery Plan; short term actions are in progress and longer term work on future commissioning plans has started.

Work is continuing with partners to look at how existing resources can be aligned to support this work. Following the final agreement of the Service Model, the contract procurement process will commence in autumn 2015.

Recommendation

Members of the Kent Health and Wellbeing Board are asked to note the contents of this report.

Due to legal obligations relating to the extension of the current contract, a procurement process is necessary in order to identify a new provider.

1.0 Introduction and Background:

1.1 In January 2014, Kent Health Overview and Scrutiny Committee (HOSC) raised concerns regarding the performance of child and adolescent mental health services across Kent. This prompted a review of the services which found disparity between how schools support CYP and staff approach to building resilience, numerous contact points and disjointed services, too much focus on Tiers of service rather than the needs of the CYP, lengthy waiting times from assessment to treatment, high numbers of cases not meeting the referral threshold and inconsistent support to young people around transition. A whole system agreement was reached that a new approach to children's mental health in Kent was urgently needed.

1.2 This issue is clearly of national concern. A national task group set up by Norman Lamb, the then Minister for Care and Support, reported similar concerns to those in Kent. This important work stream for Kent strategically fits with work across the country in improving children's emotional wellbeing provision. It strategically aligns with the NHS 5 Year Forward View, the 49 recommendations of Future in Mind, the mental crisis care concordat and KCC transformation programme for 0-25 years old.

1.3 Emotional wellbeing underpins a range of positive outcomes for children and young people and is a key multi-agency agenda. Nationally and locally, demand is rising for specialist mental health services: 3 children in every class have a diagnosable mental health condition (10%) and there is recognition of the need for a whole-system approach to promote wellbeing, identify need appropriately, and intervene earlier.

1.4 Over the last year a huge amount of work and negotiation has taken place to transform children's emotional wellbeing services in Kent. The Emotional Wellbeing Strategy has been developed and consulted on widely with children, young people and families.

1.5 In light of the complexity of the challenge agreement was reached across the system to extend two major children and young people's contracts to allow the time for organisations to develop a major transformation programme for children's and young peoples emotional wellbeing services across Kent.

1.6 This work has been developed though a range of partnership structures and governance arrangements to ensure whole system commitment and agreement. This has included regular reporting to both the Childrens and Kent Health and Wellbeing Board, bespoke strategic summit events, Clinical Commissioning Group governance structures and KCC 0-25 Portfolio Board.

This report summarises the:

- Final version of the Strategic Framework
- A multi-agency Delivery Plan
- The Model
- The Procurement Process

- Financial and Activity Mapping

2.0 What's Different in the New Model?

- A Single Point of Access (SPA) to ensure swifter referral and appropriate sign posting
- Anti-stigma campaign associated with poor mental health
- Whole school approach to improving CYP resilience
- Upskilling children's workforce
- Support to families through universal and accessible services
- Making the most of technology
- Focussed on the needs of the child and young person
- A whole system approach to reduce transfer between services
- Partnership working between Health and LA for efficient use of resources
- Improved Specialist support for long term mental health problems and during crisis
- Smooth transition between children's and adult mental health services for the 14-25's

3.0 Overview of Activity

3.1 Development of the Emotional Wellbeing Strategy and supporting Delivery Plan (presented to HOSC on 5 June 2015) has been driven by a real desire to engage with and listen to the views of children, young people, families and professionals of all backgrounds. In total, around 650 contributions have been received since June 2014 via a range of online surveys, workshops, and engagement events. The amount of interest and quality of responses given by such a wide cross-section of the local population and workforce underline the importance of this agenda, both at a strategic level and in the everyday experience of families in Kent.

3.2 The aim of such extensive engagement was to piece together a variety of perspectives in order to understand how best to design a 'whole system' approach: one not only focussed on the quality of commissioned services (crucial though these are), but also on strengthening partnership working at every stage, improving the visibility and accessibility of support, and underlining the role of all partners to promote and protect emotional wellbeing.

3.3 In addition to engagement activity, the content of both the Strategy and Delivery Plan has been directed by the findings of a refreshed Emotional Wellbeing Needs Assessment, and from a range of national and local reviews and best practice guidelines.

3.4 A draft Service Specification has been written and circulated to all CCG commissioners and Clinical Leads and KCC colleagues and the feedback is currently being collated and incorporated into the document and will be finalised by September 2015 ready for the initiation of the procurement process.

3.5 This issue is everybody's business. Families, schools and universal services play the key role in promoting children's emotional wellbeing. In addition to universal provision KCC commissions and manages contracts that deliver a range of services in relation to emotional wellbeing and is responsible for 2 key contracts relating to emotional wellbeing - the Young Healthy Minds Service and the Children in Care element of the CAMHS contract. The NHS Clinical Commissioning Groups are responsible for commissioning targeted Child and Adolescent Mental Health service. The specialist services are commissioned by NHS England.

4.0 Strategic Framework

4.1 The Strategy was developed following initial surveys and facilitated discussion groups with children, young people and families and from service providers.

4.2 The draft Strategy has been shared widely and a12-week period of engagement ran from 20 October 2014 to 5 January 2015 through the following channels:

- **Online consultation survey**, hosted on kent.gov.uk and CCG platforms, with links through the Live it Well website and KELSI. The survey was further promoted through the Schools e-Bulletin, GP bulletins, Members' bulletins, District Council and Voluntary and Community Sector (VCS) networks, Health Watch Kent and Kent Public Health Observatory.

- **Presentation of the draft Strategy and engagement discussions** held at a wide range of strategic and local multi-agency forums, including Kent Health and Wellbeing Board, Health and Social Care Cabinet Committee, Clinical Commissioning Groups, Mental Health Action Group Chairs, local Health and Wellbeing Boards, patient involvement forums, and Children's Operational Groups.

4.3 In addition to the discussions held, a range of individuals and organisations responded to the engagement. Overall findings indicated:

- 100% of respondents identified parents and carers as the primary group needing additional information and support around emotional wellbeing issues.

- Schools were identified as the second key group needing additional information and support around responding to emotional wellbeing**.**

- The structure of the strategy is around four themes: Early Help; Access; Whole Family Approaches; and Recovery and Transition. However, importantly the underpinning action to promote emotional wellbeing at every opportunity was unanimously welcomed.

4.4 Following the engagement, a number of amendments have been made to the original Strategy to incorporate feedback received (including the addition of content relating to children affected by Child Sexual Exploitation and to target health inequalities). (Please refer to the Strategy document provided to the committee on 5 June 2015).

5.0 Development and Engagement Activity for The Delivery Plan

5.1 In addition to the online survey, a number of engagement events were held during November and December 2014 to inform development of the supporting Delivery Plan. These included:

- Practitioner workshops,

- Further engagement with young people, including the development of a second film sharing young people's views about the most valuable methods of delivering support.

- A second Emotional Wellbeing Summit (18 December 2014). A number of KCC members attended the summit events.

5.2 The draft Delivery Plan summarises findings from the Kent Emotional Wellbeing Needs Assessment, engagement activity, and best practice reviews and outlines a series of

recommended actions that together will lay the foundation for a whole-system approach to emotional wellbeing.

5.3 The recommended actions will be achieved through a combination of improved partnership working, particularly in relation to much more and more effective communication, training for universal services staff, and also access to consultation with specialist professionals, as well as key procurement activity.

5.4 This means that some of the actions can be implemented in the short-term, which began in March 2015, while others will need to be included within procurement exercises for new services beginning in October 2016 (when existing contracts with providers will expire). Suggested timescales are included within the Delivery Plan, alongside recommended lead agencies.

5.5 This is clearly a multi-agency action plan; founded on the vision agreed by key strategic stakeholders and partners at the Emotional Wellbeing Summit in July 2014 that emotional wellbeing is 'everybody's business'. The recommended actions will therefore only be achievable with involvement and commitment from a wider range of partners than before – for example, in supporting relevant workforce development or embedding it within planned programmes of training.

5.6 Work is therefore continuing with partners to identify how existing resources can be realigned to support the 'whole system' approach, recognising that this is intrinsically connected to the success of specialist commissioned services in meeting need. The emotional wellbeing and mental health needs of children in care will be considered as part of this work. A technical group has been drawn together to lead on this element, led by the Clinical Commissioning Groups (CCGs).

6.0 The Model

6.1 The detail required to deliver the model will be contained within the national specification guidance and the service specification will inform the future contracts and the contractual framework required. A contract technical group has been established which has developed the Service Model in partnership with commissioners and clinicians (see Appendix 1).

6.2 Key points of the model include the following:

- Promoting emotional wellbeing – how to embed this in all the work that we do this will include a multi-agency communications strategy.

- A single point of access/triage pathway model across emotional wellbeing early intervention and mental health services.

- Enabling children and young people to receive timely access to support; development of drop-ins or safe spaces in schools.

- Increased availability of consultation from specialist services.

- A 'whole family' protocol, defining how parents and carers will be involved and identifying and responding to the wider needs of the family within assessments of the child's emotional wellbeing.

- Effective implementation of multi-agency tools and protocols to identify children and young people who have been affected by Child Sexual Exploitation (CSE), and rapid access to specialist post-abuse support.

- Emphasis in the model for continued improvement of performance to agreed contract requirements across the system

- Smoother transition between services, particularly from children's to Adult's Mental Health services and additional support for those aged 14-25 and leaving care.

7.0 Procurement Process and Contracting

7.1 The service will be procured by NHS West Kent CCG acting as a lead commissioner on behalf of other CCGs across Kent and Medway and Kent County Council. The structure of this arrangement will be defined using the standard model NHS collaborative commissioning agreement.

7.2 As this is a healthcare service commissioned by the NHS it will be procured in accordance with the relevant statutory regulations – the Procurement Patient Choice and Competition Regulations 2013. These place extensive obligations on the commissioner to act in a transparent and proportionate way, to treat providers equally

and in non-discriminatory way, and to procure the service from providers that are most capable and best value, while ensuring proper management of conflicts of interest.

7.3 The procurement aspects of the commissioning project will be led by NHS Commercial Solutions, the procurement partner of NHS South East Commissioning Support Unit (SECSU) which supports NHS West Kent CCG.

7.4 The service will be contracted using the standard NHS Healthcare services contract. In accordance with NHS recommended practice, the contract will have an initial term of 3 years and an optional extension of 2 years. The contract management for the service will be based on the provisions of the standard NHS contract, supported by the pricing model and key performance indicators defined in the service specification referred to above.

7.5 Initial assessment of the provider market indicates there is already an established wide pool of potential providers for the service. Accordingly, there is no requirement to conduct market development activity prior to the formal procurement process.

7.6 The procurement approach will be structured to mirror the provisions of a fully-regulated procurement procedure, taking account of the requirement to execute an assured and robust process within a challenging timetable. Subject to detailed planning (currently in progress) the approach will use either (a) the restricted procedure (a two-stage approach comprising an initial shortlisting stage (pre-qualification) and a tender stage) or the competitive dialogue procedure (a three-stage approach comprising an initial shortlisting stage (pre-qualification), a dialogue stage, and a final tender stage).

7.7 The procurement will be executed within the overall governance structure of the collaborative commissioning programme, resourced by a multi-disciplinary team combining subject matter experts for commissioning, clinical quality and patient safety, financial management, patient experience, workforce, information governance systems and technology, and other resources as appropriate. The team will include representatives of patient groups.

7.8 When the project team has completed the evaluation stage and its recommendation of preferred bidder have been approved, it will initiate two parallel streams of work to

(a) conclude the contract with the preferred bidder, and

(b) work with the preferred bidder on mobilisation and transition to the new service.

8.0 Financial Envelope:

8.1 The current dedicated financial envelope to deliver the new model is over £22m. This includes over £16m Health and Local Authority funding for the specialist services for children with significant mental health problems including those who are in Local Authority care and those who have been victims of child sexual exploitation.

8.2 In addition, there will be over £5m invested in support services which intervene earlier, through provision which provides additional support to children, young people and their families.

8.3 There will also be enhanced support, information and guidance offered to those services which work universally with children's - for example Children's Centres, health visiting, schools and services for adolescents. This will be delivered through information about technology available, workforce development including training and regular information provided to services.

8.4 Kent is part of a national bid for Big Lottery Funding for the Headstart programme. This programme of work is already investing in research and pilot programmes both in Kent and nationally. This will see new resource for Kent for supporting schools in promoting resilience and wellbeing, in reducing the stigma attached to ill mental health and providing guidance in how the curriculum can incorporate teaching about good mental health.

9.0 Next steps:

9.1 During Autumn 2015, the following activity will take place:

- Continued implementation of short-term improvement actions identified in Delivery Plan

- Continued scoping of the interdependencies of current pathway developments e.g. neuro development, learning disabilities, Early Help, health visiting, eating disorders pathways.

- Finalise the new NHS Child and Adolescent Mental Health specification, including the Child in Care element of the contract and the early intervention contract and agreeing contract procurement frameworks.

- Present the Model and Specification to each CCG for approval.

- Seek KCC and CCG governance approval for the proposed model and financial envelope (see Appendix 2) to deliver the new service.

- Technical group to complete activity, capacity mapping and recommend resource allocation.

- Consider consultation route for new procurement and contract framework

- Market engagement to inform development and costing of the model

9.2 It is anticipated that formal procurement processes will begin in the autumn 2015, subject to approval of specifications.

10.0 Recommendations

Members of the Kent Health and Wellbeing Board are asked to

(i) NOTE the contents of this report.

11.0 Appendices

Appendix 1 Service Model

Appendix 2 Needs Assessment

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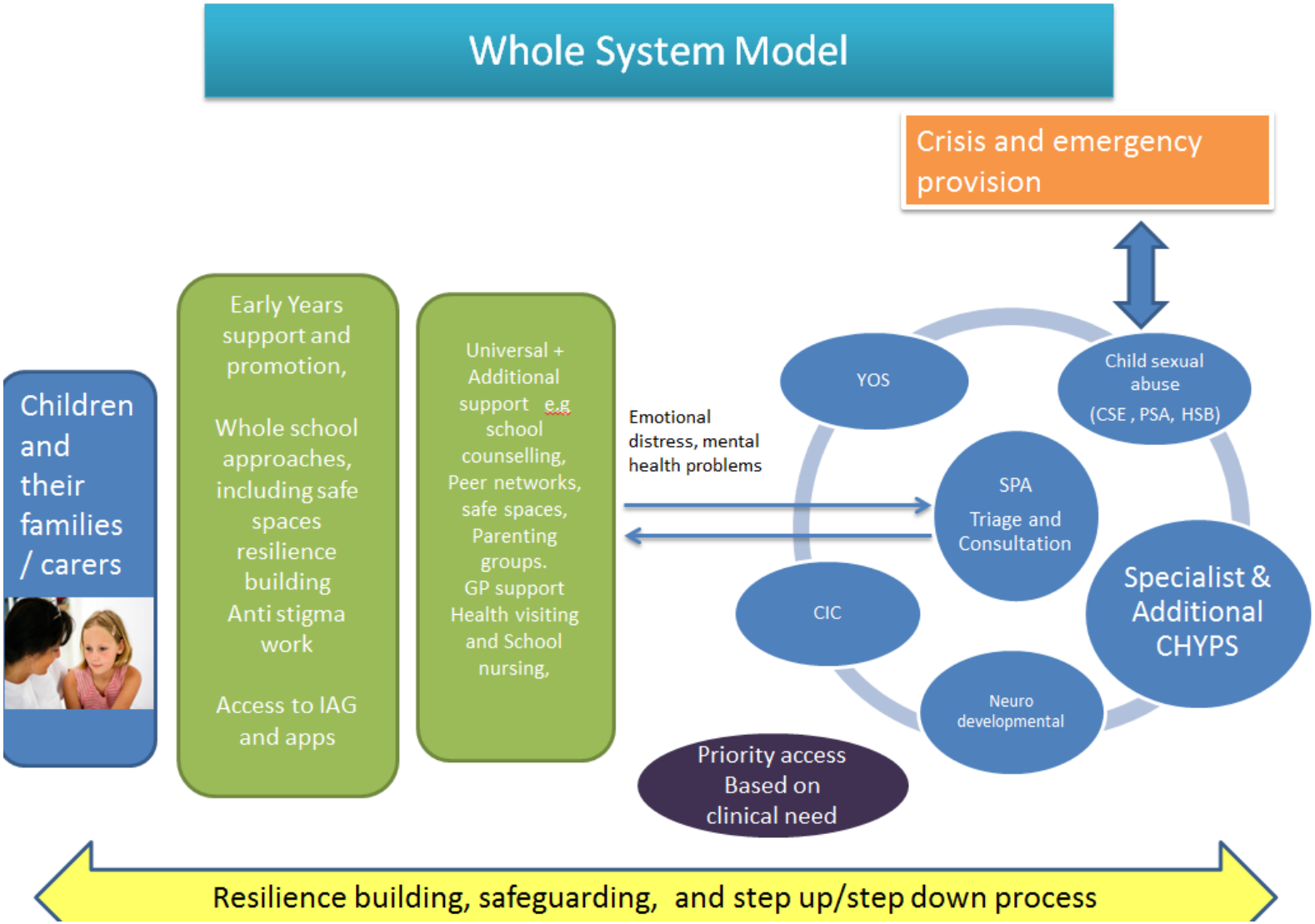
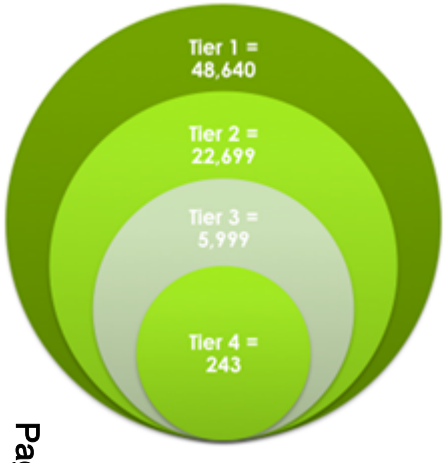
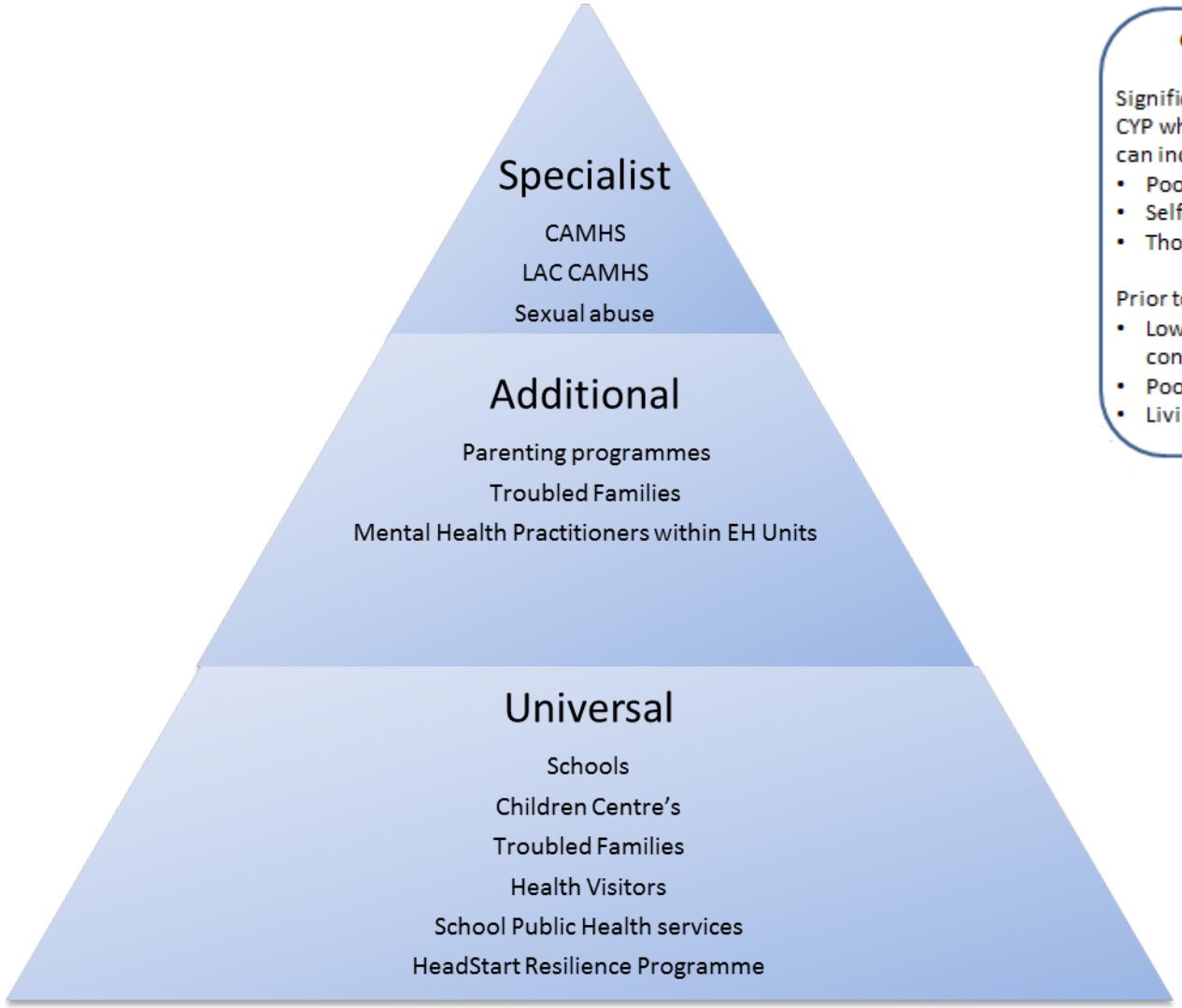
APPENDIX 1 – The Service Model



APPENDIX 2 – Needs Assessment





Child Sexual Exploitation JSNA

Significant behaviours identified by CYP who are being sexually exploited can include:

- Poor mental health
- Self-harm
- Thoughts of suicide

Prior to abuse CYP can exhibit

- Low self-esteem and lack of confidence.
- Poor mental health
- Living in a chaotic household

From: Roger Gough – Cabinet Member for Education and Health Reform

To: **Kent Health and Wellbeing Board**

Subject: **Kent Health and Wellbeing Board and Local Health and Wellbeing Board Relationships and Future Options**

Summary:

This report provides a brief overview of the piece of work being undertaken to review the relationship between the Kent Health and Wellbeing Board (KHWB) and Local Health and Wellbeing Boards (LHWBs). This report outlines the current relationships between the boards and provides details gleaned from an audit carried out to determine how the KHWB and the LHWBs are functioning and working locally and together.

In addition, this report describes the insight gathering, which has been undertaken with key stakeholders, and the key themes, issues and ideas which have emerged from this process. This insight gathering and audit material has helped to provide some context which has shaped the future options and recommendations for the Kent Health and Wellbeing Board and the Local Health and Wellbeing Boards.

Recommendation – for the Kent Health and Wellbeing Board to discuss the recommendations outlined in section 7 of this report.

1. Background

1.1 The Kent Health and Wellbeing Board was established following the enactment of the Health and Social Care Act 2012. From 1 April 2013 it became a committee of Kent County Council, prior to April 2013 the Health and Wellbeing Board operated in shadow form.

1.2 Bringing together County and District Councillors, senior officers from KCC, the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from Kent Healthwatch, the intention was to provide an effective body where commissioners, patient representatives and elected officials could have a collective overview of the health system in Kent, align areas of work, and share commissioning plans and good practice.

2. Local Context

2.1 Given the scale and geography of Kent, it was agreed that a series of sub-committees known as Local Health and Wellbeing Boards should be created. It was intended that the local Boards would lead and advise on the development of integrated commissioning strategies and plans at the local CCG level. This would ensure that there was a local focus on health and wellbeing, including a clear interest and emphasis on prevention, and enabling effective local engagement and monitoring of local outcomes.

2.2 It is recognised that the LHWBs have delivered good work at a local level. However, it has been identified that since their introduction, they have struggled to achieve clarity on the scope, purpose and direction of the local boards. In addition there is a lack of a clear mechanism for communication between the local boards and the Kent Board. LHWB priorities may differ in line with local needs and demands, but the membership, size of the Board, and level of engagement with member organisations can also differ. This has consequently led to a variety of ways of operating at the local level. Whilst this is inevitable, and to a certain extent desirable, it can create difficulties in terms of monitoring progress and empowering the Local Boards to deliver key outcomes.

3. Scope of the work

3.1 In response to the issues highlighted above, and the LHWBs' request for a stronger sense of purpose, it was decided that work was required to look in detail at how the KHWB and the LHWBs are currently operating, and how an audit and insight gathering process can be used to support and develop future recommendations for the boards. The Audit captures the current priorities and actions of both the Kent board and the LHWBs, and the mechanisms for sharing information between the boards. The audit has helped define current roles and responsibilities, aiming to provide clarity and consistency in the future. This process has identified gaps within the relationships between the boards. The Audit provides some key context for current issues and therefore provides a basis for future options and possible changes to ways of working and relationships, described within the future options section of this report.

3.2 The second phase of the project concerned engagement with key partners and stakeholders. It was important to identify these key stakeholders and partners and arrange individual and group meetings with a wide variety of people to obtain a clear understanding of where the current issues lie, as well as identify how we can ensure that the LHWBs feel empowered to deliver their responsibilities with greater clarity and purpose, whilst the Kent Board focusses on strategic issues.

3.3 The conversations with stakeholders and partners have provided key themes and information which has helped to identify gaps in the ways that the LHWB and the Kent Board are working, and identify possible options for future relationships. This has informed proposals as to how the boards should operate in the future to ensure stronger and more sustainable relationships.

4. Audit

4.1 Audit Process

4.1.1 The audit process was designed to establish the current relationships and ways of working of both the LHWBS and the Kent HWB. This process has also helped to identify how these two tiers of boards are working together, and how effective this relationship is.

4.1.2 The audit process has mostly been carried out through desk top research which has involved looking at the LHWB and the Kent HWB published data and information online. Assessing the content of the minutes has also helped to identify a lot of key information concerning the quality of the discussion and actions taken forward from each meeting.

4.1.3 The attendance and the membership of the boards has also provided some key context around the roles and responsibilities of those on the board, and helped to shape some ideas around the capabilities and willingness of these members. Whilst looking at this in detail it was also important to assess the frequency of the meetings, and whether there is a consistent and regular approach for the boards across Kent.

4.1.4 A key part of the process of understanding the current ways of working and relationships between the Kent HWB and the LHWBs is by looking into the Boards' Terms of Reference and Work Plans, if they should have them. Again, this has aided in determining any variation between the boards, as well as between what the Terms of Reference and Work Plans suggest should be done, and what is actually achieved.

4.1.5 A further piece of work has been undertaken to add to the audit which highlights the LHWB priorities (as reflected in the CCG and others' plans), the specific agenda items discussed at the LHWB meetings, and the health priorities in each local area. This information helps to map the boards' position in relation to the issues that have been identified locally.

4.2 Audit Outcomes and Emerging Themes

4.2.1 The Kent HWB is a statutory body; therefore the minutes and agendas are published online. The LHWBs publish information, minutes, agendas and attendance details on their local authority websites. From studying this information, however, there seem to be discrepancies concerning the quality and quantity of the information provided. In some cases, information was not provided at all and the frequency in which boards meet is also unclear.

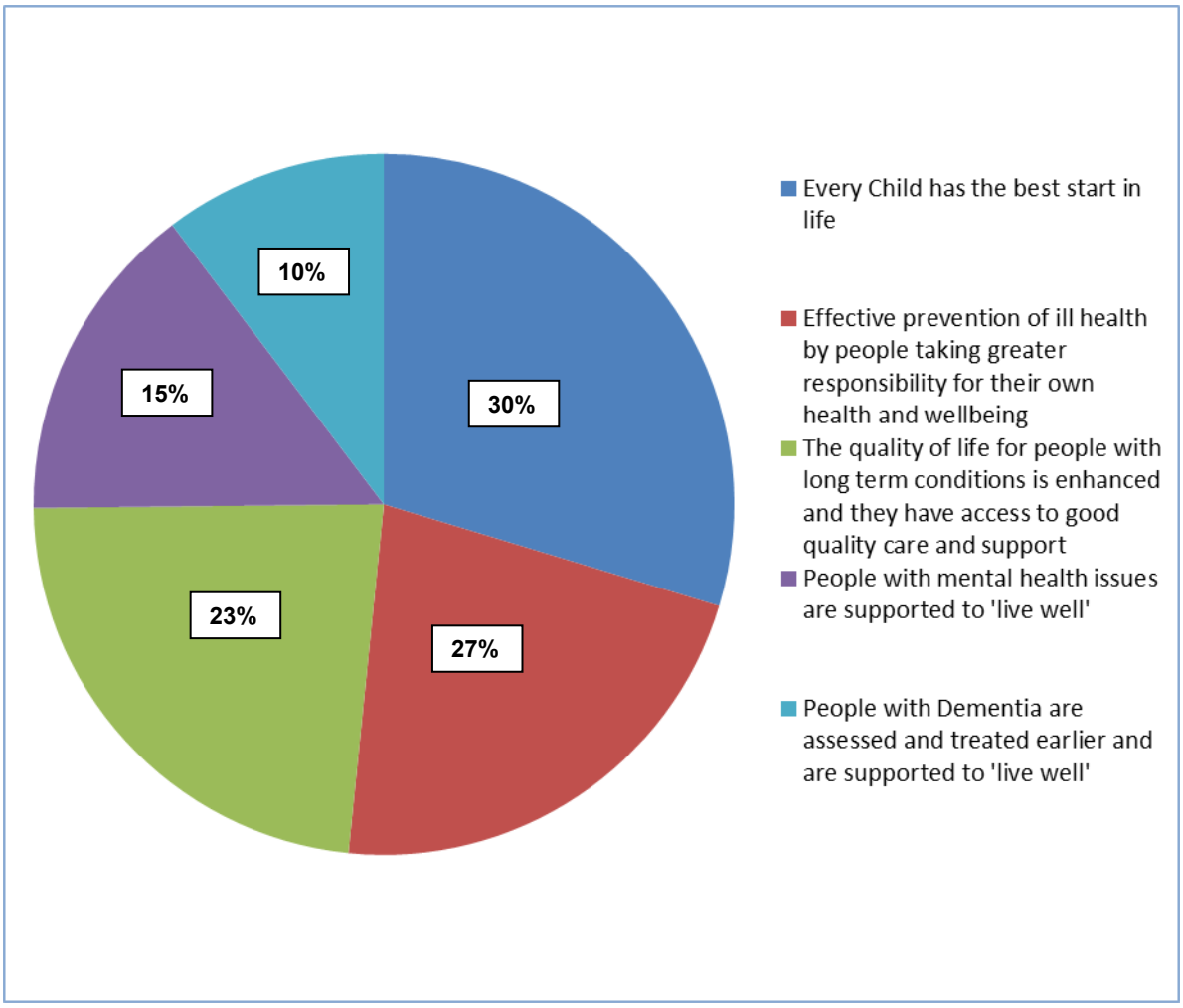
4.2.2 It has been recognised that there are several differences between the seven boards in the ways in which the meetings are scheduled and consequently run. Some of the LHWBs meet regularly and fairly frequently, every two or three months, others appear to meet less frequently with irregular timing between meetings. Similarly, the attendance differs significantly across the boards where some have frequently high levels of attendance, with many of the same members attending each time; however, some of the LHWBs have more inconsistent attendance. It is also important to note that some of

those who attend on a regular basis are official members; however, some LHWBs have frequent attendance from unofficial members, or representatives. In some cases there is reliance on a smaller 'core' group of attendees. This raises questions around membership, sustainability and succession planning.

4.2.3 A key part of the audit process was to assess the level and quality of work currently being undertaken by the LHWBs. It was recognised that within this scope, it would be important to understand not only the Local Priorities but the content of the LHWB meetings plus the quality of these conversations and the actions taken forward. As part of this process, the health and wellbeing priorities have been identified for each local area. This helps to inform the accountability and functions of each of the boards. Whilst this information usually relates specifically to public health priorities it raises wider questions about how the local boards are focusing on local priorities, how these are identified by the board and subsequently how they influence the agenda setting.

4.2.4 From this part of the audit it is clear that the specific health issues and priorities within a local area have been discussed in some detail within the LHWB meetings. In some cases there is a clear link between the priority and agenda items of the LHWBs, but in other cases there seems to be no obvious link. Due to the lack of publicly available LHWB work plans, it is difficult to identify whether the boards are addressing the priorities by design, or whether they are identified locally in a different way, such as being discussed at sub groups. It could for example be the case that other sub groups are taking forward local priorities and that the LHWB is providing a platform to discuss these issues through update reports from these group as opposed to specific agenda items.

4.2.5 The chart below represents the Kent Health and Wellbeing Strategy Outcomes, and the percentage of time the LHWBs spend on activities relating to these outcomes. Broadly speaking this shows that LHWBs are maintaining a focus on the five outcomes of the Joint Health and Wellbeing Strategy. Concerns that, for example, children's issues may not receive sufficient attention because agendas may concentrate on those regarding adults would appear to be unfounded. However, the chart does not give any indication as to whether discussion of issues on the agenda has led to concrete action or improved outcomes.



4.2.6 There is a wider issue about transparency which should be considered, given that the LHWB's are public facing and information about their work should be more readily available. However, there also needs to be a much closer connection and communication stream between the LHWB and the Kent Board and an agreement about the work plan and focus of the local boards. In this sense the issue around transparency links with the role of the Kent HWB and its role as a co-ordinating and to some degree 'tasking' group for the local boards. It has been suggested that the Kent Board needs to be operating at a higher strategic level and consequently feeding information and direction down to the Local Boards. From this, the LHWBs should have the knowledge, capacity and capability to deliver outcomes locally and consequently feed this information back up to the Kent Board. In this way the Local Boards will be more accountable and empowered to improve the health and wellbeing within their geographical areas.

5. Insight Gathering

5.1 Insight Gathering Process

5.1.1 Ensuring partner and stakeholder engagement was a vital process within this piece of work. It was identified that it would be important to have some attributable and informal conversations with relevant colleagues and partners to determine their views. It also provided the opportunity for issues to be raised.

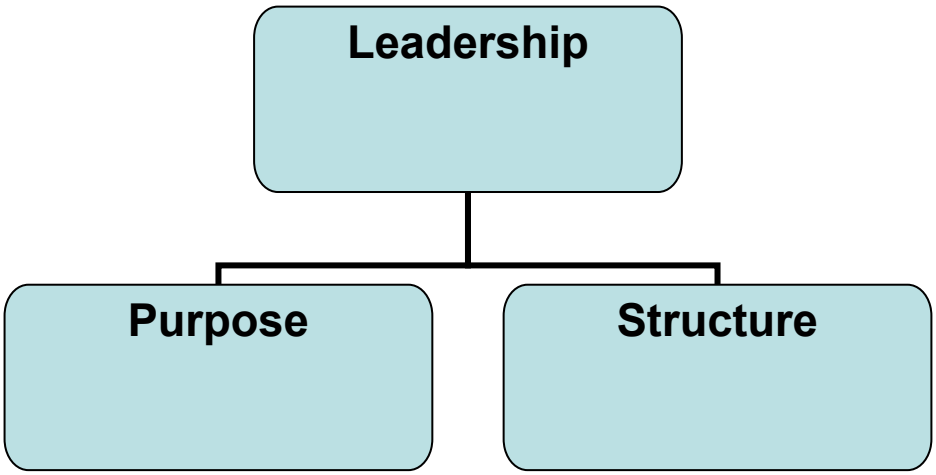
5.1.2 A number of key individual stakeholders and groups of people were identified as part of this engagement process. These included the following:

- A group meeting for the Chairs of all 7 LHWBs in July.
- Individual meetings with the Chairs of the LHWB
- Group or individual meetings with key KCC Members such as Graham Gibbens, Peter Oakford, Chris Smith, and Geoff Lymer
- Some KCC Corporate directors and Heads of Commissioning
- We also met with key external Partners such as Steve Inett (Healthwatch) and Dr Robert Stewart. (Chair of Pioneer Steering Group and Director of Clinical Design)
- The Kent Leaders (through attendance at their meeting on the 21st July).
- The Joint Kent Chiefs (through attendance at their meeting of March 12th)

6. Key Themes derived from Insight Gathering

6.1 The LHWBs have carried out good work to deliver outcomes locally but there are several issues which have been identified through conversations with partners and stakeholders, as areas for improvement.

6.2 Many of these key issues were identified in a number of different ways, and are common across different organisations represented on the boards. These common themes were raised by LHWB chairs, partners, senior officers and Members. Indeed there were common themes identified from across both the audit and the insight gathering. The key issues concern communication and relationships between the boards, accountability and purpose, engagement and representation, confidence and competence and the role of the Kent HWB. They can be grouped under three key headings; Leadership, Purpose and Structure.



Where there is a lack of leadership, the purpose and structure of the Local Boards is likely to be unclear. All three are required to ensure a fully functioning and effective working model.

6.2 Leadership

6.2.1 Feedback identified that there are issues around whether the members of the LHWBs have the perceived confidence or the skills to make a difference locally. One of the issues highlighted was that the boards are not statutory and therefore membership is voluntary and that this meant some partners were not willing to engage or share information freely. It was felt that members needed to be empowered to deliver outcomes.

6.2.2 Some stated that that there needs to be stronger communication streams coming from the Kent board to ensure that the Local Boards understand the high level priorities and strategies and feel as though they have the power to make a difference. It was felt that the Kent Health and Wellbeing Board needed to have a greater focus on the overarching strategic plan and priorities and consequently feed these messages down to the local boards. It was also felt to be important to recognise that the communication streams need to be improved from the LHWBs back to the Kent Board, and that they could provide a platform for Kent Board to understand what is being delivered locally, which would give the local boards greater confidence that the work they were undertaking was contributing to the Kent priorities and that it was having an impact.

6.2.3 Another common area of concern was that there is no agreed work plan between the Kent Health and Wellbeing Board and the LHWBs, and a lack of clarity around the ways in which the boards could be communicating to each other. It is this lack of clarity that has caused some members of the LHWBs to feel as though they are not empowered to deliver outcomes and make a difference. It is felt that the Kent Board should be working hard to be a strategic body which filters relevant information down.

6.2.4 In summary it was felt that the Kent Board needed to provide stronger leadership and direction based on the priorities set out through key documents such as the Joint Health and Wellbeing Strategic and JSNA and relating this to the work of the local boards more effectively. It was often

expressed that the Kent Board focused too much on the detail and rather should be setting the strategic direction whilst empowering the local boards to deliver the outcomes that are collectively agreed.

6.2.5 Whilst it is important to note that it was felt that the Kent HWB should be the leader for the Local Boards and be empowering the boards to be achieving outcomes locally, local partners must accept this role and invest responsibility and accountability in their representatives on the LHWBs. Without support from partner organisations, the LHWBs cannot function simply on the clear direction of the Kent HWB.

6.3 Purpose

6.3.1 Many stated that the Kent Board needed to start focussing more on policy as the county wide statutory board. However, there is some confusion over the role of the LHWB to support these responsibilities with the activities that they carry out locally and whether the LHWBs are acting as a statutory sub structure of the Kent Health and Wellbeing Board.

6.3.2 A key issue raised was that of accountability and whether the LHWB's were an important or indeed the right vehicle for taking forward specific areas of work. Due to the lack of clarity around the purpose of the boards, some organisations and members did not appear to be bought into the LHWB as a vehicle for tackling priorities and this was felt to be a particular issue for social care. In fact some commented that members of the LHWBs could sometimes focus too much on operational and local issues rather than considering the wider priorities.

6.3.3 This was felt to emphasise that the local boards are more of a collection of partners than an entity in their own right with partners not devolving accountability to the LHWBs as a vehicle to deliver their activities. The effectiveness of boards to make decisions and to hold their constituent members to account can therefore be compromised.

6.3.4 There is no standardised terms of reference represented across each of the LHWBs. This adds to the difficulty in understanding the representation of the members on the boards, as well as the roles and responsibility to the boards, and in sharing information with partners and to their own organisations. Some local boards have adopted terms of reference especially where there is a degree of co-terminosity between CCGs and district councils. Where boards straddle more than one district boundary issues of comparative influence in any decision making process has been difficult to resolve. The status of district authority officers has also proved problematic including whether they can be bound by the KCC code of conduct which would require them to declare any interests they may have that are relevant to the meeting.

6.3.5 Some district councils also find themselves having to attend multiple boards where their district straddles two CCG areas.

6.3.6 Whilst the good work being done locally by the boards was highlighted, the lack of clarity of purpose can mean some partners do not see the board as an effective vehicle for delivering their priorities. The purpose of the boards needs to be revisited and clarified in order to empower members. This is very much linked to the discussion around leadership and direction from the Kent Board.

6.4 Structure

6.4.1 Many respondents expressed confusion around representation on the LHWBs and the capacity in which people attended. From local government there is representation from both officers and Members. A number of members will fulfil more than one role. For example a local authority member of the local board could be chairing the board, representing their own district at a local board whilst also attending the Kent Board as a representative of their own authority, district councils more generally and their own health and wellbeing board. Who speaks for whom and when is not always clear. There is no mechanism to determine who should represent local boards at the Kent Board and vice versa.

6.4.2 There has also been a question raised around the roles of VCS on the local Boards. Some boards have VCS representatives but this is not consistent and there remains a question over the capacity in which they attend; is this as a provider or as a champion of the sector and if so what are the mechanisms for filtering information back in to the local VCS? An additional report has been provided on this issue setting out the opportunities for a future relationship between the VCS and the Kent HWB and local boards and should be read in conjunction with this report.

6.4.3 There is also an issue around how the Kent Board engages with partner organisations who are not board members. It has been established that providers should not be board members; however, an effective communication stream was felt to be vital to ensure that the provider relationship with the local board is constructive and effective. Some areas have established, or are proposing, arrangements where commissioners and providers meet collectively at a health economy level outside the local board structure. The relationships between these groups and the local boards are unclear apart from sharing membership of a number of people.

6.4.4 There are inconsistencies around how the LHWBs work with their sub committees. It has been recognised that some of the sub groups to the boards have been set up directly through the LHWB, for example the Mental Health Task Group in Canterbury. However some of these groups existed prior to the LHWBs being introduced. This has, in some cases, caused difficulty in developing a clear link between the sub groups, and a lack of a clear communication stream throughout.

6.4.5 Some LHWBs utilise their Integrated Commissioning Groups to a greater extent than others. Similarly Children's Operational Groups that exist in most areas are still exploring their relationships with local boards. (Also known as

Local Children's Partnership Groups these are intended to give consistency to partnership working to drive improvements in specific outcomes related to children and young people). It has also been recognised that some of the LHWBs may have effective relationships with some but not all of their sub groups. For example Ashford has a Lead Officer Group which acts as a steering group for officer prior to putting issues to the board, and also a Health Infrastructure Working Group. Ashford LHWB works well with these sub committees but less effectively with others, where communication streams and links are less clear.

6.4.6 Different boards are developing different substructures in order to address local priorities. Other differences exist in the existence of groups that may supplement the work of the boards such as Integrated Commissioning Groups. It is clear that there is no common work plan or strategy for the LHWBs and how they should be utilising their sub committees to improve the health and wellbeing within their geographical areas. There is a lack of clarity around the purpose of these sub committees and how the LHWBs could, or should, be relating to them.

7. Recommendations

7.1 Kent Health and Wellbeing Board

7.1.1 The Kent Health and Wellbeing Board will produce an outline work programme for the start of each year to enable local boards to plan their activity accordingly.

7.1.2 The Kent Board will clarify the means by which local issues can be escalated to the Kent Board.

7.1.3 The Kent Health and Wellbeing Board will ensure that relevant issues are referred to local boards with clear expectations regarding further action at a local level.

7.1.4 The Kent Board will provide policy support to the local boards to assist in the development of relevant substructures and work programmes.

7.1.5 Opportunities for development work for both chairs of the boards, and individual boards themselves, will be investigated and made available to local board members.

7.1.6 The Kent Board will provide data and information through its sub-group the Multi-Agency Data and Information Group.

7.2 Relationship between the Kent Board and local boards

7.2.1 The LHWB chairs will meet with the chair of the Kent Board every six months. This meeting will include consideration of the workplan of the Kent Board, and its relationship to the work plans of local Boards.

7.2.2 Each LHWB will send a representative to every Kent HWB, to update the Kent board on their activities locally, and to take any relevant information from the Kent board back. This representative will also be responsible for liaising with the Kent Board concerning issues and matters that would benefit from consideration at the Kent Board.

7.2.3 Proceedings of the Kent Board to be a standing item on all local board meeting agendas with particular reference to issues referred from the Kent Board for local consideration and action.

7.2.4 All agenda items that come to the Kent Board will be considered as to how local boards could and should be involved in their future progression.
All local boards will provide an annual report to the Kent Board regarding how they have been progressing with the five outcomes of the Kent Joint Health and Wellbeing Strategy, and their engagement with the commissioning plans of their constituent organisations. The report will also describe how issues referred from the Kent Board have been considered and how local implementation of any necessary activity has been supported.

7.3 Board business

7.3.1 All local boards will develop a work programme for the coming year. This work programme will relate to:

- the five outcomes of the Kent Joint Health and Wellbeing Strategy
- the health and wellbeing priorities of the area as identified by the Kent Public Health department
- the health inequalities within the area and between the area and others in Kent
- Engagement with the development of commissioning plans of the organisations represented on the board.

7.3.2 Engagement with the commissioning plans of partner organisations should focus on opportunities to promote integration, especially between health and social care services. Whether the plans offer the best possible approaches to local issues should also be considered.

7.4 Structure and Governance of local boards

7.4.1 All LHWBs should have an agreed Terms of Reference by March 2016. Proposals for Terms of Reference, to be drafted following discussion at meeting of Chairs of Boards, to be brought to the Kent Health and Wellbeing Board at its meeting in January 2016.

7.4.2 Local boards to review their membership, substructures and associated working groups to ensure they are fit for purpose. Substructures should provide capacity to deliver the activity required to implement the work of the

board to deliver the five outcomes of the Joint Health and Wellbeing Strategy and allow proper oversight of commissioning plans. The substructure may include the local Children's Operational Group(s) and Integrated Commissioning Groups. The responsibilities of groups in a Board's substructure for reporting to the Board on specific outcomes from the H&WB Strategy should be clearly defined.

7.4.3 Relationships between the local boards and other meetings of commissioners and providers should be clarified.

7.5 Wider relationships

7.5.1 The substructure adopted by the local boards must also ensure that the appropriate relationships with service providers within the area are properly represented.

7.5.2 Appropriate relationships with representatives of other important sectors and organisations should also be reflected in the membership of the board or within its substructures. These should include the Voluntary and Community Sector and could include other local stakeholders such as Parish Councils.

8. Background Documents

Appendix 1 Kent Health and Wellbeing Board Organisational Structure

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Kent HWB

Members

Roger Gough (Chairman), Dr Fiona Armstrong, Dr Bob Bowes (Vice-Chairman), Ian Ayres, Cllr Andrew Bowles, Hazel Carpenter, Paul Carter (KCC Leader), Andrew Scott-Clark, Dr Darren Cocker, Ms Patricia Davies, Graham Gibbens, Felicity Cox, Steve Inett, Andrew Ireland, Dr Mark Jones, Dr Elizabeth Lunt, Dr Navin Kumta, Dr Tony Martin, Peter Oakford, Simon Perks, Dr Robert Stewart, Cllr Paul Watkins, Cllr Lynne Weatherly

Ashford CCG HWB	Canterbury and Coastal CCG HWB	Dartford, Gravesham and Swanley CCG HWB	South Kent Coast CCG HWB	Swale CCG HWB	Thanet CCG HWB	West Kent CCG HWB
Members	**Members**	**Members**	**Members**	**Members**	**Members**	**Members**
Cllr Michael Claughton Dr Navin Kumta Cllr Peter Oakford Simon Perks Bill Millar Neil Fisher Paula Parker Faiza Khan Mark Lemon Caroline Harris Tracy Dighton Martin Harvey Stephen Bell Philip Segurola John Bunnett Sheila Davison Christina Fuller	Eileen Shrubsole Debbie Smith Jayne Faulkner Faiza Khan Dr Mark Jones (Chairman) Sue Chandler Velia Coffey Amber Christou Michelle Farrow Neil Fisher Graham Gibbens John Gilbey Joe Howes Steve Inett Mark Lemon Paula Parker Simon Perks Cllr Ken Pugh Jonathan Sexton Sari Sirkia-Weaver Anne Tidmarsh Paul Watkins Alison Hargreaves (Secretary) Christopher Ives	Councillor Mrs Ann D Allen MBE Lesley Bowles John Britt Andrew Scott - Clark Andrew Scott- Clark Councillor Jane Cribbon Councillor Roger Gough Catherine Handley Dr Elizabeth Lunt Melanie Norris Councillor Tony Searles Debbie Stock Ann Tidmarsh	Councillor Paul Watkins (Chairman) Dr Joe Chaudhuri (Vice-Chairman) Theresa Oliver Karen Benbow Councillor Sue Chandler Councillor Patrick [Pat] Heath Jennifer Hollingsbee Mark Lobban Geoff Lymer Michael Lyons Ms Jessica Mookherjee Jan Perfect Mr Steve Inett		Colin Thompson Dr Tony Martin Councillor Mrs Iris Johnston (Vice-Chairman) Hazel Carpenter Dominic Carter Esme Chilton Councillor Graham Gibbens Councillor Elizabeth Green Madeline Homer Mark Lobban	Gail Arnold Julie Beilby William Benson Councillor Mrs Annabelle Blackmore Dr Bob Bowes (Chairman) Lesley Bowles Alison Broom Cllr Alison Cook County Councillor Roger Gough Jane Heeley Fran Holgate Dr Caroline Jessel Dr Tony Jones James Lampert Mark Lemon Jonathan MacDonald Reg Middleton Cllr Mark Rhodes Dr Sanjay Singh Penny Southern Malti Varshney Cllr Lynne Weatherly

Sub Groups

Children's Health and Wellbeing Sub Committee	Children's Operational Group	Children's Operational Group	Integrated Commissioning Group	Health improvement partnership	Children's Sub Committee	Task and finish group on long term conditions
Lead officer group	Mental Health Action Group	Health Inequality groups	Children's Strategic and Operational group	Swale/DGS Integrated Operational Commissioning Group		Childhood obesity task and finish group
Health Infrastructure Working Group	Joint Commissioning Delivery Group	Mental Health group	Healthier South Kent Coast Group	Children's Operational Group		Tobacco control and smoking cessation working group
	Alcohol strategy group and safeguarding group					Children's Operational Group
	Children's Centres District Advisory Board					
	KIASS Local Delivery Group					
	Troubled Families Local Operational Group					

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From: Roger Gough – Cabinet Member for Education and Health Reform

To: Kent Health and Wellbeing Board -

Subject: Developing the relationship between Kent's Health and Wellbeing Board and the VCS

Status: Unclassified

Summary:

The Kent Health and Wellbeing board previously raised the question as to whether it should be developing its relationship with the VCS (Voluntary and Community Sector) in Kent. Since then the review of the local health and wellbeing boards has also raised the issue of representation and developing the relationship with the VCS at a local level.

Similarly KCC has been reviewing its strategic relationship with the sector in the future and nationally the role of the VCS sector in supporting communities and individuals has been increasingly debated over the past few years. This report sets out a number of considerations for the Kent Health and Wellbeing Board (KHWB) in regards to developing its future relationship with the Kent VCS.

Recommendation(s):

The Health and Wellbeing Board is asked to:

1) Comment on the content of the report

2) Consider the options for the board's strategic and local relationship with the VCS and identify next steps

1. Introduction:

1.1 The review of the local boards has provided an opportunity to consider the future relationship with the VCS. This report is intended to begin the conversation about how the boards can utilise their cover across a range of services and partner organisations to develop their relationship with the sector, which goes beyond service and organisational boundaries to sharing best practice and intelligence to the benefit of stakeholders and communities.

1.2 Whilst there is clearly a vital role for the VCS to play in improving the health and wellbeing of Kent's residents, we know that the majority of VCS organisations in Kent do not have a direct relationship with public sector agencies. They are not funded by the public sector to provide services but are focused on their own mission, supported by other means and driven by the needs of communities and residents.

1.3 KCC has recently developed a VCS policy, which has been informed by an in-depth 12 week consultation with the sector. Whilst the policy specifically

sets out KCC's corporate relationship with the sector in the future, some parallels can be drawn and it perhaps provides useful context for the board's discussion about its own relationship with the VCS. Equally partners around the HWB table are likely to be reviewing or re-establishing relationships with the VCS in response to changing conditions and new models of care.

1.4 A key driver of KCC's policy is that its future relationship with the sector must focus not only on those organisations it commissions but must increasingly recognise the need for a collaborative relationship with the wider sector. Similarly the infrastructure support KCC provides to the sector must ensure it continues to thrive; providing opportunities for the sector to skill share, access funding advice and business support. A criticism from the sector itself has been that KCC has had an overly paternalistic relationship with the VCS and in the future this should be one built on equal partnerships. A relationship predominantly based around funding has led to our engagement being focused on a relatively small number of organisations perhaps at the detriment of accessing the vast amounts of intelligence the wider sector holds and inadvertently limiting our view of the innovation across a vast array of organisations.

1.5 This report is intended to be a 'think-piece' to begin the Kent and local health and wellbeing boards consideration of how they develop their relationship with the VCS, what relationships are most important and how best to achieve it.

2. National context

2.1 The Voluntary sector nationally plays a central role in the delivery of health and social care services, The Kings Fund stated in its 2011 report entitled *'The voluntary and community sector in health- the implications of the NHS reforms'* that "The statutory sector spends £3.39 billion on health services provided by voluntary and community organisations (Clark et al 2010)[1]". Furthermore the role of the VCS in preventative services and the emphasis placed on 'social prescribing' by the Secretary of State has only increased the importance of GP's and CCG's in particular, developing a relationship with the voluntary and community sector. The Five Year Forward View is also clear that we need to design better ways for the VCS to work alongside the NHS and to engage communities and citizens in the future of health care.

2.2 A recent review commissioned by Public Health England, the Department of Health and NHS England which has been led by an advisory group including representatives from the VCSE sector, is looking into the role of the sector in health and care and the current state of collaboration and partnership working. In its interim report it has stated that the current approach to partnering, funding and commissioning the VCSE sector are not creating an environment in which better health and wellbeing outcomes will be achieved. Particular issues were also highlighted around short term funding, with some organisations feeling that their work is seen as an add-on and therefore resourced with repeated short term funding. Whilst the role of the VCSE in improving health and wellbeing outcomes is recognised within policy, it is not consistently supported in practice and very often

[1] http://www.kingsfund.org.uk/sites/files/kf/Voluntary-and-community-sector-in-health-implications-NHS-reforms-The-Kings-Fund-june-2011_0.pdf

organisations do not feel they are treated as equal partners. Whilst effective funding is required, this alone will not improve health and wellbeing outcomes. This analysis is certainly replicated in the findings of KCC's consultation on its VCS policy and has informed the future relationship this sets out.

2.3 The role of the sector is not simply as a service provider and since the introduction of the Health and Wellbeing Boards the sector has been attempting to establish their relationship with the boards and its role in developing key documents such as the JSNA and JHWS. The local intelligence the sector can offer in terms of identifying local needs and gaps in provision has been often highlighted nationally but the extent to which this has been utilised has differed greatly and many in the sector would argue it is underused and underrepresented in the development of strategic priorities.

2.4 Regional Voices[2] was awarded funding from DoH to support effective VCS engagement with health and wellbeing boards; in the South East this is led by RAISE[3]. They work with the VCS by giving them up to date information on HWB'S and identifying ways of influencing the boards. They have developed a range of models for engaging the VCS on HWBs ranging from a single voice, to multiple representatives or sub groups which support the development of key documents such as the JSNA and health and wellbeing strategies.

2.5 A national survey by Regional voices in 2015[4] found that only 9% of respondents felt they were linked with the work of the HWB. Where there was representation from the VCS on the boards only 31% of respondents felt they were able to discuss the activity of the health and wellbeing board with the VCS representative and 42% of respondents did not feel that the VCS rep on the HWB was accountable to the wider sector. However VCS reps on the boards felt that they were able to influence the JSNA and JHWS so that it reflected community needs compared to the wider sector that did not.

3. The voluntary sector in Kent

3.1 There are approximately 4,658 registered charities active in Kent, of which, 3,631 operate at a local level[5]. 43% of these charities have an income under £10K.

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[2] Regional Voices are "are a voluntary sector Strategic Partner of the Department of Health, NHS England and Public Health England and work with other partners, supporting voluntary and community organisations to understand changes within the NHS and support organisations to influence these changes, in order to achieve better outcomes" *They support the voluntary sector to influence local strategic decision making in health and social care. http://www.regionalvoices.org/health-wellbeing*"

[3] RAISE aims to help the voluntary and community sector in the South East be as effective as possible. They provide information, advice, connections and practical ideas for voluntary and community organisations, particularly in the area of health and social care. RAISE collaborates with 8 other regional networks to form Regional Voices to build the capacity and capability of the voluntary and community sector to engage with the health and social care agenda and act as a critical friend to health decision-makers by providing a coordinated response to consultations and programmes

[4] http://www.regionalvoices.org/hwb-reps/survey

[5] NCVO and Big Society Data based on UK Civil Society Almanac definitions http://data.ncvo-vol.org.uk/areas/kent

3.2 In 2013/14 KCC's total spend with Kent based VCS organisations for the provision of services was £123m, (this does not include all grant funding). Whilst KCC is a significant funder of the VCS in Kent, District Councils and NHS partners equally provide significant investment into the local VCS. However public sector contributions to the sectors income as a whole should not be overestimated as nationally, income from individuals is the largest proportion of income for organisations of all sizes. For small organisations this is particularly significant with 56% of their income coming from individuals.

3.3 The sector brings in significant investment to Kent; research by NCVO and Big Society Web found that the 3142 charities in Kent[6] with a reported income have an income of £398.7m[7]. We should also not underestimate the sector as a significant employer, as well as the significant social and economic value of the many volunteers who provide the backbone to a range of VCS organisations. In 2012/13 the largest charities in Kent (those with an income greater than £500K) employed 6489 staff (FTE)[8]. In the same year these charities also had 11,386 volunteers within their organisations[9].

3.4 The largest group of charities in Kent fall within Education/Training with 1795 charities operating in this area[10]. The largest group of beneficiaries is Children and Young People with 1969 charities supporting these. 942 charities are supporting elderly and older people and 808 people with disabilities.

3.5 Housing Associations, (where registered charities) and NHS charities, whilst not considered in the general charities figures above, must also be recognised for the considerable role they play in supporting individuals and communities in Kent and the important relationship they have with a range of public sector partners. The future relationship with the VCS should consider the wider VCS in this context.

4. Current relationship with the VCS in Kent

4.1 At present the VCS is not represented on the KHWB. Nationally there has been some confusion about the role of Healthwatch in relation to the VCS with some boards believing that it represent the sector, however it is clear that its role is to promote and support the involvement of the public in the commissioning and provision of local services. Furthermore where VCS representatives are at the HWB table, the level of engagement of the wider sector still remains a challenge.

4.2 That said, many partners around the health and wellbeing board table have existing relationships with the VCS, although these are often specific to a service or geographical area and most often developed through a funding arrangement. What appears to be missing is a mechanism for the VCS to

[6] This is based on the "general charities" definition. This definition takes all registered charities as a base, but excludes certain categories of charity to produce a tighter definition. The general charities definition excludes independent schools, faith charities, those controlled by government and others.

[7] This total income figure is based on the latest income of charities in the population, so does not reflect the total income in one financial year http://data.ncvo-vol.org.uk/areas/kent/income

[8] http://data.ncvo-vol.org.uk/areas/kent/workforce Figures based on 103 charities who returned data

[9] http://data.ncvo-vol.org.uk/areas/kent/workforce. Charities are not required to record this, and measurement can be inconsistent, results should be treated with caution. Only 65 charities returned data on volunteers.

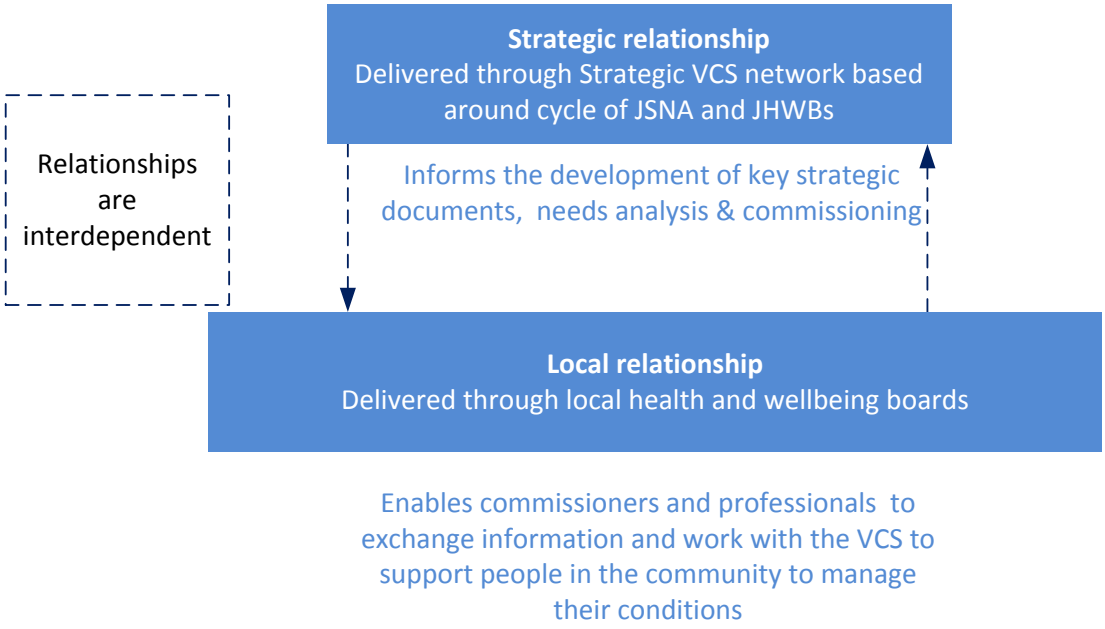
[10] NCVO and Big Society data http://data.ncvo.org.uk/areas/kent/classification

engage with public sector partners collectively or indeed a conscious decision as to whether such a mechanism is required, to establish an ongoing and mature relationship for the benefit of all stakeholders

4.3 The HWB does not need to duplicate relationships with the VCS where they already exist but a strategic relationship with the sector which helps to identify the needs of communities and assess the capacity of the sector, could be beneficial to all stakeholders around the health and wellbeing board table. Similarly at a local level developing a more in-depth understanding of the sectors ability to contribute to meeting the health and wellbeing needs of the population could be particularly beneficial.

5. Future relationship with the VCS

Kent Health and Wellbeing Board's relationship with the VCS



5.1 **Developing a strategic relationship- influencing local health and social care commissioning**
Whilst KCC has begun to address its strategic relationship with the VCS, the principle of moving towards a more collaborative relationship, where the VCS is recognised as a key strategic partner is one that could be equally developed across the HWB agenda.

5.2 The VCS whether funded by public sector agencies or not, plays an important role in the health and wellbeing of communities and perhaps more importantly because of its position rooted within local communities is a valuable source of knowledge about local needs and gaps in provision. Embedded in local communities, VCS organisations often play a role in demand management; supporting those who may otherwise require health or social services. Many of these organisations are likely to be micro or small in size however the impact of any of these organisations 'falling over' is likely to be significant to public sector organisations.

5.2 A better understanding of the VCS and how the sector contributes to the priorities of the KHWB could be both beneficial to stakeholders but through an ongoing dialogue could also provide the VCS with a better understanding of commissioning priorities. With a consistent criticism from the sector that there should be more information available about commissioning intentions and better market engagement, this is an area where arguably a future relationship should focus. In addition, an ongoing dialogue between the sector and the KHWB partners could enable the refinement of commissioning processes, to make them more accessible and where appropriate the development of grant funding pots where it is considered a more appropriate mechanism to meet identified needs.

5.3 However, representation at the KHWB perhaps falls short of forming a meaningful relationship between stakeholders at the board and the VCS; the sector is vast and in many ways is not one sector but a range of organisations which come together under the not-for-profit and charitable banner. To form a relationship with such a sector through one representative is perhaps unrealistic and the capacity in which the VCS would be represented would need consideration; if this is a commissioner provider relationship then providers more generally should be represented.

5.4 The establishment of a VCS network which could be opened up to a wide range of VCS organisations could be more effective if run alongside the cycle of reviewing the JHWS, the JSNA and setting strategic priorities of the KHWB. In this capacity the VCS relationship would be focused on identifying need, demand and the strategic 'system' issues rather than simply a funder, provider relationship. Furthermore a mechanism such as this would support the Terms of Reference of the Kent Health and Wellbeing Board *to develop and implement a communication and engagement strategy for the work of the HWB; outlining how the work of the HWB will reflect stakeholders' views and discharge its specific consultation and engagement duties (…).*

5.5 However, establishing a strategic relationship between the board and the VCS will only be successful if the local relationships and understanding of the VCS are also strengthened. Local networks will need to feed into the strategic overview of the Kent Board and arguably it is those local relationships which will be most important to commissioners given that most VCS organisations will not be pan Kent but embedded in local communities.

5.6 Understanding and accessing the local VCS market

Stakeholders from across District Councils, health, public health and social care have varying relationships and understanding of the local VCS sector and how it is supporting local communities and individuals. With increasing emphasis on people managing their own health, set out in the Five Year Forward View, clinicians will need to be able to work alongside and access the VCS to help support people to manage their own health and conditions.

5.7 Representation at the local health and wellbeing boards is perhaps a good mechanism for developing local intelligence and information exchange, however to date this has varied across the CCG areas, as identified in the recent review of local health and wellbeing boards. Furthermore the capacity in which VCS representatives attend the local boards needs to be clarified; ultimately representation at the board should be on behalf of the wider VCS with a responsibility to sharing information and acting as a

local conduit, if it is to be successful. Representation in this way could help to identify gaps in the market, unmet need and enable commissioners to develop local solutions to navigating the VCS sector and understanding the support available to patients/service users in their area. Development of this local relationship would also provide vital intelligence to feed into the strategic overview of the Kent Board.

5.8 Further consideration of Healthwatch is perhaps also required, with the possibility of establishing a more effective engagement mechanism between Healthwatch and the VCS. Whilst some work is being undertaken to identify a Healthwatch representative within VCS organisations arguably the interface between the two could be better articulated or formalised in the future.

6. Conclusions:

6.1 The review of the local health and wellbeing boards and the work which will evolve as a result has provided an opportunity to rethink the relationship with the VCS through both the Kent and Local Boards. Perhaps though a wider question for the board, that requires further consideration is the level of engagement boards should have with providers. If the VCS is to be engaged in this capacity then the debate will need to be broadened out.

6.2 However, representation on local boards could certainly provide the foundations for better local relationships with the VCS, as has been highlighted in the review of the local boards and could help to develop local solutions to navigating the vast array of services the VCS has to offer. However, the capacity in which VCS representatives attend local boards needs defining and the responsibility that representatives have in providing a conduit for information to the sector must be clearly set out for it to be an effective mechanism for engaging a diverse and changing sector.

6.3 Given the localised nature of the VCS and the subsequent diversity from one geographical area to the next, developing local networks and relationships will be vital. If issues of accessing the VCS and navigating through a complex but vitally important sector are not dealt with locally, then a strategic relationship will simply be another engagement mechanism without any real impact; that is unable to focus on the 'bigger picture' bogged down in the detail of local issues. However, developing a strategic relationship to run in parallel to local engagement would provide the Kent Board with intelligence on collective demand and pressures- aggregating locally held intelligence into a strategic view and an opportunity to share good practice.

6.4 The development of both a local and strategic VCS engagement mechanism is perhaps a timely piece of work to be taken forward given the recent review of the relationship between the local and Kent Board. As work to improve this evolves it would be pertinent to consider how a more developed and mature relationship with the VCS can further support the health and wellbeing agenda in Kent.

7. Recommendation(s):

The Health and Wellbeing Board is asked to:

1) Comment on the content of the report

2) Consider the options for the board's strategic and local relationship with the VCS and identify next steps

Author:
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From: Dr Robert Stewart, Chair Integration Pioneer Steering Group

To: Health and Wellbeing Board, 16th September 2015

Subject: **Update on Health and Social Care Integration**

Classification: Unrestricted

Summary:

This report is intended to update the Health and Wellbeing Board on the current status of the Health and Social Care Integration programme, including recent developments and plans up to 2016.

Recommendation(s):

The Board is asked to consider and comment on the content of this report and proposed next steps in taking forward health and social care integration

1. Introduction

1.1 The national Integrated Care and Support Pioneer programme was launched in November 2013 to assist selected authorities to progress with their health and social care integration plans at pace and scale. As one of the original integration Pioneer sites Kent established an Integration Pioneer Steering Group (IPSG) as a sub-group of the Health and Wellbeing Board to coordinate the delivery of the objectives identified in the Kent Pioneer bid.

1.2 Kent's Pioneer programme is structured to support implementation at a local level, providing added value to CCG areas as they work to implement their vision for integration and facilitating shared learning across Kent in areas of commonality. This was further supported by the introduction of the Better Care Fund as the driver for integration in 2015/16.

1.3 This report highlights some of the key developments during 2015 and the next steps for 2016.

2. Financial Implications

2.1 **The Better Care Fund (BCF)**: The BCF plans continue to support integration from a local perspective and engagement of providers. A dedicated KCC Finance Officer is in post to manage the arrangements on a day to day basis, to ensure all requirements are met and the complexity of this system is managed. Updates are routinely reported to the Social Care, Health and Wellbeing Directorate Management Team held with CCG Accountable Officers, to ensure alignment of the BCF with local plans and priorities.

2.2 **Integration Pioneer Programme Budget**: The funding from NHS England that was available during 2014/15 to support the activities of the Integrated Pioneer Programme and team has not been automatically allocated for 2015/16. A support plan is now required and has been produced to bid for funding and other types of support available. A range of support and funding has been requested via this process and the outcome is awaited from NHS England.

3. The Report

Progress continues against a range of long standing projects and initiatives plus a number of newer high profile and innovative development are in progress across Kent as follows:

3.1 **The Innovation Hub**: The Kent Innovation Hub has been providing a way for members of the public and organisations to progress with an integrated health and social care system. The Hub is a network of local, national and international organisations from across health, social care, the voluntary sector, industry and academia. Earlier in 2015 The Hub was recognised by the EU as a site of excellence as part of the CASA European Innovation programme in the category of Integrated Regional Policy, Business and Knowledge. Kent as a pioneer continues to take a lead role on Europe across national and international partners. The concept of innovation hubs will be developed further in conjunction with a current submission for Kent to become a test bed site for innovation.

3.2 **Innovation Test Bed Site submission**: To develop the work of innovation hubs an application to become a test bed site for innovation is in progress. This incorporates the 'Internet of Things' and how innovation could revolutionise health and social care and specifically support frail, elderly people to remain independent for as long as possible. Applications to become a test bed site were invited by NHS England and following the initial expression of interest on 13.6.16, the Kent Integration Pioneer Programme team were invited to participate in an event on 29.7.15 to meet private sector companies who are developing innovative approaches and services in the health and social care sector. A further invitation was issued to attend the NHS Expo on 3.9.15 to meet again with companies to explore the 'combinatorial' potential of working together on a technological platform of innovation, research and alternative delivery models. A final submission is now being developed and NHS England will select five test bed sites by the end of December 2015 to go forward for full support and funding.

3.3 **Think Local Act Personal**: Kent signed up to the national 'Making It Real programme' earlier in 2015. Making it Real (MIR) is a set of "I" statements and descriptors of what good personalised care and support looks like developed from the perspective of people receiving care and support and carers. It covers six areas: information & advice; active & supportive communities; flexible integrated care & support; workforce; risk enablement; personal budgets & self-funding. Events are now underway in each CCG locality with members of the public to measure the progress against the original MIR action plan. The

feedback received will feed in to the review of progress made on integration and forward planning in to 2016/17. As one of two Pioneer sites in England leading the way on this work, the Kent team have been asked to facilitate a workshop at the next national Pioneer Assembly on 29.9.15, to share outcomes, learning and best practice.

3.4 **Shared Care Planning:** West Kent CCG continue to lead on the procurement and implementation of a shared care plan system. The CCG has procured a system from Orion Health and now is implementing the first phase. Care plans developed by GPs to avoid unplanned admissions to hospital are impacted. This means moving care planning from the restricted-access GP systems to visibility and real-time management by all of a person's care team for 2,250 people. The next phase of work will build on this to expand the number of care plans being managed through this system. The CCG has provided links to the national pioneer informatics workstream and further work will take place to share learning across Kent, supported by Bruce Pollington, Chief Clinical Information Officer within Kent. The system was presented at a national conference hosted by NHS England on 3.6.15, as an example for other authorities to consider.

3.5 **European and International Engagement:** Kent continues to lead for the National Pioneers on EU and International engagement. This work is high profile nationally and senior sponsors within NHS England are supporting Kent in linking with the EU and feeding back into the National Pioneer and New Models of Care programmes. There is a range of funding bids currently in progress in addition to the current work programmes. A separate update specifically on this area of the Pioneer work is planned, once the outcome of current bids has been confirmed.

3.6 **Year of Care Programme:** This programme is a whole-system intelligence dashboard which helps commissioners understand the cost and activity of their population across the health and social care economy. The dashboard will be instrumental in evaluating the integration projects being delivered across the county. The programme is currently focusing on the following three areas:
(i) Collecting the remaining outstanding data
(ii) Improving data quality
(iii) Supporting commissioners with their plans to use the dataset

3.7 Further progress has been made on the collection of GP data. Presentations have been made to the Governing Bodies/relevant committees in all CCGs. All these bodies have agreed to support the collection of GP data for Year of Care except Canterbury and Coastal where further discussions are taking place. NHSIQ have reviewed the draft Data Quality Improvement Plan supporting this work and described it as excellent.

3.8 **External Communication and Engagement:** In recent months there have been several opportunities to raise the profile nationally of health and social care integration in Kent. In June Kent were the guest editors of the national Pioneer newsletter Relay, focussing on European and international work, technology and changing practice. An article by Dr Robert Stewart was

published in the July edition of The Commissioning Review, focusing on innovation and how technology can support health and social care in the future. The Kent team have been asked to host the national Pioneer assembly in January 2016 and planning is now underway for this event. The content will focus on innovation linking with the Test Bed site submission covered in 3.2.

3.9 **Estuary View Vanguard Site:** The Kent Integration Pioneer is supporting developments with the Vanguard site. Several members of the IPSG are members of the Vanguard Steering Group and sub groups, working in collaboration and supporting the establishment of the Vanguard. A Whole Systems workshop was held on 23.7.15 to launch the programme included a pre-meet for GPs, where GPs signed up to a Memorandum of Understanding. A further 13 GP practices have now signed up, with one more practice pending. The population size covered by these arrangements is now 170,000. Hubs covering practices in Canterbury, Whitstable and Faversham are being developed, with further details on what the hubs will look like to follow. GP practices in Herne Bay are not included in these arrangements. Due to the increase in the number of GP practices involved, the governance arrangements and terms of reference for Steering Group are being reviewed, to factor in the number of GPs involved. A number of sub groups are currently being set up, with plans for the Finance modelling sub group to be in place for October. Planning permission has been granted for the new build at Estuary view, to develop a community hospital facility and an extra care nursing home. Plus retail on a nearby site. Options are now being worked up with developers for the site.

3.10 **Locality Implementation**: Delivery of plans at a local level continues with priorities linked to the Better Care Fund. A summary of local implementation is as follows:

Ashford and Canterbury: The focus is on community networks. Examples include a community Geriatrician outpatient service in Faversham, with the national Age UK project extending to Faversham. In Herne Bay a community Geriatrician clinic is now in place to support patient management in the community linking with the national Age UK project. In Canterbury a project to support GP's ability to access beds as an alternative to sending patients to hospital is being developed. In Ash and Sandwich links are being developed with local agencies and schools to support development of a Dementia Friendly network. In Whitstable the Umbrella Centre Support, Physic Garden and Over 60's club have been supported by the community fund. The work going on relating to the Whitstable Vanguard site is covered under 3.7 above.

Dartford, Gravesham, Swanley and Swale: Integrated Discharge Teams continue to help patients leave Medway Foundation Trust and Darenth Valley hospitals when they no longer need acute inpatient care. The teams assist ward staff and managers with complex patient discharges and aim to safely discharge patients into the appropriate care setting. Teams consist of social care case managers, case officers and discharge coordinators providing a service 8am-8pm Monday to Friday and 10am to 6pm weekends and bank holidays. Further integrated working takes place via Integrated Primary Care

Teams and their complex patients focus for this year. Plans are starting to take shape with regard to the development of the garden city at Ebbsfleet, to implement the vision in the NHS Five Year Forward View, in the healthy new towns programme. An expression of interest will be submitted by 30.9.15 to become one of five long term partners to develop healthier neighbourhoods and towns. If successful, this will be supported (if successful) by the Test Bed site submission covered at 3.2.

South Kent Coast and Thanet: Work is underway on the Integrated Care Organisation (ICO) with the aim of being a fully operational ICO by 2020. The Compact agreement is being been finalised and will support partnership working. The first future Workforce workshop was held in July for clinicians and managers in South Kent Coast focusing on the new model of care and the skills required to deliver the model. This will be repeated for Thanet in September. This work will feed into an ICO workforce plans for both CCGs. High level road maps have been developed which highlight key milestones to be achieved for the first three years of the programme. A joint post between KCC and the two CCGs has been recruited to, to support the work of the Executive Integrated Programme Board for the ICO and associated projects for both CCGs. The CCGs and KCC are currently considering alternative delivery models such as mutuals for integrated care. One of the key domiciliary providers is using this for their delivery and this is providing a good opportunity to integrate case management , domiciliary provision and community nursing care.

West Kent: The Care Plan Management System went live on 22.6.15, including access to training on the system for GPs, surgery staff and social care staff. Information Governance is covered and an assurance pack has been produced to support this. Fortnightly meetings are taking place between ICT, Orion and WK CCG to monitor implementation and progress Phase 2. The next step is to review the business case benefits realisation in conjunction with the associated costs of roll out.

4. Conclusions and Next Steps

i) Integration of health and social care is progressing in Kent at the pace and scale intended and reflecting local priorities and plans.

ii) The Integration Pioneer Programme and team continue to provide coordination, focussed resourcing, flexibility and developing expertise required to support the diverse and expanding range of projects and programmes.

iii) If current bids and applications are successful health and social care integration will move in to a new phase during 2016 of increasing innovation and redesign of services, helping to deliver the vision in the NHS Five Year Forward View, within public sector financial constraints.

iv) The Integration Pioneer Programme team are already adapting and preparing for the new phase. The next meeting of Integration Pioneer Steering Group on 8.10.15 will be an innovation event and will engage stakeholders on

progress to date with the Test Bed site submission and introduce the innovation companies that have been identified so far as partners in this combinatorial approach.

5. Recommendation(s):

5.1 The Board is asked to consider and comment on the content of this report and proposed next steps in taking forward health and social care integration.

6. Background Documents

none

Contact details

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Relevant Director
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Director Older People and Physical Disability
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From:	**Dr Robert Stewart, Clinical Design Director and Chair Integration Pioneer Steering Group**
To:	**Health and Wellbeing Board 16th September 2015**
Subject:	**Update on the Kent Health and Social Care Integration Test Bed Site Submission**
Classification:	**Unrestricted**

Summary:

The Health and Wellbeing Board is asked to:

1. **Note** the progress made on the Kent Health and Social Care Integration Test Bed Site Submission; and

2. Approve progression to the next stage of the application to become a Test Bed Site for innovation in integrated health and social care.

1. Introduction

In May 2015 NHS England issued a call for expressions of interest to health and social care organisations to become test bed sites for innovation to transform the delivery of health and social care services. The Kent Integration Pioneer Programme team responded to this call and submitted an expression of interest on 12.6.15. Following an earlier report to the Board on the Test Bed Site submission, this report contains an update on activities to date and confirms the next steps, for continued approval by the Board.

2. Substance of the Report

2.1 The Test Bed Site submission was produced by the Kent Integration Pioneer Team on behalf of the Kent Health and Wellbeing Board and the 23 partner member organisations of the Integration Pioneer Steering Group. The submission was produced in conjunction with the Academic Health Science Network for Kent, Surrey and Sussex, who have been providing an advisory role. A copy of the initial submission including the full list of partner member organisations is attached as Appendix 1. The Kent Team working on the Test Bed Site submission are as follows:

- Dr Robert Stewart, Clinical Design Director and Chair Integration Pioneer Steering Group
- Anne Tidmarsh, Director Older People and Physical Disability, KCC

- Dr Bruce Pollington, Chief Clinical Information Officer, Kent Community Health Foundation Trust
- Mags Harrison, Transformation and Integration Pioneer Programme Manager, KCC
- Paul Hitchcock, Business Development Director, Kent Surrey Sussex Academic Health Science Network

2.2 Outline of the submission:

- Reducing frailty using the digital revolution by empowering independent living
- Using Kent's international reputation and connections to implement innovative solutions that transform the way care is delivered
- Development of a Kent Innovation Centre which will investigate, test and incubate innovations that can be disseminated for local implementation through a network of innovation labs across Kent.

2.3 Challenges to be addressed through Test Bed site:

- Innovative solutions to transform care including sharing of information of all providers with the citizen at the centre
- Promoting the use of apps, self-monitoring devices and remote monitoring to make the citizen more in control of their own condition
- Improved personal experience
- Harnessing the passion of clinicians and care professionals to change the model of care
- Reduction in the need for acute hospital admission and long term care
- Testing solutions to enable implementation at pace and scale
- Meaningful real time evaluation through recognised outcome framework developed by the University of Kent
- Kent to become a recognised centre for digital solutions, new living environments and robotics

2.4 Types of Innovation to be developed:

- Citizen held information that can be utilised to promote innovation and ownership that can move away from a medically dominated model of care towards supported self-care
- Analytics to help the citizen interpret their own health data, supported by care professionals when appropriate

- Analytics to monitor the acutely deteriorating person in the community
- Televideo consultations to increase confidence of the citizen and their carer to remain in the community and facilitate remote clinical and care support
- Innovative diagnostics to ensure that clinical and social risk is appropriately managed in the community
- Innovative design solutions that:
  - Provide a supported living environment including robotics
  - Reduce social isolation
  - Enable communication
  - Facilitate increased community capacity

2.5 In response to the submission, the Kent team were one of 32 health or social care organisations invited by NHS England to a national event on 29.7.15 to meet with potential innovators. A total of 268 companies attended the event ranging in size from single operators and start-up companies to large established multi-national companies.

2.6 Kent Team Requirements from Innovators:

- Shared vision and onsite assistance
- Willingness to participate in the Kent Innovation Centre to test and develop innovations on behalf of our network of innovation labs
- Support to create space for innovation and engagement of clinicians, care professionals and the citizen
- Change management / transformation capability to produce the workforce of the future
- Understanding of the need for flexibility to enable dissemination across a variety of organisations with decision making at a local population level (CCG)
- Support to promote independence and reduce social isolation through building community connections
- Ability to scale up and disseminate innovations nationally and internationally

2.7 Members of the Kent team met with approximately 30 innovators on 29.7.15 to explore the potential for future collaboration on the Kent submission. A further meeting with selected innovators took place on 3.9.15 at the NHS Expo to explore

the combinatorial potential and discussions are continuing throughout week commencing 7.9.15.

2.8 Next Steps

i) Test Bed sites to provide a list of their potential innovation partners to NHS England by 11.9.15.

ii) Commence work on the full Test Bed site submission document.

iii) Hold innovation engagement event for all Kent stakeholders including Integrated Pioneer Steering Group members, lead clinicians and care professionals on 8.10.15, to determine which innovations could support implementation of their local plans.

iv) Finalise full Test Bed site document and submit by the deadline of 4.11.15.

Notification of successful application is anticipated at the end of December 2015, with funding and support attached to the value of £2m for five selected Test Bed Sites, with all projects to be completed by 31.3.18.

3. Brief Update on other areas of work for the Kent Integration Pioneer Programme

Other areas of work currently being undertaken by the Kent Integration Pioneer Programme team overlap with and support the Test Bed Site submission to varying degrees and are summarised for information as follows:

3.1 European and International Engagement: Kent continues to lead for the National Pioneers on EU and International engagement. This work is high profile nationally and senior sponsors within NHS England are supporting Kent in linking with the EU and feeding back into the National Pioneer and New Models of Care programmes. There is a range of funding bids currently in progress in addition to the current work programmes. A separate update specifically on this area of the Pioneer work is planned, once the outcome of current bids has been confirmed. All on-going work will link with the Test Bed site submission.

3.2 External Communication and Engagement: In recent months there have been several opportunities to raise the profile nationally of the health and social care integration work taking place in Kent. In June Kent were the guest editors of the national Pioneer newsletter Relay, focussing on the European and international work, technology and changing practice. An article by Dr Robert Stewart was published in the July edition of The Commissioning Review, focusing on innovation and how technology can support health and social care in the future. The Kent Integration Pioneer team have been asked to facilitate a workshop at the next national Pioneer assembly on 29.9.15 on their Think Local Act Personal Making It Real work, in order to share learning and good practice. In January 2016 the Kent team have been asked to host the whole national Pioneer Assembly event and planning is now

underway for this event. The content will focus on innovation linking with the Test Bed site submission.

3.3 **Estuary View Vanguard Site:** The Kent Integration Pioneer (IPSG) is supporting developments with the Vanguard site. Several members of the IPSG are members of the Vanguard Steering Group and sub groups, working in collaboration and supporting the establishment of the Vanguard. Several IPSG members attended the Whole Systems workshop held on 23.7.15 to launch the programme. Members of the Vanguard leadership team have been invited to join the IPSG to ensure they benefit from the range of developments taking place including hopefully the Test Bed Site submission.

4. Recommendations

The Health and Wellbeing Board is asked to:

i) **Note** the updates on developments for health and social care integration.
ii) **Approve** progression to the next stage of the application to become a Test Bed Site for innovation in integrated health and social care.

Report submitted by: Dr Robert Stewart, Clinical Design Director and Chair Integration Pioneer Steering Group

Email: robert.stewart@wgd.co.uk Tel: 01303 893010

Report Author: Mags Harrison, Transformation and Integration Pioneer Programme Manager

Email: mags.harrison@kent.gov.uk Tel: 03000 415347

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Appendix 1

Pro forma for potential Test Bed sites

To ensure we are able to invite the right groups to the matchmaking phase of the Test Bed Programme (http://www.england.nhs.uk/ourwork/innovation/test-beds/) we are inviting local health and social care economies who think they may be able to form potential sites to put themselves forward by completing this form. The form provides an opportunity to demonstrate how potential sites meet the criteria set out in the prospectus and to confirm the real world health and social care challenge(s) they are seeking to address through their test bed programme.

Submissions should be sent to innovation.england@nhs.net by midday 12 June.

1	**Background**
1a	Please confirm the lead organisation for your submission and provide a named contact, including their email and phone number
	Nominated contact for the submission: Mags Harrison, Transformation and Integration Pioneer Programme Manager, Kent County Council mags.harrison@kent.gov.uk - 03000 415347 On behalf of: Dr Robert Stewart – Practising GP and Chair of the Kent Integration Pioneer Steering Group robert.stewart@wgd.co.uk - 07912 535551 Anne Tidmarsh – Director Older People Physical Disability, Kent County Council anne.tidmarsh@kent.gov.uk – 03000 415521
1b	Please list all the partners involved, indicating where organisations are formal partners or affiliated members. Please describe how well engaged your partners are and how you plan to work together to develop a test bed.
	The partners involved are the membership of the Kent Integration Pioneer Steering Group:

Name	Organisation/Job Title
Dr Robert Stewart	Chair Kent Integration Pioneer Steering Group
Roger Gough	Chair Kent Health and Wellbeing Board
Ian Ayres	Accountable Officer West Kent CCG
Patricia Davies	Accountable Officer DGS/Swale CCG
Simon Perks	Accountable Officer Ashford/Canterbury and Coastal CCG
Lorraine Goodsell	Transformation Programme Director, Ashford/Canterbury and Coastal CCG
Hazel Carpenter	Accountable Officer South Kent Coast/Thanet CCG
Andrew Ireland	Families and Social Care, Kent County Council
Anne Tidmarsh	OPPD, Kent County Council
Mark Lobban	Strategic Commissioning, Kent County Council
Mags Harrison	Programme Manager Transformation and Pioneer, Kent County Council
Andrew Scott-Clark	Public Health
Marion Dinwoodie	CEO, Kent Community Health NHS Trust
Ivan McConnell	Kent and Medway Social Care Partnership Trust
Rachael Jones	East Kent University Hospital Foundation Trust
Sarah Overton	Maidstone and Tunbridge Wells Hospital Trust
Susan Acott	Chief Executive, Dartford & Gravesham NHS Trust.
Lauretta Kavanagh	Commissioning Support Unit
Steve Innet	Healthwatch Kent

Amber Christou	Head of Housing Swale Borough Council (acting as District Lead)
Lesley Clay	Joint Planning Manager, Canterbury City Council
Alison Mills	Project Manager, Pioneer, Kent County Council
Bruce Pollington	Pioneer Chief Clinical Information Officer
Jenny Billings	University of Kent
Geraint Davies	SECAMB
Mark Lemon	Strategic Business Advisor, Kent County Council
Alison Davies	Integration Programme Health and Social Care, Kent County Council and South Kent Coast and Thanet CCGs
Dr John Ribchester	Clinical Lead and Chair of MCP Vanguard, Estuary View, Whitstable

This test bed will be developed through the Kent Integration Pioneer Steering Group (IPSG), which is a working group of the Kent Health and Wellbeing Board – the membership of the IPSG is listed above. This working group has been in existence for 2 years.

The formal partners are the 7 CCGs and Kent County Council, which are the statutory commissioners of health and social care for the 1.5 million citizens of Kent.

The IPSG also includes the acute, community and mental health providers as well as the ambulance trust, voluntary and social care providers, Public Health, HealthWatch and the University of Kent and these would make up the affiliated membership.

There are associated organisations that are important in making this site effective, including KSS AHSN, SEHTA (South East Health Technologies Alliance) and various international partners including the Digital Health Institute (DHI) in Scotland, South Denmark, Netherlands, Catalonia and Italy.

The Kent CCGs and Kent County Council Social Care have agreed and approved the application on 3 June 2015 and this has been endorsed by the chair of Kent Health and Wellbeing Board and the Leader of Kent County Council. The IPSG was keen for the test bed site to be developed and this was agreed and endorsed at the last meeting on 18 May 2015. This bid has been discussed with Dr Thallon, local Medical Director NHS E and approach encouraged.

There is enthusiasm and engagement from the CCGs and KCC for the test bed site including an Internet of Things, provided it can be valuable to implement local transformation based on increasing the empowerment of citizens to take more control of their care using technology and the digital revolution.

There is serious ambition in Kent to address the clinical, social and financial challenges and a determination that all of the resources of health and social care will be brought together by 2020 using a smart specialisation approach:

- Strengthening of local innovation ecosystems and building local capabilities
- Supporting local supply chains to invest and collaborate
- Catalysing and levering the differing opportunities of social innovation
- Branding and positioning places as centres of smart specialisation

This will be aided by establishing a Kent Innovation Centre in association with the DHI in Scotland to enable innovations to be tested, to engage with industry and enable dissemination at pace and scale across Kent, nationally and internationally using our Innovation Hub communication platform and the AHSN. The Innovation Centre linked to our network of innovation labs will facilitate implementation of our Internet of Things and use of combinatorial technologies. It forms the basis of various initiatives and bids including use of structural funds/LEP and EU funding as well as bringing international innovations from Japan, USA and New Zealand – Kent Integration Pioneers is leading international work with the national programme.

	The test bed site will be managed through the IPSG, allowing all of our members to participate by establishing a network of innovation sites owned by the individual organisations and facilitated by the IPSG. The members are enthusiastic to progress this bid to help address the issues of frailty and loneliness and promote digital independence. Our countywide use of the NHS number and the nationally recognised work in information sharing and intelligence will help us to move at pace. This bid builds on the success of Kent to establish good relationships with external partners and links well with other EU bids and projects such as the Room for Life which as a result of collaboration with Zeeland allows people to try out different living environments and technology to empower independent living. Kent has a reputation for employing technology at scale having been one of the original Whole Systems Demonstrator sites and recognises the new opportunities that being a test bed will bring.
1c	Please confirm if you are working with your local AHSN, if so who is the lead contact you are working with
	Paul Hitchcock Business Development Director Kent Surrey Sussex Academic Health Science Network incorporating Enhancing Quality & Recovery Email: paul.hitchcock@nhs.net Tel: 07824 867813 Website: www.kssahsn.net
2	**Tackling real world health and social care problems**
2a	Please describe your test bed, how the members will work together, what resources are available to innovators and what sorts of innovation your locality might benefit from [500 words max]
	Our test bed will comprise of a network of local innovation labs across Kent linked to the proposed Kent Innovation Centre. Each locality/CCG has its own focus of integration of health, social care and the voluntary sector (innovation lab) which will enable the workforce to organically transform to meet the changing needs of their communities across the 1.5m population of Kent identified by the NHS number. Our focus will be on technology meeting the needs of the frail person and promoting independence and prevention, linked to intelligent information and building community capacity. Co-design with the citizen, care professionals and their communities will be key to ownership of the transformation aimed at the older person, but also relevant to children with complex needs, people with mental health and learning difficulties, to reduce isolation and loneliness. New technologies will promote independent living, moving from a medically dominated model of care towards supported self-care, which will include self-monitoring using wearable devices, smartphones, apps with analytics, adaptations to buildings and robotics. This will be informed and mentored by international partners with a central innovation centre that will test innovations and produce standards to enable innovators and the private sector to participate. Members will work together in the network of "labs" which will encourage transformation at pace and scale; learning, sharing and disseminating good practice, including close collaboration with our Vanguard MCP site in Whitstable, the PMCF site in South Kent Coast and the KSS AHSN. This change management will be facilitated by Kent Integration Pioneers as a working group of the Kent HWB and communicated locally, nationally and internationally through the Kent Innovation Hub, which has won an international award.

	Resources available to innovators • Innovation labs will encourage innovators, communities and the private sector to develop local solutions in transformation, eg new living environments as in the Room for Life project • Innovators will be encouraged to participate in the Kent Innovation Hub, which will increasingly be available to all citizens and innovators, including academics and the private and voluntary sector • The innovation centre will encourage innovators to participate and contribute to growth and wealth generation linked to structural funds, including the adoption of technology, robotics, designed living environments, digital independence and workforce change Our test bed site will benefit from the following resources: • Investment in m(obile)Health including video enabled technologies • Investment in the network of innovation labs and use of virtual technology • Investment in the innovation centre including employment of designers • Innovative community diagnostics and robotics • Capability to deliver change management of our health and social care workforce locally • Training to make care workers technology-aware • Innovative co-design techniques to ensure communities and care professionals own transformation • Innovative approaches to increase community capacity, including volunteering/engaging with creative arts to reduce isolation.
2b	Please describe the real world health and social care problem(s) that you are looking to address within your test bed (*note: this will be used to help match you with relevant innovators, so please provide enough information for them to understand the problem, or problems, you want their help with*) [500 words max]
	We would welcome collaboration as a Test Bed with Innovators to provide better personalised care for people living with multi-morbidity and advancing frailty with appropriate care available in community settings so that acute hospital attendance can be avoided. We recognised that all too frequently acute hospital admission is not the best place to care for people in these circumstances and that hospitals find it difficult to address the issues that patients present with; as they are often not actually acute health needs , they could have been averted if tackled earlier. We equally need to address the challenge of keeping more people in their own homes as they become increasing frail. We would also welcome approaches from innovators to better support the needs of people with learning disabilities and those with mental health concerns. The issues presented by acute delirium as well as dementia at times of ‘acute decompensation’ warrant a special mention as people in these circumstances often do particularly badly from acute hospital admissions but are often challenging to look after and to keep safe in ‘out of hospital’ settings with any degree of efficiency. They are also much more likely to be discharged to a care home where they will stay. As an Integration Pioneer were are seeking to accelerate improvements in all these areas and recognise the need to do much more in terms of prevention and self-care. The NICE public health guidance - Disability, dementia and frailty in later life - mid-life approaches to prevent or delay the onset of these conditions is currently in draft and once ratified, identifies which primary prevention approaches to be adopted in midlife are most effective and cost-effective to prevent and delay the onset of disability, dementia, frailty, and other non-communicable chronic conditions in later-life. Additionally the NICE public health guidance - Independence and mental wellbeing (including social and emotional wellbeing) for older people is anticipated for publication in Nov 2015, which is tasked with advising upon what are the most effective and cost effective ways to improve or protect the mental wellbeing and /or independence of older people. Innovations that facilitate any of this guidance at significant scale will be of particular interest including

	those that address the barriers and motivators to support positive behaviours, which at a population scale would be welcome including motivational science, digital and internet technologies.
3	**Satisfying the minimum criteria**
3a	Please demonstrate that your site has effective leadership, with strong relationships between the participating bodies, and indicate how the test bed will be managed and where governance and alliance management systems are already in place [300 words max]
	The proposed Kent Test Bed will be supported through the Kent Integration Pioneers steering group, a working group of the Kent Health and Wellbeing Board. The steering group comprises senior leadership from across all health and social care providers, all CCG Accountable Officers, Commissioning of Social care, Director of Public health, NHS England Area team, CSU, Voluntary Sector representation, Healthwatch Kent and the Health & Wellbeing Board. It also has a representation from our academic partner the University of Kent within the Centre for Health Service Studies. There are ToR and governance structure in place for this group which is tasked coordination of the delivery objectives of the pioneer programme bid. Including Integrated Commissioning: • Design and commission new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that means the avoidance of hospital and care home admissions. • Clinical Design partnerships between the local authority and CCGs with strong links to innovation, evaluation and research networks. • Year of Care tariff financial model and risk stratification will be tested and adopted at scale. • Integrated budget arrangements as the norm alongside Integrated Personal Budgets. • Outcomes based contracts supported by new procurement models Integrated Provision: • Proactive models of 24/7 community based care, with fully integrated multi-disciplinary teams. The community / primary / secondary care/ voluntary sector care interfaces will become integrated. • A workforce with skills to deliver integrated care. • Integrated IT systems to improve patient / service user care, underpinned by personal health records that can be accessed by the individual. • Systematise self-care so that people with long term conditions can do more to manage their own health and social care needs preventing deterioration and over-reliance on services. • New kinds of services bridging silos providing the right care in the right place. The Integration Pioneers Steering group has a commitment to evaluation and has involved academic partners from the onset, embedding evaluation within the creation and development of transformation through a validated evaluation framework.
3b	Please describe your site's current ability to share health related data and informatics across all parties and your plans to further develop this in the future [300 words max]
	As a Year of Care Early Implementer, Kent is recognised as a system leader in its ability to share data having developed a person level, linked dataset across health and social care provider and commissioner dataset sets, costed at activity level. All secondary care, community care, Out of Hours provider, Ambulance service, Mental Health and Social Care data are represented and the project has 50% of primary care data and hospice data covering a population of 700,000 currently within the dataset and anticipates the completion of this by autumn 2015. Further linkage with the voluntary sector is planned over the summer with Age UK projects and with the

	Fire and Rescue Service. The approach has been nationally recognised as having created a powerful commissioning tool, http://www.nhsiq.nhs.uk/resource-search/publications/population-level-commissioning-for-the-future.aspx The dataset can be used to identify a capitated budget for target cohorts, but also to identify matched control groups for service evaluation in a whole place context. A Cube dashboard has been developed to enable in-depth multivariate views of the data so a wide range of reports can be swiftly constructed. Further development is with the Personal Social Services Research Unit (PSSRU) where an evaluation of the Year of Care Tariff will be conducted. Added to this, the multi-method evaluation framework developed within the Centre for Health and Social Studies (CHSS) will capitalise on this dataset further by testing the process of linking the sets to variables such as quality of life, experiences of seamless care, service utilisation and self-management at the patient level, providing tracked information on what processes brought about what changes and movements through the system for individual patients. Such information will contribute towards understanding future service utilisation, cost and outcomes with detailed reference to how services are provided to produce such outcomes.
3c	Please describe the scale of your site – including the population size covered –Please describe how and over what time frame the test bed will reach an appropriate scale which will enable robust evaluation that is statistically significant [300 words max]
	Our site will cover 1.5 million citizens of Kent Kent already has in place nationally recognised advanced intelligence information systems relevant to our Year of Care program, led by the Kent Public Health team and informed by our Kent Chief Clinical Information Officer We have agreement to use an evaluation framework in two sites developed by the University of Kent using EU funding and covering a population of 300k on an "Action Based Research" and want to extend this across Kent over the next two years. They will be focusing on a Kent network of innovation labs to transform the workforce to meet the changing needs of our population, learning from our international partners and using technology and robotics to enable change. The initial sites will go live by September and will enable co-design/co-creation for local implementation and will inform the developing network in an incremental way that enables spread at pace and scale, engaging a further 600 000 by April 2016. Our evaluation framework is outcome based to actively inform and redesign our services with the citizen at the centre. Full evaluation will be available by 2017/18 at the latest but interim analysis will be available by April 2016 and provided by the University of Kent which will be statistically significant. As a test bed site, this common evaluation framework will be resourced and form part of the action learning research reporting to Kent Health and Wellbeing Board There are other components of evaluation based on working with Newton Europe that can demonstrate already statistically significant transformation and efficiency of social care. This will be linked to an associated but separate analysis of acute admissions at the William Harvey Hospital has been agreed as a national evaluation site Also, partnerships are already being developed at a European level through the Health and Europe Centre and internationally with significant appetite for mHealth collaboration. Added to this, the evaluation conducted by CHSS forms part of a successful Horizon 2020 project 'SUSTAIN', which has synergy with the aims and objectives of Kent Pioneers, so that the analysis will be informed by broader European learning.

3d	Please demonstrate that you have a commitment to conducting real world demonstrations of combinatorial innovations in live clinical settings – including evidence that you have buy-in from clinical leaders and front line staff. What mechanisms exist to enable combined innovation across multiple partners? [300 words max]
	Kent has strong leadership through the Kent Integration Pioneer program including the appointment of Kent Chief Clinical Information Officer to maximise benefit of information sharing across organisations. There was much discussion at a meeting on 24/2/15 with Simon Stevens in Kent looking at the 5yfv with the clinical (CCG) leaders stating that there was much enthusiasm to change the models of care in several localities in Kent. All areas in Kent have been holding summit meetings over the past year where local stakeholders have been discussing what integrated care should look like and this has included providers, commissioners of health and social care and district councils. There is a large amount of evidence documenting the commitment to innovate in multiple (combinatorial) ways. Real world implementation in clinical settings can be demonstrated by the implementation of integrated discharge teams in North Kent, interoperability platform in West Kent, Integrated Care Organisation development in South Kent Coast, Dementia Friendly Communities and neighbourhood teams in Canterbury and Ashford, GP sharing information across practices in Folkestone, establishment of emergency visiting paramedic practitioners and developing an "Ageless society" in Thanet. These have only been achieved by using different innovations across multiple partners including HealthWatch and full engagement of clinicians. Kent County Council has an efficiency partner engaging over 100 staff in the design, implementation and transformation of social care involving 100 staff, which has been very successful. Kent has local health and wellbeing boards to bring together local stakeholders and front line staff in combining approaches and technologies across multiple partners. Kent HWB has repeatedly shown the drive from clinical CCG leaders to innovate and change care including participation in YoC and personalised budgets - KCC innovatively implemented the Kent Card several years ago to enable citizens to take control of their social care budget.
3e	Please demonstrate that you will be able to move at pace and complete rapid and robust evaluations – including making swift decisions during the development of the test bed to ensure its success [300 words max]
	As we already have a fully linked dataset covering 700,000 people this means that the data collection methods need to conduct large scale robust evaluation are already in place. Developing and refining the dataset is part of the continuous improvement process. The Pioneer programme has a formal link with the Centre for Health and Social Studies, University of Kent as its evaluation partner and the Kent Year of Care Programme has formal links with the Personal Social Services Research Unit, University of Kent. As complete dataset exists from April 2014 for 700,000 people this means a control group can be identified and benchmarking activities undertaken at project initiation. Secondary Users Services (SUS) data flows with a 2 month time lead so that 'whole system difference' can potentially be identified at this time scale enabling rapid cycles of Plan Do Study Act improvement methodology. This work will be supported by the CHSS evaluation framework and central to the success of developing a rapid approach to evaluation is its implementation science approach. This approach centres on combining the skills of a broad stakeholder group with evaluation data obtained through a responsive multi-method design, and using the results to shape the initiatives towards and agreed set of person-centred outcomes. Data will be gathered through a core set of established metrics and validated surveys, which will enable a robust body of evidence to quickly emerge. This will enable comparisons to be made

	across sites, and inform how roll-out of initiatives happens, facilitating the transfer of good practice at pace and scale.
4	**Dissemination and evidence**
4a	How will you make the results and evaluation of the test beds available to others? Please describe how will results be shared and disseminated. [300 words max]
	The test bed site sitting under Kent Integration Pioneers (KIP) will use its internationally recognised established Innovation Hub concept to disseminate and share learning to transform care, locally, nationally and internationally. By establishing a network of innovation labs across Kent (in collaboration with the Vanguard and Prime Ministers Challenge sites), we will harness the passion of clinicians to empower transformation of services and workforce, based on the changing needs of our communities by codesign with our citizens. In this way innovation labs can learn from each other, preventing the need for reinvention, and will be reported through the Kent Health and Wellbeing Board of which the KIP is a working group.It will also be shared with the national Integration Pioneers and Vanguard sites as well as our international partners Evaluation and Information Intelligence is key and the KIP will work with the University of Kent (evaluation) Kent Public Health (nationally recognised excellence in information intelligence e.g. Year of Care) and Newton Europe (efficiency partners already working to transform social care and investigating acute admissions in A&E). Our site will capitalise upon workstreams within Horizon 2020 (EU) funded project; SUSTAIN which includes targeted dissemination activities and a deliverable roadmap. Findings will be promoted at an early stage through targeted dissemination to various groups: • Service users • Health and social care managers and professionals • Third sector • Commissioners • Policy makers In this way, best practice can be disseminated across the wide stakeholder group in an action based research to move from a medically dominated model towards supported self care focussing on frailty and improved use of technology. The road map will consist of an electronic and interactive guide developed from the evaluation evidence to improve existing services and support decision making for future integrated care.
4b	To the best of your knowledge, has your proposed test bed clinical need been successfully addressed in any other global context? [300 words max]
	Kent has a reputation for innovative use of technology, eg Whole System Demonstrator site for telehealth and telecare. Now is the time to build on this, using the digital revolution to implement our Internet of Things. Elements of our tests bed has been addressed in other global contexts described below but not in the combinatorial way that our site will bring together. Kent International team includes our Brussels office and the International Health Alliance – we are an international leader for the NHS and Social Care looking at innovative global approaches to transform services with a focus on technology with the citizen at the centre. Kent has been working with a series of international partners for several years to be outward looking, sharing innovations and good practice, which have formed the basis of our test bed site and informing our bids for international funding and co-operation:

	• Denmark mentoring to implement innovation/living labs, transforming care • Scottish Digital Health Institute partnering to implement a Kent Innovation Centre to design/evaluate technologies • Catalonia working to implement their knowledge around mHealth • Netherlands designing different community solutions and linking to the opportunity of bringing creative arts to decrease exclusion and improve capabilities - Room for Life project • Swedish Innovation Pioneers instigated our Innovation Hub to link innovators at all levels • New Zealand working to promote information sharing and implementing care plans across all organisations with the citizen at the centre • Japan linking technology, robotics, diagnostics, focussed on the oldest population in the world • USA has interesting models of care, eg care navigators working alongside GPs and care professionals Active associated partners: SEHTA (South East Health Technology Alliance) links to 1300 members in 20 countries linked to 800 SMEs looking at promoting local businesses KSS AHSN facilitating dissemination, innovation and transformation Oliver Wyman facilitating international cooperation and linkage to the USA

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Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **22nd July 2015.**

Present:

Simon Perks – Accountable Officer, CCG (in the Chair);

Councillor Brad Bradford, Lead Member – Highways, Wellbeing and Safety, ABC
Deborah Smith – KCC Public Health
Sheila Davison – Head of Health, Parking & Community Safety, ABC;
Neil Fisher – Head of Strategy and Planning, CCG;
Mitchell Fox – Kent Police Divisional Commander (East Kent)
Martin Harvey – Patient Participation Representative (Lay Member for the CCG);
Tracy Dighton – Voluntary Sector Representative;
Mark Lemon – Policy and Strategic Partnerships, KCC;
Stephen Ingram – NHS England
Simon Cole – Policy Manager, ABC
Richard Robinson – Housing Improvement Manager, ABC;
Dave Harris - KCC Social Services;
Michael James – Case Kent;
Christina Fuller – Cultural Projects Manager, ABC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;

Apologies:

Philip Segurola, KCC Social Services, Peter Oakford, KCC Cabinet Member – Specialist Children's Services, Chris Bown, Interim Chief Executive East Kent Hospitals Trust, Dr Navin Kumta, Clinical Lead and Chair Ashford Clinical Commissioning Group, John Bunnett, Chief Executive, ABC, Tracey Kerly, Head of Communities and Housing, ABC, Paula Parker, KCC Social Services, Caroline Harris, HealthWatch

1. Election of Chairman and Vice Chairman

It was agreed that Dr Navin Kumta and the KCC Public Health Representative be elected as Chairman and Vice Chairman respectively of the Board for 2015/16.

2. Election of Chairman of the Lead Officer Group

It was agreed that Caroline Harris be elected as Chairman of the Lead Officer Group.

3. Notes of the Meeting of the Board held on the 22nd April 2015

The Board agreed that the notes were a correct record.

4. East Kent Hospitals University NHS Trust and Update on Constitutional Standards

4.1 Simon Perks explained that Chris Bown, Interim Chief Executive of East Kent Hospitals University NHS Foundation Trust, was unable to be at the meeting but advised that he was happy to give an update to the Board as he had been involved with the Trust over this issue. He also explained that at the previous meeting he had agreed to give an update on the nature of the constitutional standards the CCG worked within. These fell broadly across four standard areas across East Kent:-

(i) Diagnostic Services
(ii) Cancer Services
(iii) Elective Procedures
(iv) Accident and Emergency

He advised that all of the above targets were under pressure and monitors were in place on the performance of the Trust and the CCG. Of the four, Diagnostic Services were back on track and Cancer Services required a marginal improvement as there was currently a 62 day wait for services. This was also a general problem across the country. In terms of waiting times for Elective Procedures, 90% were within the target of 18 weeks of being treated but certain procedures such as Orthopaedic Care faced a number of challenges. A number of these cases were dealt with in hospital rather than being referred back into secondary care. He explained that an Improvement Plan had been agreed with the Trust and the plan was to return to full compliance by October 2015 at the latest.

4.2 In terms of Accident and Emergency he explained that the target had been achieved until March 2014 but since then it had not been delivered and at the current time was actually in decline. He explained that East Kent Hospitals were in the bottom 10 of acute Trusts in the whole country and he believed that the way in which Trusts had been achieving the target prior to March 2014 had been unsustainable. This was largely due to the fact that the Trust had significant workforce problems and a scale of vacancies which included some very senior clinical positions. He referred to the recent announcement by the Secretary of State in which he had expressed a wish to reduce the overall costs of locum staff employed within the various Hospital Trusts throughout the Country.

4.3 He said that a meeting was due to take place on 29th July 2015 with the Monitor and NHS England to scrutinise the Improvement Plan and to assess whether it would help deliver compliance to the standard. Simon Perks said he had doubts whether this would be achieved by Autumn but he stressed the need for it to be achieved prior to Christmas. He said the pressure was not so much on the overall numbers attending A & E but it related to the nature of the care required to be provided, in particular to the elderly who arrived with more complex conditions. Steps were being taken to reduce the number of those members of the elderly population who were required to attend A & E and to provide preventative services at an earlier stage.

4.4 In response to a question, Simon Perks explained that there was no short term proposal to re-configure the delivery of the services but in the long run he considered that this would be inevitable particularly as in East Kent emergency cases were handled across three relatively small hospitals. He referred to the recent decision of the governing body at the William Harvey Hospital to close the Chemotherapy Unit and he said that this was an example of where the Unit had insufficient staff to operate safely.

4.5 In response to a question as to the reasons why people attended A & E rather than other services, Simon Perks said that he had examined a report on patient records which had been done to assess which pathway those people had followed for care. He said it was apparent that people had not understood which care provider to seek assistance from and there was also evidence that the signposts for appropriate care were not clear enough.

4.6 Tracy Dighton said she would like to flag the issue of the importance of the voluntary sector and care navigators and expressed the hope that the funding issue could be put on a more stable basis. Simon Perks said he agreed with the point and considered that the voluntary sector had a large role to play in any new model of care.

4.7 Simon Perks explained that the Interim Chief Executive of the NHS Hospitals Trust would be in post for a year and he said that the Trust had appointed a new Chairman and that the Trust was being re-inspected by the CQC shortly with their report being published in October. He explained that he had had a recent meeting with the Hospital Trust and they were keen to look at a strategy across the whole healthcare system, a process which would be led by the CCG as Commissioners.

4.8 Richard Robinson explained that it was important to include work Housing Services undertook within this area in terms of the health agenda and he referred to the Farrow Court scheme which would be opened in Autumn and the recent completion of the Chamberlain Manor scheme and works in progress at Aldington and Little Hill, St Michaels. He hoped that GP's could be encouraged to promote the facilities that would be made available via these different schemes following their completion.

4.9 In response to a question about communications with the public, Simon Perks said that he believed that the new Trust was more open and were keen to get their communications processed right with a clear vision of where they intended to go.

The Board agreed that Chris Bown, the Interim Chief Executive of East Kent Hospitals University NHS Foundation Trust, be invited to attend the October meeting of the Board.

5. Focus on Sustainable Development for Health and Wellbeing

5.1 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. The presentations had subsequently been published with the agenda for the meeting.

(a) Preparing for Growth

5.2 Simon Cole, Policy Manager, Planning and Development, Ashford Borough Council, gave a presentation. The presentation covered the timeline for the development of the new Local Plan and supporting Infrastructure Schedule which would be effective up to 2030.

(b) The Next Five Years

5.3 Neil Fisher, Head of Strategy and Planning, CCG, gave a presentation. The covering report explained that the purpose of the presentation would be to show how services in Ashford may look in the next five years following the implementation of the CCG's Five Year Forward View. This included changes in how services were provided and what the impact of Community Networks might be.

(c) Planning for the Future

5.4 Stephen Ingram, Head of Primary Care, NHS England South (South East) gave a presentation. The covering report explained that the presentation would cover the direction of travel for NHS England South and how they were helping to identify future service and asset requirements given democratic trends and the need for an integrated approach to health service provision.

(d) Discussion and Questions

5.5 Simon Perks referred to a point made by Stephen Ingram during his presentation and said that he would support the location of primary care facilities at the William Harvey Hospital. He also explained that at Ivy Court, Tenterden Sunday working was being tested. He believed that the general theme of all presentations was that there was a need to speed up the overall planning process. Simon Cole confirmed that from his point of view there was a need to pull together the evidence base which would be used when the proposals set out within the draft plan were presented to the local examination in public. It was clear from the presentation from Stephen Ingram that the answers to primary care were now changing in that in future years this could see the General Practitioners having larger surgery lists but employing a team of people who would assist and provide specialist services freeing up the GP for the more critical consultations with patients.

5.6 Mark Lemon asked whether NHS funding included any contributions from developers and commented that several items of infrastructure might not actually be located in Ashford and therefore there would be a need to look to effective transport provision for patients to get to those facilities.

5.7 Stephen Ingram said that NHS England did not receive any funding direct from developers and their main source of funding was to provide revenue support to facilities once they had been provided. The level of revenue available was adjusted every five years based on the population growth.

5.8 In response to a question, Simon Cole explained that agencies, such as KCC Public Health could feed into the overall process by way of the Health Infrastructure Group but stressed that this was not the only way that this could be undertaken. He said his task was to produce a plan that was flexible and one which could have been demonstrated to have been produced on a sound basis.

5.9 Sheila Davison suggested that KCC Public Health might wish to join the Health Infrastructure Group which would now also have a link with the Hospital Trust.

5.10 In conclusion, Simon Perks said that it was important to link the Hospital strategy with achieving a single vision for Ashford prior to going to the public with the Board's thoughts and ideas. He said that the development and work of community networks was crucial in terms of engaging the public with the proposals for the future.

The Board recommended that:

(a) the need for partners to provide policy direction and infrastructure detail to support the drafting of the local plan be noted.

(b) the Health Infrastructure Working Group consider the draft on behalf of the Ashford Health and Wellbeing Board.

(c) representatives of East Kent Hospital Trust and KCC Public Health be invited to join the Health Infrastructure Works Group.

6 Lead Officer Group (LOG) Report – Performance Progress Plan and Theme Setting

6.1 The report provided an update of the work which had been progressing since the previous meeting held on the 22nd April 2015. The report also set out details of the following "must do" projects identified by Lead Officers given their need for a multi-agency approach:-

- Community Networks (Lead – Neil Fisher, CCG)
- Farrow Court (Lead - Richard Robinson, ABC)
- Rough Sleeping (Lead – Sharon Williams, ABC)
- Dementia Day Care (Lead – Lisa Barclay, CCG)
- Healthy Weight – Obesity (Lead – Simon Harris, ABC)
- Infrastructure Planning (Lead ABC)

6.2 Christina Fuller explained that the Performance Plan was being reviewed. She hoped to be in a position to report back to the Board in October.

6.3 Richard Robinson said that it was intended that Farrow Court would be completed by the end of September and that he wished to encourage all health professionals to attend the opening event.

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)

Noted.

(b) Kent County Council (Social Services)

Dave Harris gave a further update to the information set out within the report published with the agenda.

(c) Kent County Council (Public Health)

Deborah Smith explained that nationally there would be a £200m cut in support to Public Health and KCC were waiting to hear how that would affect their budget.

(**d) Ashford Borough Council**

Sheila Davison gave an update and explained that Ashford had now completed the purchase of Park Mall Shopping Centre and advised that there would shortly be a public exhibition of proposals to develop Elwick Place.

(e) Ashford Children and Young Persons Health and Wellbeing Committee

No update available as former Chairman of the Committee had left and the post was yet to be filled. Simon Perks said that this would be discussed outside of the meeting.

(f) Case Kent/Voluntary Sector Representative

Noted.

(g) HealthWatch Kent

Keith Fearon explained that HealthWatch were producing a report on out of area mental health beds/placements and that they would welcome any contributions from partners.

8 Update on the Kent Health & Wellbeing Board – 15th July 2015

8.1 Mark Lemon gave a summary of the major issues considered at the meeting of the Kent Health and Wellbeing Board on 15th July 2015. These included:-

(i) Public Estates Initiative involving NHS and KCC.

(ii) Mental Health Group Concordat including S136 issues relating to those with mental health problems that involved the Police.

(iii) Quality and the Health and Wellbeing Board which stemmed from the Francis Report into the issues at the Mid-Staffordshire Hospital Trust.

Mark Lemon further explained that a Workforce Sub-Committee had been established and would meet shortly. An initiative by HealthWatch to engage the public would also be undertaken.

9 Update on the Kent Health and Wellbeing Strategy event and KCC health and Wellbeing Review.

9.1 Mark Lemon explained that the event on the 17th June 2015 had been well attended with over 100 colleagues from across all the agencies and the event had allowed KCC to take stock of the current strategy. An overview of performance against the current five objectives showed mixed progress which was probably inevitable given that it was only the mid-point in the overall five year strategy. He explained that a report on the event would be submitted to the Kent Board in the Autumn.

9.2 In terms of a review of the work of the Health and Wellbeing Board, discussions had been held with the future Chairpersons of the other local Boards and Mark Lemon explained that now Dr Navin Kumta had been appointed as Chairman of this Board a discussion with him would also take place. He also explained that details were provided on how Boards in other areas of the country operated which included some Boards which operated on a basis of full delegation.

The Board noted the report.

10 Forward Plan

10.1 The Board noted the Forward Plan of subsequent meetings. Simon Perks suggested that at either the October or January 2016 meeting the Board could consider the East Kent Health Strategy.

10.2 Annie Jeffreys explained that she had received a letter from the CCG advising that she had been appointed to the Board, however, it appeared that this decision had not been formally ratified. Simon Perks said that he would ensure that this issue was placed on the agenda for the next meeting.

11 Next Meeting

11.1 The next meeting would be held on the 21st October 2015.

CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Thursday, 9th July, 2015
at 6.00 pm in the Canteen, Council Offices

Present: Dr Mark Jones (Chairman)

Jane Durant
Jayne Faulkner
Jo Pannell (for Steve Innett)
Faiza Khan
Councillor S Chandler
Velia Coffey
Neil Fisher Mr
Gibbens
Councillor Howes
Mark Lemon
Paula Parker
Councillor Cllr Pugh
Councillor P Watkins

1 **APOLOGIES FOR ABSENCE**

Simon Perks, Sari Sirkia Weaver, Lorraine Goodsell, Jonathan Sexton, Cllr Andrew Bowles, Debbie Smith, Mark Kilbey, Steve Inett, Amber Cristou.

2 **MINUTES OF THE LAST MEETING AND ACTIONS**

The minutes were approved as an accurate record.

Actions:
All actions were complete except the action under item 4 regarding sourcing age related statistics on alcohol related acute admission. This action is still ongoing.

3 **MATTERS ARISING NOT ALREADY ON THE AGENDA**

It was noted that a review of the structure and function of the Health and Wellbeing Board would follow the priorities that will be presented later in the meeting.

4 **CANTERBURY HWB STRATEGY AND PRIORITIES FOR CANTERBURY - FAIZA KHAN**

Faiza Khan gave a presentation and reported that her remit was to identify key areas that were showing poor performance in the district. Nine priorities have been identified and a slide was presented for each.

It was noted that they are grouped into three main areas; starting well, living well, ageing well with any targets set to be achieved in the next three years. All data is on a district level rather than based on the local Clinical Commissioning Group (CCG) area. It was agreed that data for wards that cover Faversham and Ash as well as the parts of Dover that are covered by the CCG area need to be included where possible.

The Board was asked to agree the priorities and the key responsible organisations.

The following comments were made:
Flu vaccination for children – The CCG does not commission these services from nurses and General Practitioners (GPs) therefore it was felt that the Children's Operational Group (COG) should be responsible for this rather than the CCG.

Smoking in pregnancy – A query was raised regarding the quality and completeness of the data however Faiza Khan advised that there is a poor quality marker against East Kent Hospitals University NHS Foundation Trust (EKHUFT) and this is definitely a concern in Canterbury.

Concern was raised that the COG does not represent Swale but Velia Coffey advised that there is effective liaison between Swale agencies and Canterbury COG.

Alcohol – It was queried how the Community Safety Partnership (CSP) would deliver the target around providing information. It was suggested that the target relates instead to the CSP effectively delivering the Alcohol Action Plan.

Obesity – It was suggested that the high student population in Canterbury could be skewing the data and it was agreed that the data should be broken down to under 25s and over 25s. It was noted that solutions for tackling for obesity are different for each age group therefore more age specific information was be needed.
Action: To be picked up by the Core Group.

Smoking amongst routine and manual workers – The Board discussed this and agreed that this is probably due to social and economic inequalities for people who do these types of work. As this probably refers to a small number of people/employers it was hoped that this could be addressed relatively quickly and easily.

Dementia – Neil Fisher advised that Canterbury is performing very well against this already.

Ageing well – It was agreed that the responsible organisation should be the Joint Commissioning Delivery Steering Group and that the priorities were narrowed to a small number of long term conditions.

The Board agreed these nine priorities and it was noted that there will be an action plan for each of them put in place with the agencies who are leading on each and progress will be reported back to the Health and Wellbeing Board.

5 **JOINT COMMISSIONING DELIVERY STEERING GROUP REPORT - NEIL FISHER**

Neil Fisher presented the report on behalf of Lorraine Goodsell and invited questions.

It was noted that Vanguard now includes all but five practices in the CCG (these five are mainly in Herne Bay).

The Vanguard programme aims to integrate primary and community services to provide proactive care in the community. It is a different model of care to the current one and focuses on identifying vulnerable people and preventing illness. It was highlighted that this is a pilot model and there are different models running across the country.

It was agreed that the NHS needed to communicate better with Local Authorities specifically around membership of stakeholder groups.

Paula Parker described the Age UK Integrated Care Programme project and advised that Ashford and Canterbury CCG and their partners had been successful in securing funding, a project officer has been appointed and a cohort of patients identified in Canterbury Ash and Faversham. The aim of this 18 month project is to reduce the number of admissions and support people in their homes.

6 **MENTAL HEALTH GROUP REPORT - NEIL FISHER**

Neil Fisher advised that this report is presented to Mental Health Action Group and it was agreed that it should also be presented at the Health and Wellbeing Board.

Action: Neil Fisher to recirculate the report with all acronyms in full.

It was noted that 15-18 year olds have now been recognised within Improving Access to Psychological Therapies (IAPT). Jayne Faulkner advised that mental health is a focus for The Department for Work (DWP) and Pensions and they have secured funding for local IAPT services which is currently out to tender. It was agreed that the CCG and DWP should work closely on this.

7 **CHILDREN'S OPERATIONAL GROUP REPORT - FOR INFO**

The report was received.

8 **ANY OTHER BUSINESS**

Cllr Pugh reported that he had attended a Health and Wellbeing session at the recent Local Government Association (LGA) Conference in Harrogate and that it had been suggested that Health and Wellbeing Boards were reviewed.
Action: Core Group to consider a peer review.

Cllr Howes advised that a document had been produced by the LGA on the future of Health and Wellbeing Boards.
http://www.local.gov.uk/publications/-/journal_content/56/10180/7363877/PUBLICATION

It was noted that any devolution and combined authorities model in the future may mean that CCG money could be released to combined authorities from NHS England as long as CCGs and Public health are significantly linked. Kent Leaders and Chief Executives are discussing the possibility of devolution and how this may work in Kent.

Mark Jones reported that clinical leaders had met recently and it was suggested that the outcome of these discussion was reported to the Core Group.

9 **DATE OF FUTURE MEETINGS**

September TBA
2 November 2015
19 January 2016
9 March 2016
10 May 2016

All meetings start at 18.00

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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 19 August 2015.

PRESENT: Councillor Roger Gough – Kent County Council (Chairman)
Councillor Ann Allen – Dartford Borough Council
Sheri Green – Dartford Borough Council
Sarah Kilkie – Gravesham Borough Council
Lesley Bowles – Sevenoaks District Council
Su Xavier – Clinical Commissioning Group
Val Miller – Kent Public Health
Tristan Godfrey – Kent County Council
Stuart Collins – Kent County Council
Tracey Schneider – Kent County Council
Cecilia Yardley – Healthwatch
Alan Twyman – Dartford Borough Council

88. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Tony Searle and David Turner, Graham Harris, Dr Elizabeth Lunt, Melanie Norris and Debbie Stock.

89. DECLARATIONS OF INTEREST

No interests were declared.

90. CONFIRMATION OF MINUTES

The minutes of the Dartford, Gravesham and Swanley Health and Wellbeing Board on 17 June 2015 were agreed as an accurate record.

91. KENT COUNTY COUNCIL HEALTH AND WELLBEING BOARD, MEETING HELD ON 15 JULY 2015

The Chairman briefed the Board on the items discussed at the Kent Health and Wellbeing Board which took place on 15 July 2015.

He reported that there had been significant discussion on the Crisis Care Concordat and the Kent Board had asked for a more detailed report to be prepared and brought back for consideration. There had been discussion of the One Public Estate initiative and the Clinical Commissioning Groups (CCG's) had been asked to develop a property strategy and to take this forward through the local Health and Wellbeing Boards. There had also been consideration of the Healthwatch report on Quality.

92. URGENT ITEMS

There were no urgent items.

93. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS

The list of outstanding actions arising from previous meetings was reviewed. It was noted that the 3rd item listed, (minute 55 – Healthwatch feedback) had been superseded and the item could be closed.

The Chairman confirmed that item 2, the inclusion of health needs in future s106 and CIL agreements, had been considered by the Kent Health and Wellbeing Board in May.

The Chairman expressed some concern at the wording of the conclusion of the note on the outcome of the workshop with the Kent Fire and Rescue Service which took place on 10 July with a view to identifying opportunities for joint working as he was unclear as to what had been achieved as a result and how this was to move forward. He was re-assured that although no “big ideas” had arisen from the workshop major steps had been taken in terms of developing a good network of contacts with KFRS and producing greater awareness of where the services could co-ordinate their efforts to complement each other and to draw upon the expertise available from KFRS. The opportunities to work together on thematic topics had also been explored.

The workshop recognised the unique position of the fire service to open up access to groups of people who might otherwise not be accessible to health and welfare services and the opportunity for cross referrals between the various services with a view to co-ordinating the delivery of health and care. There were good opportunities for work on dementia, dealing with vulnerable families, smoking cessation and dealing with issues such as obesity by linking into initiatives such as Firefit. The ability of Fire Officers to be seen as role models also meant that they were able to reach out to young people and engage with them on levels not possible for other practitioners and that they were widely trusted within the wider community. This opened doors in ways that could be built on by other services. The Fire Services were spending less time dealing with fires and this meant that there was greater capacity for making their expertise available to assist partner organisations. This was reflected in the key Fire Service message , “Think Fire, Think Need”. There were also opportunities to co-locate other services in space available in the KFRS estate.

It was felt that it would be beneficial to document the activities being carried out between the health, care and welfare agencies and the KFRS to provide assurance that this joint working was progressing in a co-ordinated way and to ensure that the anticipated benefits were being made and that opportunities were not being missed. Each Operational Group (HIG and/or COG as appropriate) was asked to document these activities for their area.

94. DEMENTIA FRIENDLY COMMUNITIES

Tracey Schneider attended the meeting to describe progress made in working towards making Kent more dementia friendly and drew on information contained in a presentation which was tabled for consideration.

The Board heard that there were a large number of Dementia Friendly Communities across Kent and currently there were 331 “Dementia Champions” who had held 1150 sessions and recruited over 20,000 “Dementia Friends”. There was also significant activity in the DGS area. The organisational structure for the delivery of dementia was outlined including the work of the Dartford, Gravesham and Swanley Dementia Forum’s , the DGS Dementia Action Alliance and its linkages to the Kent Dementia Action Alliance and the Kent Health and Wellbeing Board. The work carried out by each of the Dementia Forum’s in their areas was described with focus on raising awareness, improving communication and public engagement.

In Swanley the Dementia Forum had delivered awareness sessions, inputted into the new gateway, organised two drop-in sessions and produced a multi-agency leaflet which explained dementia and wider issues around problems with memory. This had proved so popular that supplies of the leaflet had run out. The Dementia Forum had also been keen to provide the Brightshadows production to three schools in Swanley which had shown initial interest but had later pulled out, possibly because governors may have considered this a difficult subject to introduce to young children. A further attempt would be made to promote this project as this was considered to be a good tool to promote greater awareness of wider mental health and confusion (delirium) as well as dementia and the money set aside for this was still available and would need to be used in the current financial year.

In Gravesham the Dementia Forum had focussed on promoting awareness, schools engagement and local mapping and had introduced the Shopsafe, Staysafe scheme first developed in Dartford. The Dartford Dementia Forum had also concentrated on these priorities and had held a small event during the year, had engaged with the local Council and churches and was looking to hold sessions to give legal and financial advice to early stage dementia sufferers and to produce a multi-agency leaflet.

The work of the DGS Dementia Action Alliance was also outlined. This was a mechanism for sharing information across the forums and boards, providing strategic co-ordination across the Clinical Commissioning Group (CCG) area, reporting on individual action plans and working on joint priorities. The Alliance was currently looking to hold a networking event to promote awareness between organisations and practitioners and at ways to engage more closely with the Sikh community.

Su Xavier advised the meeting that she would provide Tracey Schneider with the contact details of an enthusiastic Sikh GP who might be willing to help with engagement. The Board also discussed ways of encouraging involvement from schools. It was noted that secondary schools were quite good at buying-in to dementia awareness initiatives but the problem area was

getting links into Primary schools. Sometimes the Secondary schools were able to provide linkages to their feeder Primary schools which could be followed up. It was also suggested that the Children's Operational Groups and Young Carers workers might be able to assist in opening-up links into schools. The Chairman also offered to take the issue of school engagement away for consideration wearing his KCC Cabinet member hat and bring the conclusions back to the Board.

The Board agreed that good work was being done in Kent on tackling dementia but that currently there was a lack of overall co-ordination between the different providers and in terms of event planning. An example was given of an event which was held but without any uptake. It was noted that it had been the intention that all Dementia Forum meetings would be attended by a representative from the Kent and Medway Trust Partnership which would have promoted co-ordination but that they were often unable to attend.

Tracey Schneider informed the Board that when she had taken on her role two years ago she had carried out 3 separate surveys of work on dementia in Dartford, Gravesham and Swanley and that it might be opportune to re-visit these to see how services had progressed and changed during that time. The Board also asked whether any integrated care pathway had been identified and was advised that one had been under development for eighteen months but had not been finalised.

It was agreed that the outcome of the 3 updated surveys should be brought back to a future meeting of the Board for further consideration which would demonstrate the direction of travel, areas of success and any opportunities for improvement. Work on the integrated care pathway for dementia should also be reported to the Board together with performance indicators such as diagnosis rates and hospital admissions.

95. HEALTH PROFILES AND PRIORITIES FOR DARTFORD, GRAVESHAM, AND SWANLEY 2015

At its last meeting the Board had considered the six health priorities agreed when the Board was originally established in 2013 and had felt that addressing all of these priorities was proving difficult given the complexity of some of the health conditions. It had been agreed that it might be more effective in improving health and wellbeing and addressing inequality by focussing on fewer priorities or possibly on a single priority. To this end health profiles providing an overall health summary and identifying key health inequalities had been produced for Dartford, Gravesham and Sevenoaks along with a separate profile for Swanley to assist with identifying key priorities. The profile for Swanley had been produced because it had been suspected that health trends in that area were being disguised by inclusion in the wider profiles for Sevenoaks and the new profile for Swanley did show that there had been a significant masking effect and that Swanley in fact had more in common with Dartford and Gravesham. The information used to develop the profiles had been drawn from data compiled by the Kent Public

Health Observatory and this more detailed information would be circulated to the Board.

Dr Su Xavier presented the key findings of the report and explained that it was clear that obesity, alcohol and smoking had the greatest impacts in terms of health but that if the Board wished to focus on a single priority than a clear cross-cutting theme was obesity. It was also noted that significant work was already being carried out on alcohol and smoking cessation through vehicles such as the Kent Alcohol Strategy and that this would continue irrespective of priorities agreed by the DGS Health and Wellbeing Board. Obesity had many impacts on other aspects of health and wellbeing and, if agreed as the key priority, strategies could be developed to target obesity across all age groups and in areas of high prevalence. The profiles had also shown a disturbingly high rate of childhood injury in the 0-4 age group in the Swanley St Mary's ward and it was suggested that this warranted further investigation to see whether there was a safeguarding issue in that area or to explain the reason for the rate of injury. It was also noted that the Chief Executive of Healthwatch was very keen to support a public health initiative and was likely to be very supportive of any initiative to address obesity.

The Chairman explained that the Kent Health and Wellbeing Board was keen to have a more proactive impact on Commissioning Plans and to this end Public Health would be setting a series of challenges to the Commissioners in September with a view to giving them half a dozen priorities to feed into their Commissioning Plans. Local Health and Wellbeing Boards would also be asked to consider setting these challenges.

The Chairman felt that the profiles and discussion had confirmed the view that the Board should focus primarily on one priority and that that should be obesity. To that end the agencies represented on the DGS Health and Wellbeing Board should establish what their current plans and strategies contain on obesity and identify whether they could do more to tackle this cross-cutting health priority. This should be taken forward by a task-and-finish group which Dr Su Xavier agreed to lead.

96. UPDATE ON IMPLICATIONS OF NEW DEVELOPMENTS FOR THE HEALTH SECTOR AND THE NEW SHAPE OF SERVICE PROVISION

Dr Su Xavier provided an update on action taken to ensure that health need and service provision implications were taken into account when planning new developments. The Ebbsfleet Development Corporation was now up and running as the planning authority and the CCG was engaging with the Director of Strategy on a regular basis. It had become clear that the Master Plan needed to be revisited and it was hoped to input to this by revising the Health Impact Assessment. The CCG was also talking to NHS England about making a bid to the Healthy New Towns Fund.

There was concern that the Ebbsfleet development might now include 15,000 new homes rather than the 11,000 homes originally envisaged. Health care

services had been planned on the basis of the original figure and this increase would have a significant impact in terms of service provision. It was further noted that although there was s106 provision for health facilities ie. premises, the CCG's predecessor, the PCT, had not bid for additional monies to equip or staff these new facilities. There was also a danger of the development increasing health inequalities in surrounding areas. For this reason it was important that wherever possible hubs were put in place which should be accessible for people from the wider DGS population.

The Paramount Park development was also a concern as the content of the Health Impact Assessment did not seem to tally with the Environmental Impact Assessment. The developer had not factored-in much beyond basic first aid provision and this could have a devastating impact on Darenth Valley Hospital if this was not addressed. There were however significant opportunities to incorporate hubs and for working health and social care into the Paramount plans but there would be no extra money from the developer for this.

The Chairman said that he would speak to KCC Property Services to see whether there was any scope for stressing the importance of public health provision with the Ebbsfleet Development Corporation and would brief the Leader of KCC, Paul Carter, who was a member of the EDC Board. He asked Sheri Green and Sarah Kilkie to brief their respective Leaders who were also members of the EDC Board.

97. REPORT FROM MENTAL HEALTH GROUP

There was no update to provide. It was noted that it would need to be established whether this would continue as a sub-group and that this may be influenced by work commissioned by the Kent Health and Wellbeing Group.

98. INFORMATION EXCHANGE

Su Xavier expressed concern at the high rates of tuberculosis in Gravesham and asked who she could contact to discuss this. It was suggested that Melanie Norris should be the first point of contact.

99. BOARD WORK PLAN

The following items were added to the Work Plan:

> Feedback from the Kent Health and Wellbeing Board on health priorities for Dartford, Gravesham and Swanley – to 7 October 2015 meeting
>
> Progress report from the task and finish working group on Obesity – to 9 December 2015 meeting.

Results and analysis from the Dementia 2 year audits – to 24 February 2016 meeting.

Progress on the Dementia Pathway and performance indicators – to 24 February 2016 meeting.

The meeting closed at 5.05 pm

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Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 23 June 2015 at 3.00 pm.

Present:

Chairman: Councillor P A Watkins (Minute No. 1 to 9 only)

Board: Councillor P M Beresford
Ms K Benbow
Councillor S S Chandler (Chairman for Minute No. 9 to 14 only)
Councillor J Hollingsbee
Councillor M Lyons
Ms J Mookherjee
Ms T Oliver

Officers: Chief Executive
Head of Leadership Support
Leadership Support Officer
Team Leader – Democratic Support

1 ELECTION OF A CHAIRMAN

The Team Leader – Democratic Support called for nominations for a Chairman for the ensuing municipal year 2015/16.

It was moved by Councillor M Lyons, duly seconded and in the absence of any other nominations it was

RESOLVED: That Councillor P A Watkins be elected as Chairman of the South Kent Coast Health and Wellbeing Board for the ensuing municipal year 2015/16.

(Councillor P A Watkins took the Chair upon his appointment)

2 APPOINTMENT OF A VICE-CHAIRMAN

It was moved by Councillor P A Watkins, duly seconded by Councillor M Lyons, and in the absence of any other nominations it was

RESOLVED: Dr J Chaudhuri be appointed as Vice-Chairman for the ensuing municipal year 2015/16.

3 APOLOGIES

Apologies for absence were received from Dr J Chaudhuri (South Kent Coast Clinical Commissioning Group), Mr M Lobban (Kent County Council) and Ms J Perfect (Case Kent).

4 APPOINTMENT OF SUBSTITUTE MEMBERS

There were no substitute members appointed.

5 DECLARATIONS OF INTEREST

Councillor M Lyons advised that he was a Governor of the East Kent Hospitals University NHS Foundation Trust.

6 MINUTES

It was agreed that the Minutes of the Board meeting held on 20 January 2015 be approved as a correct record and signed by the Chairman.

7 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raised on notice by Members of the Board.

8 EAST KENT HOSPITALS UNIVERSITY FOUNDATION TRUST

The Board received a presentation from Ms R Jones (Director of Strategy and Business Development, East Kent Hospitals University NHS Foundation Trust) on the Trusts 2 to 10 Year Strategy 'Delivering our Future'.

The Board was informed that a recent Care Quality Commission (CQC) report had provided an overall rating of 'inadequate' for the Trust. A further inspection was planned for July 2015 by the CQC.

The Trust faced operational issues in respect of A&E services, poor performance in respect of waiting time targets (the A&E four-hour target was unmet) and workforce constraints, with significant agency staff costs.

The Board was advised that the Trust had performed well in respect of infection control rates for Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Diff) and had a hospital death ratio that was 20% lower than the national average. In addition, new models of care and service improvement were being developed (one-stop Out Patient clinic facilities and a new hospital in Dover).

However, there were pressures of increasing demand (1% growth per year) which equated to an additional 76,000 people using the Trusts services over a 10 year period and increased patient expectations for quality care provided close to home. Demographically, East Kent was predicted to have both an increasing younger population (1.3% growth per year) and over 75 year old population (3.5% growth per year).

In addition, the Trust faced financial challenges despite a £6 million surplus for 2013/14 on a turnover of £526 million. The financial position of the Trust was projected to worsen with a deficit of £40 million projected for 2017/18 rising to a deficit of £147 million by 2020.

The Board was advised that if no changes were made, the Trust would be dealing in 2023 with a 16% increase in inpatient demand (an additional 15,000 people), an increase of 17% for day cases (12,000 people) and an increase of 15% for outpatient services (92,000 people) that it did not have the spare capacity in staff, estate or beds to deliver.

The proposals for meeting this demand involved:

- Changes to the current pattern of unsustainable services over 3 hospital sites, which was supported by a clinical consensus that reconfiguration was

required and concerns that 3 site unselected medicine was unsustainable in the medium term;

- The reconsideration of future care delivery (service consolidation/centralisation, local service delivery, delivering existing services in different setting and/or starting new service delivery); and
- An integrated care strategy (health and social care campus) with integration with primary care services and the creation of teaching nursing homes. As part of this, some services could be localised - Tier 0 (self-care and preventative activities), Tier 1 (primary care), and Tier 2 (non-acute care) – and some services could be centralised - Tier 3 (secondary non-complex acute care) and Tier 4 (tertiary complex acute care).

The Trust was working with Ernst and Young to model possible options and researching good practice and models of care. It was seeking to develop a clinical model with clinicians and staff and working with Clinical Care Groups and other providers to agree an East Kent Health Economy approach to the issues. There was also an on-going patient and public engagement strategy that had seen the trust speak to over 767 people (56% face-to-face).

The process for the strategy was based on two phases:

- Phase A – Preparatory works (stakeholder analysis and mapping with the gathering of general views) followed by Pre-Consultation (gathering views on proposed changes prior to public consultation).
- Phase B – Formal public consultation (gather views on the details of the proposed changes), post consultation (feedback analysis and report generation) and finally the identification and agreement of a preferred option.

The outcome would have to deliver a clinically, operationally and financially sustainable position for the Trust.

In response to Councillor P A Watkins question as to whether the proposed timetable for public consultation in early 2016 was achievable given the length of time previous consultations had taken, the Board was advised that the important factor was that a proper public consultation with clear and viable options needed to be conducted and that if it meant the public consultation needed to be undertaken at a later date than planned then it would be.

The Board discussed the need for reducing agency expenditure in the NHS, both locally and nationally, and the importance of encouraging local schools and colleges to promote health careers in order to develop a new generation of clinical staff with local ties. Ms R Jones acknowledged that while the Trust's focus was on more traditional methods of recruitment, it had tried alternative models for recruitment, such as a programme targeted at local schools and colleges to promote careers in health which had provided sufficient new staff to tackle a shortfall in theatre staff at Queen Elizabeth the Queen Mother Hospital (QEQM).

Councillor J Hollingsbee urged the Trust to review its position in respect of work experience opportunities so that 15 year olds could take part as there was more chance of influencing career choices at that age.

Ms K Benbow informed that Board that the integrated care plans for both the South Kent Coast CCG and the Trust were compatible, although still in early phases. The importance of avoiding unnecessary admissions to A&E and hospital were emphasised.

RESOLVED: (a) That Ms R Jones be thanked for the presentation and it be noted.

(b) That the Board receive a further presentation prior to the proposals going to public consultation.

9 CCG 2015/16 OPERATIONAL PLAN AND THE 2015/16 QUALITY PREMIUM

Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) introduced the report on the CCG's Operational Plan 2015/16 and the Quality Premium 2015/16.

The Board was advised that the main focus of the commissioning plans related to 'Out of Hospital' services as part of a multi-speciality community provider (MCP) model. However, the plan also included schemes that would impact on 'in hospital' pathways and the patient overlap between 'in hospital' and 'out of hospital' care.

In respect of mental health services, the intention was to embed a psychiatry liaison in hospitals to reduce the number of sections taking place for patients presenting with mental health issues and deliver an improved patient experience with better outcomes in the setting of an acute hospital. A new performance indicator in respect of 'Early Intervention in Psychosis' had also been adopted.

As part of the hospital programme in the operational plan, emphasis was placed on working with the East Kent Hospitals University NHS Foundation Trust (EKHUFT) and other secondary care providers to develop new models for secondary care and engaging with EKHUFT to ensure that the consolidation of outpatient services to six sites preserved equitable access to outpatient services, particularly for Deal and Shepway patients.

The CCG also planned to implement a new practice level model for community nursing to ensure that care was better co-ordinated with GP Specialist Nursing for vulnerable patient groups and managing the care of patients with long term conditions.

RESOLVED: That the South Kent Coast Operational Plan 2015/16 and Quality Premium 2015/16 be noted.

10 ELECTION OF A CHAIRMAN FOR THE REMAINDER OF THE MEETING

The Chairman, Councillor P A Watkins, left the meeting during Minute Number 9 and in the absence of the Vice-Chairman, the Team Leader – Democratic Support called for nominations for a Chairman to preside at the remainder of the meeting.

It was proposed by Councillor M Lyons, and duly seconded, that Councillor S S Chandler be elected Chairman for the remainder of the meeting. In the absence of any other nominations it was

RESOLVED: That Councillor S S Chandler be elected as Chairman for the remainder of the meeting.

(On being elected, Councillor S S Chandler assumed the Chairmanship for the remainder of the meeting.)

11 PUBLIC HEALTH PERFORMANCE AND PROGRAMME UPDATE

Ms J Mookherjee (Consultant in Public Health, Kent County Council) presented the report on developing the Public Health Strategic Delivery Plan and Commissioning Strategy.

A strategic review was being undertaken to develop a new commissioning model that tackled health inequalities and reflected the shared priorities and objectives of local partners. Key outcomes would be delivered through integrated service delivery rather than standalone provision. In addition, new contracts would be commissioned to allow for flexibility to reflect changes in demand.

However, key programmes would continue to be commissioned while the review took place, structured under a 'Starting Well', 'Living Well' and 'Ageing Well' approach.

The key public health priorities were:

- Smoking (particularly while pregnant)
- Healthy eating, physical activity and obesity
- Alcohol and substance abuse
- Wellbeing including mental health and social isolation
- Sexual health and communicable disease
- Wider determinants of health (including Crime)

Overall, greater innovation and integrated working was vital to ensuring the maximum impact on shared priorities and public health outcomes was achieved against the backdrop of reductions in the public health budget. The work of falls prevention

Members of the Board discussed the Folkestone Community Hub approach to service delivery, noting that while well received it was not a 'one-size-fits-all model' and might not be the best approach for all locations. However, lessons learnt from the Hub approach could be applied elsewhere.

RESOLVED: That the update be noted.

12 INTEGRATED CARE ORGANISATION UPDATE

The update on Integrated Care Organisation was presented by Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group).

The Board was advised that locality areas had been agreed and Local Delivery Groups had been formed in Dover, Deal, Folkestone and Romney Marsh. The composition of each of the Groups was the same with GP lead support, statutory and voluntary agency attendance and patient and public attendance. It was recognised that each locality had its own issues and would have its own service delivery model as a consequence. The Dover and Folkestone localities were also in receipt of the Prime Minister's Challenge Fund.

Each of the Groups had a 'hub' which was Buckland Hospital for Dover; Deal Hospital for Deal; Romney Marsh Day Centre and Martello for Romney Marsh; and Royal Victoria Hospital for Folkestone.

The Board was advised that as part of the Integrated Care Organisation programme, best practice was being developed for patient and public involvement and both groups had been involved from an early stage.

RESOLVED: That the update be noted.

13 FEEDBACK FROM THE DEVELOPMENT SESSION AND NEXT STEPS

Ms M Farrow (Head of Leadership Support, Dover District Council) presented the feedback from the Development Session held on 31 March 2015. Members of the Board were advised that an update would be given at the next meeting in respect of the agreed next steps from the Development Session, particularly around clarifying the role of the Board in respect of Integrated Care Organisation development.

RESOLVED: That the feedback be noted.

14 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 4.46 pm.

MINUTES

Health and Wellbeing Board – Eighth Formal Meeting

Meeting held on Wednesday 20 May 2015 at 09:30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present	**Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC (Chair)*** **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*** **Terry Hall (TH), *Public Health, KCC*** **Su Xavier (SX), *Swale CCG*** **Patricia Davies (PD), *Accountable Officer, Swale CCG*** **Chris White (CW), *Swale CVS*** **Tristan Godfrey (TG), *Policy Manager, KCC*** ***Hannah Gates (HG), Housing Strategy Officer, SBC***	**Cllr Chris Smith (CS), *Deputy Cabinet Member Adult Social Care & Public Health, KCC*** **Helen Stewart (HS), *Kent Healthwatch*** **Becky Walker (BW), *Interim Strategic Housing and Health Manager, SBC Housing*** **Dr Fiona Armstrong (FA), *Chair, Swale CCG*** ***Bill Ronan (BR), KCC*** ***Charlotte Hudson (CH), Safer & Stronger Communities Manager, SBC*** ***Stephanie Curtis (SC), Safer & Stronger Communities Officer, SBC*** ***Liza Thompson (LT), Service Director, SATEDA***
Apologies	**Cllr Andrew Bowles (AB), *Leader, SBC*** **Penny Southern (PS), *Director Learning Disability and Mental Health, KCC*** **Alan Heyes (AH), *Community Engagement Lead, Mental Health Matters***	**Debbie Stock (DS), *Chief Operating Officer, Swale CCG*** **Paula Parker (PP), *Commissioning Manager, KCC*** **Andrew Scott-Clark, Director of Public Health, KCC** **Steve Furber (SF), Vice-Chair, *Swale Mental Health Action Group***

NO	ITEM	ACTION
1.	**Introductions**	
1.1	KP 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.4, 6.1: Total Resource Pilot to be fed into action plan and a draft to be	**PP**

	circulated as soon as ready	**AC/RW**
3.	**Domestic Abuse Services in Swale**	
3.1	SC and LT introduced a presentation on domestic abuse, the CSP agenda and SATEDA. The key points were: ▪ a local Community Safe Plan is in place, with priorities including Crime, Anti-Social Behaviour, Domestic Abuse, Reducing Reoffending, and Supporting Victims; ▪ from April 2013 CCGs became statutory members of CSPs; ▪ Swale has the second highest rate of Domestic Abuse incidents in Kent; ▪ Government definition of domestic abuse can encompass but is not limited to: psychological, physical, sexual, financial, and emotional. ▪ SATEDA is a client-led service providing safe options for clients; ▪ referrals come from across the Borough from various organisations, although there have been no referrals from GPs to date. Referrals can be made via email at admin@sateda.org; ▪ there is an e-learning package available for health professionals at http://kdac.org.uk/health-professionals/; ▪ would like to strengthen links with GP surgeries to encourage referrals and sign-posting; ▪ 48% of those referred are identified as having a mental health issue, but referrals from Mental Health are very limited; and ▪ training can be provided, along with leaflets, posters and information cards.	**CCGs via SC**
3.2	Points made in the discussion included: ▪ GPs may not be aware of SATEDA or may be referring through other routes such as Safeguarding. Work is required to improve referrals from GPs and better links with the local hospitals is required; ▪ a representative from the CCGs should attend CSP forum; ▪ SATEDA work with all members of the community regardless of sexual orientation or gender. The only exception is the Freedom Project which is written for women. SATEDA received 16 male referrals in 2014; ▪ most cases are repeat cases as victims are unlikely to leave on the first occasion. A telephone call-back service is provided which may assist repeat victims; ▪ it may be useful for SATEDA to link into Health Care Services via both CCGs.	**CCGs** **SATEDA/ CCGs**
4.	**Troubled Families Update**	
4.1	CH introduced a presentation on the Troubled Families Programme. The key points were:	

	▪ Phase 1 a 3 year 'payment by results' programme has completed, identifying 503 families and 'turned around' 236; ▪ Phase 2 has a five year extension with a target of 1,292 families, the largest cohort in Kent. New measurement criteria applies and is based on a family focused plan.	
4.2	Points made in the discussion included: ▪ good links exist at an operational level; however, improvement is required at a strategic level; ▪ a briefing from Public Health is required; and ▪ Troubled Families should be set as an agenda item at Kent H&WB.	**CH** **KP**
5	**Total Resource Pilot**	
5.1	AK provided introduction to project in Olivia Crill's absence. The key points are: ▪ two strategic outcomes are being focussed upon for the pilot - 'keeping vulnerable older people safe in their own homes' and 'reducing obesity in children, young people and adults'; ▪ the pilot will examine all spend relating to these outcomes, seeking a move towards a commissioning for outcomes approach, and will demonstrate value around this methodology; ▪ there are two priority outcomes around Health and Social Care integration with the Better Care Fund, and examining activity, nutrition and lifestyle choices; and ▪ data collection is about to start with reporting due August/September 2015.	
5.2	Points made in the discussion included: ▪ focusing on obesity in children may be limited, there is a requirement to consider linking adult behaviour into this; and ▪ the pilot will help to initiate the change process which can be complex. This is useful when considering the County-wide commissioning process, particularly as funding and resources are increasingly limited, requiring better and more efficient services.	
6	**Additional Board Members**	
6.1	KP opened up the option of additional members to the Board for debate, following KICA's request to attend Swale's H&WB. The key points raised include: ▪ clarity is needed regarding the purpose of the Alliance and how they would contribute to the Board. We must be mindful of strategic governance, but as a meeting in public they are welcome to attend; ▪ KCC H&WB view is also necessary to provide guidance on inclusion of KICA membership; ▪ we must be mindful that there may be a conflict of interest in having a	

	provider attend, although they are welcome to present; ▪ others such as KFRS and the Police should also be included on the Forward Plan and invited to present.	**RW**
6.2	It was agreed to invite KICA to present to a future Board meeting, and a view about their membership of the Board would be deferred until after we had heard from them.	**AC/RW**
7	**Better Care Fund – verbal update**	
7.1	TG presented on the standing item. The key points were: ▪ now in implementation phase so less to update on; ▪ joint commissioning is already in place for Children's Services, LD and Mental Health; ▪ it would be useful to see a local dashboard of indicators reporting local outputs in North Kent, including wider Health and Social Care; ▪ DFG funding is now included within the BCF budget, but it is unclear how this will affect next year's delivery. There is growing concern across Kent as it is still unclear where the focus of DFGs is locally. Reassurance was provided that there is a legal duty to pass on the DFG funds to LAs but this does not yet have a specific time frame. It was suggested that this item be discussed at Kent H&WB; and ▪ BCF should remain as a standing item, with the additional provision of a data/performance dashboard.	**AC/RW & TG**
8	**Kent Health Wellbeing Board**	
8.1	There was a short discussion on the Kent H&WB agenda. Items of note were: ▪ Confirmation that the workforce review is based around a five year time period; and ▪ the Kent and Medway Infrastructure Framework looks at how planning and health fit together, focusing on the future growth at Ebbsfleet and Ashford to ensure health needs are taken into account in the planning process.	
9	**Partners Update/AOB – verbal update**	
9.1	**Swale Borough Council** ▪ Universal Credit roll out very quiet so far. ▪ Housing Team is currently appearing on BBC Housing Enforcers. ▪ Submitted Local plan, examination in public due in Sept 2015. ▪ Election outcomes shared: Conservatives remain in administration and Andrew Bowles as Leader with the same Cabinet, which will be reviewed in August 2015. ▪ The number of safeguarding referrals is increasing noticeably. ▪ Positive feedback has been provided from KCHT around improved	

	hospital discharge rates from Medway into Swale and the positive effect this has had on A&E.	
9.2	**Swale CCG** ▪ Urgent Care Review across North Kent, overarching principles for future development. New service aims to be in place October 2016, to include a paramedic practitioner pilot led by South Kent Coastal for Swale. ▪ Year-end financial duties met, although MFT did not meet year end targets for A&E. Community Care Service review is going out to tender. Integrated commissioning wants to focus on Older Persons moving forward. ▪ Educational commissioners across South East to identify those who may want an apprentice-type health role 16-25 years but not limited to this age. ▪ Home First project saw 95% rate return home rather than into a care setting.	
9.3	**Kent Healthwatch** ▪ Health Watch Bus will be out w/c 8 June 2015. Details to be sent out but will not visit Sheppey.	
9.4	**Public Health** ▪ Physical inactivity pilot now open in Swale. ▪ Tobacco Control Alliance championing smoke-free homes initiative in child centres, and also smoke free parks in Ashford. ▪ KCC signed declaration on tobacco control.	
9.5	**KCC** ▪ Thom Wilson will be delivering COG programme at a workshop in early June, with the aim to report back to July H&WB. Looking at a district-based model, 12 groups, with safeguarding critical component. ▪ KCC Social Care -, Phase 2 of transformation looking at broadening out to LD housing and what provision is required. ▪ Three public health contracts coming up for review. ▪ There is a H&WB Strategy review event on 17 June.	

Next meeting date: **Wednesday 15 July 2015**

Time: **9.30am – 11.30am**

Location: **Committee Room, Swale Borough Council**

All meetings will be in public

Future Meetings Dates (all 9.30 – 11.30 at Swale House):

16 September 2015

18 November 2015

MINUTES

DRAFT MINUTES

Health and Wellbeing Board – Ninth Formal Meeting

Meeting held on Wednesday 15 July 2015 at 09:30am

Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present	**Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC (Chair)*** **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*** **Terry Hall (TH), *Public Health, KCC*** **Tristan Godfrey (TG), *Policy Manager, KCC*** **Becky Walker (BW), *Interim Strategic Housing and Health Manager, SBC*** ***Housing***	**Dr Fiona Armstrong (FA), *Chair, Swale CCG*** ***Bill Ronan (BR), KCC*** **Paula Parker (PP), *Commissioning Manager, KCC*** **Chris White (CW), *Swale CVS*** **Helen Stewart (HS), *Kent Healthwatch*** **Julie Blackmore (JB), *Maidstone Mind*** **Alan Heyes (AH), *Community Engagement Lead, Mental Health Matters***
Apologies	**Patricia Davies (PD), *Accountable Officer, Swale CCG*** **Cllr Andrew Bowles (AB), *Leader, SBC*** **Su Xavier (SX), *Swale CCG*** **Penny Southern (PS), *Director Learning Disability and Mental Health, KCC*** **Steve Furber (SF), Vice-Chair, *Swale Mental Health Action Group***	**Debbie Stock (DS), *Chief Operating Officer, Swale CCG*** **Andrew Scott-Clark, Director of Public Health, KCC**

NO	ITEM	ACTION
1.	**Introductions**	
1.1	KP 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.4, 6.1: KFRS included on Forward Plan for November 2015 and Police have been invited. ▪ 6.2: Invitation sent to KICA to present to the Board, awaiting reply.	

DRAFT MINUTES

3.	**Healthy & Wellbeing Improvement Partnership Action Plan**	
3.1	TH and AC introduced the Draft Health & Wellbeing Improvement Partnership: ▪ TH has been suggested as new vice chair and this needs to be formalised; ▪ first reiteration of draft action plan has progressed. The Board were asked how they would like to develop the plan; ▪ the six draft ambitions were agreed, although resources, outcomes and activities still open to suggestions; ▪ two types of activity are suggested, that which is already happening with progress updates, and that which is we would like to make happen, which could be additional or substitute; ▪ requirement to look at priorities and work into budget setting, but must ensure this is not just a monitoring plan; ▪ the Total Resource Pilot is referenced in many of the actions, and health inequalities work is included throughout the Plan; ▪ one purpose of the Plan is to escalate it to organisations and the Board with aim of increasing resources and re-prioritising actions etc; ▪ request made for a discussion on Ambition 3 Mental Health, a running commentary to be provided by the Health & Wellbeing Improvement Partnership Group (HWIP);	**TH/SX**
	▪ a Mental Health support worker is present at Swale House in Housing one afternoon per week; ▪ request made to invite MHAG to HWIP; and	**RW**
	▪ the sub groups that sit beneath the H&WB were clarified. There are three sub-groups: the HWIP, Integrated Commissioning Group, and COG that have individual action plans, with the KCC H&WB Group over-arching all.	
3.2	Points made in the discussion included: ▪ there are occasions when clients decline services and concern was raised over what help can be provided in these cases; ▪ there are many lifestyle/prevention initiatives to decrease alcohol intake ,but uptake is voluntary unless under Mental Health Act; ▪ Troubled Families provide an approach to offer help but this is not mandatory for families unless there are concerns around safeguarding, mental health or crime etc.; and ▪ family change and influence are very important.	
4.	**COG Update**	
4.1	AC provided an update following the Kent Health and Wellbeing Strategy event on 17 June: ▪ each District in Kent should have a COG in place by Sept 2015;	

	▪ work around this is being led by Thom Wilson at KCC to set priorities across the county; and ▪ Swale may not be ready for a COG by this date.	
4.2	Points made in the discussion included: ▪ the Faversham COG is covered under Canterbury CCG, but as Children Services are delivered through a district footprint a Swale COG is required, although Swale will need to link in with the Canterbury COG; ▪ the COG is outcome driven, and therefore it is important that the appropriate members are invited to attend; ▪ the September 2015 deadline is ambitious – it is a complex task setting up the group with issues that require H&WB steer. Good support from KCC is required to ensure the Swale COG is effective; ▪ KCC will need to establish the COG with Swale representing on the group, and this will need to be fed back to KCC; ▪ AC is attending the next CHWB meeting on 30 July and will circulate notes to AK; and ▪ the chair of COG to be invited as member of H&WB.	**BR** **AC** **RW**
5.	**Health & Wellbeing Away Day Discussion**	
5.1	AC opened up the discussion on arranging an away day to enable the next stage of development of Swale's H&WB. It is a year on from the previous facilitated away day and it is thought that it would be useful to hold another event to review progress and enable the Board to move forward.	
5.2	Points made in the discussion included: ▪ an annual away day is a good idea. Generate ideas through 1-2-1 conversations with the facilitator in advance, and bring these to the away day; ▪ a steer from Kent Board would be helpful, and a KCC representative should be invited; ▪ KCC are aware of issues for local HWBs with are common issues arising - a report is being compiled on this for the September KCC Board; ▪ the recent LGA conference highlighted the differences across HWBs boards nationally, although the one strong thread identified is the need for a peer review process; ▪ it is important that focused outcomes are delivered from the away day; ▪ Mark Lemon is part of a regional group that looks at SE issues, and how we can support local clients; ▪ it would be beneficial if this could be rolled out as training for officers, members, and chairs; and ▪ the away day could be arranged on the afternoon of the September Swale H&WB, or as early in October as possible.	**AC/RW** **AC/RW**

DRAFT MINUTES

6.	**Better Care Fund – verbal update**	
6.1	TG advised that as the BCF is now at the implementation stage he is not so involved. A report is due out this week and a copy should be sent out soon. The Board were asked how they would like to receive future updates: ▪ BCF is currently monitored through the Executive Programme Board, and is also monitored in Medway, although focus on this is now reducing; ▪ unclear if BCF should now remain as a standing item as it is in motion; ▪ continue to require updates as these are key to adult health and the health economy; and ▪ suggestion that is an occasional item with a paper sent to other Boards and circulated to Swale's H&WB.	**TG**
6.2	Points made in the discussion included: ▪ would be useful for other regular updates - Integration Pioneer and Social Care Act; ▪ other items now also require monitoring, e.g. the Vanguard Programme; ▪ Care Act implementation and integration should be included as new standing items instead of BCF; and ▪ the new standing items should be noted on the Forward Plan.	**DS/PP** **RW**
7.	**Kent Health & Wellbeing Board**	
7.1	There was a short discussion on the Kent H&WB agenda. There was agreement that the proposal to establishment a task and finish group to consider strategic workforce issues was much needed.	
8.	**Partners Update / AOB – verbal update**	
8.1	**KCC Commissioning** ▪ There is a new commissioning framework available on the Kent Gov website. ▪ Part 1of the Care Act has been implemented and was intensive. Phase 2 preparation is in place. ▪ There is a change in the cap in care costs and an increase in capital threshold, resulting in self-funders also needing a full assessment. ▪ There is a commissioned independent advocacy service on website. ▪ Transformation programme for adults with LD is due to be implemented - there are five projects and one is a rehabilitation and enablement. Also looking at how Ashford, Dartford, Swanley and Swale can be more efficient working together. ▪ The acute demand work/return home work is now in the next phase. Ashford is complete, Darenth Valley and Medway outcomes are important. Require visible view of services. ▪ Work underway around the voluntary sector outcomes and LD services. Providers, contracts and the future is more about independent living.	

- Project Swale (sustain, research, evaluate project) is looking at working more effectively with Medway Hospital and the community hospitals, and who returns home.
- Emergency Planning, heatwave notices have been sent out, also to CCG Communications Team.

8.2 **Swale CVS**

- Several upcoming events for young people planned for over the summer, particularly on the Island.
- Big Local is successful in gaining further funding, and will be continuing on east of the Island, MHAG are attending.
- Telephoning befriending funds now in place on top of visiting and lunch clubs.

8.3 **Public Health**

- Apologies to be noted for TH's absence at September meeting.
- Kent Nature Partnership is a natural way to wellbeing in green and blue open spaces.
- Six to eight weeks ago £200 million cuts announced to Public Health grant budgets - KCC looking at £ £4.25 million cuts/7% contract value. Current in-year budget cut, which may impact on Q4. New funding not available.
- Public Health Consultation document pending.

8.4 **MHAG**

- There is a project running for men's Mental Health and football (KCC Public Health).
- Wellbeing cafes are still open, though the Sheppey café is quiet with low take up and may close.
- Sittingbourne Wellbeing café is still running, but requires further funding - trying to widen remit.
- Increase in use of Helpline in Swale.

8.5 **Healthwatch**

Link from annual report: http://www.healthwatchkent.co.uk/annual-review-2015

healthwatch_kent_annual_review_2015.p

- Report on KCC H&WB around Integration Work force and finance, with a Task & Finish Group already set up.
- Red Bus week was in June, with feedback available soon.
- Swale event 'Think Local Act Personal' ensuring that commissioners and providers give what people want. This will be disseminated across Kent.

DRAFT MINUTES

	▪ Healthwatch and CCG looking to put regular meetings in place.	
8.6	**KCC**	
	▪ Reviews underway: 1. local H&WBs; 2. CCG level officers group has attendance issues, looking at other ways to share information/ meeting arrangements; 3. A JSNA Kent event is scheduled for later in 2015 4. Ways to keep updated with reviews, pilots, vanguards across Kent 5. A workforce Task & Finish Group has been organised with Health and Education England looking. Attendance agreed from all eight CCGs and major providers. A draft report is due March 2016.	
8.7	**Swale CCG**	
	▪ Urgent care redesign across Dartford, Gravesend, Swanley and Medway. Model for Swale produced in full consultation, with options appraisal being developed, considering an at home or community based service. An urgent care centre place is also being considered - this may be based in one hospital, financial aspects to this (due Nov 2016). ▪ Adult community services tender process is looking to change services across next year, currently at PQQ stage, hope to be in place by April 2016. ▪ Ambulance waits decreasing, but still higher than targets. There is concern that targets are decreasing with the Quality and Safety Team looking at a plan with Medway Hospital. ▪ Paramedic practice pilot in Swale September 2015, based on Thanet model of an urgent home visiting service. ▪ New health and social care qualification available to those without qualifications as a stepping stone, with Math and English included, going live in September 2015.	
8.8	**Swale BC**	
	▪ Overview and Scrutiny paper delivered, detail to be taken forward with MHAG and HWIP.	**AC/RW AH/JB**
	▪ All agree that in the future the H&WB will start at 10am for two hours, with CCG meeting held in advance at 9-10am.	
	▪ KP has met the new MFT chair and has been invited to visit Medway hospital, and will invite the MFT Chair to attend SBC.	**KP**
	▪ Meeting around COG establishment to be arranged by KCC, to invite AK, BR, AC, and RW.	**BR**

Next meeting date:	**Wednesday 16 September 2015***
Time:	**10.00 - 12.00pm**
Location:	**Committee Room, Swale Borough Council**

DRAFT MINUTES

***This meeting will be in public**
Future Meetings Dates (all 10.00 - 12.00pm at Swale House): **18 November 2015**

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 11 June 2015 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Hazel Carpenter (Thanet Clinical Commissioning Group), Councillor L Fairbrass (Thanet District Council), Councillor Gibbens (Kent County Council), Mark Lobban (Kent County Council), Colin Thompson (Kent County Council), Councillor Wells (Thanet District Council),Clive Hart (Thanet Clinical Commissioning Group) and Larissa Reed (Thanet District Council)

1. APPOINTMENT OF CHAIRMAN AND VICE CHAIRMAN FOR 2015/16

Councillor Gibbens proposed, Councillor Wells seconded and Members agreed that Dr Martin be appointed as Chairman of the Thanet Health and Wellbeing Board for the ensuing year.

Dr Martin proposed, Councillor Wells seconded and Members agreed that Councillor Fairbrass be appointed Vice-Chairman of the Thanet Health and Wellbeing Board for the ensuing year.

2. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 12 February 2015 were agreed.

3. DEVELOPMENT OF THE THANET HEALTH AND WELLBEING BOARD

Alisa Ogilvie, Chief Operating Officer, Thanet CCG, presented her report noting that there would be an executive group set up which would report to the Thanet Health and Wellbeing Board (THWB). She added that there had been a THWB development workshop held on 3rd June during which it was agreed that there should be a shift of responsibilities from the CCG to THWB and that the purpose of this item was to seek ratification from those present to move in that direction.

In response to comments and questions it was noted that:

- Members highlighted that they felt the development session had been a useful exercise. Advice from TDC and KCC policy officers would now be required in order to progress the proposed developments;
- delivery was what mattered to the public, therefore it was important to demonstrate least one successful and meaningful outcome quickly.
- this development of THWB should take place over the next 12 months to coincide with a retendering exercise that KCC would be undertaking.

It was agreed that the executive group would provide an update on the development of the THWB at the next meeting.

4. DEMENTIA BRIEFING

Colin Thompson, Consultant in Public Heath, KCC presented the report which gave a background to the condition and gave an update on work carried out both within Thanet and nationally.

In response to comments and questions it was noted that:

- there is still a degree of stigma attached to dementia, this could adversely impact early identification and treatment;
- some councils have offered dementia awareness training;
- an assessment would be required to establish the level of support and facilities (both medical and non-medical) available to those with dementia within Thanet;
- E-Kids, Age UK Thanet, and dementia friendly café's provide some support to dementia suffers. Links to these organisations would be made available on the TDC's website.

Members agreed that the executive group would appoint a lead officer to establish the level of dementia service available in a medical setting and within the community.

5. AGE UK SUPPORT

Diane Aslett and Nicola Parish from Age UK gave a presentation on the work of Age UK with a particular focus on the Support at Home Service.

It was noted that there was a focus on the early identification of problems before issues could develop in more serious conditions.

It was recognised that the Support at Home Service prevented repeated hospital visits by enabling those discharged from hospital to get back on their feet and regain independence.

6. QUALITY PREMIUM 2015/16

Adrian Halse, Senior Business Analyst, Thanet CCG introduced the report which gave some background to the principles of the quality premium and detailed specific indicators chosen by the Thanet CCG.

In response to comments and questions it was noted that the Thanet CCG had been required to submit its proposals to NHS England in May, however it wished for the Thanet Health and Wellbeing Board to ratify the indicators. These indicators were largely derived from blanket indicators issued across the country.

Members agreed to ratify the list of indicators as set out in paragraph 4.2 of the report, namely:

Urgent and Emergency Care	30% aligned to *Number of non-elective patients who are discharged at weekends or bank holidays*.
Mental Health	30% aligned to *Number of people with severe mental illness who are currently smoking*.
Local Priorities	10% aligned to *C2.5 People with diabetes diagnosed less than a year who are referred to structured education*. 10% aligned to *C3.12 Hip fracture: timely surgery*.

7. EKHUFT POSITION STATEMENT

The Chairman introduced the item, and noted the following:

- there would need to be a shift of increased care provision with in the community rather than in hospitals.

- the health service had seen a trend of medical specialisation, however there would be an increasing demand for consultants with more generalised expertise, this knowledge would take time to develop.
- that acute health care could not continue in its current form when faced with changing budgets and demographic, Buckland Hospital could be an example of what future health provision might look like.

In response to comments it was noted that effective communication would be vitally important, and co-ordination would be required with elected Members at TDC and KCC.

8. ADULT SOCIAL CARE TRANSFORMATION

Mark Lobban, Director of Commissioning Social Care, KCC presented the item. He noted that this was to update Members regarding phase two of the transformation. Mr Lobban advised that the modelling was based upon success demonstrated in Ashford where improvements to the Ashford enablement team had resulted in 90% of people having no on-going care needs after a period of enablement.

In response to questions and comments it was noted that:

- the Thanet Health and Wellbeing Board would have a role in assessing the success of the integrated support proposal;
- the transformation would require a larger domiciliary workforce with care providers becoming more specialist;
- there are currently some perverse incentives in domiciliary care that encourage dependency on the service rather than independence;
- more needed to be done to get young people interested in domiciliary work, there was recognition that current pay and conditions were not an incentive to young people to embark on a career as care workers;
- secondary schools received an invitation to the East Kent Social Care and Health Careers Event which would take place in October 2015.

It was agreed that the executive board would look further into the transformation programme at its next meeting.

9. HEALTH INEQUALITIES IN THANET

Colin Thompson, Consultant in Public Health, KCC presented the report noting that compared with the other districts in Kent, Thanet had the widest gap in health inequalities between its areas.

Members agreed the recommendations as set in the report, namely:

“Thanet Health and Wellbeing Board should ensure that tackling health inequalities is one of its key priorities.

A health inequalities action plan should be developed. This work should be led by Kent County Council Public Health, in partnership with all stakeholders. The action plan will be brought to the next Health and Wellbeing Board.

All Stakeholders to identify a lead individual who will take the responsibility of reducing health inequalities.

Establishing a Thanet Health Action Group as a sub-group of the Health and Wellbeing Board. This group can deal with more detailed actions relating to localised health issues such as implementation of the local alcohol action plan.”

10. THANET HEALTH PROFILE

Colin Thompson, Consultant in Public Health, KCC presented the document, noting that the profile is produced by Public Health England each year. He added that it was evident that a number of indicators showed Thanet as significantly worse than the England average.

It was noted that these issues of inequality were persistent and on-going, they had been highlighted in 2004 and remained a problem. More resource was required into areas where inequality was most prevalent.

Members agreed that the executive group would look into inequalities as a priority order to drive the issue forward.

11. REPORT ON THE CHILDREN'S BOARD

Members noted the report.

12. AGENDA TOPICS FOR THE NEXT MEETING

A number of items were referred to the executive board for investigation and development, an update on these items would be provided at the following meeting of the THWB.

Meeting concluded: 12.00 pm

WEST KENT CCG HEALTH AND WELLBEING BOARD
DRAFT MINUTES OF THE MEETING HELD ON 21ST JULY 2015

Present:

Dr Bob Bowes (Chair)	Chair of West Kent CCG
Gail Arnold	Chief Operating Officer, WK CCG
Tracey Beattie	Mid Kent Environmental Health Manager, Tunbridge Wells Borough Council
Hayley Brooks	Health and Communities Manager, Sevenoaks District Council
Cllr Roger Gough	Chair of Kent Health and Wellbeing Board
Jane Heeley	Tonbridge and Malling Borough Council
Fran Holgate	HealthWatch
Dr Tony Jones	GP Governing Body member, WK CCG
Mark Lemon	Strategic Business Advisor, Kent County Council
Dr Andrew Roxburgh	GP Governing Body member, WK CCG
Dr Sanjay Singh	GP Governing Body member, WK CCG
Malti Varshney	Consultant in Public Health, Kent County Council
Cllr Lynne Weatherly	Tunbridge Wells Borough Councillor

In attendance:

Francesca Guy (minutes)	Deputy Company Secretary, WK CCG
Dave Pate	Chief Inspector, Kent Police
Karen Hardy	Public Health Specialist, Kent County Council
Sophie Lyon	South East Commissioning Support Unit
Sarah Robson	Housing and Community Manager, Maidstone Borough Council
Heidi Ward	Health Improvement Team, Tonbridge & Malling Borough Council
Yvonne Wilson	Health & Wellbeing Partnerships Officer, WK CCG

1. WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting. Apologies had been received from the following:

William Benson, Chief Executive, Tunbridge Wells District Council
Cllr Bosley, Sevenoaks District Council
Dr Caroline Jessel, NHS England
Cllr Mark Rhodes, Tonbridge and Malling Borough Council
Louise Matthews, Deputy Chief Operating Officer, WK CCG
Reg Middleton, Chief Finance Officer, WK CCG
Penny Southern, Director of Learning Disability and Mental Health, Kent County Council

2. MINUTES OF THE MEETING HELD ON TUESDAY 19TH MAY 2015

RESOLVED: That the minutes of the meeting held on Tuesday 19th May 2015, be approved as a correct record.

3. MATTERS ARISING

3.1 Progress against the following actions was discussed:

03/15: It was not possible to report on Better Care Fund performance as it was not yet being reported across the whole of Kent.

03/15: Malti Varshney reported that she had identified the outstanding actions from previous West Kent Health and Wellbeing Board (WKHWB) meetings and these had been discussed at the agenda setting meeting with a view to incorporating them into the work plan.

05/15: Malti Varshney clarified this action and noted that districts and boroughs had been asked to approach the schools in those wards where childhood obesity was high and work with the schools to identify actions.

05/15: Malti Varshney reported that it was too soon to draw any conclusions about whether free school meals had had an impact on childhood obesity.

05/15: Dr Roxburgh reported that the CCG's Clinical Strategy Group had agreed a revised maternity specification, which incorporated guidance on healthy eating and the prevention of childhood obesity. This would be discussed with Maidstone and Tunbridge Wells NHS Trust (MTW) and incorporated into the contract.

05/15: Malti Varshney reported that she had followed up with public health commissioning the role that health visitors could have in influencing the childhood obesity agenda.

4. DELEGATED AUTHORITY TO WRITE TO COMMISSIONERS ON BEHALF OF WEST KENT HEALTH AND WELLBEING BOARD

4.1 The board agreed to give delegated authority to Cllr Lynne Weatherly to write to commissioners on behalf of the WKHWB in relation to obesity. The Chair thanked Cllr Weatherly for taking this on.

5. HEALTH AND SOCIAL CARE INTEGRATION

5.1 The Chair opened the discussion by stating that Health and Wellbeing Boards had been set up to promote integrated commissioning for health and social care. In order to achieve this objective, transparency was needed around the total spend on health and social care. Kent County Council (KCC) had been asked for data in relation to adult social care, but had not been able to provide it so far.

Mark Lemon commented that he had discussed this with the social care team at KCC who had indicated that there were difficulties in identifying spend against each of the budget allocations and therefore it was not possible to ascertain the total resource spent in West Kent.

The WKHWB agreed that it would be beneficial to share the data that was available, with the caveats described. The Chair agreed to write to Cllr Roger Gough in order to pursue this information.
Action: Dr Bob Bowes.

5.2 Better Care Fund

It was noted that it was not yet possible to provide a performance report on the Better Care Fund as it was not yet being monitored across the whole of Kent. The performance report would be brought to a future meeting once this information was available.

6. WEST KENT CCG CQUINS

6.1 Gail Arnold reported that the development of CQUINs (commissioning quality and innovation) was mandated as part of the way commissioners procured care from providers. There were a number of national CQUINs for particular types of providers but commissioners were also asked to negotiate local CQUINs with their providers. These could seek to address issues where the CCG area or Trust was an outlier for example. Ms Arnold reported that the CQUINs were monitored regularly through performance and contracting meetings. For CQUINs where data was published annually, proxy indicators were developed. The CQUINs were designed to be stretch targets and if the Trust did not meet the target then they would not earn the money.

6.2 Cllr Gough asked to what extent providers delivered on CQUINs and what this indicated. Ms Arnold responded that providers were more focussed on meeting CQUIN requirements then they had been previously and therefore achieved the majority of CQUINs. However no provider in West Kent had ever earned 100% of their CQUINs.

6.3 The board noted that the CQUINs needed to be aligned with the CCG's strategy and something that could be incorporated into a provider's contract.

7. PLANS FOR ALCOHOL SUMMIT

7.1 Chief Inspector Dave Pate gave an update on his proposal to hold an alcohol summit. Chief Inspector Pate noted that alcohol misuse was a significant issue for a number of partners including the police service, NHS and Crown Prosecution and therefore needed an integrated approach. The proposal was to initiate the "Total Place" concept to address alcohol misuse and the related costs to the population and resources.

7.2 Chief Inspector Pate outlined the current alcohol strategy and the recommendations going forward.

7.3 The Chair commented that it was difficult to get an understanding of the total cost of alcohol misuse to health and social care and limited evidence on what was effective. The Chair suggested that alcohol-related A&E admissions needed to be coded separately in order to get an understanding of the scale of the problem. Ms

Arnold suggested that Maidstone & Tunbridge Wells NHS Trust (MTW) should be invited to attend the summit.

7.4 Dr Singh supported the proposal but commented that a distinction should be made between those patients with alcohol addiction and those who have occasional alcohol toxicity. The strategy should address both groups of people.

7.5 Dr Jones suggested that the summit should also look at provision of community detox and rehabilitation.

7.6 Malti Varshney commented that the summit needed to explore what opportunities there were to work with other partners on issues such as licensing, extended hours and happy hours etc.

7.7 It was also commented that education needed to be addressed as part of the summit.

7.8 Subject to these comments, the Board agreed the following recommendations:

1. Commission a West Kent wide task and finish group to identify stakeholders
2. Initiate a West Kent alcohol prevention summit to provide clear messages of the scale and cost of alcohol misuse; engage partners in alcohol identification, brief advice and signposting
3. Ensure that services are joined, with clear referral pathways that are promoted and accessible.

7.9 Malti Varshney commented that it would be beneficial to have an elected member champion. The Chair and Ms Varshney agreed to canvass opinion outside of the meeting. **Action: Dr Bob Bowes/Malti Varshney**

8. UPDATE ON OBESITY TASK GROUP

8.1 Jane Heeley gave an update on progress against the Obesity and Healthy Weight Action Plan. Ms Heeley noted that the draft action plan addressed all of the recommendations; however some of the actions would require further clarity.

8.2 Ms Heeley noted that there were two actions that had associated cost:

- Development of a training programme to support the "Make every contact count" principles
- Development of a marketing campaign to highlight the problems associated with obesity.

8.3 The WKHWB was asked to agree the above actions with a view to the Task and Finish Group developing a costed options appraisal.

8.4 Dr Jones commented that the intention was to hold a Practice Learning Event which would cover the concept of holding difficult conversations with patients around weight management.

8.5 The WKHWB agreed that action plan and agreed for Jane Heeley to develop a costed options appraisal for the training programme and marketing campaign.
Action: Jane Heeley

9. UPDATE ON CHILDREN'S OPERATIONAL GROUPS

9.1 Hayley Brooks reported that a model of delivery for Children's Operational Groups (COGs) was currently being developed and it was expected that this would be finalised early next month. The plan was also to identify priorities for each of the localities.

9.2 The Chair asked whether there was anything that the WKHWB could do to support the COGs. Ms Brooks responded that the board would be required to sign off the model of delivery.

9.3 The Chair noted that the CCG would need to identify a clinical lead for children's services.
Action: Bob Bowes

10. DISTRICT COUNCIL LEAD FOR WEST KENT HEALTH AND WELLBEING BOARD

10.1 Ms Varshney reported that Cllr Blackmore was no longer the leader of Maidstone District Council, however would continue to attend the Health and Wellbeing Board to represent Maidstone.

11. ANY OTHER BUSINESS

11.1 Dr Roxburgh noted that air quality had a significant impact on health and asked whether this was something that the board should be addressing. Malti Varshney agreed to add this to the work plan.
Action: Malti Varshney

11.2 Hayley Brooks commented that Sevenoaks District Council had bid for funding to set up a text message alert system for COPD patients to alert them when the air quality was poor.

12. DATE OF NEXT MEETING

The date of the next meeting is Tuesday 15th September. It was noted that the next meeting was due to be hosted by Maidstone Borough Council.

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