AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 25th May, 2016, 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), Dr J Bryant, Ms H Carpenter, Mr P B Carter, CBE, 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, Cllr K Pugh, Mr A Scott-Clark, Dr R Stewart, Cllr P Watkins and Cllr L Weatherly

Webcasting Notice

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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 the meeting

4 Minutes of the Meeting held on 16 March 2016 (Pages 5 - 8)

To receive and agree the minutes of the last meeting

5 Draft Sustainability and Transformation Plans - Presentation

6 The Kent Better Care Fund (Pages 9 - 36)

To receive a paper that presents the final submission of the Kent Better Care Fund Plan (KBCF) 2016/17, the approval process and development of the S75 Agreement as well as the final outturn position for the KBCF 2015/16

7 Workforce Task and Finish Group - Final Report and Recommendations (Pages 37 - 50)

To receive a report that summarises the findings of the Workforce Task and Finish Group, including the five priority areas identified to take forward as well as an outline of the indicative action plan

8 Addressing Obesity: Progress Report from Local Health and Wellbeing Boards (Pages 51 - 60)

To note the progress made in addressing obesity by local health and wellbeing boards and to comment on the proposed recommendations

9 Abridged Kent Joint Strategic Needs Assessment (JSNA) Overview Report 2016 (Pages 61 - 72)

To comment on the key strategic findings of the refreshed JSNA Overview Report 2016 and endorse the priorities

10 Forward work programme of the Board (Pages 73 - 76)

To receive a report setting out a proposed Forward Work Programme for the Board

11 Minutes of the 0-25 Health and Wellbeing Board (Pages 77 - 90)

To note the minutes of the 0-25 Health and Wellbeing Board meetings held on 12 January and 22 March 2016

12 Minutes of the Local Health and Wellbeing Boards (Pages 91 - 136)

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

Ashford – 23 March 2016
Canterbury and Coastal – 9 March 2016
Dartford, Gravesham and Swanley – 6 April 2016
South Kent Coast – 26 January 2016
Swale – 27 January 2016
Thanet – 24 March 2016
West Kent – 19 April 2016

13 Date of Next Meeting - 20 July 2016

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
03000 416647

Tuesday, 17 May 2016

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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, 16 March 2016.

PRESENT: Mr R W Gough (Chairman), Mr I Ayres, Ms H Carpenter, Mr P B Carter, CBE, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr S Inett, Mr A Ireland, Mr S Perks, Cllr K Pugh, Mr A Scott-Clark and Cllr L Weatherly

IN ATTENDANCE: Mr M Sage (Finance Manager (Frontline Services)), Mrs A Tidmarsh (Director, Older People & Physical Disability) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

202. Chairman's Welcome
(Item 1)

The Chairman said that Dr M Jones and Dr D Cocker were stepping down as clinical chairmen of the Canterbury and Coastal CCG and the South Kent Coast CCG respectively. He thanked them for their contribution to the work of the Kent Health and Wellbeing Board. He also said Dr Jones would be replaced by Dr S Phillips and that a decision on Dr Cocker's successor was awaited.

203. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr F Armstrong, Dr B Bowes, Dr M Jones, Dr N Kumta, Dr T Martin, Mr P Oakford, Dr R Stewart, Cllr P Watkins and Cllr Mrs L Weatherly.

204. Declarations of Interest by Members in items on the agenda for this meeting
(Item 3)

There were no declarations of interest.

205. Minutes of the Meeting held on 27 January 2016
(Item 4)

Resolved that the minutes of the meeting held on 27 January 2016 are correctly recorded and that they be signed by the Chairman.

206. A - Commissioning, Operational and Transformation Plans
(Item 5)

(1) Mr Ayres gave a presentation about West Kent plans for 2016/17 and beyond. A copy of the presentation is available online as Appendix I to these minutes.

(2) In response to a question about repatriation of services from London, he said there was a need to take a Kent and Medway level view and to work with partner organisations to develop a shared agenda that would make a meaningful contribution to minimising any deficit.

(3) Ms Carpenter and Mr Perks gave a presentation about the East Kent plans for 2016/17 and beyond. A copy of the presentation is available online as Appendix 2 to these minutes.

(4) In response to questions, Mr Perks said that financial challenges for 2016/17 were similar to those of 2015/16 and that the allocation was sufficient to enable the required services to be delivered. Ms Carpenter said that the financial challenges facing East Kent were not easy and it was essential to avoid agreeing any contracts that could not be afforded. Ms Carpenter also said that issues relating to commissioning maternity services were about quality and meeting the expectations of patients rather than the re-design of service delivery.

(5) Ms Davies gave presentations about Swale and Dartford, Gravesham and Swanley plans for 2016/17 and beyond which are available on-line as Appendix 3 and Appendix 4 of these minutes.

(6) In response to a question, she said that the gap in funding for the QIPP in Dartford, Gravesham and Swanley had widened. She also said that there some efficiencies that could be made but the challenge of closing the gap should not be under-estimated.

(7) In response to a suggestion that the gap in funding in Dartford, Gravesham and Swanley was the largest in the country it was confirmed that Guildford and Waverley CCG had the biggest gap.

(8) The emphasis on children, learning disability and mental health in all the plans was welcomed.

(9) During the discussion it was generally accepted there would be less money going forward however it was too early to quantify the precise impact on primary care. In the short term work was underway to realise efficiencies including: acting on the findings of an audit conducted by the Canterbury Vanguard carried out in conjunction with the community trust that had identified potential efficiencies; reducing some of the pressures in primary care to increase its attractiveness as a place to work and thereby retain staff who had the option of retiring; and trialling different ways of working.

(10) In the longer term, in order to deliver the STP's, it was necessary to bring together learning from new ways working being trialled such as paramedic practitioners working in the community, pharmacists working in general practice and various approaches to apprenticeships as well as identifying the appropriate skills mix and working with universities and other education providers to produce people with the right skills.

(11) It was also suggested that similar issues applied to social care services, particularly, in relation to the redesign of jobs and the need to make them attractive in both the public and independent sectors across Kent.

(12) Resolved that the presentations outlining the extent to which plans for 2016/17 and beyond reflected the Joint Health and Wellbeing Strategy, their contribution to the wider transformation agenda and the extent to which they assist integration and the "nine must do's" be noted.

207. B - Better Care Fund 2016/17
(Item 5a)

(1) Anne Tidmarsh (Director, Older People and Physical Disability) introduced the report which provided an update on the Better Care Fund 2016/17 in relation to policy and planning requirements, financial allocations, and the assurance and approval process.

(2) In response to a question, she said the reasons for the increase in the Social Care Capital Grant from £7.2 million to £14 million were not known, however, there was opportunity in conjunction with district and borough councils to re-consider how services were delivered.

(3) It was also suggested that it would be worth looking at the totality of spending on care and to move to full integration especially in relation to adult care.

(4) Resolved that:

(a) Progress on developing the Kent Better Care Fund Plan 2016/17 be noted;

(b) The sign off process would include Mr Gough (Chairman of the Health and Wellbeing Board), the Social Care and Wellbeing Directorate Management team and the CCG Accountable Officers' Group and that partners would ensure that their elements of the plan went through the respective internal sign off process.

208. Joint Strategic Needs Assessment
(Item 6)

(1) Mr Scott-Clark introduced the report which presented the outcomes from the Kent JSNA workshop held in September 2016 which had been used to assist with the development of a range of actions and a vision for the future.

(2) Resolved that:

(a) The report be noted;

(b) The actions set out in Section 3 of the report, designed to improve the JSNA development process, be approved;

(c) The future direction of the Kent JSNA, as set out in Section 4 of the report, be agreed.

209. Kent Health and Wellbeing Board Work Programme
(Item 7)

Resolved that the Forward Work Programme be approved subject to confirmation of the date for the Obesity Review.

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

Resolved that the minutes of the local health and wellbeing boards be notes as follows:

Ashford – 20 January 2016
Canterbury and Coastal – 19 January 2016
Dartford, Gravesham and Swanley – 24 February 2016
South Kent Coast – 24 November 2015
Thanet – 21 January 2016
West Kent – 16 February 2016.

211. Date of Next Meeting - 25 May 2016
(Item 9)

By: Roger Gough, Chair of Kent Health and Wellbeing Board

To: Kent Health and Wellbeing Board – 25th May 2016

Subject: **The Kent Better Care Fund**

Classification: Unrestricted

Summary: This paper presents the final submission of the Kent Better Care Fund Plan (KBCF) 2016/17, the approval process and development of the S75 Agreement. It also presents the final outturn position for the KBCF 2015/16.

FOR INFORMATION

1. Introduction

1.1 Kent's Better Care Fund for 2015/16 sought to implement the building blocks for establishing an integrated system. The Kent Plan for 2016/17 builds on these early developments to support the implementation of Sustainability and Transformation Plans (STP's) and ensure a fully integrated system by 2020.

1.2 It was agreed at the March Health and Wellbeing Board (HWB) that the Better Fund Plan would be signed off before the next HWB on 25th May. The final submission was made on 5th May and was agreed by Roger Gough, Chair of Kent HWB, on 29th April, prior it its submission.

2. The 2016/17 Kent Plan

2.1 As in 2015/16 the Better Care Fund will contribute to improving outcomes identified within the Health and Wellbeing Strategy:

- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with dementia are assessed and treated earlier.

2.2 Each health economy via the existing BCF Section 75 agreement has governance and project management arrangements in place to deliver the required new models of care. For example an Integrated Executive Programme Board exists in North Kent, Thanet and South Kent Coast with a multi-agency approach.

2.3 In broad terms the plans and how each of these areas will contribute to the required national conditions is outlined below.

2016/17 Schemes	National conditions supported
• Integrated working through local models that deliver 7 day access	• Delivery of 7-day services • Data sharing between health and social care
• Develop models that support integrated working	• Joint approach to assessment and care planning • Invest in NHS commissioned out of hospital services
• Self-Management	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Maintenance of Social Care	• Maintain provision of social care services
• Disabled Facilities Grant	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Implementation of the Care Act	• Maintain provision of social care services
• Carers support	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
• Delayed Transfers of Care – action plan	• Invest in NHS and social care commissioned out of hospital services • Joint approach to assessment and care planning • Delayed Transfers of Care

2.4 In 2015/16 the national allocation for the Kent Better Care Fund was £101m. For 2016/17 this has been increased to £105m. The Social Care Capital Grant has ceased and the Disabled Facilities Grant has been increased from £7.2m to £13.1m. The detailed allocations are as follows:

Contributions to BCF	£m Contribution	What's included
Social Care (via CCGs)	£32.4m	Includes £28.7m Protection of Social Care and £3.5m for Care Act Implementation.
CCGs	£59.8m	Includes Carer's Break Funding £3.4m; Out of Hospital Commissioned and DTOC Services £26.2m.
District/Boroughs	£13.1m	Disabled Facilities Grant.
Total BCF Funding	**£105.3m**	

3. Assurance Process

3.1 For 2016/17 the assurance process has become integrated within the core NHS operating and assurance process. The first stage of the overall assurance of plans was local sign-off by the relevant local authority and CCGs. The policy framework

signals the needs for stability in 2016/17, and a reduction in the overall planning and assurance requirements on local areas. There was no national assurance process and regional teams work with the Better Care Fund Support Team to provide assurance to the national Integration Partnership Board. HWB's are expected to sign off the final version of plans submitted. Due to timing issues NHS England agreed that the Plan could be endorsed by the Health and Wellbeing Board on 25th May 2016 after the final submission on 5th May 2016.

3.2 The second submission was made on 21st March 2016 and was 'partial assured' with development areas highlighted for the final submission. Whilst the complexity of the Kent system was acknowledged there is a requirement for greater detail on Risk Share, 7 Day Services and DTOC. As well as milestones and delivery plans. National Support has been provided and the Kent team secured three days from PPL Consulting. A workshop took place on 21st April to develop a clear understanding of the requirements to ensure a fully assured plan. Further work will take place in the first quarter to develop the 7 day services and DTOC plans.

4. S75 Agreement

4.1 There is a requirement for the S75 agreement to be signed off by 30th June 2016. A Deed of Variation is being drafted to cover a continuation the joint commissioning arrangements during 2016/17. This will include the revised agreement covering the funds flow and scheme details.

5. KBCF 2015/16 Outturn

The table below shows the summarised outturn position:

	Budget	**Outturn**	**Variance**
Revenue	90,768.6	90,768.6	0.0
Capital	10,640.0	9,574.3	-1,065.7
TOTAL	**101,408.6**	**100,342.9**	**-1,065.7**

The Capital underspend is due to £1.3m Care Act IT Monies and £200k Social Care Capital Grant (which has been rolled forward) offset by an overspend on the Disabled Facilities Grant of £400k. The detailed position is shown within Appendix Two.

6. Recommendations

The Kent Health and Wellbeing Board is asked to:

(1) Endorse the Kent BCF plan and submission made to NHS England.

(2) Note the work undertaken as part of the assurance process.

(3) Note the progress made towards the S75 Agreement 2016/17.

(4) Note the KBCF 2015/16 Outturn Position.

Authors

Mark Sage, Finance Manager (03000) 416636
Anne Tidmarsh, Director Older People and Physically Disabled (03000) 415521
Jayne Urwin, BCF Coordinator, (03000) 416792

Appendix One – Kent Better Care Fund Plan 2016/17
Appendix Two – Kent Better Care Fund Outturn 2015/16

The Kent Better Care Fund 2016/17 Narrative

Contents:

1. The Kent Vision for Integrated Care
2. The Case for Change
3. Governance and Management of the Better Care Fund
4. Integration Plans 16/17
5. Risk Share Agreement
6. The National Conditions
7. The Joint Approach Going Forward
8. Kent Better Care Fund Plan Sign Off
9. Additional Documents

Owner: The Kent Health and Wellbeing Board

Date: 3 May 2016

Version No: 8

1. The Kent Vision for Integrated Care

Kent's Better Care Fund for 2015/2016 was about implementing the building blocks for establishing an integrated system that will "*transform services within the community so they support independent living, empower people and place a greater emphasis on the role played by the citizen and their communities in managing care"* (Kent JSNA). Delivery within the plan has resulted in establishing programmes of activity across the health and social care footprints in North, East and West Kent that will increase the pace and scale of integration and development of the New Models of Care as outlined in the NHS England Five Year Forward View and associated guidance.

The Kent plan for 2016/17 will build on these early developments to support the implementation of Sustainability and Transformation plans (STPs) and ensure a fully integrated system by 2020. This will be achieved through sustaining the current system – with targeted improvements to support urgent care, delayed transfers of care, reablement and commissioning of out of hospital provision and the maintenance of social care services. But with an eye to the future and the development of local integrated health and social care models which incorporate a broad range of person centred and outcome focussed interventions, encompassing prevention, early intervention, primary and community health services, social care, home care, residential and nursing care and in reach to acute health care.

1.2 The Kent Context

The county council is largely responsible for adult and children social care services; it currently works in partnership with 7 Clinical Commissioning Groups and 12 District Authorities that commission related health care and housing services respectively. The provider landscape is also extensive, with 4 acute trusts spread over 7 hospital sites, 2 community health providers across the county, 1 mental health and social care partnership trust, 1 ambulance trust and many third sector and voluntary organisations including 4 hospices.

Kent has a population of 1.5 million. Overall, the population of Kent is predicted to grow by 8.4% over the next seven years, representing an extra 123,000 people. Including significant growth in North Kent due to the development in Ebbsfleet. The biggest increases are to be expected in the older age groups; 65 to 84 and over 85. The 65 to 84 growth is anticipated to be 21.4%, an extra 49,000 people, but the largest increase will be in the over 85 age band, at 27.1%. This represents an additional 10,000 people.

1.3 What will change?

As in 15/16 the Better Care Fund will contribute to improving the following outcomes identified within the Health and Wellbeing Strategy:

- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing.
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.
- People with mental ill health issues are supported to live well.
- People with dementia are assessed and treated earlier.

It is recognised that we need to go further and faster in order to deliver the whole system change required, developing greater alliances and exploring appropriate footprints in planning and integration. At the Kent Health and Wellbeing Board on 27 January 2016 *(https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6179&Ver=4)* all Clinical Commissioning Groups and Social Care identified how they will meet the ongoing challenges with the development of STPs and the development of areas such as the MCP, ICO and Mapping the Future. A commitment was given to use the BCF to ensure implementation across Kent and see significant change to:

- Improve people's experience and promote their health and wellbeing

- End the current crisis driven model of care
- Create a value driven and outcome focussed culture that nurtures creativity and innovation in meeting people's needs
- Support people to access good quality advice and information that enable them to self-care/manage
- Create the right conditions which enable people to find solutions that support their wellbeing outside of traditional medical or service driven models of care and support
- Encourage community development and increase volunteering, befriending and good neighbour schemes
- Support carers in their vital role through the provision of advice and individually tailored support
- Provide flexible and proactive models of care and support that can increase and decrease according to need
- Free professionals up from the rules and bureaucracy; to do the *right thing* and provide person centred holistic support that promotes wellbeing
- Provide responsive models of long term care that can flex up or down according to people needs
- Bring services together to ensure better communication and better use of resources and create a better experience for people

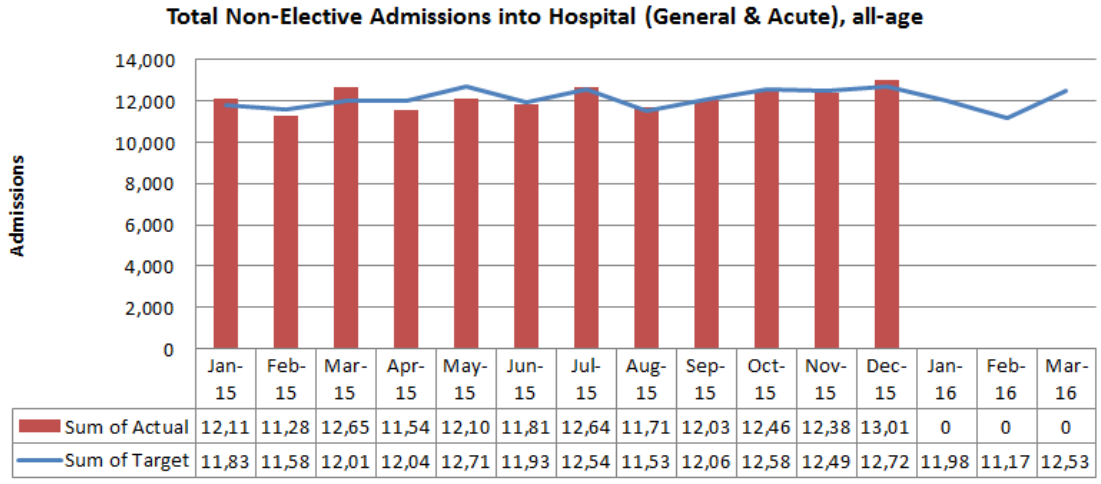
For those users of services this will make it clearer around:

- *"What care will you receive?"* – clear service models and pathway specifications
- *"Who will provide your care?"* – provider/organisational models, the new shape of integrated, local out of hospital providers (ICOs/MCPs/ acute physical provision and acute mental health provision
- *"Who will commission your local services?"* – commissioning models with local Health and Wellbeing Boards, aligning primary and specialist commissioning to seek devolution within the new models of care.

2. The Case for Change

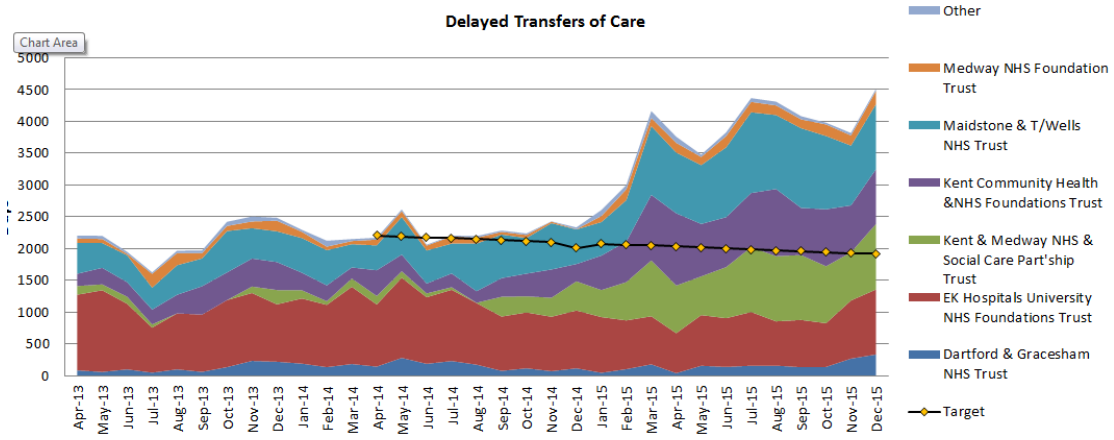
Kent has continued to use information provided through a Public Health led longitudinal study using risk stratified (based on a local version of the King's Fund tool) Kent whole population person level linked datasets to demonstrated variation in service utilisation (and costs) over time, across different services and different risk stratified groups. The Kent LTC Year of Care Programme comes to an end in March 2016. The programme has successfully built a linked data set comprising data from 12 health and social care organisations and 128 GP practices. The programme has also used risk stratification to identify a cohort of patients most likely to benefit from integrated care services. This approach is now being used to support the development of capitated budgets for intermediate care organisations being developed in East Kent. Kent's approach to the use of risk stratification is described in a case study on the NHSE website which can be found by following this link:
http://www.nhsiq.nhs.uk/media/2747711/risk_scores_case_study.pdf

As part of the BCF plan for 15/16 a 1% reduction in non-elective admissions was targeted. The graph below evidences that this has been achieved and continues to help control demand.



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Sum of Actual	12,11	11,28	12,65	11,54	12,10	11,81	12,64	11,71	12,03	12,46	12,38	13,01	0	0	0
Sum of Target	11,83	11,58	12,01	12,04	12,71	11,93	12,54	11,53	12,06	12,58	12,49	12,72	11,98	11,17	12,53

In line with national trend DTOC figures have risen, but priority work continues to achieve the 2.5% national target with a 3.5% stretch for NHS patients receiving acute care. Kent aims to maintain current levels of DTOCs system-wide (i.e. including non-acute such as mental health, palliative care or rehabilitation) and halt the current upward trend.



Delivery of the Better Care Fund during 15/16 has identified what has worked well and where continued improvements are required in 16/17. Examples of what has worked well are:

- Governance structures – allows for open debate, planning and monitoring of delivery
- Alignment of commissioning and integration of commissioning
- Joined up provision – IPCTs, IDTs, and real inclusion of the voluntary sector

Some examples of the results from this include in North Kent a 1% reduction in ambulance conveyance, low DTOC – Nov 1.74% and better patient experience.

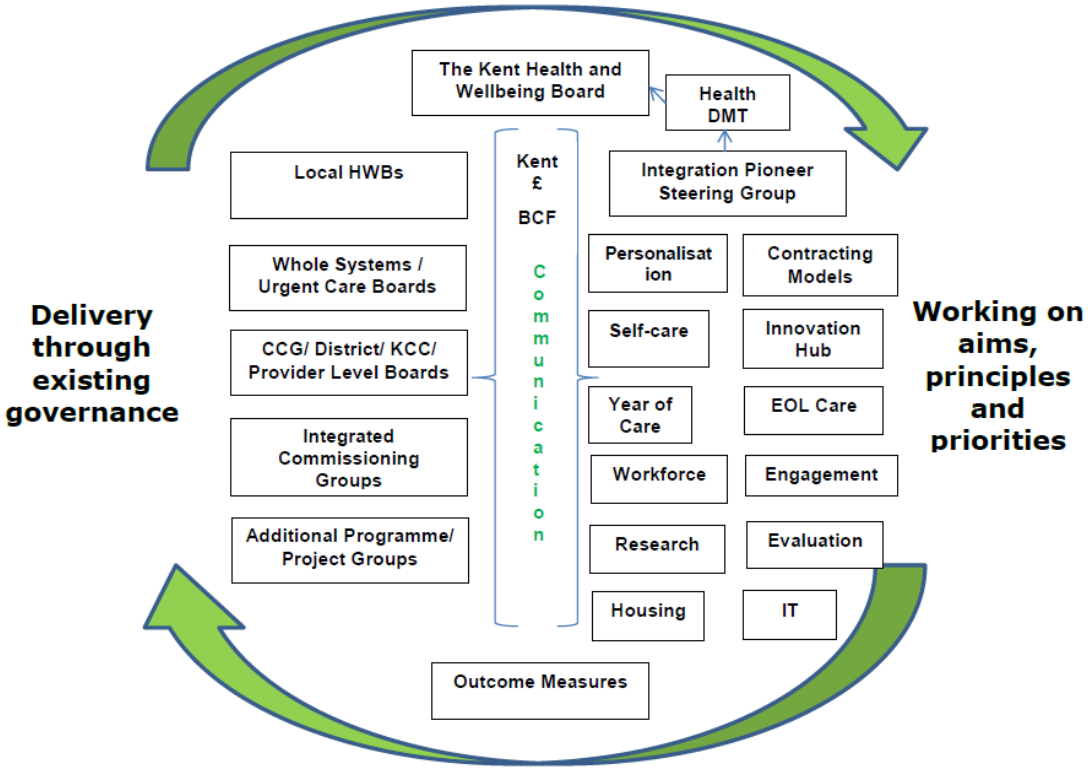
In Thanet the establishment of a detailed integrated working programme plan overseen by an 'Integrated Executive Programme Board' – co-chaired by KCC and the CCG. Integration is being driven at a local level with the development of strong town based (Margate, Ramsgate, Broadstairs and Quex) integrated health and social care teams. These have been built to enable GP practices to increasingly work together to join health and social care within a single infrastructure. This local service model will be supported through a multi-disciplinary 'hub' based at the local acute hospital, to be developed in 2016/17.

3. Governance and Management of the Better Care Fund

Kent's governance for delivering as an Integrated Care and Support Pioneer is set out below, the responsibility and management of the Better Care Fund will sit within this. Existing governance structures will ensure delivery and the Integration Pioneer Steering Group provide advice and guidance.

The risks and mitigations associated with the Better Care Fund are outlined in section 5 below.

Kent is committed to engaging and involving with the public and wider stakeholders and as a Pioneer will use ICASE (www.icase.org.uk) as a mechanism to provide updates on our progress within integration and the implementation of the Better Care fund.



4. Integration Plans 16/17

The planning template identifies the detailed areas of spend for the Kent 16/17 BCF. Each health economy via the existing BCF Section 75 agreement has governance and programme and project management arrangements in place to deliver the required new models of care. For example an Integrated Executive Programme Board exists in Thanet and South Kent Coast with a multi-agency approach.

In broad terms the plans and how each of these areas will contribute to the required national conditions is outlined below.

2016/17 Schemes	National conditions supported by the scheme
• Integrated working through local models that deliver 7 day access:	• Delivery of 7-day services • Data sharing between health and social care
• Develop models that support integrated working	• Joint approach to assessment and care planning • Invest in NHS commissioned out of hospital services
• Self-Management	• Invest in NHS commissioned out of hospital services • Delayed Transfers of Care
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5. Risk Share

Risk sharing agreements and contingency plans for delivery of the Better Care Fund are outlined in the Section 75 agreement. Each Partner shall be responsible for their own risk under, or in connection with the Agreement. The Partners have agreed that if there are any overspends, then such overspends are at the risk of that partner and reported to the pooled fund manager. Provision for overspends are the responsibility of individual partners and are held outside of the pooled arrangement.

This response to risk and reward reflects the partner's current risk appetite. It has therefore been agreed to reflect risk at an Organisational Level. This will be reviewed over the course of the year at quarterly Finance and Performance Monitoring meetings.

Some key risks identified in the delivery plan are:

There is a risk that:	**Mitigating Actions**
Increased pressure on Acute care could result in additional long term placements or long term social care input. Lack of rapid response for health and social could result in additional admissions to hospital and long term care.	BCF plans and Kent's Pioneer Programme designed to develop service models to mitigate risk. KCC Adult Social Care Transformation is also targeting this risk.
Shifting of resources may destabilise existing providers, particularly in the acute sector.	The development of our plans will be conducted within the framework of our Kent Pioneer Programme. This facilitates whole system discussions and further work on co-design of, and transition to future service models.
The implementation of the Care Act will result in an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	Ensure the use of the Care Act money is in line with allocation.
Primary care not at the centre of care-coordination and unable to accept complex cases.	Engagement with clinical leads and primary care providers essential as part of implementation of the BCF and Pioneer programme.
Absence of effective demand management, investment in voluntary sector and equipment will result in additional NHS and social care admissions.	Monitor/tracking systems in place to assist in determining effectiveness – further development of performance based dashboard.
Workforce and Training – The right workforce with the right skills may not be available as required to deliver the integrated models of care. The types of training to deliver new models of care may not be in place. Additional risk is presented by age demographics of GPs and future resources impacted by retirement.	Workforce and training is a key objective of Kent's Integration Pioneer Programme. A programme of work is structured to explore the requirements of future workforce and implement changes to meet these requirements.

6. The National Conditions

The table below identifies how the plan will meet the national conditions:

Maintenance of Social Care Services

Significant work to transform social care services has taken place during 15/16, alongside the implementation of the Care Act. £28.7m will be used from Kent's Better Care Fund to maintain social care and continue to support the significant numbers of people with complex needs, who live in their own homes, want to stay and be supported in their own homes and those who require carer support services which enable carers within Kent to continue in their caring role.

Numerous Schemes within Kent's Better Care Fund are dedicated to the maintenance of Social Care; £7.5m toward the provision of domiciliary care, £3m toward residential provision and £1.6m toward provision of Direct Payments to support service user's social care needs.
Kent Adult Social Care has developed a clear vision to support integration by 2020 with the model described through three groups of approaches; Promoting Wellbeing, Promoting Independence and Supporting Independence. This is a means of describing differing types of interventions that support people accessing 'the right care at the right time' in order to be as independent and well as possible at all times.

Milestones:

- The Acute Workstream supports increased independence by reducing inappropriate referrals from hospital discharge into residential placements. The new ways of working are being fully rolled out across Kent and should be complete by the end of Summer 2016.

- In addition the Enablement Workstream which concentrates on increasing the number and quality of clients being enabled so they can remain independent and living within their own homes for longer, will also be fully rolled out by the Summer 2016.

- Further work will take place during 2016/17 to assess and design a further phase of adult social care transformation to deliver the vision of integration by 2020.

Metrics:

Kent aims to maintain the current proportion of people still at home 91 days after discharge at 85.9% or higher.

Residential Admissions are expected to drop as a result of funding against reablement, carers and domiciliary services.

7 day services

For 16/17 £2.1m directly linked to delivering 7 day services – this includes building on successful pilots for GP extended hours and implementation of a 7 day community equipment service across Kent.

Since 1st November 2014 Kent County Council has been operating an 8am-8pm 7 day a week service, mainly supporting the Acute Hospital sites. The

extended access is being facilitated locally via a rota system including both Short Term Pathway staff and Adult Community Teams. This way of working was introduced following an organisational restructure and has now become core working hours. The extended access includes weekends and Bank Holidays excluding Christmas Day only and staff are operational on each Acute Hospital Site. The 8am-8pm is available according to business need with agreement from health partners. The 8pm may vary when comparing the Acute Hospital KCC teams, but this is reviewed and can/has changed according to need, and is being monitored to improve accessibility and performance.

Further work is now taking place within the Adult Social Care Transformation Programme to identify the steps required to achieve extended working hours in all areas of delivery.

The CCGs are undertaking multiple projects and initiatives designed to meet the 7 day model required be in place by 1st April 2017 as part of the new GP contract. The work will be driven through engagement with the localities. Two area examples are laid out below.

South Kent Coast and Thanet

- **Enhance Primary Care** - Building on the Prime Ministers Challenge Fund (PMCF) pilot (8am-8pm/7days a week) which has provided the opportunity to look at different ways of working in general practice, and helped see how GP services could be designed from the way that patients experience GP services for the future, opportunities for patients to be seen at their local 'hub' by another GP or another appropriate health care professional (for example, pharmacist, paramedic practitioner, MIU nurse practitioner (out-reaching) or rapid response nurse).
- **Primary Care Home Model** - Primary Care Home Team which incorporates a practice team (integrated nursing team, ICT, primary care visitor co-ordinator, geriatrician, primary mental health worker, voluntary sector [e.g. Age UK] with the aim of keeping people well and enabling self-care), as well as social care workers, specialist nurses, paramedic practitioner and end of life care support from hospices, with the aim of serving a wider population and providing a point of access to care and services e.g. ambulatory care.
- **Personal Health Budgets** - Continue to deliver and improve the provision of Personal Health Budgets including continued allocation of commissioner resource to deliver Personal Health Budgets, including a review of progress to date and scoping of opportunities for improving processes and systems
- **KMPT Single Point of Access** - Single Point of Access soft launch of 24 hour 7 day week service (incl. Bank Holidays) across Kent and Medway for patients accessing KMPT services with urgent or emergency referral (KMPT
- **Project: Liaison Psychiatry -** The CCGs are working with mental health, children's mental health and acute hospital providers to improve access to Liaison psychiatry to meet the 2020 target of 24/7 provision. In 2016/17 the CCG plans to increase access to 12 hours, 7 days per week. An additional 3 consultants including CAMHS consultant psychiatrist have been agreed, with a substantive recruitment process

initiated.

Canterbury and Coastal

Encompass MCP, which incorporates 16 of 21 GP practices, is developing an integrated model of care to facilitate effective delivery of high quality, person centred and coordinated primary and community care. In 2016/17 the MCP will focus on developing integrated Community Hub Operating Centres(CHOCs) based on its Town Team localities of Whitstable, Faversham, Canterbury and Sandwich and Ash. The CHOCs will deliver integrated health and social care services across localities and will seek to reduce activity in the acute setting in respect of unscheduled attendances and admissions and facilitating timely discharges. The MCP will also continue its Paramedic Home Visiting programme linked to General Practice, which is resulting in a reduction in conveyance, and which will see Community Paramedics mapping into the CHOC integrated teams.

Where it is appropriate, the MCP will coordinate and align with EK wide schemes aimed at reducing acute activity, including unplanned admissions and delayed discharge. The MCP will also work with Public Health and CCG prevention programmes to support people to stay well and live independently in the community. This includes supporting specific developments within the Health Trainer programme in the Canterbury and Coastal CCG locality. The MCP is also investing in developing a social prescribing model within the CHOCs that will reduce social isolation and support people to optimise their health and wellbeing through a community asset based model.

There is also a development in Ashford as a 'fast follower' with clinical leadership from Ashford Clinical Providers (ACP) now a member of Vanguard (E**n**compass) MCP Steering Group.

Ashford Clinical Providers recognise that commissioning needs robust locality wide cost effective alternatives to allow shift from hospital to community built on the strengths of local Primary care. Shared early outcomes from key Vanguard projects have enabled ACP to refresh their plans and adopt a similar integrated hub model approach across three localities based on the following geography:

- Ashford South
- Ashford North
- Ashford Rural

The vision for the Herne Bay Integrated Care Centre is to commission "A resource for the community where primary and community care will work together to relieve pressure on the local health economy by providing a wide range of services closer to patient's homes", with the intention to base the centre at the Queen Victoria Memorial Hospital (QVMH).

The ICC will act as a hub where patients will be able to access a range of urgent and outreach services including access to diagnostics. This will include minor injury and illness, urology, DVT, wound and day case clinics. The service will be delivered in accordance with the 'Priority Three'.

The service will be nurse led with GP oversight provided by all four local

practices with support from the Community Network to ensure maximum interface between primary and community care.

Current services of this nature are not located locally to the population of Herne Bay, requiring travel to Canterbury, Margate or Whitstable with limited public transport options. Care will be overseen by local GPs to ensure the patients are known and to identify where core primary care services need strengthening to reduce the burden on other services. The ICC will provide advice including self-care and social care which can be wrapped around the patients' needs, will help to reduce the impact of any potential downgrading or changes to acute services and will assist in ensuring the viability and suitability of the community hospital in the context of a growing population need in the locality.

Milestones:

Qtr. 1:
Work towards the change in hours to 8am – 8pm (daily) – ensure that reduction in the inappropriate work that the nurses are doing has ceased.
KMPT Single Point of Access; launch of Urgent and Emergency Referrals pan Kent (4th April 2016).

Qtr. 2:
Primary Care Home; Implement multi-disciplinary locality teams.
KMPT Single Point of Access; Impact evaluation to occur in July 2016.

Qtr. 3:
Primary Care Home; Implement full integrated front door model at QEQM.
KMPT Single Point of Access; Phasing in of other localities for routine referrals.

Qtr. 4:
Enhanced Primary Care; Full implementation of technological solutions at hub level.
Evaluate all strands of the Primary Care Home.

Metrics:

Non Elective Admissions to Hospitals are expected to decrease as a result of seven day services being available to service users.

Seven day working should also facilitate discharge and help halt the increase of DToCs within Kent.

Kent also expects to maintain an 80% performance in the number of service users reporting that they have had enough support from local services or organisations to help manage their long term condition via access to seven day services.

Data sharing
Areas have been developing their Local Digital roadmaps which include exploring how to improve data sharing across systems. The footprint covers North Kent including implementation of hospital access to GP records via

Vision 360, initially for A&E department at D&G and then for other providers; East Kent (working on developing the Medical Interoperability Gateway) and West Kent who are piloting a Care Plan Management System in conjunction with KCC and other partners. This seeks to bring health and social care information together by taking a direct feed from partners' systems. Crucially, the information collected can then be used to create one holistic care plan; this is contained within CPMS and can be updated and used by everyone.

Work on the Kent Integrated Data Set has also resulted in 128 out of 195 (66%) GP practices signed up to share their data. Following presentations to GP patch meetings 20 (out of 61) practices in West Kent have now signed up. 8 out of 14 practices in Ashford have now agreed to share their data.

Within the Better Care Fund £750k has been allocated within West Kent to develop System Enabler Information Systems

Milestones:

- Arrangements are in hand to continue the linked dataset once the Year of Care Programme ceases at the end of March.

- A Memorandum of Understanding has been drafted to underpin the partnership and funding arrangements for the Kent Integrated Dataset.

- Funding is also being sought from NHSE for programme management support to CCG's to develop capitated budgets. Jonathan Bates, CFO at Thanet and South Kent Coast CCG's will chair the new Kent Integrated Care Payments Group involving commissioners and providers which will lead the work on developing capitated budgets. The PSSRU will present their analysis of the linked dataset at the March meeting and will make recommendations for using the data to build capitated budgets.

A methodology has been agreed with HSCIC to collect and allocate costs to GP prescribing data.

Metrics:

Better data sharing and the resulting improvements to holistic care planning should result in improved performance across the full set of BCF Metrics

Joint assessments and care planning
One of the key social care priorities for 2016/17 is the integration of health and social care, and this includes planning for joined up approach to assessments and care planning. CCG areas are in varying stages of plan development, but all are in progress.
Milestones

Integrated Discharge Teams exist across the health and social economy of Kent and further work is planned to embed this into the community.

Milestones:

- Further development of shared care plan systems – Jan 2017

- Embed the MDT approach to patient information – March 2017
- Discharge to assess model – joint approach to assessment – ongoing pilots 16/17

Metrics:

Joint assessments and resulting improvements to holistic care planning should result in improved performance across the full set of BCF Metrics.

Local Action Plan for DTOC

DTOC plans are in development and are a key social care priority for 2016/17. Plans are in development within the CCG areas. The plan is coordinated by the Health and Wellbeing Board and has streams in each of the three Health Economies in Kent.

The Medway and Swale System Resilience Group are working with the Emergency Care Improvement Programme to identify good practice in reducing DTOCs. There are a number of initiatives that are in progress to address DTOC which see an integrated approach across health and social care:

Swale CCG is piloting a 'Home to Assess' model, where patients considered appropriate are discharged and assessed within 4 hours of discharge within their own home. Health and social care teams within the IDT at MFT work to the 'home is best' principle, discharging patients home with support as opposed to a step down community bed, where appropriate. This has resulted in a significant reduction in the demand for community beds in Swale.

East Kent CGGs, KCHFT, EKHUFT and KCC are currently piloting a 'Discharge to Assess' scheme which has already been successfully introduced in other parts of the country such as Sheffield, Manchester, Worchester, and Oxford.

Discharge to assess provides an opportunity for patients who are medically optimised to be transferred in a timely way from the busy acute hospital environment to their own home with support and further assessment or to an appropriate community setting for ongoing assessment and rehabilitation.

Objectives:

1. Maximise people's capacity for independent living, increase the number of people able to remain living at home and reduce the number of people permanently admitted to long term care.
2. Support timely hospital discharge so that patients only stay until their acute medical episode is finished and then move to a more appropriate location for assessment of their future care needs.
3. Provide an environment which helps people meet their rehabilitation and reablement potential and to become as functionally independent as possible.

Integrated discharge teams have also been set up in all of the hospitals. In DVH and EKHUFT they have also introduced the care navigator role as part of the integrated discharge teams linking the support the voluntary sector can access to facilitate timely discharges from the acute hospitals.

Surge Resilience Groups and Executive Systems Boards have emerged in each Health and Social care economy to drive the whole system changes required to support the acute sector.

Thanet and South Kent Coast CCGs are implementing a three stage programme of DTOC reduction:

Implementing Safer Flow Bundle

- Implementation of Safer Flow Bundle in Community Hospitals has now commenced (KCHFT)
- Implementation of new staggered timetabled MDT board rounds at QEQM to enable IDT, Matron, Acute Therapy and Site Management attendance (EKHUFT)

Developing an effective Medical model

- Implementation of the first phase of re-launched acute medical model at QEQM on the 19th April to provide consistent senior medical decision making support to Ambulatory Care and the Clinical Decisions Unit. (EKHUFT)

Effective Site Management

- Run 5 month piloting of Head of Clinical Operations posts at WHH and QEQM and Site Senior Matron at K&C (EKHUFT)

West Kent has developed a transformation plan to tackle DToCs which mirrors plans in East:

Governance & Senior Leadership

- DToC reimbursement implementation to be delayed indefinitely following discussions at first COO meeting. Delayed transfers of care workshop and follow up workshops required to be clear on policy and procedure.
- MTW and KCHFT to implement Choice Policy following a review of current policies

Whole system capacity review

- Development of a directory of services to understand what services are available – both self-referral and clinician referrals
- KCC and CCG to further discuss Joint Commissioning arrangements, identify best practice, review progress to date, issues and actions to take forward. a programmed approach to creating Joint Commissioning arrangements and for applying those new arrangements to the services to support DToC.

Safer Bundle

- To commence a project to roll out best practice in Discharge Planning ward by ward, over the next six months. This would include, 8am consultant led board rounds seven days a week, a standardised whiteboard designed to set and monitor targets, discharge checklists used for every patient, clinical and functional criteria for discharge being recorded on each patient's record (as recommended previously by ECIST), rolling completion of discharge notices (EDN) by daytime staff.

Discharge to Assess

- Implementation of the discharge to assess model in WK

Dartford, Gravesend and Swanley CCG have a system recovery plan in development for 16/17.

Key projects which will address improvements to DToC are:

- Implementation of Discharge to Assess in DGS – to identify patients suitable to have assessment of care packages carried out in their home environment post discharge as opposed to this being done in hospital
- Implementation of national SAFER patient flow bundle, which includes effective management of patients to achieve their Expected Date of Discharge (EDD) and includes increased discharges before midday and at weekends, and weekly systematic review of patients with extended lengths of stay
- Review of the Integrated Discharge Team at DVH
- Review of CHC processes

Plans in Development:

In order to prevent hospital admissions and to provide a more efficient discharge process, reducing delayed transfers of care, KCC has reviewed services that have been effective in preventing admissions and reducing delays.

All proposed services have been tested and implemented in Kent, but not on a consistent basis or across the whole of Kent. It is believed that by implementing these services county-wide, Kent would start to build the evidence which in subsequent years can be built into the fully integrated pooled budgets as set out in the Sustainability and Transformation Plans.

It is proposed that funding is agreed for the overview of services below and that DTOC targets are agreed and monitored as part of the BCF and local planning and monitoring.

The Protection of Social Care funding is already targeted at prevention of admissions and improving delays, but because of the pressures on Local Authority budgets, increases in hospital activity and demographic pressures, this fund is already fully spent. A reduction or diversion of this fund would

have a negative impact on admissions and delays.

Some examples of these services include:

- Kent Enablement at Home OTs working in Acute Teams and across community hospitals within each locality.
- Physios to support integrated care centres
- Agency to support flexing beds in escalation
- Care Navigators
- Rural Care Packages
- Home from Hospital Support

KCC and CCGs already have integrated commissioning and provision for Learning Disabilities and Mental Health in place and arrangements for children are progressing. For Older people and Adults with Physical Disabilities the plan is to work towards full integration including pooled budgets and above services will be included. This will be part of the next stage of KCC's Transformation work and CCGs' Strategic and Transformation Planning which includes Vanguards, Integrated Care Organisations and other New Models of Care.

Milestones:

- The Accountable Officers and DMT hope to agree the investment in DTOC services and where the monitoring of the impact would take place before the end of Qtr. 1

- Implementation of Direction of Choice Policy (EKCOOs) – Qtr. 1

- Removal of prescribed discharge to assess pathways and introduced two pathways " home with support" and "safe assessment bed" (EKCOOs) – Qtr. 1

- Hot Ambulatory Care at WHH relocated and service delivered – Monday to Friday – Qtr. 1

- Detailed system recovery plan reviewed at the DGS System Resilience Group (SRG) – Qtr. 1

- Redesign pathway (East Kent Discharge to Assess pilot) signed off July 2016 – Qtr. 2

- Review of all DTOCS by EKCOOs – Qtr. 2

- QEQM and K&C accepted onto the NHS England's "New Care Models" rapid improvement programme (EKHUFT) – Qtr. 2

- Review and confirm substantive Site Management Model and senior out of hours roles (EKHUFT) – Qtr. 2

- Medical workforce plan to support re-launch of acute medical at WHH – Qtr. 3

Metrics:

Reduced length of stay for patients

DToC list reduced and less patients waiting for social care package of care.

Improved number of patients that need no further health or social care input after the assessment period

Increased patient experience

Kent anticipates that the above work streams will slow, and ultimately halt the increase in DToC numbers across Kent.

Investment in NHS commissioned out of hospital services
£26.2m is identified for out of hospital services, full details of this can be found in CCG Operational Plans (links in additional document section).

The Better Care Fund contains many projects investing resource in this area, including £5.5m for the provision of Community Equipment and Telecare, and £4m toward support for carers.

In Thanet this money will be invested into:

- GP step up beds
- The provision of equipment to support individuals in the community
- Development of integrated health and social care teams including integrated nursing teams and the development of ICT to support sharing of patient records
- Rehabilitation beds at Westbrook House.
- Support for carers

Milestones:

- A project involving the commissioning of “Hilton Nursing Partners” is in progress throughout Kent. This nursing group provides a short 3-5 day recovery service in the service user’s home upon discharge from hospital. The project is to be expanded and in full roll-out by the end of Quarter 2 upon agreement by all CCG partners.

- High level milestones are provided within CCG operational plans and will link to the roadmaps identified within STPs.

- Key milestones will need to align with further development of areas such as the MCP, IACO and Mapping the Future, therefore full details of delivery dates are not yet available

Metrics:

Investment in NHS Commissioned out of Hospital Services should result in improved performance across the full set of BCF Metrics.

7. The Joint Approach Going Forward

Since the development of the plans for 15/16 significant work has taken place through the joint governance forums across Kent to engage the entire system, to help understand the impact on providers as integration develops, for example the East Kent Whole System Clinical Strategy. Further work is taking place alongside Districts within the devolution agenda and to explore how to make best use of the Disabled Facilities Grants. KCC social care and district councils are working together to explore ways of encouraging closer working arrangements to facilitate the pathway for a service user requiring a DFG. A paper was taken to the Districts chief executive group to request project development and support for 2016/17 to work up a model for a new way of working which is most suitable and appropriate for Kent.

KCC are working closely with District Councils to share responsibility for areas of activity currently covered by social care capital grant which has been removed from social care and added to DFG funds this year, as existing commitment needs to be covered, and all work contributes to increasing the independence of people living with disabilities, facilitating them to remain living in their own homes, and decreasing their dependence on statutory services in the future.

Across all CCG areas detailed work has been carried out within the Making it Real agenda and Think Local Act Personal to further embed the use of I Statements and ensure meaningful involvement from patients, users and carers. Full details of this work is contained within the Integrated Care Pioneer Progress Reports.

A key concern raised has been on future capacity and workforce requirements. Therefore a Kent wide task and finish group has been set up to sit under the Kent Health and Wellbeing board. This will explore how to develop a more integrated support workforce, look at recruitment and retention and how we support the over 50 workforce. Kent will be hosting workforce events across each locality to promote careers in the Health and Social care sector and a draft Integrated workforce strategy is in development.

The Kent Health and Wellbeing Board continue to play a key strategic role in ensuring alignment across the variety of initiatives and monitoring of delivery. The Board has considered and endorsed the proposed planning footprint to support the delivery on the proposed STP.

8. Kent Better Care Fund Plan Sign Off

The Kent Better Care Fund Plan will go before key members of the Kent Health and Wellbeing Board on Friday 29th April, in addition to electronic circulation.

The full Kent HWB will meet on 25th May for formal sign off.

9. Additional Documents

JSNA: http://www.kpho.org.uk/joint-strategic-needs-assessment
JHWBS: https://www.kent.gov.uk/__data/assets/pdf_file/0014/12407/Joint-Health-and-Wellbeing-Strategy.pdf
SKC CCG: http://www.southkentcoastccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Thanet CCG: www.thanetccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Canterbury CCG: http://www.canterburycoastalccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Ashford CCG: http://www.ashfordccg.nhs.uk/about-us/our-plans-reports-and-strategies/
West Kent CCG: http://www.westkentccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Dartford CCG: http://www.dartfordgraveshamswanleyccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Swale CCG: http://www.swaleccg.nhs.uk/about-us/our-plans-reports-and-strategies/
Kent Integration Pioneer: http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/kent-integration-pioneer

APPENDIX TWO

BCF Financial Expenditure Reporting 2015/16

	Q4 15/16 (Cumulative)		
	Plan Value £k	Outturn £k	Variance £k
Revenue			
Community, Equipment and Adaptations	11,756.0	11,756.0	0.0
Telecare/Teletechnology / eHealth	0.0	0.0	0.0
Integrated Crisis and Rapid Response Services	3,465.4	3,475.4	10.0
Integrated community teams	24,047.8	24,157.8	110.0
Integrated discharge teams	6,789.8	6,879.8	90.0
Other Early Supported Hospital Discharge Schemes	24,730.1	24,730.1	0.0
Integrated Assessments	0.0	0.0	0.0
Integrated contacts and referrals	0.0	0.0	0.0
Medicine management schemes	0.0	0.0	0.0
Peer support / befriending schemes	0.0	0.0	0.0
Self-management schemes	2,377.7	2,377.7	0.0
Mental Health Services	1,017.0	1,017.0	0.0
Dementia Services	500.0	500.0	0.0
Reablement / Enablement services	3,179.9	3,179.9	0.0
Support to Primary Care	3,407.4	3,423.4	16.0
Workforce development	298.0	298.0	0.0
Carers support	1,699.0	1,360.0	-339.0
Joint integration posts	265.6	149.6	-116.0
7 Day working schemes	1,596.5	1,596.5	0.0
Falls prevention	446.0	446.0	0.0
Care Home projects	327.4	327.4	0.0
End of life care	1,300.0	1,529.0	229.0
The Care Act Implementation	3,565.0	3,565.0	0.0
Revenue Total	**90,768.6**	**90,768.6**	**0.0**
Capital			
Social care capital grant	3,432.0	1,899.0	-1,533.0
Disabled facilities grant	7,208.0	7,675.3	467.3
Capital Total	**10,640.0**	**9,574.3**	**-1,065.7**
BCF TOTAL	**101,408.6**	**100,342.9**	**-1,065.7**

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From: Workforce Task and Finish Group

To: Health and Wellbeing Board, 25 May 2016

Subject: Workforce Task and Finish Group: Final Report and Recommendations

Classification: Unrestricted.

Summary:

The Workforce Task and Finish Group held a succession of meetings between October 2015 and March 2016. This paper summarises the findings of the Group, including the five priority areas that have been identified to take forward along with an outline of the indicative action plan. It also sets out how it is proposed that this work will be consolidated and operationalized along with the support available to achieve this.

Recommendations:

The Health and Wellbeing Board is asked to:

1. Agree that the Workforce Task and Finish Group has completed its work but that the work continue in the form of a working group of the Integration Pioneer Steering Group and align with the Workforce Action Board to meet the needs of the STP;

2. Agree that the priority work areas for the group are to be those identified by the Task and Finish Group:

- ***existing and emerging gaps***
- ***new models of care***
- ***productivity***
- ***recruitment and retention***
- ***cross-cutting – 'the Brand of Kent'***;

3. Support the principle that the developing action plan recognises both the importance of activities at the local and county-wide levels.

1. Introduction

(a) The HWB agreed to establish the Workforce Task and Finish Group because ***workforce has been identified as a priority area that needed addressing***. Similarly, it was recognised that it was not an issue that could be tackled by each organisation on its own, though there were actions that were being and could be

taken locally. During the period of the review, the announcement about the Sustainability and Transformation Plans (STPs) has been made and these will be discussed at the same meeting as this paper. The recommendations of this report are intended to be ***supportive of STP implementation***.

(b) The Group identified five priority areas early and pursued these in depth in later meetings, hearing from a range of guest speakers. It was also able to draw on the expertise found in the HE KSS Kent Workforce Summit. All participants found these stimulating and the discussions began to produce a series of clearly identifiable actions to take forward.

(c) There was also agreement in the Group that addressing the workforce challenge was so fundamental that care was needed to ensure that decisive outcomes were achieved. The importance of determining the right actions to take, with the right people or organisations tasked with progressing them, is as important as ensuring the actions are supported by the whole system, with the lessons learnt shared in a timely fashion.

(d) The work of the Workforce Task and Finish Group as established by the Board at its meeting of 20 May 2016 has now concluded with the production of this report. However, a positive momentum for shifting to a more joined up strategic approach to workforce issues across Kent and Medway has been created and it is important that this is not lost. For this reason, the Group is requesting that the work be allowed to continue in a more appropriate forum. An indicative action plan which will be the initial focus of the continuing work is included in this report.

(e) Different staff groups and types take longer to develop than others. The medical workforce we will have in five years' time is already in the process of being trained. Bands 1-4 staff have a much shorter lead in time but will not be able to perform all the functions of other staff groups. In order to properly frame any analysis of the gap between the staff we will have available across Kent and Medway in 3-5 years' time and the staff we will need, there needs to be a clear vision of what health and care services will look like at this time. This way, we can work on identifying how to close the gap.

(f) The ***Sustainability and Transformation Plans*** (STPs) provide this opportunity. The STPs are intended to be the first step in a ***shift from planning on the basis of an individual organisation to planning as a system.*** The Workforce Task and Finish Group main finding is the need to make the same shift in workforce planning. Continuing the work of Group will go a long way to enabling the workforce element of the STPs to be supported and advanced.

(g) In a guidance letter published on the STPs (16 February), it was explained that 'Health Education England has agreed that they will establish ***a local Workforce Advisory Board*** to coordinate and support the workforce requirements for each STP footprint.' Detail around what are now known as Workforce Action

Boards (WABs) began to come through subsequently. In Kent, a lot of valuable preparatory work has already been undertaken by the current Workforce Task and Finish Group and involving Health Education England.

2. Context, risks and current situation

In both Health and Social Care there are significant workforce challenges. The figures below provide some examples of the context that the Health and Well-being board discussed from which the Workforce Task and Finish group was established:

- 10% of nursing posts (acute, community, primary care and mental health) in Kent are vacant.
- Of these vacant posts, 5% are filled by temporary staff, 2% by agency, and 3% remain unfilled.
- The hardest hit areas are Mental Health (20% vacant), Learning Disabilities (16%) and School Nursing (19%).
- There has been significant recruitment from overseas by NHS trusts in the last year, including from Portugal, Spain, Ireland, Italy, Philippines, and Poland. However there are now concerns that this supply is diminishing.
- Kent has a turnover rate of 27.7% for care workers in social care, slightly better than the national average but a high percentage (Skills for Care report, December 2015).
- Kent has a turnover rate of approximately 19% in care managers, slightly better than the average for the South East (Skills for Care report, December 2015).
- There are not enough school leavers to fill all the posts needed in Health and Social Care.
- GP recruitment and retention remains a challenge. The number of GPs aged 55 and over has doubled over the last 10 years and a BMA poll of 15,560 GPs in 2015 reported 34% intended to stop by 2020. 28% in the poll were seeking to reduce from full time working and 16% reported unmanageable levels of stress. A report into GP access to the Public Accounts Committee in March 2016 has shown a 3.5% rise in the number of consultations in primary care from 2004-05 to 2014-15 with only a 2% increase in staff over the same reporting period.
- Medical recruitment remains a challenge. Data from the annual Foundation F2 Career Destination Reports show an increase from 6.7% in 2013 to 9% in 2015 of doctors reporting they were planning to leave the UK for their next post and also a decline in the number of doctors planning to apply to GP and

Core Medical Training from 47.1% to 44.6%. To maintain GP workforce figures it is estimated 50% of all Foundation 2 doctors would need to enter GP specialty training. In General Practice Specialty Training there has been a 16.5% decrease in numbers of doctors applying from 2013-2015: whilst the number of programmes have increased and in 2014-15 overall 12% of training programmes were unfilled. HEE KSS has traditionally recruited fully in Round 1 this was not the case in 2015.

3. Key findings

(a) Ahead of the first meeting, a number of organisations represented on the Group completed a 'Key Themes' table that aimed at identifying areas of common concern and activity. One of the main lessons from this was the way ***short term planning has been heavily prioritised over the longer term***. Given the lead in time required for training professionals to new or developing roles, the need to approach workforce planning in a new way was clear from the beginning.

(b) Early discussions concentrated on identifying the following priority areas for further exploration:

- ***existing and emerging gaps***
- ***new models of care***
- ***productivity***
- ***recruitment and retention***
- ***cross-cutting – 'the Brand of Kent'***

(c) Relating to ***existing and emerging gaps***, the Group had presentations from HE KSS and from Social Care on the current workforce situation that helped identify key areas of concern. All other things being equal, there were some staff groups (such as adult nursing, to take just one example) where the supply would not meet the expected need.

(d) This connected with the discussion around ***New Models of Care*** and the drive towards more integration across the health and care sector. One of the challenges in workforce planning identified by the Group in relation to New Models of Care is the tension between needing to know what Models are being developed in order to develop the appropriately skilled staff. On the other hand, the choice of Models will be influenced by what workforce is available. This point applies more widely across the whole health and care sector and now needs to be seen in the broader context of the STPs.

(e) To resolve this, there needs to be a shift towards a ***focus on the skills required by a given workforce rather than how many of a particular staff group are needed***. The Group received a presentation on planned changes to the Public

Health Skills and Knowledge Framework being conducted by Public Health England[1]. There was a broad acceptance that the methodology used here could be used in areas other than for public health. For example, it could help identify overlapping skills between the social care and health workforce when looking to put together integrated teams or create the new job roles for the different New Care Models being developed across Kent.

(f) Another main area of focus was what could be learnt from other areas, in England and elsewhere. There was a lot of interest in the Group following a presentation on the workforce transformation work that had been carried out in ***Leeds***. Other models that had featured heavily in discussion or as part of other presentations that generated interested were ***the Buurtzorg model*** from the Netherlands, ***the Esther model*** from Sweden, along with integrated teams in Cornwall and work in London aimed at making the move between organisations streamlined.

(g) Given that both health and social care are facing significant financial challenges currently and will continue to do so over the next few years, and combined with the predicted gap between supply and demand for certain, one response is to consider how to achieve more with what we have. The Group were given a presentation on a piece of work on ***productivity*** using a systems dynamics approach which stimulated a discussion on how to make future demand modelling as robust as possible[2].

(h) The Group received feedback from a very successful East Kent Education Event and have heard that a similar one is being arranged in West Kent. Separately, HE KSS made available the resource of the next available quarterly Kent Workforce Summit. The timing was fortunate, and the Summit of 13 November was devoted to producing recommendations on ***recruitment, retention and 'the brand of Kent.'***

(i) One main theme in this area was the need to establish a more ***comprehensive career pathway*** setting out how working in one area can lead to progressing to a different and potentially more challenging area of work after a period of time. This applied across health and social care. Bands 1-4 were a particular priority here, these staff groups being seen as central to the longer term sustainability of the health and care workforce and the integration of the two services. There is also a shorter lead in time for Bands 1-4 staff groups compared to some others, which may be a consideration. A presentation on the HE KSS Career Progression Programme looking at this was well-regarded by the Group[3].

[1] Presented by Claire Cotter (Programme Manager, Workforce Development, Public Health England)

[2] Presentation given by Dr Mark Joy (Senior Lecturer School of Health Sciences, Faculty of Health & Medical Sciences, Surrey University)

[3] Given by Mike Bailey (Careers Progression Programme Manager, Health Education England working across Kent, Surrey and Sussex)

(j) The broader public health dimension was also discussed. The role of ***prevention*** and programmes like ***Making Every Contact Count*** were recognised as having a large part to play in making the system more sustainable. This connects with productivity in that resources spent on particular conditions would be released for other activities, but is also tied in with new models of care and delivering services in a different way.

(k) Another area considered was that of ***cultural barriers*** between health and social care, and between different areas within each sector (such as acute and primary care). There needs to be a greater awareness of how the world looks from the different perspectives, with measures taken to overcome this at sufficient scale to prepare the way for truly integrated teams.

4. A Workforce Framework for Health and Care

(a) Running through the work of the Group was the idea that there is a need to shift from planning as organisations to adopting a coordinated system wide approach. It was suggested that this could perhaps be organised in a similar format to the Surrey Health and Social Care Careers Collaborative (which formed part of the Bands 1-4 presentation, see Appendix 1). As will be discussed below, the exact shape needs to take into account broader policy changes in health and care.

(b) There is a lot of valuable work going on around workforce across Kent and Medway and this will continue. There is a workforce strand, for example, of the East Kent Strategy Board. The role of the proposed committee will be in part to disseminate knowledge of this, and similar, work and support it where possible. This will lead to a more efficient approach as work beginning in one area that has already been trialled somewhere else will be able to build on what has been done.

(c) There will also be work that is more usefully planned on a County-wide basis. This will include work that could help address the workforce challenges across Kent but which would need piloting or trialling in a particular geographical area or for a particular pathway of care. As set out in section 5 below, the Group could help identify the best fit for a trial or pilot.

(d) These different approaches need to continue alongside each other. There is no magic solution to the workforce challenge but the many actions that we can take need to be as effective as possible.

(e) In order to take the action plan forward, there has been discussion about how to carry on the work of the Group. The Workforce Task and Finish Group was established originally as a time-limited undertaking, but there was a shared desire not to lose the momentum created by the Group and follow up on the recommendations. In addition, the Group heard about the NHS England Pioneer

workforce support offer which is being developed[4]. It makes sense to bring this strand of work together with other workforce activities. Therefore, the recommendation of the Task and Finish Group is that it becomes a working group or committee of the Integration Pioneer Steering Group. It was felt the Integration Pioneer Steering Group was a pre-existing structure that would be well placed to continue the work. As a sub-committee itself of the HWB, the continuing work of this group around workforce would remain accountable to the Board.

(f) Following the Comprehensive Spending Review, the role and remit of Health Education England is in the process of change. If Kent and Medway wish to make a step-change towards a more strategic approach to workforce planning across health, social care and public health, there could be a way to align the changes to support each other. This idea has been given impetus by the announcement in the STP guidance that Health Education England will establish a local Workforce Action Board to support the workforce requirements of each STP footprint.

(g) The Kent HWB has already established strong links with the local team of Health Education England (covering Kent, Surrey and Sussex) and the Task and Finish Group has already carried out much of the preliminary work that other areas of the country will need to do prior to being able to fully capitalise on the support of the WAB. This provides an opportunity to make real progress in the workforce elements of the STPs.

(h) The prime intention behind establishing a workforce committee of the IPSG is to enable a clearer operational focus, with any relevant changes of membership and support. The role of the WAB and how it fits with other parts of the system has become clearer. To avoid duplication of effort and maintain this focus, the WAB and the committee proposed in this report could be one and the same. Because this will build on the work already undertaken in Kent, it may be that arrangements in Kent and Medway are different from those in other footprints across Kent, Surrey and Sussex.

(g) The local team of Health Education England are making available a £200,000 fund to support the further consolidation of the progress made by the Task and Finish Group and build on the positive relationship established with the Kent Health and Wellbeing Board. This fund is in addition to the regular work of Health Education England and the prime intention is to operationalize the emerging action plan as well as ensure workforce development is promoted across Kent in a strategic manner. Applications for funds will be welcomed from the successor group to the HWB Workforce Task and Finish Group/Workforce Action Board as well as from any commissioner or provider of health or social care services, or from an organisation involved in the education or training of the health and care workforce. This fund will be for the 2016/17 financial year and further details will be circulated shortly. It will be

[4] The Group heard from Hemlata Fletcher (Development Manager, Integrated Care Pioneer Support Team,New Models of Care Programme, NHS England)

jointly administered by the local team of Health Education England and the Strategy, Policy and Assurance Division at KCC.

5. Indicative Action Plan.

(a) The Task and Finish Group would not have been established last year without a consensus that workforce was an issue that required a system wide approach. This was, and remains, the case. The STPs are valuable in reinforcing the idea of place based planning across the system, of which workforce is a part. Action needs to be taken alongside the development of the STPs and steps taken to improve the workforce situation before they formally commence in October.

(b) To this end, the Task and Finish Group has begun to develop an indicative action plan. However, the Group was never intended to be the workforce planner for the wider Kent health and care economy. It had a strategic focus but following this report there needs to be a decisive shift of focus to the level of operational detail. As set out above, this is the main reason behind the recommendation to continue the work under the IPSG.

(c) This section of the report does not intend to prejudge any of the deliberations and decisions by the successor group but does indicate the direction of travel that the discussions have pointed in.

(d) As the context section sets out, there is a shortfall between workforce supply and demand. Several of the suggested actions below are short term and/or tactical, like undertaking education events, or much of the work around Bands 1-4. While these will help, they will not completely close the gap, and will address different parts of the workforce. Being a national issue as well as a local one, there will ultimately be a limit to how much of the overall gap can be closed but there are actions that will address part of the gap. Were the system as a whole able to take a strategic approach to workforce activity it could be possible to aggregate up the impact of individual actions to gauge how much of the gap remains. One approach would be to do this against the aggregate workforce plans of the providers.

(e) The STPs are intended to show how the Five Year Forward View will be delivered and therefore what the shape of service delivery will be like in the medium and longer term. From this point, we can collectively work backwards and map what actions need to be taken to reach this point, taking into account what is already being done.

(f) Although the examples in the action plan below (paragraph i) are quite specific, the Group did discuss in broader terms what the direction of travel could be for finding workforce solutions. For example:

- Assigning the quick wins to the right person or organisation(s) to action as soon as possible;

- Concentrate on the workforce needs of a particular pathway, for example COPD;
- The workforce requirements of an emerging new model of care;
- Addressing a priority residual gap identified from a mapping exercise.

(g) There is currently, and will continue to be, work addressing some of the workforce challenges being lead at a national level, like the 10-point plan for GPs. Other work will focus on factors around supply and demand specific to Kent, or where Kent is an outlier compared to other areas.

(h) The action plan below is indicative only but gives an idea of the kind of work that could be progressed under the five priority areas (there are overlaps between some of them).

(i) Indicative Action Plan:

- ***Existing and emerging gaps***
    - Research into retention. a. Analysis of exit interviews from providers to understand the reasons staff leave; b. Analysis of staff (number and type) moving between Kent and Medway based organisations compared to leaving Kent and Medway.
    - Development of a Workforce Framework for Health and Social Care.

- ***New models of care***
    - Programme of events, experience and training to overcome cultural barriers between different areas of work.
    - Pilot programme to adapt methodology of new Public Health Skills and Knowledge Framework.
    - Further exploration of lessons to be learned from Leeds Workforce Transformation.
    - Pilot programme to test the Buurtzorg Model within Kent.
    - Pilot programme to test the Esther Model within Kent.

- ***Productivity***
    - Pilot programme to test workforce productivity modelling with a focus on improving efficiency.
    - Follow through from the LGA/Newton Europe front end WHH work, and consider what it would mean if some of the clinical and professional requirements were shifted: a. Use Community Physicians instead of hospital in-patient consultants; b. In order to use the GP professional capacity to the full, increase Nurse Specialists' capacity; and c. In order to increase nursing capacity, look at which tasks could be delegated to HCAs and Care workers.

- ***recruitment and retention***

- Utilising skills of a. Health and Social Care Pre-Employment Programme Co-ordinator; b. Apprentice Health Ambassador.
- Careers events in West and East Kent.
- Production of definitive guidance on legal position for work experience placements.
- Bands 1-4 career progression. Development of idea of Surrey Hubs adapted for Kent.
- Professional Care Register: Care certificate for the social care sector workforce.

- ***cross-cutting – 'the Brand of Kent'***
  - Joint health and social care presence in schools promoting health and social care careers.
  - Development of one central online workforce hub.

(j) The emphasis above is on recommendations that can be taken forward locally and regionally. This does not preclude national policy or system issues being tackled in the most appropriate way.

(k) In all cases, care will be needed to correctly identify the right people or organisation(s) to take work forward to ensure that the work of the Group was consolidated and concrete achievements made. This is likely to be an early priority for the proposed working group.

6. Recommendations

Members of the Health and Wellbeing Board are asked to:

1. Agree that the Workforce Task and Finish Group has completed its work but that the work continue as a working group of the Integration Pioneer Steering Group and align with the Workforce Action Board to meet the needs of the STP;

2. Agree that the priority work areas for the group are to be those identified by the Task and Finish Group:

- ***existing and emerging gaps***
- ***new models of care***
- ***productivity***
- ***recruitment and retention***
- ***cross-cutting – 'the Brand of Kent'***

3. Support the principle that the developing action plan recognises both the importance of activities at the local and county-wide levels.

Background Documents

None.

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Appendix 1

Surrey Health & Social Care Careers Collaborative

'Through partnership working to meet the workforce challenges of the health and social care sectors in Surrey'

Appendix 2 – The Work of the Group

(a) On 20 May 2015, the Board agreed to establish a task and finish group to look specifically at strategic workforce issues across the County. Workforce had been identified by the Board as one of the main barriers to implementing the necessary changes to the health and care system to make it both sustainable and deliver improvements to the quality and effectiveness of care. On the other hand, it was recognised that if the right actions could be identified, workforce could be changed to a major enabler.

(b) The original Membership of the Group as agreed is set out below:

- Susan Acott (CEO DGH) / Andy Brown (HR Director, DGH)
- Roberta Barker (Director of Workforce, MFT)
- Amanda Beer (Corporate Director Engagement, Organisation Design and Development, Kent County Council)
- Paul Bentley (Director of Workforce and Communications, MTW)
- Bob Bowes (Clinical Chair, NHS West Kent CCG)
- Chris Bown (CEO EKHUFT) / Sandra Le Blanc (HR Director, EKHUFT)
- Alison Burchell (Chief Operating Officer, Medway CCG)
- Hazel Carpenter (Accountable Officer, Thanet CCG)
- Helen Cunningham (Human Resources and Organisational Development Director, Medway Community Healthcare)
- Patricia Davies (Accountable Officer, DGS CCG and Swale CCG)
- Bethan Haskins (Chief Nurse, Ashford CCG and Canterbury and Coastal CCG)
- Tristan Godfrey (Policy and Relationships Adviser, KCC)
- Roger Gough (Chairman, Kent HWB)
- Steve Inett (Chief Executive, Healthwatch Kent) / Andrew Heyes
- Andrew Ireland (Corporate Director for Social Care, Health and Wellbeing)
- Paul Jones (Interim Director of Human Resources, KMPT)
- Nicky Lucey (Director of Nursing and Quality, KCHFT) / Margaret Daly (Deputy Director of HR and OD)
- Sarah Macdonald (Director of Commissioning, NHS England)
- Francesca Okosi (Director of Workforce Transformation, SECAmb)
- Mike Parks (Medical Secretary, Kent LMC) / Liz Mears (Clerk, Kent LMC)
- Andrew Scott-Clark (Director of Public Health, Kent County Council)
- Philippa Spicer (Managing Director, HE KSS)
- Robert Stewart (Chair, Integration Pioneer Steering Group)
- Ian Sutherland (Deputy Director, Children and Adults, Medway Council)
- Anne Tidmarsh – (Director Older People and Physical Disability, Kent County Council)

(c) In practice, there were changes to the individuals representing different organisations and a flexible approach to representation was adopted. In addition, it was agreed at an early meeting to extend an invitation to Ann Taylor from the Kent Integrated Care Alliance, who duly took part. Francesca Okosi (Director of Workforce Transformation, SECAmb) was elected as Chairman, and Anne Tidmarsh (Director

Older People and Physical Disability, KCC) as Vice-Chairman. Support was provided by officers from HE KSS and KCC.

(d) The Group originally arranged to meet six times between 13 October 2015 and 14 January 2016. However, it was agreed at the 6 January meeting that it was important to spend time getting right the shape of the final report and recommendations. A seventh meeting was arranged for 8 March 2016 to discuss the final report and recommendations.

From:	Dr. Faiza Khan, Interim Deputy Director of Public Health
To:	Health and Wellbeing Board 25th May 2016
Subject:	Addressing Obesity: Progress Report from Local Health and Wellbeing Boards
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary: Obesity is a serious and growing problem. Nearly 770,000 adults in Kent are estimated to be either overweight or obese. Moderate obesity (BMI 30-35 kg/m2) reduces life expectancy by an average of three years, while morbid obesity (BMI 40–50kg/ kg/m2) reduces life expectancy by 8–10 years. This 8–10 year loss of life is equivalent to the effects of lifelong smoking. Obesity is a key risk factor for circulatory disease, cancer and diabetes, which is a precursor to circulatory disease. In Kent, the prevalence of obesity is variable for both children and adults. Tackling obesity requires a joined up multi-agency approach across the county.

In the November meeting of the Kent Health and Wellbeing Board (HWBB) it was decided that local health and wellbeing boards would undertake a review of their action plans for addressing obesity and improving population outcomes for children and adults and a progress report should be brought to the May meeting of the Kent HWBB. This paper reports on the progress made for each locality.

Recommendations:

The Kent Health and Wellbeing Board is asked to note the progress made in addressing obesity by local HWBBs and comment on the following proposed recommendations:

- Obesity should continue to be a priority for the local HWBBs across Kent
- Tackling obesity should be integral to the prevention strategy of the sustainability and transformation plan (STP).
- A countywide partnership healthy weight group should be set up with representation from the local healthy weight groups/HWBB. The group would be responsible for monitoring the progress of the local action plans and sharing learning.

1. Introduction

Obesity is one of the greatest challenges facing modern society. The costs to the individual in terms of health and wellbeing, and to the NHS and wider economy mean that it cannot be ignored. Obesity occurs when energy intake exceeds energy expenditure over a period of time. Our present environment is obesogenic, encouraging high consumption of calories coupled with low levels of activity and this interacts with behavioural, genetic, and other factors. Inequalities feature in obesity with some population groups being particularly at risk, including those who are socially deprived, on low levels of education, have learning difficulties or are from certain ethnic groups.

Obesity has to be tackled at every stage of the life course. Obesity in pregnancy has serious risks for both mother and child. There is an increasing number of obese children who are at risk of serious conditions including type-2 diabetes, cardiovascular disease, certain cancers, lung disease and kidney failure which will follow into adulthood. Adults who are obese have a much higher risk of a number of serious conditions including diabetes, heart disease, stroke and arthritis than the general population and experts are recognising an increasing number of people with severe and complex obesity. Approximately nine years of life is prematurely lost to obesity related conditions. Obesity is forecast to cost the NHS in the region of £50bn by 2050.

The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity in Dartford, Shepway and Swale. The highest rates for children 4-5 year olds are found in Shepway, Dartford, and Swale. The highest rates in 10-11 year olds are in Gravesham, Thanet and Dover. The Kent trend has not significantly changed in year R and year 6 for overweight, obese and excess weight in 2010/11-2014/15.

A national childhood obesity strategy is being developed and is scheduled to be published this summer. A county wide obesity strategy is also being developed and will be available after the publication of the national strategy to ensure consistency between the two.

2. Progress in local areas to date

Action plans have been developed for most areas and presented at the local HWBBs. The action plans take account of a whole systems approach to tackling obesity/excess weight and utilise four strategic themes. The strategic themes are based on key areas of evidence based actions which can be carried out to reduce levels of obesity. The themes are:

- **Theme 1** – Environmental and Social Causes of unhealthy weight. This theme recognises that action needs to be taken to tackle the wider determinants of health such as improvements to housing, the built environment and open spaces and parks.
- **Theme 2** – Give every child the best start in life and into adulthood. This ambition is enshrined in the Marmot Report and the Healthy Child Programme. It is one of the outcomes of the Kent Health and Wellbeing Strategy. An increase in the initiation and 6-8 week prevalence of breastfeeding is a key part of this strategy, as is establishing healthy eating patterns and encouraging physical activity such as active play, playground games and sports.
- **Theme 3** – Develop a confident workforce skilled in promoting healthy weight.
  This theme stresses the importance of developing a confident and skilled front-line workforce who are able to raise the issue of obesity and provide brief intervention in a range of settings. This should be part of a holistic programme that supports making every contact count.
- **Theme 4** – Provide support to people who want to lose weight.
  There is a need to provide a comprehensive well communicated pathway for adults and for families to access community weight management programmes. People are more at risk of becoming overweight or obese as they get older, when they experience life changes such as pregnancy or retirement, and if they stop smoking. In addition specific population groups which are particularly at risk of becoming overweight or obese include, children where one or both parents is obese, socially deprived groups or those on low income, those with low levels of education, some ethnic minority groups and people with learning difficulties. Specialist weight management should be provided as the gateway to bariatric surgery and these pathways need to be jointly developed across the health sector and include services provided as part of the South East National Diabetes Prevention Programme.

The action plans have been completed jointly by local partners that include District Councils, healthy weight service providers, community and voluntary organisations. Local specific issues have been accounted for in each of the action plans. Appendix 1 outlines the 4 themes and priority actions for each of the theme that the local HWBBs have being working towards.

2.1 **Swale**

An action plan has not been developed in Swale because of the potential restructuring of the local HWBB. The Swale HWBB has not met since January and therefore has not had the opportunity to review a local action plan. A meeting was held to discuss developing an action plan which was attended by Cllr Ken Pugh, representatives from Kent Public Health, Swale District

Council, Kent Community Healthcare Trust and the Community Liaison Manager. A number of actions were agreed but concern was expressed about the ability for a plan to be signed off in the time-frame because of the current status of the HWBB. (this paragraph has been sent to Cllr Pugh for comments)

2.2 **Thanet**

In Thanet, discussion points have been around identifying health champions in partner agencies' and attention to creating play spaces when decisions are made by the council's planning department. Parks and cliff walks to be promoted. Interventions' aiming to reach out to marginalised individuals and families have been identified as a priority. There is a need to consider early health notification and child protection issues when dealing with overweight children. The role played by the media, elected members, local role models and campaigns is key in the delivery of an obesity action plan.

2.3 **West Kent**

In West Kent, a comprehensive review, including a detailed mapping exercise has been carried out by the West Kent HWBB's Healthy Weight Task and Finish Group. It was supported by a wider group of colleagues, resulting in the development of the Board's Strategic Action Plan for Healthy Weight. The Sugar Smart campaign has assisted in developing positive interactions between communication and delivery teams. The Healthy Weight Task and Finish Group has joined with a pilot study being undertaken by Leeds Beckett University. The Cabinet Member for Health at Tunbridge Wells District Council is the member champion on the Healthy Weight Task and Finish Group.

2.4 **Ashford**

The Ashford Action plan reflects the activities that are being undertaken in the Ashford District aligned to the new draft Kent Healthy Weight strategy. Further work is being progressed in targeted areas of Ashford over and above those activities mentioned in the plan. This is being initiated by a local task and finish group that will support and feed into the Ashford Health and Wellbeing Board. The group is looking at innovative ways of reaching out to people in the most deprived population groups who are less likely to change behaviours. This will include audit mapping of existing services and effective engagement with the local communities to co-design tailored programmes that target groups will be eager to be involved in. Healthy weight is one of the Board's key priorities.

2.5 **South Kent Coast**

South Kent Coast CCG and Local HWBB have made tackling unhealthy weight a key priority for joint work over the next few years. South Kent Coast's 'Prevention and Self Care Strategy' and its health inequality strategic

work are prioritising reducing the levels of childhood obesity and are working closely with Public Health to improve outcomes for people with hypertension and long term conditions. Dover and Shepway District Councils are working up robust plans for increasing the level of physical activity and engaging the population in making healthy lifestyle choices. The South Kent Coast, Healthy Weight Strategy is currently in draft form and will be published in 2016.

2.6 **Canterbury**

In Canterbury, key partners have completed the action plan framework. The Local Children's Partnership Group have convened an obesity sub group with membership across the partners to take forward the agenda.

2.7 **Dartford, Gravesham and Swanley (DGS)**

DGS, HWBB has secured Local Government Association facilitation for a half day workshop to discuss cross cutting themes in the obesity agenda. Board members will identify a champion in their organisation and demonstrate how this agenda will be taken forward corporately. Opportunities for Councillors/role models to raise the profile in the media across DGS will be prioritised. Consideration on the contribution from planning/licensing will be given by the District Councils.

3. Recommendations

The Kent Health and Wellbeing Board are asked to note the progress made in addressing obesity by local HWBBs and comment on the following recommendations:

- Obesity should continue to be a priority for the local HWBBs across Kent
- Tackling obesity should be integral to the prevention strategy of the sustainability and transformation plan (STP).
- A countywide partnership healthy weight group should be set up with representation from the local healthy weight groups/HWBB. The group would be responsible for monitoring the progress of the local action plans and sharing learning.

Report Author	Relevant Director:
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Appendix 1

Health and Well-being Boards across Kent have been mapping local activity against the following themes, In addition they have also identified baseline activity, desired outcomes, partners required to deliver the priority, timescales and any funding implications.

Theme 1: Take action on the environmental and social causes of unhealthy weight (ES)

Priority – Improve food standards in all settings (ES1)

Actions – ES 1.1 Provide public education including knowledge and skills across all age ranges
ES 1.2 Increase access to nutritious and tasty food
ES 1.3 Provide training for front-line staff and identify champions
ES 1.4 Implement mass coverage campaigns e.g. sugar reduction campaign/C4L/one you

Priority – Increase levels of physical activity in all settings (ES2)

Actions – ES 2.1 Increase usage of leisure, sport and recreational facilities
ES 2.2 Increase use of the natural environment including parks, public rights of way and natural open spaces
ES 2.3 Implement Kent Active Travel Strategy
ES 2.4 Identify and mentor people who are inactive
ES 2.5 Implement mass coverage campaigns e.g. sugar reduction campaign/C4L/one you

Priority – Reduce social isolation (ES3)

Actions – ES 3.1 Local authorities should work with partners and communities to create safer homes and environments
ES 3.2 Local authorities should work with partners and communities to develop healthier environments including Healthy Towns

Priority – Create healthier environments (ES4)

Actions – ES 4.1 Undertake health impact assessments on major new builds
ES 4.2 Use planning and licensing powers to create healthier environments
ES 4.3 Reduce adult absenteeism caused by unhealthy weight

Theme 2: Give every child the best start in life and into adulthood (BS)

Priority – Pregnancy and the first year of life (BS.1)

Actions – BS 1.1 Increase the number of women who have a healthy weight prior to and throughout pregnancy
BS 1.2 Provide specialist support for all women with a BMI of 30 and above
BS 1.3 Increase the number of eligible women who apply for Healthy Start
BS 1.4 Increase breastfeeding initiation rates in all maternity services
BS 1.5 Set a baseline and a Kent target for continuation of breastfeeding at 6-8 weeks
BS 1.6 Train all health visitors to support parents and carers to responsive introduction of complimentary foods to their babies

Priority – Early Years and Preschool (BS.2)

Actions – BS 2.1 Ensure consistent messages in line with Government guidelines are provided by all those working with this age group
BS 2.2 Commission a variety of training opportunities for practitioners around healthy lifestyles as part of an integrated model
BS 2.3 Develop and implement policies that cover healthy choices in play, learning and in snack and meal provision
BS 2.4 Health visitors to provide advice and support about healthy weight when children are weighed and measure at 2 ½
BS 2.5 Promote the UK Physical Activity guidelines for under 5's and ensure physical activity is embedded in all settings

Priority – Young Children (Key Stage 1&2) (BS.3)

Actions – BS 3.1 Deliver a whole-family and whole-school approach to promote healthy eating and physical activity, to cheive or maintain a healthy weight
BS 3.2 Embed physical activity and physical literacy into cross-curriculum delivery
BS 3.3 Provide targeted support to schools which have the highest populations of children who carry excess weight
BS 3.4 Provide complete care pathways for the treatment of child obesity, reflecting the provision of services that are based on need and evidence based practice
BS 3.5 Develop school based interventions that reduce stigma associated with obesity in children

Priority – Young People (11-19 years) (BS.4)

Actions - BS 4.1 Provide 11-19 year olds with information and encouragement about the benefits of a healthy diet and physical activity with additional life skills
BS 4.2 Identify and support those overweight, to achieve a healthy lifestyle in Early Help settings

BS 4.3 Deliver a whole-school approach to promote healthy eating and physical activity and ensure appropriate physical activity opportunities are available (and taken up) outside competitive or school sport offerings
BS 4.4 Young people to have access to complete care pathways for the treatment of obesity
BS 4.5 All relevant staff to have the capacity and knowledge to provide appropriate advice/brief intervention especially to those at risk of weight gain

Theme 3: Develop a confident workforce skilled in promoting healthy weight (SW)

Priority – Training for front line workforce (SW.1)

Actions – SW 1.1 Develop MECC programme that includes building confidence and ability to give advice on healthy weight
SW 1.2 Identify key staff to be trained in MECC and motivational interviewing

Priority – Identify train and mentor Champions (SW.2)

Actions – SW 2.1 All partners to identify locality champions for healthy weight within their organisations
SW 2.2 Provide training and mentoring programme

Priority – Work with voluntary sector and other organisations to identify peer supporters/buddies (SW.3)

Actions – SW 3.1 Provide training and mentoring for community champions

Theme 4: Provide support to people who want to lose weight (SP)

Priority – Universal provision (SP.1)

Actions – SP 1.1 Healthy Living Pharmacies to offer lifestyle support
SP 1.2 Locality National Child Measurement Programme Groups to provide interventions linked to the measuring timetable
SP 1.3 Engage with communities to maximise assets
SP 1.4 Front line staff to signpost to refer for physical activity and healthy eating programmes

Priority – Primary Care (SP.2)

Actions – SP 2.1 Target groups already being seen at practice-on registers or new patients
SP 2.2 Target patients with a BMI >28 with a strong family history of diabetes or have hypertension
SP 2.3 Identify patients with non-diabetes hyperglycaemia for diabetes prevention

SP 2.4 Prioritise physical activity solutions to obesity-related conditions

Priority – Family Support (SP.3)

Actions – SP 3.1 Implement the children and young people's healthy weight pathway
SP 3.2 Children's Centres, Early Help, Health Visiting and School Nursing services to provide advice and support
SP 3.3 Increase uptake of family weight management programmes

Priority – Adult programmes (SP.4)

Actions – SP 4.1 Implement a strong adult weight management pathway
SP 4.2 Make use of the range of community options for example health trainers, weight management courses, NDPP, exercise referral, commercial programmes and provide support for maintaining changes
SP 4.3 Provide specialist weight management programmes with lifetime follow up to ensure maintenance of behaviour change

Priority – Specific groups (SP.5)

Actions - SP 5.1 Provide lifestyle interventions in areas of highest prevalence/deprivations
SP 5.2 Provide lifestyle interventions for people with poor mental health
SP 5.3 Make reasonable adjustments and proactive targeting of protected groups with disabilities including easy read materials
SP 5.4 Ensure that people from black and Asian ethnic origin are offered advice and support
SP 5.5 Ensure that provision is tailored to the needs of male participants as they are under-represented

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From:	Roger Gough, Chairman and Cabinet Member for Education and Health Reform Andrew Scott-Clark, Director of Public Health
To:	Health and Wellbeing Board 25th May 2016
Subject:	Refreshed Kent Joint Strategic Needs Assessment (JSNA) Overview Report 2016
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This abridged version of the refreshed Kent JSNA Overview Report 2016 focuses attention upon the key locality and Kent wide priorities that have emerged from the refresh of the current JSNA.

Detailed commentary and recommendations upon the many conditions and other health and wellbeing influences are contained within a separate detailed document which is to be found on the Kent Public Health Observatory (KPHO) website at www.kpho.org.uk. The site also holds further supporting resources such as the locality Health and Social Care Maps.

Eight priorities, comprising six clinical areas and health improvement/prevention, and two influencing priorities namely demographics and growth emerge as those that necessitate commissioning action either at county level or at specified Clinical Commissioning Group (CCG)/district localities.

Recommendation: The Health and Wellbeing Board is asked to comment on the key strategic findings of the refreshed JSNA Overview Report 2016 and endorse the priorities.

Abridged Kent JSNA Overview Report 2016

1. Background

1.1 The purpose of the Joint Strategic Needs Assessment is to analyse the current and future health and wellbeing needs of the local population to inform the commissioning and provision of health, wellbeing and care services.

1.2 The current Kent JSNA has recently been refreshed with the most up to date data available. The Health and Wellbeing Board previously considered in September 2015 six key priorities for Kent from the JSNA for the 2016/2017 commissioning/contracting round

1.3 This abridged version of the refreshed Kent JSNA Overview Report is intended to focus attention upon the key locality and Kent wide priorities that have emerged from the refresh in order to support development of the Sustainability, Transformation Plans (STP) and future commissioning and provision of health and care services.

1.4 The report identifies eight priorities, comprising six clinical/health improvement areas:

- Diabetes,
- Cancer,
- Stroke,
- Mental Health,
- Healthy weight and
- Health inequalities

Included are two influencing priorities namely:

- Demographic pressures and
- Population growth

These strategic priorities will require commissioning action either at county level or at specified Clinical Commissioning Group (CCG)/district localities.

1.5 This report is structured to highlight those priorities that have a locus at County and sub County level. Priorities centred on the CCG(s) are grouped according to East Kent, North Kent and West Kent. Detailed commentary and recommendations on the many conditions and other health and wellbeing influences are contained within the detailed Kent JSNA which can be viewed on the Kent Public Health Observatory (KPHO) website at www.kpho.org.uk.

2. Kent Emerging Priorities

2.1 Diabetes

2.1.1 Across Kent, the recorded diabetes prevalence has risen from 4.5% in 2006/07 to 6.2% in 2014/15, an average annual increase of 0.2%. This rate of increase is similar across all CCGs, with none of the CCGs increasing at a significantly different rate to Kent.

2.1.2 West Kent CCG consistently has had the lowest prevalence (5.48%). Whilst Thanet (7.12%) and Swale (7.07%) CCGs tend to have fairly high prevalence. In 2014/15, West Kent and Canterbury and Coastal CCGs had significantly lower recorded diabetes prevalence than Kent, whilst East Kent, South Kent

Coast (SKC) and Thanet CCGs have significantly higher prevalence. In North Kent Swale CCG has significantly higher prevalence.

2.1.3 From 2006/07, the emergency diabetes admission rate increased steadily across Kent from 76.0 admissions per 10,000 population to 131.4 in 2014/15. All CCGs have had a similar increasing trend, with Thanet CCG consistently having the highest rate. West Kent CCG has had the lowest emergency admission rate since 2010/11. In East Kent, Canterbury and Coastal (156.8), South Kent Coast (154.4) and Thanet (160.0) all have significantly higher emergency admission rates per 10,000 population than Kent (131.4), whilst West Kent CCG had a significantly lower rate (105.7) in 2014/15.

2.1.4 Amputation rates show a steady rise in hospital admission rates across Kent over these time periods, from 0.24 to 0.65 admissions per 10,000 population. In North Kent the Swale CCG rate has increased notably since 2009/10 to 2011/12 (pooled), to 1.19 admissions per 10,000 population in 2012/13 to 2014/15 (pooled).

2.1.5 Diabetes related blindness is low. Between 2006/07 to 2014/15, the admission rate in Kent has increased steadily from 0.96 admissions per 10,000 population to 1.93 admissions. In East Kent Thanet CCG has consistently had the highest rate, although the rate in North Kent Dartford, Gravesham and Swanley (DGS) CCG increased to a level similar to that of Thanet CCG in the last time period.

2.1.6 Obesity accounts for 80–85% of the overall risk of developing Type 2 diabetes. Deprivation is strongly associated with higher levels of obesity. Physical inactivity, unhealthy diet, smoking and poor blood pressure control also increase the risk of diabetes or the risk of serious complications for those already diagnosed.

2.1.7 All CCGs in Kent have priorities that recognise that this clinical area requires commissioned action but specifically mentioned by Canterbury and Coastal and South Kent Coast CCGs.

2.1.8 Recommendations:

- That the population is advised about how to change behaviour to achieve a healthier diet and take more physical activity.
- Primary care should keep updated records of people's level of risk and create a recall system which will allow patients to be contacted and invited for regular reviews. In Kent this will be expected to be implemented through the National Diabetes Prevention Programme from 2016.
- Effective systems should be in place to ensure that people know what services and treatment is available, especially those aimed at people who are disadvantaged.

- Increase the number of people with diabetes who are achieving NICE targets for care management and the numbers of people who are receiving all of the nine NICE key processes of diabetes care reported in the National Diabetes Audit.

2.2 Cancer

2.2.1 Cancer is one of the largest causes of mortality in Kent. Cancer was recorded as the underlying cause of death in 29% of mortalities in 2014. This figure is even more pronounced in younger adults with cancer, accounting for 43% of premature mortalities (death under 75 years) in Kent in 2014.

2.2.2 The prevalence of cancer has increased due to a combination of an increasing average life expectancy of the population and an increased occurrence of risk factors for cancer (e.g. obesity). Survival rates have been improved due to better diagnosis and treatment.

2.2.3 There are marked inequalities in health outcomes of cancer between men and women, with the former group experiencing a significantly higher incidence of cancer mortality and years of life lost due to the disease. Similarly, there is inequality in the distribution of cancer diagnosis and outcomes associated with socioeconomic status.

2.2.4 In Kent the most common cancers in men are: prostate, colorectal and lung cancers: in women, breast, colorectal and lung cancer. The highest incidence of cancer in Kent is seen in East Kent in the Dover and Thanet districts. Analysis of CCG Quality and Outcomes Framework (QOF) 2014/15 data also suggests that the incidence of cancer is higher in East Kent than in North and West Kent.

2.2.5 The trend in one year survival after cancer diagnosis is upward, and is 69% in Kent overall, which is consistent with the England average. However, lower one year survival is noted in both East and North Kent namely Thanet and Swale CCGs (2009-2011).

2.2.6 Early diagnosis of cancer e.g.at stage 1 or 2, improves prognosis. The proportion of cancers in Kent which are diagnosed early is slightly lower than the England average. This will have a negative impact on morbidity and mortality, and may limit treatment options available to patients.

2.2.7 Nationally it has been demonstrated that the route of diagnosis is associated with survival, with emergency presentations having low survival outcomes compared to other routes. For example between 2006-13 one year survival was 97% for colorectal cancer patients diagnosed through screening,

compared to 82% for patients diagnosed via urgent GP referral, and 49% for emergency presentations. For cervical cancer the figures are 99%, 83% and 45% respectively and for female breast cancer the figures are 100%, 97% and 53% respectively.

2.2.8 There is variation in the rate of urgent GP referrals across Kent, with significantly higher rates of urgent referral noted in East Kent compared to North and West Kent.

2.2.9 Public Health England report lower uptake of bowel screening in East Kent (Thanet) and North Kent (DGS and Swale) and gradually reducing engagement for cervical screening (77.1%) across all Kent CCGs. They reinforce the need to increase breast screening rates across the County currently at 77.6%.

2.2.10 Both Thanet and Swale CCGs specifically mention cancer in their priorities. A cancer strategy and action plan has been developed by Thanet CCG and KCC Public Health.

2.2.11 Recommendations:

- Prevention of cancer and subsequent death involves both reduction in risk factors for cancer, such as smoking and obesity and early detection of pre-cancerous changes through screening programmes.
- Risk factors for cancer include the male sex and lower socioeconomic status. These risk groups should be targeted to reduce cancer incidence.
- More work is needed to understand the significance of the high rate of urgent GP referrals to cancer services in East Kent.
- Improving uptake of screening programmes with a particular emphasis in more deprived communities that have the lowest uptake rates

2.3 Stroke

2.3.1 The prevalence of stroke in Kent is increasing. Between 2006-07 and 2013-14, the prevalence of stroke increased by 1.34% across Kent and Medway compared to 0.94% for England.

2.3.2 The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards and national and local benchmarks. Kent's stroke providers score quite well relative to the rest of the South East Coast Strategic Clinical Network (SCN), with high organisational scores in East Kent - Ashford, Canterbury and Margate. There are low scores in West and North Kent - Maidstone and Dartford.

2.3.3 Atrial Fibrillation is a known risk factor for stroke and its identification along with treatment is important for prevention. Across Kent there is a variation in assessing this risk of having a stroke amongst individuals with known Atrial Fibrillation and providing appropriate intervention. Overall the Kent & Medway prevalence of atrial fibrillation (1.80%) was higher than England (1.57%) in 2013/14; however, the rate of change between 2006/07 and 2013/14 was not increasing at a greater pace than England.

2.3.4 As more people are surviving stroke, an important role is placed upon post stroke care. This includes services such as early supported discharge (within 10 days) and multidisciplinary community rehabilitation services. The South East Coast SCN recently published guidance for commissioners on post stroke care "Life after Stroke" to better support those who have had a stroke to get back to living a full and active life and reintegrating within society.

2.3.5 Thanet CCG specifically highlights stroke in its priorities.

2.3.6 Recommendations:

- Public health commissioners should continue to commission services that promote healthier lifestyles, smoking cessation, and cholesterol and hypertension management as well as NHS Health Checks to reduce stroke risk factors.
- Service Commissioners should commission acute stroke care services to meet core performance and quality standards to achieve best possible outcomes for individuals who are affected by stroke.
- Service commissioners should commission post stroke care to ensure that stroke patients can recover as best as possible and minimise the impact of disability on their life and wider society.

2.4 Mental Health

2.4.1 The number of people with mental health problems can be calculated by using The Adult Psychiatric Morbidity Survey (2007) and applying it to the Kent population.

- estimated number of people with common mental illness: 85,000
- estimated number of people with only one common mental illness: 25,000
- estimated number of people with severe mental illness: 58,000
- estimated number of people with more than one mental health problem: 58,000.
- estimated number of people with depression over 65: 20,000

2.4.2 The majority of people with the worst mental health in Kent are aged 35-65 years old. The over 65s also face non dementia related depression and anxiety. There is a strong link between the severity and duration of common mental illness and socioeconomic conditions. The risk groups include perinatal women, offenders and substance misusers.

2.4.3 Mental health including suicides is mentioned in priorities by three East Kent CCGs – Canterbury and Coastal, South Kent Coastal and Thanet CCGs

2.4.4 There are a significant number of recommendations from the Needs Assessment including dual diagnosis and these include:

- Commission in a way that enhances local community asset mapping and development, and engagement, thereby enabling people to feel connected and in control.
- Commissioners must ensure there is equity in the delivery of psychological therapy.
- Ensure all front line professionals feel equipped to tackle emotional wellbeing and sign post to early help for community wellbeing. e.g. training and support and suicide prevention
- Improve social and community support via integrated work from troubled families, drug and alcohol services, mental health services and criminal justice systems.
- Commissioners to prioritise the health improvement of people who have mental health diagnosis – and the mental health of people with physical health problems.
- CCG and KCC commissioners to work together strategically on a joint approach to commissioning children's mental health, particularly following guidance and recommendations the in JSNA for Children and Adolescent Mental Health Services (CAMHS) and prioritising supporting parents and Early Help.

2.5 Healthy Weight

2.5.1 The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in North and East Kent. The percentage of adults classified as overweight or obese (2012) in the County had risen from 63.8% to 64.6% whilst that for children aged 10-11 has dropped from 33.5% to 32.7%. Children aged 4-5 has also dropped from 22.5% to 20.8%.

2.5.2 The prevalence of obesity varies across Kent, with the highest prevalence rates of adult obesity to be found in North Kent in Dartford and Swale CCGs and in East Kent Shepway CCG. The highest rates in four to five year olds

are also found in these CCGs. The highest rates in 10 to 11 year olds are found in North Kent DGS CCG, and in East Kent in SKC CCG (Thanet and Dover). The Kent trend has not significantly changed in year R and year 6 for overweight, obesity and excess weight 2010-11 to 2014-15.

2.5.3 People who are obese are at far higher risk than the general population of serious illness including diabetes, heart disease and stroke. Approximately nine years of life is prematurely lost to obesity related conditions.

2.5.4 Healthy weight including obesity and physical activity is cited as a priority by both North Kent CCGs (DGS and Swale) and three East Kent CCGs – Canterbury and Coastal, South Kent Coastal and Thanet. Local health and wellbeing boards have prioritised healthy weight and have been involved with reviewing local action plans for addressing obesity and improving population outcomes for children and adults.

2.5.5 Recommendations:

- Commissioners should develop an integrated model for obesity that includes other related health improvement strands such as emotional health and wellbeing, smoking and alcohol.
- Facilitate workforce development to enable the combined workforces of the health economy to feel confident in raising the issue of weight and providing consistent advice about the benefits of behaviour change.
- Commissioners should adopt a more targeted approach to ensure that the needs of those most at risk are met.
- Commissioners should facilitate better data sharing across the system to enable a more robust measurement of outcomes and inform commissioning of effective interventions based on more accurate calculations of return on investment.
- There is a need for better evaluation of what works, and links to academic partners would provide more robust methodologies.

2.6 Demographics

2.6.1 The projected growth in Kent's population to 2020 highlights the growth particularly in the two age bands of 65–84 (9.6%) and over 85 (13%). This has implications for both health and social care as these two age cohorts place increasing pressures on services through increasing numbers of patients with long term conditions needing complex care and treatment from different organisations.

2.6.2 It brings into focus the need for strategies and interventions to support Living Well and Ageing Well to help modify the impact that these individuals will present and to ensure that efforts to maximise life expectancy are achieved. This issue reinforces the need to have robust prevention programmes in place to support investment in behaviour change. It takes time, effort and new approaches to keep people with these conditions well and out of hospital.

2.6.3 The KCC produced strategy forecasts for population show the larger increases in general population occurring in both North Kent DGS CCG and East Kent SKC CCG areas (10% for DGS, mainly focused on Dartford area and 7% for SKC, mainly focused on Dover area). Ashford shows a 5% rise. The remaining areas are between 1% and 4%

2.7 Health Inequalities

2.7.1 Whilst health outcomes have been improving for Kent as a whole, the differences in these outcomes between affluent and deprived populations persist. Current data highlights this - whilst mortality rates are coming down across all deprivation deciles, the gap between the most affluent (the bottom line) and the most deprived (the top line) has not changed over the last 10 years, suggesting that efforts to tackle health inequalities are not yet having an impact on mortality rates.

2.7.2 Whilst Kent scores above the England average on a range of indicators, this countywide analysis hides the great diversity and disparities which exist within and between Kent's communities. Local Kent data demonstrates that poorer health behaviours and outcomes correlate strongly with these deprived areas: obesity prevalence, smoking prevalence, teenage pregnancy rates, alcohol related disease, registered disease prevalence, to name a few.

2.7.3 What is noticeable in the latest mortality and life expectancy data is that the tenth decile (most deprived), suffer disproportionately poorer health outcomes than other deciles. Analysis indicates that excess premature mortality in these areas is primarily caused by preventable chronic diseases which are the result of behavioural risk factors such as smoking, physical inactivity and poor diets.

2.7.4 A new action plan is being developed that aims to focus more systematic efforts towards the most deprived geographic areas in Kent. This will have the greatest impact on reducing health inequalities and the life expectancy gap.

2.7.5 Both South Kent Coast CCG and West Kent CCG specifically have health inequalities as a priority. Thanet Health and Wellbeing Board have prioritised health inequalities and a multi-agency sub-group focusing on inequalities has recently been established.

2.8 Growth

2.8.1 The Kent and Medway Growth and Infrastructure Framework (GIF) has been developed to provide a clear picture of housing and economic growth to 2031 and the infrastructure needed to support this growth.

2.8.2 Primary healthcare required to support population growth to 2031 was mapped, and the analysis of the provision of GP numbers identified that there is a lack of capacity in proposed growth areas. One hundred and forty-six additional GPs and associated premises of 24,100 sq.m and 121 additional dentists and associated premises of 6,000 sq.m will be required.

2.8.3 The number of additional beds required to support population growth, including both hospital beds and mental health beds was also examined and the following was highlighted. Dartford, Gravesham, Medway and Canterbury are all near capacity in bed provision, despite facing significant housing growth. The forecast population growth could equate to 515 additional hospital beds across Kent and Medway, with a further 106 additional mental health beds.

2.8.4 In North Kent DGS CCG will be under significant pressure in the next 15 years with Ebbsfleet Garden City comprising just 50% of the growth across the CCG area. Young professionals and young families are expected to move into the area but the older generation will also be invited to support community cohesion and avoid the creation of a dormitory town. The CCG state that existing healthcare services are already under significant strain and new models of care and a focus on prevention are going to be a priority to manage the current population healthcare demands and new growth.

2.8.5 There are limitations on the data used for the GIF, but there is a clear need to refine the picture of health and care infrastructure to meet future growth in the next and future iterations of the GIF. The GIF authors cite whilst the findings of the GIF should be read with caution; they highlight a critical challenge in

funding health and social care provision to meet future demand. In particular, the GIF has highlighted challenges in such provision in growth areas where the viability is more marginal.

3. Recommendation

3.1 Recommendation: The Health and Wellbeing Board is asked to **comment** on the key strategic findings of the refreshed JSNA Overview Report 2016 and **endorse** the priorities.

4. Contact details

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

To: Health and Wellbeing Board, 25 May 2016

Subject: **Kent Health and Wellbeing Board Work Programme**

Classification: Unrestricted

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1. Introduction

(a) Following the Board's agreement in September 2015 that a Forward Work Programme should be developed and shared with local Boards, a draft was presented to the Board on 27 January 2016. The approach set out at this time was approved by the Board.

(b) The draft Forward Work Programme has been amended and updated. This is attached. The Forward Work Programme will remain a live document and is a standing item on the Agenda.

2. Recommendation

Members of the Kent Health and Wellbeing Board are asked to agree the attached Forward Work Programme.

Background Documents

None.

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WORK PROGRAMME –2016/17
Health and Wellbeing Board

Agenda Section	Items
20 July 2016	
Area 1 - Assuring Outcomes for Kent	• Review of Outcome 2 – Prevention of ill-health • Review of "Mind the Gap" • Obesity Review
Area 2 - Core Documents	
Area 3 Promotion of Integration	• Final Sustainability and Transformation Plans
Area 4 Notifications	• Kent Environment Strategy
Area 5 Reports to the Board	• Crisis Care Concordat – Annual Report • HWB Work Programme • Local board minutes • Minutes of the 0-25 Health and Wellbeing Board – 15 June 2016
21 September 2016	
Area 1 - Assuring Outcomes for Kent	• Review of outcome 3- Quality of Life for people with long term conditions • Relationship between the Kent Board and Local Boards Update
Area 2 - Core Documents	
Area 3 Promotion of Integration	• The Kent Board and Voluntary Sector Update
Area 4 Notifications	• One Public Estate/Local Estates Strategies Update
Area 5 Reports to the Board	• KSCB Annual report • HWB Annual Report • HWB Work Programme • Local board minutes • Minutes of the 0-25 Health and Wellbeing Board
23 November 2016	
Area 1 - Assuring Outcomes for Kent	• Review of Outcome 5 - Dementia
Area 2 - Core Documents	• JHWS Development Process
Area 3 Promotion of Integration	• Sustainability and Transformation Plans Update
Area 4 Notifications	
Area 5 Reports to the Board	• Update on the Joint Health and Social Care Self-Assessment Framework • HWB Work Programme • Local board minutes • Minutes of the 0-25 Health and Wellbeing Board

Updated 10 05 16

25 January 2017	
Area 1 - Assuring Outcomes for Kent	• **Review of Outcome 1 – Every Child has the Best Start in Life**
Area 2 - Core Documents	•
Area 3 Promotion of Integration	• **Better Care Fund Plans for 2017/18**
Area 4 Notifications	•
Area 5 Reports to the Board	• **Progress report on the Kent Emotional Health and Wellbeing Strategy for Children, Young People and Young Adults (CAMHS)** • **HWB Work Programme** • **Local board minutes** • **Minutes of the 0-25 Health and Wellbeing Board**
22 March 2017	
Area 1 - Assuring Outcomes for Kent	
Area 2 - Core Documents	•
Area 3 Promotion of Integration	• **Review of Commissioning Plans**
Area 4 Notifications	•
Area 5 Reports to the Board	• **HWB Work Programme** • **Local board minutes** **Minutes of the 0-25 Health and Wellbeing Board**
Other items not allocated to a particular meeting	
	HWB Strategy Refresh

0-25 Health and Wellbeing Board

12 January 2016
Medway Room, Sessions House, County Hall

MINUTES

In attendance:

Andrew Ireland (AI)	KCC – Corporate Director – Social Care, Health & Wellbeing
Thom Wilson (TW)	KCC - Head of Strategic Commissioning (Children's)
Michael Thomas-Sam (MT-S)	KCC - Strategic Business Adviser
Peter Oakford (PO)	KCC - Cabinet Member SCS
Roger Gough (RG)	KCC - Cabinet Member Education and Health Reform
Supt Simon Thompson (ST)	Kent Police
Samantha Bennett (SB)	KCC – Public Health
Patrick Leeson (PL)	KCC – Corporate Director – Education & Young People's Service
Jane O'Rourke (JO)	Head of East Kent Children's Commissioning Support Team
Penny Southern (PS)	KCC – Director of Disabled Children, Adults Learning Disability and Mental Health
Amber Christou (AC)	Swale District Council
Clare Hayward (CH)	East Kent Children's Commissioning Support
Sue Chandler (SC)	South Kent Coast LCPG Chair
Sari Sirkia-Weaver (SSW)	Canterbury LCPG Chair
Angela Ford (AF)	
Ally Watson (AW)	

Apologies:

Lee Russell (LR)	T/Supt Kent Police
Ally Hiscox (AH)	Deputy Chief Operating Officer NHS Swale and NHS Dartford, Gravesham and Swanley CCGs
Mark Lobban (ML)	KCC - Director of Strategic Commissioning
Debbie Stock (DS)	NHS – Dartford, Gravesham, Swanley and Swale CCG Chief Operating Officer
Abdool Kara (AK)	Kent District Councils Chief Executives
Florence Kroll	KCC – Director of Early Help
Philip Segurola (PS)	KCC - Director Specialist Children's Services
Gill Rigg (GR)	Kent Safeguarding Children Board Independent Chair
Karen Sharp (KS)	KCC - Head of Public Health Commissioning

		ACTION
1.	**Welcome and introductions/apologies**	
2.	**Minutes of the last meeting and Matters Arising:** Accuracy of minutes approved. LCPG – meeting last week – indicators at initial level in slides today, proposal is to set up a virtual group. JSNA – SB and PL met to discuss needs – this is progressing. Next is to identifying priority areas, undertake in depth work, and pulling together data. **An update will come back to the next meeting.**	**SB**

3.	**Item 3 – Children with Disability Lifespan Programme – Penny Southern** PS is now a member of this board. PS is the Director Disabled Children, Adults LD/MH. Disabled children's service was together with SCS last year, but the re-structure merged services for children with Adults to ensure the pathway of care from children to adults. The Lifespan Programme covers all ages, looking at YP through to adulthood with no cliff-edge at 18. Penny gave a presentation on Lifespan which is currently in a "design phase". **Questions:** MTS – mentioned joint commissioning – how will it unfold in the immediate future? PS - Hoping health colleagues will have similar thoughts, working with TW and Children's Commissioning. From April, will have an integrated commissioning model for adults with LD for 18+. AC – pleased to see transition as often have to manage YP with MH and LD. Keen to support not putting YP in to residential care. Districts and housing need to be involved. If they are not involved, we will end up with more homeless YP. AI – the reason for it to come to this meeting is in order to capture the whole aspect of people's lives, give greater continuity in terms of support. This issue is a key part of the agenda for 0-25 HWB, need to translate onto a wider platform to ensure it is being achieved. AI – helpful introduction to board of what is going on, clearly new legislation for DC and YP with additional needs. **At next meeting, resume of work going on under 0-25 HWB SEND Sub-Group and how this fits in.**	**PL**
4.	**Item 4 – Headstart – Angela Ford** Angela Ford gave presentation. 5 year strategy to be funded up to £10m through Big Lottery. If successful there will be £6-8m coming into Kent. At last meeting it was agreed for governance to the Board. The strategy is still in draft form – but CYP have been really engaged. **Questions:** ST- when talking from police point of view, is the social media aspect looked into? AF – look at digital world in a positive way, needs further development. It's about how they behave online to get right skills to facilitate themselves online, same as in lives. ST – opportunity for joined up working with police – "safer internet use".	

	AF – are the Board generally happy with the approach? AI – it is a huge project, clearly important to ensure linkages and communications with all other stakeholders.	
5.	**Item 5 – LCPG/CYPP – Thom Wilson** Thom gave presentation. **It was agreed that feedback from the Chairs would be a standing item on the agenda going forward.** Outcomes & Indicators: Hoping that this board happy to confirm the 4 outcomes. These encompass the things with aspire for C&YP in Kent. AI – struggling with 0-25 year olds as language. If we leave that bit out the outcomes are sound. SSW – there big challenges in Canterbury – all will fit into the outcomes. **Indicators** Do people have any views about those or other criteria? SC – only one reported as a rate or % - some will be pretty small numbers when broken down. The lower in numbers you go, the more likely to get distortions as samples are so small. As long as broad data number is available. Don't know how increases workload or overcomplicated. Need to understand distortions. SW – Data is available, but it is a lot of work. TW – the dashboard is the same across 12 districts, they have a number and then when looking at action planning, someone comes to meeting from PH or BI to inform and feed in. AC – welcome the structure, but within what is set out, flexibility for autonomy. TW – definitely opportunity for local indicators, question will always be will they go into dashboard. It would be straightforward to develop a dashboard with blanks. AC – that sounds reasonable SC – population groups TW – not on these slides, but has been to this group previously SC – data will relate to population groups, if facility is incorporated into dashboard would be beneficial **CYPP Public Consultation** PO – 120 people have completed consultation. People are getting fed up with consultations and don't bother to do. AC – not yet agreeing any changes, until then, nothing to consult on other than the document. SC – in this case not going to get any valuable responses back, more likely to find it valuable if considered as a document. AI – considerable amount of stakeholder engagement, but how much	

	have schools been involved? PL – history of attending previous groups were pretty unproductive, know that AEO have been encouraging. AI – issue of schools being part of stakeholder consultation is important, which could undermine case for public consultation. Is there a relatively easy mechanism? PL – Need to know about it and have communications strategy, but don't need a consultation. Need to know about local boards etc and the plan, but think that if it is sent as a consultation would get 0 responses. RG – link to further effort to get schools engaged in area groups in local children's groups. Communication about this and why they should be involved. TW – there is a clear message not to do a public consultation and think about schools and how to communicate and engage. Intention is to be annual. Next year informed by dashboard and based on relative performance. AI – Grants - I would want to be clear that there is proper monitoring of where this gets reflected in budget as it doesn't rest with this board. TW – brief reassurance – existing grants, coming to an end, managed through CC with EH. New grants will continue to be EHPS budget and responsibility. Doesn't imply that this group becomes responsible for everything. PS – when talk about 0-25 and CYP, I assume we're talking about children with complex disabilities – where is the voice of that and the families? Where is the measure that talking about all children – access, inclusion, bullying and going on to apprenticeships etc. There is no indicator to say a good job has been done. Not sure if specialist schools involved – no measure to say disabled child has a voice. TW – once we have selected the indicators then we will have a better understanding of the ages ranges they cover. These will be selected using the approach outlined **An update will come back to the next meeting.**	**TW**
6.	**Item 6 – UASC Update – Andrew Ireland** AI – position hasn't significantly moved on since last briefing given to this group. The number did break the 1000 UASC barrier but a large number became 18 on 1st January. The Rate of arrivals over last couple of months has slowed providing a period of respite and time to re-group. Movement to national dispersal group is slow. Three secretaries of state wrote to all LAs with a national offer to take YP from Kent. Response has been disappointing, only 6/7 LAs have come in with an offer, most of which not signification, with 1 exception, 1 offer stipulated only able to take under 5s.	

	Ladesfield centre is now empty and will close in January. Appledore is still needed, and KCC is still operating 2 reception areas. Over 450 YP managing as care leavers, living within the county, so significant issues around that. Pressure on resources is still significant and concern currently is that it will grow unless national system happens, and happens quite quickly. Members concerned, as are officers, need contingency plans to manage issue within the county. Have started to get some English as 2nd language programmes underway with support from Patrick's division, but still some big gaps. **Questions/issues to be considered:** AC – would age change on 1st January be an issue every year? We are concerned about the potential for increasing homelessness if nothing changes; need to look at supported accommodation. Don't get a sense of working together to date AI – regarding care leavers and accommodation, we are looking at getting forward projection – though it will be limited in value due to status. What we don't know is who will arrive. Growing sense that we are being left to manage it.	
7.	**Item 7 – CAMHS Transformation & Governance – Ally Watson** Ally Watson – PM from West Kent CCG gave update. Kent TP approved by NHS England in December and released to CCGs. Kent Plan is being used by national team as a model of best practice. Re-procurement of CAMHS contract. Working with current provider SPFT implementing some of the transformation work before re-procurement goes through. Extended until March 2017 to allow work to be implemented. Being overseen by procurement board. Co-chaired by Andrew Ireland and Ian Ayres – meets monthly. Looking to seek approval from this board to dissolve current board and in place transformation board and subgroup. Some cross over of groups being set up – important to keep separate as huge complex area of work. AI – draft specification should be finished by end of January. Available for people to peruse in the near future for whole EMHWB service. Work is on track to meet timetable. CCG/Karen and AI due to go to HOSC, get clarification for full consultation. Remain confident will stay on track and will be delivered.	
8.	**AOB** No AOB.	

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0-25 Health & Wellbeing Board
22 March 2016
Swale 2 & 3, Sessions House, County Hall, Maidstone

MINUTES

In attendance:

Andrew Ireland (AI)	KCC – Corporate Director – Social Care, Health & Wellbeing
Thom Wilson (TW)	KCC - Head of Strategic Commissioning (Children's)
Michael Thomas-Sam (MT-S)	KCC - Strategic Business Adviser
Peter Oakford (PO)	KCC - Cabinet Member SCS
Roger Gough (RG)	KCC - Cabinet Member Education and Health Reform
Supt Simon Thompson (ST)	Kent Police
Samantha Bennett (SB)	KCC - Public Health, Consultant
Florence Kroll (FK)	KCC - Director of Early Help
Abdool Kara (AK)	Kent District Councils Chief Executives
Gill Rigg (GR)	Kent Safeguarding Children Board Independent Chair
Philip Segurola (PS)	KCC - Director Specialist Children's Services
Hema Birdi (HB)	District Manager EHPS, Maidstone
Jenny Hollingsbee (JH)	Cabinet Member, Communities SDC
Sarah Robson (SR)	Head of Communities
Oliver Hartland (OH)	Swale BC
Tony Witton (ToW)	KCC - Arts & Culture

Apologies:

Patrick Leeson	KCC - Corporate Director – Education & Young People's Service
Jane O'Rourke	Head of East Kent Children's Commissioning Support Team
Penny Southern	KCC - Director of Disabled Children, Adults Learning Disability and Mental Health
Kim Shubrook	Headteacher, Westcourt Primary & Nursery School
Jess Mookherjee	KCC - Public Health
Sharon McLaughlin	District Manager 0-25, Thanet

1. Welcome & Introductions

Introductions were made and apologies given, including Patrick for item 6.

2. Minutes of last meeting & matters arising

Checked for accuracy, all ok.

JSNA is an action, and is on the agenda.

Patrick's item – **CYP HWB Standing Group for SEND** is to be deferred to next meeting, or he will need to send a representative.

UASC Update: Nothing has dramatically changed. We are still seeing a lower level of arrivals, and work is still going on at government level about a national dispersal. Dispersal work is getting there slowly, think it will still happen, though the concern is that we are now end of March. The pattern is that arrivals will increase in spring, hopefully not to the same level as last year. Andrew continues to press the urgency with DfE and government. Happy to continue to update at each meeting if needed, if dispersal happens, it will be important to update.

3. ARTS presentation

Tony Witton gave presentation. ARTS & Culture Service.

ACTION: SB to send his presentation which has notes attached.

The service is part of the Economic Development division of KCC – the objectives are split into 3 areas: business growth, skills development, community wellbeing.

A recent success was that KCC Arts had an item on the agenda at the National Arts Conference last month.

Questions:

Do you work with employers?
Yes we do, with a range of organisations including Turner Contemporary, to small practitioners. Have a Cultural transformation board. The Inspire programme which is about 25 organisations working in schools. Pilot project in Dartford BC, putting artists into schools to work on designs and then they will be taken and made into vinyl wraps that then cover bin lorries. We are putting creative practitioners into school to help young people to work creatively. The YP also get to learn about the waste industry who are funding the project.

HB – do you work closely with LSC and apprentices?
Yes, last year we put a bid in with the National College for Creating and Cultural Skills in Essex. We put in place external funding with 11 apprenticeships across the county.

AK – how do we find out what's going on in borough?
This is challenge for us – we used to have district based coordinators, now down to 3 working across Kent. Board members should use Tony as point of contact.

AI – what is the evidence base? Question for Sam…that this activity brings about significant impact amongst CYP?
SB – quite good evidence base. Also benefit about being engaged and finding something that you are good at.
FK – one element about work and apprenticeships, one about using arts to improve outcomes – a lot of evidence in YJ world to improve outcomes – depends on what you're looking at. Quite a challenge in terms of funding. Need to think about being more innovative.

AI – link between this and employment is secure as is wellbeing. Challenge is about as we get into more tighter times, how to determine who to invest in. This area would need strong evidence base. If shaky, then it wouldn't get funding, need to be really focused.
FK – lottery funding to give some scope to test, depends on the quality, need to ensure have the right quality to make an impact.
ThW – don't think it always has to do with money. This is a group that considers the universal needs. Might be a way for Arts to engage with CYP without looking at it financially. Arts providers could be part of network working with kids locally. Will put in better position with Grant funding starts again.
ToW – aware as a sector that don't have strong evidence base. Need to look at ways to work with colleagues.

PS – do you have teams working with asylum seekers?
TW – an org currently in Canterbury who have just started to work
PS – need a follow on discussion

AI – interesting and stimulating presentation may need to come back to group at some point. Not for next couple of meetings (as needs time to develop).

4. LCPG Feedback (standing item)
The second meeting of chairs was on 10th March, next one is in April. There are formal minutes which can be shared. There is a standing agenda item that the group will feed back to this board.

After discussion it was agreed that the Chairs would use the three questions, but we would not refer to it as Signs of Safety questions:

- What are we worried about?
- What is working well?
- What do we need to do more of?

Things to be worried about – lack of EMHWB data, all agreed is #1 priority, but lack of robust KPI. There is a meeting to discuss EWB data that Public Health leading on. An Indicator of EWB in EH Notifications was added to the strategy – on the agenda.

Capturing VoC – approx. 200-250 comments on strategy – Sevenoaks keen to make more meaningful. Discussion about role of elected members – all agreed that members from KCC and districts welcome – concern that may become over politicised.

PO – should be a lead member from each district – cannot stop members from districts attending if they wish. Despite considerable interest it is not likely that a high number will attend.

ThW – numbers increasing, about half now. We are collecting a register of core members and will look to fill in gaps.

Grants came up as strength and worry. Next time around we wish for a longer process and to be more engaging about developing creative ideas.

PO – FK and I spent a long time going through grants – some districts done lots of work, others less so. Need to use grants for reason they are there, not £40k to 1 company because it does not support diversity.

FK – cap on money as to how much can be put. Majority of local groups did a really good job in making recommendations.

What worked well – reduction in duplication. Dashboards – showed a mock up for one district and people were really positive about how it would work.

Needs to happen: Need to ensure think about education trust proposals and impact on LCPGs. The next meeting in April will focus on OBA to turn final strategy into action – how we look at indicators, how the people in partnerships will work together to improve the indicators.
HB – still early days, learning lessons and feed in next year. Keep development.

AI – so far there's quite a bit of consistency in areas of discussion across groups?
TW – Jane Smithson, ThW or Commissioning Officers have been going to the meetings until now as the groups develop. Now that the strategy is drafted and dashboards are in place we expect groups to start to focus on delivery.

FK – how are you finding bringing together the partners?
JH – learning and improving, once in blueprint in terms of membership, and get more people round table, will then start to be really interesting. Lots more joining up to be done.

AI – where are we in terms of dashboards?
ThW – some gaps – some data added, domestic abuse and EH notifications with EMH as primary need. Not reported in the way we needed, so need to work with MIU to get turned round – Jane is trying to resolve but we are 90% there. SC, PH, EH send data to populate workbooks. Will be done by end April.

AI – does sound like doesn't need to be perfect before it starts.
ThW – dashboard for next meeting and this meeting will look at live data.

5. CYPP

ThW – the strategy went out yesterday. Would like approval from the board on specific areas. Hoping to finalise by end March. Coming to this group for views and approval. There was discussion in last Chairs meeting as to whether call 0-25 or children and young people. Proposal is to use children and young people.

AI – Whilst it is right that 25 represents the last point by which YP would be in touch with services, the numbers would be very low. Equally people may feel this is a strategy for everyone up to 25 years old, which is not the case.

ThW – agreement that going with CYP.

PS – I really like the strategy, it is accessible. Some of the outcome pages need to be a bit more precise – should include CSE and links between missing children and CSE – can we augment missing to include CSE?

PS – CiC very much about partnership, but looking at care leaver outcomes, requires partnership to deliver, so disappointed nothing specific for care leavers. Could you consider adding an indicator for care leavers?

FK - reads really well, indicators great. What is missing is how to promote Voice of the Child as not a specific indicator. Voice of parents and children – might need a section that's an expectation that each groups meets.

ThW – this was also raised by the Chairs group.

HB – that was important to the group – who wanted to see how we can do more

ST – regarding the police – this is totally aligned – only thing not in there is human trafficking and modern day slavery.

AK – interesting prioritisation question. Are we more concerned by volume issues or seriousness? Need to be clear if asking to develop a dashboard or saying the majority of things are happening elsewhere, through other strategies and groups.

ThW – one other thing is reliability of data – i.e. CSE – need to review indicators in 1 year, CSE may have better data then.

PS – don't want to end up with a page of statistics. Need to tell the story, but data in itself will be dry, need a creative narrative.

FK – EH Notifications re MH will be problematic to get process in place, is it the right indicator? We should consider referrals to CAMHS, not EH Notifications to CAMHS yet. Have a sub-set of them to look at main reason; also why don't have CAMHS on there?

ThW – really pleased that this was raised as we have concerns about EH notifications for mental health. We have not included CAMHS referrals as they are not an indicator of wellbeing, it's a performance measure. However I agree that is a better indicator than notifications.

SB – Mental health outcomes are useful when they pick up at crisis points. A measure of outcome about how system working, another one is domestic abuse.

ThW – Self-harm is in there for emotional wellbeing, the question is whether there is a second suitable indicator. **ACTION:** TW to speak to SB outside of the meeting.

AI – need to take the conversation re indicators offline. General sense is that it is good, but not finished yet. Clarify process by which final version gets agreed – worked on here and with LCPGs, goes to County HWB Board, internal governance in stakeholder/partner organisations, do CCGs want to look at it, we want to get choreography right. I suspect a route that says we finish it and it goes to HWBB isn't adequate, would be lovely if were as simple.

AK – several indicators in there that worth sharing with Community Safety Partnerships. Domestic violence is an issue. Swale CSP now use Repeat notifications. In terms of governance there may be a parallel environment strategy, which District Councils were asked to endorse. If this goes to HWBB we also have local HWBs that may need to get involved.

AI – further discussions about governance should take place outside of the meeting. **ACTION:** ThW to follow up with Barbara Cooper's office regarding the Environment Strategy.

MTS – remind meeting that not about creating new work for a hobby. This strategy is linked to a statutory responsibility, Section 10 Duty to Cooperate. For KCC internally the issue is as to whether KCC adopt as council policy, Peter will take this as cabinet member.

AI – further internal discussions offline. Include AK suggestion, and go to Barbara and her team to find out how model worked and utilise HWBB as key vehicle by which commissioners are engaged. To come back to content, how we get to final point, offline discussion re indicators, are we expecting to see another iteration at next meeting, or final?

TW – It will be the final version with the dashboard.

AI – opportunity for CCGs to contribute if choose to and anyone else round table. Please ensure that CSE is included to represent the level of priority that KCC and partners place upon this area.

ThW – Deadline for comments – 12th April and then specific areas for further work/discussion.

AI – thank you Thom. We've had a good long look, think reading mood is looking good and should get to something that will be really valuable and will look and read well, layout and dashboard will be valuable tools for LCPGs to work with and look through. Congratulations to you and Jane.

6. CYP HWB Standing Group for SEND

As Patrick was not present, this item has been deferred to next the meeting.

7. JSNA Update

Sam Bennett gave a presentation. **ACTION:** Stephanie to attach presentation to minutes.

AK – is all the data by home addresses not institution?
SB – yes

RG – there are a number of PH graphs which show the same picture. When you get into the worst decile they drop off from where expected, interesting to see phenomena in this scenario.

ThW – some of the challenge has been about how it gives clear direction to commissioners. Is there an equivalent that plots CCGs?
SB – yes, could be looked at.

MTS – do you think there's a link to greatest needs?
SB – yes lots of work done to counter that.

AK – worry about what's above or below the line. What would be interesting would be to take the worst decile and look at Kent and Medway – what is the place that worst decile is and do as a landmark.

SB – showed most deprived decile slide.

AI – back to questions, I support ThWs contribution. Identify at a local level to give greater understanding, trying to pick that out as opposed to presentation. Much more accessible and useful, needs more work still, data can be cut in different ways. To develop a model like this, a more traditional approach is better.

AK – fantastic piece of work – only thing around what's the narrative about this and the CYPP indicators? Need to be able to explain locally how they work together.

SB – big overlap with indicators. CYPP is a partnership piece of work and needs to be driven by agencies. Hopefully will provide what will work.

AI – feels that all are very supportive of this approach. We do need to look at ways of making it stronger. What are we going to do with it? Are we going to present different cuts of information in the same way? What is bigger plan re JSNA? Is a conversation needed with the Director of PH?

SB – he's going to meetings about next years, but what bring back to you, once approach agreed to show what can do.

AI – Very keen to support this. **ACTION:** AI to have conversation with Director of PH.

Back on agenda in a few months once worked on further.

8. AOB

Nothing raised.

Next meeting: 15th June (moved from 3rd May due to Elections).

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Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health and Wellbeing Board held on the **23rd March 2016.**

Present:

Navin Kumta – (Chairman);

Councillor Brad Bradford, Lead Member - Highways, Wellbeing and Safety, ABC;
Geoff Lymer - Deputy Cabinet Member for Adult Social Care and Public Health, KCC;
Simon Perks - Accountable Officer, CCG;
Neil Fisher - Head of Strategy and Planning, CCG;
Lisa Barclay - Head of Programme Delivery, Ashford CCG;
Martin Harvey - Patient Participation Representative (Lay Member for the CCG);
Deborah Smith - KCC Public Health;
Mark Lemon - Policy and Strategic Partnerships, KCC;
Sheila Davison - Head of Health, Parking & Community Safety, ABC;
Helen Anderson - Chair, Local Children's Partnership Group;
Caroline Harris - Voluntary Sector Representative;
Christina Fuller - Head of Cultural Services, ABC;
Louise Piper - East Kent Mental Health Commissioning Team;
Julie Blackmore - Acting Chief Executive, MIND;
James Walker - Operations Manager, MIND;
Daniel Carter - Principal Policy Planner, ABC;
Belinda King - Management Assistant, Health, Parking & Community Safety, ABC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;

Also Present:

Councillors Clokie, Galpin, Koowaree.
Annie Jeffrey - Co Chair of the Ashford Mental Health Group

Apologies:

Philip Segurola - Social Services Lead, KCC; Peter Oakford – Cabinet Member, KCC.

1. Urgency Provision

The Chairman advised that in accordance with Section 100B(4)(b) of the Local Government Act 1972 he had accepted the late inclusion of an item regarding details of local Health and Wellbeing Board activities associated with the promotion of healthy weight as a matter of urgency by reason of special circumstances, namely that the Action Plan needed to be returned to Kent Public Health within the next two weeks. This linked with the intention to undertake an Obesity Review as timetabled within the Kent HWB Work Programme 2016/17.

2. Notes of the Meeting of the Board held on the 20th January 2016

The Board agreed that the notes were a correct record.

3. Ashford Health and Wellbeing Board Priorities

3.1 Following the previous meeting when a list of indicators had been considered for Ashford in terms of its performance as compared to the comparator CCGs, for this region and England, it had been discussed at the Lead Officer Group where two priorities, namely smoking and obesity (adults and children) were agreed to be put forward for approval by the Board.

3.2 Deborah Smith advised that in both of these cases Ashford was worse than the national average and explained that a further report on this issue would be presented to the next meeting of the Board.

3.3 In response to a question, Deborah Smith said that the voluntary sector would have a huge contribution to play in terms of taking forward these priorities which she believed should be delivered in partnership.

3.4 In response to a comment, Deborah Smith also acknowledged that the public were not generally aware of the definition of obesity and the use of Body Mass Index (BMI). Caroline Harris said that if partners wished to use her as a conduit to share information with other members of the voluntary sector, she would be happy to do so.

The Board recommended:

That (i) smoking and obesity (adults and children) be agreed as priorities.
(ii) further reports be presented to the Board updating on progress for the priority areas.

4. Ashford Healthy Weight Action Plan

4.1 The report had been accepted on to the Agenda by the Chairman as a matter of urgency. The report explained that the Ashford Healthy Weight Action Plan was Ashford's local response to the Kent Healthy Weight Draft Strategy 2016-2020. The report identified local priority actions for discussion and feedback as well as an Action Plan documenting current healthy weight action by Partners. The report was an opportunity for Partners to provide support for the Ashford Healthy Weight Action Plan and, subject to any detailed feedback give authorisation to the Chairman of the Ashford HWB to present the completed Healthy Weight Action Plan i.e. the KCC template to the Kent HWB for their meeting in May 2016.

4.2 Deborah Smith advised that following consideration by the Board, it was hoped that the Healthy Weight Action Plan i.e. the completed KCC template could be presented to the Kent Health and Wellbeing Board and therefore if

there were any additional comments e.g. from the CCG and voluntary sector following the meeting, they should be submitted to her by 4th April 2016.

4.3 In response to a question, Deborah Smith explained that the data presented within the plans had been drawn from information from Public Health England. The necessary references would be included in the final document. Deborah Smith also acknowledged that reference to nutrition should be reflected in the paper and also to note that the taking of certain psychiatric medicine could lead to weight gain.

The Board recommended:

That (i) the Chairman of the Ashford HWB be authorised to present the Healthy Weight Action Plan i.e. the KCC final template to the Kent HWB subject to any further comments received from Partners by 4th April 2016.

(ii) the Healthy Action Plan and KCC template be circulated electronically to all members of the Board with a request that if they have any comments on the document, that they be sent to Deborah Smith at deborah.smith@kent.gov.uk by 4th April 2016.

5. Mental Health

5.1 Prior to consideration of the presentations, Councillor Galpin asked how mental health support would be provided to vulnerable people now that the much used and popular Live it Well Centre was set to close.

5.2 Mark Lemon explained that the services were commissioned by KCC and that following a procurement process the new contract had been won by Shaw Trust. Shaw Trust had had discussions with MCCH about how the facility can be developed and how support could be given to those providing services from the Centre. Reference was made to the complicated lease arrangements that existed in regard to the KCC owned building.

5.3 Councillor Galpin thanked Mark Lemon for the response but asked what would happen to those people who were displaced following these new arrangements. Mark Lemon undertook to raise this matter with his relevant colleagues at County Hall with a view to issuing a statement to the Board on the present situation.

5.4 Councillor Bradford advised that he had visited the Live it Well Centre recently and said that he understood that from next week the public would need to be registered to be able to use the facility. He believed the current arrangements, which included the provision of a good meal for a low price, was very worthwhile and he explained that users and staff were worried what would happen in the future.

5.5 Mr Claughton, who was the Chairman of the Ashford Access Group expressed concern at the handling of the situation by the Kent County Council and said that representatives from the Shaw Trust had not been willing to

attend meetings of the Mental Health Action Group to discuss their proposed arrangements for the use of the premises.

5.6 Annie Jeffrey read a detailed statement from the Shaw Trust which other members of the Board acknowledged was in a similar format to the version they had already seen.

Presentations

5.7 Following the meeting the presentations had been published with the Agenda for the meeting and were available on the Council's website https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=1977

(a) Mental Health Strategy

Louise Piper – East Kent Mental Health Commissioning Team gave a presentation on the Five Year Mental Health Strategy for East Kent. She explained that the strategy set out the East Kent Clinical Commissioning Groups priorities for improving the mental health outcomes for the adult population of East Kent in the next five years. The presentation also explained the six priority areas for change and it was noted that an online survey was running from 1st April to 31st May 2016, copies of which were available by emailing the following address:-

ekmentalhealth.commissioning@nhs.net

Louise Piper explained that she was scheduled to attend a number of meetings to give updates on the developing Mental Health Strategy but said that if any Partners were aware of other organisations who wished to meet with her and her team, they should contact her direct.

Following a question, and after clarification, it was noted that from 1st April 2016 a police cell was no longer considered an appropriate place to hold those experiencing a mental health crisis. Use of a police cell as a 'place of safety' for those under-18s was specifically prohibited.

Louise Piper advised that steps were being taken to identify alternative arrangements and she undertook to let members of the Board know details in due course.

Lisa Barclay commented that in terms of young people, there was a representative from the Child and Adolescent Mental Health Service (CAMHS) in all accident and emergency sites in the county. The importance of early intervention was emphasized.

Geoff Lymer commented on different approaches to mental health and outlined concerns about how support was currently provided. He undertook to make enquiries as to whether there were any examples of best practice on this issue in other parts of Europe that might be useful to the Board.

(b) Wellbeing Café

Julie Blackmore, the Acting Chief Executive of MIND and James Walker the Operations Manager gave a presentation on the work of the Ashford Wellbeing Café which operated from the Stour Centre. Julie Blackmore explained that the purpose of the café was to provide out of hours support to people experiencing mental health problems which did not require hospital admission and which could be supported by mental health support workers and volunteers. The report advised that to date 42 individuals had been supported who mostly attended regularly and there were an average of four new service users per week. Individuals had attended in the region of 300 occasions. Julie Blackmore further explained that currently the café was open on Friday and Saturday evenings and these two sessions a week were provided at a cost of approximately £52,000. To provide an additional session per week would cost a total of £78,000. She believed that the work undertaken by the café had helped the individuals who had attended and had also reduced the potential financial implications on service providers.

In terms of funding, Lisa Barclay advised that the CCG had identified funding for a further period of six months and she asked whether Board partners could assist in funding the café for the remainder of the year.

(c) Other Local Voluntary Sector Projects

Lisa Barclay explained that the CCG had funds as part of their transformation plans and intended to work with the voluntary sector on initiatives such as self-harm, providing a universal service across partners, improving crisis services; and establishing single points of access.

Recommended:

That (i) Mark Lemon seek clarification of the services to be provided at the Live It Well Centre, information on the commissioning process, and advise as to any gaps in service provision associated with the changes. Mark to arrange for a statement to be presented to the Board.

(ii) the Chief Executive of the Shaw Trust be invited to the next meeting to give an update on what would be delivered from the premises and to discuss any teething problems encountered with the new arrangements.

(iii) the statement referred to in (i) above be circulated to the Board and members of the Ashford Borough Council.

(iv) the Board consider that the Wellbeing Café should continue to be supported and requested the Lead Officer Group give consideration to potential funding for the remainder of the year and this be brought back to the next meeting of the Board.

6. Ashford Borough Council Local Plan

6.1 Daniel Carter, Principal Policy Planner, Ashford Borough Council gave a presentation which covered:-

- Local Plan to 2030
- Infrastructure Delivery Plan
- Current Community Infrastructure Levy

Daniel Carter explained that in May 2016 the draft Local Plan would be submitted to the Council for approval following which it would be subject to an eight week consultation period. It was anticipated that the public examination would be held in late 2016, early 2017 with a view to adopting the new Local Plan by Summer 2017.

6.2 In response to a question Daniel Carter explained that the Local Planning Authority's Infrastructure Plan should inform a review of the Growth Infrastructure Plan as part of that it was essential that the future needs in Ashford were known. He also advised that provision needed to be evidenced based and Partners were encouraged to ensure that they responded to the draft Local Plan and Infrastructure Plan in due course.

The Board noted the report.

7. CCG Annual Operating Plan

7.1 Enclosed with the Agenda was a draft Annual Operating Plan detailing the commissioning intentions for the forthcoming financial year. The document was a work in progress with a final submission to NHS England due on 4th April 2016.

7.2 Neil Fisher explained that this one year operating document formed Year 3 of the Five Year Plan. He indicated that the Plan represented not a change of direction but an acceleration of pace. He explained that the gaps in the document regarding constitutional standards were still subject to discussions with providers. An update on the acute provider remaining in special measures was provided and also the financial position of the CCG was highlighted. Neil Fisher undertook to supply a copy of the latest draft as of 31st March 2016. He asked that if any Partners had comments they be sent to him direct.

Recommended:

That (i) the Board formally support the current draft of the Operating Plan.

(ii) the final annual Operating Plan be shared across membership of the Board, community networks and public meetings.

8. East Kent Strategy Update

8.1 The report advised that the East Kent Strategy Board had been established by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of East Kent. The update outlined the latest developments regarding the future of local health and care services. The importance of maintaining a local focus was emphasised.

8.2 Simon Perks advised that in future it was anticipated that the East Kent Strategy Board would communicate with all stakeholders and would become a regular monthly feature.

Recommended:

That (i) the contents of the report be noted.

(ii) a copy of the monthly communication be forwarded to Partners and for distribution to Borough Councillors and the various Parish Councils within the area.

9. Kent Health and Wellbeing Board Meetings – 27th January and 16th March 2016

9.1 The Agenda contained links to the full Agenda papers for the above meetings. The Chairman explained that several of the issues covered at the above meetings had also been discussed at this meeting of the Board.

10. Partner Updates

10.1 Included with the Agenda were A4 templates submitted by Partners:-

(a) Clinical Commissioning Group (CCG)

Update noted.

(b) Kent County Council (Social Services)

Update noted.

(c) Kent County Council (Public Health)

Update noted.

(d) Ashford Borough Council

Update noted.

(e) Voluntary Sector

No update available.

Caroline Harris explained that a full update would be presented to the next meeting.

(f) Healthwatch Kent

Update noted.

(g) Ashford Local Children's Partnership Group

Update noted.

11. Forward Plan

11.1 The Chairman asked that a standard item from the Local Officers Group be produced to give an update on progress on the Board's priorities.

11.2 In addition to the items listed for the July meeting, it was noted that the Board had agreed that the Shaw Trust should be invited to the July meeting together with an update on the possible financial support for the Wellbeing Café. It was also agreed that the Kent Joint Strategic Needs Assessment be included in the Forward Plan for October 2016.

11.3 It was also suggested that Jim Kelly of the Ashford Care Providers be invited to address the Board at a future meeting.

12. Dates of Future Meetings

11.1 The next meeting would be held on 20th July 2016.

11.2 Subsequent dates:-

19th October 2016
17th January 2017

(KRF/AEH)

MINS: Ashford Health & Wellbeing Board - 23.03.16

Queries concerning these minutes? Please contact Keith Fearon:
Telephone: 01233 330564 Email: keith.fearon@ashford.gov.uk
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CANTERBURY CITY COUNCIL

CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD

Minutes of a meeting held on Wednesday, 9th March, 2016 at 6.00 pm in the Canteen, Council Offices

Present: Dr Mark Jones (Chairman)
Velia Coffey
Neil Fisher
Mr Gibbens
Councillor Howes
Steve Inett
Mark Lemon
Simon Perks
Cllr Pugh
Sari Sirkia-Weaver
Councillor P Watkins
Sam Bennett
Cllr Andrew Bowles
Wendy Jeffreys
Sarah Phillips
Cllr Simon Cook
Karen Sharp (for item 3)

1 **APOLOGIES FOR ABSENCE**
Amber Cristou
Jonathan Sexton
Cllr Sue Chandler

2 **MINUTES OF THE LAST MEETING, ACTIONS AND MATTERS ARISING**
The minutes of the meeting were agreed as an accurate record.

Actions from the previous meetings:
Actions outstanding from 12 November 2015
Item 2. Faiza Khan and Velia Coffey to meet with Amber Cristou and Cllr Sue Chandler to discuss who should be responsible for Health and Wellbeing Strategy priorities in Dover and Swale. *This has been passed to Sam Bennett to follow up*.
A meeting has been arranged and the outcome reported at the next meeting.

Actions from 19 January 2016
Item 3 Meeting between Canterbury City Council planning and Canterbury and Coastal CCG to be arranged.
Complete.

Item 4 Samantha Bennett to review the Draft Obesity Framework with the Joint Commissioning Delivery Steering Group to identify work that is already in progress on obesity and assess where focus can be brought. Details to be brought to the core group. There is an item on this agenda.

Item 6 Simon Perks to advise what information can be shared with the Health and Wellbeing Board from the East Kent Health and Social Care Strategy Board.
This has been raised with the programme director regarding engagement and a monthly report will be shared with the HWBs.

Item 8 Sari Sirkia-Weaver to make contact with the Chairs of neighbouring LCPGs and bring a joint report back to the HWB.
A meeting is due to be held on 10 March.

3 **PUBLIC HEALTH SERVICES TRANSFORMATION - KAREN SHARP**

Karen Sharp gave a presentation regarding progress with the Transformation Programme and gave an update on some of the outcomes.

The consultation process was highlighted and some of the results of the research was presented regarding the importance of patterns of behaviour, motivations and the importance of a holistic approach rather than addressing single problems.

It was noted that many of the services are due to be re-procured therefore what is commissioned needs to fit with the new structures in providers and with other organisations such as local councils. Therefore the recommendation will be not to re-procure until this can be further aligned.

The Board agreed that this was a really positive approach and the focus on changing behaviours was welcomed by the Board as was the decision not to procure immediately.

Concern was raised that mental health provision for young people stops at 19 and there may be a gap for 19-25s with regard to mental health.

It was reported that Northgate Ward are running a pilot with a Health Trainer in the medical practice. Their caseload is determined using GP lists to target specific preventative care to high risk patients.

4 **STRATEGY AND PRIORITIES FOR CANTERBURY. - SAM BENNETT**

Samantha Bennett reported that at the previous meeting the Board had agreed reporting on priorities on a rolling programme of 2 priorities per meeting. The Core Group had since narrowed the priorities to obesity and alcohol as these had been identified as being the ones where partnership working could have the most impact and therefore these two will be focussed on.

It was noted that Making Every Contact Count should be used to reinforce messages and this can be cross cutting across all the priorities.

Alcohol

Velia Coffey advised that responsibility for actions around this had been delegated to the Community Safety Partnership (CSP) who had been working with the Clinical Commissioning Group (CCG) and Public Health. It was noted that the high student population in Canterbury is not relevant as the anomalously high admissions were by children. This is being further investigated by the Local Children's Partnership Group.

It was noted that the CSP have been working with enforcement teams and specific operations have been undertaken with the police and trading standards targeting premises selling to those underage, groups of street drinkers etc in both Canterbury and Herne Bay. There has been good collaboration with the night time economy in Canterbury.

A query was raised as to whether age ranges for admissions had been broken down further and whether it was for example, 15/16 or 8/9 year olds. It was reported that numbers are small, ages are known and it is known which wards they live in. Samantha Bennett advised that she has looked at A&E data to establish the reason for their admission but the data is not detailed enough and since the numbers are very small it makes it difficult to identify which injuries are alcohol related. Also it cannot be identified whether it is the same small number of children re-presenting or whether it is new cases each time. Work is being done to improve the recording of alcohol as an underlying cause for admission.

Obesity

The obesity framework has been used to list all the activities across organisations regarding obesity and has identified that there is already a lot of work being undertaken around this.

Obesity in year 6 school children is of concern. Wendy Jeffreys advised that she has met with Kent Community Health NHS Foundation Trust, Canterbury City Council and local children's centres to look at the activities available for children and has also identified schools with a spike in obesity levels to help them learn from what other schools are doing around tackling obesity.

It was agreed that schools needed to be fully engaged for the work on both alcohol misuse and obesity whilst recognising that they have limited resources to commit to these issues specifically.

Sari Sirkia-Weaver reported that a representative of the Healthy Weight Team sits on the Local Children's Partnership Group (LCPG) and has commented that it is difficult to get children to come along to healthy weight meetings and there is a need to encourage parents to bring their children. Once the children are attending the success rate is very high. Again, a focus on Making Every Contact Count and giving a consistent message would improve take up rates for healthy weight groups.

Samantha Bennett advised that the report on tackling obesity will be circulated when it's complete and will go to the Kent Health and Wellbeing Board (HWB).

It was agreed that this work would be led by the Local Children's Partnership Group and would be brought to the next HWB Core Group meeting and the next HWB meeting.

5 **2016/17 PLANNING ROUND UPDATE- NEIL FISHER**

Neil Fisher gave an update and advised that there are two plans being produced by the CCG, one for the next 12 months and a five year strategic review.

The 12 month plan is due on the 4th April 2016 and feedback has already been received on the first draft. The report will be circulated before it is submitted on 4 April.

KCC have concern over the one year sustainability plans and the fact that the plan will include Medway, not just Kent. It is expected that the Medway Maritime Hospital will require significant resources and this could have an impact on the rest of Kent.

6 **EAST KENT HEALTH AND SOCIAL CARE STRATEGY BOARD UPDATE - SIMON PERKS**

It was noted that the Board will produce regular updates for stakeholders to increase transparency.

It was noted that a good outline for the plan needs to be produced by June in order to get access to Sustainability and Transformation funding. This plan must now include Medway as well as Kent and there is a risk that some of the initial work that had gone into a Kent plan will be lost.

Sarah Phillips advised that the Programme content has only recently been developed and NHS England have given some indications of the topics. It is clinically led and the Clinical Forum will have a number of sub groups centred around prevention and self care. Each group will follow a similar format and produce an aspirational view on each workstream.

Concern was raised that the HWB had not been consulted or involved in this plan and a request was made for a joint members briefing for all Councillors in the CCG area before it is made public. It was stressed that stakeholders must feel that they have been consulted and welcomed this whilst noting that a planning framework needs to be in place first.

7 **LGA DEVELOPMENT DAY**

Mark Jones advised that Kate Herbert from the LGA had met with the Core Group and with Mark Lemon and agreed an away half day. There will be an initial stocktake questionnaire circulated to all Board members which will be used as a starting point for the Development Day. The session will be used to scope some possibilities for the future role of the board.

Mark Jones stressed the need for all Board members to participate and be available for the Development Day if at all possible.

8 **MENTAL HEALTH ACTION GROUP REPORT - NEIL FISHER**

Comments and questions were invited.

9 **LOCAL CHILDREN'S PARTNERSHIP GROUP UPDATE - SARI SIRKIA WEAVER** Sari Sirkia-Weaver drew attention to the work being done by the obesity group and alcohol misuse group. It was also noted that Canterbury has been chosen as a pilot for young people aged 16-24 not in education, employment or training (NEETS) group

10 **ANY OTHER BUSINESS**

Mark Jones advised that this is the last time he will chair the Board as he is standing down as Clinical Chair of the CCG. Dr Sarah Phillips will take over as Clinical Chair and the Board was asked for their opinion on her taking on the chair of this Board. Sarah Phillips was duly appointed as Chair for future meetings. The

Board thanked Mark Jones for all his work.

11 **DATE OF NEXT MEETING**

10 May 2016,18.00, Canteen at Canterbury City Council Offices.

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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 6 April 2016.

PRESENT: Councillor Mrs Ann D Allen MBE (in the Chair)
Councillor Tony Searles
Councillor David Turner

Debbie Stock

Sheri Green
Stuart Collins
Sarah Kilkie

Cecilia Yardley

ALSO PRESENT: Adam Green, Stephanie Holt, Val Miller Tracy Schneider, and Karen Sharp

68. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Roger Gough, Dr Elizabeth Lunt, Graham Harris, Anne Tidmarsh, Andrew Scott - Clark, Melanie Norris, Lesley Bowles, Dr Su Xavier, and Tristan Godfrey.

In the absence of the Chairman, Councillor Gough, it was agreed that Councillor Ann Allen should Chair the meeting.

69. DECLARATIONS OF INTEREST

There were no declarations received.

70. MINUTES

The Minutes of the meeting of the Board held on 24 February 2016 were agreed as a correct record of that meeting.

71. KENT COUNTY COUNCIL HEALTH AND WELLBEING BOARD

It was noted that the Chairman, Councillor Gough nor any other Member who had attended the Kent Health and Wellbeing Board meeting, were present at this meeting of our Board.

Accordingly, it was agreed that consideration of the minutes of the Kent Health and Wellbeing Board held on 16 March 2016 be noted without discussion.

72. URGENT ITEMS

It was noted that there were no urgent items for the Board to consider.

73. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS

The Board received a report on work issues which were outstanding from previous meetings and noted that a number had been added to the Board's work plan.

Arising from this it was noted that the request for funding from the Violence Reduction Initiative in Dartford and Gravesham had been drawn to the attention of local Community Safety Partnership for consideration and that should funding be withdrawn from the Initiative, Community Safety Partnerships would look provide funding for this.

74. UPDATE ON PUBLIC COMMISSIONING PROGRAMMES

At the meeting of the Board held on 7 October 2015 Karen Sharp, Head of Commissioning, Public Health, reported on a new direction being undertaken in Public Health Commissioning in Kent, which involved a move away from the currently favoured multi track individual specialist treatment approach to an holistic approach where more generically trained staff provided the necessary support and counselling services.

Following on from that report the Board received an update from Ms Sharp on the progress of the reviews being undertaken into the services which were commissioned from the Public Health Grant.

The Board noted that the services under review were

- Services for children, including the Health Visiting service,
- School Public Health (school nursing) service; and,
- Core public health programmes for adults, including healthy weight, health trainers and smoking cessation services.

It was reported that a number of consultation events and assessments had taken place in the past few months with stakeholders and that currently the tendering of all these services had been halted to allow for reviews of resources and further consultation between with Kent County Council, providers and partners

The Board agreed to note the progress made.

75. KENT ALCOHOL STRATEGY: UPDATE

The Board received reports on the Kent Alcohol Strategy, which was launched in April 2014 and the progress which has been achieved in its implementation

across Kent to far, together with an update on the progress of the Strategy in the Board area.

Val Miller provided an update on the Kent wide strategy, on behalf of Linda Smith, KCC public health, and highlighted the following headline issues

- The introduction of multi - agency alcohol plans in all districts in Kent
- The falling trend for alcohol related hospital admissions amongst under 18 year olds
- The growth in alcohol advice being given to Kent residents by trained professionals
- Significant improvements in the quality of alcohol related services resulting from progress in commissioning strategies, policy developments, data sharing agreements between health commissioning bodies and service providers for individuals with both mental health and substance misuse issues.
- The introduction of “Know Your Score” in January 2016.
- Acknowledgement of the work of Kent Community Alcohol Partnerships by ministerial visits to relevant areas in north Kent.
- The inclusion of alcohol screening in several public Health commissioning contracts.
- The introduction of development of alcohol care pathways and the inclusion of health related data into the licensing process into the work programme for this year.

Additionally Adam Green provided a detailed verbal report on the work undertaken by the commissioned providerhis Company dealing with Alcohol related issues in the Board area.

Having noted the information provided and the verbal report from Mr Green the Board agreed to receive a final report on the Alcohol Strategy in 12 months - time.

76. DEMENTIA FRIENDLY COMMUNITY AUDITS: RESULTS AND ANALYSIS

Tracy Schneider, reported on the progress made by the Dementia Friendly Communities programme which has been operating since May 2013, together with an update on a recent workshop event held at Longfield Academy.

The Board was informed that three smaller forums have been established:- Swanley and the Northern parishes, Dartford, and Gravesham to consider matters on a more local level and the following work has been undertaken..

Swanley and Northern Parishes: There have been two smaller open information events in Swanley, one at the Orchards academy and one in the Town Council rooms. Awareness raising and environment have been a large focus in this area and a 3rd event will be held this May in Hextable during dementia awareness week..

Dartford: An awareness event was held at Temple Hill in 2015 and events are planned for dementia awareness week. Front Line staff from Dartford Borough Council had attended dementia awareness training sessions. Alterations have been made to the Town Centre Shop Safe scheme to open it to those with dementia, and the scheme will now become a Shop Safe - Stay Safe scheme.

Gravesham: Gravesham has adopted the Dartford Shop Safe - Stay Safe Scheme and now work in Gravesham is looking at encouraging a dementia friendly shopping centre and High Street. Local schools have also been involved in the dementia work.

The event at Longfield Academy sought to inform local residents regarding Dementia and how it manifested itself, what help was available, and how to deal with specific issues.

The Board thanked Ms Schneider for her presentation and noted the contents of the reports.

77. DEMENTIA CARE PATHWAY AND PERFORMANCE INDICATORS

The Board received a report which provided an overview of the range of initiatives which are currently underway across Dartford, Gravesham and Swanley to help improve access to a timely diagnosis of dementia and to ensure that people affected by dementia, both patients and carers are supported to live well with dementia and avoid unnecessary crisis events.

The report also outlined an initiative that was in progress to develop a dementia/cognitive impairment community hub, which it was hoped, would provide an excellent opportunity for partnership working between health and the voluntary sector to deliver an integrated, local community service to make sure the right services are in place for the local population.

It was noted that there were currently some concerns amongst the voluntary sector regarding the fragmentation of services for those with dementia and the high levels of “churn” amongst social service staff making continuity of care somewhat difficult.

The Board noted the report.

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

The Board was informed that the Kent Health and Wellbeing Board had recently received a report which provided an overview of the recently launched Kent and Medway Growth and Infrastructure Framework (GIF), and an associated action plan.

The GIF was developed in response to the growing pressure on local authorities to deliver housing and economic growth and the necessity to provide improvements and additions to physical and social infrastructure to support the growth.

The Report sought to obtain the Kent Board's input to the development of the GIF, with a view to strengthening particularly the health and social care infrastructure evidence base and using it to help shape health infrastructure provision to support housing growth.

The Kent Board recognised, amongst other things, that a sound statistical base was required to allow for informed plans to be formulated and decisions to be taken.

Accordingly our Board received a presentation and report on the GIF and the progress in its implementation from Ms Stephanie Holt, Head of Countryside Leisure and Sport Group of KCC Planning and Enforcement.

It was noted that Mrs Stock was currently working with KCC to ensure that robust accurate data was being provided by the CCG to help with the formulation of the GIF, but that other data sources were required.

Accordingly it was suggested that liaison with planning policy officers from each of the three constituent local authorities would be beneficial and that the help of the CCG Local Estates Forum could be elicited.

The Chairman thanked Ms Holt for her report and presentation and the Board agreed to note the content of each.

79. OBESITY UPDATE

A brief update on the work of the Obesity initiative was given to the Board by Val Miller, together with the latest version of the Obesity Plan Mapping Template.

Ms Miller reported that the Obesity Plan Mapping Template was now largely complete but that the follow areas required further attention.

- Social Care data – further consultation with care providers was necessary

- Kent County Council Public Health involvement – Input from Andrew Scott – Clarke was required

- The impact of Type II Diabetes needed to be added to the Template.

The Board noted the Template and the work undertaken so far.

80. MEMBER AVAILABILITY FOR A BOARD MEETING IN AUGUST.

Following enquiries regarding the availability of Members to attend the scheduled Board meeting on 10 August 2016, it became apparent that a significant number of the Board could not attend on that date.

It was therefore agreed that Board Members be canvassed to ascertain their availability on either the 3rd or 17th of August 2016 to allow the meeting to be re arranged.

81. INFORMATION EXCHANGE

There was no information for dissemination to other Members.

82. BOARD WORK PROGRAMME

The Board received and noted the schedule of work programmed to be considered at its meetings in the current year together with a list of items still to be scheduled.

It was also agreed that consideration of the Local Childrens' Partnership Groups be asked to consider the Kent Teenaged Pregnancy Strategy in the course of its work monitoring delivery of the Childrens and Young People's Plan.

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 26 January 2016 at 3.00 pm.

Present:

Chairman:	Councillor P A Watkins
Members:	Councillor P M Beresford Ms K Benbow Councillor S S Chandler Dr J Chaudhuri Ms C Fox Councillor J Hollingsbee Mr S Inett Councillor M Lyons Councillor G Lymer Ms J Mookherjee
Also Present:	Ms K Sharp (Kent Public Health) Mr M Lemon (Kent County Council) Ms J Leney (Shepway District Council)
Officers:	Head of Leadership Support Team Leader – Democratic Support

37 APOLOGIES

An apology for absence was received from Mr M Lobban (Kent County Council).

38 APPOINTMENT OF SUBSTITUTE MEMBERS

There were no substitute members appointed.

The Board noted that Mr S Inett had replaced Ms T Oliver as the Healthwatch Kent representative on the South Kent Coast Health and Wellbeing Board since the publication of the agenda.

39 DECLARATIONS OF INTEREST

There were no declarations of interest made by Members of the Board.

40 MINUTES

It was agreed that the Minutes of the Board meeting held on 24 November 2015 be approved as a correct record and signed by the Chairman.

41 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

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

42 PUBLIC HEALTH PROGRAMMES

The Board received a presentation from Ms K Sharp (Head of Commissioning Public Health) on the transformation programme for services commissioned by Public Health.

The drivers for change in the commissioning of public health services were:

- NHS Five Year Forward View (calling for a radical upgrade in prevention);
- Health and Wellbeing Board Priorities (calling for a radical upgrade in prevention);
- Care Act (a responsibility to provide services that prevent the escalation of care needs);
- Demographics (a growing, ageing and diversifying population);
- Health Inequalities;
- Improving Healthy Life Expectancy; and
- Financial and Contractual (reduction in grant in 2015/16)

The services commissioned from the Public Health grant were:

- Services for children, including the Health Visiting service;
- School Nursing service; and
- Core public health programmes for adults (healthy weight, health trainers and smoking cessation services).

The outcomes were judged against the Starting Well, Living Well and Ageing Well objectives.

It was recognised that the current approach was not achieving the desired improvements in respect of health inequalities and there was a need for radical change. This included recognition that unhealthy habits reinforced each other and that to achieve real change services needed to focus on multiple unhealthy habits and the value of early childhood intervention to foster good habits.

The Board was advised that consultation and engagement had identified a number of key issues and local priorities that would be addressed through the revised service models and approaches. The need for new models of communication to reach both targeted groups and the wider public was discussed, including utilising opportunities through social media.

The timeline for the transformation programme was to transition to the new service models from April 2016 onwards following engagement and consultation (March and September 2015) and the development of revised models of procurement (October 2015 to April 2016).

In response to a question from Councillor P A Watkins, the Board was advised that discussions were ongoing between the South Kent Coast Clinical Commissioning Group and Public Health on the co-design of community nursing services to better integration with primary care providers.

There was concern expressed over the lack of awareness in schools of the school nursing service and the importance of both physical and mental health being covered was emphasised.

The need to integrate the work of voluntary and community sector agencies, which were often not in receipt of public funding, into wider public health provision in a co-ordinated way was raised.

RESOLVED: (a) That the presentation and the work undertaken be noted.

(b) That the recommendations for future delivery be noted.

(c) That the involvement of the South Kent Coast Clinical Commissioning Group in the procurement process be noted.

43 DELIVERING THE FORWARD VIEW: NHS PLANNING GUIDANCE 2016/17 - 2020/21

The Board received a presentation from Ms K Benbow (Chief Operating Officer, South Kent Coast Clinical Commissioning Group) on delivering the NHS Forward View.

The NHS Forward View set 3 essential tasks for NHS England in delivering it:

- Continuing to implement the 5 Year Forward View;
- Restoring and maintaining financial balance; and
- Delivering core access and quality standards for patients

As a result of this, the South Kent Coast Clinical Commissioning Group was required to produce the following plans:

- A 5 Year Sustainability and Transformation Plan (STP) to implement the 5 Year Forward View in the South Kent Coast area, based upon better integration with local authorities (and particularly prevention and social care) and focused on local populations rather than individual organisations; and

- A 1 Year Operation Plan for 2016/17 (OP) which supported the delivery of a high quality STP.

The Board was advised that the STP was an ‘umbrella plan’ with a number of specific delivery plans beneath it and was required to cover all areas of primary care commissioning by NHS England and South Kent Coast Clinical Commissioning Group. The STP had to be submitted to NHS England by the end of June 2016 for approval and there would be funding available from 2017/18 onwards to support the STP.

The deadline for the submission of the draft Operational Plan was 8 February 2016 with the deadline for the submission of the final Plan on 11 April 2016. There were 9 key elements to the Operational Plan:

- That it developed a high quality STP with critical milestones designed to accelerate the delivery of the 5 Year Forward View;
- That the system be returned to aggregate financial balance (the CCG was meeting this target but East Kent Hospitals University NHS Foundation Trust was not) with a focus on efficiency, productivity and unwarranted variation in the demand for health care;

- The development of a local plan for the sustainability and quality of general practice;
- Ensure the delivery of Accident and Emergency and ambulance targets;
- Ensure the delivery of referral to treatment time target;
- Deliver the 62 day treatment target for cancer;
- Achieve and maintain 2 new mental health access standards and achieve a dementia diagnosis rate of at least 67% (currently 62%);
- Transform care for people with learning disabilities (working with Kent County Council); and
- Implement an affordable plan to make improvements in quality and require providers participate in annual publication of avoidable mortality rates.

There were also a number of targets relating to 7 day service provision for acute hospital services (25% of the population would have access to services that were compliant with 4 priority clinical standards) and enhanced primary care services (20% of the population would have access) by March 2017 with the intention of improving ease of access to services and reducing deaths by increasing primary care and consultant cover and access to diagnostic services at weekends.

The Board was advised that as the Operational Plan built on existing work being undertaken by the South Kent Coast Clinical Commissioning Group, engagement with the community and stakeholders had already been considered.

In response to a question from Councillor P A Watkins, Mr M Lemon (Kent County Council) advised that the transformation of social care services was needed as part of the NHS Forward View and to achieve the required financial savings.

The Board discussed the issues affecting the recruitment of new doctors and nurses and the importance of work force planning at both primary care and the hospital trust level in ensuring there were sufficient resources to deliver the plans.

RESOLVED: That the presentation be noted.

44 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 4.46 pm.

DRAFT MINUTES

Health and Wellbeing Board – Formal Meeting

Meeting held on Wednesday 27 January 2016 10am

Assembly Room, Swale House, East Street, Sittingbourne, ME10 3HT

Present	**Cllr Andrew Bowles (AB), *Leader, SBC (Chair)*** **Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC*** **Abdool Kara (AK), *Chief Executive, SBC*** **Amber Christou (AC), *Head of Residential Services, SBC*** **Cllr John Wright (JW), *Cabinet Member for Housing and Lead Member for Health, SBC*** **Bill Ronan (BR), *KCC*** **Dr Fiona Armstrong (FA), *Chair, Swale CCG*** **Mark Lemon (ML), *Strategic Relationships Advisor, KCC*** **Kate Herbert (KH), *LGA***	**Julie Blackmore (JBL), *Maidstone Mind*** **Sarah Porter (SP), *Policy and Performance, SBC*** **Ally Hiscox (AHi), *Deputy Chief Operating Officer, Swale CCG*** **Karen Sharp (KS), *Head of Public Health Commissioning, KCC*** **Terry Hall (TH), *Public Health, KCC*** **Becky Walker (BW), *Strategic Housing and Health Manager, SBC Housing*** **Cllr Sarah Aldridge (SA), Swale BC** **Jane Barnes (JB), Assistant Director-Older People and Physical Disability, *KCC***
Apologies	**Patricia Davies (PD), *Accountable Officer, Swale CCG*** **Chris White (CW), *Swale CVS*** **Su Xavier (SX), *Swale CCG*** **Helen Stewart (HS), *Kent Healthwatch*** **Tristan Godfrey (TG), *Policy Manager, KCC***	**Alan Heyes (AH), *Community Engagement Lead, Mental Health Matters*** **Cllr Penny Cole (PC), *Deputy Cabinet Member Adult Social Care & Public Health, KCC*** **Cllr Roger Gough (RG), *Cabinet Member Education and Health Reform, KCC***

NO	ITEM	ACTION
1.	**Introductions**	
1.1	AB welcomed attendees to the meeting.	
1.2	All attendees introduced themselves, and apologies were noted.	
2.	**Minutes from Last Meeting**	
2.1	The minutes from the previous meeting were approved.	
2.2	Matters arising: ▪ P.2, 2.2: AK provided an update; LCPG is now up and running with Alan Bayford as chair. ▪ P.3, 6.1: AC provided update: Cllr Pugh attended September Kent H&WB and raised Swale's concerns; further follow up at the Swale H&WB workshop held in November.	

DRAFT MINUTES

	▪ P.4, 7.1: RW advised that Planning are aware that Health need to be a consultee, and contact details have been shared. ▪ P.4, 7.3: AC advised that two multi-agency prison release meetings have been held, and a protocol drawn up. There are plans to formalise a strategic overview, particularly in regard to changes at Elmley. ▪ P.4, 7.3: AK advised no cuts to front line services for 2016/17.	
3.	**Review from the LGA workshop**	
3.1	KH presented a Next-Steps refresher on Swale's H&WB workshop held November 2015. ▪ Reminder of the five LGA self-assessment tool statements provided. (i) Visions and ambition – agreed that the meetings are well managed and the board is ambitious, with partners agreeing the 'big ticket' items, do require narrative for change. (ii) System leadership and partnership working – ability to influence already evident, but a sense this could be improved and requirement to align to others' strategies and plans. (iii) Delivery and impact – outcomes impact are good, although JSNA data should be used. (iv) Communication and engagement – need to increase public engagement, and methods of gathering views require improvement. (v) Integration system redesign – require more emphasis on prioritisation and prevention, along with maximum value for money across all partners. ▪ The key message focuses on the importance of not underestimating the time required for joint working and improving relationships, and how we can collectively improve jointly determined outcomes through a problem-solving approach.	
3.2	Points made in the discussion included: ▪ a supportive approach which recognises all that is going on across the Borough to improve the health and wellbeing of residents and to enable self-responsibility can be taken forward through an effective problem solving operational group; ▪ there is a need to understand from KCC the minimum required to fulfil Local Board requirements, whilst enabling a thematic outcomes-focus of an operational group; ▪ the chair of the DGS H&WB has suggested a merger with Swale H&WB; ▪ there are critical issues unique to Swale – so any merger would need to be designed to enable these to be identified and prioritised; and ▪ the strategic role can line up with the expectations of County, whilst an operational group can focus on Swale issues.	

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4.	**Discussion on options and next steps**	
4.1	ML provided an update following on from the KCC H&WB paper of September 2015. ▪ The paper sets out the local H&WB requirements, although there is no prescribed method for delivery. ▪ A merger between the H&WBs of Swale and DGS has been mooted, subject to discussions with DGS. ▪ A local solution-focused group will provide a forum to move Swale's local issues forward.	
4.2	Points made in the discussion included: ▪ the lack of commissioning powers and different footprints has led to an ineffective Swale board. However, it was pointed out that some LHWBBs are starting to take on some commissioning powers; ▪ the workshop in November provided a way forward with the suggestion of a thematic based operational group which can be established. This needs to be worked up further to set out who will sit on the group and what this means for the LHWBB; ▪ an annual meeting/workshop could set the programme of priorities, and the thematic operational group could then take these forward; ▪ Thanet and South Coast are looking at a joint commissioning board, particularly due to the many changes ahead and the new models of care being implemented; ▪ agreed that an annual board meeting or workshop should be established to agree to the priorities, and each operational meeting should be thematic-based, and the approach reviewed at the end of 2016/17; ▪ discussions regarding the Swale and DGS merger need to be taken forward through a meeting with Cllr Gough, Swale and DGS CCG, Cllr Bowels, Cllr Pugh, Abdool Kara, and Amber Christou; ▪ establish what the DGS secretariat arrangements are; and ▪ operational group meetings should be established, the themes/priority suggestions should be emailed to group members.	**AC** **AC** **RW** **AC**
5.	**Public Health Programmes**	
5.1	Care Act implementation and integration (verbal update) unavailable - agreed to defer and Public Health Programmes presentation provided.	
5.2	KS provided an update as follows: ▪ requirement for efficiency due to proposed 10% cut in funding 2016/17; ▪ key question around accessibility of services in Swale and whether they are set against need; ▪ children and young people focus groups established a need to look at adolescents, the purpose of the health visiting service, and aligning services with local priorities;	

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	▪ adult health improvement consultation discovered that the public desire a realignment of services in areas where there are high health inequalities; ▪ recognition that unhealthy habits substitute for one another - therefore move towards a 'dual diagnosis' model with integrated service provision; and ▪ a procurement strategy for integrated services is the next step.	
5.3	Points made in the discussion included: ▪ LCPG can ensure the most appropriate representation from SBC prior to any commissioning; and ▪ requirement for increase in counselling services across Swale.	
6.	**Kent Health and Wellbeing Board**	
6.1	KP, PD, and FA to attend KCC Board. No specific issues or comments to take forward.	
7.	**Partners Update / AOB – verbal update**	
7.1	**Healthwatch (**RW gave update provided by HS) ▪ Public voice events held in Swale in January. ▪ Visiting two hard-to-reach groups in January to get feedback on local issues. ▪ Next mental health project has been approved, focusing on out-of-area placements, repatriation process, and length of stay. ▪ Kent-wide PPG project nearing completion - this is linked in with local work in Swale. ▪ Project on patient choice under discussion. ▪ Discharge 'Home to Assess' project and current review / development (social services).	
7.2	**Swale BC** ▪ Completed purchase of third property for use as temporary accommodation. ▪ Marmot indicators 2015 are Kent-wide and not reflective of Swale's issues. Public Health will look to localise these. ▪ CCG and Virgin have been invited to deliver a presentation to Members. ▪ Local Plan examination letter due imminently, with an increased number of homes required in Swale. The increase in population will impact on health care provision requirements. ▪ Spirit of Sittingbourne has reached agreement with a cinema provider. ▪ Devolution negations currently ongoing. Kent CC have suggested a focus on health and social care. North Kent are looking at a focus on growth and regeneration. ▪ 2016/17 budget agreed no major impacts.	**TH**

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7.3	**Swale CCG** ▪ NHS CCG planning guidance to develop a sustainability and transformation plan over the next five years. ▪ Seasonal pressures over the Christmas and New Year period were well managed. ▪ Industrial action currently planned for 10 February – plans are in place. ▪ Virgin Care successful in the services review tender for Memorial and Sheppey Hospital. ▪ Urgent care review underway after a pause. ▪ NHS England agreed that CCG can take delegated commissioning of some GP services. ▪ The diabetes programme across Kent, Surrey and Sussex want to work with Swale CCG.	
7.4	**KCC – Learning Disabilities and Mental Health** ▪ Stakeholder workshop on 28 January looking at 'Home to Assess'. ▪ Blackburn Lodge – currently reviewing the plan with no change due over next two to three years.	
Next meeting date: TBC		
Future Meetings Dates **TBC**		

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THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 24 March 2016 at 10.00 am in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Clive Hart (Thanet Clinical Commissioning Group), Mark Lobban (Kent County Council), Sharon McLaughlin (Thanet Children's Committee) and Linda Smith (Kent County Council)

In Attendance: Val Miller, Public Health Specialist for Healthy Weight, KCC and Kallie Heyburn, Head of Strategic Planning and Commissioning, Thanet CCG

16. APOLOGIES FOR ABSENCE

Apologies were received from the following Board members:

Colin Thompson, substituted by Linda Smith;
Councillor Gibbens;
Councillor Wells;
Councillor L. Fairbrass;
Madeline Homer, substituted by Penny Button;
Hazel Carpenter.

17. DECLARATION OF INTERESTS

There were no declarations of interest made at the meeting.

18. MINUTES OF THE PREVIOUS MEETING

The minutes were agreed as a correct record of the meeting that was held on 21 January 2016.

19. THANET HEALTHY WEIGHT ACTION PLAN

Val Miller, Public Health Specialist for Healthy Weight, KCC led discussion with a presentation to the Board. She said that the Action Plan was still work in progress and that it was an iterative process as officers were still collating information from partner agencies including KCC. Adult excess weight was prevalent in the county, with two thirds of adult population viewed as being obese. Prevalence of obesity in Year 6 school children was observed as well.

The Board was concerned about children leaving primary school overweight. It was reported that other Health and Wellbeing Boards were working on similar issues using the same action plan template across Kent. The causes of obesity were shared in the 2007 Foresight Report's 108 factors that included genetics, exercise, environment, diet and psychology.

Val Miller said that it was important for organisations to start thinking about workforce development to help address this significant health issue. Providing training to frontline staff to pass on the message on healthy weight would build the confidence of staff to engage residents and raise issues about obesity when providing them with services. It was also essential that adequate resources would need to be commissioned to provide services for weight loss to individuals who require such services.

Concerns were raised about the BME and disability groups being under represented at forums were these issues were debated. There was a need for joined up working and for the Board to use its influence to identify sources of funding that could be shared and accessed for weight loss services.

Communication across agencies was key in order to share information on what different agencies were doing in addressing this health issue. Having an influence over planning, licensing, leisure and environmental services would also help fight obesity for the local communities. Children in the age group 11-19 years did not have as much services to help them with overweight problems. There was a need to consider early health notification and child protection issues when dealing with overweight children. There was a key role to be played by the media, elected Members, local role models and campaigns. It was observed that the sugar tax recently introduced was a step in the right direction by government.

Members suggested that this action plan on healthy weight be made part of the Thanet Health & Wellbeing Board agenda. This plan could include working with schools and nurseries programmes that promote healthy weight for children as well as the diversionary activities by the Justice system that work with children that were picked off streets. It was important to be aware that children from deprived areas and families were more vulnerable and susceptible to obesity problems.

The interventions should therefore aim to reach out to these marginalised individuals and families. Identifying health champions in partner agencies' staff would also be a good start. Attention should be given to creating play spaces when decisions are made by the Council's planning department. Parks and cliff walks should also be promoted. These efforts could be supplemented by sending out subtle messages like promoting smoke free homes for families. The Board should ask difficult questions that would help progress the agenda for healthy weight. This could include challenging the services that were being provided by vending machines in work places, leisure centre leasing conditions and the general food marketing approaches by organisations.

The Board noted the presentation.

20. INTEGRATED COMMISSIONING AND ALIGNMENT

Kallie Heyburn, Head of Strategic Planning and Commissioning, Thanet CCG made a presentation to the meeting. She said that the proposed approach of integrated commissioning and outcomes based commissioning would provide seamless services to patients. A workshop was held on 3 March 2016 with members of the Integrated Commissioning Group together with clinical leads, commissioning manager and chairs of the Local Partnership Groups to start mapping out the services that were currently being offered. The finance picture would need to be clearly identified in order to quantify the efficiency savings whilst improving services being offered. It was hoped that the proposed plan would be implemented in 2017/18.

Board members said that the proposed integrated working should be put at the centre of activities of the partner agencies that are working towards integrated commissioning of health and social care services. There are a number of organisational challenges that would need to be overcome in order to achieve full integration by 2020. These included the current budgetary constraints, budget deficit and efficiency savings.

The other significant challenge is for the integrated commissioning group to establish a new model of integrated working. This would include rewording the terms of reference of the group and bring together the appropriate commissioners to this debate and work out the governance issues leading to an agreed change model that cuts across sectoral interest barriers.

Board members agreed that it would be helpful for the Away Day session that has been planned for early May 2016, be used to develop the Board further and bring in the right professionals to sit on it. This would help ensure that governance arrangements for the commissioning group are set out appropriately in order to move forward the agenda for integrated commissioning.

Some of the questions that would need to be considered are: 'are we seeking to identify a model for service delivery or just to identify the outcomes? Do we want to commission the outcomes or just the model? It was important for the commissioning leadership to identify the model of care and its functionality. What would be the roles and responsibilities between the strategic commissioners and the people who are accountable for the new organisation?'

Members noted the presentation.

21. VERBAL UPDATE ON HEALTH INEQUALITIES IN THANET

Linda Smith, Public Health Specialist for Thanet, KCC introduced the item for discussion.

Thanet Health Inequalities profile
KCC Public Health is taking a new approach to reducing health inequalities in the county, by producing focussed analysis of the most deprived areas. Multivariate segmentation techniques have been used to identify different 'types' of deprivation affecting communities in Thanet:

- Young people lacking opportunities;
- Families in social housing;
- Young people in poor quality housing.

The Health Inequalities Group has met twice and work is underway to develop a Thanet Plan based on these revised Public Health Locality Profiles.

Thanet Child Health Profile
Highlighted for discussions were areas of improvement such as the teenage pregnancy rate in Thanet is at its lowest since records began in 2001. Alcohol-related hospital admissions for those under 18 years are also declining.

The 0-19 year population is set to increase by 3% over the next five years equating to 1000 additional young people in the area by 2020. Wards with relatively high levels of child poverty (50%) are some of the poorest in Kent.

Education attainment and unauthorised absence from school continue to be a key challenge in several wards.

Department of Health Visit
The Department of Health (Equity and Communities) and Public Health England are collaborating and sharing resources to tackle health inequalities. They will be visiting Margate and talking to the various partner agencies Colin Thompson will be coordinating the visit; date to be confirmed.

Dual Diagnosis: Care Improvement
A revised partnership joint working agreement to improve care for individuals with a mental health and a substance misuse condition (dual diagnosis) has been agreed by the Strategic Steering Group for Kent and Medway in March 2016. This will be supported by a Kent and Medway Partnership Trust dual diagnosis policy, a care pathway, training and webbased resources for practitioners. It will be implemented with immediate effect and promoted in the coming months.

The report was noted.

Meeting concluded: 11.20 am

WEST KENT HEALTH AND WELLBEING BOARD
DRAFT MINUTES OF THE MEETING HELD ON 19 APRIL 2016

Present:

Dr Bob Bowes - Chair	Chair, NHS West Kent Clinical Commissioning Group (NHS WK CCG)
Alison Broom	Chief Executive, Maidstone Borough Council
Cllr Pat Bosley	Sevenoaks District Council (SDC)
Penny Graham	Healthwatch Kent
Dr Tony Jones	GP Representative, NHS WK CCG
Mark Lemon	Strategic Business Adviser, KCC
Dr Andrew Roxburgh	GP representative, NHS WK CCG
Dr Caroline Jessel	Clinical Transformation and Outcomes Lead, NHS England (NHS E)
Malti Varshney	Public Health Consultant KCC, NHS WK CCG
Cllr Lynne Weatherly	Portfolio Holder, Tunbridge Wells Borough Council (TWBC)
Cllr Maria Heslop	Tonbridge & Malling Borough Council (TMBC)

In Attendance:

Ian Ayres	Accountable Officer, WK CCG
Satnam Kaur	Chief Housing Officer, TMBC
Hayley Brooks	SDC
Stephanie Holt	KCC
Karen Hardy	KCC Public Health
Val Miller	KCC Public Health
Jane Heeley	TMBC
Tracey Beattie	TWBC
Yvonne Wilson	NHS WK CCG (Minutes)
Linda Hibbs	Kent Housing Group
Heidi Ward	T&MBC
Andrew Holmes	Department for Work & Pensions, JobcentrePlus, Tonbridge
Jeremy Cross	Citizens Advice Bureau
Eleanor xx	Citizens Advice Bureau
Mr Walsh	Member of Public

1. WELCOME, APOLOGIES FOR ABSENCE AND SUBSTITUTES:

The Chair welcomed everyone to the meeting, especially Penny Graham, the new Healthwatch representative on the Board and Mr Walsh, member of the public.

Apologies had been received from the following Board members:

Cllr Roger Gough	Kent County Council
Lesley Bowles	Chief Officer for Housing, Health, Communities and Business, Sevenoaks District Council – Substitute, Hayley Brooks)
Reg Middleton	Finance Director, NHS WK CCG
Gail Arnold	Chief Operating Officer, NHS West Kent CCG
Dr Sanjay Singh	GP representative, NHS WK CCG
Julie Beilby	Chief Executive, Tonbridge & Malling Borough Council (TMBC) – Substitute, Jane Heeley

Cllr Annabelle Blackmore	Maidstone Borough Council
Gary Stevenson	Head of Environment & Street Scene, TWBC – Substitute, Tracey Beattie
Penny Southern	Director of Disabled Children, Adults, Learning Disability & Mental Health, KCC

2. DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS

There were none.

3. MINUTES OF THE PREVIOUS MEETING HELD 16 FEBRUARY 2016

3.1 The minutes of the previous meeting were agreed.

4. MATTERS ARISING

4.1 The Chair, Bob Bowes reported on the following Action Points from previous meetings:

9/15: CCG formally recruited a GP, Dr Brynn Bird to the role of Clinical Lead for Children

11/15: Active Travel Strategies and Plans – Still awaiting feedback from the TWBC Officer who co-ordinated the Board report to be able to draft letter to MPs as agreed at the xx meeting. ***ACTION:*** TWBC. LTP4 Consultation due in May 2016.

4.2 The Chair reported that work was now underway to establish the Self Care Task & Finish Group including the identification of group membership; governance; tasks to support the delivery of the implementation plan and meeting dates. Progress update will be scheduled at a future Board meeting. ***ACTION: YW/T&F Group Chair***

4.3 The Chair reported that the Frail Elderly Task & Finish Group had been established and met once since the last Board meeting. ***ACTION: YW/T&F Group Chair***

5. KENT HEALTH & WELLBEING BOARD

The Chair read out the following report from the Kent HWB Chair on key issues from the Kent Board meeting:

5.1 The Board considered Kent's Better Care Fund submission for 2016-17 and agreed that it should be signed off by the Chairman, working with the formal processes of the CCGs and local authority

5.2 As is usual at the March meeting, commissioning plans for the coming year were reviewed and approved. Plans were considered in the light of their compatibility with the Health and Wellbeing Strategy, their contribution to transformation and integration and fulfilment of the nine 'must do's' in recent NHS England guidance

5.3 Proposals to enhance the operation of the JSNA, emerging from the September 2015 conference, were approved to be taken forward

5.4 The formal part of the meeting finished a little earlier than usual to allow Board members to undertake a full hour's informal discussion of the implications of the STPs, in particular for the role of the Board. Options including a strong role for a reshaped Board in STP governance, and a strong role for the Integration Pioneer, were discussed. There were a variety of views but agreement that the Board must engage fully with the STP if it were not to see its relevance much reduced, and also that strong clinical engagement was vital.

6. NEW PLANNING ARRANGEMENTS FOR HEALTH AND SOCIAL CARE

6.1 Ian Ayres, Accountable Officer, NHS WK CCG gave a presentation which provided the CCG's perspective of the key drivers for change in the health service (and social care) arena; new requirements for planning and delivering services 2016 - 2021; priorities and new models of care; local financial framework and the wider policy context.

6.2 Mr Ayres outlined the new requirement on health service stakeholders to establish stronger collaborative partnerships to deliver financial stability in the healthcare system based on the reversal of the separation of the commissioning and provider functions (which had been the thrust of healthcare policy and practice for more than 20 years) and development of new service models. Across the country, 44 planning 'footprints' (defined geographic areas) are now the focus for the creation of a 'place based' Sustainability and Transformation Plan (STP) that sets out the steps for delivering balanced finances for the whole system by 2021. STP must be submitted by June 2016. Each organisation in the system must also produce a 1 year Operational Plan that relates to the overarching STP. Operational Plans must be submitted by April 2016. Mr Ayres highlighted the financial challenges facing the NHS including delivering £22billion efficiency savings. 'System leaders' have now been agreed in each of the 'footprint' areas. The planning footprint is Kent and Medway. The system leader is Glen Douglas CEO, Maidstone & Tunbridge Wells NHS Provider Trust.

6.3 Mr Ayres outlined NHS England's objectives for 2016/17 – which placed strong emphasis on tackling inequalities, addressing poor outcomes, driving improvements in quality of care and experience of care, and prevention of ill health and support for people to live healthier lives. Mr Ayres emphasised that the role of the Health and Wellbeing Board and contribution of partners across the local authorities in West Kent and community sector was vital in delivering these ambitions and the local priorities expressed in the Health and Wellbeing Strategy and West Kent profile. Mr Ayres also explained that the CCG was committed to working with KCC on the Integration Pioneer framework.

6.4 Mr Ayres concluded his presentation by directing Board members to pp10-12 and 14, 15 of the accompanying presentation which reflected the national context and the CCGs local priority themes, population groups and financial matters:

- Nine must do's for 2016/17 NHS England Planning Guidance
- Planning Priority Themes (including working with local councils; Frailty; Dementia; avoiding the need for Urgent Care – which links with WK HWB work streams around self-care, social prescribing and the Frail and Elderly
- NHS WK CCG allocations and Draft Financial Framework

6.5 Points shared in discussion included:

- Caution, not to underestimate the scale of challenges facing the NHS (£22bn savings) as this has never a requirement (ML).
- Need for the public to better understand that hospital/health services will look radically different in the future (ML)
- Devolution is another factor of which to be mindful (ML)
- Acknowledgement of the scale of challenges facing health and other partners and particularly in light of local appreciation of the change in the character of local populations, plans for housing growth/spatial planning matters.(AB)
- CCG has new role in the commissioning of primary care services and an invitation will be extended for a representative from the WKHWB to sit on the CCG Primary Care Committee (BB)
- Need to discuss opportunities for 'cross-fertilizing' workforce at grass roots level/consider opportunities for better use of workforce (DrTJ)

6.6 The Chair thanked Mr Ayres for his presentation and reminded members of the need to reflect on the relationship between the issues highlighted and WK HWB responsibilities. **ACTION: BB**

7. WELFARE REFORMS AND HOUSING PLANNING BILL (2015 – 2016): IMPACT ON HEALTH

7.1 The Chair introduced Andrew Holmes DWP and Satnam Kaur, TMBC who were invited to present the two main areas of the report's focus, welfare and work related measures, housing measures and potential impact. The Chair invited Board members to assess any likely responses in relation to the Board's ability to "control; influence and affect any change".

7.2 Andrew Holmes reflected on the challenges facing DWP and its customers in light of the Government's Welfare Reforms which requires public bodies like DWP to do more but with fewer resources. DWP was now looking at ways of increasing effectiveness, making better linkages with health and building relationships that might assist the clients/patients who were often accessing both services. Mr Holmes

emphasised that DWP was not looking to interfere with the patient-GP relationship or GP decisions. DWP is interested in creating better understanding about other support available to help patients back to work.

7.3 Mr Holmes outlined initiatives being trialled in other parts of the County with partners including the CAB; the promotion of better use of the 'Fit Note' and other developments including JobcentrePlus participation in GP training programmes which was seeking to enable better outcomes.

7.4 Comments and questions in discussion included:

- Format of previous Protected Learning Time Event with Jobcentre Plus had not been successful, different approach to strategic discussions needed
- Acknowledgement required that there were no 'simple solutions'; change likely not to happen using 'traditional' methods – role for therapy; third sector 'unofficial' sector also has an important role to play and sustainable funding principles/arrangements were key
- When considering the potentially complex circumstances of patients/JobCentrePlus clients opportunities for building confidence, skills in 'alternative routes' to work were needed
- Need to consider external funding resources e.g., 'Tomorrow's People' Project in MBC; Building Better Opportunities Fund to create opportunities for people furthest away from the jobs market that helps with skills development and to bridge the divide between work and ill health in its different forms. 12/05/2016 decision on external funding for Kent districts. (AB)

- WK HWB and local GPs interested in and committed to developing approaches to Social Prescribing as in other areas this was helping individuals and communities establish a sense of belonging and cohesion. Important to recognise strong local interest in this (recent events at which pioneer, Sir Sam Everington spoke was evidence of this). Recognition this was chance to release resources.

7.5 Satnam Kaur, Chief Housing Officer at TMBC presented those sections of the report outlined in pp5 -11, which considered the links between the welfare and housing reform measures and health. Ms Kaur summarised the main issues as follows and emphasised the interconnectedness of the new measures:

- Fundamental shift in the approach to housing need
- Pledges in relation to Home Ownership
- New definitions of Affordable Housing
- Expansion of 'Starter Homes'
- Wider housing market conditions were set to have local impact (Rising Property Prices and Rental levels)

- Changes within the Social Housing sector (end to life-time tenancies; extension of Right To Buy; introduction of Pay To Stay)
- New Definition of Child Poverty
- Benefits rate freeze
- Rent Reductions
- New eligibility criteria for benefits, including further reductions to benefits cap
- Young People Housing related benefit restrictions

7.6 Ms Kaur reflected on early indication of the effects in West Kent; drew the attention of Board members to section 5 of the report on 'cumulative impacts of the reforms on health and wellbeing: implications for West Kent' and offered examples of some characteristic features emerging from the changes including:

- Rise in number of evictions (private landlords issuing notice to quit)
- Rise in waiting lists for housing – across West Kent 3500 people on waiting lists and unable to access market products (Challenges exist for Local Authorities with regards to meeting statutory duties)
- Increase in homelessness
- Rise in need for temporary housing/longer stay in temporary accommodation
- Increasing financial hardship (including as a result of rise in private sector rents)
- Increase in overcrowded households
- Private sector housing becoming increasingly unaffordable
- Benefit Cap – likely new impact will affect 2-3 bedroom households

7.7 Ms Kaur encouraged the Board to consider areas where they had the potential to intervene to mitigate negative effects of the reforms and shared some examples of good practice across West Kent. Ms Kaur commended the report to Board members and invited careful consideration of the recommendations as set out in section 8 of the report.

7.8 Comments and Questions in Discussion:

- Partners poised to support local GPs in serving their patients better, whilst also respecting the GP role and client confidentiality. Other agencies can offer advice and sign-posting around a broad range of issues such as debt/money management; relationship breakdown and welfare/benefits using volunteer advisers in different settings across West Kent.
- Recommendation on Making Every Contact Count within all the agencies in West Kent should be given the highest priority by the Board (Need to articulate what it means for Every Contact to Count and ask Commissioners to ensure it happens).
- Scope for boosting GP knowledge about what other sectors can offer, e.g., housing professionals access people in their own homes and are well-placed to sign post

- Needs careful thought about the most effective/appropriate models for communities as there is some experience of establishing projects yet, these were not accessed by patients
- Good evidence base exists which can assist in identifying initiatives that deliver good outcomes e.g., network of advice providers who have agreed a local referral protocol (Currently, 30 providers are offering cross-referrals)
- Across West Kent, different demography in communities so a number of different approaches needed.
- Advice services can also offer home visits; focus on needs and tailor services and support where needed (e.g., specific to frail elderly people)

7.9 The Chair thanked Ms Kaur, Mr Holmes for the presentation and other officers for bringing the report to the Board.

7.10**RESOLVED:**

a) That the Board agree to all the recommendations laid out in the report and as there are a number of existing partnership bodies within the housing arena give further consideration to the most appropriate mechanism for seeking delivery of the recommendations and points highlighted in the accompanying discussion.

b) Ensure clarity about what it means to a service user, if 'every contact counted' and ensure services which seek to deliver on that ambition are effectively commissioned. *ACTION*: Malti Varshney and Hayley Brooks to establish a Task & Finish Group to determine how to assure delivery of the actions agreed.

8. GROWTH AND INFRASTRUCTURE FRAMEWORK (GIF)

8.1 Stephanie Holt, Head of Countryside, Leisure and Sport at Kent County Council, gave a short presentation on the work carried out to date to develop a comprehensive picture of the plans and needs linked to the development and delivery of housing and economic growth which also includes associated infrastructure such as roads, rail, public services (including health facilities).

8.2 Ms Holt explained how the GIF had been developed to date covering the period up to 2031, with full endorsement from Kent County Council in July 2015 and Kent leaders in September of the same year. The GIF was intended to identify infrastructure priorities and inform a sustainable approach to funding infrastructure. A 10 point action plan has been created to enable a framework for sustainable and effective approach to planning, investing and delivering infrastructure that supports growth.

8.3 Ms Holt outlined the importance of securing the Health and Wellbeing Board support to strengthen the health and social care information within the existing

Framework document and refine the evidence base. Ms Holt explained that in time, the GIF will provide an essential tool capable of informing conversations about growth across the County; inward investment and in helping to situate Kent's position in relation to the capital and region-wide.

8.4 Board members suggested the following useful information sources be accessed:

- CCG Business Intelligence Unit
- CCG GP data set out in the Quality Outcomes Framework
- Sustainability and Transformation Plan – *when produced*
- West Kent Health and Wellbeing profile
- Respective local authorities

8.5 **RESOLVED :**

a) **That the report recommendations are duly noted by the WK HWB**
b) **Ms Holt invited to make contact with each borough planning department, and CCG Business Intelligence Unit**

9. <u>OBESITY TASK AND FINISH GROUP</u>

9.1 Jane Heeley, Task & Finish Group chair introduced the report on the work carried out to address obesity at a population level in West Kent. Ms Heeley reported to the Board that the comprehensive review included a detailed mapping exercise and assessment of the Strategic Action Plan for Healthy Weight. This work had been undertaken by the Task & Finish Group members, supported by a wider group of colleagues who have been consulted on the proposed actions to address obesity.

9.2 Ms Heeley explained that the report included three appendices (the mapping exercise; a report on the local contribution to the Public Health England Change4Life campaign with a sample selection of resources used on display for Board members to view). The strategic action plan had been updated and outlined the intention of the Task & Finish Group to develop the 'total place' principle/approach endorsed by the Board to future work.

9.3 Ms Heeley explained that the mapping template (appendix 1) is organised around four main themes under which suggested actions, partner agencies, timescale, funding and additional effort required to ensure outcomes are set out:

Theme 1 – Environmental and Social Causes of unhealthy weight;

Theme 2 – Give every child the best start in life and into adulthood;

Theme 3 – Develop a confident workforce skilled in promoting healthy weight; and

Theme 4 – Provide support to people who want to lose weight.

Ms Heeley advised the Board of a particular area of major concern around Theme 3 - development of workforce skills to provide brief interventions and implement 'making every contact count'- and explained that this delivery action requires a focus by all partners.

9.4 Ms Heeley advised Board members that The Task & Finish Group had recently signed up to the Community of Interest for this research project recently commissioned by PHE, Local Government Association and the Association of Directors of Public Health. This is a three year programme exploring with local authorities and other partners what a whole systems approach to tackling obesity might look like on the ground. The goal is to produce a draft road map by the autumn of this year and publish it in final form by September 2018. Ms Heeley commended the review to the Board and invited consideration on the recommendations at section 5 of the report

9.5 Responses from Board members:

- The Chair welcomed the review of work and thanked Task & Finish Group members, the Board's Obesity Champion and Jane Heeley. The issues highlighted in the review report and appendices now needed to be addressed.

- Workforce development issues were vital to the success of this and other areas of the WK HWB work, and is acknowledged as a priority area of work.

- The Task & Finish Group was asked to give greater consideration to interventions designed to promote better engagement with local people (particularly with sections of communities who were 'seldom heard)' and to encourage active and empowered communities.

9.6 **RESOLVED: That the Board accept the recommendations set out in the report:**

a) Approve the revised Strategic Action Plan for Healthy Weight and agree to its presentation to the Kent Health and Well-being Board. ACTION: VM, JH

b) That KCC and CCG will produce integrated commissioning plans that clearly identify how excess weight is addressed in a systematic way, including tiers 1 to 4 and across all age ranges. Preventative services and evaluation methods should be included as core components of these plans. ACTION: KCC, CCG

c) Principle partners are brought together to review how Theme 3 – Developing a confident workforce, skilled in promoting Healthy Weight, in the mapping template can be addressed. If this is found to be a Kent wide issue, it is recommended that the Kent Health and Well-being Board requests a county wide review. ACTION: BB, YW

d) Healthwatch and PPG representatives are invited to become champions for this agenda. ACTION: YW, SI/PG, SS

e) The Task and Finish Group identify a programme of campaigns associated with healthy weight and promotes these through partners with the assistance of Media and Communications colleagues. ACTION: JH, LW, T&F Group, KCC, LAs

10. ANY OTHER BUSINESS

10.1 Future Agenda Item

Development of Local Children's Partnership Groups agreed as an agenda at the June meeting. Thom Wilson (Head of Strategic Commissioning, Children's Social Care, Health & Wellbeing, KCC) and the four local Chairs to be invited to present a report.

10.2 Re-Election of Chair and Vice-Chair

The Chair advised the Board that the current Terms of Reference made provision for the re-election of its officers annually and that this would be done at the June meeting. Bob Bowes reported that he would seek re-selection to the position of WK HWB Chair.

10.3 New NHS West Kent CCG Primary Care Committee: Recruitment Lay Member

Chair Bob Bowes reported that NHS West Kent CCG had taken on co-commissioning of GP services and had set up a new Primary Care Committee on which the CCG was seeking lay and independent members on this body which would drive developments in new approaches to primary care. A formal invitation to join the new Primary Care Committee was extended to a member of the WK HWB. The CCG was seeking an individual with an interest in developing out of hospital services

11. DATE OF NEXT MEETING

Tuesday 21 June – Maidstone Borough Council.